Research on Canadian Values in Relation to Health and the Health Care System

Final Report

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OVERVIEW

HEALTH CARE AND VALUES: CURRENT CONSENSUS AND EMERGING DIVISIONS

It has become something of a truism to note that public debate about the health care system must ultimately confront the issue of values. But beyond the broad consensus that the health care system is profoundly linked to core societal values, what are the nature of these connections? More importantly, what are the real world implications for the future of the health care system?

These are difficult questions which are made even more challenging by the somewhat amorphous nature of the notion of "values". A rational economic framework may provide more precision in estimating the cost/benefit ratios of various options, but it also runs the risk of missing the essential foundations of the debate in the public's mind. The current research vividly underlines the difficulty of applying a purely rational calculus to these complex problems.

The National Health Forum has squarely acknowledged the centrality of values in the debate about health care. This research project examines the role of values in the debate about health care. It attempts to refine our understanding of the way that values shape public preferences for the future of health care in Canada. This research builds on existing quantitative research on values and health care conducted under the aegis of the *Rethinking Government* project. Quantitative survey research provides a useful but limited vehicle for understanding this problem. The current project uses a combination of linked qualitative and quantitative research tools in order to secure a deeper insight into this problem.

If we understand values broadly to refer to relatively stable cultural propositions about what is deemed to be good or bad by a society, then we are close to the definition used in this study. This normative domain can only be roughly approximated in survey research. The current research uses qualitative focus groups to approach this problem. It also uses concrete *scenarios* specifically designed to provide real world examples of the nature of the tradeoffs involved in deciding about the future of health care. Both the discussion and the actual decisions made by the groups are designed to illustrate the underlying values (or interests) which are most instrumental in shaping public judgements. It is important to note that values do not operate in isolation. It is the potent interaction of strong values and high vested interests which produces such high levels of concern about health care. Once we combine various images and knowledge about health care, with a general sense that the system is under pressure, we have an incendiary combination.

The current research also includes a hybrid quantitative design. The broader communities where groups were conducted were surveyed in order to provide statistically reliable data. We also measured focus group participants before and after the discussion sessions to assess the impact of talking about these questions. Finally, we rotated the application of a basic package of "objective" information in order to test the impact of this knowledge on attitude formation. Together these design refinements provide a strong basis for assessing the role of values in this debate. Following are some of the key themes emerging from this exercise:

Basic Images and Concerns: The Emerging Defining Issue?

The groups revealed an unusual mixture of concern and eloquence. Few topics we have researched generate such a blend of articulate and passionate responses. It is the powerful interaction of strong vested interests (everyone can get sick, all will die) and powerful values (pride, equality, compassion, national identity) which produces the capacity for more heat than light in future debates.

Images of the health care system are incomplete and dominated by the more visible, traditional institutional structure (viz. hospitals, doctors). There is a broad consensus that the Canadian health care system is a collective accomplishment, a source of pride and a symbol of core Canadian values. The values of equality, access and compassion are salient to perceptions of the system and often held in contradistinction to perceptions of the American system. Moreover, the system is seen as relatively effective and sound. It may be the only area of current public endeavour which is seen as a clear success story.

It may then be ironic that this singular public success story is also seen as under clear threat. There is a consensus that the system is under acute pressure. The public are increasingly wary of the signals and actions they see in this area and feel frustrated with changes which are clearly producing declining confidence. Unlike other areas of public endeavour, where there is a sense that the system doesn't work, or costs far too much, the public are actually satisfied, comfortable and even proud of the health care system. It is therefore not surprising that they feel frustrated and frightened by ominous signals about its fragility.

This sense of declining confidence is fuelled by a barrage of messages and real world examples of declining service. The public perceptions of problems in the health care system reflect many of the themes evident in broader concerns about government. One of these themes is a growing wariness of "expert" prescriptions for the health care system. Participants spoke of conflicting interests of different expert stakeholders (e.g., doctors advising on the use of alternative medical practitioners with whom they compete). Although trust in individual doctors remains high, there is deteriorating trust in the broader profession. The expert-public gap on the debate about health care is a recurring theme of broader research. With the stakes so high, and strong perceptions of mixed motives amongst various experts, the public are insisting on inclusion and real influence on these issues.

The participants seemed to believe that the affordability problems currently plaguing the system are the legacy of abuse and mismanagement. Much like broader views on government overspending, it is much easier for participants to attribute this to waste or inefficiency than a fundamental shortfall in public resources against services delivered. This conviction of abuse and inefficiency was pervasive and often alloyed with numerous real world examples (e.g., doctors overprescribing, patients burdening the system with frivolous ailments).

Does dialogue matter? Does information matter?

The research design supports the conclusion that talking about these problems has a significant impact on attitudes and judgements. It also shows a modest but somewhat puzzling impact from providing basic information. Further testing of "deliberative" impacts, however, is necessary before drawing conclusions about the impact of information.

By far the more important influence was the simple process of sitting down and talking about these issues in a small group. Three major impacts were detected as a consequence of discussing the issues:

(i) People became more confident in the system. The sense of imminent decline (and perhaps collapse) of the current system was significantly lower after these discussions occurred. This suggests that there are exaggerated fears about the system which can be somewhat calmed through a process of dialogue.

(ii) The role of values increases and the role of economics declines. Participants are more likely to see the debate as essentially about values rather than economics following the discussion. This reflects a broader tendency for the groups to reject a rational calculus in approaching health care. This may partly reflect the social psychology of small group discussions where moral imperatives are more "socially desirable" than pecuniary criteria.

(iii) Issues around two-tier produce polarization. Of those going to groups, the clear majority changed their views about two-tier issues. Unlike the change in values or confidence (which produced greater consensus), the groups generated stronger polarization on the two-tier issues. This may well serve as a harbinger of the eventual divisiveness of the two-tier issue in the real world. Interestingly, most of the other values and attitudes tested were fairly stable.

Soft Resolve Around Hard Choices

The groups had great difficulty with many of the choices. In summary, we can conclude that most groups eschewed a rational calculus of decision-making where real human welfare (i.e., illness) was seen as threatened. Despite the apparent plausibility, or even inevitability, of many of the tradeoffs and choices presented, the groups were ingenious at avoiding the hard choices. Often the basic premises of the exercise (e.g., we simply can't afford to do this any more) were rejected. We get the sense that public and experts do not share a common universe of discourse about the public policy issues.

Whatever the reasoning or judgement involved, this finding has important implications for the Forum. If the public reject hard choices even in the controlled environment of a small group, with specific scenarios designed to illustrate the points, then the prospects for a rational debate in the broader public arena are even lower. This finding reconfirms a consistent conclusion of other research in this area — the gap between expert rationality and public values. It would be prudent to acknowledge the public's entrenched resistance to a purely economic mode on health care.

The Priority of Values Over Economics

Another way of seeing this question is by noting the pre-eminence of moral considerations over economic considerations. The core values which seem to be impervious to economic questions are accessibility and the quality of the system itself. These link to other values such as security, well-being and compassion. It is also important to note that these issues are being connected (spontaneously) to issues of national identity and national unity. In the aggravated unity environment following October 30, and in a world where federal withdrawal is registering uncertainties and anxieties about our societal character, the issue of health care assumes even greater symbolic significance. Particularly in English Canada the connections of preservation of health care to the maintenance of a distinct Canadian identity is an important issue.

Innovation: Pragmatism, Scepticism and Guarded Receptivity

The groups tested attitudes to a number of forms of innovation (e.g., shift to a more prevention-based approach, more family responsibilities for care-giving, private clinics, "alternative" medical approaches). A number of key conclusions are evident. First, people were generally loath to tradeoff elements of the current system against the promise of better or fairer future performance. This reflected a general scepticism that reform and innovation may well be code for withdrawal. It also reflects fairly high attachment to the current system, which is seen as successful. Why trade the uncertainties of potential improvement in results, fairness or costs against the proven security of a working system? It was not that people could not appreciate the value or logic of innovations, but rather that they were reluctant to exchange innovations for the core system. Receptivity varied by area tested.

Alternative medical approaches received relatively strong support — although not as a replacement for the traditional system but as a complement, the key criteria here were pragmatic (what works). Preventive approaches and social programming to reduce health costs were understood in principle, but rejected in practice. The logic was too speculative, the payoff too delayed, the potential for abuse too high, to justify a major shift from current approaches to prevention. These approaches were fine, up to the point where they threatened treating sick people (the way we currently do). This reflects our earlier quantitative research showing that enthusiasm for innovation declines as one worries about one's personal health.

The issue of increased family responsibility for the care of sick family members was rejected outright. It was seen as a particularly offensive and intrusive form of off loading broader societal responsibilities.

The issue of private clinics and "two-tier" systems deserves special attention. Although championed by many (including a growing number of doctors) as a solution to the fiscal problems confronting the health care system, private clinics are clearly rejected by most participants. They are seen as a part of a slippery slope which will lead to an American style system and sacrifice the core values and merit of our system.

Although this conclusion is largely consistent with our earlier research, we offer the following caveat. There is evidence of growing support for private clinics and other two-tier features, particularly in the quantitative component of this research. The potential support for two-tier may well be understated in the focus groups. In fact, those supporting these approaches are rather meek in the face of strenuous group support for more socially desirable values such as compassion and equal access. Yet the quantitative data show growing (albeit still minority) support for two-tier. Moreover, there is heightened polarization which is clearly connected to one's sense of economic and health security. Health and wealth are also strongly interdependent.

In general, we find that enthusiasm for terms such as innovation, efficiency, freedom of choice and prevention is systematically higher amongst the more secure members of society. Stripped of the moderating influence of the group, the quiet power of the checkbook may well provide a more rapid tilt to two-tier approaches, once these options take root in the medical market place.

Final Synthesis

The public is highly concerned about the health care system and it may well be emerging as the defining issue for governments in the near future. People are proud of the existing system and see it as a source of collective values and national identity. They are worried about the future viability of the system and are resistant to many of the options/alternatives currently on the table. Cynicism about change is high and the public reject many of the premises for "reform". They believe cost problems are rooted in mismanagement and abuse and would prefer to see these dealt with first. Failing this solution, people prefer fuelling the system with new public resources in order to preserve its integrity and core values.

The public will be resistant to a rational discourse on the costs issues because they are more likely to see these issues in terms of higher order values. The evidence suggests that further dialogue will tilt the debate more to values than economics. The public will insist on inclusion and influence in this crucial debate and they will reject elite and expert authority. Finally, we predict growing division around two-tier questions with heightened support for those who see this option serving their personal economic or health interests.

CHAPTER

1 INTRODUCTION

1.1 Study Objectives

In establishing the broader public policy context within which health care issues are currently situated, the drive to reduce public indebtedness looms large over the horizon. At both the federal and provincial level, the 1990's has confirmed deficit reduction as the dominant factor over program and resource decisions. The dominance of the deficit reduction agenda has been premised, however, on the promise of something more tangible than a clean balance sheet. At the federal level, for example, great emphasis has been placed on the linkage between deficit reduction, economic prosperity and sustainability of cherished programs such as health care.

In pursuing these principles, governments have attempted to prioritize their existing spending habits requiring extremely difficult choices over what to preserve, what to reduce and what to eliminate. Inevitably, health care, as the single largest consumer of public expenditures, has been central to this debate and both provincial and federal governments have begun to struggle with these tough choices.

At the same time, there can be little doubt that the issues surrounding the country's health care system have gained significant currency in recent years because they touch cherished and core values of Canadians. Indeed, at a time when other traditional elements of the Canadian value system have been placed under demonstrable stress, health care has increased in both importance and prominence as a shared and common value. In fact, health care has always engendered strongly positive characteristics among Canadians: shared risk, compassion, fairness and common responsibility. In recent years, however, its significance has broadened into symbolic terms as a defining characteristic of being Canadian, one of the national tenets of our citizenship.

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#1 The purpose of this research was to help decision-makers and stakeholders understand the values and priorities that Canadians want to see reflected as health care in Canada evolves to meet the public policy challenges of the coming years. Specifically, the two prime research objectives of this study were:

? { #2 ☐ to conduct a focused dialogue about health with a cross-section of Canadians; and

#3 ☐ to identify underlying values and tradeoffs.

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1.2 Organization of this Report

The qualitative and quantitative results are presented separately. The following chapter presents the findings of the focus group research. Chapter three is devoted to an analysis of the quantitative data produced by this study. The fourth and final chapter of this report contains a synthesis and integration of the key focus group and quantitative findings and presents the conclusions of the study. This reports also contains five Appendices. Appendix A includes the text of the eight scenarios which were discussed in the focus groups. Appendix B contains the moderator's guide. The handout used in the deliberative exercise is presented in Appendix C. The survey questionnaire used to collect all of the quantitative data is found in Appendix D. Finally, verbatim comments on the health care system are found in Appendix E.

CHAPTER

2 QUALITATIVE FINDINGS

This chapter presents the findings of the focus groups. A brief discussion of the methodology is followed by summary findings for each of the eight scenarios tested in the groups. A separate summary of the focus group with aboriginal Canadians is provided. Where appropriate, notable differences according to group composition (e.g., location, age, activist *vs.* general public) are highlighted.

2.1 Focus Group Methodology

(a) Location and Composition of Groups

A total of 18 focus groups (including two pretest focus groups) were conducted in five different regions of Canada between April 9 and May 7, 1996. Exhibit 2.1 presents the details regarding focus group location and composition.

As indicated in the exhibit, the design of the research aimed to include the participation of a cross-section of Canadians. Additional details on the selection criteria are presented below.

EXHIBIT 2.1
Language and Composition of Focus Groups

Location	Group Type	Deliberative Exercise
Ottawa (2) (pilot)	General population (25-60 years)	
	General population (25-60 years)	✓
Halifax (2)	Activists (25-60 years)	✓
	General population (25-60 years)	
Montreal (2)	General population (60+ years)	
	General population (25-60 years)	
Quebec City (2)	Activists (25-60 years)	✓
	General population (25-60 years)	
Windsor (2)	Activists (25-60 years)	✓
	General population (25-60 years)	✓
Sudbury (2)	General population (60+ years)	✓
	General population (25-60 years)	✓
Regina (2)	General population (Aboriginal)	
	General population (25-60 years)	✓
Edmonton (2)	Activist (25-60 years)	✓
	General population (25-60 years)	
Vancouver (2)	Activists (60+ years)	
	General population (25-60 years)	✓
TOTAL	18 focus groups	10 deliberative exercises

- ☐ *Centre Size:* Both large cities (e.g., Vancouver, Toronto, Montreal), as well as smaller centres (e.g., Regina, Quebec City, Sudbury) were selected as it was anticipated that residents from smaller centres may have different views/concerns about the health care system.

☐ *Age:* 1) People under 25 years of age were excluded because they were expected to be somewhat detached from the issue of the health care system and, thus, would be less involved participants in the groups. 2) Four groups with individuals aged 60 years and up were formed to ensure that the particular views of this important segment of the population, especially in the context of health and the health care system, were collected in the research.

☐ *Language:* Four groups (in Quebec) were conducted in French with the remaining groups being conducted in English.

☐ *Activism:* We conducted four groups with a subset of the Canadian population who are more involved in current issues as past research has demonstrated that this third of Canadians tend to have a significant influence on public policy debates.[1]

☐ *Aboriginal Canadians:* A focus group with Aboriginal People from the Regina area was conducted.

Focus group participants were drawn randomly from the general public. Potential participants were contacted by telephone at their homes during the evening. Using a script, recruiters introduced the study to the people contacted, applied the screening criteria and invited those who met the criteria to participate in the study. Participants were offered a $50 honorarium for participating in the study.

A total of 145 people participated in the focus groups; there was an average of approximately eight participants per focus group.

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[1] Involved Canadians were determined on the basis of whether they had ever made a speech to a public audience, written an article for a publication, served as an officer of a club or organization, written a letter to the editor or called a television or radio talk show.

(b) Focus Group Implementation

All the group discussions were conducted in the evening (two sessions per evening) with each group lasting two hours. The focus groups were held in dedicated focus group facilities (where available) or hotel meeting rooms.

The two focus group moderators relied on discussion guides based mainly on questions provided by the National Forum on Health. The guide was designed to measure the depth of core attitudes and beliefs held by the study population with respect to the values involved in the debate around health and health care.

A core group of questions were used to initiate the discussion in all of the focus groups. These initial questions allowed participants a chance to begin thinking about the broader issues of values and health and the health care system and to provide spontaneous reflections on the study issues before the scenarios were presented.

Participants' views about underlying values were obtained by using eight "scenarios" (i.e., short stories) designed to highlight one or two key issues. The eight scenarios were selected by the research team, in consultation with the National Forum on Health, from 12 scenarios designed by the Forum. The eight chosen were those which the research team felt would be the most appropriate for use in the group discussions. While the scenarios were tested across all the focus groups, only two were discussed in any one particular group. This ensured that each scenario and its accompanying questions received adequate time for processing and reflection by focus group participants. Each scenario was tested in four different groups.

Participants were provided with a text version of the scenario and an audio-tape version. Participants were able to follow the scenario using their written version as the tape was played. The inclusion of the audio-tape version made it easier for participants to digest the content of the scenarios.

In 10 of the 18 focus groups, a "deliberative" exercise was conducted. This involved providing participants with some basic factual information about the Canadian health care system (see Appendix C). The moderator walked participants through six graphs and solicited their reaction to the material. The purpose of the deliberative segment of the groups, which lasted 10 to 15 minutes, was to assess whether or not providing participants with information had an impact on their views. Impact was measured in terms of participants' subsequent comments in the groups, as well as by comparing their responses to the pre- and post-surveys. (A description of this survey component is presented in the next section.)

(c) Caveat: Some Limitations of this Study

Focus group research has a number of inherent strengths and weaknesses. In comparison to survey research, one of the main limitations of focus groups pertains to the external validity of the findings. That is, the extent to which a finding is generalizable to the study population as a whole. Of course, focus groups are not meant to provide representative results; surveys are used for this purpose. Focus groups, rather, provide in-depth information about the core beliefs and felt experiences of people, particularly on complex topics.

The overall research design of this project was strengthen by the addition of a quantitative component (this component and its results are described in Chapter 3). It is important to note, however, that even with the addition of the quantitative component, the results are still not, strictly speaking, generalizable to the

Canadian population. This is particularly the case when one begins to narrow the unit of analysis to specific types of participants. This study included dedicated groups with seniors and one focus group with aboriginal Canadians. This was done in an effort to ensure that a wide-range of people had an opportunity to participate in the study, not as a way of ascribing the results generated form these groups to the broader population. Similarly, the data were not analyzed based on other participant characteristics (e.g., gender, race, etc.). Particular caution should be exercised with respect to the findings generated from a single group of aboriginal Canadians.

2.2 Findings

This section begins with a brief analysis of participants' general perceptions of the health care system followed by a synthesis of participants' reactions to each of the eight scenarios examined in the groups. Complete texts of the scenarios are contained in Appendix A. The moderator's guide, which includes the questions posed to participants, is included in Appendix B. We suggest that the reader familiarize themselves with the scenarios and related questions before proceeding.

(a) Perceptions of the Health Care System

The initial series of questions posed to participants were aimed at obtaining information to help understand participants' "going-in" position on the broad topic of health care and values. Participants were ask to discuss, in a general way, their views of the health care system based on their personal experience. More specifically, they were asked to identify the key positive and negative aspects of the current system.

There was a tremendous amount of consistency in the views of participants about what the strengths and weaknesses of the health care system were. In a number of cases, participants took the opportunity to voice their concerns about the future of Canada's health care system.

Perceived Strengths of the Health Care System

Many participants prefaced their comments by stating that Canadians were very fortunate to have benefited from such a good system. Participants tended to describe accessibility/universality and quality as the twin pillars of the health care system, with accessibility being somewhat more important for the majority. Participants expressed approval and took pride in the fact that "both rich and poor" received the same quality of health services in Canada. Doctors were often praised for their expertise and ability, if not, as we shall see later, for their altruism and objectivity.

Perceived Weaknesses of the Health Care System

Participants' discussion of weaknesses was deeper, more varied and expressed mainly in terms of concern about the future. Participants agreed that the health care system was showing numerous and obvious signs of stress, and in some instances deterioration. Increases in the time patients must wait for treatment, hospital closings, reductions in service, the imposition or contemplation of user fees by governments, visibly overworked staff (mainly nurses), lack of specialists and the loss of doctors to the United States were most often mentioned as symptoms of stress.

When participants spoke about the future of the system, almost all did so in bleak terms. Taken together, participants' vision of the Canadian health care system in the 21st century was one which had become overburdened with aging baby boomers and "Americanized", complete with user fees and a growing gap between the level of care available to rich and poor. Few were optimistic about the possibility that breakthroughs in health research, medical technology, public awareness about health issues or improved health care management systems might coalesce to counter some of the more ominous trends identified by participants.

There was general agreement that the stress on the system was the result of fiscal pressures. Yet, most participants felt that these fiscal pressures were the result of mismanagement of the system (e.g., political expediency, poor administration, duplication, lack of planning, etc.) and patient and doctor "abuse" and misuse of the system. Other sources of fiscal pressure identified by participants included the rapid development of expensive medical technology and an aging population.

Abuse of the system was raised as a main concern in all of the group discussions, particularly in the focus groups with seniors. With respect to abuse of the system by patients, participants identified fraudulent use of the system (e.g., non-residents receiving treatment with health insurance cards) as a problem, but not the main concern. For most participants, the core problem was that too many Canadians were taking the health care system for granted: "People are running to the emergency room for things that could be handled in a clinic." A number of seniors remarked that too many of their friends and relatives paid unnecessary visits to their family doctor: "You know, sometimes these people are lonely and want someone to pay attention to them. They know their doctor will listen."

Most participants felt that patient "abuse", or misuse, was not usually the result of wilful misconduct, but, rather, the product of ignorance about the workings and costs of the system and, more importantly, the resulting poor judgement about appropriate courses of action to take when one is ill. Participants agreed that all Canadians needed to be educated about these issues.

Participants' views of doctors tended to be far less charitable. In all of the discussion groups, at least one or two, and often a majority of participants, felt that too many doctors were manipulating the system and their patients in order to further their own economic interests.

Participants identified two main types of "abuse" of the system by doctors. First, a number of participants complained that some doctors seemed to schedule "unnecessary" return visits. Seniors were said to be especially vulnerable to this practise: "They make you come back for return visits. You have to be vigilant and watch this. They prey on older people." The second prevalent example of abuse was the over-prescribing of drugs by doctors: "I had a bad sun burn. The doctor prescribed this cream, but it came in a huge bottle. I only needed a bit, so almost all of it was wasted." and, "There is a reason why doctors prescribe so much medication, they own the drug companies."

The general perception of most participants that fiscal pressures on the health care system were mainly the result of mismanagement and abuse is very significant. As indicated in the following sections, many participants were doggedly unwilling to restrict themselves to the narrow options and tough choices put forward in the scenarios and related questions. This reaction was apparently conditioned by their rejection of the premise which underlies the rationale for having to make the difficult choices. In short, many participants felt that the alternative remedies of improving the management of the system and eliminating abuse and misuse had to be exhausted *before* some of the options described in the scenarios could be contemplated.

(b) Scenario 1: Alternative Treatments and Medicines

There was consensus among participants that the cost of alternative medicines and approaches, such as acupuncture and chiropractic, should be covered by the health care system *if* they were proven to be effective. This pragmatic approach to the issue was largely based on participants' generally positive personal experience with alternative approaches. Many participants put forward anecdotes telling how they or someone they knew had benefited from chiropractic, acupuncture, homeopathy or other approaches: "My back bothered me for years. My doctor had me sleeping on a wooden board. I went to see a chiropractor and I've been okay ever since."

Despite participants' personal experiences and awareness of the existence of considerable anecdotal evidence to support the assertion that certain alternative approaches are effective, most agreed that consumer demand did not constitute sufficient grounds on which to base a decision to publicly fund an alternative health service, treatment or medication. The notion that consumers/patients should have an important say in the process held a great deal of appeal to participants, particularly in light of their perception that the "medical establishment" has fought against the inclusion of alternatives into the mainstream of the health care system. After some deliberation on the issue, however, there was general agreement that "scientific proof" or "medical evidence" was required before funding a procedure: "You have to know whether it works or not. You have to study it." In the end, there was agreement that if there was enough consumer demand for an approach to be covered by the health care system, its effectiveness should be objectively studied. If it were proven to be effective, the procedure should then be covered, at least partially. This requirement for scientific verification of results was supported even in the focus group with Aboriginal Canadians.

The question of what should be considered "effective" was discussed in some groups. Here too, participants were able to reach general agreement. For most, a procedure that "helped" a patient, or was proven to have a significant "positive impact" should be deemed effective for the purposes of making a decision about coverage. In support of this view, a few participants noted that a higher standard of effectiveness (e.g., a cure) was not warranted given that traditional approaches sometimes had no positive effect on patients.

The issue of who or what should judge the effectiveness of a procedure was also debated. Participants quickly found themselves in a quandary. On the one hand, they agreed that *medical evidence* was necessary. On the other hand, most felt that the majority of "establishment" doctors were biased against alternative procedures: "It would be like putting the fox in charge of the chicken coop." Discussion led participants to suggest that an "independent" body or panel should be charged with the task of judging effectiveness. Many suggested that this body be composed of various stakeholders with different interests and perspectives, including some from outside of the medical profession. Specific suggestions for panel members included doctors, nurses, representatives of the Canadian Medical Association, alternative health practitioners, academics, government scientists and officials, lawyers and patients/ consumers.

Participants' openness to examining the possibility of funding alternative medical procedures, such as acupuncture, chiropractic and homeopathy, was not carried over into the discussion of multi-cultural health care. Participants were given a number of examples and questions to react to, including examples of Native-Canadian medicine and the idea of allowing ethnic groups an approximately equal share of money spent on health care. Regardless of the example or question, most participants reacted negatively.

The fact that acupuncture and other alternative medicines discussed previously in the groups were not western medicines was seemingly lost on participants. Seniors in particular reacted negatively, as discussion of ethnic medical approaches and multi-cultural health care conjured up images of third world conditions and folk remedies. The issue was clearly disassociated from the other questions raised by the scenario about covering alternative approaches and negatively linked to immigration and native issues: "If they choose to immigrate here, they should content themselves with the system that we have", was a typical response.

(c) Scenario 2: Emphasizing Prevention or Acute Care?

Participants found the questions raised by this scenario very challenging. While people were drawn to the inherent appeal of the prevention argument, they also found it unconscionable that someone who was seriously ill should have to be put through the situation described in the scenario.

Understandably, many participants' first reaction to the question of which regional board had made the right decision (i.e., emphasize prevention or acute care), was that "both were important": "You need a large budget for prevention and a large budget for [acute] care." Quite a few participants tended to go outside the parameters of the scenario and related questions for solutions. These often revolved around "eliminating abuse and inefficiency" in the health care system. Other participants suggested that money for prevention not be taken from acute care budgets, but from other areas of government spending, such as foreign aid.

Most participants appreciated the prevention point of view. They believed that the systems ought to focus more on the broader determinants of health. Many felt that more emphasis on prevention could both provide a healthier population and result in long term cost savings. When forced to choose between one of the two approaches outlined in the scenario, however, the vast majority reluctantly said that emphasis should be placed on acute care. Almost all older participants and those who had indicated to the group that they had suffered a serious illness supported this choice. It seemed that when forced to choose, participants tended to see prevention programs as somewhat intangible in contrast to the awesome and concrete nature of acute care medicine. In addition, some participants expressed doubt about the effectiveness of prevention programs: "People will make [poor] lifestyle choices no matter what you tell them."

It was apparent from the discussions that most participants were uncomfortable with the idea of making choices in which a person's health would be negatively affected, perhaps to the point of dying. Similarly, there seemed to be an unawareness or denial among participants that these sort of choices are made every day: "You're talking about a human life!"

On the issue of regional variations in waiting lists, participants' initial reaction was one of puzzlement and some dismay. The situation described in the scenario struck them as "unfair". A broader discussion of decision-making in the health care system, however, led most participants to conclude that regional/local health authorities were probably in the best position to assign priorities because of their more immediate knowledge and appreciation of "local needs".

Should Private Clinics Be Allowed to Open?

The issue of whether or not to allow private clinics to open in order to give people more choice was discussed in depth. The issue was framed in terms of giving Canadians who face a medical dilemma similar to the one described in the scenario the option of paying for more timely health services. The issue generated a great deal of discussion among participants; it was clear they realized that the question of whether or not to allow aspects of private health care to take root in Canada was key to the future of the health care system.

On the whole, the views of participants were surprisingly mixed, at least initially. The discussion of pros and cons was most often characterized by pragmatism rather than principle and ideology. In the end, most participants opposed allowing private clinics to open. The question of whether these clinics should be partially subsidized was not discussed in detail since most were opposed to allowing people to pay for the *full cost* of private health services, let alone the partial cost.

Opposition to private clinics was rooted mainly in the fear that they would attract "all of the best doctors", particularly specialists, as well as the best equipment and support staff. Participants who opposed the suggestion mainly on principle feared that no matter how private clinics were run and regulated and despite assurances which might be given about the preservation and preeminence of the public system, the core value of equality of access would be compromised. Dilution of equality of access, these participants warned, would eventually cause the Canadian system to resemble its American counterpart, where "the rich get the best quality care and everyone else gets inferior care." Participants who mainly opposed private clinics on principle were more adamant in their opposition, while those who in the end opposed the idea on mainly pragmatic grounds tended to vacillate during the discussion.

Participants who supported the idea of allowing private clinics to open did not defend their view with vigour. Essentially, supporters indicated that private clinics were acceptable as long as the public system was maintained: "Private clinics are fine, as long as no one is denied medical treatment." Some participants talked about the importance of giving people a choice, others suggested that private clinics would relieve some of the pressure on the public system.

In response to a question on how health care was different from other commodities and services sold in the marketplace, participants agreed that its main difference lies in the fact that it was directly related to "life and death". Some also indicated that it was different because it was an important source of national pride and identity.

(d) Scenario 3: Shifting Resources from Health Care to Long-Term Prevention

The majority of participants who were asked to react to this scenario tended to side with the character (Mariella) who opposed shifting resources away from direct health care in order to pay for programs aimed at promoting the general health of the population (e.g., job creation, cleaning up the environment). It is important to note, however, that a number of participants had difficulty following the counter argument in favour of channelling resources away from treatment towards improving the health of the general population. This difficulty was at least partially due to the fact that the positive correlation which exists between better health and higher levels of employment and education was not mentioned in the scenario. To some participants, therefore, the ideas of creating jobs and cleaning up the environment had merit, but they had some trouble seeing how they were related to cuts in health care.

Once participants understood the connection between improvements in the environment, education and other indicators of socioeconomic status, some supported a slight shift in funding aimed at promoting the general health of the population: "It makes sense. It's a long-term strategy about treating the cause rather than the symptom." Most participants were much less sanguine and remained reluctant to take funding away from health care to pay for "prevention programs writ large", as one participant called it. Some participants said their opposition was mainly based on their inability to countenance a policy which would reduce health services, no matter how promising the long-term impacts of a prevention strategy were. For others, opposition stemmed mainly from a lack of confidence in governments' ability to achieve the intended impact of prevention programs (i.e., a healthier population): "The government has wasted a lot of money on job creation." and "There is no certainty about the [desired] long-term effects."

Overall, participants were divided concerning how much weight should be given to what patients and consumers want, as opposed to what the "experts" think, in deciding the level of public funding for health care. Their comments here, as well as in other segments of the focus groups, suggested that their confidence in doctors' and other "experts'" ability to make choices in the interest of the public had been seriously eroded: "Doctors look after their own interests just like everybody else." At the same time, participants evinced a great deal of respect for the doctors and the other health care professionals they dealt with on a *personal* level, along with considerable confidence in the ability and judgement of doctors in treating the individual patient. They also appreciated the fact that knowledge and expertise were needed in making decisions in such a large and complex field as health care.

There was consensus among participants that Canadians had a right to health care. In terms of qualifying this right, participants tended to indicate that Canadians had a right to the level of services they currently enjoyed. When asked how they characterized the level of services currently available to Canadians, the vast majority described it as "quality" services.

When asked if it was reasonable for Canadians to continue to expect to receive the same level of quality services in the future as they do now, most agreed that it was. In fact, a few participants suggested that "we should aim higher". This positive attitude in relation to setting health policy objectives stands in contrast to the generally pessimistic prognosis given by participants when they described their vision of the future of health care in this country. This suggests that Canadians' personal pessimism of the future does not translate into softer expectations of those who design and administer the health care system.

Participants generally agreed that the health care system had a great deal of special importance to them as Canadians: "It's a basic, fundamental tenant of being Canadian." Many agreed that the universality of the system helped to distinguish Canada from the United States in a way that showed us to be a more generous and compassionate society. Others said they derived pride from the quality of the system.

The few francophone participants who commented on the issue were less enthusiastic in their comments. They indicated that the accessibility and quality of the system generated a certain amount of pride, but did little for their sense of identity.

(e) Scenario 4: Prevention vs. Treatment

This scenario directly tested the participants' understanding of the broader determinants of health and its link to the health care system and other social programs.

In virtually every group, the preliminary general discussion about the health care system and the state of health usually generated considerable talk about the value of prevention. Many participants bemoaned the lack of attention paid to prevention in the approach taken to health care. This scenario tested the limits of that belief.

There were some participants in every group who were strongly convinced of the merits of focusing on prevention and very root causes of health problems, including those caused by social and economic factors. They were a minority, but a distinct presence. Most participants had a more limited view of what prevention constituted; they confined it to the context of the health care system. They tended to see prevention more along the lines of education about lifestyle or encouraging proper nutrition or fitness.

Most participants balked at the notion that the health care system would intervene in a direct way in the community to provide a material change in peoples' living conditions. With respect to the scenario, for example, almost all thought providing Jimmy with a furnace would be a smart thing to do. They could also see how it would result in cost saving to the state overall. However, they did not see it as the responsibility of the health care system. Rather, it was seen as the responsibility of social services departments or some other agency of government.

Part of the problem was that most participants did not see a solid connection between buying the furnace and health care. There might be a relationship, but not direct enough to justify the involvement of health care system. This dichotomy really speaks to the scepticism many people feel about prevention issues, particulary as one broadens out those issues and tries to get at them in a more holistic way. Many people are uncertain about the actual results that accrue from prevention measures.

When they were asked whether they would prefer to save the lives of ten heart attack victims or reduce the number of heart attacks, and thereby save one hundred lives, participants' views tended to be roughly split. However, in our view, even that overstates the level of support that would actually exist for such a choice. The question is designed — by guaranteeing the saving of one hundred lives — to overcome the basic problem that undercuts support for reallocation to prevention and the related uncertainty inherent in this shift.

The discussion surrounding this scenario brought into sharp focus the way in which participants think of health care and the health care system. Most drew a clear distinction between prevention issues that "made great sense" and would help to create a healthier population on one hand, and treatment: what the health care system ought to concern itself with. Most participants tended to see the health care system as an insurance policy, for themselves and their family. They pay into it expecting that one day they might need it and they will have a right to draw on it and to expect that it will devote the required resources at that point. The fundamental responsibility of the health care system is to treat the sick. Anything else is peripheral to its mission which is reallocate resources from treatment to prevention, because it might mean that they do not get the care they need.

Support for prevention measures, within the health care framework, is strongest the more tightly connected the measures are to traditional understandings of health care and the more limited and they are focused in their scope. There was also clear undertones in the groups which indicated a belief among some participants that prevention in terms of making healthy lifestyle choices was largely a matter of *personal* responsibility. This view helped to contribute to the resistance to reallocating resources from prevention to treatment. Some of the problems that this scenario encountered were also related to concerns about the funding crisis in the health care system. People are inclined to think that the system is already stretched to the maximum and they were concerned that activities like the one contemplated could result in health care dollars being spent too broadly in society at the expense of its ability to be prepared for acute care.

(f) Scenario 5: Meeting the Needs of the Dying Compared to Delivering Acute Care

Participants had a great deal of difficulty making the hard choices they confronted in this scenario. Initial discussion of the importance of ensuring that the needs of the dying were met as fully as possible compared to trying to save lives when chances of success are very poor, resulted in most participants saying that both were very important. Similarly, participants were reluctant to say whether they thought too much emphasis was placed on saving lives at any cost to the detriment of other needs. Generally speaking, participants exhibited a tendency to want to go outside of the parameters of the scenario and related questions for suggestions and solutions.

In some cases, participants simply reiterated the need to reduce waste and inefficiency and curb abuse as a way of finding the resources needed to properly fund both palliative care and acute care. The most interesting and often made suggestion, however, was that the chronically ill should be given the right to die, or at least made more aware of their right to refuse treatment. There was a surprising amount of consensus and an equally surprising absence of rumination surrounding this issue. Often basing their opinion on the personal experience of having known someone who had died of terminal illness, participants estimated that there were substantial numbers of people who would choose death over the continuation of treatment if this option were more openly discussed and available. The resources saved by not having to expensively prolong the lives of patients who choose to die, they reasoned, could then be spent on improved palliative care and acute care for those who choose to live.

When participants were asked to restrict their discussion to the relative merits of palliative versus acute care funding, the vast majority indicated that it was more important to focus on saving lives, even when the chances of success were small: "The needs of the dying are important, but the primary objective of the health care system has to be saving lives and curing people."

Participants' difficulty in making "hard choices" was unabated as discussion turned to identifying the grounds on which society should decide which needs should receive greatest priority. Together with finding the issue distasteful, a large part of the problem for many participants stemmed from their reluctance to accept the premise on which such a discussion was based. Quite a few participants were simply not prepared to accept that Canada had reached the point where "rationing" of medical services was required. Their often passionate arguments pointed to numerous areas, both inside and out of the health care system, where they felt resources could be found: "Look at all of the money that is wasted in this country, whether its perks for politicians or the cost of peacekeeping in Bosnia. Our health care system is the most important thing [that we have]."

In the context of the focus groups, the participants who accepted the premise for rationing health services sometimes became apologetic in explaining their support for using the amount of benefit produced per cost as the most appropriate criteria for deciding which, whether, and at what level health services should be funded: "I don't mean to sound callous, but... ." In the eyes of these participants, using a "formula" or analytical technique to determine the cost-effectiveness of services seemed like the only thing to do under the circumstances.

In the end, participants remained about equally divided on the issue. The real point of debate, it is important to note, did not centre on what criteria should be used for determining funding levels for health services, as much as whether or not circumstances really warranted the adoption of any such measures.

(g) Scenario 6: Guidelines to Encourage the Use of Less Expensive drugs

Participants had a moderate amount of difficulty in reaching a decision on the key question raised by this scenario. After initial discussion in which a few participants expressed moral indignation at what they considered to be "putting a price on a human life", participants generally agreed that it was acceptable to use cheaper, but slightly less effective drugs, in order to save resources and channel the savings towards meeting other needs. Most participants qualified their response by stating that they had been swayed by the information in the scenario which indicated that the drug *would still be available* to doctors if the latter felt its use was necessary to save someone's life. Participants sought to make it clear that they were not compromising survival, but rather trading-off comfort and speed of recovery for a substantial saving of resources.

Participants' response to this and other scenarios indicate that Canadians are willing to support cost-saving measures which reduce qualities such as choice, comfort and timeliness, as long as these measures do not jeopardize lives. This is how the majority of participants reconciled the conflict between providing the "best possible care" on the one hand, and making sure that there were sufficient resources to ensure that all Canadians can receive treatment. This view is strongly linked to the difficulty that many participants have in accepting the premise that the country has reached a point where it must consider rationalizing health services in a manner that might cost lives. In this scenario, for example, the hypothetical suggestion that the more expensive drug could increase patient comfort, but have no long term impact on the patient's health, rendered the issue almost insignificant. Participants did not hesitate to say that if such a drug was significantly more expensive, then it should not be available to doctors.

Participants acknowledged the ethical dilemma faced by the doctors in the scenario, but there was a consensus that these doctors had not compromised their professional ethic. In considering the situation, participants once again adopted a pragmatic approach. Their response to the issue came easily: Physicians can only be expected to operate within the parameters set by the state: "They simply have to do their best with what is given to them." From this perspective, the choice is not made by the doctor, but by the state. Some participants also emphasized the importance of having the state set clear guidelines in order to relieve doctors of the burden of having to make choices which might make them feel like they are compromising their principles.

Participants were less certain about whether or not a doctor should have to disclose to patients the fact that the treatment they are receiving may not be the most beneficial. Some participants said that they would like to know this in order to have the choice of going to the United States to obtain treatment. Others said that they would maintain peace of mind by not knowing this information. A few took a less personal and more philosophical stance: "There is always going to be a treatment out there that is probably better that what we receive here, especially in the U.S.. So what if what we receive here is not the absolute best available? It's still pretty good." Most ultimately felt that the patient had a right to know if there were alternatives available to the treatment they were receiving.

Finally, in some focus groups, the issue of whether or not people should be given the option of purchasing more expensive (and presumably more effective) drugs was discussed. Opinion was mixed, and varied according to region. In Quebec City, for example, participants rejected the notion out of hand. They saw this as akin to allowing private clinics to open and argued that giving people this choice would undermine the bedrock principle of universality. In Windsor, Ontario, on the other hand, participants were more pragmatic. For one thing, they were quite familiar with the practise of purchasing medicine across the boarder in Michigan. They were also apparently more familiar with the U.S. health care system. Even in this group, however, opinion was at best divided. Participants who were opposed voiced similar objections to those articulated by their Quebec City counterparts. Conversely, those who supported giving people this option said that it was far different than allowing private clinics to open. They pointed out that there was no potential for a shift in resources away from the public system because choice would be limited to medication and no portion of additional costs would be born by the provincial health care system.

Overall, this was an issue that generated the most even split on the two-tier question because many people could not see how allowing people to purchase the more expensive drug could weaken the system for others. As a consequence, opposition was restricted to those (still a majority) who were philosophically opposed to allowing different levels of care, rather than those who worried about the practical impacts of introducing two-tier medicine.

(h) Scenario 7: Increasing the Level of Responsibility that Families Have for Taking Care of their Own

Discussion of this scenario was often emotional, but produced a clear consensus among both young and old. Participants strongly agreed that it was not fair to expect families to assume increased responsibility for caring for their own and that the state should in no way rely on such an assumption in making allocation decisions. In fact, the idea seemed outrageous to quite a few participants, despite the fact that a few had talked of having assumed these types of responsibilities in the past (e.g., feeding a hospitalized relative).

Participants listed a number of mutually reinforcing arguments against even a slight shift in responsibility away from institutions and health care professionals towards families. The main objection was that such an approach ran counter to dominant societal trends such as the growth of single parent families, the increased number of families where both parents have to work, longer working hours, individualism, consumerism and atomization of society: "Women have gone back to school, gone to work and seen their marriages break-up." Participants emphasized the significance of these trends as a way of showing that most people were not equipped, either financially or emotionally, to take on the sort of responsibilities described in the scenario. Other arguments against assuming responsibility included the following:

- ☐ Parents have already been expected by the state to take-on more responsibilities in other areas, such as the schooling of their children.

- ☐ Older participants agreed that they did not want to burden their children and spouses. They also emphasized that it was naive to assume that they would even want to be taken care of by their children.
- ☐ Younger participants echoed the above views, with many frankly admitting that they could not "handle" taking care of a parent;
- ☐ Some expressed concern about the ability of a family member of taking proper care of a recovering patient, especially when the family member was older: "What if something goes wrong? Would we get training?"

The idea of compensating people who assume significant responsibility for looking after someone, through a tax credit for example, produced mixed responses.

Some participants felt that this was fair and reasonable. They supported a policy which would provide such compensation, but would not require anyone to assume more responsibility for a relative unless they freely chose to do so.

Others rejected the idea. In some cases, participants were apparently still worked-up by the earlier discussion. A few said they found the idea of the state "paying people" to take care of a relative distasteful: "You are bribing people to do the right thing". Others said that such a policy would open the door to abuse, particularly parent abuse. In the end, these participants preferred that the state stay away from the issue completely and leave matters to family members: "It has to come from the heart. People have to want to do it or else it won't work."

On balance, however, there was considerable scepticism that government would put the required resources into the hands of people or communities. Many saw it as a thin veil for service reductions.

Predictably, participants also unanimously rejected the idea of fostering more widely in society the expectation that families will look after their own.

Participants, including seniors, said that this would prove to be a fruitless attempt at "turning back the clock". Many did not have fond memories of the days of more individual responsibility in this area. In this vein, several pointed out that it was in response to the inadequacies of that approach that the current system had evolved. Finally, some added that they doubted governments' ability to have any success in changing public attitudes: "What are they going to do? Put adds on TV? It was TV that helped to make us the way we are" (i.e., individualistic and materialistic).

Participants also strongly agreed on a final point. They encouraged government to facilitate and fund home care and other forms of community-based care in which health care professionals looked after people: "Everybody knows that people recover faster and are happier in their own home. It's also cheaper. But professionals should look after people, not family members."

(i) Scenario 8: Principles of the Health Care System

The scenario about competing values generated remarkable consensus among participants in all groups in which it was discussed. With one exception, all values were considered to be valid principles around which to organize the health care system.

The one exception was equal shares for groups. This was dismissed as an operating principle by virtually all, and expressed with a fair degree of vehemence. Part of this opposition is likely driven by the connection that was made between this kind of approach and different ethnic or religious groups. Other research shows that the rapidly changing face of Canada is fuelling some backlash or intolerance on the part of some people and this would have coloured some responses on this point.

For many other people, however, it was simply an invalid criteria on which to base resource allocation. Other discussions indicated that many people were quite open to alternative forms of medicine provided that effectiveness could be established. They were not open to funding alternative medicines as a way of achieving a sense of balance between groups.

None of these concepts can be understood outside of the context of real angst about the financial viability of health care and diminishing levels of access and quality. People have a well defined hierarchy of values as demonstrated in discussions of this scenario.

Overwhelmingly, equal access and quality of care were the most important criteria for virtually all participants. There were divisions about which one was more important of the two, but no real belief by most that anything else was of equivalent importance. Participants also tended to think that they reflected a consensus in Canadian society about values and health care. It was a badge of some nationalistic pride that there was a "Canadian" way of looking at these issues.

Some of those most concerned about fiscal issues would rank efficiency very highly. They were concerned that the absence of a cap on health care spending would have a negative impact on government deficits and tax rates. Most participants, however, tended to disagree with these participants' "sense of priorities". It was not that others were unconcerned about efficiency in health care, they were, and often this would lead to discussions about causes of inefficiency, such as the practices of physicians or overuse by patient or poor administration. Most simply did not want efficiency to be the driving force in health policy. Similarly, the concern of virtually all participants about government deficits did not lead them to think that the health care system was the main problem. Most felt it was the highest priority and savings should be found elsewhere.

Most people did think that maximum benefit for dollar had to be a consideration for society. As discussed elsewhere, they did not like the tradeoffs inherent in that approach and did not confront them easily. However, there was a sense that health care dollars were not being spent in the wisest fashion. Combined with the belief that dollars were now very limited, this created an acceptance among many that tough allocation decisions would have to be made to preserve the elements of real value in the system.

The prime areas of conflict that people saw emerging from the different principles were between equal access, on the one hand, and quality of service and maximum return on the other hand. They expressed combative resistance to giving up on either quality or access. When pushed, most tended to look for solutions that compromised equal access but did not eliminate it. Examples would be the willingness by some people to accept user fees for doctor or hospital visits, or the willingness by some to think that private clinics might be a way to get more money into the system. Most did not advocate these approaches as desirable. Rather, if convinced (and this constitutes a large "if") that governments could not afford to maintain the status quo — maintaining the status quo was the first choice overwhelmingly — ultimately they felt more comfortable looking at solutions that introduced more resources into the system to forestall a diminution in quality.

Summary of Focus Group with Aboriginal Canadians

A special focus group consisting of aboriginal Canadians was held in Regina. The issue of aboriginal health and the relationship of aboriginals to the health care system is obviously a subject that cannot be done justice in one focus group in one region. However, we felt that our research in this area would not be complete without some insight on this subject. The composition of the group included some Métis and some First Nations, both status and non-status.

This particular group was conducted along different, more traditional lines than were the other groups. Rather than use the scenarios to stimulate discussion, more direct and focused probing was used to elicit the views of participants on core principles and values as they relate to health care.

Even more so than participants elsewhere, these participants were focused on decline in the health care system. There was a very strong feeling that the service delivered to them had diminished in both quality and access, as had the infrastructure through which they receive services.

As were the other participants in this project, those in the aboriginal group were very attached to the health care system and the underlying principles of that system. In keeping with Saskatchewan attitudes on this subject, there was some pride of ownership over Medicare. They tended to talk of the system, its values and what it represents about Canadians as a people, in very similar ways to other participants.

Most tended to be pessimistic about the future of health care. Perhaps as a consequence of the health care restructuring that had gone on in Saskatchewan — or perhaps that restructuring has taken a more serious toll on them — there was a real sense on the part of participants that the decline they felt was already occurring would continue into the future.

Participants in this group were anxious that the federal government continue to have a strong role in health care. This might be thought to be anomalous in a province which has traditionally had a lot of faith in its provincial government to protect and advance health care. However, like many Canadians, these participants' fears about lack of sufficient health care funding led them to want all of their governments to focus on that area. More particularly, however, these participants felt that they had a special relationship with the federal government and that the federal government had a special fiduciary responsibility to them.

All that being said, there was very little understanding of the federal role in the area of health care. While the principles of the Canada Health Act were understood by them to be the principles underlying the health care system, there was little understanding of the Canada Health Act itself. Few had heard of it or what it represented. When the principles embodied in the Act were presented to them, they felt that they were appropriate and that it was important for the federal government to be playing that role.

They had an interesting take on alternative medicines. Many in the group felt there ought to be a role for a more spiritual aspect to medicine. There was a sense that modern, science based medicine did not place enough emphasis on "healing" in a true sense. They tended to view traditional or alternative forms as complementary to science based medicine — not as a replacement. For instance, allowing an aboriginal Canadian to have a spiritual advisor in the hospital room with them to help with prayer. They also felt, similarly to participants in other groups, that ultimately the alternative forms ought to pass some test of effectiveness.

Participants in this groups seemed somewhat more aware of the broader issues of health than did other participants. As a consequence they had a different understanding of what prevention meant in a health context. They did not conceive of it only as education, which is what others tended to do. Rather, they tended to focus on the role of poverty and lifestyle problems and the relationship between those issues and health.

Despite their enthusiasm for prevention, they shared other participants' reluctance to reduce the priority placed on acute care. There was even less acceptance of the paradigm that said that there were only so many dollars to be spent on health care and choices and allocations had to be made within that envelope. They were more willing to challenge that assumption and to suggest that what was really required was more money in the system.

In wanting to see more money in the system, though, they were more resistant than other participants to any form of private involvement. The commitment to public administration and to universal access was very strong and willingness to look at any compromise of access was limited to one participant.

CHAPTER

3

QUANTITATIVE FINDINGS

3.1 Background

One of the principal advantages of focus group work is the capacity to iteratively refine and test research issues in a much more open-ended, naturalistic and flexible fashion. However, the capacity to generalize (external validity) is severely limited by both the nature of recruitment, very small sample sizes and the somewhat reactive and artificial social psychology of the focus group.

A quantitative enhancement was added to help redress this problem. A mini-quantitative survey during the recruitment period and a very brief quantitative post-survey after the group was conducted. Several of the questions included in this mini-quantitative study were already asked of a representative sample of Canadians under the auspices of the *Rethinking Government* study.

The five key objectives of this quantitative component are outlined below:

#1 1. enhancing the generalizability/external validity of the findings from this study;

#2 2. mapping differences between members of the Canadian population as a whole (respondents of the *Rethinking Government* study) and respondents of this survey;

#3 3. providing a method of measuring attitudinal and demographic differences between those who were willing to participate in a focus group and those who were not;

#4 4. providing a method of determining the causal influence of focus group sessions on public judgements; and

#5 5. measuring the impact of deliberative focus group sessions on public judgements.

3.2 Methodology

The methodology used in conducting this quantitative component of the study is outlined below.

Screening Questionnaire: During the recruitment of focus group participants, potential participants were screened using a four-minute (14 item) questionnaire examining attitudes concerning the study issues (e.g., values surrounding health care, perceptions of health care in Canada), as well as general demographic characteristics. After the potential participants had completed this battery of questions, they were asked if they would be willing to participate in a focus group session. A total of 800 individuals were asked this battery of questions.

Post-Participation Questionnaire: At the conclusion of each focus group session, participants were asked to respond to another short attitudinal questionnaire, which basically encompassed the same set of questions as the screening questionnaire.

The quantitative component yielded the following two data outputs:

- a 14 item survey of 803 people living in and around the nine centres in which the focus groups were conducted; and
- 93 matched pre- and post- surveys of focus group participants.

3.3 Findings

Findings from the quantitative research are organized around the following four major themes:

- differences between the survey findings and the findings of the *Rethinking Government* survey;
- differences between focus group participants and non-participants;
- influence of participating in the focus group sessions based on the pre- and the post-survey results; and
- influence of the deliberative exercise on participants' attitudes based on the pre- and post-survey results.

(a) Survey Findings

The findings detailed below encompass both the Health Forum Survey and selected replicated questions from the *Rethinking Government* study. A number of differences between the findings from the two surveys are discussed below. Prior to moving to this discussion, we would like to provide some possible explanations for the presence of differences in responses to these identical questions:

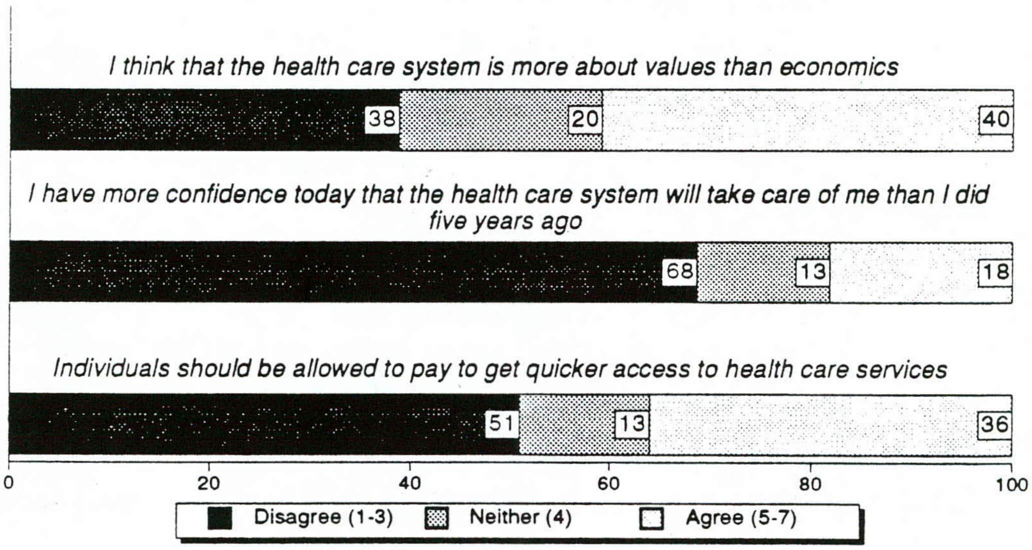
- ***Sampling effect***: the *Rethinking Government* sample was randomly selected to represent the Canadian population. The Health Forum sample was limited to the nine centres in which the focus groups were conducted.

A comparison of the two samples reveals that the latter sample is overrepresented by urban dwellers, people under 60 years of age and females. Income and education indicators, however, are representative of the population as a whole.

- ***Time effect***: the two surveys were conducted approximately seven months apart. Peoples' attitudes may have been influenced by events related to health care which occurred between the two time periods.
- ***Questionnaire design effect***: the *Rethinking Government* questionnaire was approximately 35 minutes long and addressed a number of topics. In contrast, the questionnaire used in this study was short (4 minute telephone interview) and focused uniquely on health care issues.

Approximately 800 respondents were first asked a battery of attitudinal questions about the health care system (Exhibit 1).

EXHIBIT 1
Perceptions of Health Care



n=803

Respondents are split in their views about whether economics or values should be paramount in the health care system. The same per cent agree as disagree with the notion that the health care system is more about values than economics. Activists, those over 60 years of age, men, and lower income Canadians are more likely than others to feel that health care is about values.

Respondents express concern about the sustainability of the health care system. Over two in three (68 per cent) disagree with the statement, "I have more confidence that the health care system will take care of me than I did five years ago". Activists, women, those with high school education, and those with higher income are particularly pessimistic about the future of health care. A similarly high level of concern about the sustainability of the system was expressed in the focus groups. This concern is fuelled by what participants viewed as *tangible* signs of stress and strains on the system.

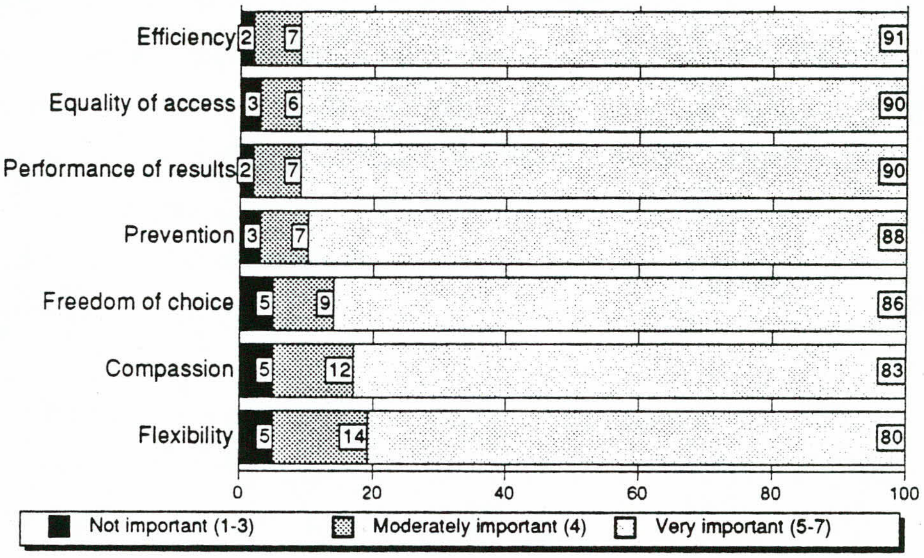
This question was also asked of *Rethinking Government* respondents (the general public). The Canadian population as a whole is slightly more optimistic about the future of the health care system than respondents to this study: 60 per cent of *Rethinking Government* respondents disagree that they have more confidence in the system.

Most survey participants do not endorse the concept of a two-tiered health care system. A majority (51 per cent) disagree that individuals should be allowed to pay to get quicker access to health care services. Those under the age of 60 are particularly negative in their views of two-tier health care.

This question was also asked as part of the *Rethinking Government* study. The general public are more opposed to a two-tier system than respondents to this study. Sixty-one per cent of *Rethinking Government* respondents disagree that people should be allowed to pay extra to get quicker access to health care services.

Respondents were also asked to rate the importance of a range of values in shaping the health care system (Exhibit 2).

EXHIBIT 2
Importance of Various Values in Health Care
"How important should each of the following values be in shaping the health care system?"



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All values are believed to be of importance in shaping the health care system; however, efficiency, performance and equality of access are assigned highest priority by the Canadian public.

The importance assigned to each of these values differs across the demographic and attitudinal characteristics examined in the study. These differences are outlined below.

- ☐ Those under the age of 60, women, and those who rate their health as good are the strongest supporters of freedom of choice as a value.

- Those under the age of 60, those with higher education, and those living in households earning $60,000 or more are the strongest proponents of an efficient health care system.
- Those under the age of 60 and women are the most likely to feel that flexibility is an important value.
- Those with university education, those living in households who earn more than $60,000 per year and who rate their health as good are more likely than their counterparts to assign importance to the performance of the health care system.
- Those under the age of 60, women, and those living in households earning less than $20,000 are particularly likely to endorse compassion as a value for health care.
- University-educated, those living in households earning $60,000 or more and those who rate their health as good are the strongest supporters of prevention.
- Few sub-group differences are exhibited with respect to the importance of equality of access.

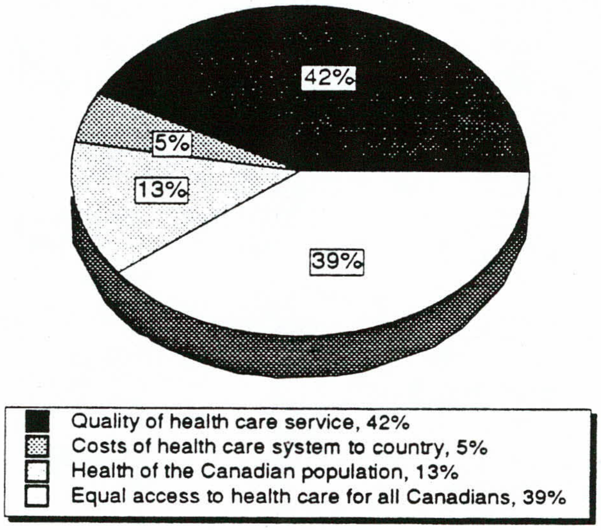
Respondents were then forced to choose which one aspect of health care was of greatest importance to them (Exhibit 3).

Quality of health care (42 per cent) and equality of access (39 per cent) are seen as the ultimate goals of the health care system. It is interesting to note how few respondents selected the costs of the health care system to the country (five per cent). This finding is very consistent with the qualitative results. In the focus groups, participants reiterated the view that these two values were the twin pillars of the Canadian systems.

The quality of health care is assigned greatest importance by women and higher income earners. Equal access is given highest priority by those with high school education and those with lower income.

EXHIBIT 3
Most Important Feature of Health Care

"Which one of the following aspects of health care is of greatest importance to you?"



n=803

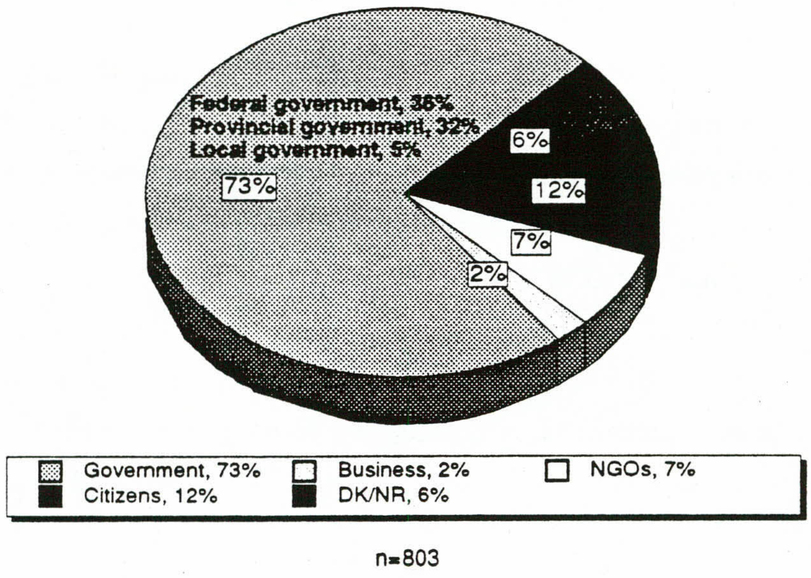
The same forced choice was asked of *Rethinking Government* respondents. The pattern of responses is quite similar for the general public (equal access and quality of service are considered to be of paramount importance). However, respondents to the *Rethinking Government* survey as a whole assign higher priority to equal access (53 per cent) and survey respondents accord higher importance to the quality of health care.

Finally, respondents were asked who should be responsible for health care (Exhibit 4).

The findings indicate that survey respondents feel that both the federal and provincial government should be actively involved in health care (although they indicate a slight preference for a federal lead role). This reflects a general desire for

EXHIBIT 4
Responsibility for Health Care

"Who should have responsibility for health care?"



partnership (and a corresponding fatigue with territorialism) among the Canadian public. It also reflects a preference for checks and balances in this area of profound importance for Canadians.

This thirst for partnership is also revealed in the *Rethinking Government* findings, although among the general public as a whole the lean is to a slight provincial preference.

(b) *Differences Between Participants and Non-Participants of Focus Groups*

In order to gain a clearer understanding of the similarities and differences between the people who participated in the focus group sessions and those who did not, a comparison of focus group participants and those who refused to participate was conducted. This comparison encompassed both the attitudinal and demographic questions addressed in this survey.

On an overall basis, few differences were found across the attitudinal and demographic questions, indicating that focus group participants were similar to the general public. However, some differences were exhibited as outlined below.

Few differences were found with respect to whether health care is about economics values (Exhibit 5). However, those who participated in focus group sessions were less likely than the general population to express confidence in the future of the health care system and to feel that individuals should be allowed to pay to get quicker access to health care.

A similar comparison was done across the preferred values for shaping the health care system (Exhibit 6). Across virtually all options, non-participants assigned slightly higher importance to the values.

EXHIBIT 5
Comparison of General Public and Focus Group Respondents — Attitudes

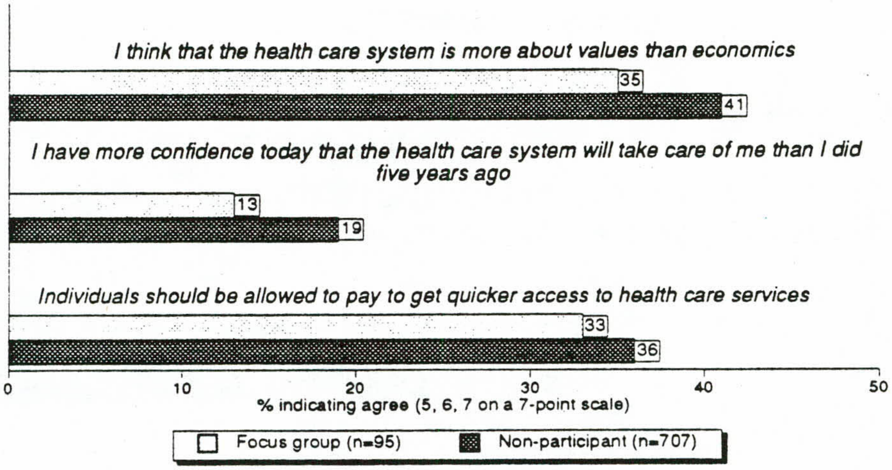
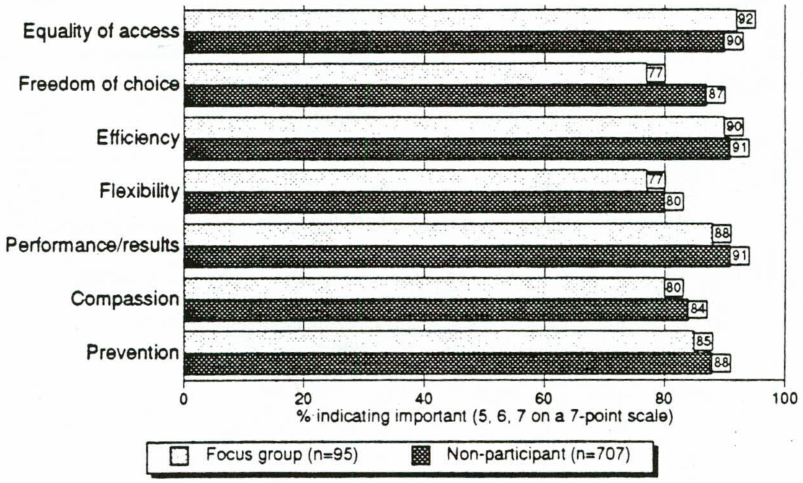


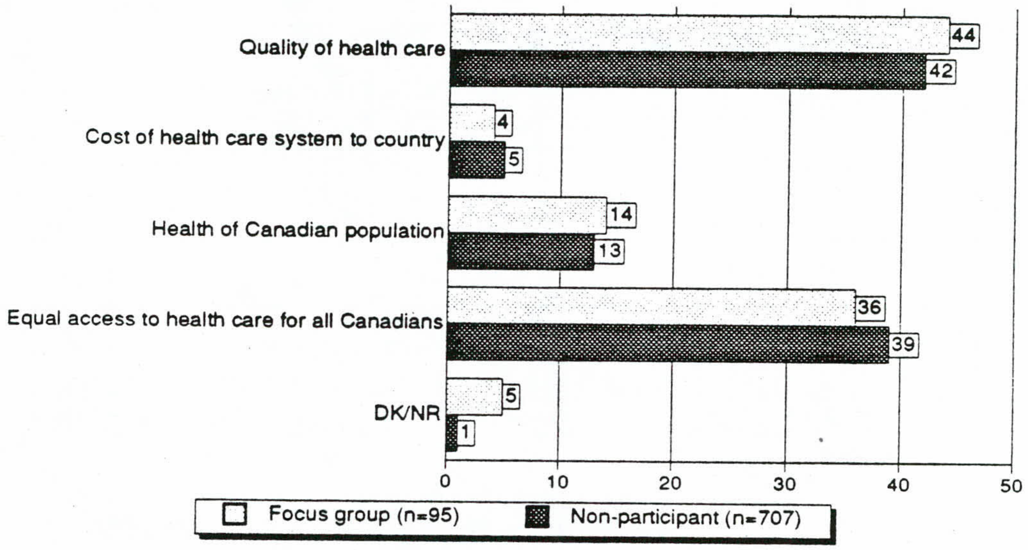
EXHIBIT 6
Comparison of General Public and Focus Group Respondents — Values for Health Care



The two groups exhibit similar preferences with respect to the most important aspect of health care (Exhibit 7) although non-participants more strongly endorse the quality of health care as being the paramount feature of the system. It is also interesting to note that the focus group participants were more likely to be unsure about which aspect is most important.

EXHIBIT 7

Comparison of General Public and Focus Group Respondents — Most Important Feature of Health Care



The two groups were also compared across demographic characteristics. Men, participants with higher education, and older Canadians were more likely than their counterparts to attend focus group sessions.

(c) Influence of Participating Focus Group Session (Pre- and Post-Survey)

As an additional feature of this quantitative component of the study, focus group participants were asked to complete a questionnaire at the end of the focus group session. This questionnaire was composed of the same questions as those asked prior to the session. By comparing the results from the pre-questionnaire and the post-questionnaire, it is possible to establish if any changes in attitudes occurred because of participation in the focus group session. (Please note that because the sample sizes used in these analyses are quite small, results should be interpreted with caution). ✓

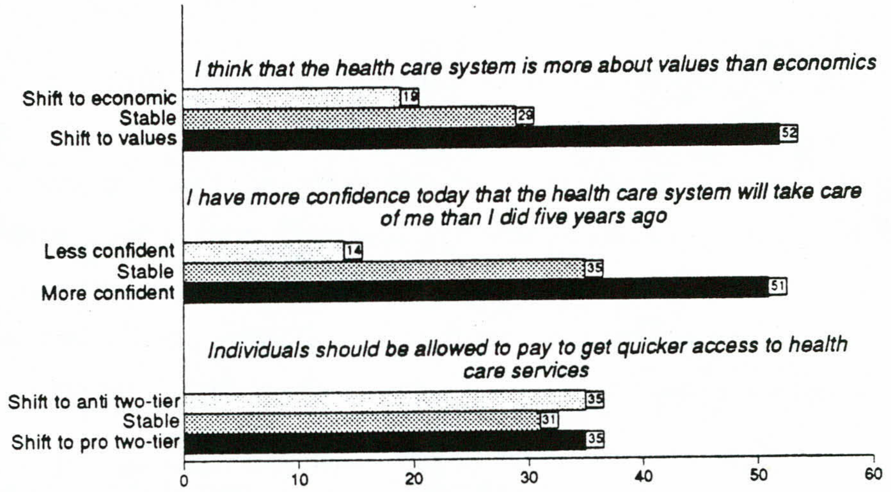
The findings indicate that taking part in the focus group sessions did influence perceptions of health care issues (Exhibit 8).

The focus group discussions augmented the belief that health care is more about values than economics. Participation in the focus group sessions also increased confidence in the health care system.

Participation in the focus group session resulted in a polarization of attitudes surrounding a two-tiered health care system. Respondents were as likely to increase as decrease their support for a two-tiered system. It is interesting to note that all of those over the age of 60 changed their views about two tier health care (33 per cent strongly endorsed the two-tier system and 67 per cent more strongly opposed this system). * ✓

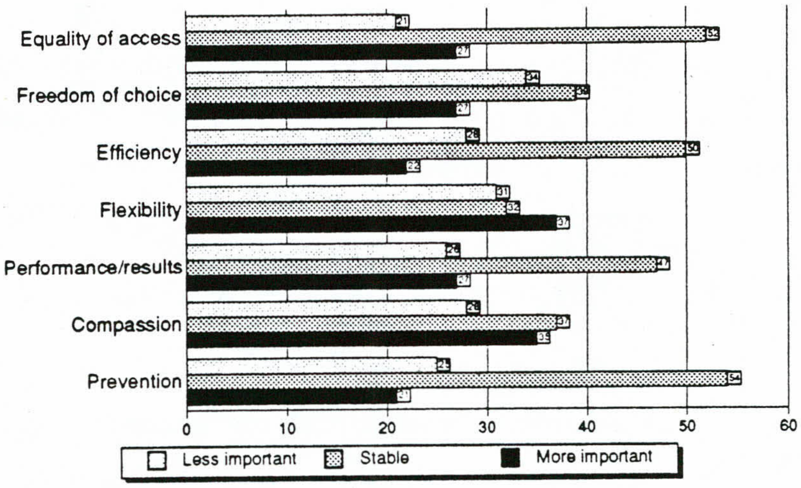
The responses of participants concerning the values which should define our health care system were also examined both before and after the focus group sessions (Exhibit 9).

EXHIBIT 8
Changes in Attitudes about Health Care



n=95

EXHIBIT 9
Changes in Importance of Values for Health Care System



n=95

Equality of access, efficiency and prevention are largely stable between the two time periods. Flexibility and compassion have a tendency to become more important to participants. Freedom of choice exhibits a slight diminishment in importance. The importance of flexibility is as likely to decrease as increase between the pre- and the post-survey.

Participants' top value preference for health care changed markedly between the two time periods, as summarized below.

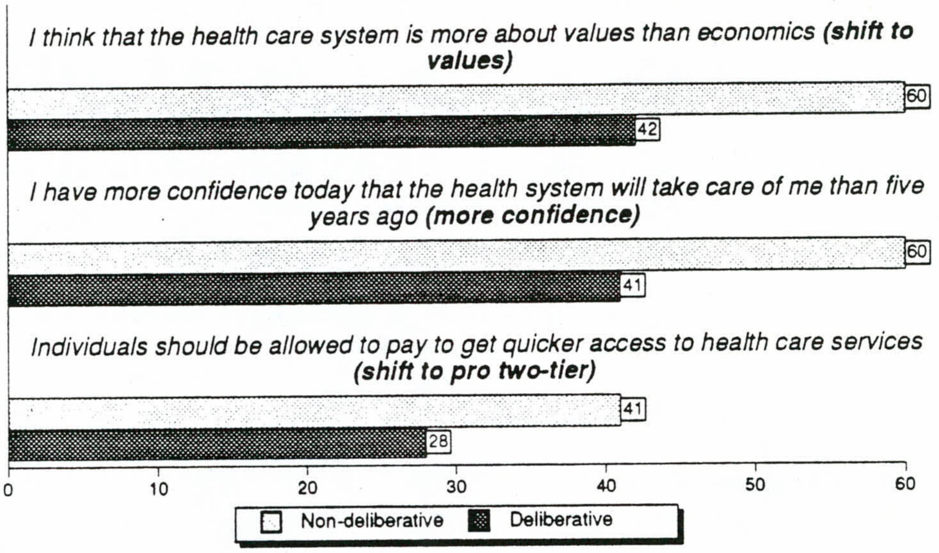
- ❑ The majority of respondents who selected quality of health care in the pre-survey either continued to select quality or changed their selection to equal access.
- ❑ All (four) of those who initially selected the costs of the system changed their preference to either quality or equal access.
- ❑ The majority of respondents who initially selected health of the Canadian population changed their selection to the quality of the health care system.
- ❑ The majority of those who initially chose equal access to health care for all Canadians either maintained this preference or changed it to the quality of health care.

(d) Influence of Deliberative Exercise (Pre- and Post-Survey)

Further analyses were conducted with respect to the impact of participation in deliberative focus group sessions on attitudes. Participants in these deliberative groups were given basic factual information about Canadian health care (see Appendix C) and asked to briefly discuss their reaction to this information. Changes in attitudes which occurred between the pre- and post-survey for both the deliberative and non-deliberative sessions are outlined below.

Exhibit 10 illustrates the impact of participation in the deliberative focus group sessions across the questions addressing values versus economics, confidence in the system and two-tier health care. In general, the "deliberative" test was a much weaker test than the test of the effects of group discussion. The "deliberative" stimuli were relatively modest and focused on economic indicators. The results of the tests are inconclusive and require further testing.

EXHIBIT 10
Changes in Attitudes to Health Care (Deliberative *vs.* Non-Deliberative Sessions)

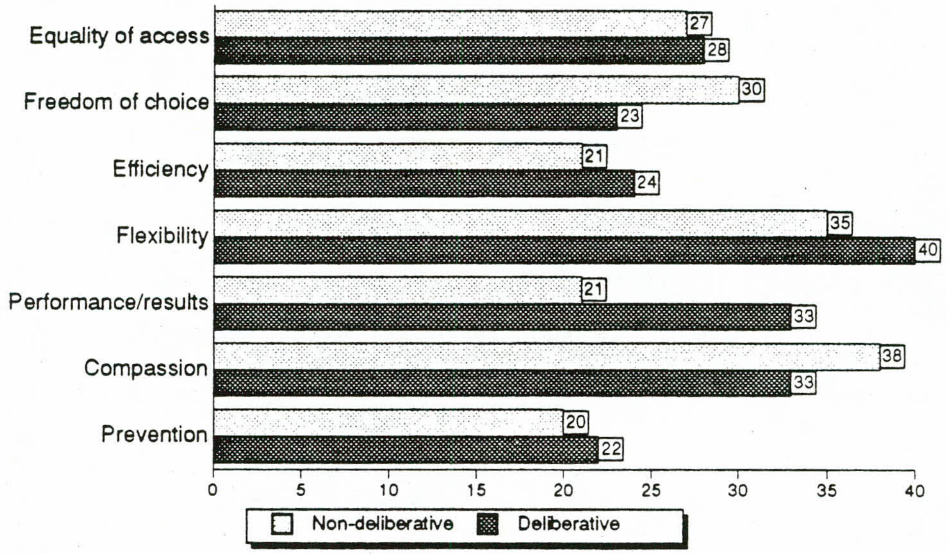


n=95

Individuals who did *not* participate in a deliberative focus group session became more values-oriented than those who attended a deliberative session. Confidence in the health care system increased by a larger margin among those who did not participate in a deliberative session. Those who did not participate in a deliberative session were also somewhat more likely to support a two-tier health care system. This somewhat anomalous finding is of marginal statistical significance and probably should be treated with suspicion until replicated in a more robust test.

Attitudes about which values should define the health care system were also examined across the deliberative and non-deliberative groups (Exhibit 11).

EXHIBIT 11
Increase in Importance Across Values (Deliberative *vs.* Non-Deliberative Sessions)



n=95

Across the majority of these values, participation in a deliberative session increased the importance that respondents attached to values, particularly the performance of the system.

CHAPTER 4

CONCLUSIONS

The combination of the focus group discussions and the two waves of survey research have helped to provide real insight into the underlying values and principles with which Canadians approach issues of health and health care.

It is important to note that these issues are very much at the forefront of what Canadians are thinking about, in terms of public policy, at this time. There is overwhelming evidence (see *Rethinking Government*) that health care concerns are at the top of the priority list for most people in the country. What was revealing about the focus group work was how much prior thought participants had put into the issues being discussed. Relative to other research of this type, participants in this project had remarkable fully thought through ideas and opinions. At the same time, the fact that participants had given the issues considerable thought prior to attending did not mean that their views were cast in stone. On the contrary, the difficulty of the trade-offs and choices that the scenarios forced on them often shook their core beliefs and forced them to reassess long held attitudes. Arguments put forward by some participants were often persuasive to others. It made the case very strongly that the debate over health care policy in this country exists in a very dynamic environment, one in which conflicting powerful forces are at play. The debate itself has the potential to shape opinion.

Health care has become top of mind for Canadians because it is something about which they care deeply, something about which they are very concerned, something in which they understand significant reforms are occurring, and something in which they believe dramatic changes will occur. They want health care reform to reflect the values they believe in and to be undertaken with an eye not of dismantling what exists, but toward improving and preserving what they consider to be important about it.

Some broad findings emerged from the research.

4.1 Pride in the Canadian Approach to Health Care

The vast majority of those who participated in the focus groups were immensely proud of the type of health care system that has been built in Canada. It was considered by almost all participants to be strongly reflective of *Canadian* values and was often contrasted with the American system of health care.

Although other competing priorities emerged over the period of the discussions, it is **equality of access** that serves as the primary source of this pride. The "Canadian" values are wrapped up equality of access — everybody gets relatively equal care when they are sick and nobody has to lose their house to pay their hospital or doctor bill. It is this feature of the system which is seen to most distinguish it from the American model (which is the point of comparison).

Many people readily acknowledge that their belief in egalitarianism is restricted to health care and that they are not troubled by wide discrepancies based on ability to pay or status in other areas of society. They have no trouble isolating health care in this way because they see health care as something of a completely different character than housing or automobiles or vacations. It is also clear that many, perhaps most, feel that they *personally* might be worse off if the system evolved into two-tiers.

One of the ways in which it is different is the fact that being as healthy as possible is seen to be fundamental to having the kind of quality of life that is believed to accompany being Canadian. It is simply seen as being more important and more fundamental. It is one thing that one person lives in a larger house or takes better vacations than other people as a result of higher income levels. Few people are willing to intervene to stop that result. It is another thing entirely that one person not receive the same treatment for a physical ailment that another person does on the basis of income. Few respondents were willing to tolerate that.

Second, equality of access is seen to be an essential component of opportunity. Variances of income or other accoutrements might be end results of the market economy, but being physically healthy is seen to be a precondition to having a fair chance at success. If there is to be equality of opportunity, to the extent possible, everyone should start from a position of good health.

Third, many people see it as a smart investment on the part of our country; one that gives us some economic comparative advantages and makes society more stable. In an era when the rapidity of change is proving deeply unsettling for many people and when economic change is having an adverse effect on many families, the fact that Canadians need not worry about either not being able to afford necessary medical treatment or being bankrupted by medical bills is seen a sensible approach.

4.2 Concerns About Future Viability

Many participants were concerned that health care would not remain as it is in future. Those concerns were driven by the following factors:

- A sense that the health care system was in decline and that its viability was threatened. A significant portion of participants in the research felt that health care in Canada was not as good as it had been. Anecdotal evidence presented to support this contention centred around government cuts in health care spending, waiting lists for doctors or procedures and the number of Canadian doctors going to the U.S..

- Regardless of whether one believed that there had already been a diminution in service, almost all believed that the future of the system was threatened. Levels of government indebtedness have convinced most that greater cuts are possible in the future. That expectation is positioned against an understanding that health care costs will continue to rise, especially things like drugs and technology — aided diagnosis and/or treatments.

- Worry by some that the will to maintain the system was not strong enough; perhaps there were other ideological agendas that were at play in undercutting the system. These were people who did not quarrel with the principle of governments getting their fiscal houses in order but felt that some governments had agendas to diminish medicare by subterfuge — that the need for spending cuts provided cover to those who did not believe in the principles of the health care system.

- ☐ Some believed that the system design contained the seeds of its own lack of viability. This *minority* saw medicare as a generous impulse but ultimately unrealistic and unsustainable.

4.3 A Reluctant Willingness to Consider Change

Notwithstanding the priority placed on equality of access, a large minority of participants were either prepared to contemplate some form of "two tier" health system or were resigned to its eventuality. Two forces seemed to be driving people in that direction.

- ☐ First, as discussed earlier, many people felt that the money to sustain the system was increasingly not available and that injecting private money into the system was one of the few options for preserving some semblance of what we have in terms of health care. Not all were of the view that "two tier" would be the end of quality care for those unable to afford private care. The arguments presented in favour of "two tier" seemed to make intuitive sense to many people. This was especially true of two arguments. The contention that those who paid privately would free up space in the public system and resources for that system was an argument that had some persuasive effects in the focus groups.

  The idea that some form of user charge would discourage abuse and overuse was also noted. Virtually everybody was of the view that this type of abuse existed and constituted a real problem for the system. Even some of those who felt that the problems associated with user charges outweighed the advantages felt that the system could benefit from some measure that put some responsibility back on to users to help control costs. Many felt this could be done simply by informing people what the actual cost of the services are.

- ❑ Second, for the first time, quality of care is starting to conflict with the higher minded principles of medicare. In health care, as in Ford cars, "quality is job one". The quantitative portion of this research found that equal numbers of people felt that equality of access and quality of care were the most important things to them personally. There is an overwhelming consensus among Canadians about the importance of equality of access as the defining characteristic of our system. That consensus is premised upon the assumption that quality is a given, as they have perceived it to be in the past. The research revealed that the consensus over equality is much less firm when it conflicts with quality of service. Participants felt that historically, our health care had been better than or at least equal to anything in the world — with the possible exception of the care available to the very wealthiest Americans. Most felt that was still the case. Most also felt that condition was threatened. As stated earlier, either through personal anecdotal experience or through their understanding of larger trends, there was a profound sense of a system in decline. Many people were prepared to entertain significant changes in the way the system is designed and administered in order to preserve quality of care. There did not appear to be a similar willingness to accept significant reductions in the quality of care in order to preserve access. It would appear that attempts to preserve the values that are important about the Canadian health care system must be premised upon continued high quality.

The standard of quality that was demanded by most participants appeared to be "among the highest in the world". As part of the constant comparisons to the American system, people tend to accept that the very highest level of care available is of a higher standard than what is available in Canada. The trade-off that makes this acceptable is that the median level of care is seen to be higher in Canada Almost all seemed to accept that in the world of endless technological advances and spiralling health care costs, not everything would be doable in our system. As an example, most had no problem with the use of the cheaper heart drug in exchange for a minor increase in risk. On the other hand, participants volunteered concerns about the "brain drain" of doctors as evidence of people's worries about the ability to maintain quality in our system with decreasing or insufficiently increasing dollars.

4.4 Values and Change

The philosophy of "two tier" did not seem terribly persuasive to people. Arguments about freedom of choice, or the right of people to access the exact care they want at the time they want it — if they can afford it — did not have many adherents around the table.

To the extent that people were prepared to contemplate a "two tier" system, it was because they felt practical considerations were overwhelming compared to what they considered to be the right set of principles — not that we had the wrong set of principles. The overwhelming preference would be for change that preserved both the quality of service and the principles of medicare as Canadians have come to know them.

There are some important assumptions built in to the value choices that people make about health care. The debate about two tier health care is a clash between individual priorities and communal priorities. One has to be careful in interpreting the priority people place on the communal values of health care, such as equality of access, over individual ones, such as freedom of choice or quality. The truth is that most people feel free to place a higher priority on the communal values because quality and choice are taken as a given.

As a consequence, they are not choosing between competing values so much as they are layering communal values on top of a baseline expectation of service. This does not diminish the communal values — they are strong and, given that they are not found in every country or society, the priority placed on them does speak to a Canadian value system. It is also true that, since Canadians recognize that a truly private system like the U.S. version might provide even greater levels of quality or freedom of choice to at least some citizens, they are choosing to sacrifice some of that from the system in order to provide equality of access to a universal system.

All this is to say that there is self interest involved in decision making on this issue. If people's assumptions about quality or freedom began to prove incorrect because of attempts to maintain equality of access or universality, it not clear that the value consensus would hold. If put to a real choice, rather than the somewhat false choice people make now when discussing this issue, those to whom equality of access is less important personally might well prefer a system that delivered the product — quality service and freedom to choose one's doctor — that they expect from a health care system.

4.5 Health Care is Fundamentally about Acute Care

Many people support putting greater emphasis on prevention conceptually. In the initial general discussion of health care, many people volunteered that greater emphasis on prevention would be beneficial and likely generate cost savings over the long run. However, the number of respondents who can follow it through all of the ramifications is considerably smaller. As either discussion or the scenarios force people to confront trade-offs, particularly reductions in acute care, they tended to back off of prevention and to articulate that ultimately the system had to be there for sick people, whatever else it was doing.

There is a fairly narrow definition of prevention within a health context. It tended to be limited to traditional things like education, vaccination and fitness. Some of the broader examples raised by the scenarios (e.g., job creation and environmental programs) seemed to most people to be good ideas but not directly related to health care and more properly the responsibility of social services departments.

Once one scratches the surface, there is significant scepticism about the efficacy of prevention measures. Many people felt the results were hard to quantify and not certain to happen. Moving resources from acute care to prevention seemed to be giving up the bird in the hand.

For most people, it was fundamentally unacceptable to deny critical care because resources had been expended on prevention. While a minority felt the other way, most people felt the priority of the health care system had to be to provide care to the sick. As a consequence, prevention, for most people, was an add-on, not a replacement option.

4.6 Health Care is Whatever Works

Opinions about alternative forms of health care were negative when linked to ethnicity or religion. Some, who were strong adherents to "scientific" medicine, felt these alternatives had no place in the system. Others thought that perhaps there were useful approaches not utilized in our type of health care. These respondents tended to feel that "scientific" medicine had some flaws, or that other approaches seemed to work for some people.

Demand and proportionate allocation of resources were rejected as appropriate consideration by participants in the research. It needs to be noted that while visible minorities were present in every group, these issues were not tested in such a way that would allow one to gauge accurately the extent to which they might or might not share this consensus. However, the perspective on this issue among the participants in the aboriginal group was essentially the same. Health care is not a multi-cultural program and there is no place for remedies that will not be effective just because somebody wants them. The vast majority felt that any alternative form would have to pass a test of some scientific rigour.

There was a point of consensus that covered most people on this issue. The bottom line for all participants was that any approved procedures had to be demonstrably effective. People felt that unless new treatments could pass a rigorous scientific test for effectiveness, they should not be funded. Many people could draw a distinction between what ought to work and what actually works. The important consideration is whether it helps patients heal.

4.7 The Line-Up Starts with the Most Ill

People had difficulty priorizing patients by ranking principles or criteria. People pay lip service to the idea that some decisions or trade-offs are necessary but find it virtually impossible to make them themselves. However, there are some considerations that are clearly not valid considerations and others that most could agree ought to be primary factors.

- ☐ Two considerations that were clearly off the table that people felt were essentially without merit were *financial ability to pay* and *first come, first served*. In rejecting *first come, first served*, respondents are implicitly acknowledging the need for choices. That is, the person first in line is not necessarily the person whom the system ought to service first. Rather, the person more in need should receive the service first.

- ☐ To the extent that there was a consensus about the most important criteria, it revolved around need or medical urgency. Most people felt that this criteria trumped all others. This fits with the earlier finding about critical care — participants' bedrock point is that the health care system cannot turn people away. The only other consideration which had potential with some people to qualify as the absolute priority of medical need was age or the linked criteria of benefit to society.

- ☐ Age was the most controversial criteria. Participants were quite literate about the high cost of critical care for the elderly and the drain on health resources that exercises in extending life for the elderly ill can be. On the other hand people were quite troubled by the idea of making a decision that a person no longer merited every attempt — it seemed to contradict their belief about the value of life. Ultimately, most felt it had to be a consideration. Many felt that if patients or families were informed, a lot would make the decision themselves. The most prevalent view, however, was that at some point, the value per dollar to society had to be considered. This is certainly an issue people are more comfortable not having to confront. They want health care administrators and doctors making common sense decisions and judgements and, on issues like this, not confronting them with the decision. Many felt it had to be a consideration, few wanted to personally have to face the consequences of that logic.

- ☐ Another area of controversy was whether lifestyle ought to be a consideration in treatment or priority. The common example that leapt to mind for people were smoking, drinking and not wearing seatbelts. A minority felt very strongly that people who wilfully create their own health risks should be penalized. Most ended up in the opposite camp. They tended to feel that this criteria was too intrusive and led to a slippery slope of conformity and state intervention with which they were not comfortable. They felt that probably everybody is harming themselves in some way and that can not invalidate a person's claim to what is considered a right of Canadian citizenship — access to quality health care.

4.8 What Does it Mean to be Canadian and Can we Afford It?

At the conclusion, one has the feeling that health care is a primary battleground for many of the larger issues, all value laden, confronting Canada.

People said that medicare was an essential part of the definition of Canadian identity. The different approach to health care was one of the main things that distinguished Canada from the United States. In a period when the unity of the country is perhaps more fragile than at any previous period and when people from coast to coast are struggling to find the common values and shared enterprise to keep the country together, it is both symbolic and disquieting that people perceive medicare to be as threatened as this study suggests.

It may be that the anxiety that many Canadians feel about the future of Canada and the anxiety felt about the future of the quintessential Canadian enterprise of medicare are linked, and so may the solutions. Certainly, the Canadian approach to health care is so central to Canadian identity that if the core principles of medicare were to disappear, one of the most effectively unifying concepts and rights of citizenship would have disappeared.

In some important ways, the debate over the future of health care in Canada and what is required to fix it is a surrogate debate for a broader one. The underpinnings of the Canadian system — that it ought to be run by the government and not run on a profit basis; that money is not the primary consideration and that all are entitled as a matter of citizenship to equal access to quality care — are examples of the typically Canadian approach to problem solving. It is an approach that for many people is emblematic of a Canadian commitment to compassion, equality of opportunity, a sense of community and common purpose. Those types of approaches are under attack every day from the forces driving change in society: high levels of government debt, the globalization of the economy and the influence of international money markets as a result of the first two factors.

These factors argue against government solutions and against the kind of tax rates required to fund universal health care. Since health care is the most valued of all the examples where this approach has been implemented in Canada, it stands to reason that if they cannot be maintained in this policy area, it is doomed elsewhere.

Ultimately, the Canadian health care system, as it has operated for the past three decades, continues to enjoy broad and strong public support. In an era when belief in government efficacy is at a low ebb, medicare is a government program that is popular and thought to be sensible. As popular as it is, people understand it to be threatened. They are not confused about what is threatening it either. They do not think it is threatened because it is not a good idea or because a new approach is required. They understand it to be threatened by steadily rising costs and by the inability of government finances to absorb those costs. For the most part, however, abuse, misuse and poor administration are foremost in Canadian minds as the main engine of spiralling costs. They will want to see these core problems addressed before contemplating other approaches to medicare.

Canadians understand that change is coming — not out of desire, but out of necessity. Much will have to change if health care is to remain the same. What Canadians desire out of the process of program reform is a program that is consistent with the one that exists now: a high quality health care system founded on the principle that health care should be accessible on an equal and affordable basis to all who need it. They like how it works. They like the security and peace of mind that it provides. They like what it says about Canadians as a people.

4.9 The Evolving Context and Implications for Communications

The period of time since the establishment of the National Health Forum has witnessed a number of important shifts in the environment, shifts which have the potential to impact upon how the recommendations of the Forum are received. Among the more important shifts are the following:

- ☐ The aging of the population continues apace, and with it the rising levels of personal preoccupation with health issues, personal and familial in nature.
- ☐ Heightened speculation about the future of the CPP and government pension support, combined with an aging population has aggravated feelings of insecurity, which in turn makes the debate about future availability of quality health services more tense.
- ☐ Several years of continued government cutbacks and stories of the impact of cutbacks have made people somewhat less convinced than they were to assume that there is rampant waste and abuse in the system. This is more likely to be felt in those provinces where major cutbacks have been the focus of acrimonious debate, but it is generally true in most parts of the country. Election outcomes, and political debates in Ontario, Alberta, Saskatchewan and Quebec have probably been most noteworthy in this regard.
- ☐ The strains on the health care system are more apparent to more people over time. A greater number have witnessed first hand the stresses evident in emergency wards, doctors' offices, etc. which makes the debate about the future of the health care system less theoretical and much more practical for those people.
- ☐ There is a modest minority of the population who are starting to feel that governments are gaining the upper hand in the fight against deficits, and beginning to wonder about the kinds of choices which balanced budgets or budget surpluses might afford in the future. At the top of most peoples' wish list is an effort to strengthen the health care system, a "luxurious" thought which seemed previously unaffordable.

The implications of these shifts could include the following:

1. The notion that there is a gap between public "irrationality" about the choices facing the health care system pitted against elite "rationality" may not apply. Instead, it may be the case that the public is increasingly aware and accepting of the difficult decisions which lie ahead. Rather than assuming that the public needs to be educated about the fact that there are difficult choices which need to be made, the Forum may want to consider assuming that the public has already moved beyond that point, and indeed may have started to come to their own conclusions already (see below).

2. The notion that the public's values and their economic self interests are clashing or incompatible when it comes to the health care system similarly may not apply. Rather, it may be the case that the public has concluded that it values the health system over all other public services, and is willing to support increased investments (and public borrowing) if necessary to avoid a situation where further rationing/erosion/tiering options are contemplated. The Forum should be cognizant of the fact that the public may no longer be conflicted about their desire for deficit management and a good health care system.

3. For many people, the health system is increasingly a personal benefit or entitlement question, rather than an abstract symbol of Canada, or an interesting public policy debate. Consequently, ideas or institutions which purport to "reform" the health care system are put under more scrutiny by the public, and on balance people are worried that they too often begin with the goal of reducing expenditures, rather than the betterment of health care. To some degree, the language of reform has become associated with problems, strains and bad news stories in health care, rather than solutions and good news stories.

In summary, we would recommend that the Forum approach its communications requirements:

- ☐ Taking care not to adopt the stance of educators of an ill-informed public, at least about the need to make hard choices.
- ☐ Seeking to prove its bona fides as a reform minded institution by avoiding the deficits versus health care paradigm.

(78)

APPENDIX A

Scenarios

SCENARIO 1

Although she tried to hide it, Charlie could see that his mother was in pain. The physiotherapy wasn't doing her any good. It had been almost a year since her back began troubling her, and nothing they had tried so far had helped. It was getting worse.

Mrs Wong had come to live with her son Charlie and his family two years ago, after her husband died. It had been difficult for her to adjust to the way of life in their small, Northern city. she missed Chinatown and her friends there, and all the comforts it provided her, especially since she had become sick.

When the first symptoms of her back problem appeared, Charlie's mother knew what it was at once. " I had this problem ten years ago,"she had told him. " I went to the Chinese healer and right away he could tell what was wrong. After four weeks of acupuncture, the pain was gone. But he told me it would probably come back again, and now it has."

There was no Chinese healers in the city in which Charlie lived, but there was a naturopath who practiced acupuncture. He had a good reputation, but his treatments were not covered under the province's health insurance plan. Treatments didn't cost much -- four weeks of treatment might cost about $ 500 - but Charlie and his family didn't have that kind of money They were having difficulty making ends meet as it was

It was for lack of money that Charlie had persuaded his mother to see his doctor almost a year ago, and after that, another doctor, and then a physiotherapist.

It had gone on too long. Looking at his mother, he decided that in the morning, he would take his mother to the naturopath. And if the naturopath thought acupuncture would help, he would go to the bank and borrow the money.

It doesn't make any sense, he thought to himself. If my mother was in Chinatown, 600 miles away in the same province, the acupuncture treatments would be paid for because the Chinese healer belongs to a publicly funded clinic. Here in my city, the public system will pay much money for treatments that do not help her, but it will not pay for the treatment that probably will.

SCENARIO 2

After waiting 3 weeks for an appointment, Mr. S., a 55 year old independent truck driver, met with a heart specialist, who advised him he needed coronary bypass surgery. Unfortunately. it would take up to 10 weeks. Mr. S. was told that his angina was stable and not immediately life-threatening, but serious all the same. For his safety, and the safety of others, the specialist said he should not return to work, and that she would review his fitness to work following the surgery.

Mr. S. complained that being laid up would bring him financial ruin, and that it would be maddening to live under the shadow of the operation for that long. The doctor listened carefully and sympathetically, but responded that there was nothing she could do.

Dejected by this news, Mr. S. pulled some strings with an old friend and got a meeting with a specialist in another major city. That specialist said he could get him in for surgery in about two weeks.

Mr. S. was pleased about this, but curious about the reason for the difference in waiting lists between the two cities. He investigated, and discovered that 5 years ago the Regional Board for the city in which he lives decided to spend more money on prevention, and consequently to spend less on acute care. The Regional Board in the other city, however, considered and rejected this option, and decided instead to ensure that programmes like the coronary by-pass programme were well-funded.

According to a recent newspaper article, the prevention program has been very successful. and the incidence of heart disease in Mr. S's Region has decreased by 5 per cent. and is a full 10 percent lower than in the Region to which he travelled for the bypass. "Maybe the Board in my Region made the right decision," he remarked to his wife, "but I'm sure glad I won't have to suffer its negative consequences."

SCENARIO 3

Walking home from the community meeting, Mariella and Pablo continued the discussion about health care funding that had begun there.

Mariella: I can't believe you supported the cuts to health care.

Pablo: It's not that I don't think health care is important. But I think we could get better value for our money – more health for our money – by spending this money on other things. That money would do a lot more good if we spent it on job creation and cleaning up the environment.

Mariella: I think it's much more important to look after the people who are sick right now than to improve the health of the general population. And besides, I doubt that the money saved would be spent on making a difference in health. Our health care system is one of the things that makes this country so special, Pablo, and I'm very worried about the impact of these cuts.

Pablo: You heard what the experts at the meeting said. There's lots of waste and inefficiency. If we get rid of that, there's plenty of money to fund the system.

Mariella: I'm not so trusting. Maybe there is lots of inefficiency, but do you really believe that quality won't suffer? These cuts will make it very difficult for the provinces to ensure that all Canadians have equal access to quality, medically necessary care.

Pablo: That term "medically necessary" is so broad it can mean anything. The health care system has expanded beyond its original intent, and beyond what we can afford. Sure, we have to see that no Canadians will lose their houses or burden themselves with debt in order to meet their medical needs, but maybe the government just can't afford to meet all the lesser needs and wants.

Mariella: Well, who's going to decide what we can and cannot afford, and which and whose needs are greatest? People like the ones at the meeting who supported the cuts? Most of those people were very well-dressed and pretty healthy looking. Not very typical of the people I work with every day in the chronic care unit. And not very typical of the people in the neighbourhood where you an I grew up Pablo. Those are the people I care most about.

Pablo: We agree then Mariella, because its these people I care most about too. I want them to have jobs, and I want their children to have good schools and safe streets. Those things don't come from doctors and hospitals.

SCENARIO 4

Jimmy was terribly sick, but Nurse J. could tell from the faint smile he formed as she entered the room that he was very happy to see her familiar face. Young Jimmy Brown, 9 years old, was no stranger to her care. This was his third visit to the emergency department since the fall. She clutched his hand and said "Everything will be alright now Jimmy. We'll look after you ."

Jimmy Brown has chronic asthma, and his condition had deteriorated since his last visit. This time Nurse J. was very worried from the signs she saw. They would look after and give him the best care possible, and probably he would get better. But everything wouldn't be alright. In a week or so, if everything went well, he would go home, but that wouldn't make everything alright. Far from it. That was where the cycle would begin again.

Since his father abandoned him and his mother two years ago, Jimmy lived in a dilapidated old house on the outskirts of town. And in that house- a shack others might call it - was a wood stove that served as the only source of heat. Jimmy's mother knew that the fumes from the smoke aggravated his asthma, but there was nothing she could do. She didn't have the money to but a furnace, or to move into a better place. And the welfare system wouldn't cover it. Nurse S.and the social worker had tried their best to intervene on the Brown's behalf, but to no avail.

Nurse S. felt frustrated and angry. The system could not or would not do anything to remedy the problem that was causing Jimmy's sickness, but whenever he got really sick the system would go into high gear and spend many times more money than the cost of a furnace to fix him up. And the cycle would begin again.

It didn't make sense; not for Jimmy, not for his mother, and not for society. They wouldn't look after him, not really. It wouldn't be alright. It was only February, and there were cold months ahead.

SCENARIO 5

The newly formed Springdale Regional Board is responsible for health services, including hospitals and chronic care facilities, for a community of 300,000 people.

Each year, the Board receives a fixed sum of money from the province, which it must divide among health institutions, agencies, and services in its Region. Money is tight, and the Board has learned it must make do with 10 percent less money than it got last year. They have ordered an extensive review of all services to assist them to set priorities.

To help them set priorities, the Board commissioned an extensive needs assessment for the Region. the study disclosed that many health needs were not being adequately met by existing services. The needs of those who are dying were identified as an area of special concern, especially in light of the Region's mission statement to ensure that those who chose to do so will be able to have a good death in the personal environment of their homes rather than in institutions. The study found that , overall, very little money was spent on palliative care compared to other health services, and to acute care in particular. The report concluded: " We spend a tremendous amount of money trying to save lives even in cases where the chances of success are very slight. Money is no object here, it seems. But once it ti decided that further aggressive treatment is futile or undesirable, we turn our backs on the dying, and spend very little money to ensure that they have as good a death as possible. "

Board members agreed that the needs of the dying were not being adequately met, and agreed also about ways to improve the situation. However, this would require additional money, and. given the cuts to their budget, there wasn't even sufficient money to fund existing programs. " The bottom line is that we cannot go on leaving these needs unmet," one member said. " We have to find the money to do this, and regrettably this will mean shifting it from other services. A good part of our budget goes to acute care, and I see little choice but to reallocate some money from acute care to palliative care. Given the other demands on our resources, maybe we can't afford that heart-lung transplant programme at the main hospital. Very few people benefit from it, and the money could accomplish a lot more good if we spent it on the dying".

SCENARIO 6

"Its hard to say at this time how serious the heart attack was," the younger doctor said. "I think she'll be fine with the streptokinase."
"Let's hope so," the older doctor replied. "I'm not happy with the new guideline. If this happened a week ago, we would have used TPA, and I would have felt better about that."

The doctors must not have realized that the woman in the elevator with them was the daughter of the 62 year old woman they were talking about, Mary S. Mary had eavesdropped intently on their conversation, but hesitated to identify herself and ask the questions that were burning in her mind. She had decided instead to return to the floor and ask the nurse. The answers she received troubled her.

The nurse explained that there are currently two drugs available for treating heart attacks: streptokinase and r-TPA (tissue plasminogen activating factor). R-TPA is slightly more effective in severe heart attacks. Some research shows that it saves about 1 additional life for every 100 uses. However, the costs difference between the two drugs is very great. Whereas streptokinase costs $460.00 per dose, r-TPA costs $2,500 per dose, more than 5 times as much.

The costs of a policy of using r-TPA in every case would be very great, the nurse explained. Given budget constraints, the hospital pharmacy had recently examined its policy in this area. and debated whether the benefit, in terms of the number of lives saved, was worth the costs. This money, it was claimed, could be used to better effect in the hospital. Some people thought the hospital pharmacy shouldn't carry the more expensive drug at all. A compromise was reached that the hospital would carry it, but that doctors would only use it when they thought the heart attack was very severe. That was probably the guideline Mary heard the doctors talking about, the nurse figured.

Mary went back into her mother's room. She was sleeping now, and her vital signs were looking good. She was a strong woman, Mary thought. She'll be home and back out in her beloved garden in no time at all. Still, it troubled her to think that her mother might not have received the best treatment possible.

SCENARIO 7

There was a profound sadness in the cafeteria. After months of rumours, it was final now. The hospital would be closing.

"They say this community doesn't need two hospitals," Nurse L. remarked. "We're bursting at the seams with more people than we can look after, but the hospital isn't needed? Obviously we're meeting somebody's needs. How will those needs be met when we close? I don't get it."

"Oh, I get it alright," Nurse S. added. "That's where community-based care comes in. These needs will be met in the community, closer to home. You know, self-help and all that. families taking more responsibility to look after their own. That's the story the public is expected to buy, hook, line, and sinker."

"I think you're being a little too cynical," Nurse J. broke in. "Community-based care makes a lot of sense. You know as well as I do that many of the people we care for could just as well be cared for in the community or in their homes."

"Oh, I agree that a lot of them could be," Nurse S. replied, "if there were a community support system, or a family able to look after them. But the reality is that in too many cases there just isn't. And until there is, it's not right to dump sick people into the community."

"I agree," Nurse L. joined in. "And it's not just the patients I'm concerned about, it's their families -- the mothers, sisters, and daughters who will bear the burden of caring for their needs. Undoubtedly this hospital isn't the best place for elderly people Mr. J in room 312. Nothing we can do will cure old age. But there's nowhere else for him to go except home. and then the burden of care will fall on Mrs. J. At her age it would be too much for her. Next thing you know, she'd be the one in the hospital. Community-based care -- I'm all for it -- if the community supports are in place. They say they're going to transfer some of the money saved from closing the hospital to the community and build up the support system. Why don't they do that first?"

"I'll tell you why," Nurse S. volunteered. "Because they have no intention of building up the support system, that's why. We've seen all of this before. Saving money is the name of the game here, and community-based care is just a smokescreen."

SCENARIO 8

Joe was a feeling a little nervous. As a respected leader in his community , the Regional Health Board had asked him to hold a meeting with his people to gauge their values about priorities for health spending in the Region. He examined the list of values they had prepared for him to go over at the meeting.

> *i) Efficiency: The health system should be as efficient as possible. Services and programmes should be effective, used appropriately, and delivered at the least cost possible.*
>
> *ii) Comprehensiveness: The range of services should include all treatments and services that meet health needs.*
>
> *iii) Quality of Care: The quality of care available to all Canadians should be as good as, or better than, other countries.*
>
> *iv) Patient Autonomy: Patients should have maximum choice in deciding what services and treatments are available to them, and under what terms they will receive them.*
>
> *v) Equal Access for Individuals: Every Canadian should have equal access to health care. Ability to pay should not be a barrier.*
>
> *vi) Equal Shares for Groups: Resources should be distributed so different communities and population groups get equal shares.*
>
> *vii) Neediest First: Resources should be distributed on the basis of need: the needs of the neediest should be met before or ahead of the needs of the less needy: resources should be distributed to individual and populations in proportion to their need for them.*
>
> *viii) Maximum Benefit for Dollar: We should strive to get the most "bang for buck". or benefit for health care dollar.*
>
> *ix) A Healthy Population: We should strive to make as great a positive impact on the health and well-being of the Canadian population as possible.*

Important issues were at stake. The budget for the Health Board had been cut back, and there were some difficult choices to be made. His community would be effected. He thought it was important that these choices be based on values instead of politics, and that the Board was wise to try to gauge the values of the communities it represented. Even so, values are hard to capture and Joe wondered how well the values on the list captured the values of people in his community and whether the meeting would succeed in bringing their values to the surface.

APPENDIX B

Moderator's Guide

Ekos Research Associates Inc./
Earnscliffe Research and Communication, 1996

NATIONAL FORUM ON HEALTH
MODERATOR'S GUIDE

I Introduction and Warm Up — 5 minutes

II Preliminary Questions & Discussion — 15 minutes

1. As you know, we will be talking about health and our health care system tonight. First off, I would like to know what you include in your understanding of "health care system".

   What are some of the main things that are part of "health" or the "health care system"?

2. We can all relate to the health care system based on our personal experience. Think about your own experiences and perhaps those of the people that are closest to you. I would like you to characterize/describe the health care system in one sentence or two. **[participants should be encouraged to jot down their response on a piece of paper to avoid yeay-saying]**

3. Describe the three best and the three worst things about the health care system
   [participants should be encouraged to jot down their response on a piece of paper to avoid yeay-saying]

III Scenario Discussion — 1 hour, 40 minutes

Scenario (as designed by the forum) will be presented for discussion by participants. The moderator will provide a written copy of the scenario and play an audio tape version as well. The moderator will ensure that at least two scenarios will be discussed in each group. More will be added if time permits.

Discussion pieces for each of the eight selected scenarios will be as follows:

SCENARIO 1

i. Do you think the health care system should pay for acupuncture for Charlie's mother?

ii. On what grounds do you think the system should decide which health services will be publicly funded? Evidence of effectiveness? Consumer demand for them? Medical opinion?

iii. Western medicine is but one of many different healing methods developed over the years by different cultures. In a multi-cultural society, should we be more willing to embrace multi-cultural health care?

iv. State whether, and why, you agree or disagree with the following statement: "The decision whether to fund a given health service should be based on evidence of effectiveness. If traditional cures and therapies from other cultures meet these standards, they should be funded. If not, they should not be."

v. Does fairness mean that different population groups, and in particular ethnic groups, have a right to an approximately equal share of money spent on them for health care?

SCENARIO 2

i. Given the information above, which Board do you think made the right decision, and why?

ii. Is it consistent with equal access that there should be such great variation in waiting lists between different regions in the same province?

iii. How would you rank the various criteria listed below for prioritizing people in a waiting list for a medical service? Are there any that you feel should definitely not be used and why?

1. medical urgency
2. benefit to the individual
3. benefit to society
4. age
5. lifestyle factors

6. first come, first served

iv. Supposing there were a private clinic where Mr. S. could get quicker treatment:

a) Are private clinics delivering more timely health services to those able to pay for them inconsistent with the principle of equal access?
b) In deciding whether private clinics are a good or a bad thing, how much difference does it make whether they are in part subsidized by the government?
c) Is it unfair if people with money can get more timely or higher quality health care than people who have to rely on the public system?

v. How would you feel about the inequality that would exist in a two-tiered system in which the public system funded only the most basic and essential services and, a second, private system, delivered more "cadillac" services to those with the ability to pay?

vi. How important do you think it is for people to have the freedom to purchase health care privately if they can afford to and believe that the add benefit is worth the cost?

vii. If everyone's basic needs were met in the public system, but some people could get more timely treatment by paying for it privately, would this be a serious inequality? Would you be prepared to accept this inequality in order to allow those with means the freedom to spend their money as they wished?

viii. How is health care different from other services in our society that are bought and sold in the marketplace? What, if anything, is so special about health care?

ix. We tolerate many inequalities in Canadian society. Some people have big houses, other live in the street. Some people drive fancy cars, while others cannot afford to buy a car at all. Is inequality in health care different than in other areas of life? If so, why?

SCENARIO 3

i. Which of the two speakers do you most sympathize with, and why?

ii. Mariella is concerned about the consequences of funding cuts for poor and needy people. How important is the government's obligation to help these people? Is there anything else more important?

iii. State whether, and why, you agree or disagree with the following statement: "We can't afford to pay for everything the public wants; we have to concentrate on what the public really needs."

iv. In deciding the level of public funding for health care, how much weight should be given to what patients or consumers would like as opposed to what experts think they need?

v. Do you believe that all Canadians have a right to health care, and if so, how would you qualify this right? A right to basic services? A right to quality services? A right to the best health services possible?

vi. Mariella thinks our health care system has special importance for us as Canadians. Do you agree? What significance or value does our health care system have for you as a Canadian citizen? Is there anything else about this country that you think is more important?

vii. Some people claim our health care system is vitally important to our national identity. Do you agree? What is it about our health care system that makes you most proud as a Canadian?

a) its high level of quality
b) its efficiency
c) its success in meeting the needs of the sick and vulnerable
d) its equality

SCENARIO 4

i. Would it be appropriate to redirect money from sickness care to prevention if the money spent on prevention would produce more benefit, and perhaps even save money in the long run?

ii. Do you think it is more important to ensure that people who are sick and disabled are able to achieve the best level of health possible or to ensure that people who are healthy do not become sick and disabled?

iii. If the same amount of money could be used either to save the lives of 10 heart attack victims over a 5 year period, or through preventive measures to reduce the number of people who would suffer heart attacks over the same time period and thereby save 100 lives, which would you choose? Why?

iv. In some cases, the cost of treating someone who is sick and in need are very great, and the anticipated benefit is uncertain and slight at best. In other cases however, tremendous benefits can be had for very little cost. If you had to choose between producing very slight benefit for one very sick person, and a greater benefit for 10 people who were less sick, which would you choose, and why?

SCENARIO 5

i. How important do you think it is to ensure that the needs of the dying are met as fully as possible compared to trying to save lives when chances of success are very poor?

ii. Interventions to save lives are often very expensive. Do you think we put too much emphasis on saving lives at any cost at the expense of not meeting other important needs?

iii. If we cannot afford to meet all heath care needs, on what grounds should we decide which needs will receive greater priority?

iv. Is the amount of benefit produced per cost an appropriate criteria for deciding which, whether, and at what level health services should be funded? What alternative criteria would you suggest, and how would you compare their importance?

v. If two services are compared in terms of how much benefit each produces in terms of cost, and both cannot be funded, should we fund the one with greater benefits per cost?

vi. In deciding where to allocate health care resources, how important is it to you that the benefits are distributed fairly among various populations? How important is this consideration compared to ensuring that the greatest amount of benefit possible is produced, regardless of who gets what and how much of it?

vii. How does information about how much money per person is spent on people in different groups bear, if at all, on fairness?

viii. If you had to choose between funding a service that delivered three healthy meals a week to shut-ins, needy seniors, and a school lunch programme that provided lunches for needy children, which would you choose? Why?

ix. What does fairness mean to you, and how important do you think it is for health care resources to be distributed fairly? How do you see the relationship between fairness and equality?

SCENARIO 6

i. Suppose the money saved from this guideline could be used to achieve greater benefit (save more lives) in the hospital by being allocated in other ways. Do you think it is acceptable to use the cheaper but slightly less effective drug? Why?

ii. Suppose that the money saved by using the cheaper drug was enough to fund a nurse to offer low-income families prenatal care in their homes, and that more lives could be saved by such a programme than by always using the more expensive drug. If you had to choose between these options, which would you choose, and why?

iii. If the more expensive treatment slightly increased patient comfort, but would have no long term impact on the patient's health, do you think it should be offered, even though the benefit for this additional cost would be relatively small compared to other uses to which the money could be put?

iv. All of us want the best care possible for ourselves and our loved ones. We also want to ensure that there is enough to go around, and that everybody gets a fair share. Do you think these two wants are ever in conflict? If so, how would you resolve the conflict?

v. Should we always do what is best for the individual patient, regardless of costs, or should we try to ensure that scarce health care dollars are used to produce as much benefit as possible?

vi. Do you feel that the doctors have compromised their professional ethic by using the arguably second best treatment?

vii. If a physician is aware of a treatment that would be more beneficial for you than any he or she is able to offer, is he or she obliged to disclose this information to you?

viii. Should physicians ever by put in a position where they are required to do anything less than what they believe is in the best interests of their patients?

SCENARIO 7

i. Do you think it is fair to expect families to assume increased responsibility for caring for their own? Is it fair to rely on such an expectation in making allocation decisions?

ii. In some cultures there is a greater expectation that families will look after their own than in others. Is such an expectation something that we should try to foster more widely in our society?

iii. When the burden of caring for someone is transferred from an institution to a family, should some part of the money thus saved be transferred to the family to assist them?

iv. If costs can be saved by relying less on professional care-givers and more on family members and informal care groups, is it justifiable to pass this burden onto them? On what grounds?

v. Should charities and volunteers be expected to assume more of the burden of care presently being delivered in institutions or by the publicly-funded health care system?

SCENARIO 8

i. How would you rank the principles listed above, and why? Are there any values you think should be added to the list?

ii. What conflicts do you see as potentially developing among or between these values, and how would you resolve them?

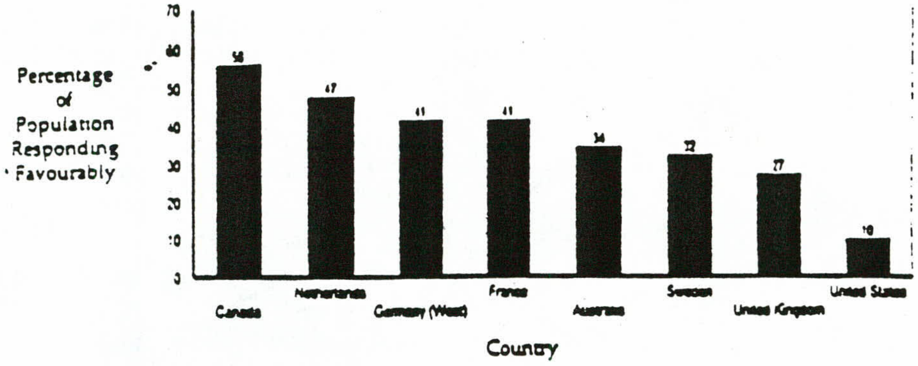
iii. Do you think most Canadians share the same values about health care and health care funding, or do you think there is a lot of variation based on things like cultural and religious differences? If different cultures do have different value priorities, how important do you think it is for the health system to reflect those differences?

iv. Should people from different cultures be able to decide how and by what means their health needs will be met, or should health care services be the same for everyone?

APPENDIX C

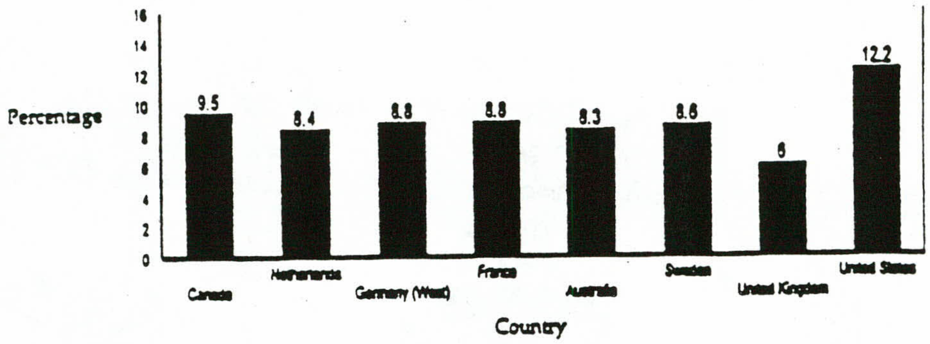
Deliberative Information

GRAPH 1: COMPARATIVE LEVELS OF SATISFACTION WITH HEALTH SYSTEM*



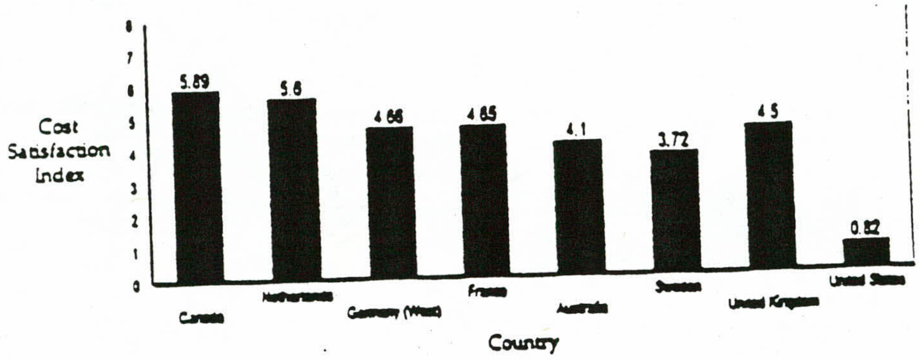
Source: Satisfaction with Health Systems in 10 Nations, Blendon et al. 1990
**On the survey, the question was worded as follows: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better."*

GRAPH 2: TOTAL HEALTH EXPENDITURE AS A PERCENTAGE OF TOTAL DOMESTIC EXPENDITURE



Source: OECD Health Systems, 1993.

GRAPH 3: COST SATISFACTION INDEX*

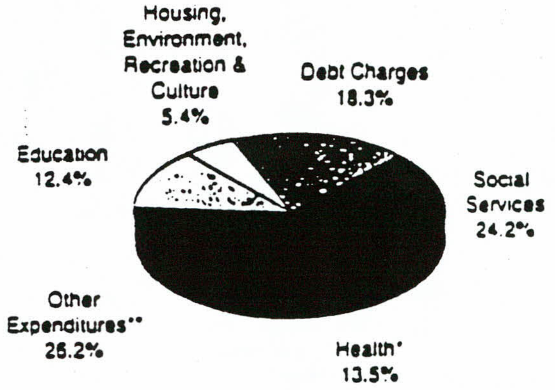


**Cost satisfaction index is the percentage of population indicating satisfaction with their health system (Graph 1) divided by the percentage of total domestic expenditure it takes up (Graph 2).*

Government Spending

Figure 3

Governments Spent $355 billion in 1993-94
(Approximately $12,340 for every man, women and child in Canada)



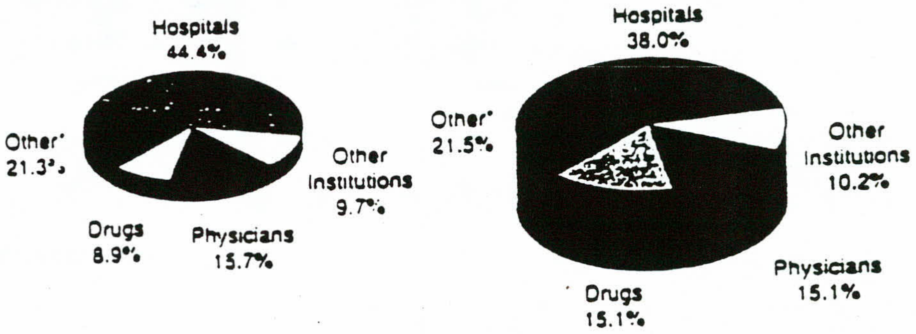
* Health includes health services and administration, research, public health, etc.

** Other expenditures include protection of persons and property, transportation and communications, resource conservation, etc.

Source: Statistics Canada

How Money was Spent on Health Care in 1975 and 1993

Figure 5



Total of $12 billion or 7.1% of GDP
1975

Total of $72 billion or 10.1% of GDP
1993

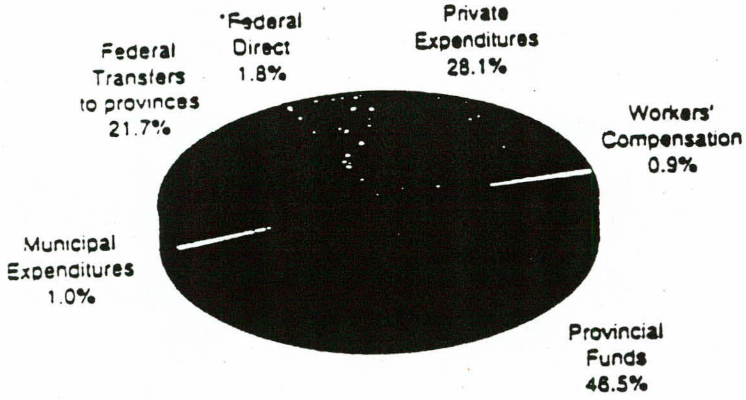
* Other includes other health professionals, capital expenditures, health research and public health

Source Health Canada

Where Health Care Funding Comes From

Figure 8

- In 1993, public health expenditures (by all levels of government) represented 71.9% of total health expenditures in Canada
- Private health expenditures accounted for 28.1%



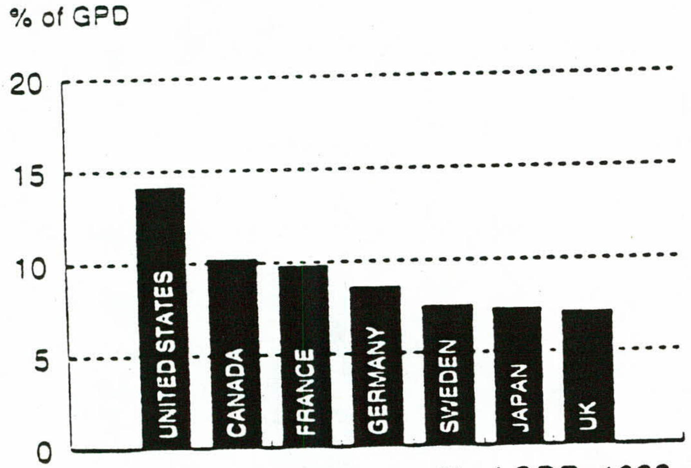
*Federal Direct includes health services for Aboriginal peoples, veterans, armed services personnel, research, etc

% Distribution of Health Expenditures by Sector of Finance 1993

Source: Health Canada

Money spent on health Relative to the Economy

Figure 6

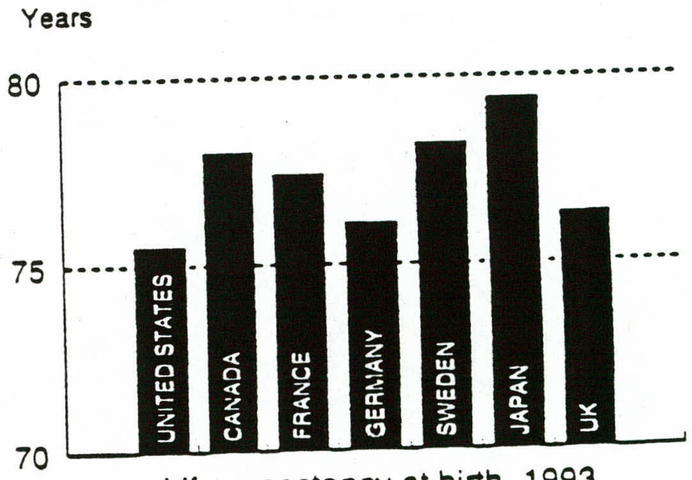


Health expenditures as % of GDP, 1993

Source: OECD Health Data

Average Length of Life Various Countries

Figure 7



Life expectancy at birth, 1993

Source: OECD Health Data

APPENDIX D
Survey Questionnaire

QUANTITATIVE COMPONENT FOR RESEARCH ON CANADIAN VALUES IN RELATION TO HEALTH

1. **Listed below are a number of statements.** Please rate the degree to which you agree or disagree with each statement using a 7-point scale where 1 means you strongly disagree, 7 means you strongly agree and the mid-point 4 means neither agree nor disagree.

	STRONGLY DISAGREE			NEITHER			STRONGLY AGREE
a. *I think that the health care system is more about values than economics*	1	2	3	4	5	6	7
b. *I have more confidence today that the health care system will take care of me than I did five years ago*	1	2	3	4	5	6	7
c. *Individuals should be allowed to pay to get quicker access to health care services*	1	2	3	4	5	6	7

2. **There are a number of values or ultimate goals which can define our health care system.** Please rate how important each of the following values should be in shaping the health care system, using a 7-point scale where 1 means not at all important, 7 means extremely important and the mid-point means moderately important.

	NOT AT ALL IMPORTANT			MODERATELY IMPORTANT			EXTREMELY IMPORTANT
a. *Equality of access*	1	2	3	4	5	6	7
b. *Freedom of choice*	1	2	3	4	5	6	7
c. *Efficiency*	1	2	3	4	5	6	7
d. *Flexibility*	1	2	3	4	5	6	7
e. *Performance/results*	1	2	3	4	5	6	7
f. *Compassion*	1	2	3	4	5	6	7
g. *Prevention*	1	2	3	4	5	6	7

3. **Which one of the following aspects of health care is of greatest importance to you?**
[Please make only one selection.]

Quality of health care service	1
Costs of health care system to country	2
Health of the Canadian population	3
Equal access to health care for all Canadians	4

4. **Now we have a few final questions for statistical purposes only. In what year were you born?**

|_1_|_9_|___|___|

5. **What is the highest level of schooling that you have completed?**

Public/elementary school or less (grade 8)	1
Some high school	2
Graduated from high school (grade 12-13)	3
Vocational/technical college or CEGEP	4
Trade certification	5
Some university	6
Bachelor's degree	7
Professional certification	8
Graduate degree	9

6. **Are you...?**

Male	1
Female	2

APPENDIX E

Verbatim Comments

Ekos Research Associates Inc./
Earnscliffe Research and Communication, 1996

- A universal first class distribution of health care. Perceived to be envied by the world.
- Good system, going broke slowly.
- Canada's health care system is a decentralized (provinces) good system accessible to every citizen.
- Canada's health care provides care for all citizens. The care is probably the best in the world.
- Allows all citizens to have access to medical facilities and doctors regardless of cost and regardless of who the citizen is.
- In my opinion, Canada's health care system is one of our greatest assets. This doesn't mean, however, that it is without flaws. I think the idea of health care is very important but it may need to be re-worked or improved.
- Canadian health care is available to anyone who needs or wants it at no personal cost whatsoever. It's one of the best plans worldwide.
- Available to everyone who lives in Canada (some form).
- Canada's health care system is a government-run program that attempts to provide free-inexpensive medical services to the general population. With regard to services, they include both re-active and pro-active aspects of medicine, with the emphasis on reaction.
- Canada's health care system guarantees free access to medical care, professionals and facilities to all Canadians.
- The Canadian health care system is a well structured system that sees that all people are eligible to receive care.
- I would describe the health care system as a universal system providing equal access to everyone.
- The health system is not cost effective or health effective. It is over-strained, under-staffed and the myth of its availability is undone by its ineffectiveness.
- Comprehensive, high quality socialized health care system.
- It's about having freedom as a Canadian. Not having to worry about cost and liability. A definite plus for Canadians.
- Health care system is universally accessible and generally effective - but it is overbuilt, costs are hidden and too much focus on large, high-tech institutions with high overheads.
- The Canadian health care system is in my opinion simply the best of its kind in the world
- Is one of the best systems Canada has.
- Accessible to all, rich or poor and equal to all as not based on a fee structure but a monthly "OHIP" premium.
- The Canadian health care system is - or should be - fair, open and accessible to all. It is also affordable for all.
- In a state of flux between universality and an unknown destination. At its best it is the single greatest most beneficial difference between us and our southern neighbours.
- Deteriorating - government involvement gets more specialized with specialists such as doctors being elected who soon lose their focus from care and focus on cost. There is a dichotomy between cost and service, they are not mutually exclusive.
- There used to be everything - now everything is being cut, sometimes I understand from the media and friends, to the detriment of patients. I am concerned with the care of the elderly, in particular.
- System is going in a backward direction falsely thinking it is going forward. Patients are being neglected and sent home too early, being told home care is better.

- Well I think too many nurses being laid off. Not enough of 1 on 1 or 1 on 2. Not enough coverage for welfare system.
- Universal and thorough. A bit slow but very comprehensive or inclusive.
- Canadian health care system is a public system which is primarily undergoing some major changes.
- I think we have one of the best health care systems in the world. If you have a problem you can go directly to your doctor or a hospital without worrying if you have insurance or not because they will look after you.
- One of the best in the world - envy of many nations about to suffer significantly from fiscal restraint.
- Fairly good, no real national direction, facing problems with funding cuts and bleak economic forecasts.
- Universally available to everyone but becoming overextended, needs to be better controlled.
- Universal health care system that for the most part provides for everyone equally but has become too expensive to continue in its present form.
- As I see, Health Care in Canada today: Health care for everyone in Canada at reasonable cost and available in all remote regions - having the use of top notch doctors, nurses and hospitals.
- A Federal Government system for universal health care. I think it is co-ordinated with the various provincial governments.
- The clinic facilities are a major asset, medicine availability. The doctors at the clinic very helpful. The operational hours are also excellent. No need for an appointment is good.
- The need of medical services when you are working at minimal wage - your medical expenses could be astronomical with no assistance if you do not have a medical plan with the company you are employed by.
- Health care in Canada today is generous - all comprehensive adequate. Reasonable in cost for what you get.
- I think that the health care in Canada is superior to most places in the world but could be improved on.
- I think the standards of our health care is going down hill due to lack of staff and rooms in hospitals.
- The health care system is in a crisis. In need of a shake up to make sure we are getting the best system for the money. But I do think despite the problems we do have a good system.
- A comprehensive government plan to cover all major medical needs of citizens of Canada. Major medical expenses are covered in almost every situation.
- Seems to be going down the drain right now-has been good for many years - till they started all the cut backs.
- In general the health care is good.
- Social welfare system with standards set by the federal government.
- The health care system is ideally a system whereby people have access to medical services regardless of economic status.
- The health care system in my opinion is a very good system compared to other parts of the world.
- Canadian health care is an inexpensive medical program that is available to most Canadians. We have excellent facilities and very good medical coverage.
- In Canada we are fortunate to have universal health care, provided equally to all. This system contributes to the fact we have one of the highest rates of taxation in the world.

- A not so efficient means to allow most citizens access to medical attention in the form of doctors, hospitals, etc. It's a good system in that we (Canadians) do not need to worry too much about how to pay for health care, which can be expensive.
- Health care in Canada is for everybody
- I think we are fortunate to have our health care system. Don't have to worry about large costs if something happens to you.
- Our health care system is adequate as I know it. My care in hospital is excellent. We have ready access to specialist.
- The health care system has deteriorated dramatically.
- The quality of health care in Alberta has been declining steadily under Ralph Klein's rule. Each month we are progressing towards a 2 tier system in which those that can pay have access to private services - quicker.
- Our health care system is set up to accommodate the needs of the sick and healthy. It use to cost us very little, now because of years of abuse from patients, doctors and governments it is in a state of change.
- Health care very essential for the society
- Health care in Alberta is being developed to a high degree of effectiveness however is in a state of transition. Cuts are not effective.
- In the past, we have had the best health care system. With a great change in technology (transplants, etc.) we live too long, help many hopeless cases - etc. We can no longer provide the same care. At this time, we are basically out of control.
- A health care system that is available to all and provides a very respectable level of care.
- The health care system (in Alberta) is generally very good with the exception of the present state of economics. People within the system are requiring more funding while tax payers are saying enough is enough.
- Our health care system is set up to accommodate all Albertans regardless of financial standing.
- Health care in Alberta, while having high standards is declining and appears to be becoming obscure.
- The Alberta health care system is undergoing an Americanization. That is it is going to hell in a hand basket.
- A good system that is undergoing some radical but perhaps too quick changes. It is an efficient and fair way to deliver health services.
- Our health care is lacking confidence in the abilities to keep the general population healthy.
- Saskatchewan is unique in its health care for our province in that it states that all people are entitled to health care. It is universal.
- Saskatchewan has historically been the backbone and designer of "Medicare" in the health care area. Open access to all citizens for health.
- The health care in Canada is quite satisfactory. Personal experience I've always received what I needed.
- Not enough first nations medical staff to meet the needs of first nations people. Everyone deserves proper medical care.
- Health care in Saskatchewan is an all round medical care for individuals. Doctor & hospital visits are reasonably accessible, doctors anyways.
- I have been very fortunate to be healthy but do see some deficiencies in the overall system.
- The health care system in Canada is comprised of two parts by acute care or hospital services and community health initiatives. One half cares for the ill, the other is focussed on education and prevention of disease/illness.

- There is great difficulty in securing a family physician but, nevertheless, it seems that there is "adequate" health care.
- Health system in Saskatchewan is a federally funded program which helps individuals in need regardless of economic, social or racial background.
- Health care in Saskatchewan is rapidly deteriorating.
- Health care in Saskatchewan is about people caring for people at a reasonable cost compared to health care in the States.
- Health care is a wellness medical system for individuals.
- Health care in Saskatchewan thus far is covering people's basic needs no more no less. The cut backs in health care are affecting the ones who cannot afford to comply with the high cost.
- Health care in Saskatchewan is a universal system of medical treatment that covers the residents of the province from cradle to grave. It is a key element of the social fabric of our prairie life style.
- Health care in Saskatchewan is government operated. It is universally available.
- An excellent system that is being handicapped by government cut back and restraint.
- Health care in Saskatchewan is a rapidly declining system where care in the past has not been based on age, financial status etc. More and more we are digressing to a state where dollars buy care.
- Our health care system is much better than the United States.

BEST THINGS ABOUT HEALTH CARE SYSTEM

Universal
Free
No complaints of quality

All people

Accessible to every citizen
Quality

Accessible to every one
Technically very good
Facilities are adequate

Free access to all doctors
Timely
Treats people with dignity

(Reasonably) non-discriminatory
Fair, for everyone not just those who can afford it

Non costly to user
Available to anyone
Best anywhere

Easily accessible
High quality of care
Basic care to everyone

Accessible
Prevention oriented
Community clinics

Available to everyone
Choice of doctors and specialty care people

Covers almost everything medical necessary to keep us healthy and well
Universal to everyone
It is covered by our tax dollars. It is something that we would stand up for.

Quality
Access
Commitment

No hospital bills
Easy access to medical help
Free (almost)

Quick and universal access
Professional and skilled help
High success rate

Equality of access
Quality of service
Value for money

Medical care
Hospital system

Fair to all, no preferences
No need to worry if ever sick to have to borrow or mortgage home.

No user fees
Few waits for doctors or tests

The ability of anybody, regardless of economic stature, to get help
A level of care that is superior to that of most of the world
Access across the country

Accessibility
Emergency care
Doctors/patients relations

Well educated and knowledgeable people (doctors, nurses)
Up to date equipment for tests
With medical plans + MSI, don't have to pay often for services (tests, doctor's visits, etc.)

Equal access
Paid by taxes
Up to date technology

MSI coverage

Universal
No limits

Its available theoretically to all citizens at no cost
Obviously one of the best in the world
Open access

Excellent doctors, nurses, etc.
Excellent facilities
No need for insurance

Accessibility
Professionalism
Compassion

No cost to get care
Fairly good quality care
Seems rather uniform

Available to everyone
No excessive hospital bills (like the U.S.)
Same level (quality) of care everywhere

A system which makes the best of a gigantic task
Everyone has access to basic services based on need not ability to pay

Universality
Quality
Accessibility

Everybody included
Clinics

Universal-everybody eligible to participate
Free choice of primary physicians

Supportive
Includes: physio, ambulance, drugs
Freedom of choice

Everyone is looked after in the system
The choice of doctors is not limited

Available to all.
No need for worry over paying.
Universal in whole country.
Rich and poor treated alike.

Universality
Availability
Cost to the patient

Hospitals are free

In general, it is completely paid for
Good facilities and medical services

It is there when needed
Keeps medical issues more or less in the open.

Many doctors
Many health care programs
Advance technology in health care

Accessible to most people
Low cost
High levels of competence

Universality
One of, if not the highest, standards of health care as it relates to the implementation of state of the art medical knowledge and practice.
Easy and generally immediate access.

Not expensive
Easy access (i.e. drop in, lots of doctors' offices, etc.)
Very convenient (but that's not very important

Easily accessible
Quite efficient

Good medical plan-low cost
Extra services-choice physio/chiro
Low costs for people not working

Very good specialists
Adequate beds at hospitals
Emergency service is excellent

We have hospitals

Dedication of staff that have not yet been laid off
Modern facilities

Cost
Service
Flexibility

It gives us confidence
It gives us unity
It gives us peace of mind

Accessible
Highly trained

Equal opportunity (i.e. for welfare recipients, poor)
Can still chose physician

Is accessible when needed
Provides some basic level for all
Some services don't require up-front payment

Relatively inexpensive
High quality
Readily accessible

Caters to all
Subsidies available

State of the art technology
Highly skilled professionals

Wonderful training programs
Fantastic facilities

Good modern facilities
Accessible
Competent health care providers

Facilities in larger centres
Emergency care at facilities
Support for senior citizens and disabled

It is accessible by everyone regardless of race or money.
The quality of health care has always been good.
There are now boards that can be approached that ordinary people can appeal to. These boards are lay-boards.

Universality of care
Historically the highest ratio of beds per population
Now on the direction of preventiveness model

Service now-pay later
OH Reserve (health committee)

No cost for medical services to treaty Indians, most of whom could not afford medical care if not provided.
Dental services
Eye glasses paid for.

That everyone is taken care of.
Medical clinics are fairly accessible.

No direct cost to the user.
Access at all times
Accessing new equipment

Free

The dedication of the workers
Caring
Availability

Universality
Comprehensiveness
Government funded
Quality service

Quality of health providers
Quality of institutions
Cheap drugs

Universal
Widely available
Affordable

Equal to all
No extra fees
Government controlled

Health care is available to everyone
Diagnostic tests are accessible

It is not very costly for us.
Everyone is allowed care if they have a health care
The waiting period for operations is not that long as far as I know.

WORST 3 THINGS ABOUT HEALTH CARE SYSTEM

Too costly for our tax base
Delays are tedious and possibly dangerous
Fraudulent use by non-Canadians is an issue
Research falling behind

Anyone can use it for any little thing
Costs tax payers major bucks

Patients sent home too soon
Hospitals not doctored from 8:00 a.m. to 12:00 p.m.
Too much life support especially for over 75 and new borns.

Not fraud resistant
Impersonal
Not enough attention on prevention.
Role of family doctor too little.

Allows non citizens to use health care paid for by Canadians which might dilute health care for Canadian citizens.

Cost
Abused by many people including non-citizens

It's losing money - perhaps waste from within
Waiting lists
Public

Not enough support (i.e. equip/personnel)
Easily defrauded by those not entitled
Not controlled well enough at both ends - patients/doctor

Expensive to operate
Opportunities south of the border drew medical workers trained in Canada
Can be too bureaucratic

Sometimes too much red tape
Too many channels to go through

Too expensive
No caps on doctors salaries
Not cutoffs for heart surgery

Costs too much at present
Too much red tape
May be too much to keep up

Ineffective in health results
Ineffectiveness in economic terms
Under staffed

Funding problems
Mis-management macro levels
Sustainability/potential for erosion

Can't afford to give free care for everyone
Very expensive
Not organized, not known what the cost

Emphasis on equipment
Hidden costs
Emphasis on large institutions

It may not survive the current political (fiscal) climate.

Bureaucratic
Slow at times (waiting list)
Technology more behind to USA

High drug prices
Governments reducing funding
Duplication of services

Drug costs for people with ongoing problems
The breakdown of federal standards and possibly different directions taken by different provinces

Waiting for tests, operations, etc.
Cuts in beds
Cutting down number of nurses

Reform implemented before systems in place
Overlog of patients
Outpatient service a scam

Too many layoffs
Letting elderly people leave hospital after a couple of days when they should stay longer

Slow
Expensive
Non educational

System was used for political purposes in the past
Not very efficient - too bureaucratic

Expensive in form of taxes
Lengthy wait for surgery if many with same problem

Open for abuse by citizens
Lengthy waits for emergency care
Rising costs for those without medical plans

Trouble keeping excellent people
No national control
Overcrowding

Too expensive
Subject to misuse
Lack of direction and awareness of costs and over capacity

Very political
Abuse

Problems of waiting lists for such things as heart by-pass operations.
Problems of queue jumping when operations are back logged.
Relatively poor control of costs.

Too generous to immigrants
Doesn't include dental

Waiting for surgery
Cut backs on types of prescriptions

Long waiting lists.

Appears admin costs are growing
Often provincial governments try to modify system

Length of time for waiting for treatment
Could be increased to perhaps eye, etc
Should not have to go outside for treatment
Overused by both patient and doctors

Waiting lists for surgery seem too long
Changing medication for no name brands

Too long waiting list for operations.
Different fees for across Canada
Too much waste

Essential surgery may have long waiting lists
In BC seniors have to pay for coverage

It is in the hands of people who want it to collapse
Too much dependence on drugs
It is breaking down.

Government toying to reduce health care benefits
Doctors billing patients for certain
Waste
People abusing the system
Not enough preventive medicine

Due to low population vs. large geographic areas, specialists and specialty resources generally are distant.
Bureaucracy.

Not personable
Not a good diagnostic and healing system
A bit slow, waits for important stuff, etc.

Sometimes waiting is too long
In hospital, very little stay after the operation
Employees of hospital should not go on strike: it should be made essential service.

Transplants-wait
Over crowding-delays
Emergency departments

Not enough doctors go to the small towns of B.C. - more incentive for them.
Too much abuse of the emergency department of the hospital.
Treating preventable illnesses in excess

Alberta health care doesn't cover very much
Hospitals are quite empty

2 tier
Waiting lists
Government involvement

Abuse (doctors/patients/government)

Uncontrollable
Selfish doctors
Costs too much money

Bloated administration
Overlapping services

Too long waiting for tests (e.g. MRI, etc), surgeries
Loss of best physicians
System can still be abused by malingerers, lonely persons

Easily abused
Too much administration
Costs too much

Present state of turmoil
Heading toward 2 tier system

Long waiting lists to see specialists

Diminished service
Inadequate institutional care
Receding quality control

Our cuts supplying the world (esp U.S.) with top quality professionals
Have way too many facilities across the province (former government's purchasing election!)

Waiting lists
Hospitals are not the best places to get well
Lack of coverage on some services leave some people unprotected

Support for preventative health
Too easily used (overused)
Over billing on other health care professionals

Saskatchewan's health programs are declining in quality.
Health's work force i.e. nurses hospital staff etc is a shrinking work force. They are leaving the province.

Rural areas here lost their clinics and small hospitals which works hardship on our agrarian population.

Economics have driven quality care givers out of province
Rural/northern have limited access to care
Right wing drive to begin private care facilities

Overcharging on prescriptions of first nations people
Poor public relations towards first nations people especially in emergency rooms
Types of services being offered in dental health

Waiting lists are too long for operations.
Indian bands should not care over their own medical concerns.

Waiting periods
Lack of hospital accommodations
Shortage of staff at all levels in hospitals

Physicians who are exceptional are not here due to lack of funding.

The best doctors leave due to $
Lack of specialists
Long waiting list

Not enough good doctors
Not enough acute care in small communities
Not enough health care dollars

Extensive wait lists
User fees
Understaffed

If a single parent is trying to make ends meet, they struggle with a sick child
It's beginning to be the rich man's luxury
As for aging people they have an enormous cost to face monthly.

Waiting lists
No rural doctors
Cut backs

Government debt threatens quality
Rules are driving good doctors elsewhere
Politicians can effect with poor policies

Waiting list
Funding cut backs
Doctors leaving

Shortage of beds
Lower calibre of doctors
Lacking good specialists
Waiting lists for elective surgery

As soon as our doctors and nurses graduate a lot of them are lured to work in the U.S.
The people in rural Saskatchewan have a tough time getting to a hospital (long distance)
It is costing our government far too much money (it should be looked at more carefully) as in patented drugs, etc.

FALL 2008 CODING SUMMARY SHEET (V13C V46 à V59K)	Report Code: 3960801	Temps de codage:
Coder's Name: Brek	Report Title: Research on Canadian Values in Relation to Healthcare (single code CB)	
Conciliation Date:		
	Highlight: [✓ Survey] Focus Group	

Variable 13C: TOTAL NUMBER OF QUESTIONS IN THE QUESTIONNAIRE OR THE MODERATOR GUIDE

(a) TOTAL NUMBER OF QUESTIONS: 14 = 10 + 4

PART E: PUBLIC OPINION QUALITY, CRITERIA FOR PUBLIC JUDGEMENT

VARIABLE	v46 Involvement	v47 ISSUE knowledge	v48 Engagement	v49 Conviction (change mind)	v50 Issue Salience	v51 Policy Priorities	v52 Policy Knowledge
Frequency							
Question Numbers							
VARIABLE	v53 General Policy Orientations	v54A Specific Policy Instruments	v54B Communication & PR Tools	v55 Satisfaction with Policy &/or Government	v56 Other Policy Ideas	v57 Effectiveness of Policy	v58 Consequences of Policy Choices
Frequency							
Question Numbers							

(b) TOTAL NUMBER OF PUBLIC JUDGEMENT QUESTIONS (V46 to V58): 0

PART F: RESIDUAL QUESTION CATEGORIES

VARIABLE	V59AOther Policy-related Attitudes Opinions…	v59B Core Political Values /ideology	V59C Other Values	v59D Trust & confidence	V59E General Knowledge	V59F Other Political Knowledge	V59G Definitions
Frequency		⑧		①			
Question Numbers		2a → g ⑦ 3		1b			
VARIABLE	V59H Current & Past Behaviour & Events	V59I Future Behaviour & Events	V59J Socio-demographic questions	v59 K Problematic Questions & Specify (Use with great parcimony only & provide a detailed justification for any Q placed here.)		V59L Other Issue-related Attitudes Opinions…	V59M Risks, benefits, drawbacks(Other Issue-related Attitudes Opinions…)
Frequency			③				
Question Numbers			4, 5, 6			1a, c ②	

(c) TOTAL NUMBER OF RESIDUAL QUESTIONS (V59A to V59K): 14

(b + c) SUM OF PUBLIC JUDGMENT & RESIDUAL QUESTIONS : 14

PART G: Consistency of Meanings/ Question formats

VARIABLE	v60 Meaning		v61 Probe	v62 Order-rotate/wording
Frequency				
Question Numbers				
Special Notes				

FALL 2008 CODING SUMMARY SHEET (V13C V46 à V59K)	Report Code: 3960801	Temps de codage: 16h20 - 16h25
Coder's Name: PO.	Report Title: Research on Canadian Values in Relation to Health Care	
Conciliation Date:		
	Highlight: [✓ Survey] Focus Group	

Variable 13C: TOTAL NUMBER OF QUESTIONS IN THE QUESTIONNAIRE OR THE MODERATOR GUIDE

(a) TOTAL NUMBER OF QUESTIONS: 14 =

PART E: PUBLIC OPINION QUALITY, CRITERIA FOR PUBLIC JUDGEMENT

VARIABLE	v46 Involvement	v47 ISSUE knowledge	v48 Engagement	v49 Conviction (change mind)	v50 Issue Salience	v51 Policy Priorities	v52 Policy Knowledge
Frequency	0	0	0	0	0	0	0
Question Numbers							
VARIABLE	v53 General Policy Orientations	v54A Specific Policy Instruments	v54B Communication & PR Tools	v55 Satisfaction with Policy &/or Government	v56 Other Policy Ideas	v57 Effectiveness of Policy	v58 Consequences of Policy Choices
Frequency	1	0	0	0	0	0	0
Question Numbers	1c						

(b) TOTAL NUMBER OF PUBLIC JUDGEMENT QUESTIONS (V46 to V58):

PART F: RESIDUAL QUESTION CATEGORIES

VARIABLE	V59AOther Policy-related Attitudes Opinions...	v59B Core Political Values /ideology	V59C Other Values	v59D Trust & confidence	V59E General Knowledge	V59F Other Political Knowledge	V59G Definitions
Frequency	0	3	5	1	0	0	0
Question Numbers		1a 2ab (2)	2c-g (5)	1b			
VARIABLE	V59H Current & Past Behaviour & Events	V59I Future Behaviour & Events	V59J Socio-demographic questions	v59 K Problematic Questions & Specify (Use with great parcimony only & provide a detailed justification for any Q placed here.)		V59L Other Issue-related Attitudes Opinions...	V59M Risks, benefits, drawbacks(Other Issue-related Attitudes Opinions...)
Frequency	0	0	3	0		1	
Question Numbers			4 5 6			3	

(c) TOTAL NUMBER OF RESIDUAL QUESTIONS (V59A to V59K):

(b + c) SUM OF PUBLIC JUDGMENT & RESIDUAL QUESTIONS :

PART G: Consistency of Meanings/ Question formats

VARIABLE	v60 Meaning		v61 Probe	v62 Order-rotate/wording
Frequency				
Question Numbers				
Special Notes				