

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

Report on Citizens' Dialogue on the Future of Health Care in Canada



Prepared for the
Commission on the Future of Health Care in Canada

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In collaboration with
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Commission on the Future of Health Care in Canada

JUNE 2002

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Executive Summary

Introduction

Public opinion polls show that Canadians are deeply attached to their health care system.¹ Polls consistently show that Canadians want and expect quick access, high quality, and universal coverage. But they also suggest that Canadians have not yet come to terms with how best to pay for the rising costs of these services, nor how best to access them in a society that has changed since Medicare was first established.

The Commission on the Future of Health Care in Canada decided to go beyond the kind of information that polls provide. They wanted to learn how Canadians reconcile the difficult trade-offs inherent in sustaining the health care system in the 21st century. The Commission was searching for reliable information on citizens' values and their preferred choices when they are asked to make difficult trade-offs. In Commissioner Romanow's words to the dialogue participants in this project:

There are no right or wrong answers here. What I want... is a better sense of what you collectively value as important and believe to be the right path to take and why. I want to understand what aspects of the solutions you prefer – and do not prefer – in order to better focus my Commission's final recommendations.

To do this, the Commission formed a partnership with the Canadian Policy Research Networks and Viewpoint Learning to organize a Citizens' Dialogue using "ChoiceWork Dialogue" methodology.²

The Process

The dialogue involved 12 sessions held across the country with about 40 citizens at each. Participants were randomly selected in a manner designed to provide a representative cross-section of the Canadian population. When contacted, people quickly agreed to commit a full day on a weekend and in some cases to travel long distances. Almost all of those who accepted showed up at the appointed time and place, despite the usual travel hazards of the Canadian winter. They were informed and thoughtful when they arrived and it was remarkable how quickly they absorbed even more information, learning from each other and the dialogue materials.

Participants were asked to reflect upon four scenarios for reforming the health care system. Each one has at its core a reform perspective under active discussion in Canada today.

¹ Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Saskatoon, November 2001.

² ChoiceWork Dialogue is a methodology developed by Viewpoint Learning. It is described more fully in Chapter I.

- Scenario 1 explores *more public investment* in doctors, nurses, and equipment, either through tax increases or by reallocating funds from other government programs.
- Scenario 2 involves a form of private payment for health care. Entitled *share the costs and responsibilities*, it proposes a system of user copayments for health services.
- Scenario 3 offers a more radical restructuring of health care to create a parallel private system. *Increase private choice* enables people to access private providers, paying from personal resources or private insurance.
- Scenario 4 proposes a major internal restructuring to *reorganize service delivery*. Each Canadian would sign up with a health care provider network, which would include doctors, nurses, and other professionals working as a team.

Citizens' first task was to use the information in these scenarios to create their own vision of the health care system they would like to see in 10 years. They then spent almost five hours working through difficult trade-offs and choices to realize their vision. The vision they developed and the choices and trade-offs they made to realize that vision were remarkably consistent across the 12 groups. These have since been further confirmed through a follow-up telephone survey with a larger sample of Canadians.

Past attempts to engage citizens in health care reform have been stymied by their resistance to making the tough trade-offs. The National Forum on Health in 1996 found, for example, that "participants were ingenious at avoiding the hard issues." The full day of discussion and the ChoiceWork methodology did not allow citizens to avoid those choices. Instead, with time, information, and an opportunity to work through the difficult trade-offs with each other, citizens were able to express their values and find acceptable choices and alternatives based upon those values.

This report presents two kinds of analysis: quantitative analysis of the pre- and post-dialogue questionnaires and the national poll, and qualitative analysis of the videotapes and observers' notes of each session.

Key Findings

Canadians are passionate about health care and very concerned about its future. They want to keep the core principles of the Medicare model that accord with their strongly held values of universality, equal access, solidarity, and fairness. But they also state very clearly that the current uses of health care resources do not correspond well to their values of efficiency and accountability. Citizens wish not only to preserve and protect the best of the Medicare system built over recent decades but also to update it and to make it sustainable for the future. To achieve that, they are ready to change their own behaviour, and they expect the providers, managers and governments to do the same. When given a chance to work through the issues, citizens are far more open to change in the delivery of health care services than most politicians imagine.

When they weigh the pros and cons of all four scenarios and discuss them with their fellow citizens, they forge a consensus that draws upon three of the four scenarios. But they go beyond the scenarios provided. They sift through possibilities, rejecting some

and accepting and refining others to come to judgment on a set of acceptable parameters for the future.

While the exact sequence of steps varies somewhat from group to group, citizens weave their logic for reform as follows:

- At first many citizens hope that the system can be “fixed” simply by eliminating waste and improving the efficiency of management and service delivery, and perhaps reallocating funds from other programs. But that hope begins to fade as they share experiences with each other, and work through the issues and the current and projected costs of health care.
- The focus then shifts to renewing the system through reforms that are consistent with the values of access based on need, fairness and efficiency. Citizens see the potential in having a team of medical professionals (doctors, nurses, pharmacists, and others) to provide more coordinated primary care, supported by a central information system. They also are very attracted by the idea that such a team would not only provide more coordinated, cost-effective care, but also would have greater incentive to focus on wellness, prevention and patient education. To make it work, they understand, will require changes in the behaviour of citizens, providers and governments.
- In working through the changes they are prepared to make in order to make these reforms work, citizens agree for example to sign up with a team of professionals for at least one year, see a nurse for routine care, and make greater use of new technologies including 24-hour phone lines. And, notwithstanding their real concerns about privacy, they agree to make personal medical information more available through a “smart card” – an electronic health card – to help ensure that care is better coordinated and to uncover any abuse of the system. They conclude that the benefits of the smart card outweigh the (privacy) costs. Citizens also pledge to assume greater responsibility for their own health, through diet, exercise and more healthy living.
- Even with these changes, participants come to realize that more funding will be required to sustain the health care system they value. They struggle with where the money should come from.
- They choose not to turn to greater private investment through a parallel private system as a means to inject more money into health care. While they explore the idea, most underline that the only way such a scenario would be acceptable is if it did not harm the public system. By the end of the dialogue, this scenario is rejected by participants who conclude it cannot meet that test, and would drain valuable resources away from the public system.
- They also wrestle with the idea of copayments. They recognize that some revenue would be generated and many believe inappropriate use of the system would be deterred. But participants are very uncomfortable with charging user fees for basic services, believing it will discourage those who are less well off from seeking needed care. This concern remains even when a subsidy for low-income citizens is proposed. Most conclude that a better way to reduce misuse of the system is through the use of information systems and the smart card. Through the electronic health cards, they expect individual use to be monitored so that corrective actions can be taken when

they are found to be misusing the system. Many also want to receive an annual print-out reporting on their use of the system and the associated costs. In the end, the door is left open to paying user fees for extra services only (for example, a second opinion provided by a physician outside of a rostered system).

- In the end participants turn to public funding and, reluctantly, to tax increases rather than to cuts in current programming. At first the hope is that transfers of funds from other programs can be used, but as citizens work through the possibilities, and one by one eliminate the candidates (such as education and social programs), they are left with tax increases as the only viable choice.
- At the same time citizens place very stringent conditions on their support for any tax increase. They insist on stronger accountability from providers and governments as well as from users. The message is “we are spending \$100 billion already; we have to get our act together.” Citizens demand greater transparency about where the money goes and what actions add value. Distrust of the way in which the health care system is being managed was palpable in every dialogue. Concerns about accountability, transparency and value for money echoed throughout each session. Citizens across the country were clear and remarkably consistent in the improvements they wanted to see in the management of the system:
 - *Greater transparency.* Citizens want to know where the money is going. They want to see regular reports for their region and jurisdiction that show how the system is being used and how the money is spent.
 - *Earmark taxes for health care.* To further increase transparency, citizens want to be sure that any additional taxes for health care will be spent on health care.
 - *Create an auditor general for health.* Citizens want documentation of value for money, and of how their jurisdiction is doing in relation to its past performance and to other jurisdictions. They believe that this information should come from an independent agency, such as an auditor general for health with an overall purview of the state of Medicare.
 - *Greater efficiency and co-operation within and among governments.* Citizens are:
 - fed up with federal-provincial disputes, which they see as adding cost and delaying decisions without improving the services they receive. They want to know more clearly who is responsible for what so that the responsible party can be held to account.
 - aware of the connection between health and other governmental responsibilities such as the environment, social programs, and housing. They want joint interdepartmental strategies to address the determinants of health.
 - demanding greater efficiency generally. For example, they believe that when regional institutions are created, provincial ministries should be reduced in size, and that politicians and ministries should not second-guess decisions at the regional and local levels. Overall, they want to see duplication reduced, and responsibilities and accountabilities spelled out more clearly.
- *Establish a national ombudsman.* Some citizens would like to have a national patient ombudsman, acting as an advocate on their behalf.

By the end of the day, citizens' responses to the scenarios reveal a much greater openness to change than there had been eight hours previously. They adjusted their "coming in" stereotypes and came to recognize merits and possibilities in approaches they did not originally like. By the end of the dialogues, an extraordinary 8 out of 10 participants (79 percent) were in favour of reorganizing service delivery. By contrast, despite considerable discussion, almost half (47 percent) remained firmly opposed to increasing private choice through a parallel private system, while 39 percent expressed support.

The Canadian Model – 2002

Health Care Values

Universality... everyone is included.

Equity... individual access is based on need.

Solidarity... we are in this together – we all contribute to health care and take from it when we need to.

Fairness... we contribute based on means.

Quality... care is timely and responsive.

Wellness... prevention is key.

Efficiency... sound management and responsible behaviour ensure value for money.

Accountability... everyone is accountable for how they use or affect the system; decision making and spending are transparent.

Citizens gain a greater sense of ownership of the health care system during the dialogues. They go beyond their roles as users or consumers, to see themselves as owners, investors, and stakeholders. Their final judgment, at the end of the day, expresses the essence of a revised health care contract among citizens, and between citizens and the health care system – governments, managers, and providers.

The health care contract imagined by Canadians in 2002 is different from the past. In the mid-1960s, when Medicare was introduced, a key goal was to protect citizens from personal bankruptcy. In 1984, when the *Canada Health Act* was introduced, the main focus was on buttressing universality and equal access. Now, in 2002, citizens who are given the opportunity to reflect deeply on the challenges we face are ready for change in order to preserve the essence of Medicare while adapting it to new realities. They believe the system as it now functions is not sustainable. Once they work through the choices and trade-offs, most Canadians conclude that they are not willing to pay more for the status quo, but they are willing to pay more if certain conditions are met.

The most important shift is the introduction of explicit economic and political values into the contract. Efficiency and accountability were part of the values identified by the National Forum on Health in 1996, but they were not articulated in health care choices. They are now, and they bring a harder edge to the logic of reform.

Thus **citizens** speak openly about their rights and responsibilities as citizens. They believe they have a right to equal access and to efficient and responsive health care. But

they also establish a list of personal responsibilities for which they are to be held accountable – to take care of their own health, to use the health care system judiciously, to adapt the way they access the system to permit efficiency gains, and to pay their fair share of the tax cost.

In summary, the unique contribution of the Citizens' Dialogue has been to enable citizens to link new and old values into a revised health care contract, updated to 2002. Then in a new and powerful way, those values have been applied to the fundamental questions of health care reform.

Citizens are trying to build a bridge to a better, financially sustainable health care system, based on the Medicare model. They used their core values and principles to give governments permission to make significant reforms. They also set some very challenging conditions for citizen consent.

The new health care contract can be paraphrased as follows:

We place a high value on equal access and universal coverage. We see health care as a public resource for all citizens. Therefore, we will help to create a sustainable health care system, on condition that governments and providers commit to three significant changes: more efficient management and service delivery, more coordinated and patient-centred care, and greater transparency and accountability in how they spend health care dollars.

With progress on these commitments, we are prepared to change our own behaviour to promote wellness, make certain sacrifices in the way we access the system, and to pay more. In paying more, our first choice is to pay through taxes earmarked for health care, so that basic services are financed through more public investment. As a backup, we will accept copayments or user fees for a limited number of additional services. On balance, we do not support the creation of a parallel private system.

Policy Implications

There are a number of important additional implications for policymakers in these results:

- First, there is a wide gap in perception between the public and health care elite in Canada. The elite has spent 10 years reforming the system to make it more efficient. But what citizens seem to be saying is that this restructuring has not improved the day to day care which they experience on a regular basis – they are paying more and getting less. Nor has it raised their confidence that the system is now more sustainable.
- There are opportunities for health care reform that did not exist in the past. Citizens are ready to adopt new ways of interacting with service providers, which policymakers have usually assumed would be resisted. In addition, they see information and communication technologies as a double win – increasing efficiency and making care more accessible. On the issue of wellness, prevention, and promotion, citizens were remarkably consistent from coast to coast. Observers

wondered if Canada is on the cusp of a major societal shift from a disease-based to a wellness-based way of thinking. Citizens have a well-rounded view of wellness. It is a personal responsibility, a result of good fortune, and a state responsibility. The state responsibility cuts across nearly every ministry of government including industry, environment, housing, transport, natural resources, agriculture, education, and more. Citizens feel vulnerable to health risks in the air, water, food and drugs that they consume. The combination of their vulnerability and their desire to live a healthy life creates a remarkable opening for public policy, across the spectrum of government programming.

- Finally, but perhaps most important, is the willingness and capacity of Canadian citizens to take up the opportunity to engage in a dialogue of this sort. What does this will and capacity to engage mean for the way that Canada practices democracy?

Engagement is needed when public policy is at a key turning point. This usually occurs when a society is reassessing its options, setting priorities, mapping the boundaries of where major change is possible. Engagement helps to clarify how deeply held values are evolving with changing circumstances. The legitimacy and sustainability of our most important public policies depend on how well they reflect those underlying (and evolving) Canadian values. But engagement only works when policymakers are ready to invest in learning and listening, when they are ready to open up a discussion on the big conflicted choices and trade-offs, and when they place a high value on the process of public learning.

This dialogue has given citizens an opportunity to update their fundamental values for health care. Their lives have changed profoundly since the 1960s, and their values have evolved as a result of that experience.

This restatement of values has major implications for public policy. It should lead to changes in the principles that govern the health care system and to more responsible and responsive behaviour on the part of governments, providers, and managers.

Citizens have had their say on health care reform in the winter of 2002. They said it well and with passion. It was a privilege to witness their dialogue.

Acknowledgments

The authors wish to express their appreciation to the large number of people who assisted the team in conducting this Citizens' Dialogue and preparing the report. The staff of the Commission on the Future of Health Care in Canada provided consistent guidance and support throughout the project. Steven Rosell and Suzanne Taschereau were the lead facilitators, assisted by Pamela Pritchard and Rod Brazier. A number of researchers, practitioners, and experts on the health care system across Canada provided advice on the development of the scenarios. Sandra Zagon provided backup to the Canadian Policy Research Networks team and helped with the translation process. Leigh McGowan provided logistical and administrative support, and Prime Strategies arranged all the on-site logistics for the dialogue sessions and the participants' travel and accommodations. Ekos Research Associates recruited the participants, analyzed the questionnaire results, and conducted the follow-up poll. Sylvia Burns did the line edit.

And last, but not least, we must recognize the 489 citizens who responded with such enthusiasm to this opportunity to make a contribution to the future of health care in Canada.

We thank you all, and take full responsibility for any errors that crept into the report