

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

Public Input on the Future of Health Care

Results from the Consultation Workbook



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

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In collaboration with the
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And, last but not least, we thank the **16,463** Canadians who went online to go through the consultation workbook, and the **1,083** citizens who completed the paper version of the workbook. As noted in the report, “the collection of thousands of quantifiable inputs from people by a governmental agency is unprecedented”.

We are grateful to you all for your contribution.

Executive Summary

Faced with the challenge of facilitating informed public input from as many Canadians as possible, the Commission on the Future of Health Care turned to the Canadian Policy Research Networks (CPRN) and Systemscope to produce a consultation workbook. The workbook included facts and arguments about the future of health care, four scenarios for the future and a set of questions. Canadians could either access and complete the workbook on-line or complete it on paper and forward their answers to the Commission. Between March 7 and May 31, 2002, a total of 16,463 on-line workbooks and 1,083 paper-based workbooks were completed.

A profile of the typical workbook participant emerged – one that differs from that of the average Canadian. Participants were older, with higher levels of education and women were overly represented. While there was participation from all provinces, Quebec’s representation was lower relative to its share of the population. Further, those employed as health professionals were most likely to participate. In fact, many people with an interest or a stake in the future of health policy made the effort to “voice” their views. While not representative of all Canadians in the survey sense, those who are motivated to be consulted and engaged are an important constituency because they have a personal connection to the debate and will likely be opinion-leaders in their communities.

Workbook participants tended to support only two of the four scenarios offered – to “add more resources” to the health care system and to “reorganize health resources delivery”. Few rated the “user fee” or the “more private choice” scenarios favourably. Preferences were clearly tied to the expressed values of the participants and the perceived implications of the other approaches. Most participants were willing to accept the consequences of a team-based approach (e.g. seeing a trained nurse instead of a doctor for routine treatments), but did not want limitations set on seeking second opinions. Additionally, support for more resources was accompanied by a willingness to pay more taxes.

Participants rejected the other scenarios because they rejected the underlying premises (particularly for the “more private choice” scenario) or were concerned about the consequences of adopting these approaches. Participants largely endorsed arguments that user fees would make them worry about “lack of equal access for everyone” and “that other efficiencies and innovations won’t happen”. They did, however, lean to the view that user fees would not prevent them from going to the doctor (46 per cent compared with 38 per cent). It is also not surprising that “more private choice” was rejected, since participants overwhelmingly believe that individuals should not be able to pay extra to get quicker service. Further, they believe that more private choice would create a system of haves and have nots.

1.0 Introduction

Over the past several years health care has emerged as the most important priority for Canadians. And yet, at the same time, EKOS Research Associates has found that people increasingly believe that the health care system has deteriorated. Out of frustration with the current system, many – especially those with the means to do so – were being motivated to consider options like a two-tier system for reforming health care. Virtually all Canadians, rich and poor alike, agreed that the health care system, until recently a source of national pride, was experiencing a precipitous decline in quality. Current concerns about quality and access pale, however, against the deep visceral fears Canadians have about the future capacity of the system.

Public concern about the quality of the health care system is not surprising given the challenges facing it today. An aging population, rising costs associated with new and expensive technologies and treatments (especially drugs), and changing societal trends all place pressure on the system. They also raise the possibility that the assumptions that underpinned the creation of Medicare may no longer be valid, such as the emphasis on doctors and hospitals as the principal costs. It is important to note that these public concerns/debates are by no means unique to Canada and indeed are common in most advanced western societies.

It was in this context that the Government of Canada appointed the Honourable Roy Romanow to head a Commission on the Future of Health Care on April 3, 2001. The mandate of the Commission, as established in the terms of reference, is to:

inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.¹

The Commission on the Future of Health Care has solicited public input into health reform using multiple channels. A consultation workbook containing information and arguments about health care reform based on four scenarios for reforming the health care system was one such tool. The four scenarios, included in the interim report of the Commission,² this should be a foot note on this page, not an end-note on page 48 were:

more public investment, shared costs and responsibilities (user fees), more private choice, and the reorganization of health services delivery. Canadians were invited to work through the information and accompanying questions in the workbook and offer their input to the Commission's work. The process was intended as an informative and deliberative consultation exercise.

The principal reason for the consultation workbook exercise was to accommodate the large number of Canadians who could not appear in-person – either before the Commission or at other consultation exercises – but who were interested in sharing their thoughts and concerns. The workbook was designed and formatted to encourage deliberation, and to convey information about the hard choices faced by the Commission. The intent was to seek input that was relevant to the issues being considered. In addition, the structured questions provided a way to quantify substantial public input. The high number of completed workbooks is an indication that the exercise did provide a way to consult, if not engage the public, on the future of health care. Ultimately, only those interested in completing the workbook used this process. That said, those who are motivated to participate and express their views are an important constituency for reform proposals.

The consultation workbook was available on-line or could be completed on paper and returned to the Commission. This report details the findings from both the on-line and mail-in versions of the consultation workbook. The results of the two different versions are also separately reported, and a technical appendix accompanies this report with breakdowns of the results by key sub-groups of the population.³ The results are presented side-by-side for comparison purposes. The publicly available consultation workbook was an adaptation of the one used in a dialogue process conducted for the Commission by CPRN and Viewpoint Learning. CPRN and Systemscope, along with input from the Commission, developed the questions and set up the system for administering the on-line participation. Data analysis was conducted by EKOS Research Associates in consultation with CPRN and Systemscope.

The Four Scenarios from the Public Consultation Workbook

- *More public investment.* Add more resources such as doctors, nurses and medical equipment to deal with Medicare's current problems – either through a tax increase or by reallocating funds from other government programs.

- *Share the costs and responsibilities.* Add more resources to deal with current problems, not by increasing public spending but through a system of user co-payments for health care services that would provide an incentive for people to avoid over-use of the system as well as needed fund.
- *Increase private choice.* Give Canadians increased choice in accessing private providers for health care services. Side-by-side with the public system, Canadians could also access health care services from a private-sector provider (either for-profit or not-for-profit) and pay for it from their own resources or private insurance.
- *Re-organize service delivery.* Re-organize service delivery in order to provide more integrated care, realize efficiencies and expand coverage. Each Canadian would sign up with a health care provider network that would work as a team to provide more coordinated, cost-effective services and improved access to care.

2.0 Research Methodology

The research methodology involved an analysis of the results of quantifiable public input provided by both an on-line and mail-in consultation workbook. Though there were slight differences in the workbooks, as necessitated by the demands of each medium, the structure and goals were similar. Each workbook began with an invitation from the Commissioner, along with a series of instructions on how to proceed and where to get additional information. Questions in the context of information about the health care system, and arguments for and against possible future courses followed.

Using the on-line system, participants had to answer each question before advancing to the next question. Not all screens included a question and in a number of places the participant could advance through a series of relevant facts before providing an answer. The paper version had an answer sheet at the back that could be filled in as the person advanced through the workbook.

Members of the public could complete the questions between March 7 and May 31, 2002. Once the data collection was complete, the results were provided to EKOS Research Associates for analysis. Since the workbook involved self-selected participation, it was never intended to be a survey in the traditional sense: the data was not statistically weighted and the results cannot be considered statistically accurate or representative of the Canadian population as a whole.

3.0 Caveats

The data should be taken for what it is. That is, the expressed views of over 16,000 Canadians on a topic of considerable interest and importance. In fact, given the time required to complete the process (approx. 20 minutes), the number of responses is a telling indicator of the level of engagement that Canadians have with health care reform. This being said, it may also indicate that those directly involved in Canada's health care system (and in turn, with a greater stake in the outcome of the consultations) were more likely to participate. The collection of thousands of quantifiable inputs from the general public by a government agency in Canada is unprecedented.

Surveys and the Representation of Canadian Opinion

Surveys are frequently used to gauge public opinion. These are often considered representative with as few as 1000 Canadians because the random process of selecting the participants ensures that every eligible person in Canada has an equal likelihood of completing the survey. It is then possible to say that a specific percentage of Canadians, plus or minus a few percentage points, have a particular opinion.

It is not possible to say this about the results here even though many thousands of people participated. The reasons are as follows:

- ❖ Participants were not selected randomly. They chose to participate and the overall results reflect this self-selection.. For example, 23 per cent of all responses came from people who self-identified as a “health professional.” This is much higher than the actual distribution of health professionals in the population, which is less than 5 per cent.

- ❖ While Internet penetration is fairly high, there is still a significant digital divide. As we show, the participants look quite different from average Canadians in having, for example, much higher education.

- ❖ Because of the nature of the data, it is not possible to conduct tests of significance with this data or to assign significance to the differences between groups in a statistical sense.

Other Sources of Bias

- ❖ *Multiple responses.* Both the on-line and paper versions of the instrument were available publicly with no mechanism for ensuring that the same person did not submit multiple completions. Though the Commission could have opted for some mechanism of registration (providing each person with a PIN), this would have clearly been more costly and would have provided an additional burden and constraint on input. Other less obvious mechanisms (i.e. allowing only one completion per IP address or computer) would have also been problematic. For example, people who work on a local network or who access the Internet from community access sites would not be able to complete the workbook if someone else had already done so from that same location.
- ❖ *Time of completion.* Participation in the workbook consultation took place over a lengthy period of time. While it is possible that the results will be affected by the time of completion, no attempt was made to analyze this aspect.
- ❖ *Weighting.* Under survey conditions it is normal practice to weight the data so that the aggregate values of the variables reflect the distribution of the Canadian public. This ensures that the aggregate values are not influenced by an over-representation of certain groups in the survey. Normally, survey data is weighted by gender, age and region. Devising appropriate weights for the data generated by the workbook represents a considerable challenge because the principle of weighting is based on the assumption that differences between the distribution in the sample and the population are not that great. The data here is so clearly skewed in terms of age, gender and province⁴ that no weighting scheme could be justified. It must then be recognized that any large differences across groups, like regions, will affect the overall distribution of responses. For example, if Quebec participants differ significantly from the rest of Canada then – had more Quebec responses been received – the overall average would have been different than the one observed here. Given the

national nature of the Commission and the potential importance of regional differences, an attempt was made to experiment with some weighting schemes. However, in the final analysis a decision was made to report the data unweighted.⁵ In effect, any weighting scheme would represent an attempt to impose a representative distribution on unrepresentative data.

4.0 Participation in the Survey

Number of Completes

In total, **16,463** people began the on-line workbook by answering the first question (their gender). The Commission also received **1,083** mail-in workbooks. Not all of the workbooks were complete. In the case of the mail-in version, some questions were left blank⁶ and, in the case of the on-line version, some people began but did not finish the workbook.

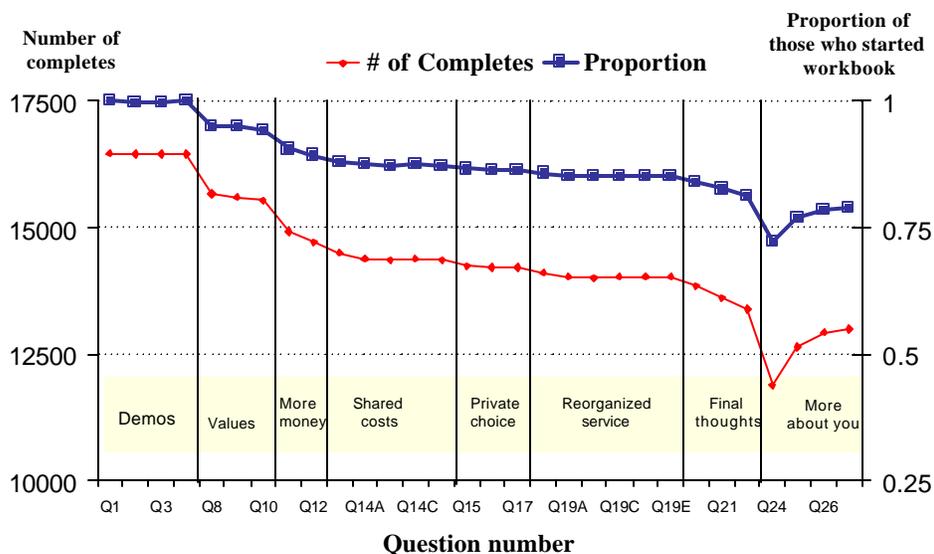
The Commission advertised that the on-line survey would take about 15 minutes. However, different computer/Internet access speeds and reading speed/skill levels may have increased the time spent by any particular individual. While the length of time the participants spent was not recorded, it is possible that lengthy completion times and/or technical difficulties could have led people some people to not complete every question. (It was technically impossible to skip over some questions.)

We are faced with somewhat of a conundrum when thinking about how to characterize the number of participants, especially for the on-line version. A strict definition of a completion would be the number who provided an answer to the last question, but this would not address the fact that some people did not complete all of the questions. Since the purpose of the consultation was to allow as many people to participate as possible, it is reasonable to keep the uncompleted responses in our pool of participants.

Dropping Out of the On-line Workbook

Figure 4.1 shows the drop-out from the workbook beginning with the first question (gender) and ending with the last question (use of health care system).⁷ Both the absolute number of responses and the percentage of the people who answered the first question are shown. An overwhelming majority of people (79 per cent or 12,992) completed the workbook (the optional income question was not answered by all of these people) so while there was some drop-out, many people, reflecting interest, completed the questions.

Fig. 4.1
Drop-out by Phase of On-line Workbook



By delineating the workbook sections by substantive area, one finds that as the workbook went on, there was a steady decline in participation until the “final thoughts” section, which seemed to further reduce participation. The “final thoughts” section also tended to have a higher than average number of missing data for the paper version of the workbook (approx. 20-24 per cent did not rank the scenarios).

Multiple Responses to the On-line Workbook

No attempt was made to limit the number of times that a person completed the workbook. However, the 15-minute time commitment required probably limited overzealous participation from any one single person. The cause of multiple responses then, could include a particular passion for health care, an accidental disconnection from the system requiring a restart or a need – part way through – to start over at another time.

An examination of the data provides some indication of the degree and potential nature of multiple responses from the same person based on one particular piece of information that was supplied by most of those who answered the first question (gender). On the same entry screen as the gender question, participants were asked to provide their email

address (this was voluntary and participants could proceed without entering anything). Eighty-eight per cent of those who filled out the gender question also provided an entry in the email address field and it is then possible to determine whether there are duplicate entries from the same person. This is inevitably an imprecise method since the email addresses were not validated and a superficial analysis revealed that some people entered nonsense in this field.⁸

Using the available information, one finds that there were 13,663 unique entries in the email field compared with 14,542 cases with data in this field. This means that 879 entries (about 6 per cent) were duplicates/multiple entries of some form and these were associated with 736 unique addresses. Most of the people who had more than one case associated with their email address entered the workbook twice, though 77 email addresses are associated with 3 entries and 25 addresses are associated with 4 or more entries. A selected examination of those who were associated with more than one entry finds that many of the “extra” or “multiple” cases are incomplete. For some reason the participant began the process of the workbook, did not finish and then later returned and started over.

Conclusion

The large number of participants means that the results are largely unaffected by either drop-out or multiple responses. On the one hand, there was a rationale to only use completed cases; that is, those cases for which one has information for all variables. Doing so would clearly reduce the problem of multiple entries from the same person to the extent these are a product of circumstances that led people to abandon and then restart the workbook. However, it would have no effect on cases of conscious duplication on the part of participants. And it would mean discarding all incomplete information provided by people, presumably in good faith (e.g. they left the workbook at some point but did not return). The results presented here include all answers to the questions as received for both versions of the workbook.

5.0 Who Participated

The background of the participants in the workbook reveals very clearly that a particular type of person took the time and effort to make their views known to the Commission. The workbook participant is more likely to be female, of higher socio-economic status (SES), to neither be young nor old and to have a stake in the health care system. The participant is also unlikely to come from Quebec, which was vastly under-represented relative to its share of the population.

Socio-demographic Characteristics

Table 5.1 shows the distribution of workbook participation in both the on-line and mail-in workbooks by key socio-demographic characteristics. Also shown is the percentage of these groups within the Canadian population. Table 5.2 examines the on-line participants from the additional perspective of Canada's Internet population. The estimates for the Internet population are derived from public opinion survey results in May of 2002.

- ❖ Women outnumber men by a wide margin in both sets of results. Only one in three participants (35 per cent and 33 per cent for the on-line and mail-in respectively) was male even though men represent almost half of the population. Women are also slightly less likely than men to use the Internet, which actually increases the over-representation of women.
- ❖ Income and education variables indicate a high socio-economic status of participants, likely reflecting a combination of interest in politics, stake in the health care system, and the digital divide.
 - The educational profile for on-line participants is particularly startling – 34 per cent reported having a bachelor degree and 28 per cent had attained a graduate degree. Only 11 per cent stopped their education at secondary school. In comparison, the 1996 Census showed that 37 per cent of Canadians have completed only elementary school (or less) and only 5 per cent have a graduate degree.
 - The educational profile for the mail-in participants is less skewed toward higher levels of education. Those with little formal education are still under-represented but there is a considerable over-representation of people with professional/trade certification and with graduate degrees.

- Using a recent *Rethinking Government*⁹ survey as a comparison (since it also faces non-reporting issues), there is modest under-representation of lower income Canadians.
- The digital divide does account for some of the difference, though there remains a considerable over-representation of people with university and graduate level education.

Table 5.1. Comparison of Demographic Characteristics of On-line Participants

	Percentage Completed the On-line Workbook	Percentage Completed the Mail-in Workbook	Percentage in Population ^a	Difference: On-line vs. Population	Difference: Mail-in vs. Population
Gender					
Male	35	33	49.5	-14.5	-16.5
Female	65	67	50.5	+14.5	+16.5
N	(16,463)	(1,070)			
Age					
Under 18	1	1	8.2	-7.2	-7.2
19 to 29	16	8	16.7	-0.7	-8.7
30-49	45	25	39.5	+5.5	-14.5
50-65	31	33	19.9	+10.2	+13.1
Over 65	8	33	15.6	-7.6	+17.4
N	(16,445)	(1,082)			
Income					
Under \$20,000	8	13	17	-9	-4
\$20-\$39,999	17	22	16	+1	+6
\$40-\$59,999	23	25	27	-4	-2
\$60-\$79,999	19	18	16	+3	+2
\$80-\$99,999	14	10	11	+3	+1
More than \$100,000	19	13	13	+6	
N	(11,974)	(936)			
Education					
Elementary school or less	1	1	37	-36	-36
Secondary school	11	18	23	-12	-5
Community/technical college or CEGEP	18	16	16	+2	
Prof./Trade certification	9	28	11	-2	+17
Bachelor degree	34	11	9	+25	+2
Graduate degree	28	26	5	+23	+21
N	(12,645)	(1,055)			

^a Population estimates are derived from a number of sources. Age distribution for population is from Census Canada (2001) and the percentage is the value for the Canadian population aged 16 or older. Census Canada age categories differ slightly from those used in the workbook (19 to 29 is 20 to 29 in the Census and over 65 plus is 65 and older in Census data). Income data is from *Rethinking Government 2002 (January)* and education distribution from Census Canada (1996).

Table 5.2. Comparison of Demographic Characteristics of On-line Participants

	Percentage In Workbook	Percentage in Population ^a	Difference from Population	Percentage among Internet Users ^b	Difference from Internet Population	
Gender						
Female	65	50.5	+14.5	48	+17	
Male	35	49.5	-14.5	52	-17	
N	(16,463)					
Age						
Under 18	1	8.2	-7.2	Under 30	29	-12
19 to 29	16	16.7	-0.7	30 to 44	36	+1
30-49	45	39.5	+5.5	45 to 64	27	3
50-65	31	19.9	+10.2	65 & over	7	+1
Over 65	8	15.6	-7.6			
N	(16,445)					
Income						
Under \$20,000	8	17	-9	9	-1	
\$20-\$39,999	17	16	+1	20	-3	
\$40-\$59,999	23	27	-4	24	-1	
\$60-\$79,999	19	16	+3	16	+3	
\$80-\$99,999	14	11	+3	14		
More than \$100,000	19	13	+6	17	+4	
N	(11,974)					
Education						
Elementary school or less	1	37	-36	0		
Secondary school	11	23	-12	29	-18	
Community/technical college or CEGEP	18	16	+2	34	-16	
Prof./Trade certification	9	11	-2	5	+4	
Bachelor degree	34	9	+25	22	+12	
Graduate degree	28	5	+23	10	+18	
N	(12,645)					

^a Population estimates are derived from a number of sources. Age distribution for population is from Census Canada (2001) and the percentage is the value for the Canadian population aged 16 or older. Census Canada age categories differ slightly from those used in the workbook (19 to 29 is 20 to 29 in the Census and over 65 plus is 65 and older in Census data). Income data is from *Rethinking Government 2002 (January)* and education distribution from Census Canada (1996).

^b Estimates of the characteristics of Internet users are based on results from the *Rethinking Government* surveys that included a question on whether the respondent has used the Internet in the past three months either at home or at work. According to this data, 75 per cent of Canadians (16 years or older) have used the Internet in the past three months. Age categories again present somewhat of a difficulty since they do not match up strictly speaking with those used by the Commission. It is possible to compare the size of the group under 30. In addition, the highest age group is close to that used by the Commission (over 65 compared with 65 and over).

- ❖ Few seniors (8 per cent) and young people (1 per cent of those under 18) participated in the on-line version of the workbook, with the bulk of participants in the 30 to 49 age range. The lack of seniors could be related to the participant's high level of education, but it is also the result of the digital divide.
 - In the 2001 Census, one finds that 15.6 per cent of Canadians are 65 or older. According to survey evidence, however, only 7 per cent of Internet users are 65 or older. As such, seniors were over-represented among mail-in participants (33 per cent of all completed mail-in workbooks were provided by seniors).
 - Younger Canadians are under-represented in terms of the general population and in terms of Internet users in both the on-line and mail-in version (only 9 per cent of the mail-in and 17 per cent of the on-line workbook completions are attributed to those under 30).

Place of Residence

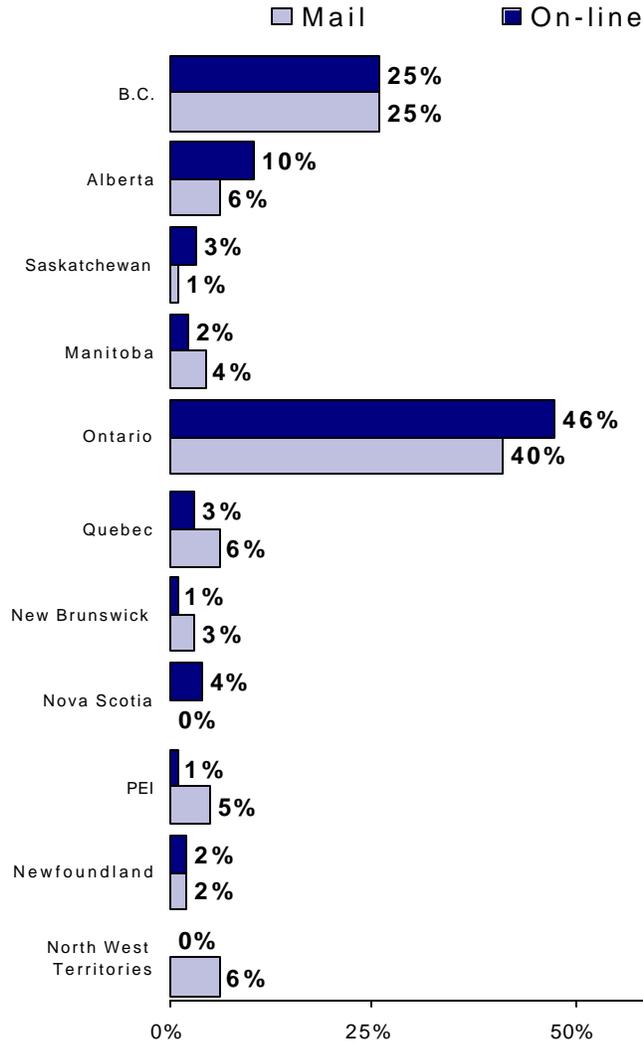
- ❖ Participants were not drawn to participate in proportion to their provincial distribution. Figure 5.1 shows that Quebec was particularly under-represented (3 per cent of the on-line and 6 per cent of the mail-in cases). If the workbook data was representative, 24 per cent of the participants would have come from Quebec.
 - The low representation of Quebec has implications for understanding the overall distribution of opinion among participants. For example, the Quebec participants tend to be less in favour of tax increases and more favourable to the user fee scenario. This means that if a larger percentage of the total participants had come from Quebec, the support for user fees among all participants would have been larger.
 - The under-representation of Quebec is compensated by a particular over-representation of British Columbia and Ontario. Participation was driven by a range of considerations that might include: the nature of the Commission's advertising and promotion strategy, and the current salience of health care as a crisis in different parts of the country.
- ❖ Twenty-three per cent of on-line participants (22 per cent of mail-in participants) report being from a rural location. Atlantic Canada has the highest proportion of participants from rural areas (41 per cent of on-line participants). In comparison, only

23 per cent of on-line participants from the Prairie provinces claimed to live in a rural area.

- Differences between rural and urban participants tend to be small or non-existent across the questions asked in the workbook.
- *Rethinking Government* surveys generally identify about 26 per cent as rural, which is very close to that reported here.

Fig. 5.1
Province

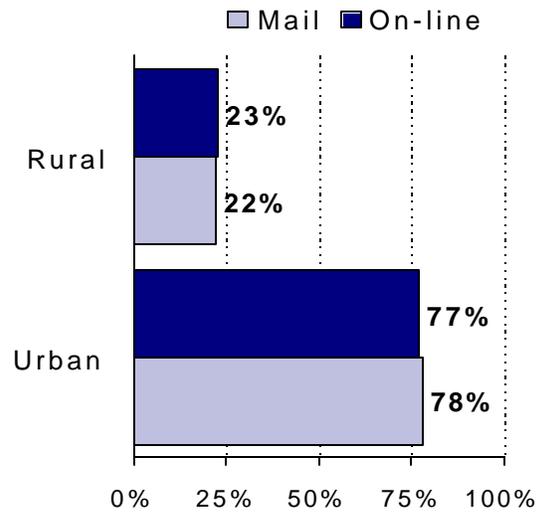
Q: Your province/territory of residence:



{on-line n=16,444; mail n=1,083}

Fig. 5.2

Rural versus Urban



{on-line n=16,452; mail n=1,078}

Health Professionals

- ❖ Almost one in four participants (23 per cent of on-line and 25 per cent of mail-in) indicated that they are health care professionals. This is a good indication that a significant portion of the consultation exercise involved stakeholders.
 - The 2001 Census indicates that only 5 per cent of Canadians (10.3 per cent of employed people) work in the health and social services sector. Even without adjusting for a looser definition of a health care professional in the Census Canada classification, the 23 per cent who participated on-line is more than four times the national distribution.
 - Health professionals who participated were more likely to be women. For example, 13 per cent of male participants are health professionals compared with 28 per cent of female participants (on-line only).
 - Health professionals were not more likely to come from a particular region.

Use of Health Services

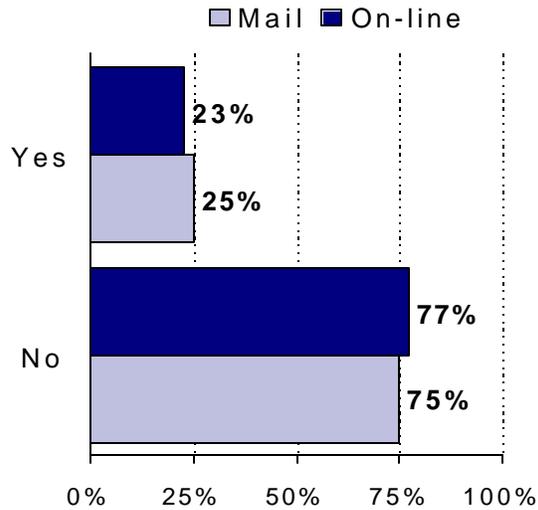
- ❖ A majority of participants used the health care system between 0 and 3 times in the past year and a small minority used the system 10 or more times.
 - Female participants have used the system more frequently than male.
 - Older respondents, though we have few seniors relative to their share of the population, used the system more frequently. Because participants who mailed their workbooks tended to be older, there is more frequent use of the health care system reported among mail-in participants.
 - Those with higher SES tend to report using the health care system less frequently.

- ❖ One can get a reasonable sense of how these self-reports compare with a more general use of health care services from the *National Health Care Survey* (June 2000, n=1210). This survey found 12 per cent of Canadians have used health services more than 10 times in a year. Workbook participants do not seem to differ too much from average Canadians in this respect.

Fig. 5.3

Health Professional

Q: Are you a health care professional?

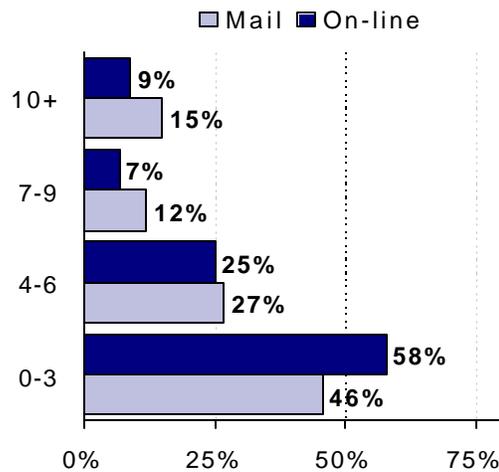


{on-line n=12,937; mail n=1,054}

Fig. 5.4

Use of Health Care System

Q: Approximately how many times in the last year have you personally used the health care system? (e.g. seen a doctor or specialist, spent time in the hospital, received care in a hospital emergency room, etc.)



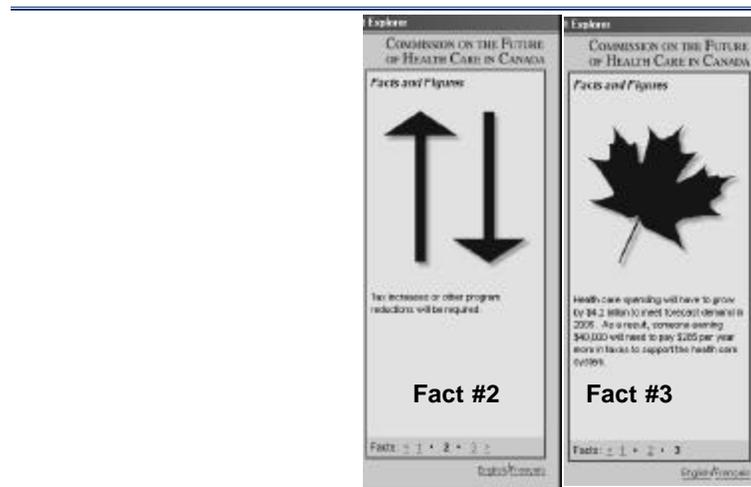
{on-line n=12,992; mail n=1,058}

6.0 Judgments on the Future of Health Care

The workbook results are presented here using a structure parallel to how the questions were presented to the participants. The only exception is that the demographic variables that appeared at the beginning and end of the workbook have already been discussed. There are then, six sections of results:

1. Values
2. Scenario 1: More Public Investment
3. Scenario 2: Shared Cost and Responsibility
4. Scenario 3: Increasing Private Choice
5. Scenario 4: Reorganizing Service Delivery
6. Final Thoughts

Each of the four scenario sections began with two screens showing a set of pro and con arguments pertaining to that scenario. These screens are replicated in the report. The first question in each of the scenario sections was a direct measure of the person's tendency to favour that scenario. Once this was answered, other relevant questions about the scenario – in terms of qualifications or consequences – were asked. Accompanying all of the questions in each scenario section was a sidebar that revealed a “fact” about the health care system and additional “facts” were available by activating links at the bottom. It is not possible to determine exactly who read the facts, particularly those which required an activation of the links, but the decision to include the facts is a reflection of the attempt to do more than elicit top-of-mind responses.



Values

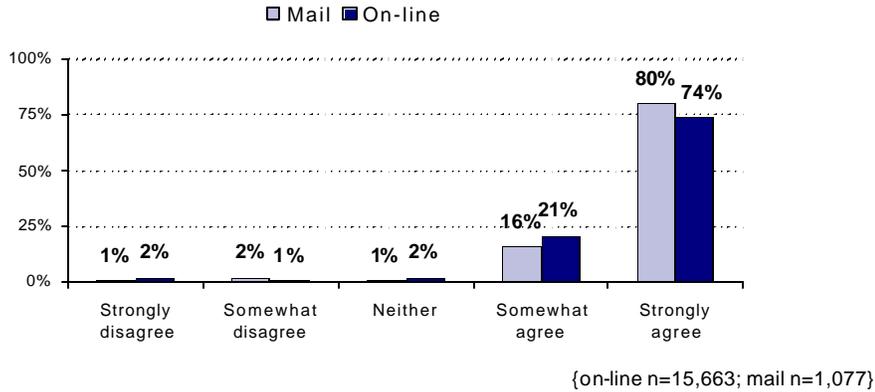
The workbook began with a short section on values. There were three questions in the section – each concerning a different value – to which the participant was asked to agree or disagree.

- ❖ For two of the three questions, participants clearly agreed with the value premise underlying the statement. Both the idea of regional equity and the idea of basing access on need are supported by 95 per cent of the participants (adding somewhat and strongly agree) of both the on-line and mail-in workbooks. Almost no one disagreed with these statements.
 - Participants from all regions of the country express equally high support for regional equity and for a system based on need.
 - There are no large group differences on these questions.

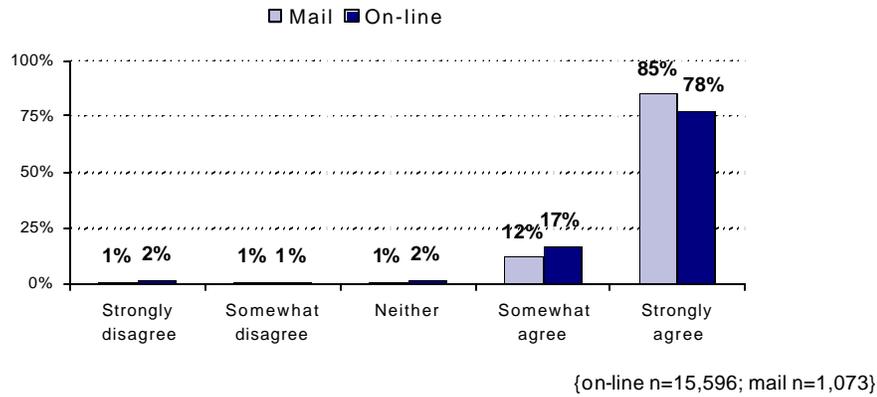
- ❖ There is less consensus among participants about the notion that people who can afford it should pay more of their health care costs. More people strongly disagreed with this notion than strongly agreed (27 compared with 6 per cent for the on-line and 33 compared with 8 per cent for the mail workbook).
 - Participants from the Atlantic region, Ontario and the two Prairie provinces expressed less agreement with the idea of having those who can afford it pay more.
 - On-line workbook participants with lower incomes are more likely to think those who can afford it should pay (34 per cent of those with household incomes below \$20,000 agreed compared with only 26 per cent of those with household incomes above \$100,000).

Fig. 6.2
Values

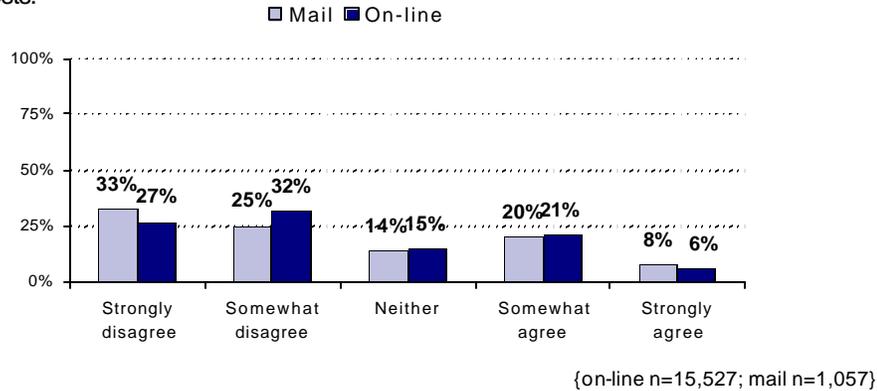
Q: It is very important to me that we have a health care system that offers basically the same services and quality of services, across the country.



Q: It is very important to me that there is equal access to health care for all Canadians based on need.



Q: I think Canadians who can afford it should pay more of their health care costs.



Scenario 1: Support for Increased Funding

The first scenario tested dealt with the idea of adding resources to the system. Figure 6.3 shows the arguments for and against this scenario.

- ❖ Participants endorsed the “add resources” scenario. Seventy-seven per cent of those who completed the on-line workbook and seventy-seven per cent of those who completed the mail-in workbook said that they felt favourable toward this scenario based on the three highest values on the scale.
 - Thirty-six per cent of on-line participants indicated they were totally favourable and only three per cent indicated they were totally unfavourable.

- ❖ While almost all participants expressed high favourability to adding resources, there were a couple of noteworthy differences:
 - Participants from Ontario were the most favourable.
 - Frequent users of the health system were more favourable than non-frequent users. For example, in the on-line results 81 per cent of those who used the health system more than 7 times were favourable compared with 76 per cent of those who used it three or fewer times (for the mail-in results the comparable numbers are 83 and 69).
 - Health professionals were less favourable to adding resources (73 per cent of health professionals were favourable compared with 79 per cent of non-health professionals in the on-line results).

- ❖ In seeking a source of new government money to be spent on health care, the overwhelming preference is for more taxes rather than cuts to areas like environmental protection or education. Only 17 per cent of on-line participants and 12 per cent of mail-in participants chose the option of reducing funding to these areas.
 - In a public opinion survey conducted for the Commission in March¹⁰, a question that posed slightly different options (tax increase versus reallocation but without mentioning the areas to be reduced) found the opposite.
 - Those who are favourable to increased government resources are more likely than those who are unfavourable to prefer a tax increase. Of those who are favourable (5-7 points on 7-point scale), 88 per cent would choose more taxes compared to only 61 per cent of those who are unfavourable toward the scenario (on-line workbook results).

Fig. 6.3
Screen Views of Scenario 1 Arguments

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Shape the Future of Health Care in Canada - Consultation Workbook

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 1: More Public Investment

Arguments in favour

If it isn't broken, don't fix it. Medicare is basically sound. Current problems, such as long waiting times, are primarily due to inadequate funding.

Public funding is the fairest. We should be willing to pay more taxes to provide good quality, reliable health care for all Canadians. We need to expand coverage to home care and pharmacare.

When it comes to changing Medicare, we should be very careful. We should make only those changes that are absolutely necessary to preserve it.

Click **NEXT** to continue.

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English/Français

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Shape the Future of Health Care in Canada - Consultation Workbook

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 1: More Public Investment

Arguments against

We can't afford to keep the current system as it is. Either taxes will have to keep going up and up, or we'll have to under-fund other important priorities such as education.

It makes no sense to transfer funds from other areas that contribute greatly to good health.

The current system provides few incentives to save money. Adding more tax dollars won't solve that. Before raising taxes we need to reform the system to introduce efficiencies and innovations.

Click **NEXT** to continue.

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Fig. 6.4

Scenario 1: More Public Investment

Q: How do you feel about more public investment? Please indicate how favourable or unfavourable you feel toward government adding more resources to improve the current health care system.

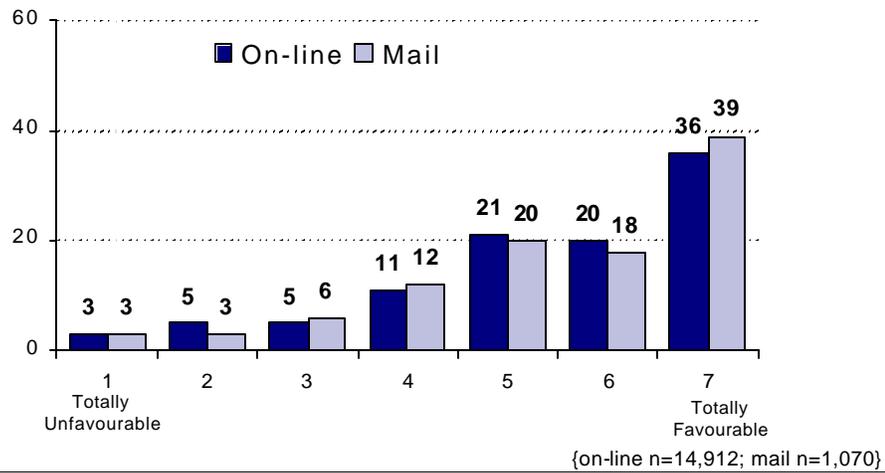
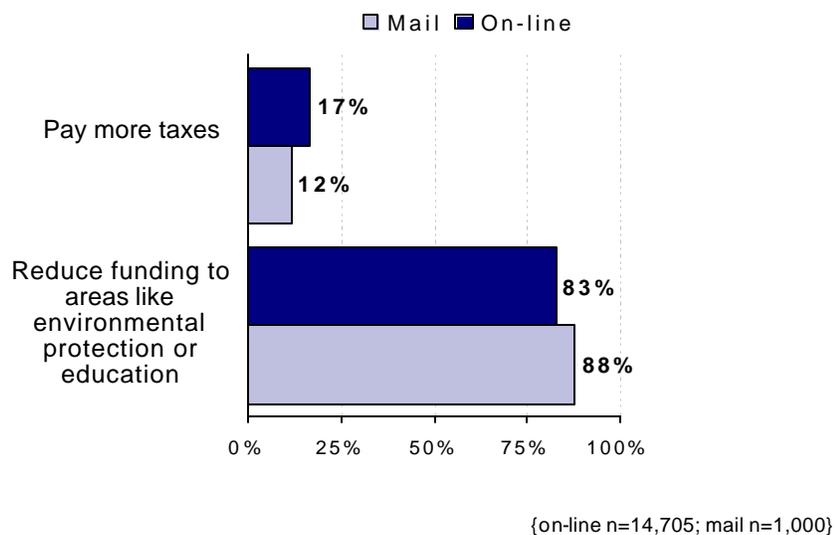


Fig. 6.5

Source of Additional Resources

Q: If government determines that more public funding is essential, my preference would be to...



Scenario 2: Low Support for User Fees

The second tested scenario involved support for shared costs and responsibilities through a system of user fees. As before, we find the mail-in and on-line participants come to similar judgments about this scenario.

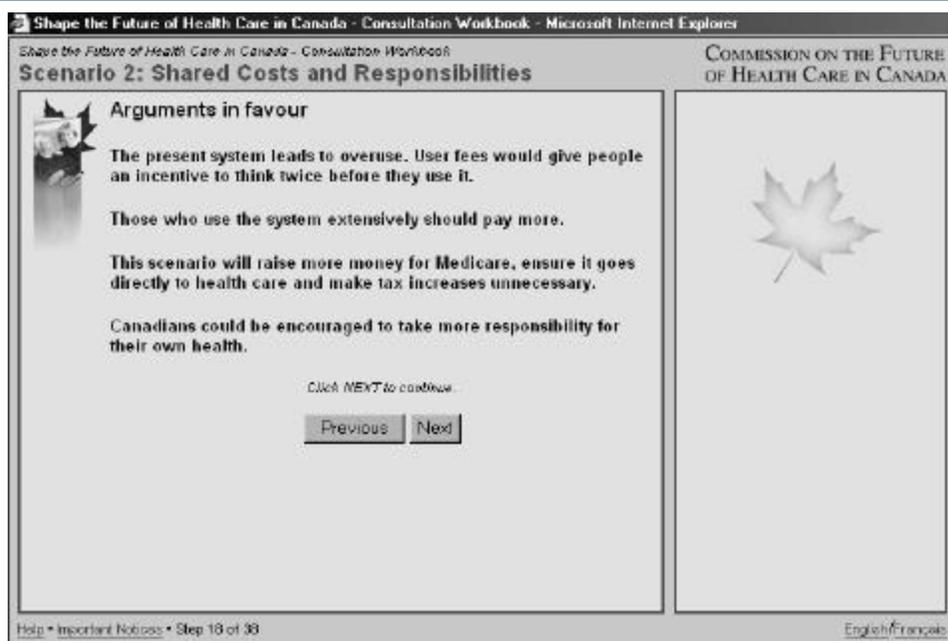
- ❖ The adoption of user fees receives low public support. In fact, with 32 per cent of on-line participants giving a favourable rating (5-7 points on a 7-point scale), this scenario receives the second lowest level of favourability; as many people take the *totally unfavourable* position (1 point on the 7-point scale) as take a favourable score (5-7 points). The results are similar for mail-in participants.
 - Ontario participants are the least favourable toward the user fee option (27 per cent) among on-line participants and Atlantic Canada was the least favourable among mail-in participants. Quebec (42 per cent and 37 per cent) is the most favourable in both results.
 - Male participants are more favourable toward user fees than female participants. For example, in the on-line workbook 35 per cent of male participants were favourable compared to 29 per cent of female participants.
 - Young adults (under 30) are more favourable than seniors. For example, 35 per cent of young adult participants on-line supported user fees compared with 27 per cent of seniors. For mail-in responses an even greater difference was found (35 per cent compared with 21 per cent).
 - Frequent health service users, the ones most likely to have to pay, are less favourable than others (among on-line participants, 27 per cent of people who use services 7 or more times in a year endorsed user fees compared with 34 per cent of those who use these services 0 to 3 times per year).
 - Health professionals who participated are more supportive of the option than non-health professionals (37 per cent compared with 30 per cent among on-line participants and 33 per cent compared with 26 per cent among mail-in participants).

- ❖ The reasons this scenario is not well supported are evident in the responses to four statements about user fees asked after the favourability component was complete. A decisive majority of both types of workbook participants says that user fees make them worry about equal access for everyone (75 per cent of on-line and 77 per cent of

mail-in participants somewhat or strongly agree), and a majority says that it makes them worry that other innovations won't happen. In addition, a majority disagrees that user fees would be better than a tax increase (55 per cent of on-line participants somewhat or strongly disagree).

- A significant group of participants (38 per cent of on-line participants and 36 per cent of mail-in participants) think that user fees would prevent them from going to the doctor, which is balanced off by a slightly larger group (46 per cent) who disagree with this statement.

Fig. 6.6
Screen Views of Scenario 2 Arguments



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Shape the Future of Health Care in Canada - Consultation Workbook

Scenario 2: Shared Costs and Responsibilities

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Arguments against

User fees would discourage people who need health services from seeking them. Early treatment leads to lower health care costs overall.

There is no clear evidence that overuse is a major problem in Canada.

This scenario puts the burden on patients, it doesn't ask doctors or hospitals or others to share the costs.

The cost of collecting user fees could be substantial.

Click NEXT to Continue

Previous Next

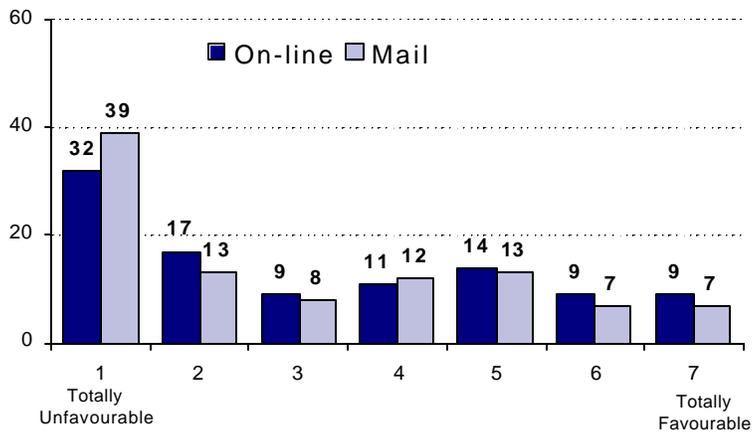
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Fig. 6.7

Scenario 2: Shared Cost and Responsibility

Q: How do you feel about sharing the costs and responsibilities? Please indicate how favourable or unfavourable you feel toward sharing the costs and responsibilities through paying user fees.

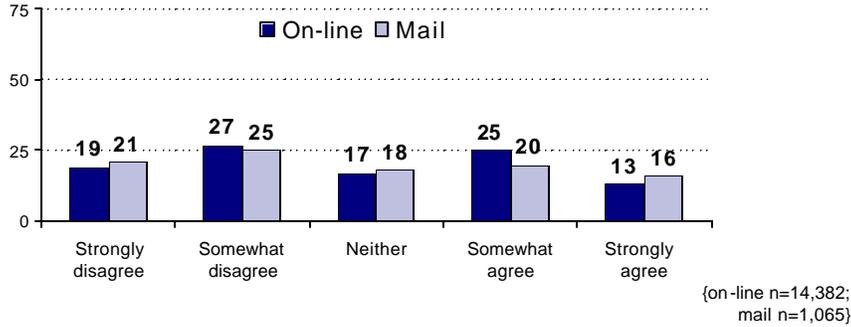


{on-line n=14,498; mail n=1,067}

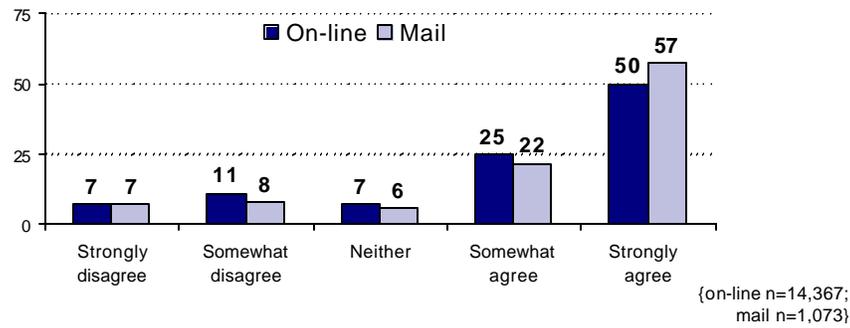
Fig. 6.8
Impact of User Fees

Q: What do you think? How would you react to user fees? Would they:

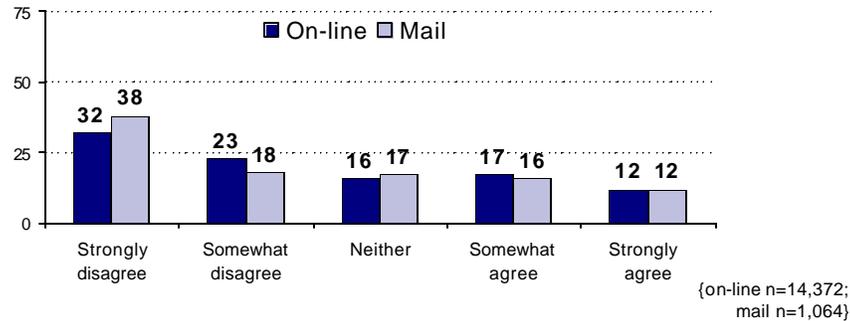
Prevent you from going to the doctor?



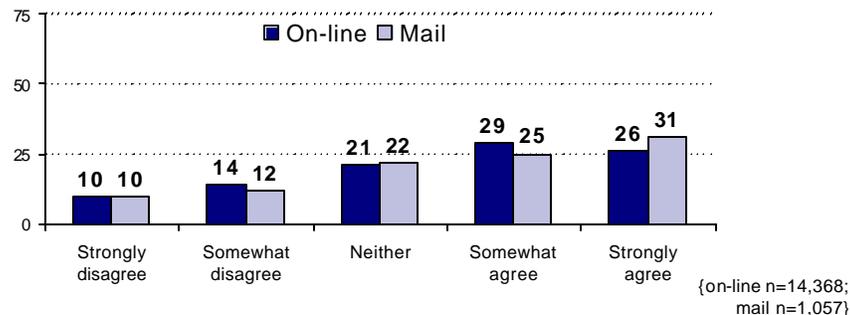
Make you worry about lack of equal access for everyone?



Be better than having a tax increase?



Make you worry that other efficiencies and innovations won't happen?



Scenario 3: Increase Private Choice

The third and least favourable scenario is to increase the ability of people with resources to access private health services. Figure 6.9 shows the arguments that were presented in favour and against this proposal.

- ❖ The least favoured scenario is to increase the opportunities for private access to health services for those who can afford to pay. Unfavourability is high and strong with one in two participants (49 per cent for on-line and 55 per cent for mail-in) saying they are *totally unfavourable* toward this scenario. About one in four are, however, favourable to some degree.
 - While participants in the highest income categories are more likely to be favourable, two out of three are still unfavourable.
 - Those from Quebec are the most favourable to allowing people to purchase services with their own resources (37 per cent of on-line responses and 24 per cent of mail-in responses from Quebec are favourable). Mail-in participants from B.C. are also more favourable to this scenario.

- ❖ Participants are unfavourable because they decisively reject the view that people should be able to pay extra to get quicker access to health care services and say that this scenario creates a system of haves and have nots.
 - Though all groups lean toward the view that people with resources should not be able to use them to jump the queue, those with higher household incomes are more supportive of allowing this type of spending. Among on-line participants, for example, 23 per cent of those with household incomes above \$100,000 supported this scenario compared with only 14 per cent of those with incomes below \$20,000 (the equivalent figures for the mail-in results are 25 per cent and 9 per cent).
 - Income is largely unrelated to perceptions of whether the scenario would create a system of haves and have nots.

Fig. 6.9
Screen Views of Scenario 3 Arguments

Shape the Future of Health Care in Canada - Consultation Workbook - Microsoft Internet Explorer

Shape the Future of Health Care in Canada - Consultation Workbook

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 3: Increased Private Choice

Arguments in favour

More private services would result in quicker service, and less waiting time.

Providing private sector alternatives would create competition and incentives to innovate and improve service.

Canadians shouldn't have to go to the U.S. to spend their own money on health care services.

Click **NEXT** to Continue.

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Shape the Future of Health Care in Canada - Consultation Workbook

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 3: Increased Private Choice

Arguments against

This creates a two-tier system of health care. Those with more money would be able to jump the queue and get faster or better service.

The poor will be disadvantaged.

Some medical professionals will want to work as much as possible in private clinics, diminishing the quality of service in public hospitals.

Health care costs will increase overall.

Click **NEXT** to Continue.

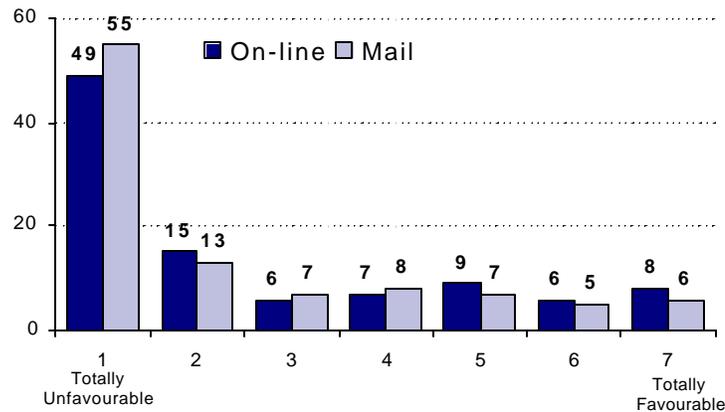
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Fig. 6.10

Scenario 3: Increase Private Choice

Q: How do you feel about increasing private choice? Please indicate how favourable or unfavourable you feel toward allowing for greater access to private health care services for those who can afford to pay.

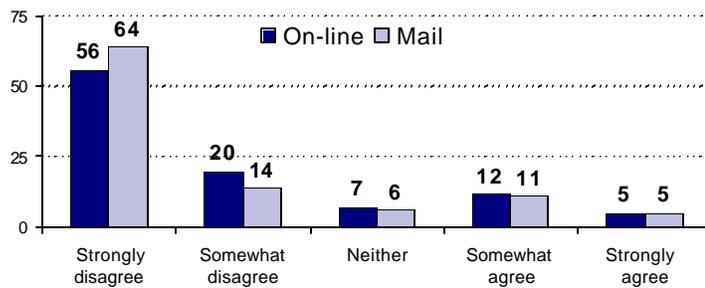


{on-line n=14,244; mail n=1,078}

Fig. 6.11

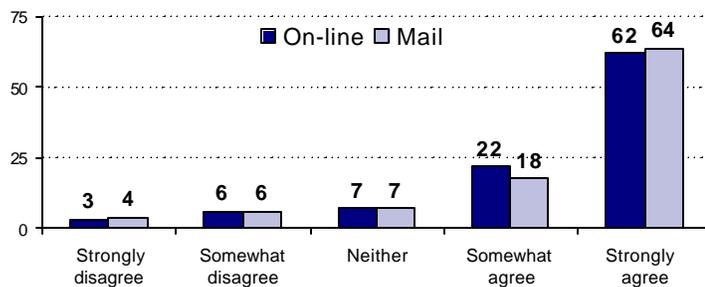
Reasons for Not Supporting Scenario 3

Q: Individuals should be allowed to pay extra to get quicker access to health care services.



{on-line n=14,214; mail n=1,077}

Q: This scenario creates a system of haves and have-nots.



{on-line n=14,212; mail n=1,073}

Scenario 4: Reorganize Service Delivery

The fourth scenario tested dealt with a change in the way that health care services are delivered. Figure 6.12 shows the arguments in favour and those against what was referred to as a team-based approach.

- ❖ The fourth scenario received the second most favourable responses next to the “add resources” scenario. Two in three participants found this scenario favourable.
 - Participants with a university education are considerably more favourable to reorganization (among on-line participants, 73 per cent of university educated participants compared with 56 per cent of those with high school or less are favourable).
 - Higher income participants are also more favourable to this approach.
 - Health care professionals are more favourable (among on-line participants, 77 per cent of health care professionals compared with 66 per cent of non-professionals) and 41 per cent of health care professionals in the on-line workbook (42 per cent for mail-in participants) take the strongest position (totally favourable).

- ❖ In general, participants are:
 - willing to use a 24-hour clinic instead of a hospital (on-line 92 per cent; mail-in 91 per cent);
 - willing to see a nurse rather than a doctor for routine treatment (on-line 88 per cent; mail-in 86 per cent);
 - willing to sign up with a family doctor for at least a year (on-line 78 per cent; mail-in 73 per cent);
 - willing to have personal information available on a “smart card” (75 per cent for both); but
 - completely unwilling to be limited in getting a second opinion (on-line 11 per cent willing; 89 per cent unwilling; mail-in 17 per cent willing; 83 per cent unwilling).

Fig. 6.12
Screen Views of Scenario 4 Arguments

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Shape the Future of Health Care in Canada - Consultation Workbook

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 4: Reorganized Service Delivery



Arguments in favour

By working together as a team, providers would offer one-step-shopping – coordinated and efficient care for the “whole person”.

Patients would have 24-hour, 7-day-a-week access to clinics and telephone advice, reducing unnecessary visits to hospital emergency rooms.

Provider networks would be funded according to the number of people they serve rather than the number of times they see people.

There would be incentives for the team to take prevention seriously.

With changed incentives and efficiently organized services, we could keep costs from spiraling out of control.

Click NEXT to continue.



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COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Scenario 4: Reorganized Service Delivery



Arguments against

Patients would not have the choice of doctors and other health care providers they currently have.

The network could become rigid and unresponsive.

This type of reorganization is not necessary as many doctors already focus on prevention and are responsive to patient needs.

There may not be significant savings. There may even be a need for more money, at least to pay for start-up costs.

Click NEXT to continue.



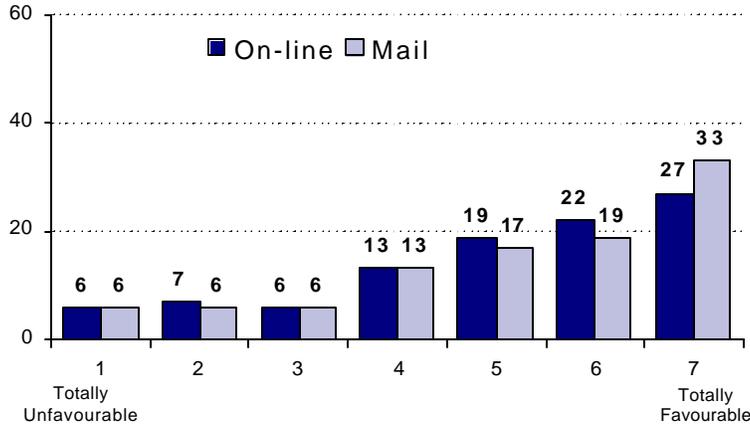
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Fig. 6.13

Scenario 4: Reorganize Service Delivery

Q: How do you feel about re-organizing service delivery? Please indicate how favourable or unfavourable you feel toward a team-based approach of health care delivery.

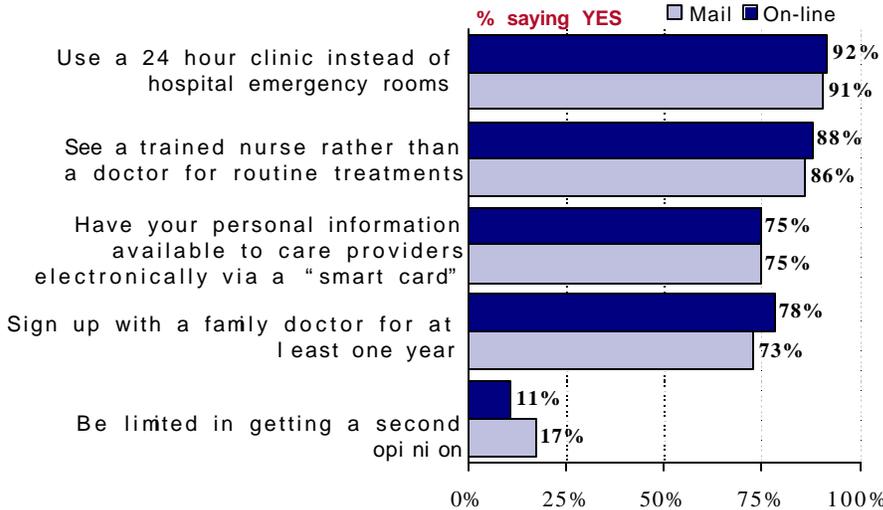


{on-line n=14,119; mail n=1,058}

Fig. 6.14

Reorganized Service delivery

Q: In a reorganized system are you prepared to..



{on-line n=14,023; mail n=1,070}

Final Thoughts

- ❖ Each of the scenarios was given a rating on a 7-point scale as people worked through the sections of the workbook. Figure 6.15 summarizes the distribution for each one by collapsing the results into unfavourable (1-3 points), neither (4 points) and favourable (5-7 points) responses. The results show that more public investment is the scenario with the highest favourability followed closely by a reorganized delivery system. User fees and more private choice, especially the latter, are not viewed favourably.
 - There was no difference between the way that on-line workbook and mail-in workbook participants evaluated the scenarios.

- ❖ In the final substantive section of the workbook, participants were asked to rank the four scenarios. The results are consistent with the findings with respect to ratings. Eighty-two per cent of on-line participants (86 per cent of mail-in participants) chose more investment or reorganization as their first choice.
 - When it comes to second choices, reorganization and more investment were again more likely to be chosen.

- ❖ Rather than the dichotomy between taxes and reallocation of existing spending, participants were provided with more options for where to get additional resources if they were added. More taxes is the decisive, plurality choice (on-line 40 per cent of participants; mail-in 48 per cent of participants).
 - Reallocation of other government spending was the second most cited reason (on-line 23 per cent of participants; mail-in 22 per cent of participants) followed by user fees (16 per cent and 14 per cent respectively) and by changes that limit choice (13 per cent and 11 per cent respectively).
 - Few people see the introduction of private insurance or a reduction in service as the appropriate course of action (on-line 5 per cent of participants; mail-in 3 per cent of participants).

- ❖ Participants were also asked to identify indications of a system that is working better in the future. A range of options was provided and multiple responses were allowed. The most frequent indicator chosen was shorter waiting times (53 per cent of on-line participants identified this as an indicator).

- Three other indicators were mentioned by approximately one in three on-line workbook participants. These include, the ease of finding a doctor, better access to home care services and the ease of getting health information.
- Mail-in participants were more likely to give multiple responses, but the ordering is consistent with the on-line results.

Fig. 6.15

Summary of Support for Scenarios

Q: How do you feel about...

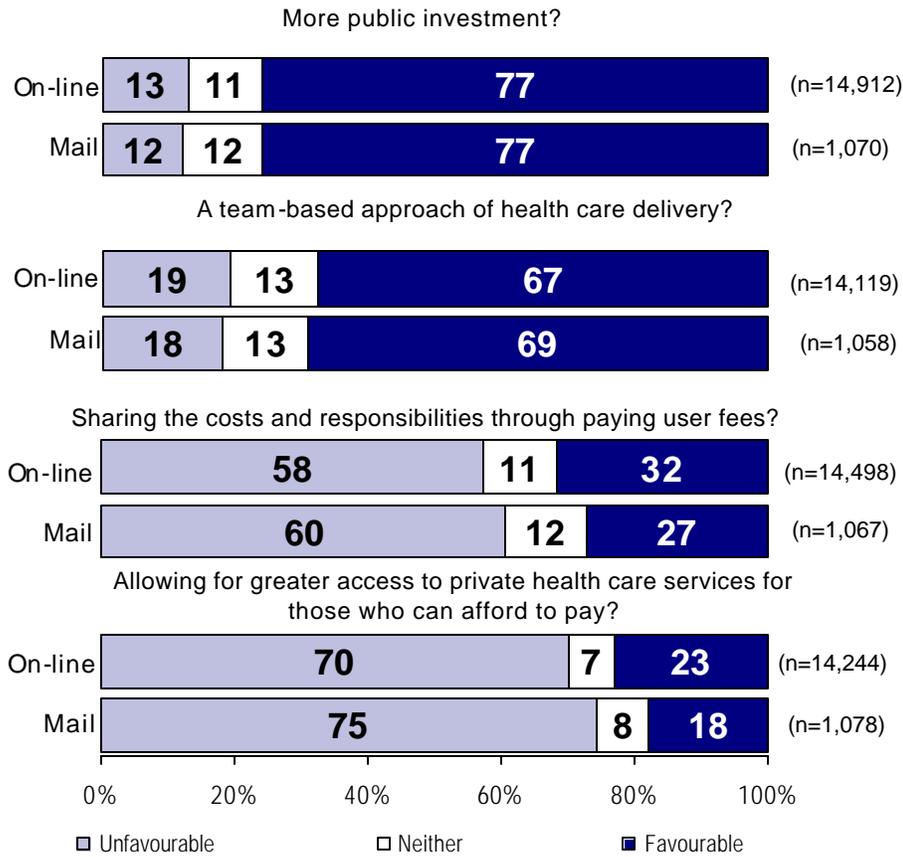


Fig. 6.16

Ranking Scenarios

Q: Please rank the four scenarios in order of your preference for the future of health care in Canada.

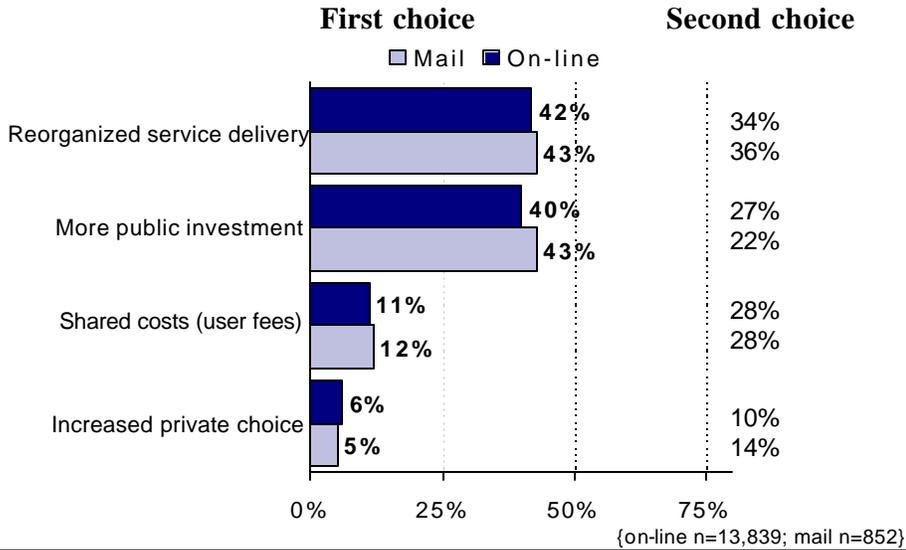


Fig. 6.17

Preferred Mode of Paying for Additional Funding

Q: If more funding is necessary in the future, how would you prefer to pay?

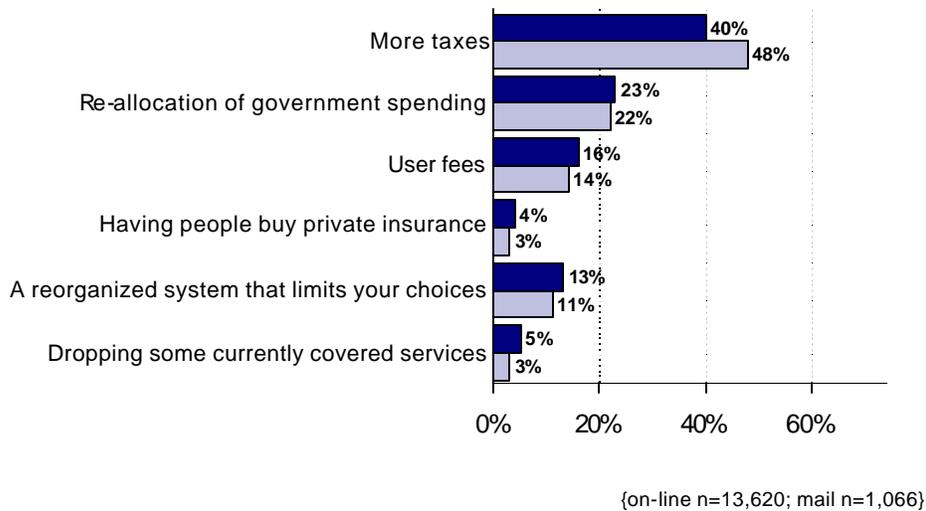


Fig. 6.18

Ranking Factors Associated with System

Q: Please rank order these factors in order of their importance in shaping the health care system for the future.

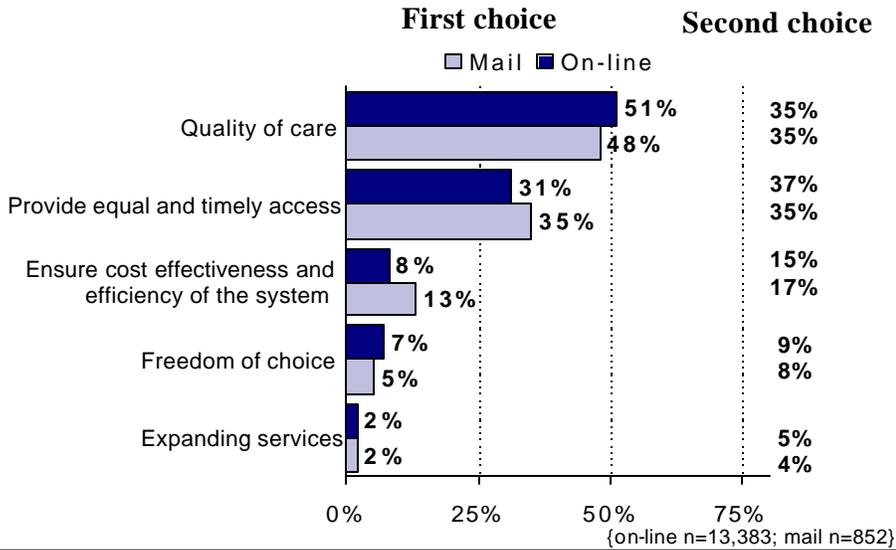
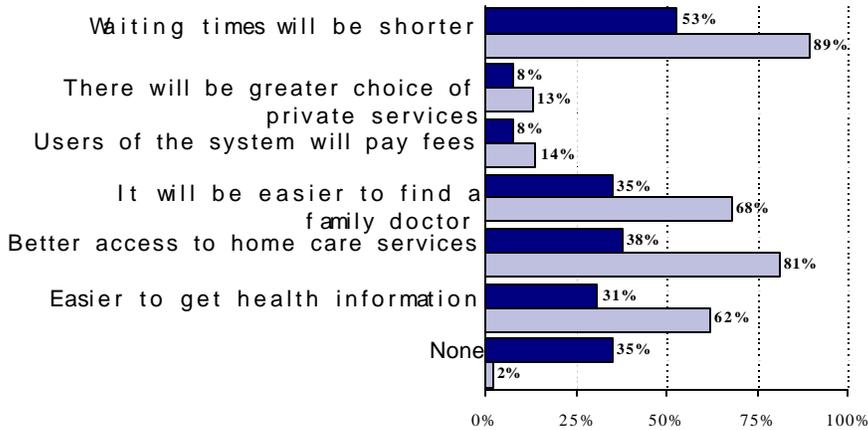


Fig. 6.19

Measures of Success

Q How will you tell the system is working better in future?



{ multiple responses accepted; overall n approx. 13,383 for on-line and 1,070 for mail}

7.0 Conclusion

The workbook results indicate four things:

Consultation exercise generated considerable input

- ❖ The consultation workbook demanded a substantial effort from participants since it was not simply a *vox populi* comment opportunity. A fifteen-minute time commitment (at minimum) was necessary and some of the questions required some thought. Despite this, over 16,000 people participated in the on-line consultation workbook and more than 1,000 completed and mailed a paper version.
- ❖ In addition to the large number of workbooks that were started, 8 in 10 of all those who started answering the on-line questions also finished. This is, of course, an underestimate since many people who did not finish (and started again) did so due to factors such as technology trouble and not out of an unwillingness to participate.
- ❖ While an evaluation of the on-line workbook was not built into the design, it is possible to infer how well the system was received. In particular, the fact that a large number of people completed the process once it began strongly indicates that the process adequately allowed interested Canadians to have their say.

The on-line consultation exercise attracted those interested

- ❖ The “average” Canadian was not the most likely participant in the on-line consultation though there were clearly people of all backgrounds who did complete the workbook. Some of this is the result of the nature of any on-line exercise, which inevitably does not reach those without easy access.
- ❖ Three somewhat related groups were over-represented: the very highly educated, those who self-identify as health professionals (stakeholders), and those between 30 and 65 years of age (few youth and few seniors took part). Though the digital divide offers some explanation, it is only one of a number of factors.
- ❖ One group, Quebec residents, completed proportionally few workbooks (3 per cent of on-line) and another group, women, completed proportionally many workbooks (more than 65 per cent).
- ❖ In comparison, the mail-in workbook tended to attract an older population.

Prescriptions from the workbook are clear

- ❖ Of the scenarios offered, participants decisively sided on one of two approaches to the future of the health care system. More resources and reforms that address service delivery are supported, while user fees and the option of more private choice are rejected.
- ❖ Taxes are the preferred source of new resources.
- ❖ Service delivery reorganization is viewed positively and most participants were willing to accept the consequences (except for limitations on second opinions).
- ❖ Given that the participants largely endorsed arguments that user fees produce worry about access and the adoption of new innovations, one can understand why user fees are rejected. At the same time, a majority does not think user fees are better than a tax increase.
- ❖ More private choice is not favoured by most, who worry that it will create a system of haves and have nots.
- ❖ The results of the two workbooks, on-line and mail-in, are very similar. The conclusions drawn from the results of online participants' responses are the same as one draws from the mail-in responses.

Representativeness versus quantity

- ❖ Self-selection substantially limits one's ability to generalize beyond the 16,000 participants to the population of Canada. That said, the results are an indication of the views of those most motivated to go to a website and provide input.
- ❖ Several questions asked in the workbook have been asked of representative samples over the past several years and this provides a way of further understanding the results.
- ❖ In general, and perhaps most importantly, the conclusion reached about the ranking of scenarios is very similar to that reached from survey findings undertaken for the Commission using questions worded slightly differently. In both cases, more investment in health care and a reorganization of service delivery are the most highly rated options.
- ❖ In one case, the findings from a representative survey showed a significant difference from the findings of the workbook. In the workbook results, 17 per cent of participants agree that individuals should be allowed to pay extra compared to 36 per cent of Canadians (*Rethinking Government, 2001*)¹¹. There is, then, the possibility that participants came to the workbook with different views about health care than the general Canadian population.

Notes

¹ Minute of a Meeting of the Committee of the Privy Council, approved by Her Excellency the Governor General on April 3, 2001.

² *Shape the Future of Health Care: Interim Report* (February 2002).

³ The two reports are *Public Input on the Future of Health Care: On-line Contributions* (Ekos Research Associates Inc., 2002) and *Public Input on the Future of Health Care: Mail-in Contributions to the Debate* (Ekos Research Associates Inc., 2002).

⁴ The provincial differences are particularly large. Only 3 per cent of all completions came from Quebec while 46 per cent came from Ontario and 25 per cent from British Columbia. In order to bring Quebec's influence on the overall numbers into line with the population of Canada, the Quebec cases would have to be assigned an unrealistic weight of 8.

⁵ One attempt involved weighting down the two provinces that were vastly over-represented (Ontario and British Columbia) and weighting up the Quebec results (because only 3% of responses came from Quebec this involved an unrealistic weight). The aggregate results were generally affected by about 1-2 percentage points though, in a couple of cases where Quebec and Ontario differed significantly, differences of 4 points were observed. The second attempt was to ignore the under-representation of Quebec and weight the data in the rest of Canada as reflective of the remaining population. When this was attempted, most of the results stayed the same and none changed by more than 1 point. The first approach was rejected on the basis of the size of the Quebec-rest of Canada (ROC) discrepancy and the second because it had only modest impact.

⁶ On the whole, missing cases represented only 1-3 per cent of the total except for a couple of the more complex questions (ranking values and scenarios had 20-24 per cent missing) and the income question (14 per cent missing). For consistency of presentation with the on-line results, the non-responses are not calculated as part of the totals represented in the figures.

⁷ Many people began the process such that the IP addresses of 20,637 people were collected even though only 16,463 responses to the first question were captured. This means that 4,174 times the first page of the workbook was activated but no information was entered. It is not possible to say anything about these people who decided to abandon the process at this stage, though clearly many may have returned to the site later when they had more time.

⁸ Confirming the form and nature of all the addresses would be a time-consuming exercise.

⁹ *Rethinking Government* is an ongoing Ekos Research Associates syndicated research initiative that involves a multi-wave public opinion survey on a range of public policy issues. Each survey wave has a minimum of 1500 cases.

¹⁰ *Future of Health Care in Canada: General Public Survey* prepared for the Commission on the Future of Health Care and submitted to CPRN (March 2002, Ekos Research Associates Inc.).

¹¹ The only difference is that the *Rethinking Government* Survey used a 7-point rather than a 5-point scale, which is unlikely to have changed the level of agreement.

**Commission on the
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