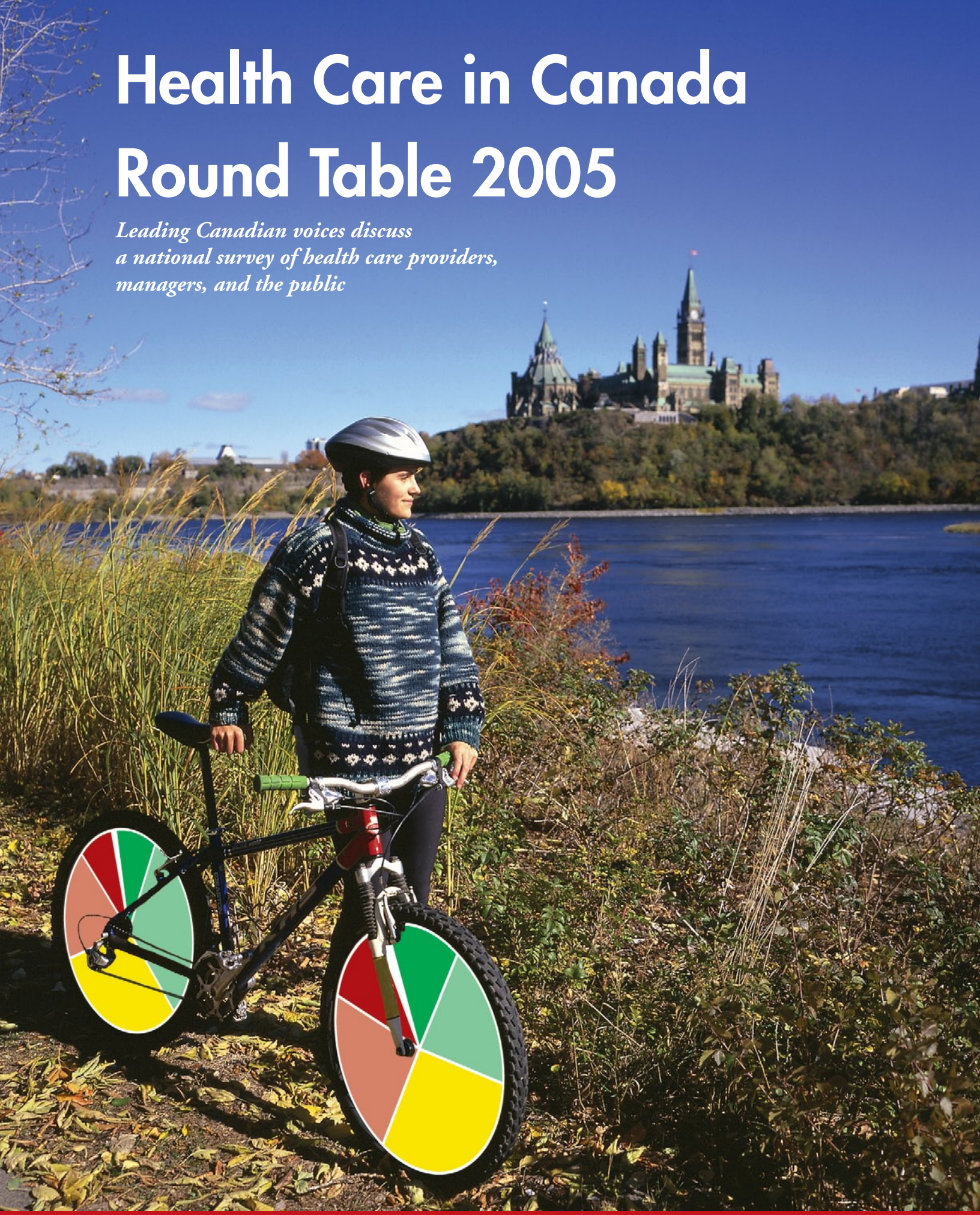
Health Care in Canada Round Table 2005

Leading Canadian voices discuss a national survey of health care providers, managers, and the public

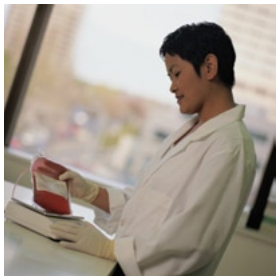


Produced by MediResource Inc., Toronto, Ontario.

Results of the 2005 Health Care in Canada Survey highlight some significant challenges ahead for those managing, working and receiving health services in Canada. Canadians are divided on the appropriate role for private payment and private insurance in the Canadian health system. A slight majority of Canadians support paying out-of-pocket for service enhancements and allowing private insurance and payment for non-emergency services outside of the public system. Support drops when asked if they would like to pay out-of-pocket to purchase quicker access to services. There is strong support for requiring health professionals to work in teams and where most needed, with less support coming from physicians for such approaches. All groups favour increased funding and incentives for health research and for improved and more consistent access to new medicines. Public health measures are strongly supported – especially school-based wellness programs, tax measures on things such as alcohol and tobacco, and implementation of a national immunization strategy. Canadians have concerns about quality, safety, and access in the Canadian health system, including waiting times for surgical services, potential of errors while being treated in hospital, and preparedness for public health emergencies.

About the survey: This is the eighth annual comprehensive national survey of the public, doctors, nurses, pharmacists, managers and trustees. It is conducted by POLLARA Research. Survey partner organizations: Association of Canadian Academic Healthcare Organizations, Canadian Nurses Association, Canadian Medical Association, Canadian College of Health Service Executives, Canadian Healthcare Association, Canadian Home Care Association, Canadian Public Health Association, Health Charities Coalition of Canada, Canadian Pharmacists Association, Merck Frosst Canada Ltd., and Rogers Media. This year's survey results provides demographic breakdowns to allow examination of responses based on gender, location, and income. For full results, including PowerPoint presentations, go to www.hcic-sssc.ca.

Methodology: Survey results are based on telephone interviews with nationally representative samples of 1,207 members of the Canadian public, 203 doctors, 201 nurses, 202 pharmacists, and 201 managers and trustees. Fielding of the core questionnaire was conducted between August 17 and September 2, 2005. Results for the public are considered to be accurate within plus or minus 2.8 per cent, 19 times out of 20, while the margin of error for results for the other groups is plus or minus 6.9 per cent, 19 times out of 20. Questionnaires were developed by POLLARA working in close consultation with the HCIC partners.



Participants

Moderator: **Martin Stringer,** CPAC

Lynda Cranston, Association of Canadian Academic Health Organizations

Colin Leslie, Medical Post

Michael Marzolini, POLLARA Research

Jeff Poston, Canadian Pharmacists Association

Sharon Sholzberg-Grey, Canadian Healthcare Association

Michael Villeneuve, Canadian Nurses Association

Elinor Wilson, Canadian Public Health Association

The 2005 Health Care in Canada Round Table was held on November 29, 2005, at the Ottawa Congress Centre.

Survey results

Martin Stringer: This is the unveiling of the 8th Annual Health Care in Canada Survey, a survey not just of the general public but also of health care professionals and stakeholders. So we're going to be looking at not just what Canadians are saying but what people involved in the field are saying and how that will relate to the election and what we might be hearing during this federal election.

We're going to hear from people in the health professions: from people representing pharmacists, nurses, the Canadian medical profession. We're also going to hear from Michael Marzolini, and he's going to kick off the presentation. He's going to give us the results. Among other things, after slight improvement Canadians don't feel that such issues as wait times and waiting lists are getting better. There's been a bit of a backsliding on that issue. We're also going to hear about their opinions on a host of other issues, such as privatization and the quality of care that they get across the country.

Hello, and welcome to the Ottawa Congress Centre. We are here to discuss health care, and health care in the context of this 2006 election. In a moment, I will introduce our participants at the roundtable that we're going to take part in over the next few hours. But first let me just remind you: if you have any questions about whether health care is going to be an issue in this election, not only is it the most prominent issue identified by Canadians, but let's just give you a reminder of some of the things that we've seen over the past few years. In the past two federal elections, the New Democrats and the Liberals have consistently attacked the Conservative party, accusing it of having a hidden agenda and being in favour of privatizing or introducing an American-style health-care system. Also, you probably remember the first thing the Paul Martin minority government did – the government that is now defunct – was convene a meeting of health ministers and first ministers and announce $41 billion in new funding for health care. And that, it was stressed by the Liberal government, was accompanied by conditions such as report cards on waiting times. We're going to be looking at issues such as waiting times with our panellists.

This summer, there was a landmark decision by the Supreme Court of Canada concerning a Quebec man. In the Chaoulli decision, the supreme court of the country said that governments cannot limit Canadians' constitutional rights to seek private health care. We'll look at the impact of that decision on Canada's health-care system.

Also, if we are in a federal election, it's because NDP leader Jack Layton and his party claim they haven't gotten enough assurances from the Liberal government that the government would crack down on private delivery of health-care services.

And last but not least, I know all of our participants probably paid attention to comments by Alberta premier Ralph Klein last week. Premier Klein, not a stranger to the debate on health care, said that he thought health care should be one of the most important issues in this campaign, but he said he didn't think that the politicians would get beyond the rhetoric.

So today we're going to try to get beyond the rhetoric. Let me introduce the participants in this roundtable.

First of all, we're joined by Michael Marzolini, chair of POLLARA research. He's going to come up in just a few minutes to present the results of his 8th annual survey on health care.

We're also joined by Lynda Cranston, president of the Association of Canadian Academic Health Organizations.

Also with us is Sharon Sholzberg-Gray, president of the Canadian Healthcare Association.

We're going to be joined shortly by Dr. Elinor Wilson, CEO of the Canadian Public Health Association.

Also, on my right, we're joined by Colin Leslie, a news editor of the *Medical Post*. He brings a journalist's perspective to this as someone who has covered in depth the issues facing Canada's health-care system.

We are also joined by Michael Villeneuve, a senior nurse consultant with the Canadian Nurses Association.

Last but not least, we're also welcoming Jeff Poston, executive director of the Canadian Pharmacists Association.

Let us start by asking Michael Marzolini, chair of POLLARA, to come up and present the latest results on this 8th annual survey of health care in Canada. And perhaps, Mr. Marzolini, you can start by giving us a bit of background on the survey. This is not just the average survey of the general public.

This is one of the most in-depth series of questions that we've ever asked on any issue.

Michael Marzolini: This is the monster survey, Martin. It's *the* survey which is probably the most unique thing that's been done in the last eight or nine years in Canada. Because it's a survey not just of Canadians but of health care practitioners of every type. It's certainly one of the most in-depth series of questions that we've ever asked on any issue whatsoever.

But thank you very much, Martin, for the introduction. It's a great pleasure to be here talking about what is the most important issue facing the country and has been the most important issue now for quite a few years. And it's nice as well that we're filling up the time when all the politicians are leaving Ottawa and going off to their ridings and giving you some good filler for that situation. But I think what we're talking about today is very important and very dangerous politically for many of the political parties, and certainly this Christmas election is bringing new meaning to the words North Poll. (That's a pretty bad one, but I just thought of it on the way over.)

The partners of this survey – and basically, we might have talked to almost everybody in the country who has a stake in the health care system in terms of the respondents – but the partners, who are the sponsors of the survey, are a large number of organizations: Canadian Medical Association, Canadian Home Care Association, Health Care Association, Canadian College of Health Service Executives, Association of Canadian Academic Health Organizations, the Pharmacists Association, the Public Health Association.

We appreciate them all: Rogers Media, of course; Health Charities Coalition of Canada; Merck Frost; and lastly, POLLARA – we had to do all the work.

The survey, and I'm required by law to tell you this, is accurate to a margin of error of 2.8%, 19 times out of 20. We spoke to a good sample of the Canadian public to produce that level of accuracy, and also to doctors, pharmacists, nurses, and health administrators – each of those a sample which is accurate to about 6.9%, 19 times out of 20.

I'm going to try to be very, very careful not to throw too much data at you; a lot of people accuse pollsters of just being statisticians who never had the personality to become accountants, [laughter] and I don't want to feed that in.

This is a lot of data, and if you wish to look at all of the data, it's on the www.pollara.com Web site. There are, on that site and various places such as Maclean's and Rogers, over a hundred slides: incredible information of such a depth that you can look at each different type of operation and look at what Canadians perceive in terms of the waiting times that are associated with it. There is certainly a lot more information than I will be presenting today. But I will present a lot of information. I'm going to run through it very quickly, and then we can have a discussion about that and perhaps provide some analytical framework to the results.

Overviewing, health care is the most important issue in the country. It has been; we identified it as such back in 1998. It is also a very dangerous issue for politicians in that it has been the top issue for this length of time. Normally, the cycle of an issue is two or three years. If an issue if the most important issue for longer than that, there is public frustration, and there is incredible frustration with the issue of health care in this country.

Specifically, the issue of health care actually means, to the public, the waiting times: how long people are waiting for timely access to health care. And certainly that is the key component of what health-care concern actually means. If you look at it over time, since the middle of 1999 it has only been eclipsed once. That was by the economy, and that was just after the terrorist attacks in New York, and it was concern over the impact on the Canadian economy and the US economy that drove that. While people are very concerned about it and they're very frustrated about it, they also see a very great decline in confidence with respect to the health care system. You can notice we've been tracking this since 1998, and at that time 59% of people thought that the health care system was getting worse; only 5% said it was getting better. Currently, it's about 50%. Is that an improvement? No, it isn't, because these are not all exactly the same people. It's become very ingrained. There's a lot of concern, a lot of pessimism, with respect to health care, and people are very, very frustrated. It will be an emerging, very important issue during the election campaign, and one which I don't envy the political parties in having to try to handle.

In terms of health and well-being initiatives to improve health and prevent illness and injury, we asked a lot of different areas of our survey, one of which was the wellness side, and you can certainly see the importance. We have almost 9 in 10 Canadians saying that physical education programs in school are very important, as is healthy eating. Some of people's own ability to take control of their situation is very, very important. So, very much, are

Overall, would you say that your confidence in the Canadian health system is rising or falling, or is it about the same as it ever was?

	1998	1999	2000	2001	2002	2003	Spring 2004	Fall 2004	Spring 2005	Summer 2005
Rising	5%	5%	6%	4%	4%	6%	6%	6%	8%	5%
Same	35%	38%	41%	41%	36%	41%	43%	45%	44%	43%
Falling	59%	55%	51%	54%	58%	51%	49%	47%	46%	50%

I'm going to read you a list of things that may or may not be important factors influencing the health of Canadians. Please tell me how you would rate what impact you think each has. Please use a 7-point scale where 1 means it has No impact at all and 7 means it has a Very strong impact on health.

	No impact at all 1	2	3	4	5	6	Very strong impact 7	
A person's level of income	10%	6%	9%	18%	30%	13%	12%	
A person's level of education	11%	6%	10%	15%	29%	13%	15%	
Genetic make-up inherited from parents	4%	3%	6%	13%	30%	19%	24%	
Quality of air we breathe	3%	2%	5%	12%	22%	22%	33%	
Access to quality health care services	3%	2%	7%	8%	21%	19%	38%	
How much stress a person has in their life	2%	1%	3%	9%	25%	25%	35%	
A person's eating habits	2%	1%	3%	7%	21%	28%	37%	

How important do you think it is that Canadians be encouraged to improve and maintain their own wellness and take measures to protect their health through each of the following programs, on a scale from 1–10 where 1 means Not at all important and 10 means Extremely important?

	Not at all important (1,2)	Somewhat not important (3,4)	Neutral (5,6)	Somewhat important (7,8)	Very important (9,10)	
Physical education programs in schools	1%	1%	10%	34%	54%	
Healthy eating programs in schools	1%	3%	11%	31%	53%	
Police checkstop programs to check drivers' blood alcohol levels	3%	5%	15%	27%	49%	
Community access programs	2%	5%	22%	40%	30%	
Public information on dietary requirements	2%	5%	22%	43%	27%	
Fines for not wearing bicycle helmets and seatbelts	8%	8%	20%	23%	41%	

In the past 2 years, do you think that waiting times for elective surgery have become longer or shorter or have they remained the same?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Longer	66%	58%	58%	64%	43%
Remained the same	22%	30%	25%	26%	33%
Shorter	3%	6%	6%	3%	17%

Thinking about how taxes might encourage reduced use of certain products, do you think taxes on the following items are too high, too low or just right?

	Too low	Just right	Too high
Gasoline	4%	11%	85%
Alcoholic beverages	18%	50%	25%
Cigarettes and other tobacco products	41%	31%	23%

How likely do you feel it is that someone might be subject to a serious medical error while being treated at a Canadian hospital?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Not at all likely	4%	7%	5%	3%	2%
Somewhat unlikely	35%	53%	42%	33%	39%
Somewhat likely	47%	36%	46%	54%	48%
Extremely likely	12%	3%	5%	8%	9%

issues like community access programs and public information on dietary requirements, and fines for not wearing bicycle helmets and seatbelts. There are many things that Canadians believe can be done to make things better.

And government can also help on that in terms of taxation. People do believe that taxation measures with respect to alcoholic beverages, for example, and cigarettes and other tobacco products, are a good method of controlling such types of health care (or wellness) abuse, perhaps you might call it. But you see here that most people believe that taxes on cigarettes and other tobacco products are too low, and only 23% believe they're too high. So there is some room there. I believe 23% is close to the same number of Canadians that are currently smoking. I could be wrong exactly on the percentage; we've been tracking for some years. It's the same thing with alcoholic beverages. Most people wouldn't assume that the taxes there are just right. Gasoline is the problem. This survey was actually taken in September and August and actually precedes the hurricane issues that drove gasoline prices up as high as they did. So this really does show that, from a public policy point of view, gasoline taxes are certainly seen to be too high and could be a political issue during the election campaign.

The Canadian public quite likes government subsidies for products and programs such as nicotine patches. And these are again seen overall as something that would be very beneficial. Where is the opposition coming from this? Probably among older people, 65 and older. Only 6 out of 10 think this is a very good idea, and that's mainly because of the word *subsidies*, which, for people who've had to be independent and strong for many years, is a word which does not work very well. We've seen this in public policy as well.

Then there's the question of quality of safety in the health-care system. In the perceptions of waiting times for elective surgery in the past two years, not very many people are saying it's getting better. In fact, of the public, two thirds are saying it's taking longer; one fifth say it's remaining the same. But these numbers are also very high among the professions: 58% of doctors, and pharmacists as well; almost the same number of nurses believe that the waiting times for surgery are getting longer as of the general public. Only the health care managers seem to be a little bit more optimistic there, but since that impacts so closely on their position, they likely would.

As for the likelihood of serious medical error, while Canadians have incredible confidence in the actual health-care system, when it comes to the quality of health care, they do believe that there is a likelihood of serious medical errors; 6 in 10 would say that it's either extremely likely or somewhat likely. Most of them say somewhat likely; they don't see it as an incredibly rampant problem. Doctors are the least

likely to see that taking place because, of course, they would be very highly involved in that and probably have a greater knowledge of what steps are taken to ensure that doesn't happen, whereas nurses are even more likely than the public to believe that this happens on a more regular basis. Managers and pharmacists show high numbers as well.

In terms of our preparation for the future – what may take place with respect to SARS outbreaks, for example, or any pandemic or public emergency situation – the public are not all that confident in Canada's preparations for taking those things into account. Just a little less than half of Canadians say that the government, or Canada, or the Canadian public health system all in all is not prepared to deal with that situation. And if you're looking at "Is the glass half full or half empty," that doesn't look like too bad a number, but the assumption is that they should be. For that reason, the numbers 44% of the public and 47% of doctors believing that the system is unprepared are quite concerning, because those number should be very much less than they are. In fact, Canadians are very concerned about another SARS-type situation – especially doctors – 81% – and also health- care managers, who have to deal with a lot of the initial issues, and nurses at 85%. Pharmacists don't seem to be quite as concerned as other groups. I'm not too sure why that is, but possibly we could discuss some of that later.

With respect to pharmaceuticals, there are a lot of issues facing the pharmacy profession. We identified a list of things that they prioritize, from the most important to least important. And the role for the pharmacist within the primary health-care team is more important to the pharmacist than any other issue, including continuing education needs, reimbursement for services other than for dispensing, working conditions, the supply and distribution of pharmacies and pharmacists, the prescribing rights for physicians, credentialing, or getting internationally trained pharmacists

If we experienced a pandemic or public emergency situation, like the SARS outbreak for example, how prepared do you think the Canadian public health system would be to deal with it?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Very prepared	6%	3%	10%	11%	3%
Somewhat prepared	48%	48%	55%	56%	67%
Somewhat unprepared	30%	33%	28%	24%	21%
Very unprepared	14%	14%	6%	9%	9%

How concerned are you that this type of situation [SARS] might occur again?

	Doctors	Pharm.	Nurses	Mgrs.
Not at all concerned	2%	6%	2%	1%
Not very concerned	17%	33%	12%	8%
Somewhat concerned	49%	48%	48%	51%
Very concerned	32%	12%	37%	40%

On a scale from 1 to 10 where ten means extremely important and one means not at all important, how important do you think the following issues are for the profession of pharmacists? BASE: Pharmacists

	Not at all important (1,2)	Somewhat not important (3,4)	Moderately important (5,6)	Somewhat important (7,8)	Extremely important (9,10)
Roles for pharmacists in primary health care teams	1%	1%	7%	38%	53%
Continuing education needs	1%	1%	7%	37%	54%
Reimbursement for services other than dispensing	3%	1%	6%	38%	51%
Working conditions	3%	2%	10%	41%	43%
Supply and distribution of pharmacies	2%	4%	19%	45%	30%
Prescribing rights for pharmacists	2%	5%	22%	44%	27%
Credentialing of pharmacy technicians	7%	5%	20%	46%	21%
Internationally trained pharmacists practicing in Canada	7%	8%	32%	35%	17%

Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree that pharmacists should have access to patients' lab results and diagnoses in order to verify that a prescribed medication is the most appropriate and effective for that individual?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Strongly agree	49%	15%	67%	49%	58%
Somewhat agree	28%	30%	28%	28%	30%
Somewhat disagree	11%	24%	3%	14%	6%
Strongly disagree	10%	28%	1%	8%	5%

I am going to read you a number of statements, and I'd like you to tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with each.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	
If a drug is covered by one province, it should automatically be covered by other provinces.	65%	28%	5%	2%	
Government drug plans should include coverage for any medications that a patient and their doctor agree are the most effective treatment	67%	20%	8%	4%	
Governments should ensure that there is a maximum limit to how much individuals should have to personally pay for drug costs	53%	31%	8%	6%	
Generally, patients take too many medications	43%	37%	13%	3%	
Pharmaceutical prices in Canada need to be competitive with the rest of the world in order to attract research and development funding to Canada	41%	36%	11%	8%	
Many patients who should be taking medication regularly are not	32%	40%	16%	4%	
The Canadian drug approval system is faster than the systems in other countries	12%	31%	22%	9%	

practising in Canada. This is a very important issue for pharmacists, and it's not one that is completely in agreement right across the board. The public like the idea that pharmacists should have access to patients' lab results and diagnoses in order to verify that a prescribed medication is the most appropriate and effective for that individual. And certainly they don't have any concerns there on the privacy issues, and neither, very much, do the pharmacists themselves or managers or even nurses. There is some concern there among doctors, who are a little sensitive toward that issue. Again, we can discuss issues why shortly.

In terms of some of the government drug plans, there is an overview of fairness on the part of Canadians. They look at a good drug plan as including coverage for any medication that a patient and doctor agree is the most effective treatment. If a drug is covered by one province, Canadians say, it should automatically be covered in other provinces. Governments should also ensure that there is a maximum limit to how much individuals should have to pay personally for drugs. Generally, they agree that patients take too many medications, and also that many patients who should be taking medications regularly are not.

We tested several issues relating to pharmaceuticals. There is agreement in pretty much all of them. In terms of majority, the only one that Canadians disagree with is that the drug approval system in Canada is faster than the systems in other countries. There's a lot of disagreement with that, not just among the general public but also among some of the professional groups. And as you might see on the second line ("the Canadian drug approval system is faster than the systems in other countries"), doctors have a very major problem with that statement, as do pharmacists, nurses, and managers. In terms of the perception, at least, the public really does think that the government is faster than the actual situation exists indeed.

Now the role of public and private insurance is probably the most news-

worthy on the short-term basis. Much of this information has certainly been in front of the cameras and in the discussion areas for a long period of time. The Chaoulli decision – I always have trouble with Italian names, but I think Chaoulli is how it's…Marzolini, of course, is Scottish [laughter] – the decision has really impacted heavily on this issue and caused a sea change in some of the attitudes that we've been tracking for eight years now, in terms of willingness to pay for faster access or the right for faster access. We've done this question a number of different ways, and we get a lot of different answers every different way we do it. And it's somewhat confusing over the years, but this is really probably the best snapshot of where the public is of any of the polls which are out there. The simple question we asked Canadians was should they be allowed to pay out of pocket to purchase faster access to health services that are currently funded under the public system. And while most people here would say no to that (54% to 45%), it really is an issue of queue jumping that they are very much against. Canadians are a very fair people. At the same time, they see the fairness on the other side of the issue, and if we change this question very slightly and use the terms that deal with very long waiting lists, that changes the number quite dramatically. In fact, it totally mirrors it and reverses it. People are saying, "Well, yes, in order to deal with unreasonable long waiting times, there should be a method of paying for faster access." We'll come to this shortly when we see the agreement level for the Supreme Court decision on Chaoulli, because that is very high and certainly does show some flexibility on the part of Canadians. And, really, the Supreme Court has acted as a politically correct rubber stamp on this whole issue. In that it is now OK to favour such a thing without being seen as un-Canadian, as being seen as greedy or venal as people have in the past when there was a case of wishing to pay to not have to worry about queues. Interesting here is that doctors and pharmacists are far more supportive of the whole idea of paying out of pocket for faster access than even the general public, and certainly so are nurses and managers.

Now, are people personally willing to pay for quicker access? Well, yes they are. That again is unusual. They don't believe that the right should be held to do so, unless it's to do with unreasonably long wait times – the Chaoulli decision. If it's a simple matter of queue jumping, they are not in favour. But would they be willing to do so themselves? Very much so. Again, if we set this question up and, rather than just purchasing faster access to health services that are currently funded under the public system, we deal with waiting or purchasing faster access in order to deal with unreasonably long waiting times, then again the numbers move up to about 6 in 10 Canadians who are willing to do this. We found in the past that

Do you think that Canadians should be allowed to pay out of pocket to purchase faster access to health services that are currently funded under the public system?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Yes	45%	73%	72%	49%	48%
No	54%	24%	27%	48%	48%

Would you personally be willing to pay out of pocket for you or your family to purchase faster access to health services that are currently funded under the public system?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Yes	49%	74%	76%	60%	63%
No	47%	23%	21%	35%	32%

In your opinion, if Canadians were allowed to purchase private insurance for health care services already covered under the public health system, would the impact of the decision be very positive, somewhat positive, somewhat negative, very negative or would it have no impact on the following?

	Very positive	Somewhat positive	No impact	Somewhat negative	Very negative	
You and your family	17%	29%	18%	19%	12%	
The Canadian public in general	13%	34%	8%	24%	14%	
The Canadian health care system	15%	36%	6%	22%	15%	
Canadian employers who provide health care coverage for their employees	23%	33%	9%	18%	8%	

Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree that such a decision [to allow Canadians to purchase private insurance for Health Care services already covered under the public health system] would…

% of respondents who strongly agree or somewhat agree that such a decision would…	Public	Doctors	Pharm.	Nurses	Mgrs.
Create a two-tier system where those who can afford to pay will get better treatment than those who can't	68%	61%	71%	75%	71%
Lead to a shortage of doctors and nurses in the public system as they leave to work in a new private system	61%	43%	63%	72%	60%
Result in increasing costs of health care	58%	45%	51%	58%	54%
Result in shorter waiting times	68%	72%	86%	70%	64%
Lead to improved quality in health care services	60%	63%	75%	46%	44%
Improve access to health care services for everyone	59%	68%	68%	43%	39%

In July, Alberta proposed allowing individuals to pay out-of-pocket for service enhancements beyond a basic service level (such as upgraded quality prosthetic joints). Would you like to see this implemented in your province?

	Women	Men	Overall
Yes	51%	59%	57%
No	42%	36%	38%

The Alberta government recently proposed that private insurance and payment be allowed for services that are non-emergency outside of the public system. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree with this proposal?

	Women	Men	Overall
Strongly agree	15%	24%	19%
Somewhat agree	40%	40%	40%
Somewhat disagree	21%	17%	19%
Strongly disagree	20%	17%	18%

women are the least likely to wish to pay for quicker access in any way, but when it's a member of their immediate family being in hospital, they totally reverse the numbers very, very quickly, and they're right there with backing for their family.

The Supreme Court ruling, which was June 2005, was that the Quebec government could not prevent Quebeckers from purchasing private insurance for health care services already covered under public health-insurance programs. Most Canadians have heard something about this ruling. At the time when it was made (in fact, we were in the field a week after the Chaoulli decision), we found that about 80% of Canadians were familiar with this and had heard of it. That's since dropped off to about 45%. That's sort of a hard thing to do. If you've heard of it, it's not like you can't not have heard of it, but we're certainly measuring recall here, and the recall is still pretty high. In fact, 45% recall is about the same – a little bit more, actually – than the same-sex marriage decision taken a couple of years ago, and the initial level of recall, which was about 80%, was about 30 points higher than Britney Spears' last marriage. [Laughter.]

So this is something that does make an impact on the public. The Canadian public looks at this issue as a Canadian flag issue. They are very, very concerned with any tampering on it, and certainly when it came to the actual ruling itself, it is very interesting that 6 in 10 Canadians (that's 59%) do strongly or somewhat agree overall with the Supreme Court decision; 39% are against. That is a very substantial margin and really, I think, will provide a lot of grist for both analysis later and discussion, because this is something that we have not really seen before: this level of support for paying out of pocket for this type of service. And we really need to look a little bit more at what that means.

Moving along with the data, what is the impact of such private insurance or health care services? Is it a good thing for the public health system, or is it a bad thing? Certainly, for you and your family, it is seen to be more positive than it is negative. It's the same thing

for the Canadian public in general. We have 47% there (versus 38%) who are saying it is a positive thing for the Canadian public. It is also a very positive thing for the Canadian health care system in general. Those are very substantial numbers, also, of course, for Canadian employers who provide health care coverage for their employees.

In terms of the public and doctors and pharmacists and nurses and managers, again, very much they see a lot of benefits to the private insurance issue and it being there, but they also see a lot of detriments. They do believe it will result in shorter waiting times, for example. They believe it will lead to an improved quality in health care services and improved access to health care services for everyone. But it will also result in increasing costs of health care, they believe. It will lead to a shortage of doctors and nurses in the public system once they leave to work in a new private system. Of course, doctors don't agree all that strongly with that issue, but many of the other professions do. And it will create a two-tier system where those who can afford to pay will get better treatment than those who can't. So there are positives and negatives to this, and certainly those have to be weighed in terms of our own values in this country.

How would you personally feel about working in a privately funded medical environment?

	Doctors	Pharm.	Nurses	Mgrs.
Very enthusiastic	10%	12%	14%	12%
Somewhat enthusiastic	31%	24%	18%	19%
Neutral	31%	50%	31%	45%
Somewhat opposed	18%	8%	21%	14%
Very opposed	9%	4%	13%	8%

Health research can include research into medical treatments as well as the best ways to provide care and manage the health care system. Would you say that you strongly agree, agree, are neutral, disagree, or strongly disagree with the following statement: There should be increased public sector funding for health research, such as at universities, teaching hospitals and other not-for-profit organizations.

	Public			Doctors			Pharmacists			Nurses			Managers		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Strongly agree	32%	33%	41%	34%	47%	46%	18%	39%	45%	22%	33%	48%	35%	28%	45%
Agree	51%	48%	42%	48%	39%	39%	57%	49%	48%	59%	49%	42%	45%	56%	42%
Neutral	11%	9%	8%	12%	8%	8%	16%	8%	3%	14%	8%	4%	14%	9%	7%
Disagree	4%	5%	5%	5%	3%	6%	6%	4%	3%	5%	8%	3%	6%	4%	4%
Strongly disagree	1%	2%	2%	1%	3%	0%	1%	1%	0%	1%	1%	1%	1%	0%	1%

Health research can include research into medical treatments as well as the best ways to provide care and manage the health care system. Would you say that you strongly agree, agree, are neutral, disagree, or strongly disagree with the following statement: Incentives should be put in place to encourage more private sector investments in health research such as at universities, teaching hospitals and other charitable organizations.

	Public			Doctors			Pharmacists			Nurses			Managers		
	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005	2003	2004	2005
Strongly agree	30%	26%	42%	26%	35%	45%	28%	34%	40%	20%	29%	37%	30%	25%	39%
Agree	46%	44%	43%	49%	44%	41%	50%	52%	50%	49%	49%	48%	40%	50%	48%
Neutral	11%	13%	7%	14%	7%	7%	16%	7%	4%	16%	9%	5%	13%	10%	5%
Disagree	6%	8%	5%	7%	8%	3%	4%	5%	4%	12%	10%	4%	10%	9%	5%
Strongly disagree	5%	5%	2%	3%	3%	1%	0%	2%	2%	3%	2%	3%	7%	4%	2%

And to what extent would you support or oppose each of the following policies to increase access to health professionals? —Requiring health professionals to work in teams with other types of health care providers.

	Public	Doctors	Pharm.	Nurses	Mgrs.
Strongly support (9,10)	39%	20%	48%	50%	62%
Somewhat support (7,8)	37%	32%	40%	31%	28%
Neutral (5,6)	18%	18%	8%	11%	7%
Somewhat oppose (3,4)	3%	12%	1%	1%	3%
Strongly oppose (1,2)	2%	17%	2%	3%	1%

And to what extent would you support or oppose each of the following policies to increase access to health professionals? —Requiring health professionals to work in the parts of the country where they are most needed?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Strongly support (9,10)	35%	7%	24%	22%	19%
Somewhat support (7,8)	32%	20%	32%	28%	37%
Moderately support (5,6)	19%	25%	25%	23%	23%
Somewhat oppose (3,4)	7%	21%	10%	8%	13%
Strongly oppose (1,2)	6%	25%	8%	18%	7%

Which of the following do you think is the most suitable term for describing people who use the health care service? Customer, client or patient?

	Public	Doctors	Pharm.	Nurses	Mgrs.
Patient	75%	85%	80%	40%	38%
Client	15%	9%	13%	46%	45%
Customer	9%	5%	6%	13%	12%

In terms of support for paying out of pocket for service enhancements – and this is something that Alberta did back in July; they proposed to allow individuals to pay out of pocket for service enhancements beyond the basic service level – there's a lot of support for that. Actually, regionally I believe it's lowest in Alberta, strangely enough, but overall, men like it a lot more than women. Women are of the majority view that it's a good thing, and almost 6 in 10 Canadians are supportive of it.

In terms of innovation, there is strong support for research into medical treatments, more health-care research. Among the public, there's been a lot of increase in terms of strong agreement that these are a good thing, and that there should be increased public-sector funding for health research, such as universities, teaching hospitals, and other not-for-profit organizations. Those numbers have been increasing pretty much year by year: 41% strongly agree with it among the public; a further 42% agree, so that's well over 8 in 10 Canadians. Those numbers are very high, and especially have been increasing among nurses; 9 in 10 are either very strongly or somewhat in agreement that that is a very good use of money.

Incentives to encourage more private-sector investment are also something where the numbers have also been improving over time. That is, incentives should be put in place to encourage more private-sector investments in health research, such as universities, teaching hospitals, and other charitable organizations. Strong support right across the board.

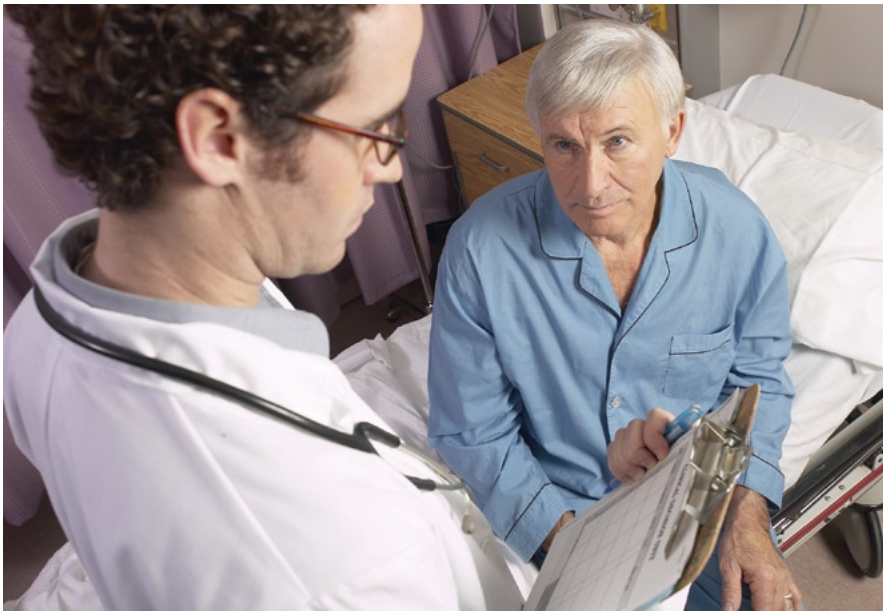
As for support for contracting out services, we asked this question last year and got 53% of the public saying this was a good idea – for example, having the contract for the delivery of public services at private clinics or having public health insurance pay for knee surgery at a private clinic rather than a public hospital. We give people those examples, and they sort of like that idea, and it has been growing on them. Now 55% of the public are in favour, which is not up to the level of doctors or pharmacists who favour it but is quite above where nurses are, and also managers.

Requiring health professionals to work in teams with other types of health care providers is very important individually to most of the organizations and the professions. Certainly the public likes the idea; 76% like the idea of having these health care teams. Pharmacists are very strong in support for that: 88%, and managers at 90%, nurses at 81%. The majority of doctors are supportive, but not as much as every other group. Just a slim majority of doctors think this is a good idea. Most of that is perhaps aimed at other professions, not just at themselves. As for the team, who should make it up, what access everybody should have to the information, we have a wealth of information on this on the www.pollara.com Web site.

There is much support for requiring patients to register with one family doctor, except among doctors.

When it comes to support requiring health professionals to work in parts of the country where they're most needed, strangely enough, everybody is supportive except the doctors who would be shipped out to Medicine Hat. Actually, the wording of the question requiring health professionals to work in the parts of the country where they're most needed means that nurses, managers, pharmacists, or any group could, in fact, be required to work in parts of the country where they're most needed.

It is interesting to see the differences between the health-care practitioners in terms of how they look at their patients or clients or the people who come under their care. Are they patients or are they clients or are they customers? It does vary. In terms of the public, 75% of them would say, "We're patients," 15% "clients," maybe 9% "customers." Among doctors, it's very much a patient-oriented relationship. They do believe that the people who use the health-care services should be referred to as their patients. And so, to a very great extent, do pharmacists. When we get to nurses, however, nurses prefer to refer to these people as their clients, which possibly reflects their movement toward service and those issue areas in hospitals and also perhaps their willingness to be different in their attitude from doctors, who they know want to refer to the people as patients. And managers also like the idea of clients. Not many people wanted to refer to Canadians using the system as customers.



Anyway, this is a very brief overview. In fact, we've gone over about one third of the data in a very fast way without much analysis or detail. I think there's a lot here that we can analyze, a lot for discussion, a lot that affects every single profession that is represented in the survey, as well as the general public. A lot that will impact on government, because it is government that for eight years, for example, has kept this issue at the top of the list as the most important issue, fostered frustration among the public, and not dealt with the issue in a way that the public had confidence in. Remembering last year's survey, there *was* optimism. There was optimism that the federal-provincial conferences, the fixes for an entire generation… I think it was only 52% or 54% of the public, but they thought that this would have a markedly better effect on things. Those things never really worked out. It went the way of the Romanow Commission, which a few years ago people had great confidence in, and then it seemed that nothing happened as a result, and there was again that frustration that has built up and will be very much an election issue, but a Pandora's box of an election issue during this campaign.

Martin, shall we introduce questions or discussion?

Discussion

Martin Stringer: Thank you, Michael. What I would like to do now is open up the discussion to our panel participants around this roundtable. And Michael, I have a dozen questions to ask you, especially as you describe this as a Pandora's box: the health care issue, which will continue to be a top-of-the-mind issue.

But let's hear from our participants from our health-care stakeholders. We've asked you to have a general, short reaction or questions or comments on what Mr. Marzolini has just held forth on in this health-care survey. So let's start with Lynda Cranston, president of the Association of Canadian Academic Health Organizations. Just your general reactions?

Lynda Cranston: I found the survey totally interesting, though I must say that, generally overall, I really wasn't surprised by a lot of the results. The Association of Canadian Academic Health Organizations represents teaching hospitals and those hospitals in regional health authorities that actually have an academic mission, so we have responsibility for not only patient service but teaching and research. A lot of research is actually done in the teaching organizations. And I'm actually a health care manager in a full-time job.

We want to decrease the use of acute care institutions in the long run. We want to focus more care in the community so that people get better primary care.

But one of the things that I thought was exceedingly interesting was that, as a manager in the system and with my colleagues who are managers in the system, we're probably a little unhappy that we don't see a bigger change, because I know a lot of us are working pretty hard to try and change the system because we all recognize there need to be changes in the system. And that's clearly identified in the survey, particularly around wait times, and I understand how people feel. One of the things that does give me a bit of hope, though, which I thought was very interesting out of the survey, was the whole issue around innovation and research. Research is really important, particularly to teaching institutions; 70–80% of the research that's actually conducted in health is actually conducted in the academic health care organizations. So that gives me a big ray of hope, because we have – the Liberals, actually have – over the last couple of years, been sinking a lot of money into research, and this is rare. We will find those solutions around new drugs and innovative ways of doing things that actually can improve the health and care of Canadians.

The other thing, and then I'll finish, is around the whole innovation approach and agenda, because generally I would say that right across the country we're trying to make major changes to the health care system. And this is a *big* shift, because let's think about the health care system that's being going down this road for a multitude of years, and now we kind of want to change it. It's like turning the Titanic around, right? It took 26 miles to turn the Titanic around. Health care is a big organization; it's a big system and it takes a long time.

But what we actually want to focus on – and I was really delighted to see the public on this wavelength – is that we really want to decrease the use of acute care institutions in the long run. We want to focus more care in the community so that people get better primary care. They get better assistance with managing their chronic disease. Yes, acute care should be there, and it should be there when they need it, and we do have to address those issues. But then we want to have more independent living for seniors. I don't want to be in a nursing home when I'm a senior. I want to be independent and live in supportive housing and those kinds of things, and then help me to a dignified and peaceful death.

And then we need to go way upstream: prevention, promotion, and protection. I was really delighted to see that they felt we really needed to focus on taking care of ourselves. And really, Canadians need to understand that they have a responsibility for their own health care. The health care system cannot solve 20 years of smoking or lack of exercise and being overweight. You look at the top two diseases that are going to get you: heart disease and cancer. They all have exactly the same risk factors. And we really, as a public, need to focus on prevention and promotion. Thank you.

Martin Stringer: OK, great! We are no doubt going to come back to some of those points. Let's hear from Sharon Sholzberg-Gray, who is president of the Canadian Healthcare Association. Your comments or reflections on what this certainly has shown?

Sharon Sholzberg-Gray: First of all, it was interesting to hear that Canadians' confidence is still faltering, and this not one year after a $41 billion, 10-year plan: new money transferred from the federal government to the provinces and territories. And that's a bit disquieting but realistic, because it takes time for money to reach the front lines and for structures and providers to be sort of there to uptake the money, so to speak, and to use it. So I think that the real problem there is a disconnect between reality and expectations,

and perhaps we should communicate that a little better. Nonetheless, it's disquieting to see this still-failing confidence.

The other thing is, and it came through loud and clear, Canadians still are concerned about access to health care. They're concerned about wait times. They're concerned about timely access. And they're so concerned that the survey seems to say that they're willing to pay out of pocket. But I ask myself, "What do they mean by out of pocket?" To me, out of pocket is $50, $500, maybe $1000. Are they willing to pay $50,000 out of pocket? I don't know what the answer would be if we asked that question. So that's the question that really has to be asked, because sometimes people want to pay for the cheap things but not the expensive things, and, of course, it's the expensive things that cost our health system a lot. And, frankly, there was a contradiction between their answers about paying out of pocket to get more timely access, and yet they want more pharmaceuticals to be paid for. And I'm saying that if you're willing to pay out of pocket for timely access, why don't you pay out of pocket for all the home care you can buy, all the pharmaceuticals that you want, and everything else? So I think Canadians want to pay possibly the cheaper things in order to access the more expensive things, and maybe that choice isn't always available to them; and that has to be explained.

Secondly, maybe they didn't understand the Chaouilli decision; that is, a Supreme Court decision allowing private health insurance only allowed private health insurance. And frankly, individuals who are unhealthy and who need health care can't buy private health insurance; it's just not on. They might be part of employer group plans, but, frankly, the employers of this country don't want to double their health care costs also.

But it's very hard, I think, in the context of a poll, to get at those issues. But it is true that Canadians want timely access, and, frankly, we have to meet those needs or they're not going to have confidence in our health system. Lynda mentioned ways of meeting those needs acting upstream first, namely preventing illness. But frankly, those who need care ought to get it in a timely way, but they have to understand that it's not just a question of quantity, quantity, quantity: how many surgical treatments can we do? There's the question of quality, and that's come up; you need quality care. And there's the question of appropriateness. You know, maybe rushing to surgery the next day isn't the right solution for everyone. Maybe it's physiotherapy; maybe it's case management; maybe it's something else. So any system that says, "the quicker the better" isn't going to be a system that meets the needs of Canadians in an appropriate way.

So the real issue is that we're trying in a survey to get at the point of view of Canadians. But health care is such a complex sector. Everyone's looking for one magic solution, and there are many solutions, and we're going to hear them today. The question is, do Canadians want to wait to hear them, and do they have the patience to wait for governments and health care managers and front-line providers to get it right? I certainly hope so, because I think we're doing a lot of things well.

Are they willing to pay $50,000 out of pocket?

Martin Stringer: OK, Sharon Sholzberg-Gray, thank you very much

Welcome to Dr. Elinor Wilson, You came in a little late. You are CEO of the Canadian Public health Association. Weigh in on what Mr. Marzolini has exposed in terms of this 8th annual survey on health care in Canada.

Elinor Wilson: I found the survey particularly fascinating from several perspectives. First of all, it was very gratifying to see public health questions on a health care survey, because I think that we have a lot of challenges, as are evidenced in the public's answers, with the understanding that, in the health system, public health is almost the foundation of that system. And while it's gratifying to see the public agreeing around lifestyle changes and lifestyle measures, it was a bit disappointing that the public lacks the understanding around the actual determinants of health which affect those lifestyle issues. In other words, people living under poverty conditions and people with less education are not going to be as well as people who live differently. So, not only do we have to go upstream and worry about individuals' behaviours, collectively as a society we need to look at the context in which people are living their lives.

I think the other thing that struck me is that as the demand for health care continues to escalate, I'm not sure – and it will be an interesting debate – that any country in the world will be able to accommodate the escalating costs of health care. The UK has done a report by Derek Wanless, saying that basically within 20 years the UK system will be bankrupt in terms of health care unless we're able to do something about putting the entire system together and creating, you know, a healthier society overall, not merely healthy individuals one by one.

So I think I'll leave my opening comments there. Thank you.

Martin Stringer: Thank you, Dr. Wilson.

I go to a fellow journalist, Colin Leslie from the

Medical Post. Your reactions? What would you lead with? What would your headline be [laughter] – or your four or five or ten headlines – in looking at these survey results?

Colin Leslie: Certainly what struck me as I saw these numbers is – we're a doctors' newspaper, so we go to physicians across the country – that number saying 70% of the public would support requiring health care providers to work in part of health teams. Only 50% of doctors supported that. And the other one was 67% would support requiring health care providers to work where needed in the country; and that fell to 27% support from doctors. Well, as soon as you use a word like "requiring," I think that gets doctors' hackles up, because in a lot of provinces, there are billing number restrictions. It's very sensitive thing. These are not government employees, for the most part. They are self-employed individuals who have one primary supplier of financial resources in terms of coming from the government. But they like to think that they have a right to choose where they practise, and I think they were uncomfortable with that kind of thing.

The public has fought for 50-plus years to build a publicly funded Medicare system that they're now telling us isn't quite working for them.

In a couple of cases, they also seem to appear to have a higher support for private funding for the health care system. We interviewed doctors all across the country, and I really think that was just a statement of frustration, that they weren't happy when they weren't able to get the care they wanted for their patients quickly enough. If government isn't able to do it, it has to be done; maybe someone else can do it. So I think that's what that was about.

Martin Stringer: You don't see that necessarily as a *carte blanche* approval of the decision, do you?

Colin Leslie: No, I don't think so.

Martin Stringer: OK. Michael Villeneuve, on behalf of the Canadian Nurses Association. Your reactions, comments?

And I'm also going to open this up to questions of Mr. Marzolini, as well. Once we're finished our initial statements, we'll have a free exchange. There's obviously still a lot of questions and some possible contradictions in some of the answers, as well. Who ever said polling was a science? Michael Villeneuve.

Michael Villeneuve: I guess we're hearing already some common themes among ourselves in what we see. I guess I was struck by your opening comment, Lynda, that you weren't too surprised by some of the findings, and the Canadian Nurses Association would probably feel the same, both in a good way and a bad way. They were troubling, some of the findings we saw, and other ones not a surprise at all.

We've been having some of the same messages sent to us by Canadians for many, many years. And I agree with you, Sharon, that it takes a long time for money to filter down. But this precedes very much the accord of 2004. So there's something else at play that concerns us. And either we haven't fixed the problems or people don't know that we've fixed the problems; and either way we have a problem that we need to resolve to communicate those messages to the public.

The second thing that I think we're struck by is that Canadians seems to have expressed different views about their worries about the system versus their actual experiences in the system. They're almost worried that they should be worried about how long they might have to wait versus how long they actually wait and what happens when they're in the system, because that often tends to be quite a positive experience. So I think how we communicate our messages and our own behaviours around that is critical.

That leads us, in the opinion of the CNA, to the third important piece, which is the private and public. I don't want to talk about it a long time right now, except to say that the public has fought for 50-plus years, as have many of us in the room, to build a publicly funded Medicare system that they're now telling us isn't quite working for them. And we totally support your position, Sharon, around the idea of what are people talking about being willing to pay for. But they are saying that the thing they find most precious somehow isn't serving them, and they're willing to go around it in some ways. So there's some kind of message there that we have failed to resolve. Our concern, I guess, would be that, given that we're launching into an election today, that six weeks of people carrying signs saying, "We support public Medicare" is not going to serve us well and that what we need is a really purposeful discussion about what's in that roster or menu of services that *will* be in the public system 10 and 15 years from now, and what we can put there to make the system sustainable.

The final piece, just as an opening comment, is our view that we did see some gender differences, which seemed to be interesting, in how women respond versus men in what they're willing to pay for, their experiences in the system, and so on. There was an interesting study, as some of you know, this week out

of Manitoba, that showed that women, who lived longer and used services differently, were not more or less healthy. So it's probably something of interest there. Is it because their experience in the system is with their children, with their elderly parents? Who knows? But they are users of the system and, I think, use the system more than men and so probably bear some closer attention to their opinions and experiences in it.

Martin Stringer: Let's finish off on opening reactions with Jeff Poston, from the Canadian Pharmacists Association.

Jeff Poston: I'd like to pick up the theme that Sharon raised. This is around the results around quality of care, and particularly focused on drugs and pharmacists.

But first of all, I'd just like to make one comment on private health insurance. From the results, you can see that the majority of pharmacists supported or appeared to support private health insurance and delivery. This isn't really very surprising, since you remember that in Canada pharmaceuticals are not part of the Canada Health Act and that about half of all prescriptions filled in Canada are paid for by the private sector, so that's not too surprising. And also it's not surprising that Canadians recognize the importance of good access to drugs, which, incidentally, they want governments to pay for. But they also recognize in the results that we have problems with the use of prescription drugs: people taking too many drugs or people that are prescribed drugs, but they aren't taking them, or they aren't taking them properly. And there's clearly a care gap here that has to be closed.

We were pleased to hear that the public appears to be willing for pharmacists and other health care providers to play a larger role in primary health care as a part of collaborative teams and as a part of community care: part of the solution that Lynda spoke to. Pharmacists are very ready and willing to do exactly that, but they would like to be paid for any new services that they provide.

And it was interesting that all of the groups surveyed, except physicians, supported pharmacists' access to patients' lab and test results to help them ensure better use of prescribed medications. And this would be a key step to improving health care for Canadians.

And finally, a bit that didn't get presented in the presentation but is in the more detailed results: I think one of the more really useful bits of the survey was the consensus that there appeared to be around what some of the barriers were to interdisciplinary care, to working in teams. And they were very interesting: problems with sharing information, lack of communication, lack of incentives, the physical location of health care providers in the community. These all top the list, and I think the findings illustrate the importance of funding and supporting the process of change in health care if we're going to address these issues successfully and build effective interdisciplinary teams.

Martin Stringer: Now I know someone quite accurately said that the issue of private versus public provision and payment of health care is the one that, of course, obsesses the political class and journalists; it's gotten the most headlines. Perhaps we could look at that, because I do want to talk about other issues.

Michael Marzolini, you might want to weigh in on the fact that within that survey of people's reaction to the Supreme Court decision with the general public as well as professionals, there seem to be some contradictions in the sense that people were saying (I think it was 54% of Canadians) that they thought it was positive to give people the option to have private insurance. They'd be ready of pay out of pocket. And yet they were also saying that they think it could lead to a two-tiered system, doctors leading the public health system, and a system based on people's ability to pay. How do you reconcile those contradictions? And then I'd ask anyone else if you want to weigh in. I know, Sharon Sholzberg-Gray, you mentioned the question of what are people saying in terms of what they're willing to pay for. I'll open it up with you, Michael.

The public appears to be willing for pharmacists and other health care providers to play a larger role in primary health care.

Michael Marzolini: Thank you, Martin.

We've done a lot of polls over the years on that topic. I've seen a lot of polls over the years, and many of them made me wonder about the comment you made earlier about whoever said polling was a science. Well, polling is a science, but the question is very important, and the wording of that question. We tried very carefully, and we had input from everybody in trying to make those questions as objective, as non-value-laden as possible, and tried to get at the truth. And we've been tracking it over time, so we have seen changes to the same question that we've asked year after year after year. Certainly there are contradictions. There are concerns that people have that are at odds with each other. But, at the same time, the frustration level is so high on this issue that people are willing to accept Chaoulli because there is nothing else on the table.

There have been so many cases of cheque writing by the federal government. Well, we have a country where 60% of Canadians do not know how many millions are in a billion; 25% can tell the difference between a deficit and a debt; and many other issues showing that people's economic literacy is not really as high as it possibly should be for good public policy.

They're a little tired of seeing huge cheques written. They haven't really seen any action. They have certainly not seen the results.

They're a little tired of seeing huge cheques written. They haven't really seen any action. They have certainly not seen the results. Sharon's point about the money getting up to the front lines – it *does* take a while. But these people have been waiting for eight years. They are willing to take the first solution that arises, and that is the Supreme Court decision. Now that is not necessarily saying that they are in favour of it. In fact, what's happened is really they're trying to send a message; they're almost voting strategically. They're saying, "Look, if you can't make the system better, we'll take the Supreme Court's decision, we'll act upon that, and we'll be happy to do so. But what we're hoping is that you will invest into the public system and make it work, make it happen, actually put the energy into the system and the political will to match the public will that hasn't been there for so much time."

And Canadians like competition. They remember when Air Canada was a real airline. They remember when the *Globe and Mail* wasn't as good as it is today because the *National Post* and others weren't there to compete against it. They like competition. It keeps service good. It keeps organizations efficient. So that's what they're looking for here. Chaoulli is a decision. Martin?

Martin Stringer: I have to weigh in, though, before our other participants. On the purely political level, you've said that this was almost a politically correct way of affirming what was not politically correct to say before the Supreme Court decision. And I want your reflections in terms of this election campaign, I mentioned at the beginning of this show we've see a wholesale attack on any party that would dare broach the subject of private insurance and private provision of medical services. What does that mean in this campaign – your hunch? You've spent years polling for certain political parties. What's your hunch in terms of whether this in fact disarms this issue in terms of pointing, say, to the Conservative Party and saying, "Well, this is the party that's in favour of privatization and private health insurance"? Does this take it out as a loaded bomb?

Michael Marzolini: Well, it is called a Pandora's box. It's also an issue that only one party has come in for the criticisms you mention, because they're the natural one to get those criticisms. And it's something that, really, they can't be all that effective on because they're always going to be under a cloud of suspicion; and, at the same time, the Liberals cannot be effective on because they've already said, when the Chaoulli decision came down, "We're not going to talk about it. It's not on the table." What that did was it drove support for Chaouilli up five points. From the initial polls that we did until now, there's a five-point difference. People are so frustrated with that type of view. They're like kids that are saying, "Why, Dad, can't I have a new bicycle?" "Well, because I said so." They're not getting the right answer, and the frustration is building there.

In terms of who can make it work in a campaign, I really do agree with Kim Campbell, in her statement in 1993, that some issues are too important to be discussed during an election campaign. I didn't at the time. In fact, I did a very nice strategy against her for doing that. But if you look at the health care issue and what we've been discussing now for eight years of polls, going around the table, all with this input into this massive poll and gleaning the entrails trying to get direction in where to proceed, we haven't come to all of the conclusions in our own heads yet. The Canadian public certainly hasn't; the Canadian public, if they're given a campaign that's going to start in real terms on January 2nd and last until the 23rd and they're going to discuss their whole future in that period, it's not going to work. They've had eight years. We haven't discussed it yet to the point where we should have. We need to have far more discussion on this issue before we can get anything resolved even in our own minds, much less the arguing that needs to take place.

But are Canadians willing to pay for faster access? They're willing to if they have to. Would they prefer not to? Yes. They would prefer a public system that works the way it should, but they have a low body-bag tolerance, as they used to say in the United States during Vietnam. They can be very easily turned away from that view by the horror stories in the media of the people who might still be with us if they had been allowed into a hospital a little earlier.

Martin Stringer: OK, let's ask anyone else to weigh in. I know, Michael, you mentioned the gender differences that appeared in terms of people's ability or approval for private health care services. Sharon

Sholzberg-Gray, you raised the issue of what people are willing to pay for. Dr. Wilson, you raised the issue of public health in general in the different socio-economic classes. Feel free to weigh in on this issue on this issue of private versus public funding of health care or paying for health care. And anyone feel free to suggest to our viewers what questions they might want to ask their politicians on the doorstep when it comes to public health. I'll let you just ruminate on that: private, public.

Sharon Sholzberg-Gray: Can I just wade in here? First of all, I said earlier that health is a very complex area, and we're trying to simplify it and ask as clear and simple questions as we can in a survey. And you note that it's very difficult for people to understand the complexities of it. Having said that, they understand what they want. They want a health system that's publicly funded and that meets their needs, and failing that they're willing to look at other things. Now what they might not know – and that's why it's important to put other numbers on the table that aren't part of a survey, but they're numbers that are out there – is that 70% of our system is publicly funded; 30% is privately funded. Most of our hospital physician side, which is our Medicare system, is publicly funded; the rest – home care, pharmaceuticals, physiotherapy outside of hospitals, long term care – all have co-payments, private pay, and whatnot. Those are the very areas that the public is saying, "I need better access to": pharmaceuticals, home care, that kind of thing. So they have to understand that. So do they want to reduce the public spending on the hospital physician side? I don't think so, also. But it's just important to put that on the table.

And then, of course, everyone is confusing private pay with private delivery. We don't even know how much private delivery there is in our system because we don't monitor that. We do know that most physicians consider themselves to be in private practice. We know there are private laboratories doing urine and blood testing, and I think they do it very efficiently. And we know there's a lot of contracting out of food services – I think that's good if it's efficient – parking lot management, whatnot. There are some private surgical clinics. The public sometimes has a problem with it and sometimes not. There are those who think, "That's the magic! We have a few joint replacements in a private clinic and we've solved everything."

The real issue is some cream skimming or some simple procedures done around the edges isn't going to solve the issues of sustaining and funding a health system in which people need access to primary health care, to complex care in cancer and heart and those kinds of things. So we have to understand the parameters of the problem

But having said that, there is new money invested. We shouldn't underestimate what happened in the '90s. The cutbacks created problems with infrastructure investment, research investment, investment in health human resources, and everything that is still with us today. It's a legacy. So when the public is saying, "Why are we waiting so long?" we're saying, "Look at the cuts we had in the '90s. All we've done is try to pay back those cuts until now. For the first time, there is some new money and new resources. Let's run with it. Let's be part of the solution. Let's have good systems for monitoring and managing wait times, for managing cases." At the same time, there are new investments in public health – I'm sure that Elinor will talk about that herself – that will help keep people out of the acute system. And frankly, it's hard to say that at the doorstep. So I think all we can say is "Stick with it." The publicly funded system is still efficient and effective. It will still provide needs in the best way. Importing the odd piece from other systems

70% of our system is publicly funded; 30% is privately funded.

that, by the way, spend more than us (and I'm including France, Germany, and Sweden here) is not the way to go, because frankly they all spend way more than we do. And maybe they have good outcomes and maybe they don't – and by the way, France pays doctors about half what we do, and I don't think anyone would think that's the solution.

The real point is there are solutions: electronic health records, case management, chronic disease management, primary health care reform, managing wait times in a more effective way, looking at appropriateness. And we're working on them, and, believe it or not, there is progress somehow. There's more demand, maybe more need; we have to measure both.

Martin Stringer: Let's weigh in on the gender difference, then. If, as an election issue, people are going to be skirting around the issue of private health care or private insurance for health care, what do you make of the gender difference in that women are less likely to say that a) they're ready to pay out of pocket or less willing to say that b) private insurance: they don't see any problem with it? Anyone?

Colin Leslie: Sure. The other thing that sort of strikes me about it is that it's already available in some provinces. In New Brunswick, Nova Scotia, Saskatchewan, and Newfoundland, you can already buy private insurance, so they're saying you can do it in Quebec. We haven't seen a huge change in how health care is

delivered in those provinces, so to suggest it could be a change, I don't know how much I can buy that. But going back to what Michael was talking about in terms of the political parties in Canada, we haven't seen a huge variety in terms of what they're willing to say. No one is coming out and taking a radically different approach, saying, "We believe in private medicine" or anything like that. I do have to wonder whether any party is going to start saying something about wait times and care guarantees: saying, you know, "If you don't get your hip replaced in four months from when you were referred to a specialist, could you have private insurance for that? Would we give you the money to go to the States for it?" I really wonder whether any party would get any mileage out of a statement like that or some kind of position on that.

No one is coming out and taking a radically different approach, saying, "We believe in private medicine" or anything like that.

Martin Stringer: Well, let's look at one party that has or is hoping to get some mileage out of it, and that's the federal government. By the end of this year, there were supposed to be commitments from the provinces on wait times. At a very, very harried and intense meeting with the provincial health ministers, the federal minister came out and said he had had a commitment to reduce wait times in five core areas. I throw it open to those of you who know the system. How much is that worth the paper it's not written on? I mean, what are those commitments? What do we know about wait times? What have the provinces agreed to? And how much can the federal government, during this election, boast, "Oh, yes, we have a commitment to reduce wait times"?

Lynda Cranston: Well, my understanding is that they actually are very close and that the information you're hearing from the Liberals is quite true. I had a discussion with the deputy minister of our province, and they actually are working on those five areas and having detailed indicators in terms of moving to the benchmarks, like how long you have in terms of getting your hip repaired or your knee, or even looking at some screening issues around cervical screening and screening mammography. So these are in the works and being discussed.

But I think it's an important point, and you raised it, about the case in Quebec. The issue that's all at the heart of it is the access issue. And I'd be interested in understanding, from doing the polling, when you talked to the public, in particular about the access issue, were these generally people who had had an experience with the health care system, or were they getting the majority of their money from the media stories that talk about access as a big issue all the time? Because when I talk to people who've actually had an experience with the system – a direct experience – it's always been very positive. That's not to say they may not have waited for a while and an inordinate amount of time, but I'm just wondering: the people that you actually interviewed for the survey, what was their experience?

Michael Marzolini: Well, they were just the general public. They didn't necessarily have those personal issues. Many of them did, but it was proportional right across the board.

Lynda Cranston: Where did they get their information from, then?

Michael Marzolini: They're getting their information from their friends, their family, what they see in the newspapers. This is very effective in terms of getting that out there. It disseminates the information. We've done focus groups on this topic, and everybody's got their own horror story. And if they don't have their own, they have their mother's or their father's or their kids' or somebody's. And really what they're looking for, it all boils down to a desire for results.

Frustration with the public… Martin, you talked about the political parties, the Liberals. And yes, the Liberals are the only ones that can actually raise the issue, because if the Conservatives raise it at all, then it will be memories of that sign saying "No two-tier health" held up by Stockwell Day in 2000. That's unfortunate, but both parties somehow – and the Liberals are the only ones that can enter that part of the campaign first – have to say, "Look, we're willing to talk about major restructuring here," because even eight years ago two thirds of Canadians wanted major restructuring. That's gone up ever since. The number is very high, and it hasn't been reacted to by the government, because the politicians that were elected in office now were basically people of a certain era, when the health care system was not just tenable but it worked; it was financially stable. They're the sons of Pierre Trudeau and Pearson and Tommy Douglas and that era of politician. So that really has impacted on the lack of willingness of the political parties to open it up.

But the other issue is that you cannot control an issue like that during a campaign. You have a short period of time, and you don't know where the public are going to take this or where the argument could go,

and you want to wrap up early and don't want it getting out of control.

Martin Stringer: Your point is well taken that this is a complex issue, and I know many journalists who think long and hard on the reflections by Kim Campbell, during that fateful election campaign, about whether complex and very dogged issues can be discussed with any satisfaction over an election campaign. And I want to get to you, Jeff; and also I want to get to you, Colin, because you address your journalism toward doctors as your main audience. But I want to ask the doorstep question: should, as a smell detector, Canadians ask their candidate, "Do we have private health care? Is private health care being practised? Is it part of the system as it is now?" Because the Canadian Medical Association – that's why I address it to you as well, Colin – we've covered your meetings for many years, and every year we can count on a resolution from the floor saying, "Yes, we have private health care. We have private provision of medical services. Let's recognize it, and let's work with it." That causes a lovely debate, which we have a great time covering, but it's doctors or health care professionals admitting that it already is part of the system. So I'm just wondering what question you would ask at the door to see whether you're getting at least an attempt to get to the issue of health care from your candidate and not just cant.

Anyway, Jeff, I know you want to weigh in on it.

Jeff Poston: I just wanted to pick up, and I think Michael touched on it, that we mustn't, in terms of looking at the fix, see fixing wait times as an expensive Band-Aid solution. There is a need for real reform in the system. We do have to make the public health system work more efficiently. We do have to do more on public health. We have to do more on disease prevention. We really have to build effective primary health care teams and really develop community care, home care. Good home care stops people being re-admitted into hospital and clogging bed space in hospitals, which contributes to eroding the efficiencies of the hospital system. So the work that's been done on wait times is important, but it's not a solution to the overall reform of the system that we need to see happen.

So I think the question on the doorstep the public needs to be asking politicians is really what is their level of commitment to the reform of the health care system and to actually keeping the momentum that I think Sharon spoke to. It's only a year ago since we saw new money, so are they going to maintain the momentum? Are they going to stick with the plan and hopefully produce this sort of reform of the health care system that we need to ensure that the system is viable for future generations?

Sharon Sholzberg-Gray: They can also ask, by the way, "Are we going to see results?" because to me that's the big question. There's money, we have to have outcomes, we have to have performance, and we have to have results: results both in terms of their access to health care and in terms of health status, which depends on a lot of things other than the health system.

So, on the results side, all of the health accords that have been agreed to in the last couple of years say that in such-and-such a year we're going to measure whether we achieve results according to comparable indicators. I would hold everybody's feet to the fire. Are the indicators there? Are they comparable? Have we made progress? Do more people have access to primary health care? I'm not sure right now, but the goal is some years off. Do more people have access to home care? That's one of the measurements that's going to be made. Do more people have access to more timely treatment? We're going to have benchmarks by the end of this year on wait times, and we're going to be knowing in a year and a half from now whether we have met them in large measure, in small measure, and whatnot. And we're supposed to have transparency in terms of those reports, and governments are supposed to let everybody know what's happening.

So the real issue is, will we get results? I'm betting on the results, and so is everybody working in the health system, because we're betting on the system meeting the needs of Canadians.

Good home care stops people being re-admitted into hospital and clogging bed space in hospitals.

Martin Stringer: Anyone else on the question you would ask or you would have Canadians ask on the doorstep?

Linda Cranston: Well, I'd not only ask the questions that both of them have alluded to, but I also think it would be really important to actually engage the public in discussion about health care. It is a big Canadian issue; it almost identifies us as Canadians, our health care system. And I think it would be important for whoever makes up the next government to actually engage Canadians on the discussion of health care, because everybody likes to jump to a solution. We all do that; it's just human nature.

Martin Stringer: Wasn't that what the Romanow Commission, after x million dollars, was about? And before him, people forget Tom Noseworthy.

Linda Cranston: Well, this is true, but I'm not talking about a commission. I'm just talking about just going out and talking to Canadians and having a discussion. But, you know, your point is well taken. However, I do take issue with Romanow. He had a great opportunity, as far as I was concerned, to actually get out there and make a real point that Canadians need to take responsibility for their own health care. They need to look at prevention and promotion activities. They need to get engaged about it being their responsibility. The health care system can only do so much, and certainly I recognize we have a big responsibility there, but, you know, Canadians do need to understand that they have to exercise, they have to stop smoking, and they have to have a healthy weight. Those are only three things they need to do.

Martin Stringer: OK, Dr. Elinor Wilson, I see your finger on the trigger, so I'm trying to get you in there. Go ahead.

Canadians really don't care about "where I live"; they expect, wherever they go, to be able to get a certain level of service and care and ability.

Elinor Wilson: Oh, thank you so much. I mean, I think I would just expand that. I think one of our biggest challenges is that when we start to talk about the health system we immediately focus on the care part of that system. And when you think about the lifespan of an individual, the amount of time they actually spend in that acute-care institution is relatively small, but that's where the focus goes, the attention goes, and the dollars go. And so we need to engage Canadians in a discussion about their entire health system, from public health through primary care through the acute care to rehabilitation to home care, because all of those pieces have to work as a seamless system.

So that's at one level. And then at the federal level, I mean, we've at least started in public health to understand that mosquitoes observe no borders; that in order to control West Nile disease, we have to have a seamless pan-Canadian public health system.

Picking up on Sharon and Lynda's comments, we don't necessarily have to have the same seamlessness in health care, but we have to have the same accountabilities. Canadians really don't care about "where I live"; they expect, wherever they go, to be able to get a certain level of service and care and ability.

And I'm not sure, having come from the health-care sector myself, but we actually have engaged the discussion about expectations. So if we think about public health, if we had not eradicated polio, the discussion about knees and hips for us aging baby boomers would be a moot point because the orthopedic surgeons would be operating on people who had post-polio challenges.

And so, we just need to put it together better in a seamless system and not only look at the individuals and individual behaviours. I was very pleased to see the taxation results, and I might be so bold as to argue that high gasoline taxes might encourage people to leave their cars at home and walk more.

Linda Cranston: Could I just say one thing? You know, to the public who's watching us talk about health care, I don't want to give the impression that we're not sympathetic to some of their issues, because I'm very sympathetic. If I was sitting with severe pain in my hip, I'd want to have my hip replaced, or if I had severe pain in my knee, I'd want my knee replaced. So I really have a lot of sympathy for people who have to deal with wait times. But I want to assure them that myself and my colleagues across the country and the teaching institutions are really looking at innovative ways to do a better way of addressing their issues. Just as an example, in Vancouver, the Vancouver Coastal Health Authority and myself at the provincial actually ran a system whereby we did hips and knees, we took a couple of ORs, and we dedicated only those ORs to hips and knees. We actually dedicated all the services right through from getting the people who are going to come into the system, teaching them, doing it, short length of stay, rehab, and we actually increased efficiency by 25%. That's astronomical! We are, across the country, working on innovative ideas to actually try and deal with the issues, because I understand there are a lot of people out there who have legitimate health concerns.

Colin Leslie: It's interesting, though. This poll really shows just how prickly an issue it is for politicians. I mean, the province that has possibly gone the farthest in terms of considering paying out of pocket paying for health care, with Ralph Klein talking about his third way, had the least support for people paying for out-of-pocket health care. So you can see why politicians are cautious about it, for sure.

Sharon Sholzberg-Gray: I jump in there because the latest statistics also show that Alberta spends more on its publicly funded health system per capita than any other province in this country. So it's actually putting its money not where its mouth is but into the publicly funded health system, which is probably a good thing for Albertans.

But I think we should go back to the seamlessness. Our association has members from the entire

continuum of care, from hospitals to long-term care to home care to chronic/ continuing care services and whatnot. We're a federation of provincial and territorial hospital and health organizations, and so we see the whole continuum ranging right down to home support services in the community. And it's very difficult, and that's where the difficulty comes at the doorstep and whatnot, to explain to people – and Elinor, I think, did it very articulately – that it's this range of services all together that's going to impact, at the end of the day, on wait times because it will impact on the number of people who need access to acute care services. At the same time, anyone who needs those services should get them in a timely way.

And if we can go back to the Supreme Court decision for a moment, we forget about the patient in that case. His name was Mr. Zeliotis. Mr. Zeliotis had two knee replacements, a hip replacement, and a triple bypass. The health system actually served him very well. His court case came upon him because of an eight-month wait for a particular joint replacement, one of three that he had. So one could argue that he wouldn't have qualified for private insurance in the first place, with all of those health needs. And number two, you could also argue that he actually got a lot of health care in the publicly funded system. And three, it's my impression that he might not have been able to afford the high price of insurance if he could have accessed it, because no one sells insurance for people who have a definite need for it. And he would have, frankly, needed to spend about $300,000 on his health care.

So these are the issues that I think we have to discuss as well. Do Canadians know how much a complex procedure costs? They probably don't. Well, maybe they do, and that's why they want to pay the small amounts and not the big ones; they want the government to pay for the high-cost drugs.

Martin Stringer: A question, then. In talking about the Supreme Court decision, it was often said that the Supreme Court did what the political class was not able to do. They analyzed wait times. They analyzed a lot of what existed, looked it boldly in the face, and said, "Is this reasonable, and is it reasonable to prohibit an individual from having a certain type of service?" Many journalists, many commentators said that not only is this opening up honest debate but that a lot of the Supreme Court justices did what politicians and the political class are not able to do.

Sharon Sholzberg-Gray: I don't mind an honest debate, but in a sense the debate is not that good, because it's more worried about access to care for those who can buy private insurance and access private care than the vast majority who can't. So when you're looking at the right to timely access to health care, you ought to look at the right of everyone – not the right of a few – whose presumed life and liberty of the security of the person was upended by their long wait. So it seems to me it was more important for the Supreme Court to look at whether the vast majority of people have access to health care in a timely way, rather than at one or two individuals, in not having the right to access private health care in this country – do they have an excessive wait? So I think the question was turned up on its end. But having said that, I think it's good to have that complex debate. Legal issues are always complex, so we shouldn't look at that too carefully. But it seems to me it's good to have the debate about where we're going and to look at it realistically.

No one sells private insurance for people who have a definite need for it.

The real problem with this is there's so much ideology in this. In other words, those who think that private solutions are the only solutions say, "Ah, there it is! Eureka! The magic solution: some private delivery, some private pay!" Those on the other side are equally ideological. So we have to have something that works, and that's the issue; practically, what does work and what doesn't work?

In the countries that have some private care on the sides, they have wait times, too. In other words, there isn't a country in this world that isn't grappling with access to care because of the increased demand, because of new technologies, because of everything. So we have to manage that, and I think we do; and, frankly, we don't spend as much as other countries doing it. Maybe we should.

Martin Stringer: Dr. Wilson, you mentioned an interesting point. This is changing topics, but it's also remaining in a larger topic that you opened up: public health as a whole. We now have a minister of state for public health, Dr. Carolyn Bennett. We know the Liberals will bring that up in the election campaign. We now have someone in charge of public health: Dr. David Butler-Jones. That will be trumpeted as a major advance, certainly in the wake of SARS and the experience of the people in the Toronto area; that was one of the catalysts for that. To what extent does that change the debate in Canada, because we now talk about avian flu, the next pandemic? There's a lot of attention on public health in the wider sense. To what extent does that change the debate, say, in this election campaign? Will people be mixing apples and oranges, or is it all part of the same thing?

Elinor Wilson: Well, I certainly think that what this government has done in public health over the last two years with the commission, headed up by Dr. David Naylor, that made these recommendations, has been quite incredible. In two short years, some very significant changes have occurred in public health. I think one of the challenges is, though, that public health is really a success when nothing happens. So if nothing is happening, then it's really quite easy to have public health shift to the back of the stove, because the pot is boiling under how many people are on a wait list to get something done. And public health rises and falls according to the latest crisis with water, the latest dead birds that are falling out of the sky, the latest mad cows we have rampaging across the country. [Laughter.]

This isn't about* either *public health* or *health care. Canada needs to have both linked in a seamless fashion.

Martin Stringer: The latest vaccine that we need billions of dollars on.

Elinor Wilson: Precisely! I think, though, that what we have seen and what we need are this continued national leadership in public health, so we *do* have a pan-Canadian way of looking at these issues. In fact, the organization that I represent (CPHA) was founded in 1912 when we had a cholera epidemic, when doctors at that time said, "Wait a minute. We can't look at this from one particular point in Canada; this could spread."

The sustainability of funding is a huge issue. We've had some resources put into the national public health agency, but, as Sharon was saying about the health care dollars, we've not seen any increased dollars going to public health on the front lines, even after SARS.

And the third thing is public health human resources. One of the key points that Dr. Naylor made was that this country lacks surge capacity in public health, and that was demonstrated very well during the SARS crisis, where *everyone* in public health was *only* doing SARS. If we'd had another public health emergency at the same time, we would have been very greatly challenged to handle it.

Martin Stringer: So your doorstep question would be "What are you willing to invest in terms of resources, vaccines, prevention programs, family planning, whatever: all of the public health programs?" Ask your candidate what he or she is in favour of.

Elinor Wilson: That would certainly be a doorstep question, but I want to make sure that we understand that this isn't an issue of either/or. We know that we need access to high-quality health care when we need it, so this isn't about *either* public health *or* health care. A country like Canada needs to have both and needs to have it linked in a seamless fashion.

Martin Stringer: OK, I want to go back to Michael Marzolini because, after having had 30 minutes at the beginning of this, I can see you pining away for lack of attention. [Laughter.] No, but a question, to get back to the polling and the crassly political…

Michael Marzolini: I was worried people were thinking I was just here to score some Tamiflu. [Laughter.]

Martin Stringer: On polling, one of your colleagues in another polling agency told us before the last election that even though health care is the number one priority (or the top-of-the-mind priority or however you want to say it), there is less and less a consensus that one political party at the federal level is going to have the silver bullet, and there's less and less of a consensus that it's going to be one level of government over another that's going to have the solution, and that people are sophisticated in their frustration over the issue.

Michael Marzolini: Well, in 2004 there wasn't much discussion on the issue at all, aside from the fear-mongering that the Liberals did against the Conservatives, and the Conservatives were scandal-mongering against the Liberals to the extent that the issue was never discussed to the extent that Canadians wanted it to be discussed. And it will be, I believe, very important in this election that we get the framework right.

And I like your question "What *would* you ask at the door?" because that's what it really has to distil down to. I'm afraid that people around these tables, we know too much about it. We actually know how certain things work. That's not what the public are looking at. When they answer the question on Chaoulli, they're answering yes to a lot of things, and it's up to us to try to figure out what they're actually saying. We can't award the public the level of knowledge that experts in the profession may have about funding formulas and things which are arcane to Joe Six-pack and Jane Housecoat. [Laughter. Lynda Cranston says, "Jane Housecoat?"] It's terrible, absolutely terrible! [More laughter and comment. Lynda Cranston says, "It should be Jane Six-pack and Joe Housecoat."] Well, you'll have to talk to George Gallup about that, because I believe he came up with the term about 40–45 years ago.

But what the public really are looking for is some indication that, yes, we can open this; we can fix it;

we can change it without harming it. It's unfortunate that, but it's almost like a Nixon going to China issue – the only ones who can open up discussion on Chaoulli and all these other aspects are the New Democrats or the Liberals, perhaps even the Bloc. The Conservatives have to be "me too-ing" it and saying, "Yes, we will look at it," but they have to be the cautious ones. They have to be almost held back by pressure from the New Democrats or, rather, from the public.

Martin Stringer: Having spent a lot of time on the Hill, the refrain that the Conservative Party must adopt within the first sentence of any answer is "We are wholeheartedly for and behind and support the Canada Health Act." Does the Canada Health Act work, and should we be mistrustful of candidates who say, "No problem with the Canada Health Act; it's working"?

Michael Marzolini: We have data that says that many of the public don't know what the Canada Health Act means or what it stands for, and of the ones that do, the majority think it needs changing. But remember that voting is not as easy as being right or wrong. Voting doesn't necessarily mean you support somebody who agrees with your point of view. We have 70-odd per cent of Canadians who are in favour of capital punishment; only 34% would vote for a candidate who stood for capital punishment, because the other 36% say that person is too extreme. If you agree with what I'm talking about, then you're too extreme for me to vote. Preston Manning found this years ago, when they ran the "We've had too many prime ministers from Quebec" ads. The Conservatives (or the Reformists or the Alliance – I forget which incarnation they were in then) had about 20 seats at that time in Central Ontario. Rural Albertans said, "I agree. We don't need any more prime ministers from Quebec," and Ontarians were saying, "I believe this; they're right, but I don't want to be *seen* as believing this. I don't want to look my neighbour in the eye thinking we both think this way." And they were the ones who got rid of their signs, and those ridings flipped back. Frankly, I think it was a marvellous strategy which a pollster developed, who will remain nameless, in order to put that across.

But really, what the public are looking for on this and trying to come to simple solutions is can it be opened? Can it be fixed? They're frustrated, so they're not in the mood for a lot of talk. They want results.

One of the only sets of results that I've seen from a government are actually on the waiting time areas. They're working very well and are talking the right language to the public. And that is the Web sites that have seen set up in Ontario and other places, saying, "Here are the waiting times in these hospitals for these procedures." You can monitor that; it's accountability, it's the right tone, it's responsible, and it's transparent. And those are the right things to talk to Canadians about right now.

Martin Stringer: OK, I want to swing the attention over to this side of the roundtable because we're under-representing Michael and Jeff and Colin. Any weigh-in, especially if you have a suggestion for a question you'd ask, or something you wouldn't want to hear, at the doorstep?

Voting doesn't necessarily mean you support somebody who agrees with your point of view.

Michael Villeneuve: I'm going to suggest that I probably personally wouldn't ask any politician at the door if they support the Canada Health Act, because we all know what they're going to say. There's nobody in the country who is going to say anything except yes.

I'm struck by your question, Martin, and I guess I'll play a little bit of devil's advocate, and I've tried to write down what you said, which was something like "Which government of which political stripe will have the silver bullet?" And I guess I'm, as I age, less and less convinced that the governments will or should have the answer when we around the table don't always have the answers, and sometimes we do.

Lynda, you gave a really, really good example of wait time reduction around hip or some kind of joint replacement surgery in Vancouver Island. I guess I would challenge ourselves in nursing – I don't exclude me or the CNA or nursing or physicians and so on – to ask the question, "Why then is that not the case across the country?" Obviously it can be done, so it's not a mystery. I'm deeply concerned. I think, that we keep going on waiting for government to act. To do what? If we know the answer, spread that around. We've known for years that there are certain hospitals that even in the worst shortage have line-ups of people that want to work at them. Figure it out! We have some deep obligation, I think, on our own parts, to take some accountability and really move some of this forward.

So I'm not sure my question is to the person at the door as much as it is here in this setting today to ourselves to act.

Jeff Poston: The question I'd ask, I think, is – this is a candidate who's running for political office in the federal government – I'd ask him what he or she sees the federal government's role in health care as being.

I think it's a critical issue, because we have this sort of tussle, if you like, going on in terms of certainly health care is clearly a provincial government jurisdiction in Canada, but there's a leadership and a funding role for the federal government. But I think it would be quite interesting because it would force candidates to really think about that question in terms of the federal government clearly having a critical role to play in terms of leadership and stewardship with respect to the health care system.

I think the follow-up question is, "If elected in a federal government, what would you do to work more effectively with provincial governments to ensure that Canadians have the access to health care that they clearly want and to make sure that it's of an appropriate quality?"

Martin Stringer: It's interesting, Michael; in your poll in the Canada health survey for the year 2005, there was a slight dip in the lack of confidence, if you will. Someone described it as probably being coincidental with the first ministers' agreement on $41 billion more for health care. But it was also coincidental with a lowering of the rhetoric between the provinces and the federal government. Probably the hottest rhetoric was at a time when the federal government seemed to be at war with both Alberta and Mike Harris in Ontario. The rhetoric was very, very high. Any reflections on that? Are we at a better state now in terms of cooperation? We've mentioned Ralph Klein. There's also Quebec, which is forging ahead with legislation for private insurance. How would you describe relations between those levels?

What governments say is "When in doubt, reorganize, restructure." What we really need to do is run with the principles we have and move forward.

Sharon Sholzberg-Gray: I'm not sure that they're always improving on the health-care side. I understand that federal-provincial meetings on other subjects end up being a lot more productive in terms of relationships and decision-making that proceeds than at the health table. That doesn't mean it can't move forward.

Martin Stringer: They tend to be very, very cooperative right on the eve of an election.

Sharon Sholzberg-Gray: That's right. But the real problem, I think, is that – and this really is the story of Canadian confederation – on the one side, the provinces and territories want as much money from the federal government as they can get – blank cheques, if you will – to do with the money as they wish, and that's understandable. On the other hand, the federal government is saying, "If I'm going to use the federal spending power, which is a constitutional power, to transfer money to the provinces and territories for services they deliver, I want to be assured of certain outcomes, of certain performance, of certain results." So you have on the one hand the provinces saying, "I don't want to do what you're telling me to do for the money," and on the other hand you have the federal government saying, "But I want you to do this because Canadians expect you to produce these results." And that's the reason for the tug of war.

I think that when they all commit, though, as they did in 2004, and they all signed the document that said, "We will be transparent; we will be accountable; we will sign on to having pan-Canadian access targets or benchmarks; we will report to the Canadian public in one way or another by certain target dates on how we're performing," it was noted. I think, Mike, you mentioned the fact that the public likes it when they see Web site information, when they see how long are the waiting lists and whether there's progress in various hospitals and health facilities across the country. That is in itself is actually some progress.

And then the real issue is let's hope we see the reports that show progress in meeting targets. The real problem, of course, is that as more and more people are taken care of through processes that Lynda mentioned – by the way, there are thousands of lights across the country because a lot of people are improving efficiencies and effectiveness and whatnot. Then there's higher and higher need or demand, however you want to describe it, and that's one of the conundrums also. Baby boomers, of course, want things and they want them right away. That doesn't mean they aren't entitled to them. But the real issue is, when we're talking about timely access, we're not talking about immediate access. We're talking about the access that's needed for your particular health status and that's appropriate for you. So we have to go right back to that.

But transparency, reporting, accountability – all of those are part of the solution – and electronic health records (I've mentioned that before), which will help the efficiency issue as well.

And frankly, I wouldn't want to start reforming the health system from scratch again. Everyone has been in a process of reform for the last ten years, and sometimes I think what governments say is "When in doubt, reorganize, restructure." I think what we really need to do is run with the principles we have and move forward. And you're right, Mike, the solutions are not all in the hands of government. They provide

the broad policy framework and the funding, and it's our responsibility to move forward with it.

Martin Stringer: In a few minutes, I want to give you a chance to talk briefly in short snappers about what you feel are the most under-reported and most over-reported issues when it comes to the health-care system. I'll let you think on that.

In political parlance, they often talk about a 400-pound gorilla that's sitting in the room, and nobody is admitting he or she or it is there. And I'm wondering about Kashechewan and other crises like the water crisis in Northern Ontario; did that remind us how much of what any of what we're discussing applies to Canada's native people? And how much of the reform, how much of any of the polling actually gives us an accurate depiction of where we're going with Canada's First Nations and native and aboriginal people? Weigh in on that one.

Colin Leslie: I certainly think it did wake people up. And even though health care is a provincial responsibility, the federal government is also a huge provider of health care because it provides health care for the armed services and for native communities in certain situations. Certainly in northern Canada, the federal government is playing a large role in how that goes about. So I think there's been a lot more interest in making sure that something is being done in those areas. You've got huge problems in some native communities in terms of diabetes rates and other things, and I think there's more focus coming on that.

Martin Stringer: What about, though, each of your interest groups? (I call them interest groups.) Each of your stakeholder groups has shown itself lacking in that field. I mean, in terms of native doctors, in terms of doctors in native communities; in nursing, it was just pointed out, the commitment was made in the new agreement last week to a higher number of aboriginal, native, First Nations nurses on reserves.

As for access to pharmaceutical products, I don't think centres of excellence are recruiting many native researchers in terms of per capita. I think we could point to everyone around the table. This is my way of getting you to weigh in again.

Sharon Sholzberg-Gray: Well, at our board meeting in June, we actually had a whole day of discussions on access of First Nations peoples to health care, health services, and to the general, broad services that would keep them well. We invited people from various communities to present, and we tried to see what could be the optimum arrangements or relationships between our members, who represented the health system generally, and the people who came as spokespersons for their particular First Nations groups, and those kinds of things. And you know what? We decided that – hah! – just like health, that's a complex issue, too: multi-jurisdictional, not easy. We were gratified, frankly, by the meetings that took place last week, because we thought that there was some effort to try to get to the bottom of the jurisdictional issues between the federal government, the provincial government, and groups, frankly: First Nations groups who want to be in charge of their own destiny and manage their own communities.

And all I can say is that we do have something to apologize for as a nation when we can't seem to do something about the health status of certain population groups, and we just have to work better at it.

Colin Leslie: Yes, I think certainly doctors are aware of that and doing a lot of things around that. I mean, we have a new medical school in Canada that just opened this fall, the Northern Ontario School of Medicine, and it's specifically targeting people in northern and rural communities and aboriginal people. And a number of medical schools in Canada have spots specifically allocated for native Canadians. So I think there are a lot of efforts going around in that area.

Martin Stringer: OK. Dr. Wilson?

If we look at the health status of our aboriginal peoples, it's sometimes very hard to believe that it could be so in a country such as Canada.

Elinor Wilson: I would certainly agree with your statements, and in fact the reason I was late was that we were meeting with the National Aboriginal Health Organization. We actually do have a memorandum of understanding with NAHO and are specifically starting to look at how we can work together on the public health issues that are facing aboriginal communities. There are those issues, there are the sets of health-care issues, but there's also the issue that Sharon raised of the determinants of health and the inequities in that population group that we do not seem to be able to adequately address in this country. And if we look at the health status of our aboriginal peoples, it's really sometimes very hard to believe that we could have that level of health status in a country such as Canada. That health status is almost equivalent to some of our developing countries in terms of morbidity and mortality and risk factors and poverty. And so I agree it's something that this country has to deal with. We're

very pleased to see what has happened this week, but there's a lot further to go.

Martin Stringer: OK, now to the fun part, where you get to weigh in, First, let's go to Jeff and Michael on that, and then we were going to weigh in on how the politicians and the media are getting it wrong, under-representing it, over-representing it.

At least 50% of the population do not believe we're prepared well enough for the next pandemic.

Jeff Poston: I think aboriginal health is an area where we can all do better. I think you recognize that. We've done a number of pilot studies in pharmacy, looking at using pharmacies that are in the North to get involved in disease screening and disease-management programs.

There are many challenges involved in managing the drug plan for native peoples. We work fairly actively with NIHB to try to resolve a number of the issues that there are around improving access and drug use amongst aboriginal people. But I think it's a whole area that needs further work.

Michael Villeneuve: I just wanted to add, Martin, that about half of the First Nations people in the country live in rural and remote settings. And as you may know, nurses provide the bulk of care to those people. What we have not done as well in nursing is recruit those people into our own profession and, despite a number of strategies, it works in handfuls of people, which isn't a very sustainable way to recruit a workforce.

Our larger concern in nursing, though, is that the system we have created – and much of this relates to your comments about poverty, Elinor – has sustained huge disparities for all people who aren't of Caucasian, European, English-speaking background. And we have failed in nursing and medicine and the other professions to really engage with that agenda and fix it. And we know from the poverty report this week that many of those new immigrants that are our future tax base live in poverty when they come to this country, and that plays out over generations of poor health. So this is much more than the aboriginal agenda for this country.

Martin Stringer: OK, you've had a chance to reflect on what has been misrepresented, over-represented, and badly represented. Weigh in. This is potentially fun. In terms of issues that are over-represented, Dr. Wilson, have we talked too much about avian flu? [Dr. Wilson laughs.]

Elinor Wilson: We haven't talked at all about avian flu, have we?

Martin Stringer: No, we of the media, I'm saying.

Elinor Wilson: But it was interesting in the survey to find out that at least 50% of the population, and including our own constituencies, do not believe we're prepared well enough for the next pandemic. Certainly there is something to be said about that delicate balance between frightening people so that they become incapable of attempting to take charge of what they *can* take charge of and having a population that's totally unprepared. And whether we talk about SARS or avian flu, we have an influenza epidemic every year; we lose about 7,000 Canadians, and yet the majority of Canadians still do not get a flu shot every year. So there's a lot of contradictory information going on there.

Martin Stringer: So that means vote for the candidate who's in favour of flu shots. I'm sorry, I'm just thinking in my election mode. [Laughter]

Elinor Wilson: Have your own flu shot!

Martin Stringer: Anyone else, on under-represented or over-represented issues?

Sharon Sholzberg-Gray: I think the over-represented issue is just the slogan "two-tier health." I think it's a simplification. If you're a politician who favours two-tier, no one admits to that, right? And if you're against two-tier, well, what does that mean, anyways? I think them not understanding that there is a single-tier Medicare system: the physician–hospital system. We have another system in the middle, which is long-term care, home care, pharmaceuticals and whatnot; which are part in, part out, co-payments, whatnot. Perfectly legitimate, I think.

And then another group of services which might be entirely out might be some physiotherapy, optometry, some chiropractic, that kind of thing. I don't think Canadians understand that we kind of have three concentric circles, so when you say, "Are you in favour of two-tier or against?" well, I don't know what the answer means. The answer means, I think, that they don't know what the health system is about. So maybe that's not a good thing if they're political people doing the policy framework that's supposed to help us solve our problems.

Martin Stringer: OK. Lynda Cranston?

Lynda Cranston: As under-represented I would have to identify mental illness and depression in the workplace. It is suggested that in a number of years' time the lost days of work due to mental illness or mental depression will exceed those lost by any other disease. I don't think a lot of people talk about it. People still hide it; it's not something that's out there and that people talk about. And it is a serious problem.

Martin Stringer: That's under-represented. How about over-represented? Anything we're talking about too much, aside from the use of "two-tier"?

Michael Villeneuve: Can I weigh in, Martin, on this? The issue – I hate to say it – of times, which we've talked about for so long, when we have some potential solutions that we won't put in place. I won't talk solely about physicians as gatekeepers, but that there may be other gateways to care for Canadians in this country. So I think the over-talked-about issue is wait times without the concurrent talk about the solutions that we won't put in place.

We know we have answers; it's not a mystery. So act!

Martin Stringer: The solution being more resources, more physicians, more nurses, more nurse practitioners?

Michael Villeneuve: Different ways to get into the system. We have, in Ontario, a report with a million people without a family doctor. Maybe what they need is certain kinds of health services, not a doctor. However and whomever, pharmacists can be used differently; nurses can be used differently. People need health services. The public tells us that. They're not demanding that they need to see a doctor. They have a need that needs to be met.

So we, as a country, can talk about wait times, and we're all going to be old and retired and it's still going to be talked about if we don't do something about it.

Lynda Cranston: That's a good segue because, for example, in a number of provinces they've introduced nurse lines, right? And the public is encouraged to phone the nurse line and have a discussion with the nurse line about the issue that's bothering them. It's been significantly shown to address the issue, reduce trips to the emergency department, allow people to wait until they can see their physician. And he's referring to the whole issue around scopes of practice and use of other people in the system.

Martin Stringer: OK, let's get to Jeff and Colin.

Jeff Poston: Yes, I think that wait time is over-simplified to a certain extent. It's not just more operating theatres and more staff; it's what we have to start to look at along the continuum of care that Elinor described. It's making the most appropriate use we can of the health human resources and the technology that we have in the system, and that's a critical issue.

I think the issue that's under-represented is quality of care. We hear the rhetoric around access all the time – "Give us access!" – but there's good and bad knee surgery; there's good and bad drug use; there are whole issues around care of the mentally ill. If there were something to rack up the agenda, it's quality of care. If there's something it's important to keep up the agenda… I can remember… Eleanor and I have probably been on panels for 20 years; we've battled to get public health up the political agenda in Canada. It's up there; I think it's absolutely critical for our future that it's kept up there.

I'd say the same about medications and medication use. People are finally realizing that drugs can do you harm if they're not used properly. At the same time, they can create enormous benefits for you if they're used properly.

The other thing that it's important that we keep focusing on and we don't lose sight of is primary health care reform.

We have, in Ontario, a million people without a family doctor. Maybe what they need is certain kinds of health services, not a doctor.

Colin Leslie: I think that one of the issues that politicians don't talk about that much is access to drugs on a certain level. I mean, this poll showed that a vast majority of the public feel that if a drug is available in one province, it should be available in the formulary of another province. And doctors are also very frustrated if they want to use a certain treatment and it's not approved by formularies. Partly they don't talk about it because formularies are kind of complex, and it means that province is covering it for, basically, people on social assistance. But that decision by the province to cover a certain drug usually sets what's used in hospitals and often sets what the insurance provides. So if it's not in the formulary, it's hard to get that drug, and that's not all that discussed by politicians; we've had a little bit of it with reception in Ontario and stuff like that. And some of the drugs are very expensive.

Martin Stringer: Certainly, as we know as journalists, it certainly has got a lot of media attention when

The public said, "We don't have the ideas. We don't know how to fix it." But they also said, "We don't believe government does, either."

a person suffering from a horrific condition has to be flown to Calgary from Southern Ontario because it's not covered on the formulary and in the insurance plan of Ontario.

Michael Marzolini started us off; you can probably finish this off, so to speak. [Laughter.]

Michael Marzolini: My view is…thank you very much. The answer I would give, by the way, at the door is "Please close the door. It's damn cold out there!" [Laughter.]

But with respect to the idea of what issues have been overplayed, I would think health care itself has been an issue – not to be overplayed, but overplayed by government.

And I go back to some of the early surveys we did when we were feeling our way through this whole process in the late '90s and 2000 – I think the last one was in 2002 – and we asked, "Where are the ideas coming from? Who do you have confidence in?" We looked at government. We looked at each of the stakeholder groups. We looked at where the ideas were supposed to come from. The public said, "We don't have the ideas. We don't know how to fix it." But they also said, "We don't believe government does, either." And they were talking about the doctors, the nurses, the pharmacists, the managers of hospitals as the people who would come up with these innovative ideas. Government was there to rubber-stamp them and say, "This will work."

And, to be a little bit mischievous, everybody sitting around the table here, aside from me, has a background in this; my view is, write your own policy. Take it to the politicians. Take it to all four political parties, and say, "Endorse this. Sign the paper. Here is your plan. Here is your action plan. You've all got the same program, but big deal. Health care is the most important issue."

Martin Stringer: Is there a chance that politicians in this campaign, which is now already under way, will treat it that way, then? Tom Noseworthy, when he came out with the predecessor of the Romanow report – a doctor from Calgary, a massive cross-Canada survey – refused when *Maclean's* said "crisis in Medicare." He said, "Despite all the problems I found, I wouldn't use the term *crisis*." Is it possible politicians will avoid that and we may not have this as a top-of-the-mind issue?

Michael Marzolini: Well, they have to date, but it's also not a wedge issue. The Liberal campaign, I remember reading – I was in another country at the time; I usually take vacations during elections nowadays, but unfortunately I haven't found anyplace to go this week – called waiting time access the top issue. And I thought, "That's interesting, because it isn't a wedge issue. Does that mean the Conservatives are in favour of longer waiting times and worse health care?"

And that's really what we're really looking for in terms of issues: wedge issues – ones that people have strong views on.

Martin Stringer: OK. On that, we're going to have to wrap it up. Obviously, there's so much to discuss, but you have provided us with a lot to think about and especially with the polling information.

But I want to thank all of you for participating in this roundtable discussion. Hopefully, it will give our viewers something to mull about and *maybe* something to ask people on the doorstep when the politicians come campaigning in this Election 2006.

To all of you, our viewers out there, I want to thank you for having participated, in addition with our panellists. Thanks for watching, and we hope this has given you something to consider when the issue of health care comes up in this Election 2006.

I'm Martin Stringer. Thanks for watching.