Medicare reform

Bringing values into health care reform

Judith Maxwell

This is the second in a series of essays in which notable Canadians give their perspectives on the future of medicare. In the next issue environmentalist David Suzuki writes on "Broadening the health care debate."

Whose values should shape health care reform? That depends on who you think "owns" the health care system. Is it the governments who administer it, the physicians, nurses and other professionals who provide the services, or the managers who direct the core institutions such as hospitals and care organizations? Or is it the broader base of citizens who use the system and pay for it through taxes, insurance premiums and out-of-pocket expenses?

All these players have an ownership stake in the health care system. The governments and boards have fiduciary responsibilities, the providers and managers have mandates to deliver and manage care and they earn their living from the work they do. Each of these players is also equipped with technical expertise about how the system does, should or could operate. And, clearly, health care reform decisions must be informed by that technical knowledge. You cannot build a pyramid unless you know how to cut and assemble stone.

At the same time, however, the consent of the governed is needed for health care reform, just as the consent of the patient is needed for treatment to begin. Citizens, as the owners and funders, also have something to offer to the construction of the health care edifice. What they offer is their core values about how the system should be financed, about what rules should determine who has access, and about the way the patient interacts with the system. The important thing to know about values is that there are no right or wrong answers. Values are the "relatively stable cultural propositions about what is deemed to be good or bad by a society."[1] They are derived from human experience, and therefore they do change over time.

Ironically, it is hard for government officials, providers, and managers to articulate their core values about health care reform because technical expertise tends to dominate personal values. And health care, no matter how technologically advanced it becomes, is a profoundly human experience. It is where we as individuals and family members must confront our own life, death and well-being, and that of the people we love. It is about me, the individual. But it is also about us, the collectivity.

Values and expertise are complements, not substitutes. Both are essential ingredients to decisions on health care reforms. Recommendations that do not accord with Canadian values are likely to be blocked because they do not attract the consent of the governed. Those that are not consistent with a sound understanding of clinical practice and good governance are likely to fail.

In the 1980s and again in the past few years, governments in Canada have commissioned task forces, commissions, advisory councils and forums to give advice on health care reform. The recommendations in their reports are remarkably similar. If you compare the reports led by Messrs Clair, Fyke and Mazankowski in the past 8 months, for example, the similarities are far more prevalent than the differences. But the stunning fact is that few of the major, long-term recommendations of past commissions have been implemented. Health care systems in Canada were shaken, stirred and reorganized throughout the 1990s, but the essence of system organization and care delivery has changed very little.

All these commissions invested in some form of consultation with stakeholders and with the public. The difficulty with the traditional forms of consultation is that they do not enable citizens to think through the fundamental trade-offs, and to find ways to reconcile conflicting values.

Almost invariably, core values are in conflict. For example, equity and efficiency are nearly always in tension. Both are extremely important to health care. One determines who gets care and how it is financed, and the other is concerned with the means and methods of delivering care. The most important challenge in health care reform is to determine how citizens will reconcile their abiding attachment to both equity and efficiency.

Public attitudes to health care reform are measured weekly through telephone polls and focus groups. The polling tells us a lot about current reactions to immediate issues. It does not tell us enough about the core values of Canadians to be able to judge how they would assess the acceptability of one option over another. Polls do not tell us what sacrifices citizens are prepared to make in order to give full meaning to a core value like equal access, or how citizens might be prepared to adapt the way they use the system in order to achieve a core value like efficiency.

During January and February of 2002, I had the privilege of witnessing a process where citizens were given both the time and the information to think through some of

these extraordinarily difficult choices. They took their challenge seriously, they learned a great deal from each other, and they came to terms with the choices in ways that would astonish many political leaders and technical experts in health care. Citizens were quick to grasp the budgetary and technological pressures we face, and yet they were able to articulate a set of values-based choices about a system that is immensely important to them. They were remarkably pragmatic and clear about the choices.

This dialogue was commissioned by the Commission on the Future of Health Care in Canada, led by Roy Romanow. The dialogue involved 12 groups of 40 citizens, selected to represent the Canadian population. Over the course of a full day, they constructed a consensus view of what an ideal health care system would look like in 10 years' time, and then worked through the trade-offs and choices that would make that system financially sustainable. The Commission will publish the report on this dialogue this month. Mr. Romanow is also engaged in an intensive dialogue with the stakeholders — providers, managers and governments. In his final report in November, he will therefore have a unique opportunity to create the synthesis of the values base of Canadians with the best technical advice available from the people who govern, manage and deliver health care in Canada.

Mr. Romanow will have all the right materials to renovate the medicare edifice. In November, we shall see what architecture he recommends.

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Reference

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Articles to date in this series

Lewis S. The bog the fog, the future: 5 strategies for renewing federalism in health care. *CMAJ* 2002;166(11):1421-2.

Chiropractic students' attitudes about vaccination: A cause for concern?

Robert Pless, Beth Hibbs

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Immunization was, without question, one of the greatest public health achievements of the 20th century.[1] Given its continuing success in controlling diseases that once maimed or killed, vaccination should be recognized as an important part of health care or, at the very least, an acceptable health care practice even to health professionals who do not perform it.[2] Unfortunately, a subset of chiropractors weigh in on the issue in a negative fashion by discouraging vaccination or raising concerns about its safety or effectiveness among their patients[3,4] or even by actively opposing immunization.[5]

In the survey reported on page 1531 of this issue, Busse and colleagues[6] discovered an unsettling trend during the professional education of chiropractic students. The authors found that while some students had negative attitudes toward vaccination on entering their training for the profession, many others appeared to develop such attitudes as they progressed through their studies. Yet the core curriculum of the Canadian Memorial Chiropractic College (CMCC), where the survey was conducted, teaches both immunology and health promotion[7] and is itself supportive of vaccination. In addition, the policy viewpoint of the Canadian Chiropractic Association also supports vaccination as it is currently practised in Canada.[5] It seems that the negative attitudes acquired by some students resulted from their stated reliance on more "informal" sources of vaccine information during their studies, such as the general chiropractic literature and informal talks held at the college.

Some of the attitudes expressed by CMCC students are truly disturbing. That 23.5% of the 119 fourth-year students agreed with the statement that "there is little scientific proof that immunization prevents infectious disease" and 16.8% agreed that "vaccines have not substantially changed the incidence of any major infectious disease" is