2008 CANADA HEALTH CONSUMER INDEX

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Health Consumer Powerhouse

Frontier Centre for Public Policy & Health Consumer Powerhouse

Canadian Health Consumer Index 2008

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September 12, 2008

Number of pages: 39

ISBN 978-91-976874-6-1

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Foreword

Which province best serves the Canadian healthcare consumer?

It is a pleasure to present the inaugural Canada Health Consumer Index (CHCI), which for the first time will allow Canadians to assess the consumer responsiveness of their province's healthcare system against the rest of the country. This consumer-oriented approach uses well-proven benchmarking and evaluation methodology from the Health Consumer Powerhouse, Europe's leading independent provider of consumer information, whose work has triggered much discussion, analysis and, ultimately, improvement in healthcare systems in Europe.

The first Euro-Canada Health Care Index, launched in January 2008, brought Canada into a comparison of 30 European countries. This groundbreaking benchmark showed that Canadians rely upon a system that is sclerotic, inefficient and remarkably stingy when it comes to providing excellent, timely care. Such an assessment provokes debate and provides policy makers with insights they can use to initiate reforms. Not all provinces perform on an identical basis. Therefore, to empower care consumers to take action one needs to be more specific.

The CHCI breaks down Canada's overall performance using the methodology of the broader international study and examines healthcare from the perspective of the consumer at the provincial level. Now, Canadian policy makers, analysts, journalists and consumers can benefit from just such a comparison.

Canadians consistently say healthcare is a pressing concern. Wait times for all levels of care, access in terms of affordability, and outcomes are all problematic. A thriving healthcare system can only exist in a culture that values the rights and autonomy of the consumer. Both safety and clinical outcomes often rest upon factors that can cost more in the short term but save time, money and, most importantly, suffering in the longer term. Preventative medicine and screening are prime examples of this.

The indicators for this Index were selected to reflect all of these concerns.

Our hope is that the provinces will learn from the mistakes of their neighbours without replicating them. There are also good examples to be found that should be adapted as made-in-Canada solutions by as many provinces as possible.

Ultimately, the Index not only highlights problems in each province, but it also shows what is possible. This is exactly what it is all about: supporting consumers so they can make informed decisions and providing policy makers with a new tool for improvement. Though the Index sometimes reveals unpleasant, even shocking, data, it will improve transparency in the provinces. Such openness and clarity is beneficial for everyone.

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1. Summary

The first Canada Health Consumer Index reveals that Canadians in different provinces enjoy very different levels of access to healthcare. While there are clear winners and losers in the overall comparison, all provinces have areas in which improvement is needed, and almost every province reflects good health policy in some facets. The lesson that should be taken from the Index by all stakeholders is that while Canada must work hard to reach the level of excellence taken for granted in much of Europe, a good deal remains to be done to make healthcare equitable and effective.

Ontario finishes first in the overall comparison, by a clear margin. While waiting times in absolute terms are a problem, the province is about average nationwide. In other respects, it performs well, leading the pack in patient rights, primary care, generosity and achieving good outcomes. British Columbia takes second place, with excellent scores for patient rights and outcomes. Nova Scotia rounds out the top three on the strength of first-place positions in waiting times and outcomes.

At the other end of the spectrum are Manitoba, Quebec, Saskatchewan and Newfoundland, in order of decreasing overall scores. It should be noted, that the seventh place and last place provinces are only separated by 21 out of a possible 1,000 points. While each of these provinces has its own problems as well as some strong points, in the big picture, each should be seen as facing some serious issues that must be addressed.

Another lesson worth taking from the Index is that the best healthcare systems are not necessarily the most expensive. Ontario and British Columbia achieve good value for money, spending less per capita to get to first and second place than many provinces that fare worse do. Quebec, despite a low overall ranking, makes do with a very small budget compared to other provinces, demonstrating efficient spending, even if this is of little comfort to Quebecers who are unable to get good medical care. Alberta, by contrast, falls squarely in the middle in overall score but spends the largest amount of money on healthcare per capita, which is indicative of an inefficient system that wastes money.

There remain areas in which all provinces must make significant progress. Access to healthcare varies widely from province to province, whether in terms of availability of family doctors and midwives, the affordability and timely approval of new drugs or the waiting time to see a specialist. However, even the best-performing provinces do not provide the standard of care that is commonplace in Western Europe. Above all, Canada lacks a culture of accountability and transparency in healthcare, and it still puts providers and bureaucrats ahead of consumers. It is from this fundamental philosophy of healthcare that all the other problems ultimately stem.

2. Introduction

2.1 What is the Index?

Canadians are not accustomed to seeing themselves as consumers of healthcare. Traditionally, the medical culture in all countries has been oriented toward passivity on the part of patients and the empowerment of healthcare providers and administrators. In Canada, however, this tendency is greatly augmented by the absolute lack of individual choice within mainstream healthcare.

We believe that change in healthcare policy and practices, in Canada as elsewhere, can only come about when Canadians stop seeing themselves as passive subjects upon whom the healthcare system acts and start seeing themselves as consumers who have the power to make decisions, to demand and receive treatment of the highest standard. This cannot happen while healthcare consumers are uninformed. Canadians cannot become true consumers without access to information about how well – or poorly – their medical needs are being met, in absolute terms and in comparison with residents of other provinces and countries. Pressure upon provincial health ministries to reform and on the federal government to permit and encourage reforms will not come about until transparent, objective measurements of healthcare are widely available.

The Canadian Healthcare Consumer Index is a first step toward filling this gap in the Canadian discussion about healthcare. By evaluating the healthcare provided in each province according to a series of consumer-oriented indicators, we are giving Canadians a tool that will empower them as they interact with the many facets of healthcare in Canada: their family doctor, if they are lucky enough to have one; the providers and administrators at hospitals; the officials who run each province's health ministry; and the smaller regional health authorities. Since our elected representatives have a role to play in shaping better healthcare, the Index can also help voters to identify the political candidates most likely to enact the changes they want to see – does a platform look to proven successes for policy directions or does it promise to re-enact approaches that have already failed elsewhere?

In January of 2008, the Frontier Centre for Public Policy (FCPP) and the Health Consumer Powerhouse (HCP) released the first annual Euro-Canada Healthcare Consumer Index, which assessed Canadian healthcare in comparison with the healthcare in 29 European states. The Canadian Index represents the next logical step, allowing Frontier to break down the Canadian picture province by province and to make policy recommendations based upon the best practices of other countries and provinces. It is also an opportunity to highlight the often-significant disparities in the quality of healthcare enjoyed by residents of different provinces. Made-in-Canada solutions to a number of problems already exist, and if each province adopted best practices from elsewhere in the country, significant progress could be achieved.

The researchers and think-tanks behind the Index projects do not subscribe to any particular political school of thought as to how to improve healthcare.

Indeed, the indicators by which the provincial healthcare regimes are evaluated are not derived from ideology or financial concerns but from the consumer's perspective: How well will my province's healthcare system work to keep me healthy, to treat me well when I am sick and to give me the highest possible degree of choice and excellence in medical care?

The Index, then, can serve as a scorecard consumers can use to assess how well their province provides healthcare and, in subsequent years, how much their province has improved. It is an instrument of empowerment, because it facilitates informed discussion among healthcare consumers about what they are getting and what they could be getting. In addition, it is an opportunity to orient the debate about healthcare away from partisan concerns and toward objective improvements in the quality, accessibility and medical outcomes of the care all Canadians receive.

2.2 Frontier Centre for Public Policy

The Frontier Centre for Public Policy is a non-partisan think-tank that operates throughout Western Canada and carries out research on public policy in many domestic policy areas, including healthcare. FCPP seeks to improve policy by providing commentary and analysis on government programs by bringing to light policy innovations and best practices from other jurisdictions and by proposing effective policy solutions in order to create high-performance government. The Frontier Centre is independent and does not accept government funding.

2.3 Health Consumer Powerhouse

The Health Consumer Powerhouse is a centre for vision and action and promotes consumer-related healthcare in Europe. Tomorrow's health consumer will not accept any traditional borders. In order to become a powerful actor and build the necessary pressure for reform from below, the consumer will need access to knowledge to be able to compare health policies, consumer services and quality outcomes. HCP wants to add to this development.

HCP has been publishing the Swedish Health Consumer Index since 2004. By ranking the 21 county councils by 12 basic indicators regarding the design of systems policy, consumer choice, service level and access to information, we introduced benchmarking as an element in consumer empowerment. Since 2005, HCP has extended this methodology to include the comparison of the healthcare systems of all 27 EU member states as well as Norway and Switzerland. Last year, Canada was included in this analysis. This year, each province in Canada was scrutinized to assess how well the provincial governments are providing and regulating healthcare from the perspective of the consumer.

2.4 Project Staff

Rebecca Walberg, MA, is the Director of Health Policy at the FCPP and the principal researcher for the Canadian Healthcare Consumer Index.

Dr. Arne Bjornberg is the Research Director of Health Consumer Powerhouse, and he has provided project support.

3. Index Scope

The Canada Health Consumer Index is a compromise between the indicators that were judged most significant for providing information about the different provincial healthcare systems from the consumer's perspective and the availability of data for these indicators. This is a version of the classic problem, "Should we be looking for the $100 bill in the dark alley or for the dime under the lamppost?"

It is critical to have a mix of indicators in different fields, from the culture and attitude of healthcare provision to more quantifiable, objective measurements of outcomes and provision levels. Also central to the relevance of the Index is a focus on indicators that are within the sphere of influence of an identifiable group of people such as a provincial health ministry. Significant aspects of prevention as well as chronic disease management hinge upon lifestyle issues such as exercise, smoking, drinking and dietary habits. Since these are not within the purview of the healthcare bureaucracy, such measures are not included in the Index while access to a family doctor, which is directly influenced by policy, is.

Similarly, compliance with medical advice depends upon factors both within and without the immediate influence of policy makers. Whether or not consumers take the medication they are prescribed at the right time, or at all, is an important part of managing health, but it is not a suitable measure of consumer-friendly healthcare. Access to appropriate pharmaceuticals, however, does depend upon provincial policy, and so each province is evaluated according to how affordable medication is for its residents and how quickly state-of-the-art drugs become available.

This focus on indicators that reflect available data, consumer orientation and responsiveness of public policy makes the Canadian Health Consumer Index a tool that can benefit all stakeholders in the healthcare system. Consumers will have a better platform for informed choice, and they will enjoy a clearer picture of how well their provincial healthcare systems perform. Governments, healthcare authorities and providers benefit from a sharpened focus on consumer satisfaction and excellent outcomes to guide them in making healthcare as responsive as possible. The CHCI is designed to become an important benchmark system that supports ongoing, interactive assessment and improvement.

3.1 Indicator areas (sub-disciplines)

The lessons learned from the Swedish Health Consumer Index, the European Health Consumer Indexes and the inaugural Euro-Canada Health Consumer Index were used in the creation of the Canadian Health Consumer Index. For ease of use, indicators are grouped into five major categories, each one focusing on a particular aspect of healthcare and consumer friendliness. Overall rankings are not always congruent with rankings within each sub-discipline. Section 7 explains each indicator.

Sub-discipline	Number of indicators
Patient Rights and Information	5
Primary Care	4
Waiting times	7
Outcomes	5
Range of Services Provided	5

The weight of a sub-discipline is entirely independent of the number of indicators under each sub-discipline – it is given only by the applied weight coefficient (see section 3.2). However, the effect of having a high number of indicators in a sub-discipline does reduce the relative weight of each single indicator in the final total score (see the table in section 3.2).

The performances of the provincial healthcare systems were graded on a three-grade scale for each indicator, with green being good (), amber being average (), and red being poor (). A good score earns 3 points, an average score 2 points and a poor score earns 1 point. When data are unavailable, a province earns 1 point for that indicator also, since providing reliable and transparent information about healthcare is a crucial aspect of consumer-friendly service and accountability.

For each of the five sub-disciplines, the provincial score was calculated as a percentage of the maximum possible (e.g., for outcomes, the score for a province was calculated as a percentage of the maximum 5 x 3 = 15). Thereafter, the sub-discipline scores were multiplied by the weight coefficients given in the following section and added up to make the final provincial score. These percentages were then multiplied by 100 (see section 3.2) and rounded to a three-digit integer.

3.2 Weighting coefficients

The weighting mechanism used to determine the next most heavily weighted sub-discipline was introduced in the HCP Euro Health Consumer Index 2006. Explicit weight coefficients for the five sub-disciplines were introduced after careful consideration and discussion with the expert reference panel about which sub-disciplines should be considered for higher weight. In the Canadian Health Consumer Index, the outcomes sub-discipline is the category with the highest weight coefficient. It is based on discussions with providers and consumers as well as the philosophy that when evaluating the performance of healthcare systems, treatment results are the most vital indicator.

The next most-weighted sub-discipline is waiting times, since this reflects both an important dimension of access, particularly in Canada, and an area of primary concern for healthcare consumers. Indicators were selected to reflect different aspects of waiting times for medical care in Canada. Here, as for the whole of the Index, we welcome input on how to improve the Index methodology and expect that as healthcare issues and priorities shift, weighting will also evolve to reflect the most pressing issues facing healthcare consumers.

In the Canada Health Consumer Index, the scores for the five sub-disciplines were given the following weights:

Sub-discipline	Relative weight	All green contribution to max score of 1,000	Points for a green score in each sub-discipline
Patient Rights and Information	1.5	150	30
Primary Care	1.5	150	37.5
Waiting Times	2.5	250	35.71
Outcomes	3.0	300	60
Range of Services Provided	1.5	150	30
Total sum of weights	**10.0**	**1,000**	

Consequently, as the percentages of full scores were added and multiplied by 100, the maximum theoretical score attainable for a national healthcare system in the Index is 1,000, and the lowest possible score is 333.

3.3 Regional variation

The Frontier Centre is well aware that wide discrepancies exist in the accessibility and provision of healthcare services between urban and rural and, especially, northern areas within each province. While most provinces maintain policies for transporting patients to medical centres for care or providers to patients in rural areas, it is with respect to prevention and access to a family doctor in non-urgent situations that the biggest disparities exist for Canadians who live far from an urban centre. Despite this, the numbers and facts used to assess each province reflect the healthcare system in total regardless of the differences between regions or health authorities.

It is therefore likely that each province will have sub-units that perform both significantly better and worse than the score that represents the province as a whole. As measurement and analysis of healthcare systems become more common, more information will become available and more discriminating judgments about the spread of indicator values will be possible. Currently, regional differences within provinces cannot be taken into account. It is worth noting that there is a degree of overlap in most provinces between rural and northern populations and the Aboriginal population, which accesses healthcare via the Non-Insured Health Benefit program.

3.4 CUTS data sources

Whenever possible, research on data for individual indicators focused upon finding a Comprehensive Uniform Trustworthy Source (CUTS). If data on the underlying parameter of an indicator are available for all, or most of, the 10 provinces from one reasonably reliable source, there was a definitive preference to base the scores on the CUTS. Examples of CUTS for

interprovincial data include Statistics Canada databases and scientific papers based on a well-defined methodology that evaluates the situation in many of the provinces.

Apart from the sheer effectiveness of this approach, the basic reason for the concentration on CUTS is that data collection primarily based on information obtained from 10 separate provincial sources, even if those sources are health ministries, generally becomes contaminated with high noise levels. It is notoriously difficult to obtain precise answers from many sources, even when these sources are all answering the same question.

The best illustration of this is the indicator for prompt treatment of cancer. Oncology is one of the five specialties identified for intensive wait-times reduction in the 2004 First Ministers' *10-Year Plan to Strengthen Health Care.* Despite the surge in attention and funding directed toward reducing wait times for cancer treatment, reliable and compatible assessments of the situation in each province are very difficult to find. New Brunswick does not provide data for provincial wait times for cancer treatment. Other provinces track some aspects of this delay, but they all measure slightly different things, whether in terms of method of treatment (radiation, surgery and/or chemotherapy), type of cancer (by site) or in terms of comprehensive tracking of all hospitals vs. selective tracking of only some hospitals. Further, cancer wait times are measured differently, whether from the moment of the decision to treat, from the referral to an oncologist or by more arbitrary milestones. The official number reported as the wait time can be the mean waiting time, the median or the range between which most patients are treated.

The indicator for prompt treatment for cancer thus measures whether approximately half of suitable patients receive radiation therapy, the most commonly reported, within two weeks in the eight provinces that do publish data in this area. CUTS is not currently available for this indicator, a situation that should change in the coming years. The lack of transparency is itself a sign of poor accountability and low consumer friendliness in cancer treatment in Canada. In the discussion that follows, indicators for which CUTS is available are marked with an asterisk (*).

It should be emphasized that when a CUTS was identified, the resulting data were still checked as described in section 6, (Methodology) to ensure that the "official" score corresponds with other assessments of that province's healthcare and to identify where other sources have been able to supply more recent and/or higher precision data.

3.5 Indicator definitions and data sources for the Canada Health Consumer Index 2008

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main sources
Patient rights and information	Healthcare law based on Patients' Rights	Is there a healthcare law with meaningful guarantees?	Yes	Patients' Rights Law, but no remedies	No	Correspondence with provincial ministries and medical associations
	Registry of doctors' credentials	Is there a readily available registry of doctors' credentials?	Yes, with verification of specialty information	Yes, with limited information	No, or not accessible	Correspondence with medical associations and patient advocacy groups
	EPR for lab and drug information	Is the province developing Electronic Patient Records wrt Lab and Medication data?	Yes, both	Yes, for drugs or lab results	No, neither	Infoway Annual Report 2007-2008
	Layman-adapted formulary?	Is there a readily available formulary in layman's terms?	Yes, available and intended for consumers	Intended for professional use	No formulary easily available	Survey of provincial health ministries
	24/7 telephone info from RN	Is there a 24/7 phone and/or website providing medical advice from RN or equivalent?	Yes	Some information but not RN	No	Survey of provincial health ministries
Primary care	Percentage with a family doctor	What percentage report having a family doctor?	More than 90%	Between 85% and 89.9%	Less than 85%	Canadian Community Health Survey 2007
	Choice in obstetrical care	Can women choose their provider of obstetrical care?	Yes, midwifery is available	In theory, but not in practice	Midwifery is not available	Correspondence with provincial colleges of midwifery and health ministries
	Access to homecare	How many home care clients are there per 1000 population over 75?	More than 250	Between 150 and 250	Fewer than 150	Comparable Health Indicators 2006
	Long-term residential care for the elderly	How many residential care beds are there per 1000 senior citizens?	More than 60	Between 40 and 60	Fewer than 40	Report on Residential Care Facilities 2005-6
Waiting for care	Unable to access same-day care - minor prob.	What percentage are unable to get same day care for a minor problem?	Less than 10%	Between 10% and 15%	More than 15%	Statistics Canada CanSim Table 105-3029
	% seeing specialist within 1 month	What percentage see a specialist within one month of referral?	More than 50%	Between 45% and 50%	Fewer than 45%	Canadian Community Health Survey 2007
	Non-urgent surgeries <90 days	What percentage of non-urgent surgeries happen within 90 days of the decision to operate?	More than 90%	Between 80% and 90%	Fewer than 80%	Canadian Community Health Survey 2007
	Prompt cancer radiation therapy	How many patients are treated within two weeks of the decision to treat?	Approximately half	Approximately one quarter	Fewer than one quarter, or no reliable data	CIHI Wait Times Tables - A Comparison by Province 2007, provincial health ministries
	Diagnostics < 1 month	What percentage of non-urgent MRI, CT and angiographies are performed within one month of the decision?	More than 60%	Between 60% and 50%	Fewer than 50%	Statistics Canada CanSim Table 105-3004
	Delay for new drugs, all categories	How many days for a new drug to be included in the provincial formulary?	Fewer than 100	Between 100 and 200	More than 200	Brogan, Inc.
	Delay for new anticancer drugs	How many days for a new anticancer drug to be included in the provincial formulary?	Fewer than 100	Between 100 and 200	More than 200	Brogan, Inc.

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main sources
Outcomes	Heart infarct mortality	What is the 30 day AMI mortality rate?	Less than 9.5%	Between 9.6% and 11.9%	Above 12%	Statistics Canada. Catalogue 82-221-X. Most recent 2005.
	Infant deaths/1000 live births	How many infant deaths occur per 1000 live births?	4 and fewer	Between 4 and 6	More than 6	Statistics Canada, CANSIM, table 102-0504, most recent (2005)
	Cancer 5-year survival	What is the arithmetic mean 5-year RSR, age-standardized, for prostate, breast, colorectal and lung cancers?	More than 60%	Between 56% and 60%	Less than 56%	Canadian Cancer Registry
	Avoidable deaths – years of Life Lost	What is the value of potential years of life lost per 100 000 population?	Less than 5000	Between 5000 and 6000	More than 6000	Statistics Canada. Catalogue 82-221-X. Three year average, most recent 2001.
	MRSA and C. diff infections	What is the sum of MRSA and C. diff infections per 1000 admissions?	Less than 5	Between 5 and 10	More than 10	Gravel, Miller et al;Simor, Ofner-Agostini et al
Generosity	Cataract ops per 100 000	How many cataract operations are carried, age-adjusted, per 100,000 population?	More than 1000	Between 800 and 1000	Fewer than 800	Waiting for Health Care in Canada: What We Know and What We Don't Know
	HPV and newer childhood vaccines	Does the province provide HPV, and meet the CPS guidelines for childhood immunizations?	HPV = Yes AND CPS score = good or higher	HPV = No OR CPS score = fair or lower	HPV = No AND CPS score = fair or lower	SOGC and CPS guidelines, and correspondence with health ministries
	% of seniors immunized against influenza	What percentage of seniors are immunized against influenza within the last year?	60% or over	Between 50% and 60%	Fewer than 50%	National Population Health Survey
	households spending >1% income on Rx	What percentage of households spend more than 1% of income on pharmaceuticals?	Under 20%	Between 20% and 30%	More than 30%	Statistics Canada
	Percentage of new approved drugs funded	What percentage of new drugs considered safe by the federal government are included in the provincial formulary?	More than 75%	Between 50% and 75%	Less than 50%	Access Delayed, Access Denied

3.6 Additional data verification – Ministry of Health feedback

In June 2008, each provincial Ministry of Health was notified of and introduced to the Canada Health Consumer Index. Individual scoresheets detailing the provisional scores for each indicator were also provided to senior administration in each province. Some feedback was incorporated into the CHCI 2008 report, and it is our hope that in future years provincial governments will participate more fully in the data gathering and verification process.

3.7 Threshold value settings

Comparisons are only meaningful if sensible benchmarks are established. Threshold levels for each score were set after studying the parameter value spreads in order to avoid having indicators showing all green or all red. Reasonable conclusions and recommendations are more likely to result when thresholds are set in a way that identifies best and worst practices.

Setting threshold values for indicators where the data are numerical values is typically done by studying a bar graph of data values on an indicator sorted in ascending order. The usually S-shaped curve is studied for notches in the curve, which can distinguish clusters of states, and such notches are often taken as starting values for scores. A slight preference is given to threshold values with even numbers. An example of this is the Potential Years of Life Lost (PYLL) indicator, where the cut-offs for green and amber were set at 6,000 and 5,000 respectively, although a mathematical algorithm searching for notches in the S-curve might have found them at slightly different numbers.

The CHCI is a value-driven exercise that seeks to generate new attention to consumer friendliness, grassroots support for better health policy and to be a helpful tool for those who formulate or study public policy. FCPP and HCP consider the development of active monitoring, both quantitative and qualitative, of healthcare services to be of the highest importance. For this reason, the first indicator, enquiring about the existence of a Patients' Rights law that is backed by meaningful guarantees, is included even though all ten provinces received a red score.

Those indicators that are common to the CHCI and the Euro-Canada Health Consumer Index use the same thresholds whenever possible in order to make comparisons between the two as straightforward as possible.

4. Results

Sub-discipline	Indicator	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
Patient rights and information	Healthcare law based on Patients' Rights	○	○	○	○	○	○	○	○	○	○
	Registry of doctors' credentials	●	◑	○	●	●	●	◑	◑	◑	●
	EPR for lab and drug information	●	◑	◑	○	●	◑	◑	○	◑	◑
	Layman-adapted formulary?	○	◑	◑	◑	◑	◑	◑	◑	◑	◑
	24/7 telephone info from RN	●	●	●	●	●	◑	●	○	○	●
	Subdiscipline weighted score	110	100	90	100	120	100	100	70	80	110
Primary care	Percentage with a family doctor	◑	○	○	○	●	○	●	●	◑	◑
	Choice in obstetrical care	●	◑	◑	●	●	●	○	○	○	○
	Access to homecare	◑	●	◑	●	●	○	◑	○	○	○
	Long-term residential care for the elderly	○	◑	◑	◑	◑	○	●	◑	●	●
	Subdiscipline weighted score	100	100	88	113	138	75	113	88	88	88
Waiting time for treatment	Unable to access same-day care - minor prob.	◑	○	●	○	●	◑	◑	◑	○	○
	% seeing specialist within 1 month	○	◑	○	○	○	●	◑	◑	◑	○
	Non-urgent surgeries <90 days	◑	◑	○	◑	◑	◑	◑	○	●	●
	Prompt cancer radiation therapy	●	○	◑	●	○	●	○	●	●	●
	Diagnostics < 1 month	◑	●	○	◑	◑	◑	◑	◑	◑	○
	Delay for new drugs, all categories	◑	◑	●	○	◑	◑	◑	◑	◑	○
	Delay for new anticancer drugs	○	○	○	○	◑	◑	●	●	◑	●
	Subdiscipline weighted score	155	143	143	131	155	190	167	179	179	155
Outcomes	Heart infarct mortality	◑	●	◑	●	◑	○	◑	◑	○	○
	Infant deaths/1000 live births	◑	○	○	○	◑	◑	◑	●	●	○
	Cancer 5-year survival	●	◑	◑	◑	●	○	○	◑	◑	○
	Avoidable deaths – years of Life Lost	●	◑	◑	○	●	◑	◑	◑	◑	◑
	MRSA and C. diff infections	◑	●	◑	◑	○	○	●	●	●	●
	Subdiscipline weighted score	240	220	180	180	220	140	200	240	220	160
Range of services provided ("Generosity")	Cataract ops per 100 000	●	◑	●	◑	●	◑	●	●	○	○
	HPV and newer childhood vaccines	◑	◑	◑	◑	●	◑	◑	●	◑	●
	% of seniors immunized against influenza	◑	◑	◑	◑	●	○	○	●	◑	○
	households spending >1% income on Rx	◑	●	○	◑	●	◑	◑	◑	○	◑
	Percentage of new approved drugs funded	○	○	◑	○	○	●	◑	○	○	○
	Subdiscipline weighted score	100	100	100	90	130	100	100	120	70	80
	Total score	705	663	600	613	762	605	679	696	636	592
	Rank	2	5	9	7	1	8	4	3	6	10

As is illustrated by the Index matrix, the Canada Health Consumer Index 2008 consists of 26 indicators in five sub-areas that describe 10 provincial healthcare systems. The aim was to select indicators that are relevant to the description of a healthcare system seen from the consumer-patient point of view. The total scores are calculated (see section 3.2) by taking the percentage of maximum score for each sub-discipline, multiplying that by a weight coefficient and then normalizing it, so that a province having all green gets a total score of 1,000. Consequently, the 3, 2 and 1 scores do not add up.

4.1 Overall scores

Ontario emerges as the clear winner in the first Canada Health Consumer Index. A mediocre performance on waiting times is more than balanced out by a good showing for outcomes and first-place finishes for patient' rights, primary care and generosity. In fact, with more attention paid to waiting times, especially for specialist consultations and radiation therapy for cancer, and reduced incidences of nosocomial infection (a problem Ontario hospitals share with Quebec's), Ontario could lead in all five categories. While there is room for improvement in all sub-disciplines, it is encouraging that Canada's most populous province is setting a good example in many respects for the efficient provision of healthcare.

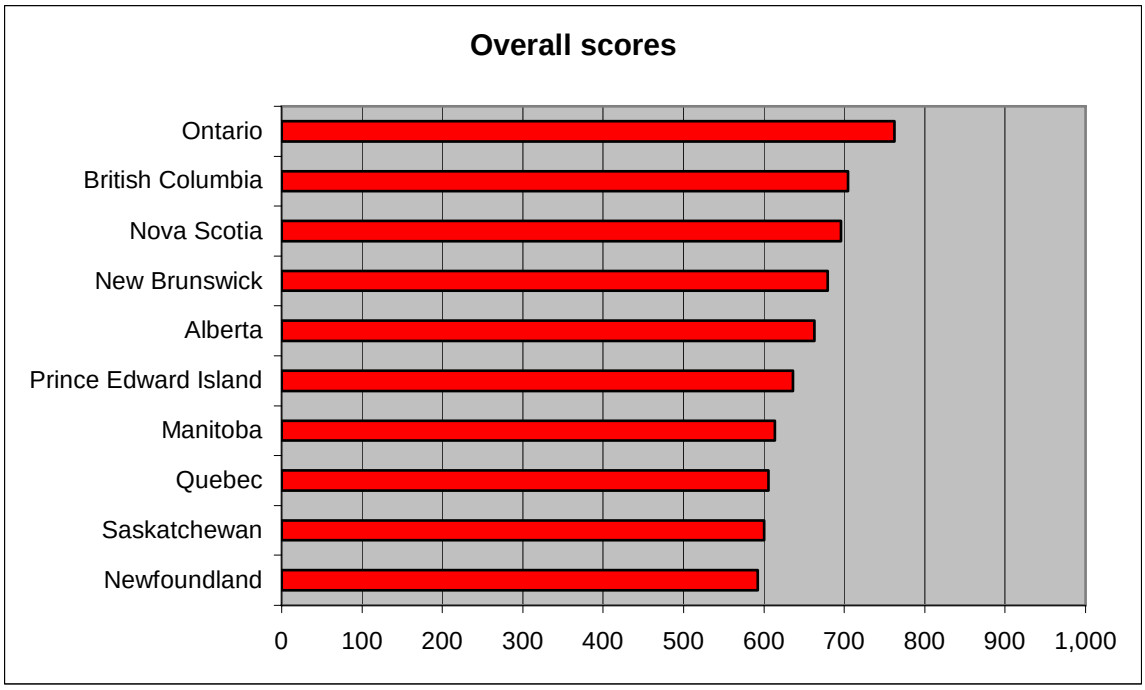
British Columbia and Nova Scotia are both noticeably behind Ontario, but they take second and third place in overall rankings. British Columbia's performance with regard to generosity, waiting times and primary care is average, but a strong culture of patient rights and a tie for first place with Nova Scotia for outcomes lift it to second place. Nova Scotia's scores are more erratic. Ranked last for patient rights and second last for primary care, Nova Scotia is second best for generosity and waiting times and shares first place for outcomes.

New Brunswick and Alberta round out the top half for overall performance. New Brunswick ties for second best in terms of providing primary care and otherwise is consistently in the middle of the pack. Alberta has an above average score for outcomes, but the second-worst score for waiting times; this is not unexpected in a province whose population has grown more quickly than its healthcare infrastructure and personnel levels have. The other three sub-disciplines show Alberta to be approximately average.

Prince Edward Island gains its sixth place finish on the strength of second-best scores for outcomes and waiting times. PEI ranks below average on primary care and second from the bottom for patient rights and finishes last for generosity. This score is the lowest by a significant margin. PEI is one of only two provinces that did not score a single green in the generosity sub-discipline, with three reds and only two indicators that rise to a middling score.

While no two provinces have identical scores for overall performance, it must be pointed out that just as Ontario stands a cut above the rest, so do the bottom four provinces function at a separate level from the rest of the country. They are spread across a range of only 21 points out of a possible

1,000. While there are differences in how Manitoba, Quebec, Saskatchewan and Newfoundland arrived at their positions at the bottom of the list, small differences in weighting would change this order, and more properly, these four provinces should be understood as contending closely for last place.



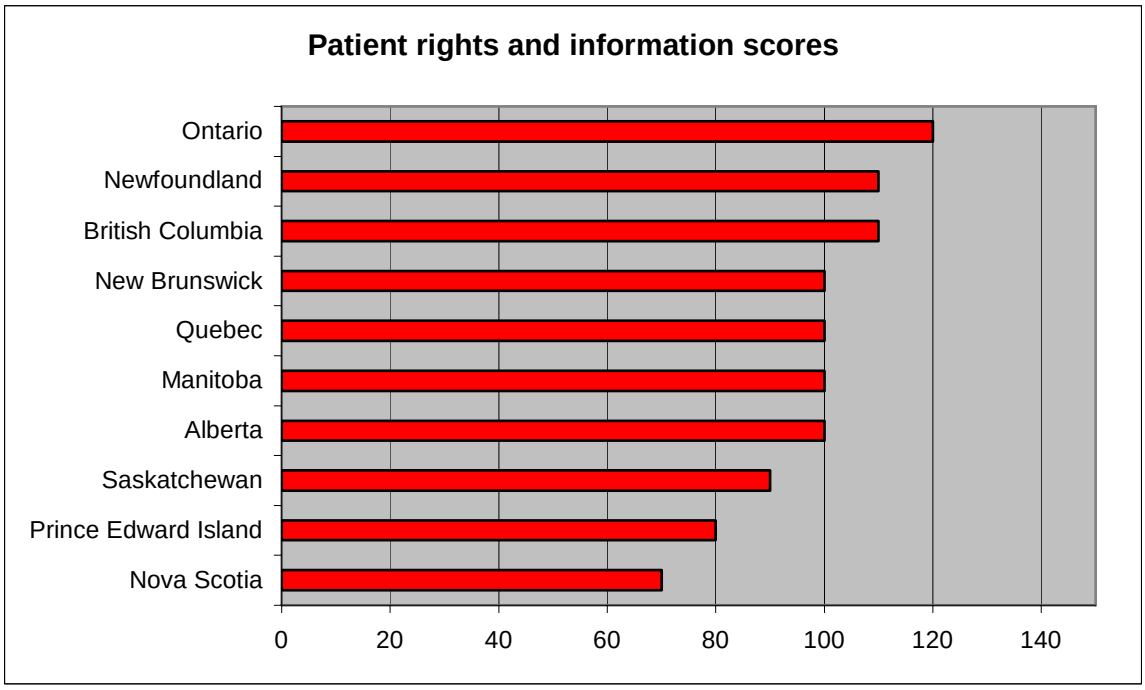
Manitoba tied for second place in the provision of primary care and average with respect to patient rights. Below average scores for outcomes and generosity bring down the final score as does the last place score for waiting times, a significant problem in Manitoba. Quebec's chief weaknesses are primary care and outcomes, for which it holds last place. More accurate and transparent reporting might lift Quebec's score for outcomes. For two of the five indicators, there is no information available, thus the red scores. On the other hand, Quebec has a middling score for patient rights, a better than average score for generosity, and it has the best score in the country for waiting times, indicating that on some counts, healthcare in Quebec is running reasonably well.

Saskatchewan places near the bottom for all categories except generosity, for which it is about average. Saskatchewan is especially stingy when it comes to pharmaceutical care in terms of "how quickly it includes new cancer drugs in its formulary and how many new drugs it does include. The province, along with PEI, has the highest proportion of households spending a significant amount of income on medicine. Newfoundland, in tenth place, needs to improve in most areas, but it has high and low scores distributed among the 26 indicators. For prompt treatment of cancer and the use of novel cancer-fighting drugs, for instance, it earns a high score, as it does for quick access to non-urgent surgeries. With regard to outcomes, the most important sub-discipline, Newfoundland needs to make significant progress if it is to provide adequate care for its residents. As part of the Maritime region, it shares in the excellent score for nosocomial infection, but for infant mortality, heart attack mortality and cancer survival, it receives low scores and is only average for PYLL.

4.2 Observations by sub-discipline

No province excels across the five sub-disciplines, and even Ontario, the clear winner, has holes in its performance. Ontario has the highest possible score in every indicator but one, outcomes, but no province obtains a perfect score in any sub-discipline, so there is much that policy makers in all provinces can learn from their counterparts elsewhere in Canada. Consumers should be aware of how much room there is for improvement in their home provinces.

4.2.1 Patients' rights and information

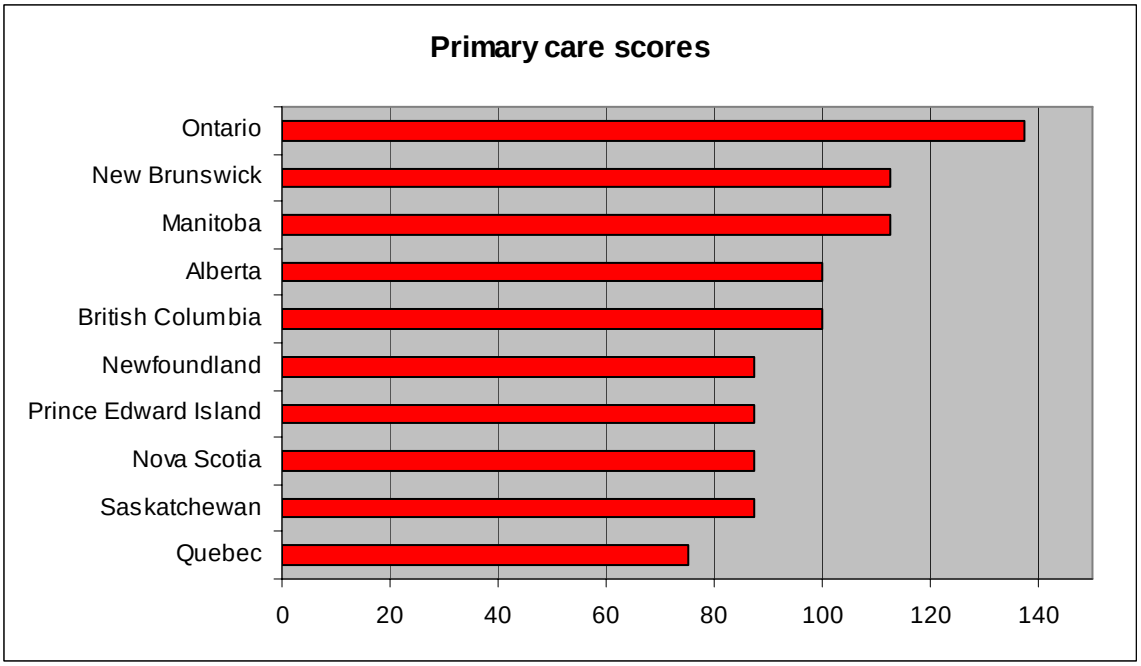


Ontario and British Columbia perform well here, but so does Newfoundland, which finishes last overall. Nova Scotia and PEI score poorly in the area of patient rights and information, which indicates the absence of a consumer-oriented culture in healthcare provision and administration. No Canadian province has a Patient Rights law with guarantees, or even without guarantees, but there is reason to believe this will soon change in some provinces. Most provinces provide health information by telephone (fewer provide information online), a relatively inexpensive tool that should be used wherever possible to help consumers make the best decisions possible about the kind of care they need and where to seek it.

While all provinces are represented at Infoway, a project to develop Electronic Patient Records (EPRs) nationwide, not all provinces are working to implement electronic record keeping and information sharing for lab results and pharmacy records. Another significant gap concerns accessible information about drugs and provincial formularies. While most provinces provide some public access to the list of drugs they will subsidize and the circumstances under which they will do so, none has this information available in a format that allows the average person – and potential consumer of a drug –to easily discover if his or her prescription is covered.

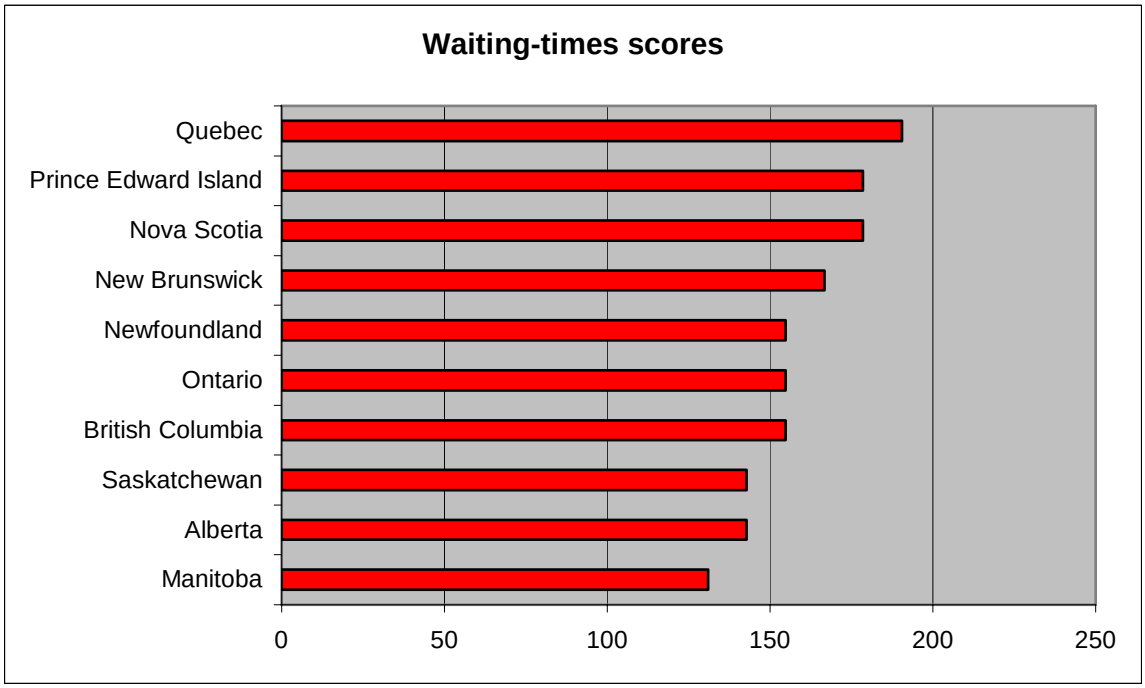
4.2.2 Primary care

Ontario has the best scores, with top marks for everything except the level of long-term residential-care beds per capita. Quebec, by contrast, has failing grades for every indicator except choice of obstetrical-care provider. Especially notable here is Quebec's score for the proportion of its population with a family doctor: While the national average is 84.8 per cent, for Quebec residents the number is only 73.5 per cent. The next lowest score is Alberta, with 81.6 per cent. While Alberta's score leaves much room for improvement, its relatively low number of people with a family doctor is at least partially due to its recent population boom – an excuse to which Quebec cannot lay claim. New Brunswick and Nova Scotia have healthcare systems that connect over 90 per cent of their residents with family doctors, a very solid score.



The Maritime provinces do not provide access to midwifery for their residents, a shortcoming that becomes harder to justify with each passing year, as the outcomes of countries and provinces that do include midwifery in the healthcare system continue to be positive. At the other end of the demographic spectrum, Nova Scotia, PEI, Newfoundland and Quebec lag badly in providing home care, a cost-effective and desirable way to allow the elderly and those with chronic conditions to remain at home and stay healthy for as long as possible.

4.2.3 Waiting times



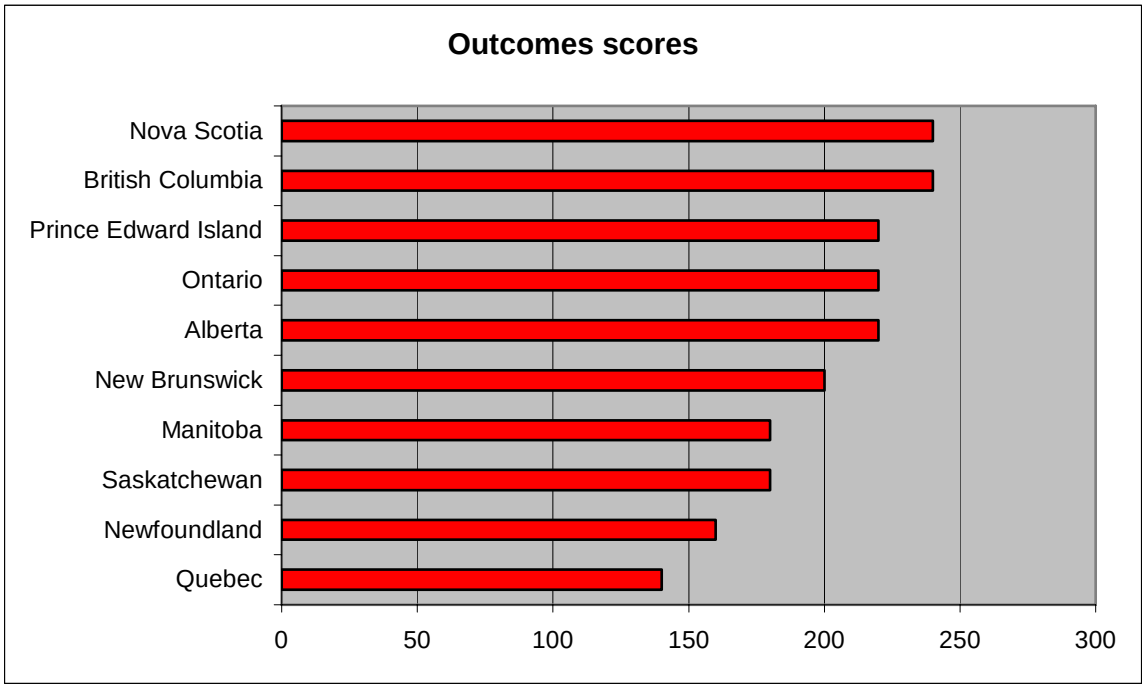
Waiting times are perhaps the most frequently discussed problem with Canadian healthcare. While there is a range of waiting times for all stages of healthcare between the initial complaint and receiving treatment, it must be kept in mind that even the best of Canadian provinces fares poorly when compared to well-functioning Western European states.

Referrals to specialists are problematic almost everywhere. Quebec is the only province to score a green for this indicator, and even there, barely more than half of patients are able to see a specialist within one month of the referral being made. Very few provinces reliably achieve access to same-day care for minor problems, and only New Brunswick, Nova Scotia and Newfoundland incorporate state-of-the-art cancer-fighting drugs into treatment without lengthy delays. Non-urgent surgeries are another problematic area, with only PEI and Newfoundland carrying out 90 per cent of surgeries within 90 days. While delays in non-urgent surgeries are not usually life threatening, patients awaiting treatment endure greatly reduced quality of life.

Radiation therapy for cancer is one of the better indicators, with many provinces beginning treatment within two weeks for about half of the patients who need it. Better data are needed, though, to allow more comprehensive analysis. For waits for diagnostic imaging and the speedy inclusion of new drugs into the formulary, only Alberta and Saskatchewan earned high scores.

Quebec wins in this category, owing largely to good scores for referrals to specialists and the prompt initiation of radiation therapy and solidly middling scores on the other indicators in this sub-discipline. The central place occupied by waiting times in the national discussion of healthcare is perhaps justified by the fact that even the best-performing province has only moderately good results. Compared with high performers outside of Canada, much work remains to be done to solve this problem in all provinces.

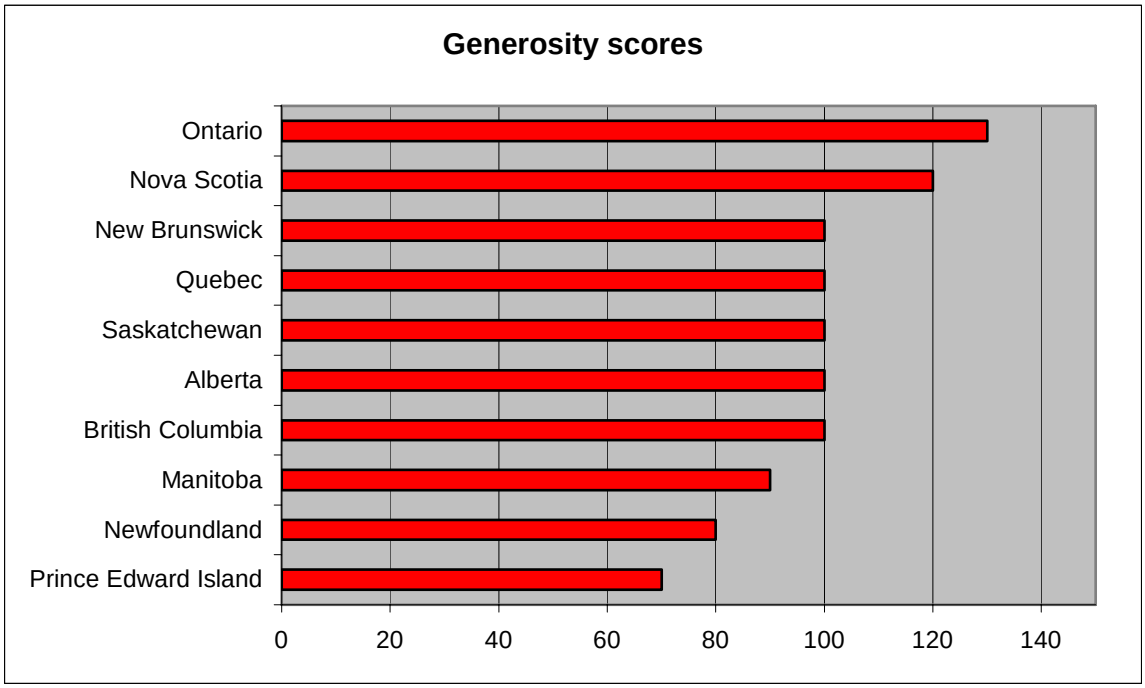
4.2.4 Outcomes



Outcomes are given the highest weight in the CHCI, because healthy consumers are the ultimate goal of any healthcare system. When looking at the scores for this sub-discipline, it becomes clear that, as in many other areas, a range of results is found across Canada. Nova Scotia and British Columbia lead the pack here. British Columbia has the highest value for PYLL and cancer five-year survival rates of all provinces, while Nova Scotia's strong performance in preventing infant mortality helps it tie for first place in outcomes. Ontario also has good results with the exception of its rates of Methicillin-resistant Staphylococcus aureus (MRSA) and C. difficile infection. If Ontario could reduce its nosocomial infection rate, it would take first place for this sub-discipline as well.

Manitoba and Saskatchewan have high rates of infant mortality. Saskatchewan's performance is otherwise average, while Manitoba has one of only two green scores for Acute Myocardial Infarction (AMI) mortality. It has the worst record in the country for PYLL, which indicates poor performance and general ineffectiveness of the healthcare system. Quebec's failure to track heart attack and cancer outcomes and its worst-in-the-country showing for puts infections put it at the very bottom. Standing out from all the indicators in this category is that infant mortality is a serious problem in Newfoundland and the Prairie Provinces, while high nosocomial infection rates are terrible in central Canada, average in the West and excellent in the Atlantic provinces.

4.2.5 Range of services provided (generosity)



Again, Ontario leads the way, with top marks for every indicator except the inclusion of drugs in the provincial formulary. This is a sore point for every province except Quebec, which includes almost 90 per cent of new drugs in its list of medicines it subsidizes, and Saskatchewan and New Brunswick, which provide coverage for just over half of the new drugs.

Cataract surgery, on the other hand, is provided quite generously across Canada. The use of newer childhood vaccinations is up to date. Those provinces that do not provide human papillomavirus (HPV) vaccinations have indicated they will do so in the near future, which demonstrates a sensible approach to investing in prevention today for the sake of better outcomes and lower costs tomorrow. The provision of flu vaccines for seniors is patchier, and most provinces could do much more to ensure this vulnerable population is protected as much as possible from the flu and the problems that can accompany it.

PEI, New Brunswick and Manitoba all fare badly in this sub-discipline. Manitoba gets an amber rating for everything except its red score for adoption of new drugs, which drags down its overall rating on generosity. PEI and New Brunswick also need to provide better access to minor elective surgeries such as sight restoration and to make it easier for their residents to access pharmaceuticals and vaccinations in order to bring their healthcare offerings more in line with those of other provinces.

4.3 Brief summary of results by province

Province	Major features, strengths and weaknesses
B.C.	British Columbia has a strong performance overall. Tied for first place for outcomes, B.C.'s healthcare clearly works well in many respects. Waiting times are the province's greatest weakness, and a generally stingy approach to the use of pharmaceuticals should be corrected to provide the best care possible in the most efficient way.
Alberta	Alberta is slightly above average for all sub-disciplines except waiting times, for which it is second from the bottom. Funding for pharmaceuticals is fairly efficient, since comparatively few Alberta households spend a significant amount of their income on pharmaceuticals. Diagnostic imaging waits are the shortest in Canada. Waits to see a doctor, on the other hand, are long, and comparatively few Albertans have a family doctor.
Saskatchewan	Saskatchewan is one of four provinces that ranks worst overall. Outcomes, primary care and waiting times are all problematic. The great strength of Saskatchewan healthcare is in its rapid inclusion of new drugs in the formulary; it has the shortest delays by far for approving new drugs and the second-highest value for the percentage of new drugs approved.
Manitoba	Manitoba is another overall poor performer. Primary care is Manitoba's major strength, for which it ties for second place, largely due to its commitment to providing both midwifery care and home care to its residents. The biggest weaknesses are lack of access to specialists and general practitioners as well as limited access to new drugs.
Ontario	Ontario is the best performer in this inaugural comparison of provincial healthcare. Nosocomial infection, wait times for specialists and delays in starting radiation therapy all need improvement. In primary care and generosity, Ontario leads the pack by a wide margin.
Quebec	Quebec falls into the bottom group of provinces, but it has some bright spots. Edging out Nova Scotia and PEI, Quebec boasts the best score for wait times, with excellent access to specialists and radiation therapy. It has adequate scores for all other waiting-time indicators. For primary care and outcomes, Quebec is in tenth place. Major improvements in access to family doctors and home and institutional care for the elderly and chronically ill are needed if Quebec is to provide an acceptable level of healthcare. Rampant infections in hospitals must be brought under control. More accountability and better reporting in general are also necessary.

New Brunswick	New Brunswick is comfortably above average overall as well as in the sub-disciplines of patient rights, outcomes and waiting times. Its strengths are in primary care, in which it lacks only midwifery services, and in overall generosity. Vaccinating seniors more effectively against the flu and lifting performance in outcomes from average to good would enhance the overall quality of healthcare in New Brunswick.
Nova Scotia	Nova Scotia places third overall, with its sub-discipline scores all over the map. Patient rights and information are the biggest weakness, as the province is at the very bottom in this category. For outcomes, Nova Scotia ties for first, and it is the second most generous province. Improved access to primary care and a more intelligent use of information technology, both for records and for providing residents with health information, are needed here.
PEI	Prince Edward Island is squarely in the middle of the pack for overall performance at fifth place, a position it achieves through a blend of strong and weak performances in the sub-disciplines. For waiting times, PEI ties for second place with Nova Scotia, providing its residents with very good access to surgery and radiation therapy. In outcomes, it ties with two other provinces for the second-highest score. The major weakness in PEI's healthcare system is its stinginess; it ranks dead last for generosity. PEI has the largest share of residents who spend a substantial amount of their income on pharmaceuticals.
Newfoundland	Newfoundland is at the bottom (by a small margin) in the overall comparison of provinces. A second-place showing in patient rights is promising, as it indicates a culture that is more oriented than the average toward the consumer. The real weak points for Newfoundland are in outcomes and generosity. More effective healthcare overall is needed to improve outcomes. A greater commitment to accessibility to drugs, both in terms of cost and delays for use, would make the best possible treatments more available.

5. Bang-for-the-Buck adjusted scores

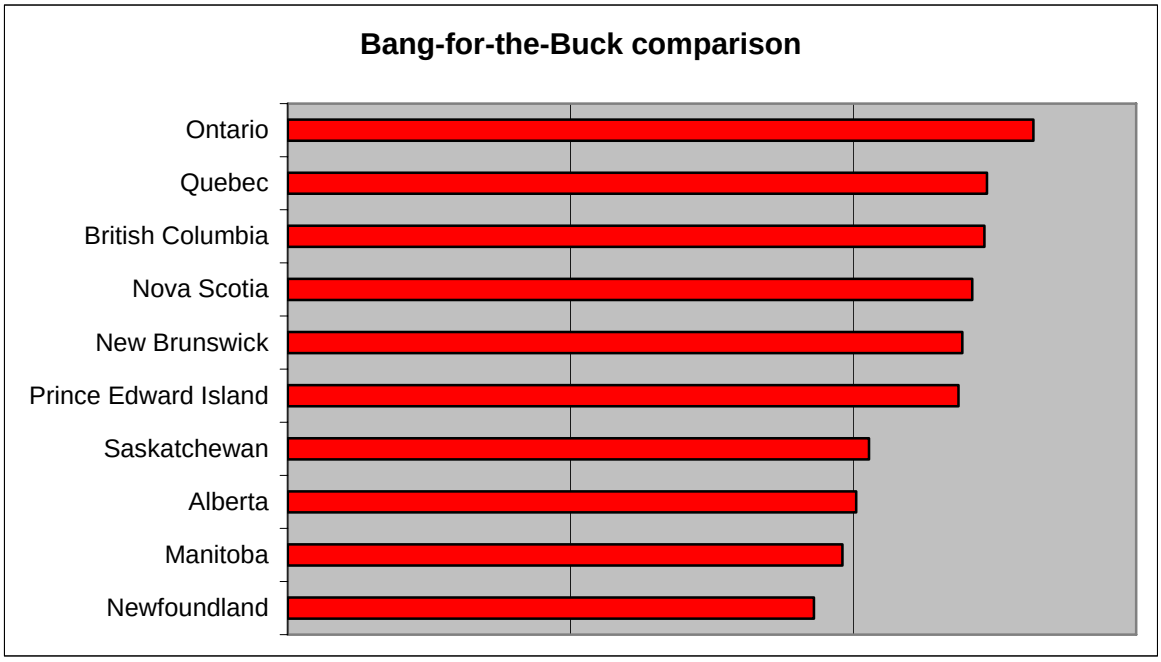
While the range of scores, both overall and within each sub-discipline, is large, there is also a lot of variation in the amount of money each province dedicates toward healthcare. Apart from the question, "Which province manages healthcare the best?" we should ask, "Which province delivers healthcare in the most cost-effective manner?" To this end, the Index includes an assessment of value for money or Bang for the Buck (BFB).

5.1 BFB adjustment methodology

To get a clearer picture of the relationship between healthcare spending and overall performance, each province's overall Index score (out of a possible 1,000) is divided by its per capita healthcare spending. Especially notable is the fact that while waiting times are often portrayed as an issue of scarcity, provincial spending levels should demonstrate that the issue is significantly more complex. The three provinces with the worst waiting time scores, Manitoba, Alberta and Saskatchewan, spend significantly more than the national average per capita – the highest (Alberta) and the third highest (Manitoba) of all ten provinces when total spending is divided by the population. On the other hand, the three provinces that do the best on waiting times, Quebec, PEI and Nova Scotia, spend less than the average, significantly less in the case of PEI and Quebec. While there are many more factors involved in the problem than funding, this should make it clear that a province's ability to provide timely consultations, diagnoses and treatment is not dependent upon its ability to spend huge amounts of money on healthcare. Serious work on cutting wait times must examine factors beyond the financial.

Province	Spending (per capita)
British Columbia	2,860.17
Alberta	3,297.74
Saskatchewan	2,920.92
Manitoba	3,128.18
Ontario	2,891.06
Quebec	2,448.86
New Brunswick	2,846.85
Nova Scotia	2,875.50
PEI	2,682.11
Newfoundland	3,183.65

5.2 BFB adjusted performance



5.3 Interpretation of BFB

The top three provinces, Ontario, B.C. and Nova Scotia, are also highly ranked in the BFB comparison. Ontario earns the top spot, indicating not only a strong healthcare program but also an efficient one. The provinces that score well on the BFB are getting good value for their healthcare dollars, so it is encouraging that the strongest performing provinces in terms of healthcare are also managing their resources well.

Quebec takes second place in the BFB metric, which reflects the fact that its poor overall performance is carried out on a comparatively modest budget. Whether or not Quebec residents consider this trade-off – lower spending for lower performance – to be a sensible one, at least they are paying considerably less per capita for their healthcare than are some other provinces. The middle-ranked provinces reflect moderate spending and moderately good healthcare.

Alberta is notable for its position on the BFB. Although it is in the top half of provinces for overall healthcare quality, from the consumer's perspective, its spending is easily the highest per capita at almost $3,300 per person per year. While Alberta's prosperity means that as a percentage of GDP, this spending is not inordinately high, it nonetheless translates into eighth place on the BFB adjusted rankings. Albertans enjoy mid-level healthcare, but they pay more for it than anybody else, and so fare poorly when value for money is considered.

Manitoba and Newfoundland fall to the very bottom of the list for BFB adjusted performance. Newfoundland spends the second most per capita on healthcare and ranks 10th in overall performance, perhaps the most glaring example of throwing good money after bad in Canadian healthcare. Manitoba spends only $55 per capita less than Newfoundland and also does poorly, which is reflected in Manitoba's ninth position in the overall BFB rankings.

6. Methodology

In April 2004, the HCP launched the Swedish Health Consumer Index, which ranked the 21 county councils, the rough equivalent of Canada's provinces, by 12 basic indicators concerning the design of systems policy, consumer choice, service level and access to information. This marked the introduction of benchmarking as an element in consumer empowerment in Sweden. The very strong media impact of the Index confirmed that the image of healthcare is moving rapidly from rationed public good to consumer-related services that are measurable by common quality perspectives. This shift in the perception of healthcare is long overdue in Canada, as was demonstrated by the inaugural Euro-Canada Health Consumer Index, released in early 2008, in which Canada placed 23rd out of 30 when compared to the EU member states, Norway and Switzerland.

For the Canada Health Consumer Index, the FCPP and the HCP aimed to follow the same approach as in earlier indexes, by selecting a number of indicators that describe to what extent the national healthcare systems are

user-friendly, thus providing a basis for comparing different provincial systems.

The Index does not take into account whether a healthcare system is publicly or privately funded and/or operated. The purpose is health consumer empowerment, not the promotion of political ideology. By aiming for dialogue and co-operation, the FCPP and HCP hope to be seen as partners in the development of Canadian healthcare and to provide helpful tools that can be used for this purpose.

6.1 Indicator selection

The aim has been to select a limited number of indicators within a relatively small number of evaluation areas that taken together present a picture of how the healthcare consumer is being served by the respective systems. A full discussion of the rationale for each indicator is in section 7.2, and the sources for each indicator are listed in Section 3.5. Where possible, CUTS is used and this is noted in the description of each indicator.

Also significant in the selection of indicators is the emphasis on metrics that are relevant to the healthcare consumer and can be changed relatively easily by provincial authorities and providers. Many analyses of healthcare dwell on resource inputs such as hospital beds or MRI machines per capita. Consumers are less concerned with inputs than they are with outputs – the care that they can access. If demand for a hospital bed can be reduced by providing outpatient care or by relying more upon home care, then a smaller number of beds per population would represent progress and not a shortcoming. Similarly, the prompt provision of MRI scans is far more relevant to the consumer than whether the province has many MRI machines.

Every effort was made to use indicators that are sensitive to policy and providers' actions. Making pharmaceuticals available by integrating them into the formulary as soon as possible and providing subsidies is within the scope of a provincial government, while lowering the cost of pharmaceuticals (as opposed to the portion of the cost borne by consumers) generally is not. Obesity and fitness, while certainly key to good cardiac health, can be influenced by government policy and the behaviour of doctors to a very limited extent, whereas prompt diagnosis and treatment of a heart attack are very much under the aegis of hospital protocols and routines.

6.2 Data collection and verification

Almost all the information used to compile the Index is publicly available. Government databases, information available for the asking from the federal and provincial health ministries and scholarly literature on healthcare and healthcare management provide a substantial share of the material necessary for scoring the provinces. This is supplemented by interviews and correspondence with providers, administrators and advocates. When conflicting information is available about a province's performance on an indicator, the most recent reliable source was used.

In June 2008, the health ministries in all provinces were introduced to the Index. In August 2008, score sheets were sent to each province, indicating

only that province's results. The ministries were invited to give feedback on the provisional scores as well as to make corrections if they thought they had more current or accurate information. New Brunswick and Saskatchewan responded, and in future years, we look forward to more communication with provincial authorities when researching each province's healthcare system.

7. Sub-disciplines and indicators

Each of the five sub-disciplines is organized around a theme, within which the 26 indicators are organized. Explanations of sub-disciplines and indicators are below.

7.1 Patient rights and information indicators

Excellent healthcare from the perspective of the consumer requires a certain attitude and philosophy. This approach to providing healthcare is independent of the funding mechanisms and levels of any given system. Traditionally, most healthcare has been oriented to best meet the needs of healthcare providers and practitioners. In Canada, where medicine is largely a function of the public sector, healthcare has been designed with the needs of administrators and institutions in mind, and this takes priority over the needs of doctors and nurses and most certainly over those of consumers. The indicators in this sub-discipline were chosen to show how well the healthcare system demonstrates consideration for the needs of the consumer.

7.1.1 Patients' rights laws

As the complexity of the medical system increases, it becomes ever more important that patients and healthcare consumers have their interests and rights protected. An essential step in this direction is a bill of rights for patients, preferably with guarantees that provide remedies for those whose rights are infringed upon by healthcare administration or providers. No province in Canada has legislation defending the rights of patients. In general, indicators were chosen that reflect disparities in healthcare between provinces. A legislated guarantee of patients' rights is of sufficient importance to justify its presence in this Index despite failing scores across the board.

7.1.2 Registry of doctors' credentials

The ability to verify the credentials of a doctor is one of the more basic aspects of consumer information in healthcare. Every province should have an easily accessible registry, ideally on the Internet, that confirms the qualifications of all doctors practising there. Facts about education and specialization should be verified by the relevant body and not simply accepted as reported by physicians.

7.1.3 Electronic patient records

Electronic patient records are among the most valuable tools for making healthcare safer and more efficient. The easier it is for care providers to access accurate information about a patient, the better the system can avoid such errors as reactions to known allergens, adverse drug interactions, misinterpretation of medical dosages or test results and the unnecessary duplication of tests. Canada lacks a standard system for EPRs, meaning that existing electronic records cannot be used by institutions or doctors using a different system. Far too many doctors and hospitals are entirely reliant on paper records, with all the inefficiencies and potential errors that accompany them. Many provinces are working to introduce electronic records, especially in the areas of medication and lab results. Provinces that are working to develop proper IT infrastructure in one or both of these areas are making progress in managing healthcare information better and more safely.

7.1.4 Layman-adapted formulary

The ability to access appropriate pharmaceutical care is an important part of overall access to the healthcare system, and it contributes to good outcomes. The ease with which a consumer can find out what drugs are covered and under what circumstances is an important indicator of how consumer-friendly his or her healthcare is. This information should be freely available to all consumers and presented in a manner that is helpful to the interested layman and not just healthcare professionals and administrators. A healthcare consumer is not likely to know the scientific name of a given drug or the medical definitions of the conditions it covers; a consumer-friendly formulary will use terms the average patient will know.

7.1.5 24/7 access to medical information

There is often no substitute for the judgment of a healthcare professional, but consumers faced with a health problem, especially after office hours, are not always prepared to evaluate how promptly they should seek care. A phone or Internet service that provides guidance as to whether one should go immediately to a hospital or wait until one's family doctor has an opening is a useful tool that can help reduce costs by avoiding unnecessary trips to the ER for minor problems. It can improve outcomes by helping patients decide when they need immediate care. Just as registered nurses make triage decisions in the ER, an RN or equivalent professional could staff an information line.

7.2 Primary care indicators

Primary care providers are usually the first point of contact with the healthcare system for consumers. Whether it is a family doctor, staff at a walk-in clinic or ER or an attending physician for an institution, primary care providers are essential to effective preventative medicine, health maintenance and good management of chronic conditions. Many Canadians, however, have trouble finding a family doctor, and women who require obstetrical care, seniors who cannot live on their own and people with chronic

or long-term illnesses that require community-based care often lack any meaningful choice, because they must wait for so long and then count themselves lucky to find a primary care provider at all. This sub-discipline measures how easy it is for residents to engage with the healthcare system at the primary care level.

7.2.1 Access to a family doctor (*)

Family doctors are integral to health maintenance and disease prevention and are key to identifying problems early when treatment is most likely to be successful and less complicated. The range between the provinces in the percentage of the population with a family doctor is striking. Quebec provides especially poor healthcare in this regard, with only 73.5 per cent of residents having a family doctor. The next lowest scoring province, Alberta, manages to provide a family doctor for 81.6 per cent of the population.

7.2.2 Choice in obstetrical care

In much of Europe, midwives care for significant numbers of pregnant women and newborns, and in the five countries with the lowest infant mortality rates, midwives provide 70 per cent of obstetrical care. Access to midwifery care in Canada is sharply limited; in many provinces, it is not included in the provincial healthcare offering, while in others, it is available in theory but seldom in practice.

7.2.3 Home care availability (*)

Most patients with a chronic or long-term medical condition prefer to be cared for in their own homes whenever possible. For appropriate candidates, home care is more cost-effective than institutionalization. Provinces with effective, responsible healthcare will provide home care for as many consumers as possible, the majority of whom will be elderly.

Note: Quebec and PEI do not report this information.

7.2.4 Long-term residential care (*)

For elderly healthcare consumers who need care that is too intensive to provide in the home, institutional care becomes necessary. When there are not sufficient beds available in long-term care homes that are designed and staffed with the needs of chronically ill seniors in mind, patients who should be in residential care are diverted to hospitals. Hospitals are more expensive than personal care homes and provide a lower quality of life than would a nursing home. Sufficient numbers of long-term care beds for seniors will become increasingly important given the coming demographic shift, as the Baby Boom generation ages.

7.3 Waiting for care indicators

Waiting times for appointments with family doctors, specialist consultations, diagnostic tests and, ultimately, treatment and follow-up care are chronic

problems throughout Canada. For the past decade, increasing levels of attention and funding have been directed toward solving this problem, thus far with very limited success. Few solutions that are sustainable or transferable to other provinces have been found. Waiting times have become politically charged, but from the perspective of the healthcare consumer, long waits are a source of distress, and they are bad medicine. Truly effective treatment requires more than excellent outcomes; it means excellent outcomes that are delivered as promptly as possible, so patients spend as little time as possible sick, in pain or with a reduced quality of life. This sub-discipline looks at waiting times from a number of different angles to see which provinces are performing the best at delivering timely care.

7.3.1 Same-day care for minor problems (*)

Canadians with a family doctor can frequently obtain same-day care for a minor problem. Those without a family doctor and those whose family doctor cannot accommodate them promptly often resort to walk-in clinics or emergency rooms. The number of residents who report trouble accessing same-day care for a minor medical problem is a useful indicator of how well a healthcare system performs in non-urgent situations.

7.3.2 Access to specialists within one month of referral (*)

Canadians often contend with significant waits for diagnosis and treatment for major problems. For a non-urgent problem that requires specialized care, the first hurdle after seeing a primary care physician (either a family doctor or ER doctor) is a referral to the appropriate specialist. The percentage of patients who see a specialist within one month of referral by their primary care physician tells us which provinces are expediting the appropriate care for this portion of the total wait. It is notable that the percentage of all Canadians who see a specialist within one month of referral is 46, which indicates a tremendous inefficiency in the healthcare system.

7.3.3 Waiting times for non-urgent surgery (*)

Another significant waiting interval is the time that passes between the specialist's decision to treat and diagnostics and surgery. While this is not the only phase for which waiting times are problematic, the time between deciding to operate and operating is often the longest single portion of the total wait from the first sign of a problem until treatment is complete.

7.3.4 Prompt radiation therapy

Very little information is available about the waiting periods for patients who require radiation therapy for cancer. Quebec and New Brunswick do not provide information, while the other provinces all use slightly different metrics for defining and measuring the relevant wait times. Indicator scores are based on estimates from the data available, and they assess the approximate percentage of patients who begin treatment within two weeks of the decision to use radiation therapy. Definitively non-CUTS data!

7.3.5 Waiting times for diagnostic testing (*)

Advanced diagnostics such as MRI and CT scans and angiographies are sometimes ordered by primary care providers, but usually by a specialist. They are generally a critical part of the decision about treatment, meaning that the appropriate therapy cannot be chosen – and the waiting period for surgery or other treatment does not start – until the proper diagnostics are carried out. Many medical conditions that require such diagnostics are time sensitive, meaning that long delays, including the wait for diagnosis, have negative consequences in terms of outcomes.

7.3.6 Delay for new drugs, all categories (*)

When a new drug is released, the federal Ministry of Health determines whether it is safe for use in Canada. After this hurdle, each province must decide whether to add the drug to its formulary. The length of time it takes for a drug to be added to a provincial benefit list varies widely by province. While a given drug is in limbo, patients who would benefit from it are unable to receive the best treatment possible.

7.3.7 Delay for new anti-cancer drugs (*)

While all delays in the accessibility of new drugs harm patients, it is in the treatment of cancer that lengthy delays are felt most keenly, as prompt treatment is closely linked to long-term outcome. The length of time each province takes to adopt the newest effective cancer-fighting drugs is therefore worth examining separately.

7.4 Outcomes indicators

A good outcome is perhaps the highest priority for healthcare consumers and providers alike. Indicators in this sub-discipline measure how effectively the system provides preventative care (PYLL and infant mortality scores), manages serious disease (AMI mortality and cancer survival) and follows best practices within hospitals (prevalence of MRSA and C. difficile).

7.4.1 AMI 30-day mortality rate (*)

The 30-day mortality rate for patients who had a heart attack measures how well the healthcare system responds to emergency. Getting the victim to the hospital, identifying the problem and initiating treatment must all happen as quickly as possible to optimize the odds of survival. While longer-term mortality rates owe more to issues within the individual's control, such as the correct use of medication and appropriate lifestyle modifications, the 30-day figure is an excellent indicator of overall emergency response. While Canada's average rate is very good compared with other countries, some provinces outperform others.

Note: Quebec does not report 30-day mortality rates for AMI patients.

7.4.2 Infant mortality per 1,000 live births (*)

Infant mortality measures quality of care not only during labour and delivery but also during pregnancy. Effective prenatal care can prevent many problems and detect others early enough for treatment to be most effective.

7.4.3 Cancer five-year survival rate (*)

The chances of surviving for five years after treatment for cancer depend on many things including the type of cancer. Prompt and effective treatment makes a significant difference in survival rates. This indicator measures the mean five-year relative survival rates (RSR) of four types of cancer (breast, prostate, colorectal and lung). RSR compares the survival rates of cancer patients with the survival rates of a control group without cancer.

Note: Quebec does not measure the five-year survival rate of its cancer patients. PEI's population is too small for five-year rates to be statistically significant, and so it is given an intermediate score.

7.4.4 PYLL per 100,000 people (*)

Evaluating the potential years of life lost by comparing statistics against the nominal life expectancy measures how well the healthcare system performs overall. Canada performs poorly overall compared with European states. B.C. and Ontario have the best scores for this indicator, and yet they would still receive a failing grade if held to the same standard used in the Euro-Canada Index. The values used here are the three-year rolling averages of each province's rates.

7.4.5 Incidence of MRSA and C. difficile

Nosocomial infection is increasingly costly and harmful worldwide. For some time, Canada has had lower rates of infection, but this is changing. MRSA prevalence reflects both hygiene protocols in care settings and appropriate use of antibiotics. C. difficile is most often transferred between patients or from healthcare workers to patients when hand hygiene is not carried out effectively or when facilities are overcrowded.

Note: The Maritime provinces are evaluated as one region in the literature on MRSA and C. difficile prevalence and thus have identical scores.

7.5 Range of services provided (generosity) indicators

Given the prominence of healthcare policy in politics, it is remarkable that there is such variation between provinces regarding what is provided. Provincial policies about what drugs and vaccinations to provide and how liberally elective surgeries are offered are not based on solid evidence about best practices, and differ widely.

7.5.1 Cataract removal operations per 100,000 people (*)

Cataract removals are a comparatively affordable outpatient surgical procedure. While cataracts can significantly impair quality of life, they are not life threatening. They are, accordingly, a useful indicator of how generously a healthcare system provides highly desirable, elective procedures to its residents.

7.5.2 HPV and newer childhood vaccinations (*)

The Society of Obstetricians and Gynecologists of Canada has recommended vaccination against HPV, which can protect against future risks of cervical cancer, for all young women. The Canadian Pediatric Society issues recommendations about which of the newer childhood vaccinations should be made universally available. The degree to which provincial healthcare systems make this state-of-the-art preventative care accessible is an important measure of both the generosity of the system and its adoption of recent best practices.

7.5.3 Seniors immunized against influenza (*)

In vulnerable populations, usually defined as the elderly, newborns and those with chronic conditions that lower resistance to illness, influenza can lead to serious health problems, and it is sometimes fatal. Routine flu shots for seniors is a simple and very cost-effective way of preventing complications, suffering and the extra burden on the healthcare system that result.

7.5.4 Household spending on pharmaceuticals (*)

Effective prevention and treatment of disease rely increasingly upon the proper use of pharmaceuticals. One important dimension of access to drugs is affordability. Different provinces use different strategies to subsidize pharmaceutical costs, and many Canadians have drug benefit programs with their employers. The proportion of households that must divert a significant amount of income to purchasing medication is a good measure of how accessible optimal care is in each province.

Note: Quebec does not report this data.

7.5.5 Inclusion of new drugs in provincial formularies

Another dimension of access to pharmaceuticals involves their inclusion in provincial formularies. Two hurdles must be jumped for a drug to be accessible to residents of any given province: The federal government must consider the drug safe for use, and provincial drug plans must include it in the list of drugs funded. The proportion of drugs approved for use that is included in formularies reflects how well a province includes the most recent therapies available.

Note: scores reflect a three-year rolling average.

8. Looking forward: trends and recommendations

8.1 Future indicators

While the overall emphasis of subsequent Canada Health Consumer Indexes will remain on consumer- and user-friendliness, indicators will evolve to reflect the changing reality of healthcare in each province as well as movement in comparable systems abroad. The HPV indicator, for instance, will likely be replaced in future years by a question that better captures the differences between the provincial healthcare systems, since all provinces not currently providing the immunization have stated that they plan to do so. This is the best possible reason for removing an indicator from the Index: All provinces have adapted to provide excellent care in that regard.

The threshold for gaining a green score for the provision of midwifery is very low this year. Any province that provides midwifery care to an appreciable number of its residents scores a green. In future Indexes, the cut-offs will rise in order to come closer to the standards in other countries. A minimum of 10 per cent of births attended by midwives is a reasonable figure for the near future for attaining a green score. In many European countries with excellent infant and maternal mortality outcomes, midwives rather than obstetricians attend as many as 70 per cent of births.

Many aspects of excellent healthcare are not addressed in this CHCI out of a desire to keep the Index to a readable length and of reasonable complexity. Other indicators that might be included in the future are the effectiveness of public health programming in the primary care sub-discipline, access to psychiatrists and psychologists, number of suicides, hospitalization rates for mental illness and the effectiveness of preventive medicine for conditions such as asthma, diabetes and heart disease.

8.2 Policy recommendations

A number of conclusions can be drawn about which provinces have the most effective and evidence-based policies. Best practices in one province ought to be adopted by the others, since the best performers are demonstrating made-in-Canada solutions that can be applied elsewhere.

8.2.1 A coherent and standardized drug review process

One of the most baffling inefficiencies and disparities in Canadian healthcare is the adoption of a different formulary by each province, with separate processes for approving the use of new drugs and including them in subsidies. There is no good reason for this. Whether a drug is safe enough to use or cost effective enough to subsidize does not differ from province to province, and the only thing accomplished by making these decisions separately, apart from inequality between provinces, is a cumbersome and expensive bureaucracy that increases both treatment delays and administrative costs. Effective use of pharmaceuticals demonstrably lowers

overall healthcare costs and improves both outcomes and quality of life. Diverting human and fiscal resources toward duplicating the approval and funding process in each province is an inexcusable waste.

Further compounding the inefficiency is that Aboriginals whose healthcare is funded by the Non-Insured Health Benefit program rather than by the provinces have access to an entirely different formulary that includes more drugs, sooner, than most of the provincial ministries. Further examples include Quebec, which adopts new medicines in much higher numbers, and in Alberta and Ontario, which have found ways to ensure that effective pharmaceutical therapy is not beyond the means of their residents. Above all, policy decisions about the approval and funding of new drugs should be logical and equitable for Canadians living anywhere in the country as well as transparent, so that consumers can more easily see what they are getting for their healthcare dollar.

8.2.2 Make healthcare truly portable

It is clear that some provinces are much better than others are at providing consultations, diagnostics and therapeutic procedures in a timely fashion. In the 21st century, a resident of a slow-moving province should not be forced to stay at home and wait when there are open treatment slots elsewhere in the country. Each province should pay for the effective and timely treatment of its residents wherever in Canada those residents seek treatment. The experience of EU states with such policies indicates that not many people would use such an option, so the total financial cost would not be crippling. The opportunity to access care elsewhere in the country, though, would empower many Canadians and provide a real incentive for improvement to health ministries and health authorities who currently save money by making treatment as inaccessible as possible. This change, combined with performance-based funding, would reward provinces that shape up while penalizing those that continue to put their healthcare consumers last.

8.2.3 Invest in infrastructure and prevention

There is no question that having a family doctor allows for the most effective preventive care and early detection of disease as well as reducing the risk of drug interactions and the duplication of tests. Family doctors also ease the way somewhat for patients who need consultations, diagnostic procedures and surgery. Access to a family doctor has two major dimensions. The first is the shortage of GPs who take new patients. Most provinces are taking steps to correct this, although allowing demand to dictate the number of spaces at universities rather than behaving as if healthcare were a command economy would probably go further toward alleviating the problem than will bureaucratic fiat. The second issue is the number of Canadians with a family doctor who cannot quickly receive care for minor problems. In such cases, consumers often do not seek care until a minor problem becomes major, greatly increasing both their suffering and the eventual cost of medical care, or they frequent emergency rooms, thus clogging up care for real emergencies and costing themselves more time and the system more money than a GP consultation would.

A partial solution to this problem is to ensure that more family doctors provide meaningful on-call availability to their patients and to make sure they are available on short notice for non-urgent problems. Far too many family doctors rely on the ER as their on-call provider. Introducing an element of compensation that is contingent upon providing after-hours coverage and a visit within 24 or, at worst, 48 hours for their own patients during the work week would help divert non-urgent cases from ERs and back to their doctors, who can provide them with appropriate, cost-effective care.

Another area where we need more investment now to improve outcomes and reduce costs in the future is IT and EPRs. At minimum, pharmacy and lab records should be electronically available to any healthcare provider a patient sees. Specialists and ER doctors have to rely on paper records and the patient's memory – and in an emergency, even those might not be available to physicians – for information about drug allergies, possible interactions with drugs being used and test results that could establish or rule out a possible diagnosis. Ultimately, the goal is a universal EPR that would contain a complete, secure medical history that can be used by any doctor, clinic or hospital that the patient authorizes.

8.2.4 Adopt a consumer-oriented culture

Healthcare in Canada still operates on the model of a rationed public good rather than a service industry governed by the same rules that operate in all other service sectors. As a result, Canadians are encouraged to see themselves as patients who must wait to see a doctor, wait to be told what to do by a doctor and then wait until they can receive the treatment the doctor chose for them. Half a century ago, this was perhaps sufficient, but today, it is simply inadequate. Lifestyle choices are inextricably intertwined with medical outcomes, and Canadians are accustomed in other areas of their lives to making judgments about their best interests and how to realize them.

Currently, a typical Canadian with a problem will wait to see a family doctor and then wait again for various lengths of time at every stage of the diagnostic and therapeutic process. Worse, the consumer will not know if the waiting time is typical or much worse than average, and even if the consumer learns that most other jurisdictions get the job done faster, he or she will have no recourse to faster treatment. An attitude of consumer empowerment and individual choice has to be adopted at every stage, so that consumers know not only what their options are but also how those options compare to those available in other provinces. Transparent data, portability of healthcare and an emphasis on patient rights and informed decision-making are all necessary to make this transition.

8.2.5 Boost midwifery programming

Canada must emulate Europe and most of the rest of the world and rely increasingly upon midwives to provide prenatal and obstetrical care. The research is unambiguous: Midwifery provides outcomes as good as, or better than, the obstetrical model of care; it leads to higher rates of maternal satisfaction, which is linked to better outcomes, and it is cost effective. Quebec and Ontario are doing quite well at making midwifery available,

although demand outstrips supply nearly everywhere. Manitoba and British Columbia have regions in which midwifery is widely available, while in Alberta and Saskatchewan, it is much more limited, and in the Atlantic provinces, it is not part of the provincial healthcare.

Moving to a model in which midwives manage a large share of low-risk pregnancies will take time and resources and will require the establishment of more midwifery training programs. In the meantime, efforts to recruit midwives from elsewhere should continue, as should the accreditation of midwives who were trained elsewhere. Most obstetrical wards have nurses who are fully qualified midwives who were educated in Europe or Asia.

8.2.6 Learn from the best

Ontario and British Columbia are two of Canada's most populous provinces. They are also highly urbanized. Whatever advantages that come with large population bases and easier access to care cannot be transferred easily to smaller or more rural provinces. Nonetheless, it is worth asking what lessons can be learned and what practices can be transferred to other provinces to allow them to obtain excellent results in a cost-effective way. Both provinces are divided into smaller regions for the delivery of healthcare. Is decentralized decision-making a key to their success? What decisions are best left to a central, arms'-length authority, and which choices are best made at the local level to best take into account regional differences?

What cultural differences enable Quebec to maintain short waiting lists and to use new drugs more effectively on a relatively small budget? Quebec shares this ability to use pharmaceuticals effectively with much of Western Europe, particularly France. Could this be mere coincidence? Following Quebec's lead in these respects could enhance healthcare elsewhere in the country. Ministers' Round Tables on healthcare typically emphasize obtaining larger budgets from the federal government rather than reforming practices within the limits of existing resources. This should change, as it becomes clear that different provinces' approaches to common problems have paid off to different degrees. Finally, when the federal government does choose to give more funding to provinces for improving their healthcare systems, tying that funding to specific, proven reforms will likely yield higher returns than would simply increasing health spending with no conditions attached.

8.2.7 Move to pay for performance-based funding

Most Canadian hospitals are funded through a global budget, and revenue is unrelated to the number of patients treated or the quality of the hospitals' outputs. In fact, under this model, every additional patient treated represents an expense to the hospital administration. The remarkable thing about this situation is not that it leads to waiting lists, inefficiencies and rationing but that it functions at all, and it has not been declared obsolete, as has happened in so many other jurisdictions. Closely linking revenue to the amount and quality of the work done will harmonize the incentives for managers with the needs of Canadian healthcare consumers. When hospitals are encouraged to provide excellent care to as many patients as possible

instead of doling out care at the pace administrators consider best, outcomes will improve, waits will decrease and eventually disappear, costs will fall and everybody wins.

9. Further reading

A significant amount of complementary information is publicly available online for those who wish to explore some of the CHCI's sources in more detail.

Provincial and federal health ministries

Canada	www.hc-sc.gc.ca
B.C.	www.health.gov.bc.ca
Alberta	www.health.alberta.ca
Saskatchewan	www.health.gov.sk.ca
Manitoba	www.gov.mb.ca/health
Ontario	www.health.gov.on.ca
Quebec	www.msss.gouv.qc.ca
New Brunswick	www.gnb.ca/0051/index-e.asp
Nova Scotia	www.gov.ns.ca/health
PEI	www.gov.pe.ca/hss
Newfoundland	www.gov.nl.ca/health

Provincial medical and midwifery associations

B.C.	www.bcma.org www.cmbc.bc.ca
Alberta	www.albertadoctors.org www.alberta-midwives.com
Saskatchewan	www.sma.sk.ca www.saskmidwives.ca
Manitoba	www.mma.mb.ca www.midwives.mb.ca
Ontario	www.oma.org www.cmo.on.ca
Quebec	www.amq.ca www.osfq.org
New Brunswick	www.nbms.nb.ca
Nova Scotia	www.doctorsns.com
PEI	www.mspei.pe.ca

Newfoundland	www.nlma.nl.ca www.ucs.mun.ca/~pherbert

Other sources of information on healthcare in Canada

Canadian Cancer Society	www.cancer.ca
Heart and Stroke Foundation	www.heartandstroke.com
Canadian Diabetes Association	www.diabetes.ca
Arthritis Society of Canada	www.arthritis.ca
Canadian Mental Health Association	www.cmha.ca
Canadian Institute for Health Information	www.cihi.ca
Wait Time Alliance	www.waittimealliance.ca
Public Health Agency of Canada	www.phac-aspc.gc.ca
Statistics Canada	www.statcan.ca

10. FAQ

What is the Canada Health Consumer Index?

The Canada Health Consumer Index measures the performance of Canada's provinces on different aspects of healthcare delivery. The information is presented as a series of easily understood rankings that are designed to empower consumers in obtaining optimal care. The Frontier Centre for Public Policy and the Health Consumer Powerhouse, which produces the Euro-Canada Health Consumer Index, are responsible for this Index. The HCP and FCPP believe that increasing transparency in healthcare systems can only benefit consumers and that revealing differing levels of performance can help to improve healthcare delivery overall.

Who will use the CHCI?

The main audiences for the CHCI are those involved in healthcare policy formation: civil servants, clinicians and journalists. The ultimate goal is to reach the consumer directly via, for example, media coverage of the Index findings.

Will consumers be able to easily understand this information?

Yes. Healthcare consumers have a clear interest in increasing their knowledge, so they can make the best possible decisions. For professional services, which can be complex to explain, there is always the danger of oversimplification. The HCP and FCPP have experience communicating complex health information in a concise way, clearly illustrating the good and the bad. We work hard to ensure our information is as accessible and consumer-friendly as possible while making sure we do not dumb down the information.

What impact will the CHCI have?

FCPP and HCP expect provincial governments to look into the findings, draw conclusions and take appropriate action to remedy the problems in their healthcare systems, as European countries have done with other indexes. Journalists and policy analysts will be able to use the CHCI as a tool to focus more closely upon the specific strengths and weaknesses of each province, and ultimately consumers will be empowered to seek the best care possible for themselves and their families, armed with the knowledge of what can be done to improve the situation.

Are the changes recommended by the CHCI affordable?

Many of the recommendations would not necessitate changes in funding. Requiring family doctors to provide better coverage for their patients is one example, as is changing the mechanism by which hospitals are funded. Other recommendations such as enhancing accessibility of preventative care and creating electronic records will involve an investment upfront in exchange for reduced spending in the future.

Is it possible to measure and compare healthcare this way?

Absolutely: One can measure and compare it in many ways. The advantages of our approach are as follows:

- it focuses on those measures that affect the ability of the consumer to best use the available healthcare services;
- it focuses on those aspects of healthcare delivery that the medical profession, administrators, regional and national politicians can actually do something about if they choose to; and
- it highlights the differences between provinces, helping consumers understand where they can and should reasonably expect more from their providers.

Are these data not already available?

Our information is complementary to publicly available data such as that provided by Statistics Canada. They have statistical information on overall public health that we use, but the CHCI also needs qualitative data in order to focus on providing consumer information. Other institutions do not deliver the comparative analyses we provide.

Is this really research?

It is compiled consumer information. It is not clinical research, and it is not to be looked upon as scholarly research but as a resource for healthcare policy makers, those who work in the field whether as providers or administrators and, of course, consumers.

How reliable are the Health Index data?

We bring data together from public sources and our own investigations and research. This is consumer information, and our philosophy is that providing data – even where seemingly inconsistent – is better than saying nothing at all. The data are as reliable as we can possibly make them and are always based upon the latest available. Healthcare data can be inconsistent, difficult to access and frequently outdated.

Ministries of Health or state agencies are given the opportunity to correct, update and validate the results. We also commissioned a survey for patients.

Highlighting this data-quality issue is one benefit of the Index exercise; it is a challenge to governments and institutions and not an Index weakness.

How were the indicators and weighting selected, and why?

A limited number of indicators were chosen within closely defined evaluation areas. Taken together, they present a telling tale of how well – or badly – consumers are being served by their healthcare systems. Indicators were selected and weighted with a view to creating concise and useful appraisals of the consumer-friendliness of Canada's healthcare systems, bearing in mind the priorities of those who rely upon the healthcare system, for example, in the emphasis upon outcomes.

Why is Ontario the winner?

A combination of top scores for a patient rights orientation, the provision of primary and the most generous healthcare offering in the country differentiate Ontario from the rest of the country. Outcomes in Ontario are better than average, and even when Ontario's middling performance with respect to wait times is taken into account, the province is still clearly the most consumer-friendly system in Canada. Further, Ontario does this in a cost-effective way, achieving better results than provinces that spend significantly more.

Who is behind the Health Index?

The Index was initiated and produced by the Health Consumer Powerhouse in conjunction with the Frontier Centre for Public Policy. The HCP is a private healthcare analyst and information provider that is registered in Sweden. The FCPP is an independent think-tank with headquarters in Winnipeg.

About the Authors

Health Consumer Powerhouse (HCP) is the leading European analyst and provider of consumer information on healthcare. To empower individuals and groups to take action, we analyse different aspects of the healthcare systems and design the outcomes as the consumer information. Transparency supports policy makers as well to reform. The HCP Indexes set the standard for a new way to look on healthcare. We work from Stockholm, Brussels and now also Canada. www.healthpowerhouse.com

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The Frontier Centre for Public Policy is an independent, non-profit organization that under-takes research and education in support of economic growth and social outcomes that will enhance the quality of life in our communities. Through a variety of publications and public forums, the Centre explores policy innovations required to make the prairies region a winner in the open economy. It also provides new insights into solving important issues facing our cities, towns and provinces. These include improving the performance of public expenditures in important areas like the local government, education, health and social policy. www.fcpp.org

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