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Canada Health Consumer Index 2009

By Ben Eisen,
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Health Consumer Powerhouse

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By Ben Eisen and Dr. Arne Björnberg

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Foreword

It is a pleasure to present the second annual Canada Health Consumer Index (CHCI). The CHCI evaluates and compares healthcare system performance in the ten provinces. The CHCI measures health system quality from the perspective of the consumer, and assesses the extent to which each province is currently meeting the healthcare needs of its residents. This consumer-oriented approach uses a proven performance measurement and benchmarking methodology originally from the Health Consumer Powerhouse (HCP), Europe's leading independent provider of health consumer information. The HCP has evaluated healthcare system performance in Europe since 2004, and its work has generated much discussion, analysis and, most importantly, consumer reform in European healthcare systems.

In January 2008, the HCP teamed with the Frontier Centre for Public Policy to create the first Euro-Canada Healthcare Consumer Index (ECHCI), which compared Canada's healthcare system to those found in 29 European countries. This groundbreaking study demonstrated that Canadian healthcare is inefficient, plagued by wait times, and generally less effective in terms of providing excellent, timely care when compared to most European systems. This assessment, which has since been confirmed by the second ECHCI in May 2009, has provoked debate and provided policymakers with insights that they can use to initiate needed reforms. Although Canadian healthcare is generally low-performing in comparison to Europe, there are differences between the ten provinces. Therefore, analysis at the provincial level is necessary.

Polls consistently show that healthcare is a pressing concern for most Canadians. Canadians want timely access to high-quality healthcare services that maximize the possibility of positive health outcomes. In order to maximize healthcare system efficiency, it is also important that resources be spent wisely, and that adequate attention be paid to primary care and problem prevention which can save money and, more importantly, suffering in the long run. Furthermore, a truly successful healthcare system can only exist in a medical culture that values the right and autonomy of the consumer by enabling him to make informed decisions about his treatment options.

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 other jurisdictions and will avoid making those same mistakes themselves. We also hope that the provinces will learn from the successes of their neighbours, and that the best practices in high-performing provinces will be disseminated across the country.

This Index highlights the problems in each province, but it also points out areas of strength and shows what is possible. This is precisely the purpose of the CHCI: supporting consumers so they can make informed decisions and providing policymakers with a new analytical tool for improvement. Though the index sometimes reveals troubling and disconcerting information, it sheds light on healthcare performance in Canada and will improve transparency in the provinces. By applying consumer-oriented performance measurement strategies to the analysis of Canadian healthcare, the CHCI promotes openness and transparency which will ultimately lead to improved healthcare performance that will benefit all Canadians.

Peter Holle,
President, Frontier Centre for Public Policy
Winnipeg/Calgary/Regina

Johan Hjertqvist,
President, Health Consumer Powerhouse
Brussels/Stockholm

1. Executive Summary

This report presents the results of the second annual Canada Health Consumer Index (CHCI). As with our first index in 2008, this year's study demonstrates that healthcare-system performance is significantly better in some Canadian provinces than in others. Our analysis also shows that even the highest performing provinces in Canada have significant room for improvement. As the International Euro-Canada Health Consumer Index demonstrated again in 2009, Canadian healthcare still lags well behind most European healthcare systems. The top-scoring provinces in this year's CHCI should be recognized for their relatively strong healthcare-system performance in comparison to other Canadian jurisdictions. However, the most important lesson to be drawn from our two major 2009 healthcare reports is that Canada still has much work to do in order to reach the level of excellence that exists in many European countries.

For the second year in a row, Ontario finishes first in the CHCI by a wide margin. It performs well in every area of the index, including the two most important categories, wait times and patient outcomes.

British Columbia is the runner-up for the second consecutive year, performing well in four of the five categories measured, with the exception of patients' rights and information. British Columbia performs particularly well in the medical outcomes component of the Index, finishing in a second-place tie. An example of the province's strong performance in this area its emergency readmission rates for common surgeries such as hysterectomies and prostatectomies. British Columbia has a risk-adjusted emergency readmission rate of just 1 per cent following hysterectomies, the lowest rate in the country.

New Brunswick, Alberta and Nova Scotia round out the top five. Alberta ties for first place in the heavily weighted patient outcomes category, but the province's score is brought down by the fact that Albertans continue to face long waits for certain medical services. Particularly troubling are the long waits for cancer radiation therapies. Only 70 per cent of cancer radiation therapies are performed within the benchmark of 28 days from the decision to treat. This compares unfavourably with neighbouring British Columbia, where 95 per cent of patients begin their radiation therapy within the 28-day wait-time benchmark.

Prince Edward Island finishes in sixth place, well clear of the four remaining provinces, which are clustered at the bottom of the index. Manitoba, Newfoundland, Saskatchewan and Quebec finish in the seventh through tenth slots respectively. Manitoba, Newfoundland and Saskatchewan have similar total scores and are separated by just 24 points out of 1,000. They are about 200 points behind first-place Ontario. Although each of these jurisdictions has areas of relative strength, their overall healthcare-system performance is well below the Canadian average.

Long waits for care are a serious problem in all of the lower performing provinces. For example, the federal and provincial governments in Canada have jointly agreed that surgeries for hip fractures should take place either on the day of admission or the next day. In British Columbia, a high-performing province, 68 per cent of hip-fracture surgeries take place within the

designated time. In Manitoba, however, only 52 per cent take place within this timeframe. In Saskatchewan, the situation is even worse, as just 48 per cent of hip-fracture surgeries take place either on the day of admission or the next day. Reducing wait times for care is one of the most important things these provinces should work on to close the gap between themselves and top-performers such as Ontario and British Columbia.

Quebec finishes in last place in this year's index, but the province's low score requires some explanation. Throughout the index, we have assigned "poor" scores to provinces that do not collect data for indicators that are tracked by all of the other provinces. This rule, which is meant to reward transparency and punish opaqueness, affected Quebec's score much more substantially than it did any other province due to unusual data collection and reporting processes in the province. Quebec must keep track of similar healthcare data as the other provinces to allow for inter-provincial comparisons and to permit its citizens to hold politicians to account if the province's performance is poor in a particular area. Although Quebec's low score is driven primarily by anomalous data collection and reporting, it should be noted that some areas of weakness are identifiable and that these areas of weakness also contributed to Quebec's low score.

For example, Quebecers are far less likely than other Canadians to have regular access to a family doctor. Just 73 per cent of adult residents report having access to a family doctor compared to over 90 per cent of residents in Nova Scotia and New Brunswick.

Interestingly, our analysis did not detect a relationship between per capita healthcare spending and healthcare performance. Some low-performing provinces such as Manitoba are among the biggest healthcare

spenders, and some high-performing provinces such as Ontario have low per capita spending. Clearly, there is no simple link between higher levels of healthcare spending and improved performance. The poor results shown by low-performing provinces are not caused by a low level of healthcare spending, and the problems that exist in these jurisdictions likely cannot be solved by simply throwing money at the problem.

Clearly, solutions other than simply increasing spending are needed to improve healthcare-system performance. This report describes a few such reforms that could dramatically improve healthcare performance across the country.

- Make Healthcare Truly Portable.
  Some provinces provide medical services more efficiently than others do. Residents of less efficient provinces should be able to travel to provinces where treatment slots are open.
- Enact Patients' Rights Laws and Wait-time Guarantees.
  The Canadian provinces, in co-operation with the federal government, are taking steps in this direction, but they should accelerate the pace with which they are creating guarantees of timely care. Long waits are the biggest single problem in the Canadian healthcare system, and wait-time guarantees are a useful tool that can be used to improve this situation. Canadians deserve guarantees, backed by the force of law, that they will receive prompt, high-quality healthcare services when they are confronted by a medical problem.
- Move to Patient-based Funding.
  Most Canadian hospitals are still funded through the global budgeting model in which hospital revenue is determined by bureaucratic processes not directly linked to the number of patients treated or the quality of hospital outputs. Under patient-based funding, the government pays hospitals for the actual services provided. By encouraging hospitals to provide excellent care to more patients, patient-based funding is one of the most effective ways government policy can work to address the problems in healthcare. The majority of Organisation for Economic Co-operation and Development (OECD) countries, including many European countries such as Sweden and the Netherlands, has already implemented some form of patient-based funding, and this approach has proven capable of dramatically improving healthcare-system efficiency.

Governments across Canada should ensure that their citizens have timely access to excellent healthcare services. All ten provinces currently fall short of this goal, and we hope this year's CHCI will help policymakers and citizens in each province identify areas where there is a need for aggressive reform efforts.

2. Introduction

2.1 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 any government funding.

2.2 Health Consumer Powerhouse

The Health Consumer Powerhouse is a centre for vision and action and promotes consumer-related healthcare in Europe.

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, Switzerland, Croatia, FYR Macedonia, Iceland and Albania. 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.

2.3 What is the Canada Health Consumer Index?

The Frontier Centre for Public Policy (FCPP) is an independent, non-profit think-tank dedicated to the promotion of innovative ideas and solutions that improve public policy in Canada. Since 2007, the Frontier Centre has collaborated with a think-tank based in Belgium, the Health Consumer Powerhouse (HCP), to promote visionary thinking about healthcare policy in Canada and around the world. Specifically, we have worked to assess the quality of healthcare in Canada by asking a specific question: How well does the healthcare system in this country and in individual provinces meet the needs of healthcare consumers? For the healthcare system to work better for Canadians, there must be a fundamental change in the way our healthcare system, our government and even our citizenry view the recipients of healthcare services. Whereas historically, recipients of medical care were viewed as passive patients upon

whom the healthcare system acted, it is time to start viewing citizens as consumers, powerful actors who are able to access relevant information, make informed decisions and demand top-quality products and services.

For this transition to take place, citizens need access to information about existing health policies, services, wait times and quality outcomes. In 2009's Canada Health Consumer Index (CHCI), the Frontier Centre and the Health Consumer Powerhouse aim to provide access to important information about the quality of healthcare services in the Canadian provinces. The CHCI is an instrument through which the Frontier Centre and the HCP can analyze the quality of healthcare systems across Canada and can make policy recommendations based on best practices within Canada and from other countries.

The CHCI rankings are neutral regarding how healthcare systems allocate financial resources and the extent to which private or public funding models are used. In other words, no points are allocated based on how a particular healthcare system is funded. Public-private and left-right ideological distinctions are not considered in the creation of the index rankings. Instead, the indicators in this index are entirely performance based and seek to measure the extent to which the actual healthcare needs of citizens are met.

The index is intended to help citizens learn the answers to important questions about their healthcare system:

Is the system designed to keep me healthy?

Will it provide me with speedy access to services?

Will I have choices and access to high-quality care when I am sick?

We hope the index will serve as a learning tool consumers can use to assess the quality of their province's healthcare and to demand improvements in areas where their province is underperforming. The index is intended to facilitate informed discussion among and between policymakers and citizens about the current state of healthcare services and how to introduce positive reforms.

2.4. Project Staff

Ben Eisen, MPP,
Policy analyst at the FCPP, and the principal researcher for the Canadian Healthcare Consumer Index.

Dr. Arne Bjornberg
Research Director of the Health Consumer Powerhouse, provided project support.

3. Index Scope

In many areas of public policy, healthcare included, performance evaluation is often based on the measurement of inputs and certain types of easily measurable outputs that do not necessarily reflect the efficacy of the relevant program or policy. Counting resource inputs such as hospital beds and doctors per capita does not tell us very much about the care that consumers actually receive. The amount of time the average person has to wait for an MRI is a much better indicator of healthcare quality than is the number of MRI machines in the province.

Instead of measuring inputs, such as spending levels and resources used, this index attempts to measure outcomes from the perspective of the consumer. In other words, we seek to evaluate the quality of healthcare citizens receive in the provinces.

3.1 Regional Variations

The Frontier Centre recognizes that in addition to disparities in healthcare quality between provinces, there also exist disparities in healthcare quality between regions within each province. Particularly, discrepancies exist in the accessibility and provision of services in urban and rural communities. Although these disparities are significant, the goal of this index is to assess the overall quality of healthcare services in each province. Higher scoring provinces may contain regions in which healthcare services are below average, and lower scoring provinces may contain regions in which health services are excellent.

As measurement and analysis of Canadian healthcare becomes more common, we hope that efforts will be undertaken to analyze healthcare quality at the sub-provincial level in order to identify high- and low-performing regions and hospitals within each province. The purpose of this index, however, is to evaluate provincial healthcare systems in their entirety. For this reason, despite their significance, regional differences within provinces are not taken into account.

4. Methodology

For the Canada Health Consumer Index, the FCPP and the HCP largely followed the same methodological approach we used in the creation of previous indexes. Specifically, the methodology is closely modelled on that used for the Euro-Canada Health Consumer Index (ECHCI).

Like the ECHCI, the CHCI selected a number of indicators that describe the extent to which provincial healthcare systems are meeting consumer needs. For both indexes, indicators must measure healthcare-system performance that directly affects consumers. The index does not take into account how healthcare is funded or any other factor that is not a direct measure of consumer-friendliness. Specifically, the index does not take into account the extent to which provinces allow private funding for health services or the presence of privately run health clinics. In other words, the index is neutral regarding healthcare funding and the role of private medicine within each system. The purpose of this index is to provide benchmarks of healthcare quality, not to wade into ideological disputes about the appropriate role of the private sector in healthcare delivery. Instead, we seek to measure healthcare-system performance without reference to funding models or related questions.

4.1 Indicator Selection

In the ECHCI and the CHCI, our objective is to select a number of indicators from within a relatively small number of evaluation areas that, taken together, present a comprehensive picture of how well the healthcare consumer is being served. A brief rationale for the inclusion of each particular indicator is provided in Section 11, and the sources for each indicator are listed in Section 4.

In the design and selection of indicators, the EHCI and CHCI have been working on the following three criteria since 2005:

- Relevance;
- Scientific soundness;
- Feasibility (i.e. can data be obtained).

There exist many useful indicators of healthcare quality, and we chose a small number for this index.

The most important criteria that we used in selecting the indicators were:

- An indicator must provide important information about the quality of provincial healthcare systems from the consumer's perspective. It must be a measure of outcomes or, in some cases, important outputs, but not simply one of inputs.
- For each indicator, there must be recent, reliable, publicly accessible data.
- In the selection of indicators for this year's index, we sought to include a broad mix of indicators that measure healthcare-system performance across several different dimensions of quality. We included indicators that seek to evaluate the openness and transparency of provincial healthcare systems as well as indicators that provide more easily quantified measurements of outcomes and wait times.

- In our selection of indicators, we emphasized metrics that provincial authorities and providers have the power to directly affect through policy.
- Indicators must reflect healthcare-system performance rather than other dimensions of public health. A great many factors aside from the healthcare system influence the health level of people living in a particular jurisdiction. This index seeks to evaluate the performance of healthcare systems and therefore does not include measures of public health in general, which are affected by diet, smoking habits, obesity and other factors. Therefore, indicators such as life expectancy, which are largely shaped by factors other than the healthcare system, are not included in the index.

This year, we made substantial changes to our list of healthcare-quality indicators. We believe this revised list of indicators allows us to make a more accurate assessment of healthcare quality in each of the five sub-disciplines. We are committed to improving the CHCI each year, and we welcome suggestions for improving our list of indicators for future years and, more generally, we welcome input on how to improve the methodology.

4.2 Data Collection and Verification

Almost all of the information used to compile this index is publicly available. Government databases and information that is readily obtainable from federal and provincial health ministries provide a substantial share of the material necessary for scoring healthcare performance in each province. When conflicting information was discovered about a province's performance on a particular indicator, we used the most recent reliable source.

Throughout the data collection process, we sought the most recent reliable data available. Many provinces are in the process of trying to improve their healthcare systems, particularly in terms of wait times, and even slightly outdated data may no longer provide a completely accurate guide to healthcare-system performance.

Data for this report are from 2006 or later.[1] There are some indicators for which we wanted to have more recent data, but we were sometimes forced to make use of data from 2007 and, less frequently, 2006 for indicators for which no newer data are available.[2] It is possible that, in a few instances, a province's performance has improved (or worsened) significantly since the collection of our data. We have, however, made use of the most-recent quality data available, and we are confident that, taken as a whole, this index provides a useful study of healthcare quality in the provinces overall and in each of the five sub-disciplines of this report.

4.3 Comprehensive Uniform Trustworthy Sources

Where possible, scores for indicators in this index are based on data extracted from Comprehensive Uniform Trustworthy Sources (CUTS). If the necessary data for assigning an indicator's score are available from a single reliable source for all, or almost all, the 10 provinces, this source was preferred to data drawn from a variety of sources. Examples of CUTS for inter-provincial data include Statistics Canada databases and high-quality research papers that evaluate healthcare performance in most or all of the provinces.

CUTS is preferred as a data source because the methodology employed in their collection is often more uniform than information obtained from 10 different provincial sources. Even where these separate sources are provincial health ministries, fine differences in data collection methods and the definition of the indicator to be tracked can make inter-provincial comparisons difficult. When a CUTS was identified for particular data, efforts were made to check the resulting data against other sources of information to ensure that the "official" score accurately reflects the reality of a province's performance in that area of healthcare delivery.

4.4 Scoring System

For each indicator, the performance of the provincial healthcare systems is graded on a three-level scale. Throughout the index, a score of "good" is graphically represented by the colour green, an average score is represented by the colour yellow, and a poor score is represented by the colour red. If a province earns a score of "good" for a particular indicator, it is awarded three points in the sub-discipline into which that indicator has been categorized. If a province earns a score of "fair" for an indicator, it is awarded two points. The province is awarded one point if its performance is poor. In instances where recent, reliable data were unavailable for a province, the province is given a score of "poor" for that indicator. Providing reliable, transparent information about healthcare is an important dimension of accountability and consumer-oriented service, which is why provinces are punished in the index for failing to monitor indicators of health-performance quality that are tracked by most other provinces.

In devising this three-level scale, we did not seek to establish a global, scientifically-based principle for the cut-off lines separating the three possible scores. Instead, these values were set after studying the provincial statistics for each indicator in order to ensure some variation in scoring. An indicator for which each province achieved the same rating would provide the reader with little information about the relative quality of the province's healthcare system. For this reason, we established thresholds at points that ensure that the top-performing provinces are rated "good," the worst-performing provinces are rated "poor" and those in the middle are rated "average."

The only exception to this rule is in the area of patients' rights law. The CHCI seeks to promote consumer friendliness and popular support for better health policy. We view the creation of patients' rights laws, backed by meaningful guarantees, as a critically important reform that would help ensure health systems in our country focus on the consumer and ensure he or she has timely access to high-quality healthcare. Many of the European countries that have the very best healthcare systems in the world have meaningful patients' rights laws on the books, and these laws have been a valuable tool that consumers have used to insist that their needs be met.

Canada is a laggard in this area, but there have been signs of progress in recent years. For the end of 2010, the provinces have committed to the introduction of wait-time guarantees in at least one of the five priority areas identified by the federal government. In a few provinces, the process is somewhat further along, and wait-time guarantees are in effect for a particular services. For example, in Manitoba, a wait time guarantee has been put into effect for radiation therapy and Quebec has implemented a guarantee for joint replacement surgery and cataracts. In Saskatchewan, the development of a wait time guarantee for coronary bypass procedures is planned, and the project is currently in the pilot stage.

These steps towards the development of wait time guarantees should be celebrated. However, despite this progress, no province has an explicit legislative guarantee of patients' rights in place, or a comprehensive set of wait time guarantees. Due to the importance of these much-needed reforms, we have included the strength of patients' rights laws as an indicator of healthcare quality even though all the provinces have been given a poor score.

4.5 Indicator Areas: Sub-disciplines

The process of creating the CHCI was informed by the lessons learned from the compilation of the European Health Consumer Indexes and the first two Euro-Canada Health Consumer Indexes. We grouped the indicators into five major categories. Each category focuses on a particular dimension of healthcare-system performance and/or consumer friendliness. In the generation of final scores, the weight of

Chart 1. Indicator Areas: Sub-disciplines

Sub-discipline	Number of Indicators
Patients' Rights and Information	5
Primary Care	5
Wait Times	7
Outcomes	7
Range of Services Provided	4

each sub-discipline is determined independently of the number of indicators within that sub-discipline. Instead, each province's final score is determined using the following steps:

- The province is given a score for each sub-discipline. This score is calculated as a percentage of the maximum available points within the sub-discipline. (E.g., if a province scores 12 out of a possible 20 points on the indicators within a sub-discipline, the province is assigned a score of 60 per cent for that sub-discipline.)
- Each sub-discipline score is then multiplied by the weighting coefficient that has been assigned to that sub-discipline. The sub-disciplines that we have determined to be most important are given the highest weighting coefficients. A brief rationale for the weighting coefficients used is provided in the next section.
- These weighted sub-discipline scores are then added up, multiplied by 1,000 and rounded to the nearest whole number. This produces an integer score between 1 and 1000, which is the province's final score.

4.6 Weighting Coefficients

The HCP introduced weighting coefficients in its 2006 Euro Health Consumer Index. This decision to weight certain indicator areas more heavily than others was based on discussions with panels of experts and on the experiences revealed in a number of patient surveys, both of which indicated that certain dimensions of healthcare quality are especially important to consumers. Specifically, consumers consistently point to patient outcomes and wait times as the most important dimensions of healthcare quality. Accordingly, sub-disciplines have been assigned the highest weight in the compilation of final scores for the CHCI. Here, as in all other parts of the index, we welcome input on how to improve the methodology.

Once the weighted scores were tabulated, they were added together and multiplied by 100. The maximum theoretical score attainable for a provincial healthcare system in the index is 1,000 and the lowest possible score is 333.

For the Canada Health Consumer Index, the five sub-disciplines were assigned the following weights:

Chart 2. **Sub-discipline**	**Relative Weight**	**All Green Contribution to Maximum Score of 1,000**	**Points for a green score in each sub-discipline**
Patients' Rights and Information	1	100	20
Primary Care	1.5	150	30
Wait Times	3	300	42.9
Outcomes	3.5	350	50
Range of Services Provided	1	100	25

5. Indicator Definitions and Data Sources for the Canada Health Consumer Index

Chart 3.

Sub-discipline	Indicator	Comment	Good	Fair	Poor	Main Sources
Patients' Rights and Information	Healthcare Law Based on Patients' Rights	Is there a comprehensive patients' rights law with meaningful guarantees?	Yes	Yes, but no guarantees or law is not comprehensive	No explicit guarantee of patient rights.	Review of recent legislative activity
	Electronic Patient Records	Has the province completed the development of an electronic health-record system with respect to drug information and laboratories?	Both	Either lab or medication, but not both	Neither	Infoway Business Plan 2008-2009
	Layman-adapted Formulary	Is there a formulary in layman's terms readily available?	Yes, available and intended for consumers	Intended for professional use only	No formulary easily available	Provincial government web sites
	Online Reporting of MRI and CT Scan Wait Times	Is there an easily accessible web site that posts expected wait times for MRI and CT scans?	Yes, both	One or the other but not both	No	Provincial government web sites
	Patient Satisfaction	What percentage of adults reported they had received "excellent" or "good" health services in the past year?	>90 per cent	85 to 90 per cent	<85 per cent	StatsCan Table 105-4080 (2007 data)
Primary Care and Problem Prevention	Access to a Family Doctor	What percentage of people older than 12 reports having a family doctor?	>90 per cent	85 to 90 per cent	<85 per cent	StatsCan Table 105-0501 (2008)
	Colon Cancer Screening	What percentage above age 50 had a colonoscopy in the past five years or a fecal occult blood test in the past two years?	>50 per cent	39 to 50 per cent	<39 per cent	StatsCan Table 105-0541 (2008)
	Breast Cancer Screening	What percentage of women 50 to 69 had a mammogram in the past two years?	>70 per cent	65 to 70 per cent	<65 per cent	StatsCan Table 105-0543 (2008)
	Asthma Readmission Rate	Risk-adjusted rate of unplanned readmissions following discharge for asthma	<3 per cent	3 to 5.5 per cent	>5.5 per cent	CIHI (2006 data)
	Hospitalization Rate for Ambulatory Care Sensitive Conditions	Acute care hospitalization rate for seven ACSC for Canadians younger than 75 per 100,000 population	<350	350 to 500	>500	CIHI (2006 data)
Wait Times	Access to Specialist Within One Month of Referral	What percentage sees a specialist within one month of referral?	>50 per cent	40 to 50 per cent	<40 per cent	StatsCan Table 105-3002 (2007)
	Wait Time for Hip-replacement Surgery	What percentage of patients is treated within the 182-day national benchmark?	>85 per cent	70 to 85 per cent	<70 per cent	CIHI Wait-time Tables and provincial web sites (2008-2009)
	Wait Time for Knee-replacement Surgery	What percentage of patients is treated within the 182-day national benchmark?	>75 per cent	50 to 75 per cent	<50 per cent	CIHI Wait-time Tables and provincial web sites (2008-2009)

Continued

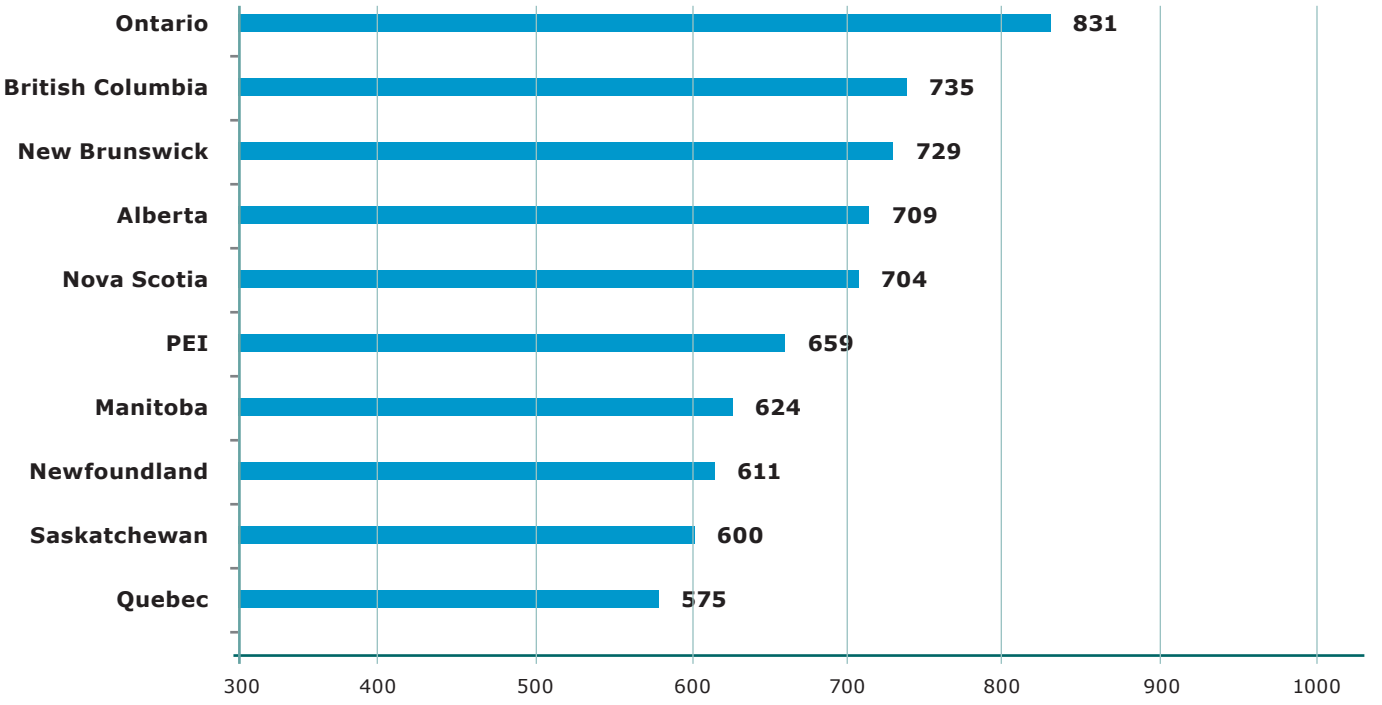
Sub-discipline	Indicator	Comment	Good	Fair	Poor	Main Sources
Wait Times (Continued)	Prompt Radiation Therapy	What percentage of patients is treated within 28 days of decision to treat?	>90 per cent	85 to 90 per cent	<85 per cent	CIHI Wait-time Tables (2008)
	Wait Time for Diagnostic Testing	What percentage of non-urgent MRI, CT and angiographies is performed within one month of decision to test?	>60 per cent	55 to 60 per cent	<55 per cent	StatsCan Table 105-3004 (2007 data)
	Wait Time for Hip-fracture Surgery	What risk-adjusted proportion of hip-fracture patients, 65 and older, receives surgery on day of admission or next day?	>65 per cent	60 to 65 per cent	<60 per cent	CIHI (2007 data)
	Cataract Removal	Average wait in days for cataract surgery from decision to treatment.	<50 Days	50 to 74 days	>75 days	CIHI (2008-2009 data)
Outcomes	AMI Mortality Rate	What is the 30-day AMI mortality rate?	<9.5 per cent	9.5 to 11 per cent	>11 per cent	CIHI (2007-2008 Data)
	Stroke Mortality Rate	What is the 30-day stroke mortality rate?	>17 per cent	17 to 20 per cent	<20 per cent	CIHI (2007-2008 Data)
	Infant Mortality	How many infant (younger than one year) deaths occur per 1,000 live births?	<4.5	4.5 to 5.5	>5.5	StatsCan Table 102-0504 (2006 Data)
	Cancer five-year Survival Rate	Arithmetic mean survival rates for prostate, breast, colorectal and lung cancer	>55 per cent	50 to 55 per cent	<50 per cent	StatsCan Table . 103-1573. Diagnoses prior to 2000. Data last updated 2008
	Rate of In-hospital Hip Fractures	Risk-adjusted rate of in-hospital hip fractures among acute care patients 65 and older per 1,000 discharges	>0.5	0.5 to 1	>1	CIHI (2006)
	Hysterectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following hysterectomy for benign conditions.	>1.3 per cent	1.3-1.8 per cent	<1.8 per cent	CIHI (2007-2008)
	Prostatectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following prostatectomy for benign conditions	>2 per cent	2 to 3 per cent	>3 per cent	CIHI (2007-2008)
Range and Reach of Services	Childhood Vaccination	Canadian Paediatric Society ranking of quality of childhood vaccination coverage	Excellent	Good	Fair	CPS web site
	Influenza Immunization for Seniors	What percentage of those over 65 had a flu vaccine in past year?	>65 per cent	60 to 65 per cent	<60 per cent	StatsCan Table 105-4045 (2008 data)
	Pharmaceutical Cost	The percentage of households that spend more than 5 per cent of income on pharmaceuticals	<5 per cent	5.1 to 9 per cent	>9 per cent	StatsCan Table 109-5012 (2006 data)
	24/7 Access to Medical Information	Is there a 24/7 phone number and/or web site providing medical advice from RN equivalent?	Yes	Some info but not RN	No	Provincial government web sites

6. Results

6.1 Summary of Results: Overall Scores

For the second consecutive year, Ontario has the highest overall score in the Canada Health Consumer Index. It performs well in every sub-section of the index. Of particular importance, Ontario earns the best score in the wait-time category and ties for first place with Alberta in patient outcomes. Ontario is also near the top of the index in terms of primary care and the range and reach of services offered. The only category in which Ontario's performance is not particularly strong is patients' rights and information, where it places near the middle of the pack. To improve in this one area of relative weakness, Ontario should proceed more aggressively in the development of electronic patient records and the enactment of comprehensive patients' rights laws that have wait-time guarantees. Ontario's strong performance across the index for two consecutive years establishes the province as Canada's leader in delivering healthcare that meets the needs of consumers.

Chart 4. Overall Scores



Although Ontario's strong performance compared to the other provinces should be recognized, Canada's most populous province should not be completely content with this achievement. As shown in the international Euro-Canadian Health Consumer Index, many European countries achieve much higher levels of healthcare quality that put them in a separate league from the Canadian provinces. This is accomplished at levels of per capita healthcare spending that are comparable to or below Canadian levels. Ontario, like all of the Canadian provinces, should look carefully at European best practices, so it can identify opportunities to further improve its healthcare system.

British Columbia finishes second in this year's index and is followed very closely by New Brunswick. Only six points separate these two provinces, and they constitute a distinct second tier behind Ontario but ahead of the remaining seven provinces. This is the second consecutive year in which British Columbia finished in second place behind Ontario. British Columbia's strong showing is driven primarily by good results in the two most heavily weighted sub-disciplines: outcomes and wait times. British Columbia finishes in third place in the outcomes category and ties for second place in terms of wait times. To close the gap with Ontario and to challenge it for first place in future indexes, British Columbia must shorten its wait times to match Ontario's, and it must improve its medical culture with respect to patients' rights and information. This is the only category in which British Columbia performs poorly, finishing in a tie with Newfoundland for last place.

New Brunswick finishes just behind British Columbia in third place. There are no areas of glaring weakness for New Brunswick, although the province is near the middle of the pack in terms of patients' rights and range and reach of services. A second-place finish in the primary care category combined with above-average results in terms of wait times and outcomes are the reasons for New Brunswick's high overall score.

Alberta and Nova Scotia form a third tier in terms of overall results, and they finish substantially ahead of the provinces that finished in the bottom half of the index. Alberta finishes in fourth place, 20 points behind New Brunswick and six points ahead of Nova Scotia. Alberta's performance is mixed across the index and, specifically, in the two most important categories: outcomes and wait times. Alberta finishes tied for first in terms of patient outcomes. Alberta's strong performance in this area, however, is balanced against the fact Albertans often face long waits for medical care. Alberta finishes in a tie for seventh place with Newfoundland in the wait-time category and ahead of only Manitoba and Saskatchewan. Alberta must shorten its wait times for care in order to achieve the top spots in future indexes. Nova Scotia performs well in the patients' rights, range and reach of services, and primary care categories, but it sits near the middle of the pack in terms of wait times and patient outcomes. These two categories are given the heaviest weight in the index, and Nova Scotia's middling performance in these areas is what separates the province from Ontario and British Columbia.

Prince Edward Island finishes in sixth place for the second straight year. PEI performs well in the patient patients' rights and wait-time categories and is slightly below average in terms of outcomes. The province performs poorly in the range and reach of services category, finishing in last place, and it finishes near the bottom of the pack in the primary care and problem-prevention category. PEI is the only province that does not have a 24/7 telehealth service, which is an important reason for its low score in the range and reach of services category.

For the second straight year, Manitoba, Newfoundland and Saskatchewan are clustered near the bottom of the overall index. Just 24 out of a possible 1,000 points separate these three provinces, which place seventh, eighth and ninth respectively.

Quebec, which finishes in last place, is a special case. The province's low overall score does not indicate a low-performing system as conclusively as do the low scores earned by Manitoba, Saskatchewan and Newfoundland. Throughout the Index, we have assigned "poor" scores to provinces that do not collect data for indicators that are tracked by the other provinces. This rule, which is meant to reward transparency and punish opaqueness, affected Quebec's score more substantially than it did any other province. We were unable to obtain data from Quebec for seven of the 28 indicators. As a result, Quebec finishes very poorly in the overall index despite the fact that the data we do have suggests Quebec's healthcare system is at least average when compared to the other nine provinces. Quebec must begin to keep track of similar healthcare data as the other provinces do so that inter-provincial comparisons are possible and to permit her citizens to hold politicians to account if the province's performance is poor in a particular area. We are disappointed that it has proven impossible to compare Quebec's healthcare system to the other provinces in a comprehensive way and caution readers that Quebec's low overall score should be taken as a reflection of the province's inconsistent data collection processes rather than as a reflection of low overall health-system performance.

While Manitoba, Newfoundland and Saskatchewan should be applauded for superior reporting on their healthcare systems compared to Quebec, their low scores across the five index sub-categories are troubling. Manitoba finishes in seventh place, over 200 points behind first place Ontario. Manitoba is below average in primary care and problem prevention and scores poorly in the important wait-time and outcomes categories.

Newfoundland and Labrador finishes in eighth place. The province is below average in all the disciplines except for primary care and problem prevention, where it earns a middling score. Improvement is needed across the board in healthcare performance in Newfoundland, especially in the important areas of wait time and patient outcomes.

The ninth place finisher this year is Saskatchewan. It should be stressed that the four bottom performers all finished very close together and that even small changes in the weighting coefficients would alter their positions at the bottom of the Index. Saskatchewan's performance should not be considered markedly worse than the other provinces at the very bottom of the list. Nonetheless, Saskatchewan residents should be concerned by their provinces' poor showing in most components of the index. Saskatchewan finishes in a tie for second place in patients' rights, but this is the only bright spot. Saskatchewan's performance is below average in each of the other categories, and in the crucially important wait-time category, the province finishes dead last. Although improvement is needed across the board, reducing waiting times is one of the most important things Saskatchewan can do to improve its healthcare system, which has finished near the bottom of this Index for two consecutive years.

The ranking is remarkably stable between 2008 and 2009, in spite of significant changes to the set of indicators. This strongly suggests that the CHCI accurately measures the relative performance of the provincial health services.

6.2 Results of the Canadian Health Consumer Index 2009

Chart 5.

LEGEND: ● GOOD ◑ FAIR ○ POOR

Sub-discipline	Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Patients' Rights and Information	Healthcare Law Based on Patients' Rights	○	○	○	○	○	○	○	○	○	○
	Electronic Patient Records	◑	●	◑	◑	○	○	○	○	●	○
	Layman-adapted Formulary	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑
	Online Reporting of Current Waits for MRI and CT Scans	○	○	●	●	●	○	○	●	●	○
	Patient Satisfaction	○	○	◑	◑	◑	◑	●	●	◑	◑
	Sub-discipline Weighted Score (/100)	47	53	67	67	60	47	53	67	73	47
Primary Care and Problem Prevention	Access to a Family Doctor	◑	○	○	○	●	○	●	●	◑	◑
	Colon Cancer Screening	◑	◑	◑	●	●	○	◑	○	◑	◑
	Breast Cancer Screening	◑	●	●	●	●	●	●	◑	○	●
	Asthma Readmission Rate	◑	◑	◑	○	◑	○	●	◑	◑	●
	Hospitalization Rate for Ambulatory Care Sensitive Conditions	●	●	○	◑	●	◑	○	●	◑	○
	Sub-discipline Weighted Score (/150)	110	110	90	100	140	80	120	110	90	110
Wait Times	Access to a of Specialist Within One Month Referral	◑	◑	◑	○	◑	●	◑	◑	◑	○
	Wait Time for Hip-replacement Surgery	◑	◑	○	◑	●	●	◑	○	●	●
	Wait time for Knee-replacement Surgery	◑	◑	○	◑	●	●	◑	○	●	◑

Continued

LEGEND: ● GOOD ◑ FAIR ○ POOR

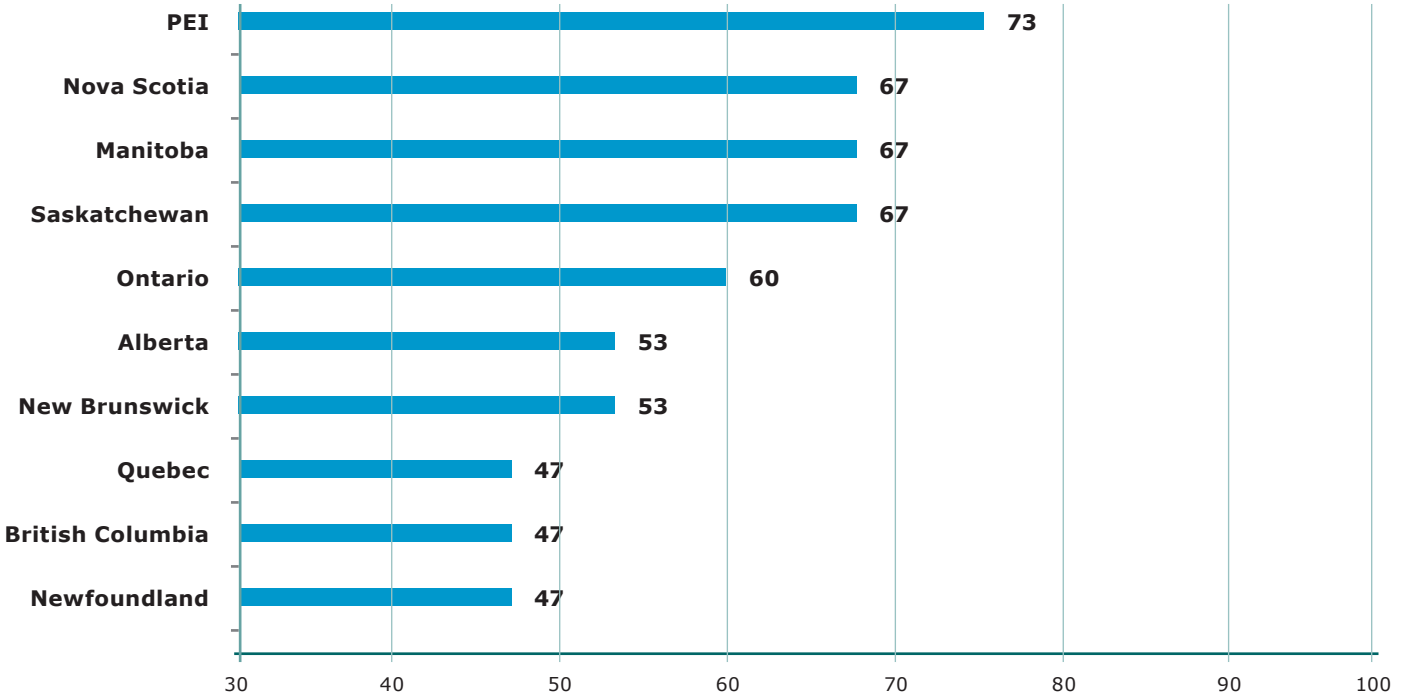
Sub-discipline	Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Wait Times *Continued*	Prompt Radiation Therapy	●	○	○	●	●	◑	●	●	●	◑
	Wait Time for Diagnostic Testing	◑	○	○	○	◑	◑	○	◑	○	○
	Wait time for Cataract Removal	◑	◑	●	○	●	○	◑	◑	○	○
	Wait Times for Hip-fracture Surgery	●	◑	○	○	◑	○	●	◑	●	◑
	Sub-discipline Weighted Score (/300)	229	171	143	157	257	214	214	186	229	171
Outcomes	AMI In-Hospital Mortality Rate	◑	●	●	●	●	○	◑	◑	○	◑
	Stroke In-Hospital Mortality Rate	◑	●	●	◑	◑	○	●	○	●	○
	Infant Mortality Rate	●	◑	○	○	◑	◑	●	●	●	◑
	Cancer Five-year Survival Rates	◑	◑	◑	◑	●	◑	◑	◑	○	◑
	Rate of In-hospital Hip-fractures	◑	◑	◑	○	◑	○	◑	◑	◑	◑
	Hysterectomy Readmission Rate	●	●	○	○	●	○	●	●	◑	◑
	Prostatectomy Readmission Rate	◑	◑	◑	●	◑	○	○	◑	◑	◑
	Sub-discipline Weighted Score (/350)	267	283	233	217	283	150	267	250	233	217
Range and Reach of Services Offered	Childhood Vaccination	◑	●	◑	◑	◑	◑	◑	◑	○	◑
	Influenza Immunization for Seniors	◑	◑	◑	●	●	◑	◑	●	○	○
	Prescription Drugs	●	●	○	◑	●	●	◑	●	○	◑
	24/7 Access to Medical Information	●	●	●	●	●	●	●	●	○	●
	Sub-discipline Weighted Score (/100)	83	92	67	83	92	83	75	92	33	67
Overall Score (/1000)		**735**	**709**	**600**	**624**	**831**	**575**	**729**	**704**	**659**	**611**
Rank		**2**	**4**	**9**	**7**	**1**	**10**	**3**	**5**	**6**	**8**

7. Observations by Sub-discipline

This section of the report provides a brief discussion of the scores for each of the five sub-disciplines that comprise the CHCI. No province earned a perfect score in any of the sub-disciplines, which means that policy-makers in even the highest performing provinces have room for improvement in each of the five major areas.

7.1 Patients' Rights and Information

Chart 6.



Unfortunately, patients' rights and information is an area of weakness for the Canadian healthcare system in general. In the international Euro-Canada Health Index, Canada placed ahead of only Latvia and Portugal in this category. Clearly, there is significant room for improvement throughout the country.

Although Canada lags behind Europe, there are signs from around the country that Canada is making some progress. All provinces have committed to the introduction of wait time guarantees in one of the five pan-Canadian priority areas by the end of 2010, and some provinces, including Quebec and Manitoba, have already instituted a wait time guarantee for some procedures.

Several provinces are also taking steps toward providing comprehensive information online about the expected wait-times for a range of medical procedures. In particular, PEI, Nova Scotia, Ontario, Manitoba and Saskatchewan should be applauded for making expected wait times for MRI and CT scans easily available online.

Many provinces are also making progress toward the creation of electronic patients' records. In particular, Alberta and PEI have been working to develop detailed electronic medical records that will contribute to improved patient outcomes in future years.

While these signs of progress should be welcomed, it is important to recognize that, in general, Canada has far to go to achieve a consumer-oriented medical culture. A high score in this sub-discipline should be interpreted as a signal that a province is making progress toward the creation of such a culture and not as evidence that such a culture already exists. The provinces are much more similar than they are different in this category, and the differences in scores should be interpreted as a measurement at the margin; the scores indicate the provinces that have begun to take steps in the right direction. In short, there is not a radically different level of respect for patient' rights in top scorers such as PEI and Nova Scotia than there is in bottom scoring provinces such as British Columbia and Newfoundland. The fact that the differences observed are measurements at the margin and not reflective of fundamental differences in healthcare quality is reflected by the relatively low weight assigned to this sub-discipline. The difference between the top score in this sub-category and the bottom score translated into a 27 point difference overall out of the 1,000 points in the index. This accurately reflects the fact that while significant differences exist between the provinces in this area, the 10 provinces are more alike than they are different.

All the provinces, even the top scorers, should look to Europe for examples of how to empower patients, protect their rights and provide them with the information they need to make informed decisions. Specific examples are provided in the "recommendations" component at the end of this report.

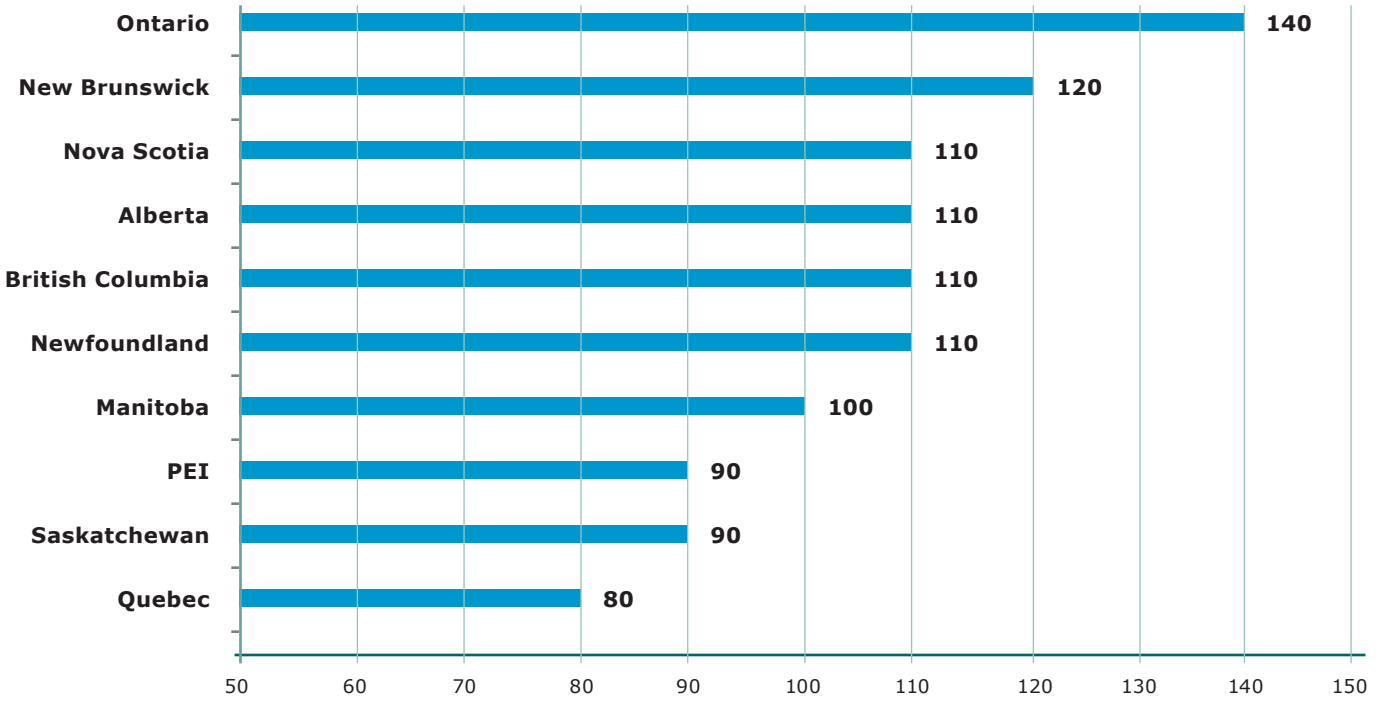
7.2 Primary Care and Problem Prevention

Ontario scores at the top of this component of the index, with 140 out of 150 points. Ontario just misses a perfect score in this category. Ontario's asthma hospitalization readmission rate places it in the middle tier rather than in the top one. This is responsible for Ontario's lost points in this sub-discipline. New Brunswick also performs very well, earning 120 out of 150 points. New Brunswick's high rates of breast cancer screening, low asthma readmission rates and the fact that over 90 per cent of its residents have access to a regular medical doctor all contribute to the province's high score in this area. Quebec finishes in last place, earning only 80 out of 150 points, which is a full 10 points below the next-lowest finishers, PEI and Saskatchewan.

One striking example of Quebec's poor performance in this area is seen by examining the percentage of adults in the province who have a regular family doctor. The national average for this indicator is 85 per cent, but in Quebec, just 73 per cent of adults have a regular medical doctor, by far the worst rate in the country.

Several provinces are clustered together in the middle of the index for this sub-discipline. Nova Scotia, Alberta, British Columbia and Newfoundland all have identical scores of 110 points, although they each lost points in different areas. Alberta's score was hurt by its performance on the "family doctor access" indicator, as just 81 per cent of its residents have a regular medical doctor.

Chart 7. Primary Care and Problem Prevention



In Nova Scotia, over 90 per cent of adults have access to a family doctor, a very good percentage, but a low level of colon cancer screening and a middling level of breast cancer screening prevent the province from earning a top score. Newfoundland scores well on breast cancer screening and asthma readmission rates but scores poorly on the hospitalization rate for ambulatory care sensitive conditions.

British Columbia earns a top score for only one of the five indicators in this sub-discipline. The province has a very low rate of hospitalization for diseases that can be managed in the community such as diabetes and asthma, which suggests these conditions are being well managed before they require hospitalization.

However, British Columbia earned only "average" scores for the other four indicators, resulting in the province's mid-pack finish in this sub-discipline.

Manitoba, PEI and Saskatchewan have significant room for improvement in this sub-discipline. In particular, Manitoba and Saskatchewan should both work to increase the percentage of the population that has access to a regular family doctor, and PEI should step up its breast cancer detection efforts. In 2008, just 61 per cent of women in PEI aged 50 to 69 reported having had a mammogram in the previous two years, the lowest rate in the country and well below the national rate of 71.4 per cent.

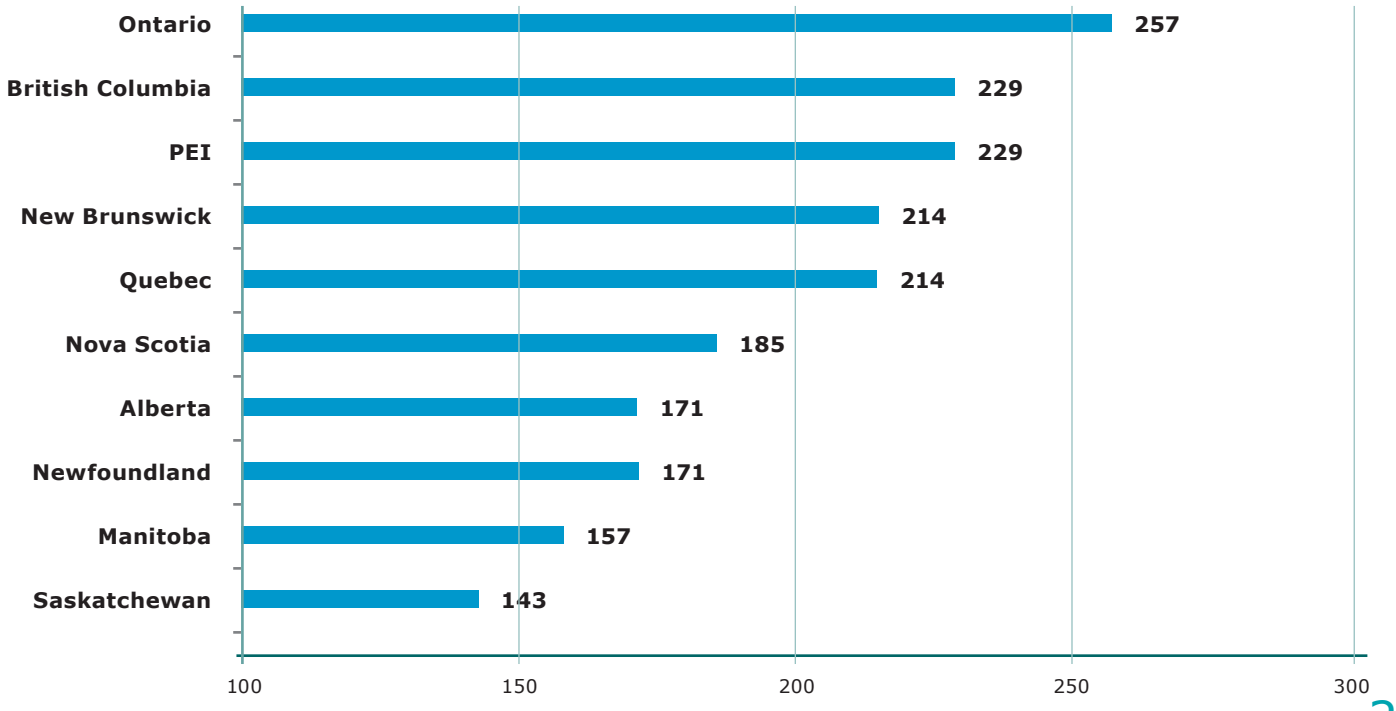
7.3 Wait Times

Wait times are the most frequently discussed problem in Canadian healthcare. Although, as the scores in this section show, there are substantial differences between the provinces in terms of performance in this area, it should be kept firmly in mind that even the best Canadian provinces fare poorly when compared to the top-performing European countries. For example, in the highest performing European countries, the expected wait time for an MRI is generally within one week. For example, in Switzerland, the wait time is routinely less than seven days. This compares very favourably to the situation in Canada. In Ontario, where medical wait times are relatively short compared to the rest of the country, the expected wait for an MRI is approximately 15 weeks. This example illustrates the fact that *wait times for care are a serious problem in every province in Canada,* and even the highest scoring provinces should look to Europe, particularly Belgium, Germany and Switzerland, for best practices on how to make healthcare more efficient and to ensure that health services be delivered promptly.

Again, Ontario is the top-performing province in this sub-discipline. Since the province earns only a middling score for hip-fractures surgeries, more work is required to ensure that these surgeries are provided promptly. Otherwise, Ontario performs very well according to most of the indicators in this sub-discipline.

Although it places near the middle of this sub-discipline in our formal rankings, Quebec is the only province whose medical wait times may actually be comparable to Ontario's. The province performs well on several indicators, including wait times for hip and knee replacements, but its score in this sub-discipline is ruined by the fact that

Chart 8. Wait Time Scores



it does not regularly report data for wait times for hip-fracture surgery or cataract operations. In the area of cataract operations, Quebec uses its own benchmark of 182 days, which does not permit easy comparison to the rest of the country, which uses a benchmark of 112 days. Furthermore, Quebec does not provide the average number of days that cataract patients must wait for their surgery, which most other provinces do. Quebec must align its reporting with the other provinces in order to improve transparency and allow citizens to compare its performance to other Canadian jurisdictions.

However, for cataract operations, it should be noted that Canada, together with Belgium, performs by far the highest number of cataract operations per 100,000 people. This most probably means that Canadians receive the operation for less severe conditions than most Europeans, which means that long waiting times are less of a problem in Canada.

British Columbia, PEI and New Brunswick form a clear second tier behind Ontario and, perhaps, Quebec in this sub-discipline. British Columbia has short waits for surgeries for painful hip fractures and offers relatively prompt cancer radiation therapy once the decision to treat is made. PEI generally performs well compared to the other provinces in this area, but it nonetheless has lengthy waits for life-improving cataract surgery. The typical wait for this procedure is approximately 80 days, among the very longest in the country. New Brunswick's performance is about average for most indicators in this sub-discipline, although wait times are shorter than average for cancer radiation therapy and hip-fracture surgery.

Alberta, Newfoundland, Manitoba and especially Saskatchewan all have considerably longer wait times for health services than do leading performers such as Ontario. In Alberta, wait times are generally about average, but a few important areas of weakness exist, including access to prompt radiation therapy. Only 70 per cent of cancer radiation therapies begin within the benchmark of 28 days compared with about 95 per cent in neighbouring British Columbia. Similarly, in Newfoundland, performance is generally middling, and it is poor in two areas: cataract removals and quick access to specialists.

The situation is particularly troubling in Manitoba and Saskatchewan. Manitoba has a "good" score in just one indicator, albeit an important one, in this sub-discipline: prompt access to cancer radiation therapy. In other areas, the province's performance is dismal. For example, Canadian governments have agreed that, as a benchmark, all provinces should aim to ensure that hip-fracture surgeries take place either on the day of admission or the next day.

In Manitoba, only 52 per cent of surgeries take place within this timeframe. In contrast, 68 per cent of surgeries take place within the designated benchmark time in British Columbia. Saskatchewan performs even worse, as just 48 per cent of hip-fracture surgeries take place during the timeframe. Saskatchewan, like Manitoba, earns only one "good" score of in this sub-discipline, as wait times for cataract surgeries are shorter than average in that province.

It must again be noted that each province's score is computed as a measure of performance *relative to the other nine provinces.* There remains much work to be done in all Canadian jurisdictions to reduce wait times to the levels found in high-performing European countries. Wait times remain a major problem throughout the country and all provinces should be working to address this.

7.4 Outcomes

Outcomes are given the highest weight in the CHCI. Quality care that results in good outcomes is generally perceived to be the ultimate objective of a healthcare system. As is the case in the other sub-disciplines, there is a substantial range in performance across the country as measured by the indicators in this category.

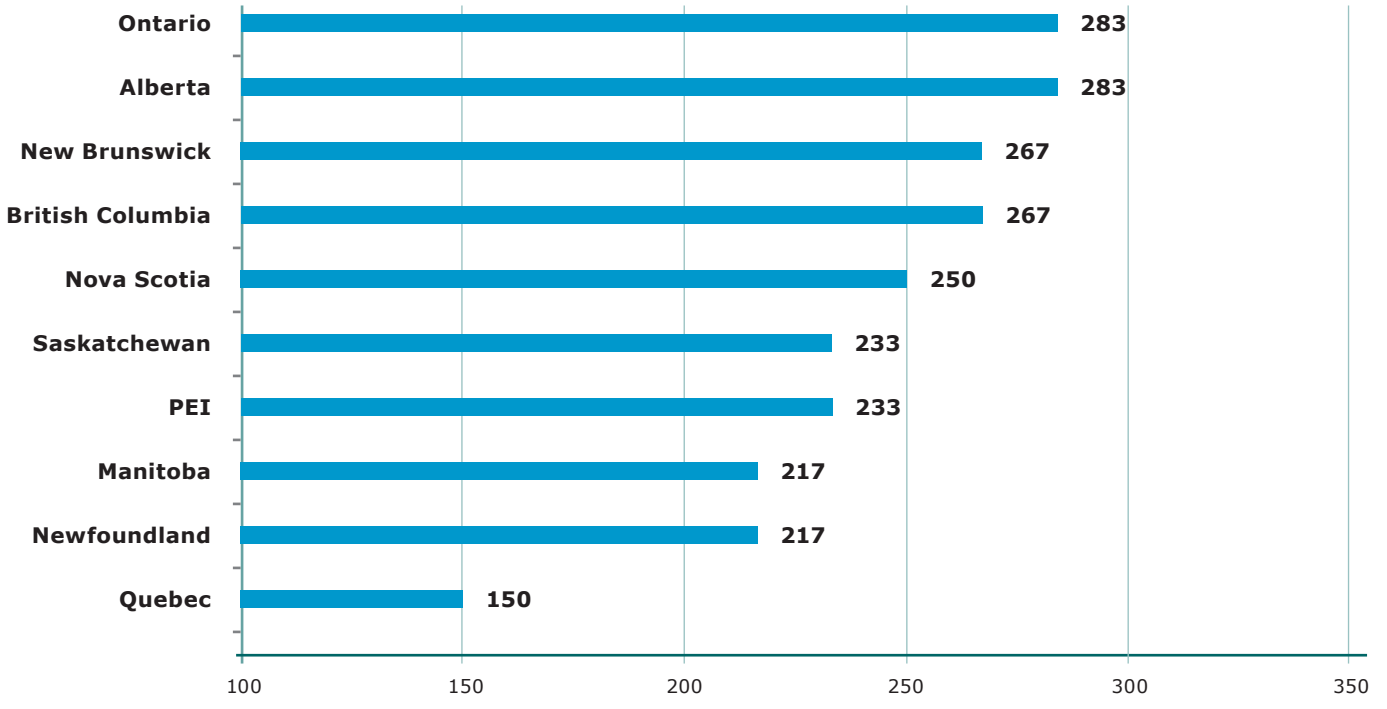
Alberta and Ontario are tied as the top performers in this component of the Index, earning 283 of 350 points. Low mortality rates for heart attacks and strokes as well as a low rate of emergency readmissions following hysterectomy surgery are the reasons for these provinces strong performances in this category. Neither province earns a "poor" score in any of the seven indicators examined here.

British Columbia and New Brunswick tie for second place in this sub-discipline. Like Alberta, British Columbia does not earn a "poor" score for any indicator, but it does not earn as many top scores as its neighbour, resulting in a slightly lower total score. British Columbia has a risk-adjusted emergency readmission rate following hysterectomies of just 1 per cent, the best performance in the country. New Brunswick performs well in several areas, including low stroke mortality rates and infant mortality rates, but the province has an above average rate of emergency prostatectomy readmission, which harms its overall score.

Quebec has the lowest score in this category, but, again, this is driven primarily by a lack of data collection and reporting rather than low scores.

To repeat, it is important that Quebec attempts to harmonize its data reporting with the rest of the country to allow for fair inter-provincial comparisons.

Chart 9. Outcomes



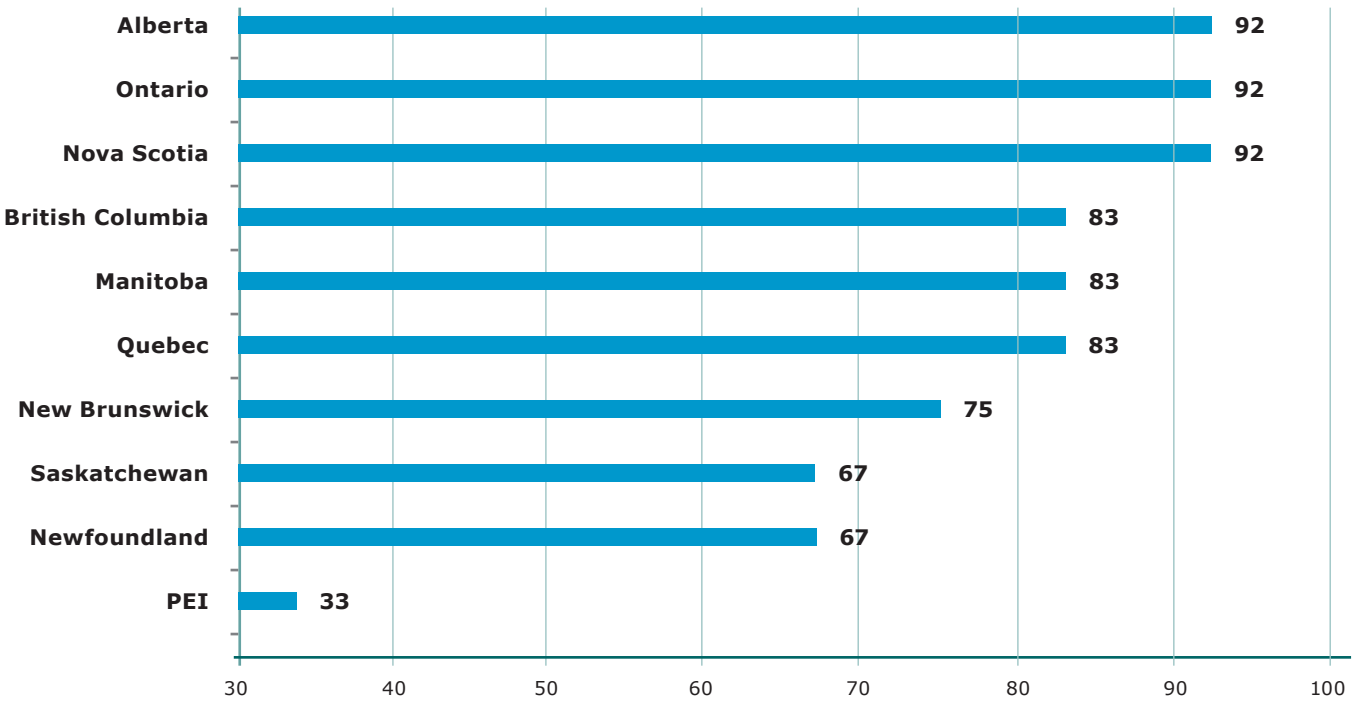
Newfoundland and Manitoba also fare poorly in this component of the index, tying for eighth place with 217 out of 350 points. Newfoundland does not earn any "good" scores, and the province's score is further reduced by worse-than-average results in terms of stroke mortality. Manitoba scores well in some categories, but high rates of infant mortality and in-hospital hip fractures cause the province to score near the bottom of the index in this sub-discipline.

7.5 Range and Reach of Services Offered

There exists some variation between provinces in terms of what services are provided through provincial health programs. We do not subscribe to the view that "more is better" and that the expansion of government programs to include the provision of a particular new service or product should necessarily be viewed as a good thing. These indicators, however, measure access to the timely and affordable provision of services to which we believe all Canadians should have access to, regardless of their income.

It must be noted, as was the case in the patients' rights category, that each province delivers a similar range of services. The differences detected in this sub-discipline exist at the margin, and the range of services offered by the different provinces is more similar than it is different. This fact is reflected in the small weighting coefficient attached to this sub-discipline. The difference between the top score in this area and the bottom is approximately 60 points out of 1,000.

Chart 10. Range and Reach of Services Offered



Although there are more similarities than differences in this area, the indicators in this component of the index demonstrate that there are disparities in terms of the range of services provided in each province. Alberta, Ontario and Nova Scotia tie for the top score in this category, as each province earns a score of "good" for three of the four indicators and does not score "poor" in any of them.

The lowest score in this category is assigned to PEI, which earned the lowest possible score, 33.3 out of 100 points, by earning a "poor" score in every catagory. By increasing the number of seniors that it immunizes against influenza, improving its childhood vaccination coverage and creating a 24/7 telephone service residents can use to contact healthcare professionals, PEI can improve its score in this category. Since the launch of Nova Scotia's telehealth line this year, all the other provinces have this type of service and PEI should take steps to create a 24/7 source of information, so that residents can easily contact health professionals when necessary.

8. Brief Summary of Results by Province

Ontario:

Ontario is the winner of this year's Index, with solid performances in every area. Nonetheless, there remains significant room for improvement in Ontario's healthcare system. Its performance continues to lag behind that which exists in most European countries. For example, although Ontario's wait times for services are shorter than those elsewhere in Canada, they must be reduced further to reach European levels. Ontario's current standing as the top performer in Canada should be viewed as a jumping-off point rather than simply as an achievement, and Ontario should strive for major improvements in order to further increase the quality of care received by consumers.

British Columbia:

British Columbia performs reasonably well in four of the five indicators, with the sole exception being patients' rights and information. British Columbia performs particularly well in the outcomes category, finishing in a tie for second place behind neighbouring Alberta. To improve its score in the main area of weakness, patients' rights and information, British Columbia should start providing online reporting of expected wait times for MRI and CT scans and attempt to boost self-reported levels of patient satisfaction by adopting a more consumer-oriented approach to the delivery of health services.

New Brunswick:

New Brunswick is the third-place finisher in this year's Index, and the province has no glaring areas of weakness in comparison to the other provinces. An area of particular strength is primary care and problem prevention, where New Brunswick ranks second behind Ontario. The province finishes in fourth place for wait times and must improve upon this middling performance in order to challenge the top spot in future indexes.

Alberta:

Overall, Alberta's health system is above average when compared with the other provinces. Alberta's strength is in the area of patient outcomes, where it finishes in a tie for first place with Ontario. The most important flaw within the province's health system is the long delays patients face when waiting for care. Wait times in Alberta are among the longest in the country. In particular, Alberta must improve access to prompt radiation therapy for cancer patients. If Alberta is able to effectively combat wait times and bring them into line with Ontario and other top performers, the province can contend for first place in future indexes.

Nova Scotia:

Nova Scotia finishes in fifth place this year, but was just 31 points out of 1,000 behind second-place finisher British Columbia. The second- through fifth-place finishers were tightly bunched together, and it should be clearly stated that the differences between them in terms of healthcare-system quality as measured in this index are slight. Since last year's index, Nova Scotia has created a 24/7 telehealth line through which residents can contact medical professionals.

This addressed a weakness that hurt the province's score in last year's index and contributed to its tie for first place in the range and reach of services category. Primary care is an area of strength, but long wait times remain a problem for many services in the province. In particular, long waits for hip and knee replacements are a major problem for Nova Scotia consumers.

Prince Edward Island:

Prince Edward Island finishes in sixth place in this year's Index, 42 points behind Nova Scotia, but well ahead of the four provinces bunched together at the bottom of the pack. Its low score in the range and reach of services category harms the province. For example, PEI is the only province that does not have a 24/7 telehealth service. Primary care and problem prevention is another area that needs improvement. Low rates of breast cancer screening illustrate this point. However, PEI performs quite well in the wait-time sub-discipline, finishing in a tie for second place with British Columbia.

Manitoba:

Manitoba finishes in seventh place in this year's index, part of a tightly clustered group of four provinces at the bottom of the index. The province's performance in the primary care, wait times and patient outcomes categories are all well below average.

The province's performance is better in terms of patients' rights and range and reach of services offered, but, overall, Manitoba's healthcare-system performance is below average when compared to the other provinces.

Newfoundland:

Newfoundland finishes in eighth place, just 12 points ahead of Saskatchewan. Primary care and problem prevention is an area of relative strength—Newfoundland is above average in this area—but long wait times and below average medical outcomes remain major problems.

Saskatchewan:

Saskatchewan finishes next-to-last in this year's Index, ahead only of Quebec, which has a low score largely due to its irregular reporting. The three most heavily weighted categories, primary care, waiting times and patient outcomes, are all areas of concern for this province. In particular, Saskatchewan's low score in the wait-time category contributes to its low overall score.

Saskatchewan's performance in patients' rights is above average. Saskatchewan's laudable commitment to transparency and open access to information is further confirmed by the fact that provincial officials provided us with the most detailed response to a set of questions that we sent to each provincial government in order to help us gather information for this report. Saskatchewan's openness and apparent commitment to improving access to information should be commended, but this sole bright spot does not compensate for the province's below-average performance in every other category of the Index.

Quebec:

In several areas, Quebec's healthcare system appears to be relatively effective when compared to the other Canadian provinces. However, Quebec's score on this Index is extremely low because Quebec's data collection and reporting processes are markedly different from the other provinces. This made it impossible to gather data for several indicators in this report and therefore impossible to accurately gauge the quality of healthcare services in Quebec. The province must align its data collection and reporting more closely with other Canadian jurisdictions to promote accountability and permit inter-provincial comparisons.

9. The (Non-)Relationship between Healthcare Spending and Healthcare Performance in Canada

The ECHCI results prove that high levels of healthcare spending do not necessarily translate into excellent healthcare-system performance. Canada is among the world's highest spenders on healthcare, and yet the performance of our healthcare system ranks below many countries that spend far less money. Canada spends approximately $3,600 dollars per capita each year on healthcare. By comparison, Italy and the United Kingdom spend between $2,500 and $2,750 per capita on healthcare each year, and both countries' healthcare performances greatly exceed Canada's.

Our experience with the international ECHCI strongly suggests that high levels of spending will not necessary translate into a high-performing healthcare system.

Our analysis of the data gathered for this inter-provincial comparison confirms that good health-system performance is not necessarily linked to high levels of spending.

We examined the healthcare spending provided by the Government of Canada, which includes both spending by provincial governments and the amount of federal spending in each province. This is the most-accurate available measure of the total amount of money, per person, that is spent on the healthcare system of each province.

Interestingly, the top performers in our Index were not necessarily the highest spenders. Ontario spends the seventh most per capita. British Columbia, the second-place finisher in our Index, is the second-lowest spender. Furthermore, some of the worst-performing provinces are among the biggest healthcare spenders. Manitoba ranks second in per capita health spending and Newfoundland ranks fourth.

Clearly, there is no simple link between higher levels of healthcare spending and improved performance. The absence of such a link was further confirmed by a simple regression analysis we performed that examined the relationship between per capita health spending and performance on this index. We were unable to detect a statistically significant relationship of any kind between these two variables. In other words, provinces with higher spending levels do not tend to have better healthcare-system performances than provinces that spend less on healthcare.

We performed this analysis of the relationship between spending and performance to demonstrate that the poor results shown by low-performing provinces are not caused by a low level of healthcare spending and to show that their problems likely cannot be solved by throwing money at the problem. Clearly, other solutions are needed, as our data shows no link between higher spending and improved health-system performance.

10. How to Interpret Index Results

In the creation of this index, the FCPP and the HCP strove to use the best, most recent data to measure and rank the performances of the 10 provincial healthcare systems from the viewpoint of the consumer. Although we made use of the best data that we could obtain, there exist imperfections in the sources that were used for this report. For example, for some indicators, different provinces use slightly different approaches to data collection and reporting that can make inter-provincial comparisons more difficult than we would like. For other indicators, we used data from 2006 because that is the most recent available. More recent data would be helpful in allowing us to gauge more precisely the current level of health-system performance.

With these points clearly stated, we strongly believe it is better to present our results, based on the best available data, to the public and to promote constructive discussion rather than subscribe to the mistaken belief that if it is impossible to perfectly measure health-system quality, we should not attempt to do so. The perfect must not be allowed to become the enemy of the good, and we believe that performance measurement and comparative evaluations should be undertaken despite the noted imperfections in the available data. We are satisfied that the data we have is sufficient to allow us to make broad statements about the variations in healthcare from province to province, as well as about system performance in specific areas such as wait times and patient outcomes.

While readers should be careful not to attribute undue importance to small differences between provinces in individual categories or even in overall scores, we are confident our methodology enables us to accurately identify meaningful performance gaps between the provinces. While the existence of a 25-point gap between Manitoba and Saskatchewan in terms of their overall scores should not be taken as evidence that Manitoba's healthcare system is markedly better than its neighbour's, the 200-point gap between these provinces and Ontario can confidently be interpreted as evidence for a meaningful disparity in health-system performance.

11. Sub-disciplines and Indicators

Each of the 28 indicators is categorized within five sub-disciplines. Explanations for each of the sub-disciplines and indicators are provided in this section.

11.1

Patients' Rights and Information Indicators (Five Indicators)

The patients' rights and information sub-discipline examines whether a province provides the patient with a powerful position within the healthcare system. Patients should have easy access to information about their healthcare options, and they should be permitted to exercise a substantial degree of informed choice in the selection of their healthcare provider. The indicators in this sub-discipline measure the extent to which patients' rights are respected and information about providers and individual health status are easily accessible to those who need it. Scoring on this sub-discipline is based on the following five indicators:

11.1.1

Healthcare Law Based on Patients' Rights

Despite the fact that it is constitutionally a provincial responsibility, Canadian health-care is largely covered by the *Canada Health Act (CHA)* of 1994. The *CHA* sets out a series of terms under which it will transfer money to the provinces for health spending. The *CHA* mandates that certain treatments must be provided at public expense. Furthermore, the *Act* imposes restrictions on additional fees for health-care services and restricts the ability of private providers to compete for healthcare consumers. Although the *CHA* guarantees universal "accessibility" to healthcare services, this component of the bill is intended to forbid discrimination and is not as a guarantee of timely, appropriate or effective treatment. The *CHA* makes no guarantees in these areas. Canada has no law explicitly guaranteeing patients' rights at the national level.

Patients' rights laws are common in Europe, and these laws have been an important tool with which reformers have pressured governments into delivering timely and effective services. In Canada, individual provinces have frequently considered various bills of rights for patients, but to date no province has enacted a law that specifically defends the rights of patients. A legislated guarantee of patients' rights is an extremely important dimension of high-quality healthcare, and the absence of such guarantees in the provinces is a major shortcoming of our healthcare system.

11.1.2

Electronic Patient Records

Electronic patient records are an important tool for making healthcare safer and more efficient. Electronic health records make it easier for healthcare providers to access accurate information about a patient, which, in turn, makes it easier to avoid errors such as allergic reactions, adverse drug interactions and the unnecessary duplication of tests. Many provinces are working to introduce electronic records, especially in the areas of medication and lab results. This indicator, drawn from Infoway's 2009 annual report, measures each province's progress toward the completion of electronic health records for medication and laboratory results.

11.1.3

Layman-adapted Formulary

The ability to access appropriate pharmaceuticals is an important dimension of healthcare quality. Consumers should be able to easily find out what drugs are covered by their province's drug-subsidization plan and under what circumstances they can be obtained. This information should be readily accessible to all consumers and presented in a format that is understandable to lay consumers and not just healthcare professionals.

Across Canada, much work remains to be done to ensure that information about prescription drugs is available in language that typical health care consumers can understand. Some provinces, particularly Alberta and Manitoba, have stated that they currently are in the process of developing more patient-friendly formularies. These praiseworthy initiatives will contribute to the creation of a more patient-centred medical culture in these provinces.

11.1.4

Publicly Listed Wait Times for Diagnostic Tests

Throughout Canada, there has been substantial improvement in recent years in terms of the provinces' publicly posting expected wait times for some medical services. In particular, most provinces post wait-time estimates for a series of five "priority areas" that have been identified by governments in Canada.

While we applaud this improvement, it is important that public listings of wait times become more comprehensive and that consumers have access to likely wait times for as many medical services as possible. The publication of this information is a vital step toward the creation of a consumer-oriented medical culture that provides individuals with as much information about their healthcare system as possible. One area for which we would like to see regular reporting of wait times is important, time-sensitive diagnostic tests such as MRI and CT scans. This indicator identifies the provinces that have easily accessible information about these tests on their web sites.

One score that requires some explanation for this category is Alberta's. Alberta received a score of "poor" for this indicator because no wait times for these tests are currently available on government websites. This information was available until May of this year, and will once again be made available in the future. The website with the relevant information has been taken down to allow the province to standardize and improve wait time data.

By the time we received this explanation for the current lack of information from the Albertan government, it was too late to consider revising the province's score on this indicator. We greatly appreciate Alberta's engagement in the CHCI process, but due to the present unavailability of this information on its websites and the

late date at which their explanation was received, the province has been given a "poor" score for this indicator. We expect the province to receive a higher score in future indices.

11.1.5

Consumer Satisfaction with Medical Services

In other areas of the economy, providers of services strive to achieve high levels of customer satisfaction. The health sector of the economy should similarly aim to meet the expectations and demands of consumers. This indicator measures the percentage of individuals who evaluated the quality of the health services they received in the past year as either "excellent" or "good" when asked about their personal experiences with the healthcare system.

11.2

Primary Care and Problem-prevention Indicators (Five Indicators)

Primary care providers are usually the patient's first point of contact with the healthcare system. Primary care providers are essential for effective preventative medicine, health maintenance and the management of chronic conditions. Unfortunately, many Canadians face significant obstacles in obtaining high-quality primary care and disease-prevention services. This group of indicators measures the ease with which consumers can engage with the healthcare system at the primary care level as well as the effectiveness of the healthcare system in terms of preventing the emergence of acute medical problems.

11.2.1

Access to a Family Doctor

Family doctors are integral to health maintenance and disease prevention. Research has shown that regular interaction with a family doctor increases the chances of identifying problems early, which is when treatment is most likely to be effective. This indicator measures the percentage of individuals over 12 in each province who have regular access to a family doctor. There exists substantial variation between the provinces in terms of performance on this indicator. For example, Quebec scores very poorly on this measure, as just 73 per cent of residents report having access to a regular medical doctor compared to over 90 per cent in Nova Scotia and New Brunswick.

11.2.2

Percentage over Age 50 Screened for Colon Cancer in Previous Two Years

Early screening for the development of cancers is one of the most important ways to improve survival rates. In particular, early detection of cancerous or pre-cancerous polyps can significantly reduce the likelihood of an individual dying from colorectal cancer. Colorectal cancer is one of the most commonly diagnosed cancers in Canada and is a leading cause of cancer-related deaths. Detecting and removing polyps early is important for preventing cancer and for surviving when a cancer does develop. A colonoscopy is a procedure used to detect potentially dangerous polyps. Many factors influence colonoscopy rates in a particular province. Some of these factors, such as individual choice, are beyond the control of the healthcare system.

Nonetheless, easy access to necessary equipment, short waits for screens and the promotion of relevant information about colorectal cancer are all factors that the healthcare system can strongly influence. For this reason, we believe this metric is a useful indicator of this dimension of healthcare quality.

11.2.3

Percentage of Women 50 to 69 who had a Mammogram in the Previous Two Years

Early screening for the development of cancers is an important way to improve survival rates. Early detection of breast cancer dramatically improves an individual's chance of survival. Breast cancer is the most common cancer among females, and mammograms are an important tool in its early detection, as they can find small lumps several years before they can be felt.[3]

As is true of colonoscopies, many factors influence the rate of mammograms in a particular province. Some of these factors, such as individual choice, are beyond the control of the healthcare system. Nonetheless, easy access to necessary equipment and the promotion of relevant information about breast cancer are factors the healthcare system can strongly influence. For this reason, we believe this metric is a useful indicator of this dimension of healthcare quality.

11.2.4

Asthma Readmission Rate

This indicator, compiled by the CIHI, is the risk-adjusted rate of unplanned readmissions within 28 days following discharge for asthma. Of course, some factors influencing readmission rates cannot be directly controlled by the healthcare system.

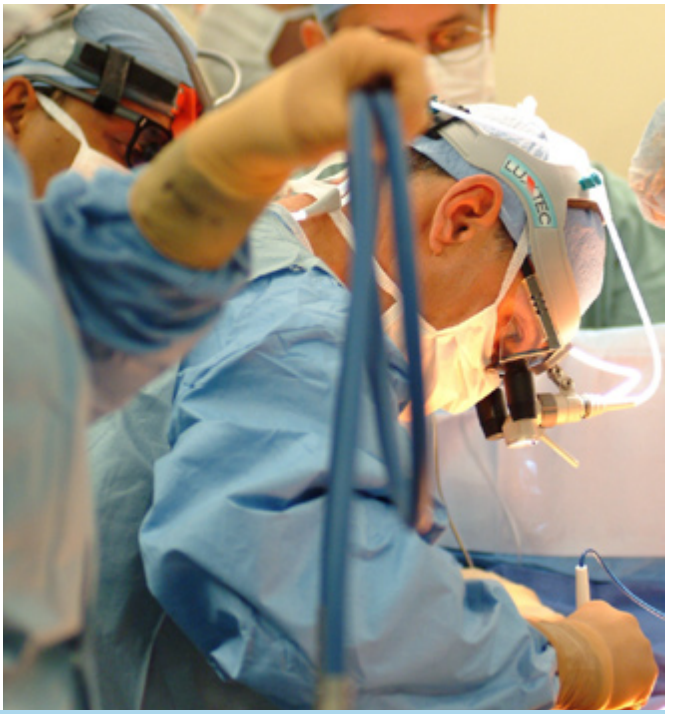
Nonetheless, hospital practices including in-patient care, education and discharge instructions can strongly influence readmission rates. Furthermore, patients admitted to hospital are likely to have poorly controlled asthma, which may be partially due to potential gaps in medical or educational follow-up in their community.[4] Low rates of readmission can therefore be taken as a reasonable indicator of healthcare-system quality.

11.2.5

Hospitalization Rate for Ambulatory Care Sensitive Conditions

Many chronic diseases such as diabetes, asthma and high blood pressure can be managed in the community through medical screening and monitoring. Effective management in the community can reduce the number of hospital stays for people with these chronic conditions. Conditions that can be managed in the community are known as Ambulatory Care Sensitive Conditions (ACSC).

This indicator, compiled by the CIHI, measures acute care hospitalization for seven ACSC among Canadians under 75 years old. This indicator is important because the effective management of ACSC in the community can improve health outcomes and contribute to the efficient use of resources. Variations in admission rates between jurisdictions may provide evidence of differential levels of accessibility and quality in community-based care.[5]



11.3

Wait Times (Seven Indicators)

Long wait times represent one of the most problematic characteristics of healthcare in Canada. Consumers with complicated conditions can be subject to a series of lengthy waits. There is often a wait to see a family doctor, to get an appointment with an appropriate specialist, to receive diagnostic procedures and then another wait for treatment. Waiting times for these services are unusually long when compared to most European countries. For the past decade, considerable attention and funding have been dedicated to addressing this problem, but with limited success. A truly high-performing healthcare system must deliver excellent outcomes and short waits for services, so that patients do not endure unnecessary periods of pain and stress while waiting for care. This category of indicators looks at wait times in several areas to examine variations in the delivery of timely care.

11.3.1

Access to Specialists within One Month of Referral

Canadians are often forced to endure long waits for diagnosis and treatment for serious problems. After they see a primary care specialist, there is often a lengthy delay before patients are able to receive an appointment with a specialist. Since many conditions are time sensitive, long delays to see a specialist can negatively affect health outcomes. The percentage of patients who see a specialist within a month of referral by their primary care physician is a useful indicator of the speed with which the healthcare system responds to consumer needs.

11.3.2

Wait Time for Hip-replacement Surgery

Hip-replacement surgeries can significantly improve quality of life but generally are not life-threatening situations. The speed with which the healthcare system provides hip-replacement surgery once the decision to pursue the surgery has been made by a doctor and patient is an indicator of the speed with which the system provides life-enhancing services in situations where the patient's life is not threatened.

11.3.3

Wait Time for Knee-replacement Surgery

Knee-replacement surgeries can significantly improve quality of life, but they are generally not life-threatening situations. The speed with which the healthcare system provides the surgery once the decision to have it has been made is an indicator of the speed with which the

system provides life-enhancing services in situations where the patient's life is not threatened.

11.3.4

Prompt Radiation Therapy

Prompt cancer radiation therapy can improve a patient's likelihood of survival. Although this is an important indicator of healthcare quality, there are inconsistencies in the way the information surrounding this indicator is collected by the provinces. Using data compiled for the CIHI Health Indicators 2009 report, this indicator is an estimate of the percentage of patients treated within 28 days of the decision to pursue radiation therapy. Although the data are somewhat scattered, there is sufficient evidence available to determine which provinces perform especially well and which perform especially poorly.

11.3.5

Wait Time for Diagnostic Testing

Advanced diagnostics such as MRI and CT scans and angiographies are often critical in determining the appropriate course of medical action. Until these scans are performed, it is usually impossible to choose the appropriate therapy. Delays for diagnostic tests can cause diseases to be detected and treated later than they would be otherwise, which can lead to worse medical outcomes. Many medical conditions detected by these tests are time-sensitive, and long delays can have negative consequences in terms of outcomes and the likelihood of survival.

11.3.6

Wait Time for Hip-fracture Surgery

Hip fractures are a serious injury and are quite common among elderly people. Hip fractures can be terribly painful, and it is important for hip-fracture surgeries to be provided in a timely fashion. However, in Canada, hip fractures are sometimes delayed because of the unavailability of operating rooms, doctors or other resources. Quick access to surgery reduces unnecessary suffering, and it increases the chances of better outcomes as well as reducing mortality rates. This indicator, compiled by the CIHI, measures the risk-adjusted proportion of hip-fracture patients 65 and older who received surgery either on the day of admission or the following day.

11.3.7

Cataract-removal Waits

Cataract removals are a relatively inexpensive outpatient surgery. While cataracts can impair quality of life, they are not life threatening. The speed with which a province provides these operations once a person has decided to have it is a useful indicator of how well each province provides desirable elective procedures for its residents.

11.4

Outcomes (Seven Indicators)

The outcomes sub-discipline assesses the performance of the provincial healthcare systems in terms of the results of treatment. Positive outcomes are among the highest priorities for healthcare consumers and providers. This is, in general, an area of strength in the Canadian healthcare systems. Although patients often endure painful and stressful waiting periods before receiving care, the quality of services they do receive when they finally reach the front of the line is quite good. This category includes measures of how well each provincial system manages serious diseases, responds to emergencies and follows best practices within hospitals.

11.4.1

AMI 30-day Mortality Rate

The 30-day mortality rate for patients who have had a heart attack is a useful indicator of how well the healthcare system responds to life-threatening emergencies. Although longer-term mortality rates are influenced more strongly by other factors such as an individual's correct use of medication and his or her lifestyle choices, the 30-day figure is a good indicator of emergency response. The speed with which the victim is taken to the hospital, the problem is recognized and treatment is initiated all influence the odds of survival.

11.4.2

Stroke 30-Day Mortality Rate

The 30-day mortality rate for patients who have had a stroke is a useful indicator of how well the healthcare system responds to this life-threatening emergency.

Although longer-term mortality rates are influenced more strongly by other factors such as an individual's correct use of medication and his or her lifestyle choices, the 30-day figure is a good indicator of emergency response. The speed with which the victim is taken to the hospital, the problem is recognized and treatment is initiated all influence the odds of survival.

11.4.3

Infant Deaths per 1,000 Live Births

Infant mortality is a useful indicator of quality of care during pregnancy, labour and delivery. Effective pre-natal care and quality services during delivery can lower the likelihood of infant mortality.

11.4.4

Cancer Five-year Survival Rate

The likelihood that an individual will survive for at least five years after treatment for cancer is influenced by many different factors. Early diagnosis and prompt and effective treatment has a significant impact on survival rates. This indicator measures the five-year survival rates for four types of cancer (breast, prostate, colorectal and lung).

Note: Data collection in Quebec was inconsistent with practices elsewhere in the country, and the population of PEI is too small to generate a sufficiently large number of cases for solid analysis. Quebec is given a score of "poor" for this indicator, and PEI receives an intermediate score.

11.4.5

In-hospital Hip Fractures

Falls resulting in hip fractures are common in hospitals. Hip fractures are often preventable, and several methods help to lower the rates of in-hospital hip fractures including identifying and monitoring high-risk patients and educating staff about this danger. This indicator is the risk-adjusted rate of in-hospital hip fractures among acute care in-patients over the age of 64 per 1,000 discharges. This is an important indicator of quality care, because it represents a complication, often preventable, of in-patient stays in acute care facilities that can sometimes be avoided by high-quality health services.

11.4.6

Hysterectomy Readmission

Hysterectomy, the complete or partial removal of the uterus, is the second most common surgery for Canadian women after Caesarean section. More than 36,000 of these procedures were performed in 2007-2008.[6] In a small minority of cases, women experience complications that require an urgent, unplanned readmission to hospital following surgeries. This indicator, compiled by CIHI, is the risk-adjusted rate of unplanned readmission following a hysterectomy performed for benign conditions.

Readmission rates provide a measure of care quality. Although readmission rates are influenced by other factors outside of the healthcare system's control, an unusually high rate of readmission suggests that practices should be carefully examined. Some hospital practices that influence readmission are infection prevention and discharge planning.[7] Variations in readmission are therefore a useful indicator of healthcare-system quality.

11.4.7

Prostatectomy Readmission Rate

Approximately 16,000 prostatectomies are performed in Canada each year for non-cancerous conditions, usually a benign enlargement of the prostate. In a small minority of these cases, men experience complications that necessitate an unplanned return to the hospital after discharge. This indicator, compiled by CIHI, is the risk-adjusted rate of unplanned readmission following surgery.

These rates provide a measure of care quality. Although readmission rates are influenced by other factors outside of the healthcare system's control, an unusually high rate of readmission suggests that practices should be carefully examined.[8] Variations in readmission rates are therefore a useful indicator of healthcare-system quality.

11.5

Range and Reach of Services (Four Indicators)

There exists some variation between provinces in terms of what services are provided through provincial health programs. This sub-discipline compares the provinces in terms of whether or not they provide high-quality affordable access to health services and products such as vaccinations and pharmaceuticals.

We do not subscribe to the view that "more is better" and that the expansion of government programs to include the provision of a particular new service or product should necessarily be viewed as a good thing. These indicators, however, measure access to the timely and affordable provision of services to which we believe all Canadians should have access to regardless of their income.

11.5.1

Childhood Vaccination

The Canadian Paediatric Society (CPS) issues a list of recommended vaccinations that should be universally accessible. The degree to which provincial healthcare systems make this preventative care available is a useful measure of the extent to which each system has adopted recent best practices. In 2008, the CPS gave each province a score on a scale from "poor" to "excellent" in terms of its compliance with CPS guidelines. We have used the provinces' rankings on this scale as an indicator of the extent to which useful vaccinations are made available to children.

11.5.2

What Percentage of Seniors Were Immunized Against Flu in the Past Year

Influenza can lead to serious health problems and even death amongst the elderly. Routine flu shots for seniors are a simple and cost-effective way of preventing influenza and the accompanying potential complications and suffering. Furthermore, it is an efficient way to decrease more-intensive utilization of healthcare services by lowering influenza rates, which represent additional cases for the medical system to absorb and treat.

11.5.3

Prescription Drugs

The proper use of pharmaceuticals is an important component of efforts to effectively prevent and treat disease. Governments in Canada and other countries use a variety of strategies to subsidize the cost of medicines. There is significant debate within the medical and policy communities surrounding the most effective, fair and rational way to subsidize the purchase of pharmaceuticals. We believe the costs of pharmaceuticals should not place an undue burden on the finances of Canadian households. In particular, poor families should be protected from facing severe financial strain because of purchasing medically necessary prescription drugs.

This indicator measures the percentage of households in each province that divert a large share (5 per cent) of their annual income to purchasing prescription drugs. This is a reasonable metric of the extent to which government policy protects individuals from severe financial challenges when purchasing expensive and/or multiple prescription drugs.

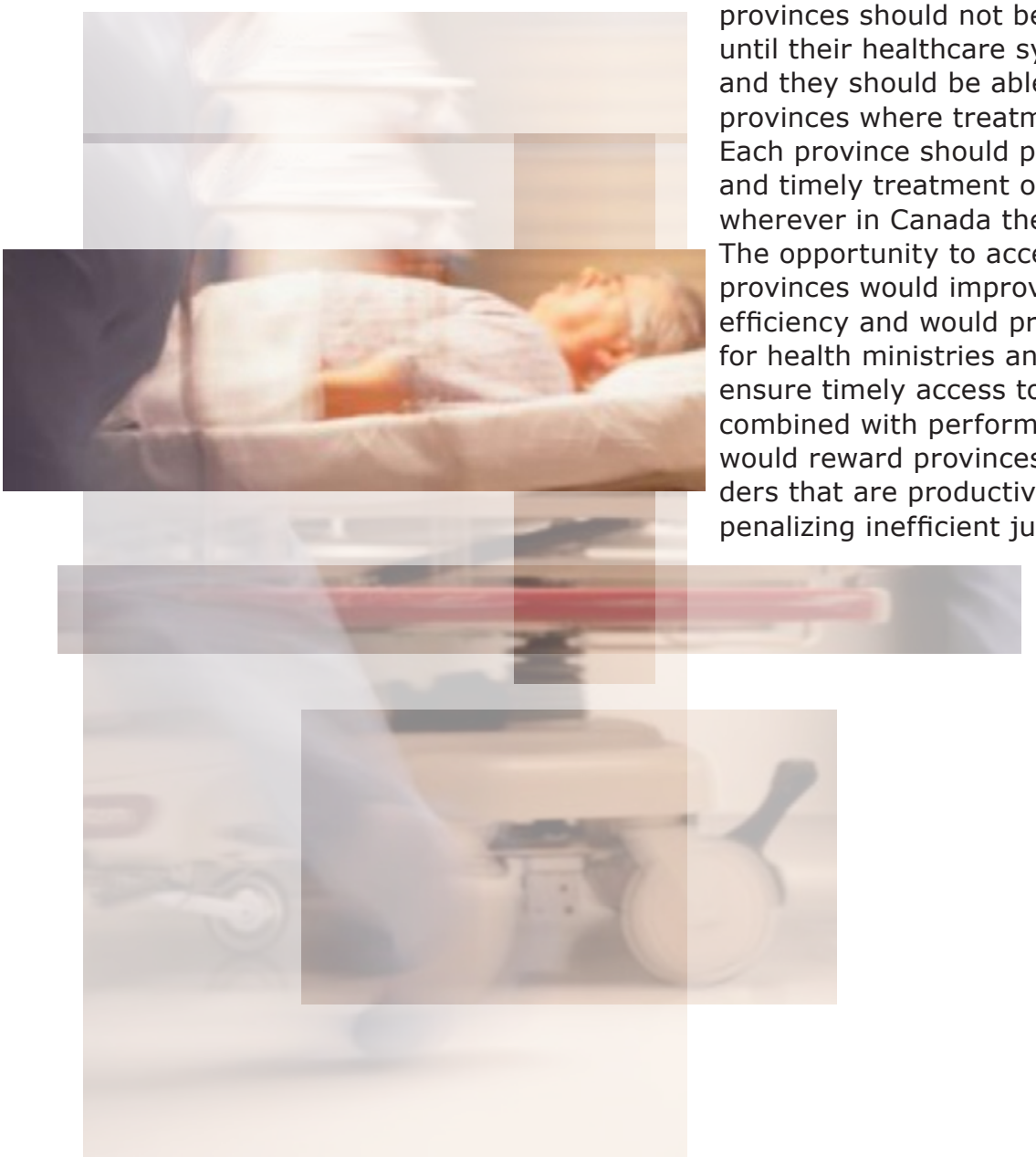
11.5.4

24/7 Telehealth Service

In some situations, consumers facing a health problem are not able to evaluate whether there is an urgent need to seek healthcare services. This is particularly true when problems arise outside of regular office hours. A telephone or Internet service that provides guidance in these situations and helps patients determine whether they should go immediately to a hospital or if they can safely wait until their family doctor is available is a useful tool in helping people make these decisions. These services can help consumers pursue the most appropriate course of action, and they can help reduce costs by avoiding unnecessary trips to the hospital for minor, non-urgent problems. Similarly, telehealth services can improve outcomes in urgent situations by helping individuals realize they need immediate care. The individuals staffing such services should be medical professionals; for example, registered nurses.

12. Policy Recommendations

This report shows that some provinces have much more effective health systems than others do. Policymakers in low-performing provinces should carefully study the practices of high-performing health systems in order to identify the best practices that they can apply in their jurisdictions.



12.1

Make Healthcare Truly Portable

Our data show that some provinces provide consultations, diagnostic exams and therapeutic procedures more efficiently than others do. Residents of less-efficient provinces should not be forced to wait until their healthcare system can perform, and they should be able to travel to other provinces where treatment slots are open. Each province should pay for the effective and timely treatment of its residents wherever in Canada they seek treatment. The opportunity to access care in other provinces would improve overall healthcare efficiency and would provide an incentive for health ministries and authorities to ensure timely access to care. This change, combined with performance-based funding, would reward provinces and health providers that are productive and efficient while penalizing inefficient jurisdictions.

12. Policy Recommendations CONTINUED

12.2

Enact Patient' Rights Laws and Wait-time Guarantees

The provinces, in co-operation with the federal government, are already taking steps in this direction, but they should accelerate the pace with which they are creating legislative guarantees of timely care. Quebec already provides a wait-time guarantee for hip and knee replacements, and the province has obliged itself to pay for these services outside of Quebec if the health system is unable to meet the wait time guarantee. Manitoba has also implemented a wait time guarantee for radiation therapy. All other provinces are introducing guarantees that will go into effect in 2010.

These first steps should be applauded, but Canada must go much further. Wait time guarantees and patients' rights laws exist in many European countries. Long wait times are the biggest single problem in the Canadian healthcare system, and these types of laws are an important tool that can be used to help improve the situation. Canadian health consumers deserve a guarantee, backed by the force of law, that they will receive prompt, high-quality healthcare services when they are confronted by a medical problem.

12.3

Move to Patient-based Funding

Most Canadian hospitals are still funded through the old-fashioned global budgeting model in which annual revenue is determined by bureaucratic processes and is unrelated to the number of patients treated or the quality of a hospital's outputs. This model distorts the patient-hospital relationship, as hospital administrators come to view each additional patient as an expense that will draw money from the budget. Under patient-based funding, the government pays a hospital for the actual services it provides, thus turning new patients into a source of revenue for hospital administrators rather than a drain on resources, while providing an incentive to maintain a reputation for providing high-quality care.

The current system is deeply flawed and leads to waiting lists, inefficiencies and rationing. Closely linking revenue to the amount and quality of the work done by hospitals will harmonize the incentives for managers with the needs of healthcare consumers. By encouraging hospitals to provide excellent care to as many patients as possible, patient-based funding is one of the most effective ways government policy can work to address the problems in Canadian healthcare. The majority of OECD countries, including Belgium, France, Germany and the Netherlands have already implemented some form of patient-based funding, and this approach has proven capable of dramatically improving healthcare-system efficiency.

13. Further Sources

Provincial and Federal Health Ministries

Canada	www.hc-sc.gc.ca
British Columbia	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.health.gov.nl.ca/health/

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
Canadian Institute for Health Information	www.cihi.ca
Wait Time Alliance	www.waittimealliance.ca
Statistics Canada	www.statcan.gc.ca/

14. FAQ

What is the Canada Health Consumer Index?

The Canada Health Consumer Index measures the performance of the healthcare systems in the ten provinces. The information is presented as a series of easily understood rankings that are designed to allow consumers to easily compare their province's healthcare system to other jurisdictions'.

Will consumers be able to easily understand this information?

Yes. The HCP and FCPP are experienced in communicating complex information about health-system performance in a concise, consumer-friendly way that clearly illustrates the strengths and weaknesses of a jurisdiction's health system. We work to make information accessible and consumer-friendly while ensuring fidelity to the original sources of data.

What is the intended impact of the CHCI?

FCPP and HCP expect provincial governments to study this report, identify their areas of weakness and take action to remedy the problems in their healthcare systems, just as several European countries have done with indexes we have compiled. We hope consumers will examine the results of this report and put pressure on governments to reform in areas where improvement is needed.

Is it possible, from a consumer perspective, to measure and compare healthcare this way?

Yes. Healthcare represents a major sector of the Canadian economy and is one of the most important areas of government activity. There is a pressing need to find relevant and comprehensive ways of assessing performance and of moving away from measuring resource inputs (staff, beds, etc) as has often been done in the past when gauging health-system quality. Our approach measures the quality of the services that are delivered, and therefore provides a measure of how well citizens are being served by their provincial governments.

Are these data already available from other sources?

The information compiled for this report is complementary to publicly available data such as that provided by Statistics Canada and the Canadian Institute for Health Information. These institutions generally do not provide the comparative analyses featured in this report.

What type of research was done for this index?

This index is based on compiled consumer information drawn from publicly available sources. It is intended to serve as a resource for healthcare policymakers and, of course, consumers.

Why do the indicators receive different weightings?

Numerous surveys show that consumers say that medical outcomes and quick access to healthcare are the most important aspects of healthcare services. Because we aim to measure healthcare-system performance from the consumer's perspective, we have heavily weighted the dimensions of healthcare quality that consumers consistently describe as the most important.

Is public health or healthcare performance measured?

Healthcare-system performance is measured. There does exist significant data on public health, which is certainly important for public policy. This report, however, focuses on the performance of provincial healthcare systems and how well they meet the needs of consumers. We exclude indicators such as obesity and life expectancy that are important measures of public health but are closely related to diet, smoking habits and the like and are not driven primarily by healthcare-system performance.

Endnotes

1. Pg. 12. In the case of five-year cancer survival rates, we used cases that were diagnosed in 2000. Data is updated annually and refined to improve the accuracy of those statistics, most recently in 2008. Of course, five-year survival rates are an imperfect measure of current healthcare-system performance, as healthcare performance from the beginning of the five-year period affects survival rate. Nonetheless, this is such an important indicator, all provinces should strive to improve it over time, and we included it in the report with the caveat that this statistic alone should not be used to evaluate the current performance of provincial health systems in terms of treating cancer patients.
2. Pg. 12. In the case of some indicators, particularly those drawn from the CIHI, the statistics were generated using three years of pooled data. In those instances, the data year cited in this report is the most recent year in which data was collected for an indicator. The advantage of using multi-year pooled data is that it improves precision, although the drawback is that it makes use of some older data.
3. Pg. 38. Educare Breast Health Care Information Website. 'Why is a Mammogram Important.' Available online: http://www.educareinc.com/pdfs/Mammogram.pdf
4. Pg. 38. Canadian Institute for Health Information. Health Indicators 2009. Available online: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_20090611_e
5. Pg. 38. Ibid.
6. Pg. 42. Ibid.
7. Pg. 42. Ibid.
8. Pg. 42. Ibid.

Further Reading

May 2009 PS061

Euro-Canada Health Consumer Index 2009

By Daniel Eriksson and Arne Björnberg

http://www.fcpp.org/publication.php/2779

June 2008 FB063

Separating the Twins

Splitting Alberta's Healthcare Ministry in two will split purchasers from suppliers

By Mark Milke

http://www.fcpp.org/publication.php/2254

For more see

www.fcpp.org

The Think Tanks behind the Canada Health Consumer Index

The Frontier Centre for Public Policy is an independent, non-profit organization that undertakes 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 local government, education, health and social policy.

Health Consumer Powerhouse

The 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 healthcare systems and provide the outcomes as the consumer information indexes. The HCP indexes set the standard for a new way to look at healthcare, as we believe transparency supports the policy-makers as well as focussing reforms. We work from Stockholm, Brussels, and now Canada.

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