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Canada Health Consumer Index 2010

By Ben Eisen, M.P.P.

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Health Consumer Powerhouse

FRONTIER CENTRE FOR PUBLIC POLICY

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.

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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By Ben Eisen

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Foreword

It is a pleasure to present our third annual Canada Health Consumer Index (CHCI). The CHCI evaluates and compares healthcare system performance across Canada's ten provinces. TheCHCI measures health system quality from the consumer's perspective, and assesses the extent to which each province currently meets the healthcare needs of its residents. This consumer-oriented approach uses a proven performance measurement and benchmarking methodology originally from the Frontier Centre's partner think tank on health policy—the Health Consumer Powerhouse(HCP), Europe's leading independent providerof 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 produce the first Euro-Canada Healthcare Consumer Index (ECHCI), which compared Canada's healthcare system to those found in 29 European countries. This path breaking study showed that Canadian healthcare is inefficient, plagued by lengthy wait times, and generally less effective in delivering excellent, timely care compared to most European systems. This assessment, which was confirmed by the second and third ECHCI in 2009 and 2010, has stimulated the needed debate, and offered policy-makers insights to initiate needed reforms. Although Canadian healthcare is generally low performing, relative to Europe, there are differences between the ten provinces. Therefore, analysis at the provincial level is necessary.

Public opinion polls consistently show that healthcare is a pressing concern for most Canadians. They want timely access to high-quality healthcare services that maximize the possibility of positive health outcomes. In order to maximize healthcare system efficiency resources must be spent wisely with adequate attention being paid to primary care and problem prevention. This can save money and, more importantly, reduce 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 have been 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 CHCI highlights challenges in each province, but it also points out areas of strength, and shows what is possible. This is precisely the purpose of the index: supporting consumers so they can make informed decisions while 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

1. Executive Summary

This report presents the results of the third annual Canada Health Consumer Index (CHCI). This year's study once again demonstrates that there are meaningful differences between the 10 provincial healthcare systems in terms of their success at delivering timely, consumer-friendly care.

As the international Euro-Canada Health Consumer Index (ECHCI) demonstrated again in 2010, Canadian healthcare still lags well behind the top European healthcare systems in terms of responsiveness to the needs of consumers. The top-scoring provinces in this year's CHCI should be recognized for their relatively strong healthcare-system performance in comparison with other Canadian jurisdictions. However, readers of this report should recognize that even top-performing Canadian provinces still have much work to do in order to reach the level of excellence that exists in European countries such as the Netherlands, France and Germany.

The purpose of the CHCI and its sister project, the ECHCI is to provide an evaluation of health-care-system performance from the *perspective of the consumer.* 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 effectiveness 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 a particular country.

Instead of measuring inputs, such as spending levels and resources used, this index attempts to measure *outcomes* from the perspective of the consumer. The CHCI seeks to measure the *consumer-friendliness* of each national healthcare system—that is to say the extent to which it meets the needs and demands of the people who rely on it.

The CHCI evaluates the consumer-friendliness of each provincial healthcare system across five dimensions—Patient Rights and Access to Information, Primary Care and Problem Prevention, Wait Times, Patient Outcomes and Range and Reach of Services Provided. For each of these categories, a number of indicators are examined to determine the extent to which each province's healthcare system is achieving results that benefit the consumer.

In this year's report, the top three provinces—Ontario, British Columbia and New Brunswick—finish in a distinct top tier in the overall rankings, well ahead of the remaining provinces. The high scores for these provinces are largely the result of wait times that are shorter than the Canadian average in important areas and patient outcomes that are similar or superior to national standards. However, our research suggests that in a number of areas—particularly wait times—even these top-performing Canadian jurisdictions currently lag behind leading European jurisdictions. The high scores earned by these three provinces should be interpreted as evidence of relative consumer-friendliness within the Canadian context, but they should not distract from the fact that much work is needed across the country to meet the levels of consumer-friendliness and timeliness of care that are taken for granted in much of Europe.

The remaining provinces fall into a distinct second tier well behind the top performers. All seven of the remaining provinces fall within a relatively narrow 51 point range, between 610 and 661 points in our overall rankings. Each of these jurisdictions has one or more areas of weakness that contributed to its ranking in the second tier.

The strengths and weaknesses of each province are discussed in detail in the body of this report. While this report details meaningful differences between the seven provinces in the second-tier in specific areas, it is important to stress that the overall scores achieved by these provinces are very close to one another by the historical standards of the CHCI and when compared to the gap between all of these provinces and the three top performers. We caution readers to be careful not to attribute undue importance to small differences between provinces in individual categories or even in overall scores. It is particularly important to stress this fact for this year's index, since so many of the provinces were clustered very close together in the overall rankings.

While the existence of a five-point gap between Alberta and Saskatchewan should not be taken as evidence that Saskatchewan's healthcare system is substantially more consumer-friendly than its neighbour's, the 100-point gap between these provinces and British Columbia or Ontario can confidently be interpreted as evidence of a meaningful disparity in terms of overall consumer-friendliness.

Saskatchewan is one jurisdiction whose results merit special attention. Saskatchewan finishes in the second tier, it has improved significantly since last year when the province finished in last place. This advance is the result of a relative improvement in wait times for several key indicators. Wait times for knee-replacement surgery and cancer radiation therapy are two important indicators in which Saskatchewan showed improved performance.

Alberta is another province of particular interest, as it has fallen in the rankings due to increases in wait times. Long waits for cancer radiation therapy, cataract surgery and appointments with specialists following a referral drove down Alberta's score. The province's strong performance in the important patient outcomes category prevented the province from falling out of the second tier. However, Alberta's generally long wait times negatively affected its overall score and prevented Alberta from challenging the top-performing provinces. Alberta finishes in a tie for seventh place in the rankings, bunched closely with several other provinces, but ahead of only PEI and Newfoundland. Alberta's long wait times are particularly troubling considering that the province's per capita spending on healthcare is among the highest in the country.

Alberta's high spending and middling performance reflects a general trend that has emerged in our analysis of the CHCI over the past several years. Historically (including this year), our analysis has not shown a relationship between per capita healthcare spending and the level of consumer-friendliness achieved in the provinces. This should be taken as evidence that 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 simply by throwing money at them.

Clearly, solutions other than simply increasing spending are needed to improve healthcare-system performance. This report describes a few reforms that could improve healthcare performance across the country. The following reforms are discussed in this report:

- Move away from global budgets to patient-based funding models
- Co-operate with other jurisdictions in the approval of new medicines
- Introduce means-tested co-payments

Governments across Canada should ensure that their citizens consistently have timely access to excellent healthcare services. All 10 provinces currently fall short of this goal, and we hope this year's CHCI will help policy-makers and citizens in each province identify areas where there is a need for aggressive reform.

2. Introduction

2.1 Frontier Centre for Public Policy

The Frontier Centre for Public Policy (FCPP) is an independent, 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. In the specific area of healthcare, FCPP is dedicated to building a culture of transparency and accountability in Canadian healthcare by evaluating healthcare-system performance from the perspective of consumers.

2.2 Health Consumer Powerhouse

The Health Consumer Powerhouse (HCP) is a centre of vision and action and promotes consumer-related healthcare in Europe. It is based in Belgium. 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, it 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, former Yugoslav Republic of Macedonia, Iceland and Albania. In recent years, Canada has been included in this analysis.

2.3 What is the Canada Health Consumer Index?

Since 2007, the Frontier Centre has collaborated with the HCP to promote visionary thinking about healthcare policy in Canada and around the world. In the specific case of our annual CHCI report, of which this is the third, our objective is to assess the consumer-friendliness of healthcare delivery in the ten Canadian provinces by asking a specific question: How well does the healthcare system in each province 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, as 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 the 2010 Canada Health Consumer Index, 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 FCPP and the HCP can analyze the extent to which healthcare systems across Canada are meeting the needs of consumers.

The rankings for the CHCI—like the rankings for the international ECHCI—are neutral regarding how healthcare systems allocate financial

resources and the extent of private sector involvement in health services delivery. 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's rankings. Instead, the indicators in this Index are entirely performance-based. 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?

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 effectiveness or efficiency of the relevant program or policy. In health policy, for example, 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 extent to which each provincial healthcare system is responsive to the needs of its users.

3.1 Regional Variations

The FCPP 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 may exist in the accessibility and provision of services in urban and rural communities. Although these disparities are important and worthy of additional study, the goal of this index is to assess the overall level of consumer-friendliness for each of the provincial healthcare systems. 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. We hope that additional 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 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. This section provides additional information about our methodological approach to evaluating the healthcare system's consumer-friendliness.

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 indicator is provided in section 11, and the sources for each indicator are listed in section 4.

Many useful indicators of healthcare quality and health-system responsiveness to consumer needs exist, and we chose a small number for this index. We used several important additional criteria in selecting the indicators.

- 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, 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.

Last year, we made substantial changes to our list of healthcare-quality indicators. We believe these changes significantly improved our collection of indicators and allowed us to make a more accurate assessment of consumer-friendliness in each province. This year, there have been additional, smaller changes and changed the benchmarks for some indicators. A few indicators were dropped because we were unable to obtain recent data, and others were added to provide a more complete picture of the relative performance of each province in terms of providing timely access to services. 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 for any component of these studies.

4.2 Data Collection and Verification

All the information used to compile this index is publicly available. Government databases and information that is readily obtainable from the Canadian Institute for Health Information (CIHI) or provincial health Ministries provide a substantial share of the data used in this report. For a few indicators, information was gathered from research performed by independent think-tanks and other entities outside of government. Most of the data that inform this report, however, was originally collected by government and is publicly available. 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. Data for this report are from 2007 or later and we made every effort to obtain data from 2010 or 2009 whenever possible.[1] We were sometimes forced to make use of data from 2008 and, less frequently, 2007 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.

For a small number of indicators, our analysts were required to exercise judgement to determine the most appropriate score for particular provinces for specific indicators. For example, for the AMI 30-day in hospital mortality indicator, British Columbia's risk-adjusted mortality rate was 9.4 per cent. The 95 per cent confidence interval around this statistic provided by the CIHI was 9.0—9.8 per cent. This caused British Columbia to be, ever so slightly, statistically distinguishable from the national average of 8.9 per cent. For the same indicator, Nova Scotia had an identical risk-adjusted mortality rate as British Columbia—9.4 per cent—and PEI had a slightly higher rate of 9.8 per cent. However, due to a smaller sample and larger confidence interval, these provinces were not statistically distinguishable from the national average. We determined that it would be unfair to award British Columbia a lower score than PEI and Nova Scotia for this indicator, considering that its measured survival rate was either better than or identical to their scores. In borderline instances such as these, we carefully examined all available data and evidence and exercised judgement as to the most appropriate score. In this case, British Columbia was given a score of "fair," (the same as PEI and Nova Scotia) rather than "poor." In a few other instances, slightly different data collection processes for the provinces in terms of measuring wait times made direct comparison more difficult than we would like. Again, in these instances, we exercised judgement based on all available evidence. It should be noted that there were very few indicators that required this sort of independent judgement, as the data was usually straightforward and easily interpreted.

4.3 Comprehensive, Uniform and 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 interprovincial 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 interprovincial 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.

In some instance, even when a CUTS was available, we consulted additional materials to confirm our findings or to determine whether more-recent information was available that should inform our score for a particular province on a particular indicator. In these instances, our researchers make a determination based on all the available evidence to determine the appropriate score for each indicator for each province.

4.4 Scoring System

For each indicator, the performance of the provincial healthcare systems is graded on a three-level scale.

Each of the three levels is represented graphically throughout the report by a colour-coded symbol, as shown below:

Green = good (●), Amber = fair (◑) and, Red = poor (○).

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 is 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 found to be poor. In instances where recent, reliable data were unavailable for a province due to data collection processes that are inconsistent with other jurisdictions, 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 the case of Prince Edward Island, sample sizes for some indicators were too small to develop results in which Statistics Canada and the Canadian Institute for Health Information (CIHI) have confidence. In those instances, PEI was given an "amber" or "intermediate" score, so as not to punish the province for its small population.

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 generally 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."

4.5 Indicator Areas: Sub-disciplines

The process of creating the CHCI was informed by the lessons learned from the compilation of the Euro-Canada Health Consumer Indexes and earlier 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.

Chart 1. Indicator Areas: Sub-disciplines

Sub-discipline	Number of Indicators
Patients' Rights and Information	5
Primary Care	5
Wait Times	8
Outcomes	6
Range of Services Provided	5

In the generation of final scores, the weight of 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 was 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 rounded to the nearest integer and then added up. This produces an integer score between 1 and 1,000, which is the province's final score.

4.6 Weighting Coefficients

The Health Consumer Powerhouse 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, these sub-disciplines were assigned the highest weightings 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.

We developed our weighting coefficients through consultations with experts as well as healthcare system users to determine what they believe are the most important elements of a consumer-friendly healthcare system.

Nonetheless, such weightings are necessarily somewhat subjective. They are useful in helping us to develop an easily understood "overall" ranking of each of the provincial healthcare systems. However, the most meaningful indications of gaps in consumer-friendliness between the provinces can be found by examining the provincial scores for the individual categories. We aim to promote accountability and to provide citizens with as clear a view as possible of overall system performance by producing an "overall" score. This component of our work requires the exercise of judgement, and readers are encouraged to pay particularly close attention to the performance gaps in the specific sub-categories to obtain a clearer sense of where each system is succeeding and where each is most in need of improvement.

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

Chart 2. Weighting Coefficients

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	37.75
Outcomes	3	300	50
Range of Services Provided	1	150	30

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.

5. Indicator Definitions, Benchmarks and Data Sources for the Canada Health Consumer Index 2010

Chart 3.

Sub-discipline	Indicator	Comment	Good	Fair	Poor	Main Sources
Patients' Rights and Information	Healthcare Law Based on Patients' Rights	Is there an explicit, 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 (2010)
	Electronic Patient Records	What is the median score awarded to a province's hospitals for the development of hospital electronic health records by the EMR Adoption Model developed by HIMSS Analytics? (1-7 scale)	>3	1-3	<1	HIMSS Analytics (2010)
	Layman-adapted Formulary	Is there a readily available formulary written in layman's terms that provides information about the appropriate use of medications and potential side effects?	Yes, available and intended for consumers	Intended for professional use only	No readily available formulary	Provincial government websites (2010)
	Online Reporting of MRI and CT Scan Wait Times	Is there an easily accessible website that posts expected wait times for MRI and CT scans?	Yes, both	One or the other but not both	No	Provincial government websites, CIHI Wait Time Tables (2009-2010)
	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 (2009)
	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.	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than Canadian average	CIHI *Health Indicators* (2010)
	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 *Health Indicators* (2010)
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 (2009)
	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 websites (2009-2010)

Sub-discipline	Indicator	Comment	Good	Fair	Poor	
Wait Times (Continued)	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 websites (2009-2010)
	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 Tables	CIHI Wait Time Tables and provincial websites (2009-2010)
	MRI Wait Time	How long is the average wait time for an MRI scan?	<8 weeks	8-12 weeks per cent	<12 weeks	*Waiting Your Turn* Fraser Insitute Wait Time Report (2009)
	CT Scan Wait Time	How long is the average wait time for a CT scan?	<4 weeks	4-6 weeks	<6 weeks	*Waiting Your Turn* Fraser Insitute Wait Time Report (2009)
	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 *Health Indicators* (2010)
	Cataract Removal	Average wait in days for cataract surgery from decision to treatment.	<50 Days	50 to 74 days	>75 days	CIHI *Health Indicators* (2010)
Outcomes	AMI Mortality Rate	What is the 30-day AMI mortality rate?	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than the Canadian average	CIHI *Health Indicators* (2010)
	Stroke Mortality Rate	What is the 30-day stroke mortality rate?	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than the Canadian average	CIHI *Health Indicators* (2010)
	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 (2007)
	Rate of In-hospital Hip Fractures	Risk-adjusted rate of in-hospital hip fractures among acute-care patients 65 and older per 1,000 dischargees.	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than the Canadian average	CIHI *Health Indicators* (2010)
	Hysterectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following hysterectomy for benign conditions.	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than the Canadian average	CIHI *Health Indicators* (2010)
	Prostatectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following prostatectomy for benign conditions.	Lower than the Canadian average	Statistically indistinguishable from the Cdn. average	Higher than the Canadian average	CIHI *Health Indicators* (2010)

Continued next page

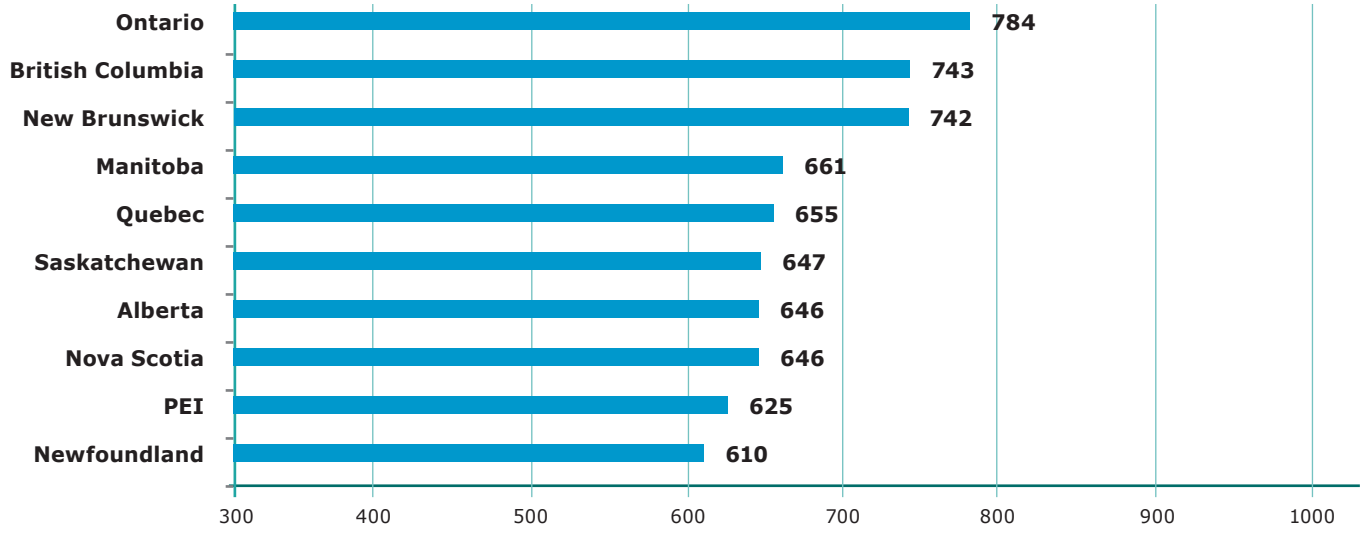
Sub-discipline	Indicator	Comment	Good	Fair	Poor	Main Sources
Range and Reach of Services	Childhood Vaccination	Canadian Paediatric Society ranking of quality of childhood vaccination coverage.	Excellent	Good	Fair	CPS website
	Influenza Immunization for Seniors	What percentage of those over 65 had a flu vaccine in past year?	>65 per cent	60 to 65 per cent	<60 per cent	StatsCan Table 105-0501 (2009 data)
	Approval Time for New Medicines	What is the weighted average time between Health Canada regulatory marketing approval and provincial public reimbursement approval for new medicines?	<300 days	300-350 days	>350 days	*Access Delayed, Access Denied* Fraser Insitute 2010 Report
	New Medicines Approved as a Percentage of NOG	How many new drugs, approved by Health Canada as safe and effective, has the province approved for public reimbursement between 2004 and 2008?	>70	40-70	<40	*Access Delayed, Access Delayed,* Fraser Insitute 2010 Report
	24/7 Access to Medical Information	Is there a 24/7 phone number and/or website providing medical advice from RN equivalent?	Yes	Some info but not RN	No	Provincial government websites

6. Results

6.1 Summary of Results: Overall Scores

For the third consecutive year, Ontario finishes on top in the CHCI rankings. However, the gap has narrowed between Ontario and other top performers over the past year. This year, only 42 points separate the top three finishers—Ontario, British Columbia and New Brunswick. All three earned a high score primarily because of a strong performance in the most important categories—wait times and patient outcomes.

Chart 4. Overall Scores



Following the top tier are six provinces clustered very close together—just 51 points separate 4th place Manitoba from last place Newfoundland. The 4th through 8th place finishers are bunched together in an extremely narrow 15 point range. It is impossible to take these small differences in scores as clear evidence of differential levels of consumer-friendliness in the healthcare systems of these six provinces.

The similar overall scores for these six provinces masks important differences in particular categories of indicators that are examined in this report. For example, Alberta performs well in terms of patient outcomes, but a very low score in the important wait-times category dramatically lowers the province's overall score. On the other hand, Saskatchewan performs relatively well in terms of wait times (an impressive reversal from our results a year ago) but performs significantly worse on patient outcomes than does Alberta and a few other provinces in this second tier. A brief summary of each province's results as well as a discussion of the results in particular categories can be found in subsequent sections of the report. These sections can be consulted for additional information on the strengths and weaknesses of each province.

The case of Quebec requires additional explanation. This year, Quebec finishes fourth in our index. Quebec's score, however, might be harmed by the fact that, by rule, we assign "poor" scores to provinces that do not collect data that are tracked by the other provinces using standard data collection methods. This rule, meant to reward transparency, affects Quebec's scores more than any other province due to its unusual data collection processes for several indicators. Quebec should move to standardize data collection processes with

other Canadian provinces wherever possible to allow for interprovincial comparisons and to permit citizens to hold politicians to account if performance is poor in specific areas.

In short, this year's results show a clear top tier in terms of consumer-friendly healthcare that consists of Ontario, British Columbia and New Brunswick, which score significantly higher than the remaining provinces, which are clustered relatively close together between 610 and 661 points.

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	○	○	○	○	○	○	○	○	○	○
	Hospital Electronic Health Records	◑	●	○	○	◑	○	●	◑	◑	●
	Layman-adapted Formulary	●	◑	◑	◑	◑	◑	◑	◑	◑	◑
	Online Reporting of Current Waits for MRI and CT Scans	○	○	●	●	●	○	○	●	●	○
	Patient Satisfaction	○	○	◑	◑	◑	◑	●	●	◑	◑
	Sub-discipline Weighted Score (/100)	53	53	60	60	67	47	67	73	67	60
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	100	120	140	90	120	100	100	100
Wait Times	Access to a of Specialist Within One Month Referral	●	○	◑	◑	○	●	◑	◑	◑	○
	Wait Time for Hip-replacement Surgery	●	◑	○	○	●	●	◑	○	◑	◑

LEGEND: ● GOOD ◑ FAIR ○ POOR

Sub-discipline	Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Wait Times *Continued*	Wait Time for Knee-replacement Surgery	●	◑	◑	◑	●	●	◑	○	◑	◑
	Prompt Cancer Radiation Therapy	●	○	●	●	●	●	●	○	●	●
	Wait Time for CT Scan	◑	◑	◑	◑	◑	◑	◑	◑	○	○
	Wait Time for MRI	◑	◑	◑	◑	●	◑	◑	◑	○	○
	Wait Time for Cataract Removal	●	○	●	○	●	◑	●	◑	◑	●
	Wait Times for Hip-fracture Surgery	◑	◑	○	◑	◑	○	●	◑	◑	●
	Sub-discipline Weighted Score (/300)	263	163	200	188	250	238	238	163	188	200
Outcomes	AMI In-Hospital Mortality Rate	◑	●	◑	●	◑	○	◑	◑	◑	◑
	Stroke In-Hospital Mortality Rate	◑	●	◑	◑	◑	○	◑	○	◑	○
	Infant Mortality Rate	●	○	○	○	◑	◑	●	●	◑	○
	Rate of In-hospital Hip-fractures	◑	○	◑	○	●	○	◑	◑	◑	◑
	Hysterectomy Readmission Rate	◑	◑	○	◑	◑	◑	◑	◑	◑	○
	Prostatectomy Readmission Rate	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑
	Sub-discipline Weighted Score (/300)	217	200	167	183	217	150	217	200	200	150
Range and Reach of Services Offered and Access to New Services	Childhood Vaccination	◑	●	◑	◑	◑	◑	◑	◑	◑	◑
	Influenza Immunization for Seniors	●	◑	◑	◑	●	◑	◑	●	◑	○
	New Medicine Approval %	○	○	◑	○	○	●	◑	◑	○	◑
	Speedy Inclusion of New Medicine in Provincial Reimburse-ment Plan	○	●	●	●	◑	●	○	○	○	◑
	24/7 Access to Medical Information	●	●	●	●	●	●	●	●	○	●
	Sub-discipline Weighted Score (/100)	100	120	120	110	110	130	100	110	70	100
Overall Score (/1000)		**743**	**646**	**647**	**661**	**784**	**655**	**742**	**646**	**625**	**610**
Rank		**2**	**7**	**6**	**4**	**1**	**5**	**3**	**7**	**9**	**10**

6.2 How to Interpret the 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 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 interprovincial comparisons more difficult than we would like. For other indicators, we used data from 2007 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 performance, 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 consumer-friendliness from province to province as well as about system performance in specific areas such as wait times and patient outcomes.

We caution readers to be careful not to attribute undue importance to small differences between provinces in individual categories or even in overall scores. It is particularly important to stress this fact for this year's index, since so many of the provinces were clustered very close together. Seven provinces in the middle of the rankings finished within 51 points of each other—it would be a mistake to conclude from these results that the small gaps between these seven provinces are evidence of a meaningful difference between the provinces in terms of healthcare-system performance or consumer-friendliness.

While the existence of a five-point gap between Alberta and Saskatchewan should not be taken as evidence that Saskatchewan's healthcare system is substantially more consumer-friendly than its neighbour's, the 100-point gap between these provinces and British Columbia or Ontario can confidently be interpreted as evidence of a meaningful disparity in terms of overall consumer-friendliness.

6.3 Brief Summary of Results by Province

British Columbia: British Columbia finishes in second place in this year's index, part of a distinct first tier with Ontario and New Brunswick. As was the case last year, British Columbia fared well in most categories, but once again did not succeed in the Patients' Rights and Information category—largely because wait times for diagnostic imaging tests are not posted online. However, a bright spot in that area is B.C.'s consumer-friendly medication formulary, which provides accessible, user-friendly information. One additional area of relative weakness is a lengthy delay in the approval of new medicines in the provincial reimbursement plan. B.C.'s average delay of 380 days in 2008 was amongst the longest in Canada and was substantially longer than neighbouring Alberta's, which took an average of 280 days to approve new medicines. British Columbia performed particularly well in the Wait Times category compared to other Canadian provinces. Waits for cataract and orthopaedic surgery and cancer radiation therapy were all shorter than the national average. British Columbia's performance

in the patient outcomes was also amongst the best in the country.

Alberta: Alberta finishes in a tie for 7th place in this year's index, part of the large second tier. Alberta, more than any other province shows inconsistent results with some areas of real strength alongside major areas of weakness. The province delivers good patient outcomes, ranking near the top of the country in that category. However, long waits for care hurt Alberta's overall score. Wait times for cataract surgery, radiation therapy and appointments with specialist are all substantially longer than the national average. None of the eight indicators examined showed a wait time in Alberta substantially shorter than the national average. Albertans suffer from long wait times for care despite a level of per capita healthcare spending in the country that is among the highest in Canada.

Saskatchewan: Saskatchewan has shown a measurable turnaround from last year when it finished near the very bottom of the Index due primarily to long wait times for care. This year, Saskatchewan caught up with several provinces and finishes in sixth place near the middle of the closely bunched second tier. The wait-time situation appears to be improving relative to the rest of the country. Waits for orthopaedic surgery are still too long, but some improvement in the delay for knee-replacement surgery moved the province from a rating of "poor" last year to "fair" this year. Reported wait times for cancer radiation therapy improved significantly since last year's report. Waits for hip-replacement surgery still reflected a "red" score. There are still areas where improvement is needed. For example, in the patient outcomes category, Saskatchewan has a higher risk-adjusted rate of hysterectomy readmission following surgery than the national average.

Manitoba: Manitoba finishes in fourth place, at the top of the large second tier in this year's index, behind New Brunswick, B.C. and Ontario. This is an improvement on last year's results. Manitoba fares well in the Primary Care and Problem Prevention category, due to high levels of breast cancer and colon cancer screening (2008 Statistics Canada data) and a low rate of hospitalization for ambulatory care sensitive conditions. Wait times remain a problem in Manitoba for several indicators—waits for cataract removal are amongst the longest in the country, as are waits for hip-replacement surgery. Between 2004 and 2008, Manitoba approved far fewer new medicines than did most jurisdictions. For patient outcomes, Manitoba's performance was generally middling—though the province does have a low rate of heart attack mortality. On the other hand, Manitoba shows an unusually high rate of in-hospital hip fractures that is larger than and statistically distinguishable from the Canadian average. One the whole, Manitoba's performance is mixed, which results in the province's ranking in the second tier.

Ontario: Ontario finishes in first place in the top tier in this year's rankings, with a score that is very similar to British Columbia's and New Brunswick's. Ontario earned a score of "fair" for all the patient outcome categories save for one—it earned one "good" score due to a low risk-adjusted rate of in-hospital hip fractures, which is an indicator of hospital safety. Ontario has no "poor" scores in this category. Wait times are also shorter than the national average in Ontario in most categories including orthopaedic surgery and diagnostic imaging. However, an unusually large number of Ontarians reported waiting more than one month the last time they were referred to a specialist for a new condition. Primary care and problem prevention is a particularly strong area for Ontario. For example, a comparatively large number of Ontarians have regular access to a family doctor.

Quebec: Quebec finishes in the middle of this year's rankings—but it is difficult to form an accurate assessment because the province does not follow national data collection standards for several of our indicators. As a result, the province was awarded a "poor" score in several indicators where actual performance might be higher. We advise caution in interpreting Quebec's score as an accurate measure of

consumer-friendliness in the province. Quebec generally performed very well in the Wait Times category, showing lower than average waits for orthopaedic surgery, specialist appointments and cancer radiation therapy.

New Brunswick: New Brunswick finishes in third place, part of a distinct first tier with B.C. and Ontario. New Brunswick's performance is relatively strong in all the categories except for the Range and Reach of Services category. Slow adoption of new medicines into the provincial reimbursement plan contributes to a low score in this category. New Brunswick's score is above average in both of the most heavily weighted categories—Patient Outcomes and Wait Times.

Nova Scotia: Nova Scotia's score is roughly in line with the Canadian average or slightly above in four out of five categories, but a low score in the Wait-times category prevents Nova Scotia from joining nearby New Brunswick in the top tier. Specifically, Nova Scotia has the longest wait times for orthopaedic surgery in Canada. Wait times for cancer radiation therapy are also above the Canadian average. To move into the top tier in future years, Nova Scotia will need to reduce its wait times in these areas. Due to its long wait lists, Nova Scotia finishes in a tie with Alberta for 7th place.

Prince Edward Island: PEI's performance is near the Canadian average in four out of five categories, but Canada's smallest province earns a low score for range and reach of services, which has a slight negative impact on its overall score. For some indicators, it was impossible to formulate an effective score because the sample sizes were too small for Statistics Canada and the Canadian Insitute for Health Information (CIHI) to develop meaningful statistics. In these instances, PEI was awarded an intermediate score so that there was no negative impact on the province's overall score or on the scores in particular categories. PEI finishes in 9th place.

Newfoundland: Newfoundland finishes in last place in this year's index, just fifteen points behind ninth place Prince Edward Island. Newfoundland's low score was driven in large part by its unusually low performance in the important patient outcomes section. Newfoundland's unusually high infant mortality rate, readmission rate following hysterectomies and in-hospital stroke mortality rate all contributed to the province's low score in this category and overall. Although Newfoundland finishes in last place, it should be clearly noted that the gap between the other provinces in the second tier and Newfoundland was quite small. These results should not be interpreted as evidence of a large gulf in consumer-friendliness between Newfoundland and the rest of Canada. Instead, they are best interpreted as showing a meaningful separation between the top three provinces on the one hand and the rest of the provinces in Confederation on the other.

6.4 The (Non-) Relationship Between Healthcare Spending and Consumer-Friendly Care in Canada

The ECHCI proves 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. Canadian governments spend 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 health care each year, and both countries outrank Canada in the annual Euro-Canada Health Consumer Index, which measures consumer-friendly healthcare. Top performers in the Index, such as Germany and the Netherlands, generally have levels of healthcare spending that are roughly comparable to Canada's, yet achieve shorter wait times and comparable or better patient outcomes.

Our experience with the international ECHCI strongly suggests that high levels of spending will not necessary translate into a system that better meets the needs of consumers. Our analysis of the data gathered for this interprovincial comparison confirms that good health-system performance is not necessarily linked to high levels of spending.

We examined the healthcare spending provided by the governments of Canada, which include both spending by provincial governments and the amount of federal spending in each province. This is the most-accurate measure available 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 and British Columbia, the top two finishers in our index spend less money per capita on health than most other provinces. Alberta and Newfoundland both have high spending levels, but finish in the bottom half of the index.

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. Higher spending provinces did not outperform lower spending provinces, on average. In other words, provinces with higher spending levels do not tend to have more consumer-oriented healthcare systems as measured in this index than provinces that spend less on healthcare.

We performed this analysis of the relationship between spending and performance to demonstrate that the results shown by the provinces near the bottom of our index are not caused by low levels of healthcare spending and to show that their problems likely cannot be solved by throwing money at them. Clearly, other solutions are needed, as our data shows no link between higher spending and a higher level of consumer-friendliness.

7. Summary of Results by Sub-category and Description of Indicators

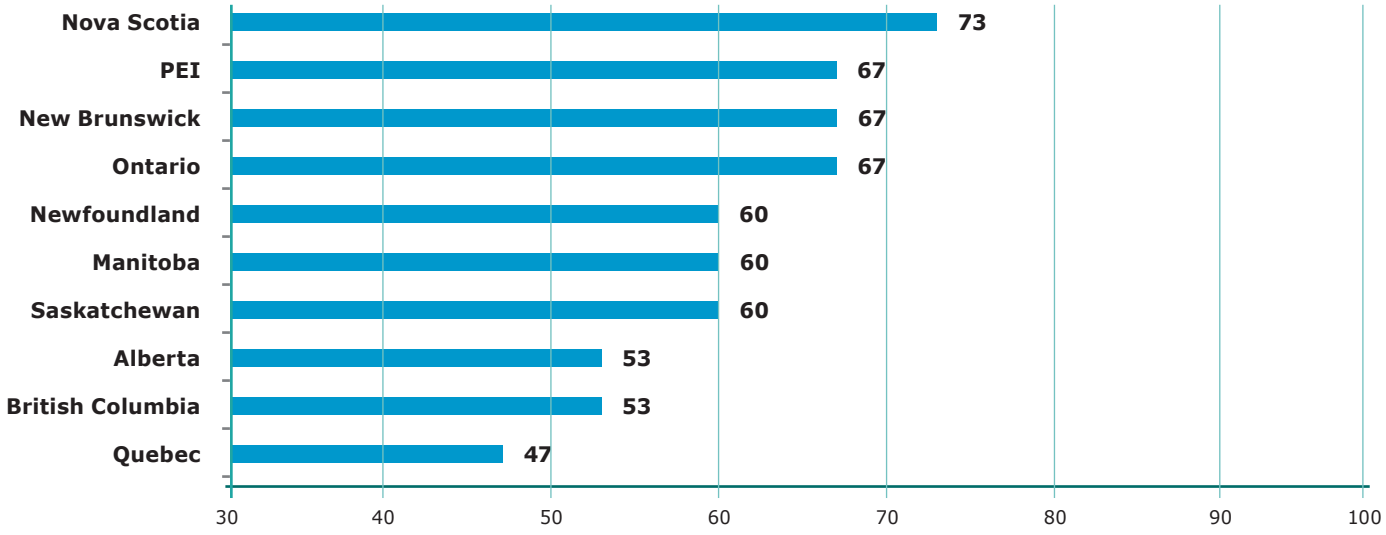
Each of the 29 indicators is categorized within five sub-disciplines. Beginning on the next page, descriptions of each of the sub-disciplines and indicators are provided in this section. This section also presents a graph showing each province's score in every sub-discipline.

7.1 Patients' Rights and Information

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 how easily accessible information about providers and individual health status is for those who need it.

Internationally, Canada is in many respects a laggard in this area. Many European countries have explicit legislative guarantees of patients' rights with enforceable guarantees of quality and timely service. Several European jurisdictions are also considerably more advanced than Canada in terms of providing consumers with detailed "provider catalogues" with quality ratings and detailed statistics to help them make an informed choice between healthcare providers. Canada has also fallen behind in the area of electronic health records penetration. Germany, the Netherlands and Norway, for example, have more extensively developed EHR systems than does Canada. While the differences that exist between provinces are significant in some cases, these differences are relatively small compared with the large gap that separates Canada from the top European healthcare systems in terms of providing patients with the information and decision rights that they need to make informed choices about their care. Gaps in the scores between the provinces in this area should therefore not be taken as evidence of radically different medical cultures—these scores reflect the differences at the margin in terms of each province's performance in this area.

Chart 6. Patient's Rights and Information



British Columbia and Alberta perform poorly in this area, largely because they do not report MRI and CT scan wait times online. B.C. has an extensive collection of statistics for wait times for various surgeries, but it does not report diagnostic imaging exams in a readily accessible, online location. Both provinces should move to provide full, transparent information on the wait times for diagnostic imaging tests—particularly because these tests have been identified nationally as a high-priority area for wait time reduction. B.C.'s low overall score in this area masks its outstanding performance for a specific indicator—the provision of a patient-friendly

online formulary. Its formulary is easy to access and understand, and it provides a great deal of information in consumer-friendly language.

Patients' Rights and Information Indicators

Below is a description of each of the indicators that was used to develop the provincial scores for this sub-discipline. New indicators or indicators for which there have been substantial changes are marked with an *. For all other indicators, these descriptions are similar or identical to the descriptions provided in the 2009 CHCI report.

Legislative Guarantee of Patients' Rights

Despite the fact that Canadian healthcare is constitutionally a provincial responsibility, the exercise of provincial power in this area is constrained by the federal *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 healthcare 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 a guarantee of timely, appropriate or effective treatment. 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.

Electronic Health Records*

Electronic health records (EHRs) are an important tool for making healthcare safer and more efficient. EHRs 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.

This year, we introduced a new indicator to measure the extent to which hospitals in each province utilize EHRs. In 2010, HIMSS Analytics released a report showing the rate of progress in all provincial and state jurisdictions in North America in terms of adopting EHRs. This project assigned a ranking to each hospital based on its development of EHRs, and then it produced a ranking for each jurisdiction by simply averaging those scores. By comparative evaluation of reports from hospitals on their utilization of EHRs, HIMSS Analytics aims to provide an accurate measure of the level of electronic supervision achieved by each hospital.[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 healthcare consumers can understand. While all provinces now have provincial drug formularies posted online, most are explicitly targeted at health professionals, are not written in plain

language and do not include information such as potential side effects and conflicts with other medicines. British Columbia's online formulary presents substantially more information than most of the formularies and is in easy-to-understand language, which is why British Columbia alone earns a green score for this indicator.

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. We would like to see regular reporting of wait times for important, time-sensitive diagnostic tests such as MRIs and CT scans. This indicator identifies the provinces that have easily accessible information about these tests on their websites.

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.

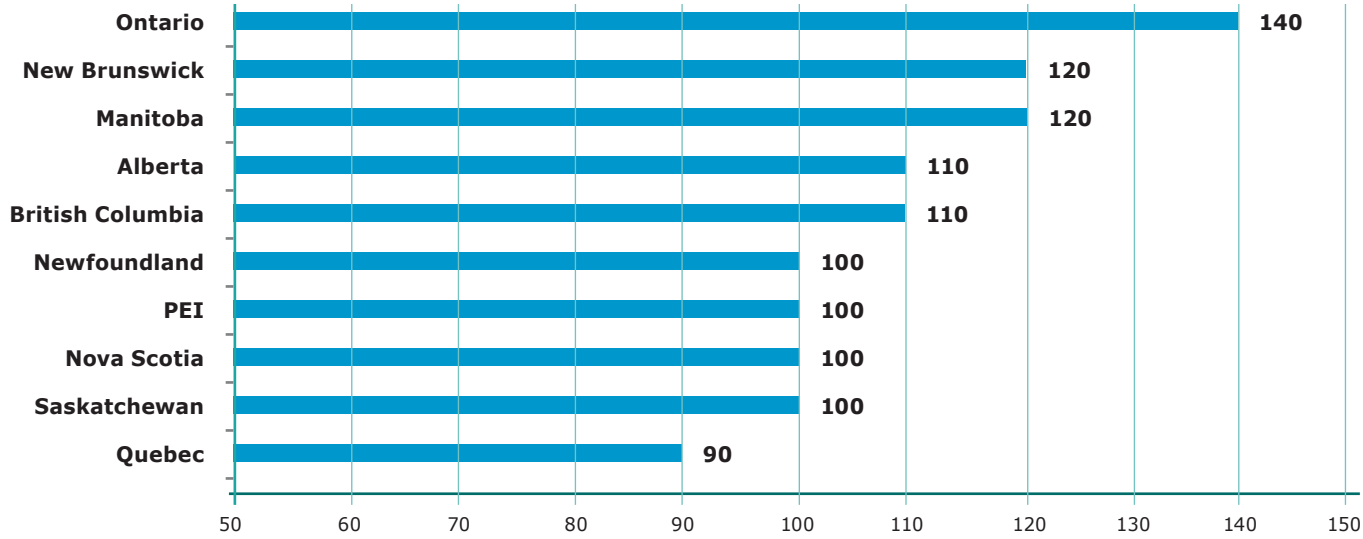
7.2 Primary Care and Problem Prevention

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.

Ontario earns the highest score in this category, with 93 out of 100 possible points. The only indicator for which Ontario does not earn a "green" score is for asthma hospitalization readmission rates—Ontario's score is statistically indistinguishable from the national average. Only New Brunswick earned a "green" score for this category. Ontario's performance is therefore average or above average for all of the indicators examined in this category.

New Brunswick, Manitoba, Alberta and British Columbia all have above average performances in this category. Alberta's performance, however, is harmed because a large number of adult Albertans do not have regular access to a family doctor—one of the indicators examined in this section. Whereas in Nova Scotia, New Brunswick and Ontario, fewer than 10 per cent of adults report going without a regular medical doctor, 19.4 per cent of Albertans reported that they do not have a regular doctor. A similarly troubling situation exists in Saskatchewan, where 16.6 per cent of residents reported not having a family doctor in 2009, when data for this indicator was

Chart 7. Primary Care and Problem Prevention



last collected for Statistics Canada.

Manitoba performed well for most indicators in this category, but its score was negatively affected by a "red" score for risk-adjusted asthma hospitalization rates, which were amongst the highest in Canada and were statistically distinguishable from the national average.

Quebec's extremely low score for this indicator is driven partly by inconsistent data collection —CIHI was unable to report results for two of the five indicators examined in this section —indicators for which all nine of the other provinces collected and reported data according to consistent standards. However, Quebec's poor score in this area was not driven entirely by data collection issues—even more Quebecers than Albertans reported in 2009 that they do not have a regular family doctor.

Primary Care and Problem Prevention Indicators

Below is a description of each of the indicators that was used to develop the provincial scores for this sub-discipline. New indicators or indicators for which there have been substantial changes are marked with an *. For all others, these descriptions are similar or identical to the descriptions provided in the 2009 CHCI report.

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 family doctor compared with more than 90 per cent in Nova Scotia and New Brunswick. Saskatchewan and Alberta both perform poorly for this indicator, with 83 per cent and 81 per cent respectively. In Manitoba, 85.6 per cent of adults have a family doctor—close to the national average.

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

This indicator was last collected by CIHI and reported to Statistics Canada in 2008, so scores for this indicator have not been updated since last year's CIHI index.

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.[4]

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 the 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.

This indicator was last collected by CIHI and reported to Statistics Canada in 2008, so scores for this indicator have not been updated since last year's CIHI index.

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 communities.[5] Low rates of readmission can therefore be taken as a reasonable indicator of healthcare-system quality.

Hospitalization Rate for Ambulatory Care Sensitive Conditions

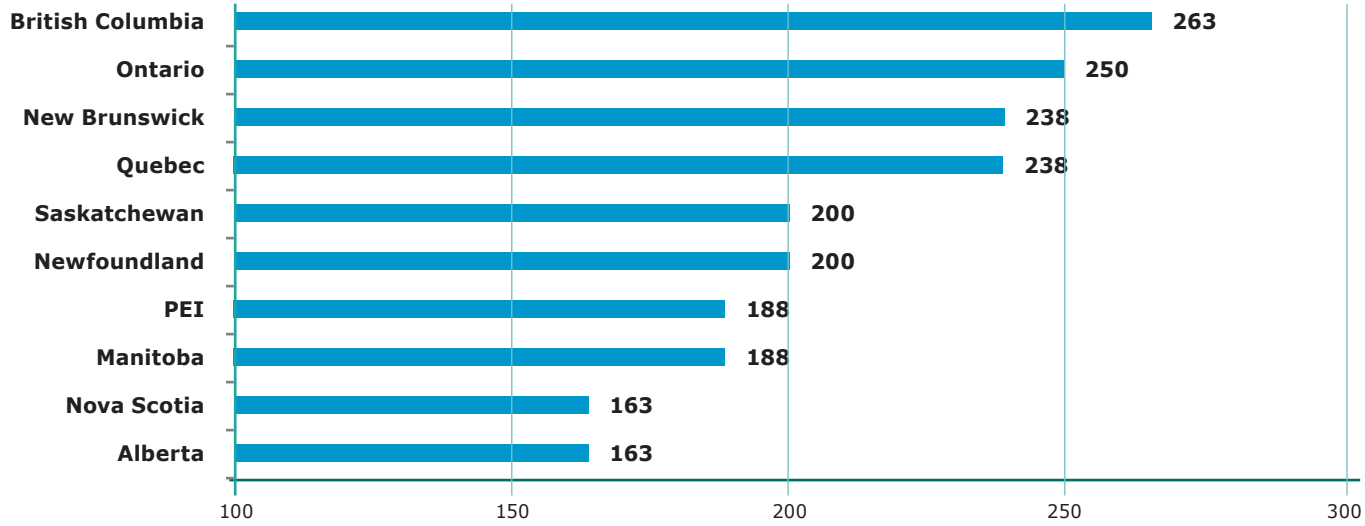
Many chronic diseases such as diabetes, asthma and high blood pressure can be managed in the community through medical screening and monitoring. Effective management in the community can reduce the number of hospital stays for people with these types of chronic conditions. Conditions that can be managed 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.[6]

7.3 Wait Times

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 with 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 looks at wait times in several areas in order to examine variations in the delivery of timely care. These scores are an indicator of relative performance compared with other Canadian jurisdictions. A high score does not necessarily mean that wait times are acceptable or short by international standards —the differences in scores merely reflect variation between the 10 Canadian provinces in the Wait-times category. All 10 provinces have significant work to do to achieve the much shorter healthcare wait times that exist in top European countries such as Germany, France and the Netherlands.

Chart 8. Wait Time Scores



British Columbia, Ontario, New Brunswick and Quebec are the four top finishers in this category. All the top performers earned points for providing relatively prompt access to cancer radiation therapy—generally keeping wait times lower than the national benchmark of 28 days for 90 per cent or more of patients. Each of these provinces still has room for improvement for some indicators. British Columbia's wait times for MRIs and CT scans are very close to the national average, and the province has not been as successful as Newfoundland and Nova Scotia in terms of ensuring that hip-fracture surgery take place within a very short time after the injury. Ontario has the shortest waits in the country for MRI exams, but a very large proportion of patients reported waiting more than one month the last time they were referred to a specialist. Saskatchewan, Newfoundland, PEI and Manitoba constitute a second tier in the wait-times category behind the top performers. Saskatchewan in particular has improved its performance significantly since last year. Though wait times are still too long for knee-replacement surgery, the province has decreased the number of individuals who are

subjected to extremely long waits of more than six months. The province has also improved its score for the "prompt cancer radiation therapy" indicator. In the CIHI 2009 report on wait times, the CIHI stated that the average wait for cancer radiation therapy was 14 days. This number had dropped to eight days when the 2010 report was released. Similarly, the number of people forced to wait more than the 28-day national benchmark for treatment dropped from 19 per cent to 3 per cent during the same period. There is, of course, room for improvement—wait times for orthopaedic surgery are still too long and above the Canadian average—but there has been improvement in important areas for Saskatchewan, which resulted in a higher score.

Each of the other provinces in the second tier also has areas of relative strength and weakness. In Manitoba, for example, wait times for cataract removal and hip-replacement surgery are above the national average. Manitoba does, however, earn a score of "good" for prompt cancer radiation therapy—the average wait time of six days is amongst the lowest in the country.

The two bottom performers in this category, Nova Scotia and Alberta, both have major areas of weakness that bring down their total scores. Wait times for radiation therapy in Alberta, for example, are amongst the highest in the country according to the CIHI's 2010 report. The CIHI also reports higher than average waits for cataract surgery in Alberta. In Nova Scotia, wait times for orthopaedic surgery are amongst the longest in Canada. Wait times for cancer radiation therapy are also above the national level.

Wait Time Indicators

Below is a description of each of the indicators that was used to develop the provincial scores for this sub-discipline. New indicators or indicators for which there have been substantial changes are marked with an *. For all other indicators, these descriptions are similar or identical to the descriptions provided in the 2009 CHCI report.

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 obtain 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.

Wait Time for Hip-replacement Surgery

Hip-replacement surgery can significantly improve quality of life, but it generally is not life-threatening condition. 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.

Wait Time for Knee-replacement Surgery

Knee-replacement surgery can also significantly improve quality of life and generally is not a life-threatening condition. 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.

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 2010 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.

Wait Times for MRI and CT Scans (two indicators)*

Advanced diagnostics such as MRIs, 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. Some 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.

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 surgery 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.

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 this operation once a person has decided to have it is a useful indicator of how well each province provides desirable elective procedures for its residents.

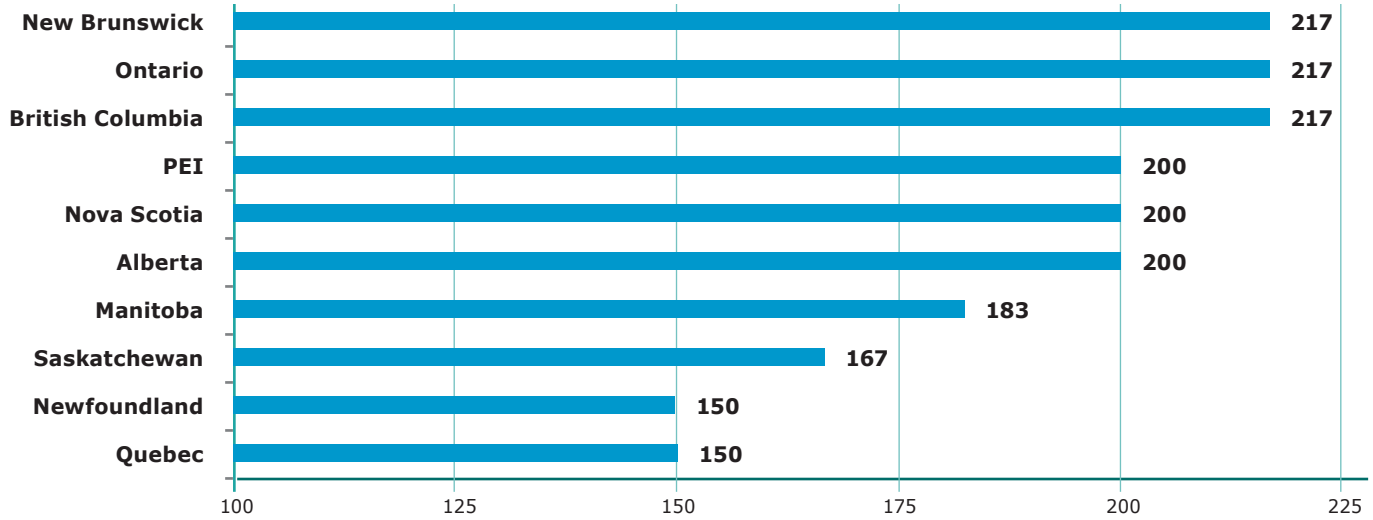
7.4 Outcomes

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.

Performance in this category is relatively consistent across the country—there are fewer large variations between the provinces in this category than there are in the Wait Times category, for example. Two provinces, however, have particularly low scores—Newfoundland and Quebec. Quebec's low score is driven primarily by the inconsistent data collection processes described earlier in this report, which make it extremely difficult to draw comparisons with other provinces. In the case of Newfoundland, however, the low score is driven by below average results that are statistically distinguishable from the Canadian average for a few indicators. The risk-adjusted stroke in-hospital mortality rate, the infant mortality rate and the risk-adjusted readmission rate following hysterectomy surgery are all higher in Newfoundland than in the country as a whole.

Manitoba's and Saskatchewan's results are comparable to the Canadian average for most indicators in this category, though they are below average in some. The only indicator for which either province earned a score of "good," indicating performance that is better than the

Chart 9. Outcomes



Canadian average, was Manitoba's score in the 30-day in-hospital mortality rate. Its mortality rate was lower and statistically distinguishable from the Canadian average for this indicator.

Generally speaking, however, the results for this set of indicators are substantially less varied than the results for the wait-time indicators discussed in the preceding section.

Patient Outcome Indicators

Below is a description of each of the indicators that was used to develop the provincial scores for this sub-discipline. New indicators or indicators for which there have been substantial changes are marked with a *. For all other indicators, these descriptions are similar or identical to the descriptions provided in the 2009 CHCI report.

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.

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.

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.

Note: Quebec did not participate in the collection of this data, and the population of PEI is too small to generate a sufficiently large number of cases for solid analysis. Quebec was given a score of "poor" for this indicator, and PEI received an intermediate score.

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 of care, because it represents a complication of in-patient stays in acute care facilities that can sometimes be avoided by high-quality health services.

Hysterectomy Readmission

Hysterectomy, the complete or partial removal of the uterus, is the second most common surgery for women after Caesarean section. In a small minority of cases, women experience complications that require an urgent, unplanned readmission to hospital following surgery. 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 quality of care. 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.

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 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 quality of care. 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.

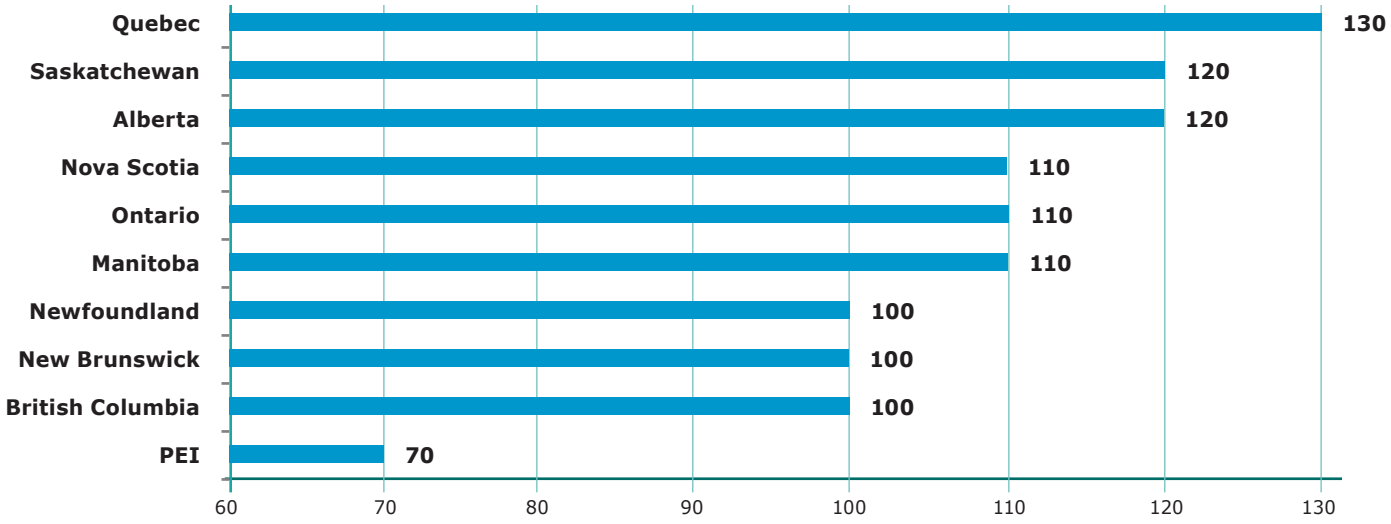
7.5 Range and Reach of Services Offered

There exists some variation between provinces in terms of what services are provided through provincial health programs. 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 that we believe all Canadians should have access to regardless of income.

This category was revised this year to focus more on the extent to which each province is approving and funding access to new medications. Each province goes through its own process to decide whether to approve new medicines that have been found by Health Canada to be safe and effective for inclusion in the provincial reimbursement plans. This process moves faster in some provinces than in others, and the provinces are not equally likely to include newly approved medicines for reimbursement. This means that Canadians in different provinces may have unequal access to the newest medications. Two of the four indicators in this section evaluate the extent to which each province is providing its residents

Chart 10. Range and Reach of Services



with access to new medicines.

Like the Patients' Rights and Information category, the differences between the provinces in this area are small when compared with the differences between Canada and Europe in terms of the range and reach of services provided. The gaps in scores again represent relative differences between the provinces.

Quebec earns the top score in this category, mostly because of its success at quickly approving new medicines for inclusion in the provincial reimbursement plan and for approving a larger proportion of the medicines deemed safe and effective by Health Canada. Quebec had, by far, the highest rate of approval for new medicines between 2004 and 2008, the period examined for scoring this indicator. The weighted-average delay for the approval of new medicines at the provincial level is approximately 275 days—compared with over 350 days in British Columbia, New Brunswick and PEI, all of which earn a relatively low score in this category.

Alberta also approves new medicines relatively quickly compared with the other provinces; however, it does not have Quebec's strong record in terms of approving a large percentage of medicines deemed safe and effective by Health Canada. Alberta's good score in this category is also driven partly by the fact that it is the only province that was deemed to be "excellent" in terms of its childhood immunization policies by the Canadian Paediatric Society.

Patients' Rights and Information Indicators

Childhood Vaccination

The Canadian Paediatric Society (CPS) issues a list of 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.

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.

Speedy Inclusion of New Medicines in Provincial Reimbursement Plans*

This indicator, drawn from data collected for the Fraser Institute's report on prescription drugs in Canada "Access Delayed, Access Denied," measures the average amount of time it took for provinces to grant reimbursement eligibility to new medicines deemed safe and effective during 2008. This statistic includes both full and restricted approvals by provincial authorities. The delay measured is the weighted average time in days between regulatory approval by Health Canada and approval for provincial public reimbursement.

Percentages of New Medicines (NOCs) Approved*

This indicator, drawn from the same Fraser Institute report, is calculated by comparing the number of full or partial reimbursement approvals for new medicines in each province with the total number of drugs that were approved as safe and effective (issued a Notice of Certification—NOC) by Health Canada between 2004 and 2008.[9] These two indicators combined give a sense of the extent to which each province is providing residents with timely access to the newest medicines. Quebec has approved for reimbursement, by far, the highest percentage of new medicines given regulatory approval from Health Canada and has one of the fastest processing times for including these new drugs in the provincial reimbursement plan.

Telehealth Service

In some situations, consumers who are 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 to a hospital immediately or wait until their family doctor is available is a useful tool for 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.

8. Policy Recommendations

This report shows that there are meaningful gaps in terms of wait times, patient outcomes and other dimensions of consumer-friendliness between the healthcare systems of the 10 provinces. However, these performance gaps are relatively small compared with the gaps that exist between even the highest scoring Canadian provinces and top-performing European jurisdictions such as Germany and the Netherlands—especially in terms of waiting times. These policy recommendations are based on policy reforms in Europe that have contributed to the top-performing countries' ability to deliver high-quality healthcare services that are responsive to the demands of consumers —without the long wait times endured by Canadian patients.

8.1 Move to Patient-based Funding

As was the case last year, most Canadian hospitals are funded through a "global budgeting" or "block funding" 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 or on a system of "capitation" in which hospitals are compensated based on the number of people treated and the conditions those patients suffered from. European experience is beginning to show that the capitation model is more successful at improving service levels, reducing wait times and keeping overall costs low. Either approach turns 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. Although the capitation or "case-based" approach may have important advantages over fee-for-service systems, we should examine all options for eliminating the system of global budgets and replacing it with a model in which government money "follows the patient."

Harvey Schipper and Menaka Pai of the University of Toronto, and Harry Swain of Trimbelle Limited, have described the "perverse" incentives created by the global budget system in detail. The authors write that even well-intentioned administrators face incentives to encourage less-sick patients to come to their hospital while encouraging the truly sick (who cost more money to treat) to go elsewhere. This is not because they are cruel or indifferent;

it is because they might face severe professional consequences or public ridicule if they overspend relative to their fixed budget, which makes no allowances for how many or what sort of individuals they treat.[10] The current system also eliminates the incentives for hospitals to pursue innovations that require up-front start-up costs.

The current system is deeply flawed and leads to waiting lists and inefficiencies. 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 Organisation for Economic Co-operation and Development (OECD) countries, including Belgium, France, Germany and the Netherlands, has already implemented some form of patient-based funding, and this approach has proven capable of dramatically improving healthcare-system efficiency.

We are glad to report this year that there are real signs that leading jurisdictions in Canada are planning to move away from the destructive global budget system and toward patient-based funding mechanisms. In April 2010, British Columbia announced that it would build on existing pilot projects and move toward province-wide, patient-based funding and away from the block-funding model.

In the throne speech in April, Ontario's government announced that it would shift toward a model in which "money follows the patient" to increase efficiency and reduce wait times. The Ontario government rightly noted in a press release that the global budget systems is an obstacle to hospitals trying to improve the quality and cost-effectiveness of their services.[11] This is one of the main reforms that the Frontier Centre has advocated for in Canadian health policy in recent years, and we are excited that Ontario and British Columbia are moving away from bureaucratic allotments of funds and toward a patient-centered model.

8.2 Co-operate with Other Jurisdictions on Medication Approval

This paper documented the delays in provincial government approval for reimbursement for new prescription drugs—this delay comes on top of the period during which Health Canada reviews the efficacy and safety of new medicines. During these delays, Canadians are often unable to access new medicines that could improve their lives.

Of course, it is important to ensure the safety of new drugs, but the work of Health Canada in this area largely duplicates the FDA's drug approval processes in the United States.[12] This creates unnecessary delays. If different jurisdictions co-operated to share information and harmonize their research, approval of new medicines could be expedited in Canada and other jurisdictions. One proposal, put forward by Skinner and Rovere, is to enter into "mutual recognition" agreements under which new medications approved in selected OECD countries could be introduced into the Canadian market in an expedited manner. This would require a high level of trust and co-operation with other jurisdictions, but the risk of a drop in quality control because of this co-operation with advanced industrial countries with sophisticated healthcare and research processes is negligible. The benefits of getting new medicines to market quickly outweigh any such risks. To ensure that people in Canada and around the world are able to access the most effective medicines possible to treat their conditions, jurisdictions should cooperate to minimize the duplication of work across borders and focus on using their combined knowledge and resources to get new, helpful medicines to consumers as quickly as possible.

8.3 Introduce Means-tested Co-payments for Medical Services

Financing public healthcare will be an enormous challenge in the years and decades ahead. Spending on healthcare already consumes a large portion of provincial budgets and the cost of healthcare is certain to rise faster than inflation in the years ahead due to an aging population. Healthcare costs continue to rise much faster than government revenue, and without innovative reforms to delivery and funding mechanisms, spending on healthcare will soon begin to crowd out spending on other important priorities like education and/or will necessitate a heavy increase in taxes. The OECD issued a report on Canadian healthcare spending in 2010, noting that spending levels will soon become unsustainable without major reform. One OECD recommendation to avert these problems was to introduce means-tested co-payments for health services. This step would bring Canada into line with European norms. Currently, Canada and the U.K. are the only two OECD countries that do not have co-payments and fund healthcare solely through government spending. All the top-performing countries in Europe have linked use of the healthcare system with individual expenses. This is seen by experts to have a number of salutary effects, including significantly lessening the burden on the treasury, and it may slightly reduce demand on the system (demand for healthcare is somewhat inelastic, so there should be modest expectations in this regard). Co-payments should be means-tested to ensure that economically disadvantaged Canadians have access to high-quality care. Co-payments are by no means a "silver bullet" that will fix our long-term healthcare financing problems—but they are one way that governments can work to reduce the growing strain on health budgets.

9. FAQ

What is the Canada Health Consumer Index?

The Canada Health Consumer Index measures the performance of the healthcare systems in the 10 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 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 was often 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 policy-makers 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 is significant data on public health, and it is certainly important for public policy. This report, however, focuses on the performance of provincial healthcare systems and on 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.

10. 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/

Endnotes

1. The only exception is for the few indicators that analyze performance over several years—for example, the indicator for approval of new medicines includes data from 2004-2008. Most indicators rely on data for one year or, in a few instances, three pooled years. These data are from 2007 or later.
2. For some indicators, particularly those drawn from the Canadian Institute for Health Information (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 were 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. Paul Christopher Webster. "Canadian hospitals make uneven strides in utilization of electronic health records." *Canadian Medical Association Journal,* August 10, 2010. Available online at http://www.cmaj.ca/cgi/content/full/182/11/E487.
4. Educare Breast Health Care Information: Why is a Mammogram Important?
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9. Brett Skinner, Mark Rovere. "Access Delayed, Access Denied: Waiting for New Medicines in Canada." The Fraser Institute, March 2010.
10. Harvey Schipper, Menaka Pai and Harry Swain. "Putting People First: Critical reforms for Canada's health care system." Available online at http://www.globalcentres.org/publicationfiles/Schipper%20Pai%20Swain%200708.pdf
11. Ontario Ministry of Health and Long Term Care. Excellent Care for All. Press Release. Available online at http://www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_pbp.aspx
12. Skinner and Rovere. "Access Delayed, Access Denied"

Further Reading

May 2010 PS089

Euro-Canada Health Consumer Index 2010

By Ben Eisen and Arne Björnberg

http://www.fcpp.org/publication.php/3285

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

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