CANADA HEALTH CONSUMER INDEX 2010

Ben Eisner, M.P.P.
Frontier Centre for Public Policy

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Atlantic Institute for AIMS Market Studies

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Atlantic Institute for Market Studies

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b) investigating and analyzing the full range of options for public and private sector responses to the issues identified and acting as a catalyst for informed debate on those options, with a particular focus on strategies for overcoming Atlantic Canada's economic challenges in terms of regional disparities;
c) communicating the conclusions of its research to a regional and national audience in a clear, non-partisan way; and
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Canada Health

Consumer Index

2010

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1. EXECUTIVE SUMMARY

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

As the International Euro-Canada Health Consumer Index 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 to 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 Euro-Canada Health Consumer Index is to provide an evaluation of healthcare 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 in that order – 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 to 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 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.

All of the remaining provinces – including Manitoba, Saskatchewan and Alberta – fall into a distinct second tier well behind the top performers. Six provinces – all of the remaining provinces except for Newfoundland – fall within a narrow 20 point range in our overall rankings. Each of these jurisdictions had one or more areas of weakness that contributed to their ranking in the second tier – the strengths and weaknesses of each province in our index are discussed in detail in the body of the report.
Although Saskatchewan finishes in the second tier, behind the top performers, it has improved significantly since last year when the province finished in last place in the CHCI rankings. This improvement has been 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 a deterioration in the province's performance in the wait times category. Long waits for cancer radiation therapy, cataract surgery and appointments with specialists following a referral drove down Alberta's score. Alberta's above average performance in the important patient outcomes category prevented the province from falling out of the second tier entirely – however, the province's generally long wait times negatively impacted the province's overall score and prevented Alberta from challenging the top performing provinces. Alberta's long wait times are particularly troubling, considering that the province's per-capita spending on healthcare is the highest in the country.

Only Newfoundland finished outside of these two clusters of provinces, finishing in last place, approximately 40 points behind Prince Edward Island, Newfoundland's particularly low score was driven in large part by its unusually low performance in the important patient outcomes section. Newfoundland's poor results in the patient outcome category cause it to fall somewhat behind the second tier, but the gap is small by the historical standards of the CHCI, and also compared to the gap between the second tier and the three top performing provinces. These results should not be interpreted as showing 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.

Alberta's high spending and middling performance in terms of consumer-friendliness 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 relationship between per capita healthcare spending and the level of consumer friendliness achieved in the provinces of Canada. 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 by simply throwing money at the problem.

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

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

Governments across Canada should ensure that their citizens 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 policymakers and citizens in each province identify areas where there is a need for aggressive reform efforts.

2. INTRODUCTION

2.1 Frontier Centre for Public Policy

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

2.2 Health Consumer Powerhouse

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

HCP has been publishing the Swedish Health Consumer Index since 2004. By ranking the 21 county councils by 12 basic indicators regarding the design of systems policy, consumer choice, service level and access to information, we introduced benchmarking as an element in consumer empowerment. Since 2005, HCP has extended this methodology to include the comparison of the healthcare systems of all 27 EU member states as well as Norway, Switzerland, Croatia, FYR Macedonia, Iceland and Albania. In recent years, Canada has been included in this analysis.

2.3 Atlantic Institute for Market Studies

The Atlantic Institute for Market Studies (www.AIMS.ca) is an independent non-partisan public policy think tank based in Halifax, NS that operates across the country. It examines such crucial issues as public education, health care, public finances, equalization, energy, labour market and demographics. We set the benchmark on public policy by drawing together the freshest most forward looking thinking available from some of the world's foremost experts and applying that thinking to the challenges we face. Our work aims at making sure we all have sound retirement prospects, good quality education for our children, and access to high quality and sustainable health care. We help people to understand what governments do well and what they do badly, how to make taxes fair and comprehensible, and how to build our economy so that opportunities are maximized for everyone.

2.4 What is the Canada Healthcare Consumer Index?

Since 2007, the Frontier Centre has collaborated with a think-tank based in Belgium, the Health Consumer Powerhouse (HCP), to promote visionary thinking about healthcare policy in Canada and around the world. In the specific case of our annual CHCI reports, of which this is the third, our objective is to assess the quality of healthcare in Canada by asking a specific question: How well does the healthcare system in this country and in individual provinces meet the needs of healthcare consumers? For the healthcare system to work better for Canadians, there must be a fundamental change in the way our healthcare system, our government and even our citizenry view the recipients of healthcare services. Whereas historically, recipients of medical care were viewed as passive patients upon whom the healthcare system acted, it is time to start viewing citizens as consumers, powerful actors who are able to access relevant information, make informed decisions and demand top-quality products and services.

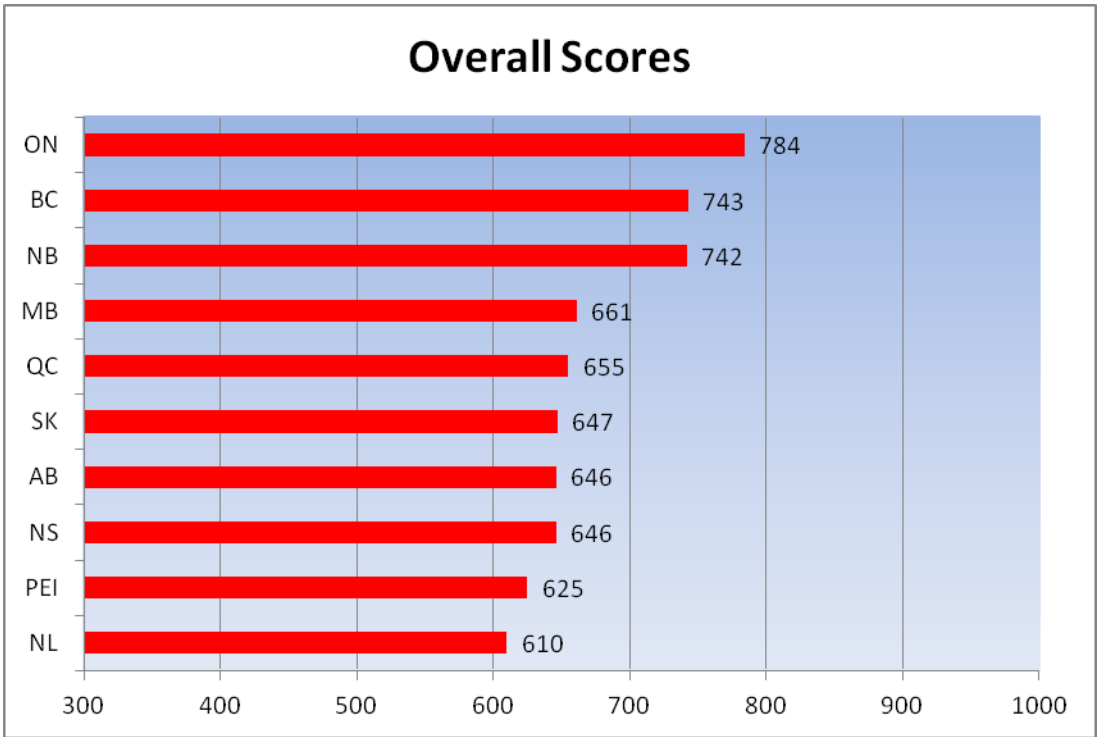
For this transition to take place, citizens need access to information about existing health policies, services, wait times and quality outcomes. In the 2010 Canada Health Consumer Index (CHCI), the Frontier Centre and the Health Consumer Powerhouse aim to provide access to important information about the quality of healthcare services in the Canadian provinces. The CHCI is an instrument through which the Frontier Centre and the HCP can analyze the extent to which healthcare systems across Canada are meeting the needs of consumers and can make policy recommendations based on best practices from other countries.

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

3.1 Overall Results

For the third consecutive year, Ontario finishes on top of the CHCI rankings. However, the gap has narrowed between Ontario and other top performers over the past year. This year, only 33 points separate the top three finishers- Ontario, New Brunswick and British Columbia. All three provinces earned a high score primarily because of a strong performance in the most important categories- wait times and patient outcomes.



Following the top tier is a group of six provinces that are clustered very close together – just 20 points separates fourth place Quebec from 9th place Prince Edward Island. 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 time (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 the 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 will sections can be consulted for additional information on the strengths and weaknesses in each province.

The case of Quebec requires additional explanation. This year, Quebec finishes fourth in our index. Quebec's score, however, may be harmed by the fact that, by rule, we assign "poor" scores to provinces that do not collect

data that are tracked by all other provinces using standard data collection methods. This rule, meant to reward transparency, impacts Quebec's scores more than any other province due to unusual data collection processes for several indicators in that province. Quebec should move to standardize data collection processes with other Canadian provinces wherever possible to allow for inter-provincial comparisons and permit citizens to hold politicians to account if performance is poor in specific areas.

Only Newfoundland finished a significant number of points behind the large second tier which is clustered between 626 and 646 points. Newfoundland finishes in last place, 38 points behind 9th place Prince Edward Island. Newfoundland's particularly low score was driven in large part by its unusually low performance in the important patient outcomes section. Only Quebec had a score as low as Newfoundland's in this category – in large measure because Quebec failed to collect data for important indicators in this category. 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 is slightly separated from the second tier, it should be noted that based on our experience from past indices, the 38 point gap between Newfoundland and PEI is still relatively small. Newfoundland's poor results in the patient outcome category cause it to fall somewhat behind the second tier, but the gap is small by the historical standards of the CHCI, and also compared to the gap between the second tier and the three top performing provinces.

In short, this year's results show a clear top-tier in terms of consumer-friendly healthcare consisting of Ontario, British Columbia and New Brunswick which score significantly higher than all of the remaining provinces, which are clustered relatively close together between 588 and 646 points.

3.2 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 has been categorized. If a province earns a score of "fair" for an indicator, it is awarded two points. The province is awarded one point if its performance is 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 were too small for some indicators to develop results in which Statistics Canada and CIHI have confidence. In those instances, PEI was given an "amber" 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."

Results of the Canada Health Consumer Index 2010

Sub-discipline	Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Patient Access To Information	Healthcare Law Based on Patients' Rights	○	○	○	○	○	○	○	○	○	○
	Hospital Electronic Health Records	◑	●	○	○	◑	○	●	◑	◑	●
	Layman-adapted Formulary	●	◑	◑	◑	◑	◑	◑	◑	◑	◑
	Online Reporting of Current Waits for Diagnostic Imaging .	○	○	●	●	●	○	○	●	●	○
	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 (/100)	**73**	**73**	**67**	**80**	**93**	**60**	**80**	**67**	**67**	**67**
Wait Times	Access to a Specialist Within One Month of Referral for New Illness/Condition	●	○	◑	◑	○	●	◑	◑	◑	○
	Wait for Hip-replacement Surgery	●	◑	○	○	●	●	◑	○	◑	◑
	Wait for Knee-replacement Surgery	●	◑	◑	◑	●	●	◑	○	◑	◑
	Prompt Cancer Radiation Therapy	●	○	●	●	●	●	●	○	●	◑
	Wait for CT Scan	◑	◑	◑	◑	◑	◑	◑	◑	○	○

73 67 80 93 60

	Wait for MRI										
	Wait for Cataract Removal										
	Hip Fracture Surgery Same Day/Next Day										
	Sub-discipline Weighted Score (/350)	**306**	306 **190**	**233**	190 **219**	**292**	233 **277**	**277**	219 **190**	**219**	292 277 **219**
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 (/350)	**253**	253 **233**	**194**	233 **214**	**253**	194 **175**	**253**	214 **233**	**233**	253 175 **175**
Range and Reach of Services and Access to New Medicines	Childhood Vaccination										
	Influenza Immunization for Seniors										
	New Medicine Approval %										
	Speedy inclusion for new medicine to provincial reimbursement										
	24/7 Access to Medical Information										
	Sub-discipline Weighted Score (/100)	67	67 80	80	80 73	80 73	87	73 67	73 73	40	87 67
	Overall Score (/1000)	**752**	**629**	**634**	**646**	**778**	**646**	**744**	**636**	**626**	**588**

3.3 How to Interpret Index Results

In the creation of this index, the FCPP and the HCP strove to use the best, most recent data to measure and rank the performances of the 10 provincial healthcare systems from the viewpoint of the consumer. Although we made use of the best data that we could obtain, there exist imperfections in the sources that were used for this report. For example, for some indicators, different provinces use slightly different approaches to data collection and reporting that can make inter-provincial comparisons more difficult than we would like. For other indicators, we used data from 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 quality, we should not attempt to do so. The perfect must not be allowed to become the enemy of the good, and we believe that performance measurement and comparative evaluations should be undertaken despite the noted imperfections in the available data. We are satisfied that the data we have is sufficient to allow us to make broad statements about the variations in 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. Six provinces in the middle of the rankings finished within 20 points of each other- it would be a mistake to determine from these results that the small gaps between these six provinces are evidence of a meaningful difference between the provinces in terms of healthcare system performance or consumer-friendliness.
While the existence of a 5-point gap 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 for a meaningful disparity in terms of overall consumer-friendliness.

3.4 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, BC fared well in most categories, but once again did not succeed in the Patient Rights and Information category – largely because wait times for diagnostic imaging tests aren't posted online. However, a bright spot in that area is BC's consumer-friendly medication formulary which provides accessible, user-friendly information. One additional are of relative weakness is a lengthy delay of approval for new medicines in the provincial reimbursement plan. BC's average delay of 380 days was amongst the longest in Canada and was substantially longer than neighbouring Alberta, which took an average of 280 days to approve new medicines. British Columbia performed particularly well in the wait time category, compared to other Canadian provinces. Waits for Cataract, orthopaedic surgery and cancer radiation therapy were all shorter than the national average. Performance for Patient Outcomes was also amongst the best in the country.

Alberta: Alberta, more than any other province, shows some areas of great strength and other areas of real weakness. The province delivers good patient outcomes, ranking near the top of the country in that category. However, very long waits for care hurt Alberta's overall score badly. Wait times for cataract removal, radiation therapy and appointments with specialist are all substantially longer than the national average. None of the 8 indicators examined showed a wait time in Alberta substantially shorter than the national average. Albertans suffer from long wait times for care despite the highest level of per-capita health care spending in the country.

Saskatchewan: Saskatchewan has shown a remarkable turnaround from last year, when it finished near the very bottom of the index due primarily to very long wait times for care. This year, Saskatchewan has caught up with several provinces and finishes in the closely bunched second tier. The wait time situation appears to be improving significantly, relative to the rest of the country in the province. 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. Waits for hip replacement surgery still reflected a "red" score. Reported wait times for cancer radiation therapy also improved dramatically since last year's report. There are still areas where improvement is needed. For example, in the patient outcomes category, Saskatchewan has a higher rate of hysterectomy readmission following surgery than the national average.

Manitoba: Manitoba finishes in the large second-tier in this year's index, behind New Brunswick, BC and Ontario. 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. Manitoba also approved far fewer new medicines that were granted regulatory approval by Health Canada than most jurisdictions between 2004-2008. 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 also 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 mid-pack ranking.

Ontario: Ontario finishes in first place in this year's rankings, with a score that is very similar to British Columbia's and New Brunswick's in the clear top-tier. Ontario earned a score of "fair" for all of the patient outcome categories save for one- it has a low risk-adjusted rate of in-hospital hip fractures which is an indicator of hospital safety. Ontario had now "poor" scores in this category. Wait time 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 was 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 the indicators examined. As a result, the province was awarded a "poor" score in several indicators where actual performance may 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 surgeries, specialist appointments and cancer radiation therapy.

New Brunswick: New Brunswick finishes in third place, part of a distinct first tier with BC and Ontario. New Brunswick's performance is relatively strong in all of the categories, except for the range and reach of services category. Slow adoption of new medicines to 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 the five categories, but a low score in the wait times categories 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 break away from the pack and move into the top tier in future years, Nova Scotia will need to reduce its wait times in these areas.

Prince Edward Island: PEI's performance is near the Canadian average in four out of the 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 for PEI because the sample sizes were too small for Statistics Canada and CIHI to develop meaningful statistics. In these instances, PEI was awarded an intermediate score so that there was not a negative impact on the province's overall score or the score in particular categories.

Newfoundland and Labrador: Only Newfoundland and Labrador finished a significant number of points behind the large second tier which is clustered between 626 and 646 points. Newfoundland finishes in last place, 38 points behind 9th place Prince Edward Island. Newfoundland's particularly 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 is slightly separated from the second tier, it should be noted that based on our experience from past indices, the 38 point gap between Newfoundland and PEI is still relatively small. Newfoundland's poor results in the patient outcome category cause it to fall somewhat behind the second tier, but the gap is small by the historical standards of the CHCI, and also compared to the gap between the second tier and the three top performing provinces. These results should not be interpreted as showing 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.

4. Results by sub-Discipline and Description of Indicators

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 health care. 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 healthcare index which measures consumer-friendly healthcare. Top performers in the index like 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 inter-provincial comparison confirms that good health-system performance is not necessarily linked to high levels of spending.

We examined the healthcare spending provided by the Government of Canada, which includes both spending by provincial governments and the amount of federal spending in each province. This is the most-accurate available measure of the total amount of money, per person, that is spent on the healthcare system of each province. Interestingly, the top performers in our index were not necessarily the highest spenders. Ontario spends the seventh most per capita. British Columbia, the second-place finisher in our index, is the second-lowest spender.

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 the problems. Clearly, other solutions are needed, as our data shows no link between higher spending and a higher level of consumer-friendliness.

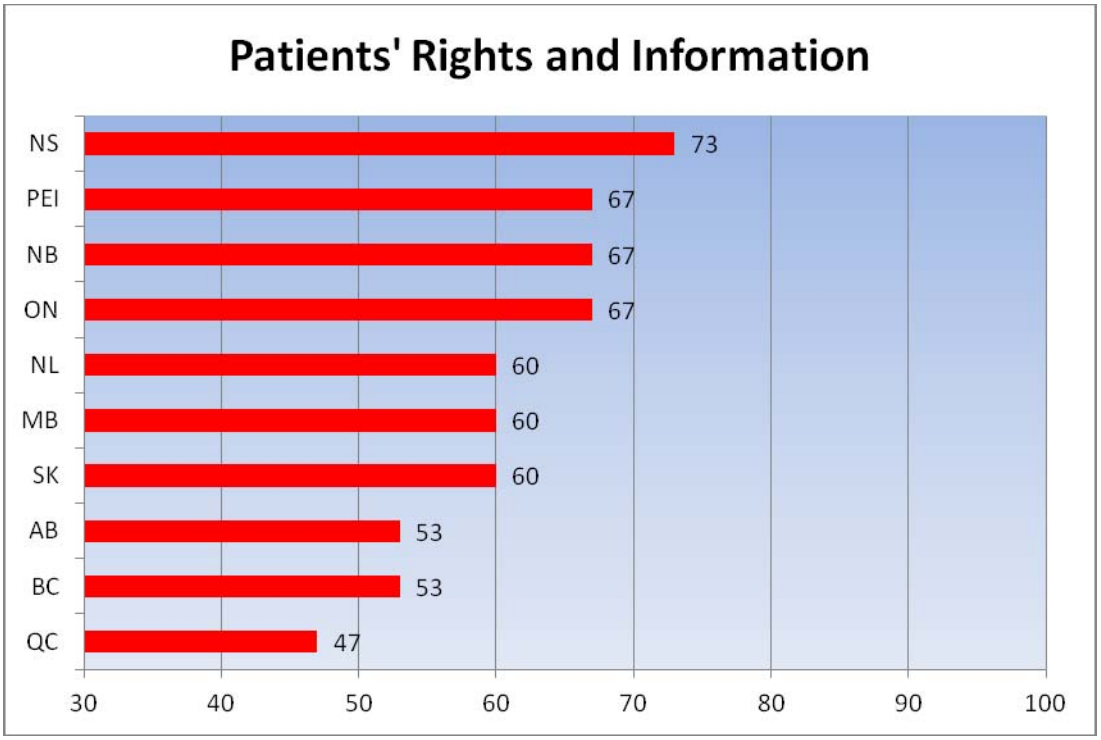
4.1 Sub-Categories and Indicators

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

4.1.1 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 information about providers and individual health status are easily accessible to those who need it. Scoring on this sub-discipline is based on the following five indicators:

Internationally, Canada is in many respects laggard in this area. Many European countries have explicit, legislative guarantees of patients rights with enforceable guarantees of quality, timely service. Several European jurisdictions also are considerably more advanced than Canada in terms of providing consumers with detailed "provider catalogues" with quality ratings and detailed statistics to help consumers 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, all have more extensively developed electronic health record systems than does Canada. While the differences that exist between provinces are significant in some cases, these differences are relatively small compared to the large gap that separates Canada from top European healthcare systems in terms of providing patients with the information and decision rights that they need to make informed choices about their own 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 different at the margin in terms of each province's performance in this area.



British Columbia and Alberta perform poorly in this area, largely because of the fact that they do not report MRI and CT scan wait times online. BC has an extensive collection of statistics for wait times for various surgeries, but does not report diagnostic imaging exams online in a readily accessible 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. BC's low overall score in this area masks its outstanding performance for a specific indicator- the provision of a patient-friendly online formulary. British Columbia's formulary is easy to access and understand, and 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 a * symbol. For all other indicators, these descriptions are similar or identical to the descriptions provided in the 2009 CHCI report.

Legislative Guarantee of Patient Rights

Despite the fact that it is constitutionally a provincial responsibility, Canadian healthcare is largely covered by the *Canada Health Act* (*CHA*) of 1994. The *CHA* sets out a series of terms under which it will transfer money to the provinces for health spending. The *CHA* mandates that certain treatments must be provided at public expense. Furthermore, the *Act* imposes restrictions on additional fees for 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 as a guarantee of timely, appropriate or effective treatment. The *CHA* makes no guarantees in these areas. Canada has no law explicitly guaranteeing patients' rights at the national level.

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

Electronic Health Records*

Electronic health records are an important tool for making healthcare safer and more efficient. Electronic health records make it easier for healthcare providers to access accurate information about a patient, which, in turn, makes it easier to avoid errors such as allergic reactions, adverse drug interactions and the unnecessary duplication of tests.

This year, we've introduced a new indicator to measure the extent to which hospitals in each province. In 2010, HIMSS analytics released a report showing the rate of progress in all Provincial/State jurisdictions in North America in terms of adopting electronic medical records. This project assigned each hospital a ranking, based on their development of EHRs, and then produced a ranking for each jurisdiction by simply averaging out those scores. By comparative evaluation of reports from hospitals on their utilization of electronic records HIMSS aims to provide an accurate measure of the level of electronic supervision achieved by each hospital.[1]

Layman-adapted Formulary

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

Across Canada, much work remains to be done to ensure that information about prescription drugs is available in language that typical health care consumers can understand. While all provinces now have provincial drug formularies posted online, most are explicitly targeted to health professionals only and do not include information such as potential side effects and conflicts with other medicines in plain language. British Columbia's online formulary presents substantially more information than most of the formularies, in easy-to-understand language which is why BC alone earns a score of green 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. One area for which we would like to see regular reporting of wait times is important, time-sensitive diagnostic tests such as MRI and CT scans. This indicator identifies the provinces that have easily accessible information about these tests on their web sites.

Consumer Satisfaction with Medical Services

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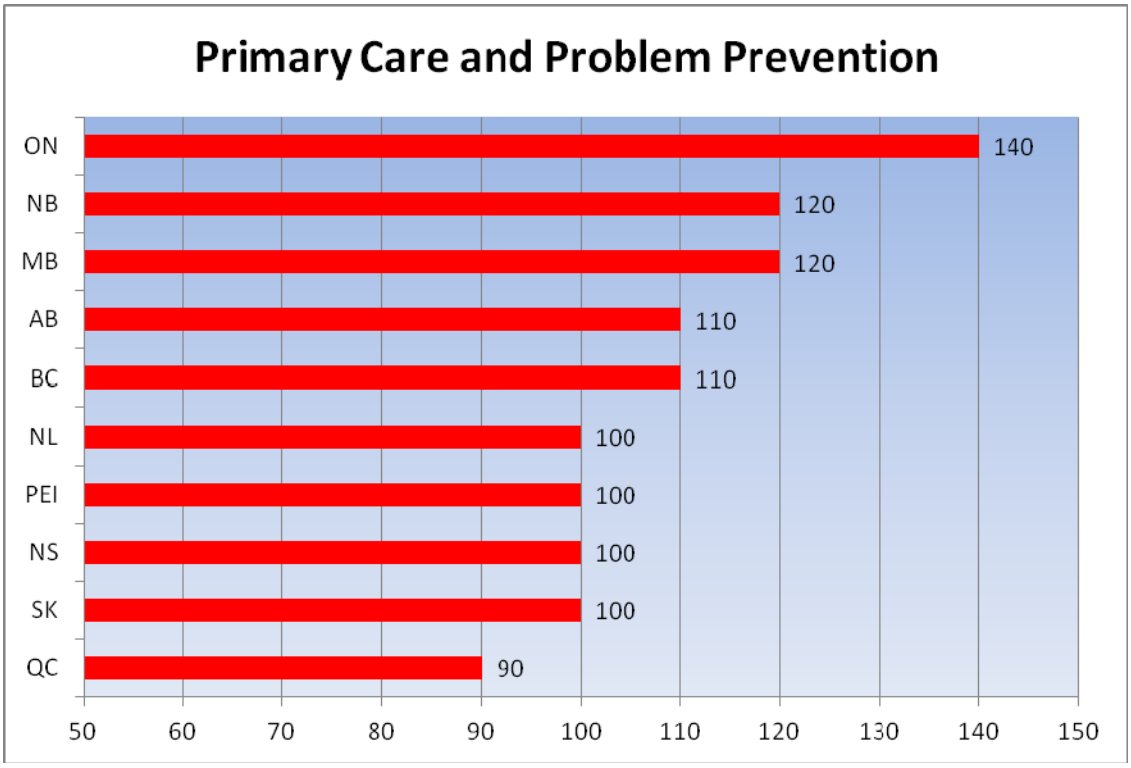
[1] Paul Christopher Webster. "Canadian Hospitals make uneven strides in utilization of electronic health records." *Canadian Medical Association Journal.* August 10, 2010. <http://www.cmaj.ca/cgi/content/full/182/11/E487>

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.

4.1.2 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 in this category 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 by the fact that a large number of adult Albertans do not have regular access to a family medical doctor- one of the indicators examined in this section. Whereas in Nova Scotia, New

Brunswick and Ontario fewer than 10% of adults report going without a regular medical doctor, 19.4% of Albertans reported that they do not have a regular doctor. A similarly troubling situation exists in Saskatchewan, where 16.6% of residents reported not having a family doctor in 2009, when data for this indicator was last collected for Statistics Canada.

Manitoba performed well for most indicators in this category, but its score was negatively impacted by a "red" score for risk-adjusted asthma hospitalization rates, which were amongst the highest and 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 9 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 that they do not have a regular family doctor when asked in 2009.

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 a * symbol. For all other indicators, 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 regular medical doctor compared to over 90 per cent in Nova Scotia and New Brunswick. Saskatchewan and Alberta both perform poorly for this indicator, with 83% and 81% respectively. In Manitoba, 85.6% of adults have a regular medical 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 necessary equipment, short waits for screens and the promotion of relevant information about colorectal cancer are all factors that the healthcare system can strongly influence. For this reason, we believe this metric is a useful indicator of this dimension of healthcare quality.

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. [2]

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

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 community.[3] 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 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. [4]

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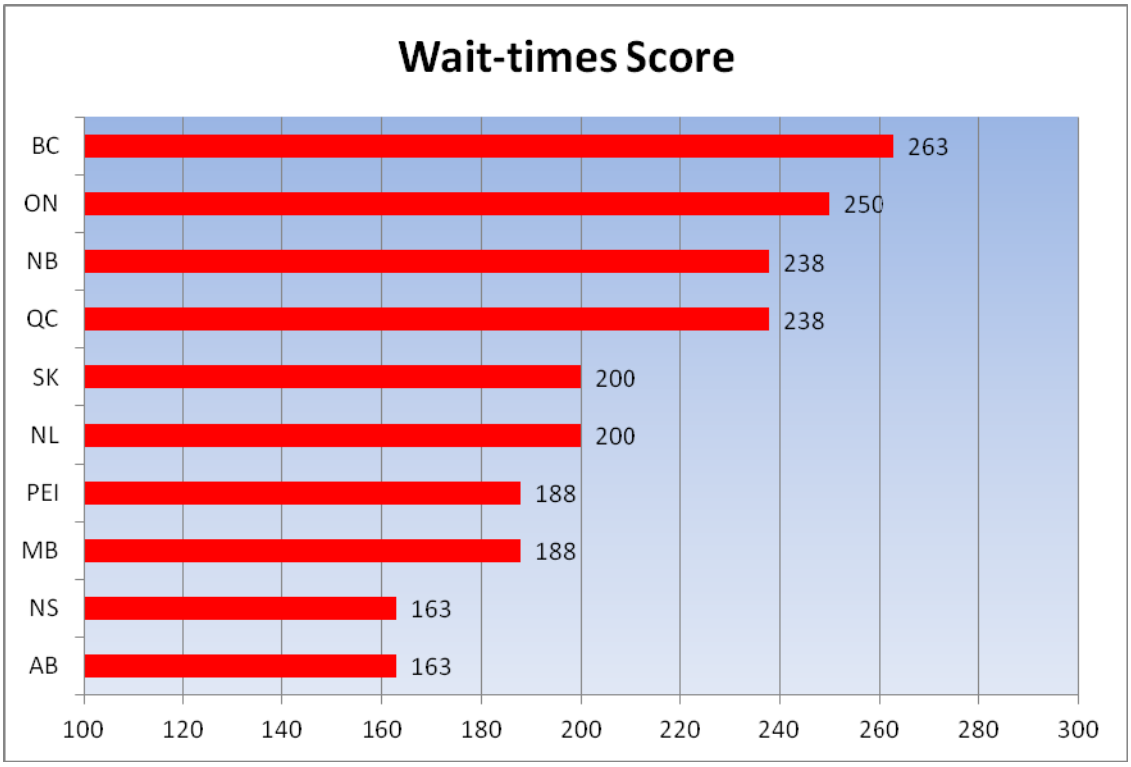
[2] Educare Breast Health Care Information Website. *Why is a Mammogram Important.* Available online: http://www.educareinc.com/pdfs/Mammogram.pdf

[3] Canadian Institute for Health Information. *Health Indicators 2009.* Available online: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_20090611_e

[4] Ibid;

4.1.3 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 to most European countries. For the past decade, considerable attention and funding have been dedicated to addressing this problem, but with limited success. A truly high-performing healthcare system must deliver excellent outcomes and short waits for services, so that patients do not endure unnecessary periods of pain and stress while waiting for care. This category of indicators looks at wait times in several areas to examine variations in the delivery of timely care. It is important to recognize. These scores are an indicator of relative performance compared to 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 ten Canadian provinces in the wait times category. All ten provinces have significant work to achieve the much shorter healthcare wait times that exist in top European countries such as Germany, France and the Netherlands.



British Columbia, Ontario, New Brunswick and Quebec are the four top finishers in this category. All of 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% of patients or more. 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 surgeries take place within a very short time frame 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 in this category significantly since last

year. Though wait times are still too long for the procedure, the province has decreased the number of individuals requiring knee replacement surgery who are subjected to extremely long waits of more than six months. The province has also improved their score for the "prompt cancer radiation therapy" indicator. In the Canadian Institute for Health Information 2009 report on wait times, CIHI reported that the average wait for cancer radiation therapy was 14 days. That number had dropped to 8 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% to 3% 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, resulting in a higher score.

Each of the other provinces in the second tier also has areas of relative strength and weakness. For example, in Manitoba, wait times for cataract removals and hip replacement surgeries 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 score. Wait times for radiation therapy in Alberta, for example, are amongst the highest in the country according to the Canadian Institute for Health Information's 2010 report. The CIHI also reports higher than average waits for Cataract surgery in Alberta. In Nova Scotia, wait times for Orthopaedic surgery is amongst the longest in Canada. Wait times for cancer radiation therapy are also above the national level.

Wait Time Indicators

Following 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 * symbol. 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 receive an appointment with a specialist. Since many conditions are time sensitive, long delays to see a specialist can negatively affect health outcomes. The percentage of patients who see a specialist within a month of referral by their primary care physician is a useful indicator of the speed with which the healthcare system responds to consumer needs.

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

Wait Time for Knee-replacement Surgery
Knee-replacement surgeries can significantly improve quality of life, but they are generally not life-threatening situations. The speed with which the healthcare system provides the surgery once the decision to have it has been made is an indicator of the speed with which the system provides life-enhancing services in situations where the patient's life is not threatened.

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

Wait Time for Hip-fracture Surgery

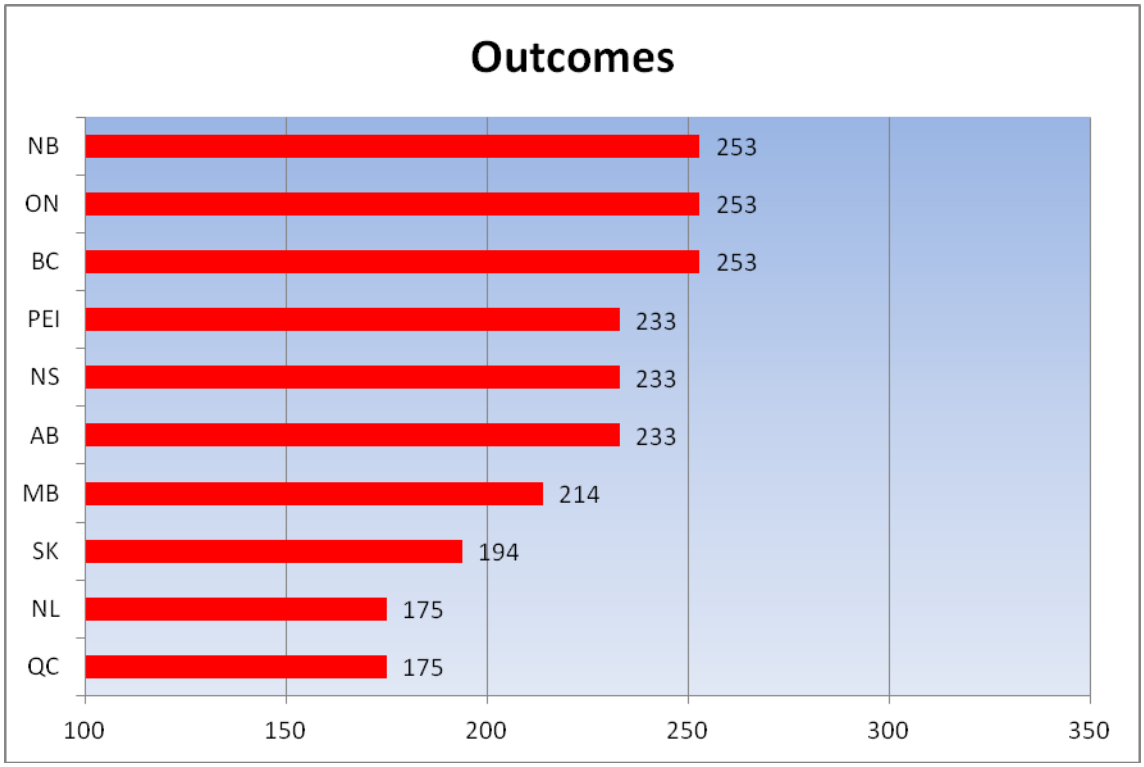
Hip fractures are a serious injury and are quite common among elderly people. Hip fractures can be terribly painful, and it is important for hip-fracture surgeries to be provided in a timely fashion. However, in Canada, hip fractures are sometimes delayed because of the unavailability of operating rooms,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

Cataract-removal Waits

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

4.1.4 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 than there are in the wait times category, for example. Two provinces, however, have particularly low scores- Newfoundland and Quebec's. For this category, Quebec's low score is driven primarily by the inconsistent data collection processes described earlier in the 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 different indicators. The risk-adjusted stroke in-hospital mortality rate, the infant mortality rate and the risk-adjusted readmission rate following hysterectomy surgeries are all higher in Newfoundland than in the country taken as a whole.

Manitoba and Saskatchewan's results are comparable to the Canadian average for most indicators in this category, though it is below average in some. The only indicator for which either province earned a score of "good" indicating performance that is better than the Canadian average was Manitoba's score in the 30-day in-hospital mortality rate. Manitoba's 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:

Following 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 * symbol. 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 participated 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 is given a score of "poor" for this indicator, and PEI receives 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 care, because it represents a complication, often preventable, of in-patient stays in acute care facilities that can sometimes be avoided by high-quality health services.

Hysterectomy Readmission

Hysterectomy, the complete or partial removal of the uterus, is the second most common surgery for Canadian women after Caesarean section. In a small minority of cases, women experience complications that require an urgent, unplanned readmission to hospital following surgeries. This indicator, compiled by CIHI, is the risk-adjusted rate of unplanned readmission following a hysterectomy performed for benign conditions.

Readmission rates provide a measure of care quality. Although readmission rates are influenced by other factors outside of the healthcare system's control, an unusually high rate of readmission suggests that practices should be carefully examined. Some hospital practices that influence readmission are infection prevention and discharge planning.[5] Variations in readmission are therefore a useful indicator of healthcare-system quality.

Prostatectomy Readmission Rate

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

[5] Ibid;

These rates provide a measure of care quality. Although readmission rates are influenced by other factors outside of the healthcare system's control, an unusually high rate of readmission suggests that practices should be carefully examined.[6] Variations in readmission rates are therefore a useful indicator of healthcare-system quality.

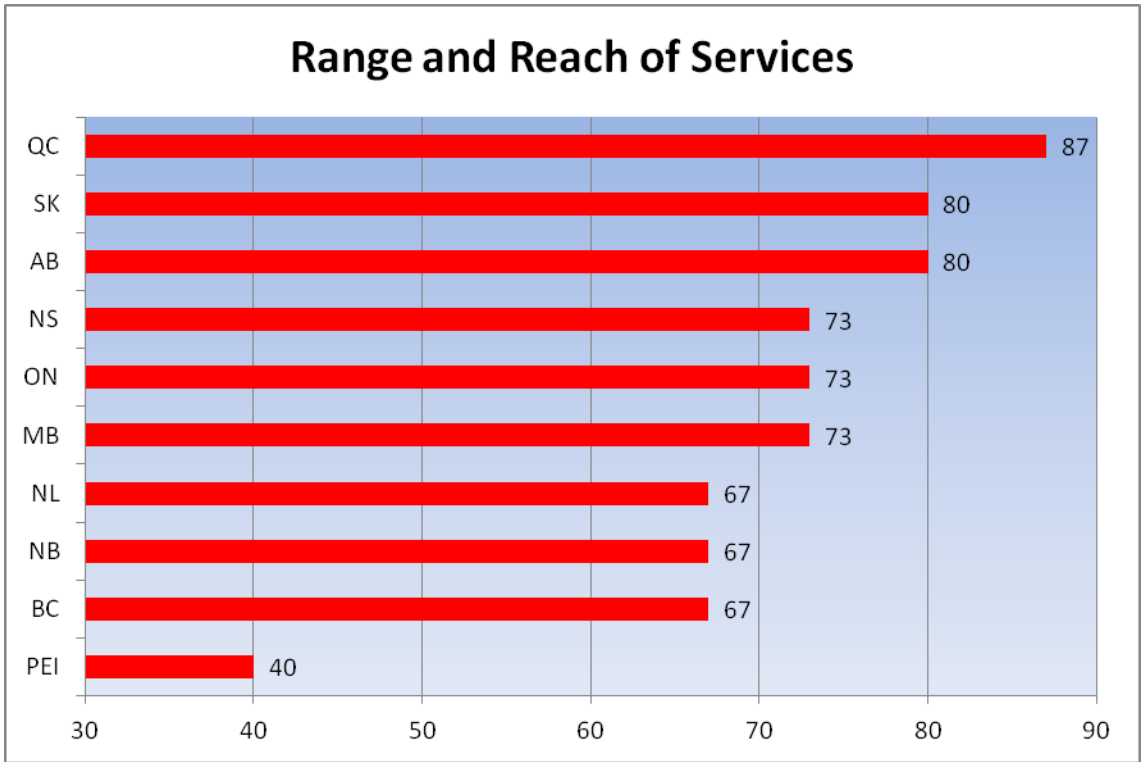
4.1.5 Range and Reach of Services

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

We do not subscribe to the view that "more is better" and that the expansion of government programs to include the provision of a particular new service or product should necessarily be viewed as a good thing. These indicators, however, measure access to the timely and affordable provision of services to which we believe all Canadians should have access to regardless of their income.
This category has been 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 to be safe and effective by health Canada for inclusion in the provincial reimbursement plans. This process moves more speedily in some provinces than others, and the different 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 with access to new medicines.

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

[6] Ibid;



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 has, by far, the highest rate of approval for new medicines that have been given this designation between 2004-2008, the period examined to develop the score for this indicator. The weighted-average delay for the approval of new medicines at the provincial level stands about approximately 275 days – compared to 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 to 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 is was deemed to be "excellent" in terms of its childhood immunization policies by the Canadian Paediatric Society.

Patient Rights and Information Indicators:

Childhood Vaccination

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

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 that 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 here 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 to the total number of drugs that were approved as safe and effective (issued an NOC) by Health Canada between 2004-2008.[7] 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 that have been given regulatory approval from health Canada, and also has amongst the fastest processing times for including these new drugs in the provincial reimbursement plan.

Telehealth Service

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

[7] Brett Skinner, Mark Rovere. "Access Delayed, Access Denied: Waiting for New Medicines in Canada." *The Fraser Institute.* March 2010.

5. 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 ten Canadian provinces. However, these performance gaps are relatively small compared to the gaps that exist between even the highest scoring Canadian provinces and top-performing European jurisdictions like Germany and the Netherlands – especially in terms of waiting times. These policy recommendations are all based on similar policy reforms that have been enacted in Europe, which 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.

5.1 Move to Patient-based Funding

As was the case last year, most Canadian hospitals are still 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 they are compensated based on the number of people treated and the conditions that those patients suffered from. European experience is beginning to show that the capitation model has been 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 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 may face severe professional consequences and even public ridicule if they overspend relative to their fixed budget, which makes no allowances for how many or what sort of individuals they treat. [8] 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 OECD countries, including Belgium, France, Germany and the Netherlands have already implemented some form of patient-based funding, and this approach has proven capable of dramatically improving healthcare-system efficiency.
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, the British Columbia announced that it would build on existing pilot projects and move towards patient-based funding province wide; away from the block funding model.

[8] Swain.

In the throne speech in April, Ontario's government also announced that it would shift towards 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 often work against hospitals trying to improve the quality and cost-effectiveness of their services.[9] This has been 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 both moving away from bureaucratic allotments of funds, and towards a patient-centered model.

5.2 Cooperate with Other Jurisdictions on Medication Approval

This paper documented the delays in provincial government approval for new reimbursement for new prescription drugs- this delay comes on top of a previous period during which Health Canada reviews the efficacy and safety of new medicines. Between these two delays, Canadians are often unable to access new medicines that could improve their lives for many months or even years while the medicine is being reviewed.

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 in the United States. [10] This creates unnecessary delays. If different jurisdictions cooperated 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 Roverre, 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 cooperation with other jurisdictions, but the risk of a drop in quality control as a result of this sort of cooperation with advanced industrial countries with sophisticated healthcare and research processes is negligible. The benefits of getting new medicines to market quickly far outweigh any such risks. In order to ensure that people around the world are able to access the most effective medicines possible to treat their conditions, Canada and other jurisdictions should work to minimize the duplication of work across borders and focus on using their combined knowledge and resources to get new, helpful medicines onto the market as quickly as possible.

5.3 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 chunk of provincial budgets, with the cost of health certain to rise in the years ahead due to an aging population. Healthcare costs continue to rise much faster than revenues and without innovative reforms to delivery and funding mechanisms, spending on healthcare will soon either begin to crowd out spending on other important priorities like education or will necessitate a heavy increase on Canadians' tax burdens. 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 is an important step, that will bring Canada into line with European norms. Currently, Canada and the UK are the only two OECD countries that do not have co-payments and fund healthcare solely through government spending. All of 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 may slightly reducing demand on the system (demand for healthcare is somewhat inelastic so there should be modest expectations in

[9] http://www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_pbp.aspx
[10] Skinner and Rovere "Access Delayed, Access Denied,"

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 healthcare financing crisis – but they are one way that governments can work to reduce the growing strain on health budgets.

6. FAQs

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

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

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

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

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

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

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

Is public health or healthcare performance measured?
Healthcare-system performance is measured. There does exist significant data on public health, which is certainly important for public policy. This report, however, focuses on the performance of provincial healthcare systems

and how well they meet the needs of consumers. We exclude indicators such as obesity and life expectancy that are important measures of public health but are closely related to diet, smoking habits and the like and are not driven primarily by healthcare-system performance.

APPENDICES

I. 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.

I.i Regional Variations

The Frontier Centre recognizes that in addition to disparities in healthcare quality between provinces, there also exist disparities in healthcare quality between regions within each province. Particularly, discrepancies 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.

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

II. Methodology

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

Like the ECHCI, the CHCI selected a number of indicators that describe the extent to which provincial healthcare systems are meeting consumer needs. This section provides additional information about our methodological approach to evaluating healthcare system consumer friendliness.

II.i Indicator Selection

In the ECHCI and the CHCI, our objective is to select a number of indicators from within a relatively small number of evaluation areas that, taken together, present a comprehensive picture of how well the

healthcare consumer is being served. A brief rationale for the inclusion of each particular indicator is provided in section 11, and the sources for each indicator are listed in section 4.

There exist many useful indicators of healthcare quality and health system responsiveness to consumer needs, and we chose a small number for this index. Several additional important criteria that we used in selecting the indicators were:

- An indicator must provide important information about the quality of provincial healthcare systems from the consumer's perspective. It must be a measure of outcomes or, in some cases, important outputs, but not simply one of inputs.
- For each indicator, there must be recent, reliable, publicly accessible data.
- In the selection of indicators for this year's index, we sought to include a broad mix of indicators that measure healthcare-system performance across several different dimensions of quality. We included indicators that seek to evaluate the openness and transparency of provincial healthcare systems as well as indicators that provide more easily quantified measurements of outcomes and wait times.
- In our selection of indicators, we emphasized metrics that provincial authorities and providers have the power to directly affect through policy.
- Indicators must reflect healthcare-system performance rather than other dimensions of public health. A great many factors aside from the healthcare system influence the health level of people living in a particular jurisdiction. This index seeks to evaluate the performance of healthcare systems and therefore does not include measures of public health in general, which are affected by diet, smoking habits, obesity and other factors. Therefore, indicators such as life expectancy, which are largely shaped by factors other than the healthcare system, are not included in the index.

Last year, we made substantial changes to our list of healthcare-quality indicators. We believe these changes improved our collection of indicators significantly and allowed us to make a more accurate assessment of consumer friendliness in each province. This year, there have been additional, smaller changes. A few indicators were dropped because we were unable to obtain recent data, and others were added – especially in the wait times category- 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..

II.ii Data Collection and Verification

All of the information used to compile this index is publicly available. Government databases and information that is readily obtainable from federal and provincial health ministries provide a substantial share of the material necessary for scoring healthcare performance in each province. For a few indicators, information was gathered from research performed by independent think tanks and other entities outside of government. The majority of the data that informs 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. Many provinces are in the process of trying to improve their healthcare systems, particularly in terms of wait times, and even slightly outdated data may no longer provide a completely accurate guide to healthcare-system performance.

Data for this report are from 2007 or later.[11] There are some indicators for which we would have liked to have more-recent data, but we were sometimes forced to make use of data from 2008 and, less frequently, 2007 for indicators for which no newer data are available.[12] 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.

II.iii Comprehensive Uniform Trustworthy Sources

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

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

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 of the available evidence to determine the appropriate score for each indicator for each province.

II.iv Scoring System

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

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[11] The only exception is for the few indicators that analyzes 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 all from the year 2007 or more recent.

[12] In the case of some indicators, particularly those drawn from the CIHI, the statistics were generated using three years of pooled data. In those instances, the data year cited in this report is the most recent year in which data was collected for an indicator. The advantage of using multi-year pooled data is that it improves precision, although the drawback is that it makes use of some older data.

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 has been categorized. If a province earns a score of "fair" for an indicator, it is awarded two points. The province is awarded one point if its performance is 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 were too small for some indicators to develop results in which Statistics Canada and CIHI have confidence. In those instances, PEI was given an "amber" 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."

II.v Indicator Areas: Sub-disciplines

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

Table One: The 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 has been assigned to that sub-discipline. The sub-disciplines that we have determined to be most important are given the highest weighting coefficients. A brief rationale for the weighting coefficients used is provided in the next section.

- These weighted sub-discipline scores are then added up, multiplied by 1,000 and rounded to the nearest whole number. This produces an integer score between 1 and 1000, which is the province's final score.

II.vi Weighting Coefficients

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

We have 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 system- however, the most meaningful indications of gaps between the provinces in consumer-friendliness can be found by examining the provincial scores for the individual categories themselves. We aim to promote accountability, and to provide citizens with as clear a view of overall system performance as possible 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 they are most in need of improvement.

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

Table 2: Weighting Coefficeints

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	100	20

Wait Times	3.5	350	43.75
Outcomes	3.5	350	58.33
Range of Services Provided	1	100	20

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.

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

Sub-discipline	Indicator	Comment	Good	Fair	Poor	Main Source(s)
Patients' Rights and Information	Healthcare Law Based on Patients' Rights	Is there an explicit, comprehensive patients' right slaw 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)
	Hospital Electronic Health Records	What was the median score awarded to a province's hospitals for development of hospital electronic health records by the EMR Adoption Model developed by HIMSS Analytics? (1-7 Scale)	**>3**	**1-3**	**<1**	HIMSS Analytics; Canadian Medical Association Journal
	Layman-adapted Formulary	Is there a formulary in layman's terms readily available 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 formulary easily available**	Provincial government web sites. (2010)
	Online Reporting of MRI and CT Scan Wait Times	Is there an easily accessible web site that posts expected wait times for MRI and CT scans?	**Yes, both**	**One or the other but not both**	**No**	Provincial government web sites. CIHI Wait Time Tables (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)
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 Cdn. Avg.**	**Statistically indistinguishable from Cdn. Avg.**	**Higher than Cdn. Avg.**	CIHI (2007 – mid year)
	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 (2008 data)

Wait Times	Access to a 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 web sites (2009-10)
	Wait Time for Knee-replacement Surgery	What percentage of patients is treated within the 182-day national benchmark?	**>75 per cent**	**50 to 75 per cent**	**<50 per cent**	CIHI Wait-time Tables and provincial web sites (2008-2009)
	Prompt Radiation Therapy	What percentage of patients is treated within 28 days of decision to treat?	**>90 per cent**	**85 to 90 per cent**	**<85 per cent**	CIHI Wait-time Tables (2008)
	MRI Wait Time	How long is the average wait time for an MRI Exam?	**<8 Weeks**	**8-12 Weeks**	**>12 Weeks**	Waiting Your Turn. Fraser Institute Report (2010)
	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 Institute Report (2006)
	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 (2008)
	Wait time for Psychiatric Care	What is the average wait time for an appointment with a psychiatric specialist following a referral from a GP (Non-Urgent Cases)	**<6.5 Weeks**	**6.5-9.5 Weeks**	**>9.5 Weeks**	Fraser Institute Waiting your Turn
	Cataract Removal	Average wait in days for cataract surgery from decision to treatment.	**<50 Days**	**50 to 74 days**	**>75 days**	CIHI (2008-2009 data)
Outcomes	AMI Mortality Rate	What is the 30-Heart Attack In-Hospital mortality rate?	**Lower than Canadian Average**	**Statistically Indistinguishable from Canadian Average**	**Higher than Canadian Average**	CIHI (2007-2008 Data)
	Stroke Mortality Rate	What is the 30-day stroke mortality rate?				CIHI (2007-2008

						Data)
	Infant Mortality	How many infant (younger than one year) deaths occur per 1,000 live births?	**<4.5 per cent**	**4.5 to 5.5 per cent**	**>5.5 per cent**	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 discharges	**Lower than Canadian Average**	**Statistically Indistinguishable from Canadian Average**	**Higher than Canadian Average**	CIHI (2007)
	Hysterectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following hysterectomy for benign conditions.	**Lower than Canadian Average**	**Statistically Indistinguishable from Canadian Average**	**Higher than Canadian Average**	CIHI (2007-2008)
	Prostatectomy Readmission Rate	Risk-adjusted rate of unplanned readmission following prostatectomy for benign conditions	**Lower than Canadian Average**	**Statistically Indistinguishable from Canadian Average**	**Higher than Canadian Average**	CIHI (2007-2008)
Range and Reach of Services	Childhood Vaccination	Canadian Paediatric Society ranking of quality of childhood vaccination coverage	**Excellent**	**Good**	**Fair**	CPS web site
	Influenza Immunization for Seniors	What percentage of those over 65 had a flu vaccine in past year?	**>65 per cent**	**60 to 65 per cent**	**<60 per cent**	StatsCan Table 105-4045 (2008 data)
	Approval Time for New Medicines	What is the weighted Average Time between HC regulatory marketing approval and provincial public reimbursement approval for new medicines.	**<300 Days**	**300-350 Days**	**>350 Days**	Fraser Institute Report. Access Delayed Access Denied (2010)
	New Medicines Approved as Percentage of NOC	How many new drugs, approved by Health Canada as safe and effective, has the province approved for public reimbursement between 2004-2008?	**>70**	**40-70**	**<40**	Fraser Institute Report. Access Delayed Access Denied (2010)
	24/7 Access to Medical Information	Is there a 24/7 phone number and/or web site providing medical advice from RN equivalent?	**Yes**	**Some information but not RN**	**No**	Provincial government web sites

IV. Further Reading

Frontier Centre for Public Policy, “Euro-Canada Health Consumer Index 2010,” May 2010. Available at http://www.fcpp.org/publication.php/3285

Frontier Centre for Public Policy, “Separating the Twins,” June 2009. Available at http://www.fcpp.org/publication.php/2254

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Use as Needed: The mixed impact of reference pricing on prescription drug costs by Brian Ferguson

The potential of private sector health care in Canada: Does it cause global warming? by Brian Ferguson

Taking the Pulse: Hospital performance indicators from the patient's perspective by Julia Witt

Private Supply, Public Benefit: Reduce wait times with specialty hospitals by Brian Ferguson

A Finger on the Pulse: Comparative models for reporting the quality of hospital care by Julia Witt

Definitely NOT The Romanow Report: Achieving Equity, Sustainability, Accountability and Consumer Empowerment in Canadian Health Care by Brian Lee Crowley, Brian Ferguson, Brett Skinner, David Zitner

Doctors Have to Make a Living Too: The microeconomics of Physician Practice by Brian Ferguson

Drug Re-Importation in North America and Europe: An overview by Brian Ferguson

Other Material

AIMS 8th Annual Report Card on Atlantic Canadian High Schools by Rick Audas and Bobby O'Keefe

Getting the fox out of the schoolhouse by Rodney A. Clifton, John C. Long & Michael C. Zwaagstra.

From Public U to Private U by Kelvin Ogilvie

Grading our Future by Rick Audas and Charles Cirtwill

What's A Degree Worth by John Phillipe

Testing and Accountability by Charles Cirtwill, Rodney A. Clifton and John D'Orsay

We don't need another hero! Why Hollywood should not be the inspiration for education reform in Atlantic Canada by Charles Cirtwill

Times they are a changin' . . How demographic reality is reshaping education by Charles Cirtwill

One Size Fits None: Putting kids' achievement first, comes with putting kids first by Charles Cirtwill and Bobby O'Keefe

Whose education is this anyway? Why the "public" in "public education" should mean the children, not the system by Charles Cirtwill and Bobby O'Keefe

The Numbers Don't Add Up by Bobby O'Keefe

Setting them up to fail? by Robert Laurie

The modified New Brunswick - Quebec Memorandum of Understanding on NB Power: An Updated Analysis by Gordon L. Weil

Response to an Analysis: Comments on the Weil Analysis of the NB Power MOU by Bill Marshall

Retreat from Growth: Atlantic Canada and the Negative-Sum Economy, by Fred McMahon

Road to Growth: How Lagging Economies Become Prosperous, by Fred McMahon

Looking the Gift Horse in the Mouth: The Impact of Federal Transfers on Atlantic Canada, by Fred McMahon

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