



# WHAT YOU DON'T KNOW CAN HURT YOU: Where does all the money go?



Barrie B F Hebb

*Series Editor – Charles Cirtwill*

June 2010

## **Atlantic Institute for Market Studies**

The Atlantic Institute for Market Studies (AIMS) is an independent, non-partisan, social and economic policy think tank based in Halifax. The Institute was founded by a group of Atlantic Canadians to broaden the debate about the realistic options available to build our economy.

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- a) initiating and conducting research identifying current and emerging economic and public policy issues facing Atlantic Canadians and Canadians more generally, including research into the economic and social characteristics and potentials of Atlantic Canada and its four constituent provinces;
- 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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## ABOUT THE AUTHOR

### **Barrie B F Hebb**

Barrie joined the Atlantic Institute for Market Studies in January, 2008, as a research economist. His field of specialization focuses on the impact governments have through their tax, spending and public policy decisions on social well-being. Prior to joining AIMS, he worked as an economist in Canada and the Former Soviet Union.

He first arrived in the former Soviet Union in 1998 as a visiting fellow in economics with the Civic Education Project. This position primarily focused on promoting reforms in higher educational institutions, lecturing in economics, and conducting research on the transition economies. He spent his first year with this project in Tashkent, Uzbekistan, and over the following three years was based in Kazakhstan, Kyrgyz Republic and Ukraine. He also held positions in Economics Departments in Canada at St Francis Xavier University, St Mary's University, and the University of Alberta and spent an additional year with the Soros Foundation's Academic Fellowship Programme in Odessa, Ukraine.

Barrie was also programme coordinator for the Aga Khan Development Network's University of Central Asia (UCA) based in Bishkek, Kyrgyz Republic. This position involved research on the development of the world's first internationally chartered university consisting of one university with three campuses in three neighbouring republics, all located in remote mountainous settings in Central Asia. In addition to offering access to high quality education programmes, UCA focuses on issues involving sustainable development in remote, rural, non agricultural, mountainous communities. He focused primarily on curriculum development, economic outlooks for the Central Asian region, staff and student recruitment strategies, and integrating ethics across the curriculum.

Most recently, Barrie was an Economic and Fiscal Policy advisor in the New Democratic Party in Ottawa. He has recently relocated to Paris, France, where he now works as a senior economist in an international organization focusing on improving private sector development in the Eurasia region.

Barrie is originally from Halifax. He received his honours BA from Queen's University in 1996 and an MA from the University of Alberta in 1998, both in economics. He currently holds a Foreign Government Award from the Russian Federation and is continuing to work towards his PhD/Canadiate of Sciences degree in St Petersburg State University and work on his Russian when time permits.

# INTRODUCTION

Canadians devote considerable amounts of their money to the health care system each year. For 2008, provincial, territorial and federal governments were forecast to spend \$171.9 billion on health or \$5,170 per person.<sup>1</sup>

In addition to direct funding of health care there is support to organizations such as the Canadian Institute for Health Information (CIHI) to assess the impact of the spending of these funds on the quality of the health care provided. CIHI is significantly publicly funded and is managed as an “arms-length” governmental organization. Its mandate is to support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health, through the collection and analysis of detailed hospital statistics provided by Canadian hospitals. As well, CIHI provides quantitative and qualitative research reports back to the hospitals that participate in the data submissions on the efficacy of their care. Each year, provincial, territorial and federal governments provide 95.6 percent of the Canadian Institute for Health Information’s (CIHI) operating budget of \$84.2 million.<sup>2</sup>

Despite the millions of Canadian tax dollars spent annually on health care and the assessment of that health care system’s performance, there is surprisingly little information that is publicly available and accessible about the quality of health care patients receive. What information is accessible is often spread through a maze of technical reports in a variety of locations making it difficult to find, put together, and understand. Even hospital annual reports are surprisingly devoid of performance information. This deficiency makes it incredibly difficult for the public to be assured that their taxes are being used to provide the best quality of care possible: care that is safe, effective, and timely.

The intent of this report is to delineate a Quality of Care Indicator Framework (QCIF) report that would in turn lead to the publication, once the data was obtained, of the first *AIMS Hospital Report Card* (HRC). This HRC focused on the quality of care patients receive from hospitals. It developed an approach to gain a more accurate picture about how well hospitals are improving patient health care by examining seven indicators selected as measures of health care performance, plus wait times (the length of time patients wait for treatment), and errors (adverse events) that may take place during treatments. This QCIF report identified the information that is needed to assess the quality of care since the analysis of specific indicators, shorter wait times, and fewer errors are associated with a higher quality of care.

Given the challenges in actually collecting and compiling wait time and healthcare error related data, this QCIF report has identified significant gaps between the information that needs to be collected, compiled, and publicly reported, and what is actually available.

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<sup>1</sup> Canadian Institute for Health Information. (2008). Spending on health care to reach \$5,170 per Canadian in 2008. *National health expenditure trends*. Retrieved November 13, 2008 from <[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_13nov2008\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_13nov2008_e)>.

<sup>2</sup> Canadian Institute for Health Information. (2008). *2007/08 Operational Plan and Budget*. Retrieved September 25, 2008 from <[http://secure.cihi.ca/cihiweb/en/downloads/fy2007\\_08\\_operational\\_plan\\_e.pdf](http://secure.cihi.ca/cihiweb/en/downloads/fy2007_08_operational_plan_e.pdf)>, 6.

# BACKGROUND

## *What is a 'Report Card'?*

When people go into hospital, what kind of care do they expect to receive? Are there hospitals that are performing better in terms of achieving quality health care? Are Canadians at greater risk of receiving lesser care in one hospital than in another? Answers to these questions are what consumers need; information that is accurate, straight forward to find, and easily understandable to assess the quality of care they are receiving.

One way to evaluate the quality of hospital care is to use specific indicators to measure and compare the care received. Indicators assist in the comparison of outcomes that reflect the quality of care a patient has received because of the treatment he/she has been given<sup>3</sup>. For example, a hospital with fewer infections from surgeries or shorter wait times for patients to receive treatments may have a lower preventable death rate. The *QCIF* Report will compare specific indicators in terms of certain outcomes such as wait times, patient safety, and preventable deaths.

The HRC was intended to provide consumers with the information needed to make an informed choice concerning the quality of care at particular hospitals and to identify problems. Hospitals would then use the HRC to see how they were assessed, why they received the grade they did, and which areas they can target to improve performance, scores and rank in the future. Consistent comparisons will show that some hospitals, all else being equal, achieve better patient care in specific areas.

## *Report Cards to Date*

Although there is currently no single type of report card that assesses the impact of hospital care on patient outcomes, there have been various health service quality reports. In the United Kingdom there is an effort underway to rank hospitals for best quality care. League tables grade hospitals according to their preventable death rates thereby providing incentives for hospitals to improve their performance. In the United States there have been public reports on health services, state-wide assessments, and various accreditation reports available for some time. In Canada, there are private assessment reports done by The Hay Group and public assessment formats completed primarily by the Fraser Institute, Maclean's Magazine, and the Health Consumer Powerhouse.

Maclean's released several annual reports on the quality of health care based on a range of data gathered by the Canadian Institute for Health Information. These reports focused on how well health care was delivered in health regions rather than by individual hospitals. The Health Consumer Powerhouse Frontier Centre for Public Policy focused on an overall picture of differences in health care systems between Canada and European nations. While it does not provide a list of patient outcome indicators below a national level, it does provide useful consumer oriented information about system wide issues, such as differences in patients'

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<sup>3</sup> Witt, J. (2005). *A finger on the pulse: Comparative models for reporting on the quality of hospital care*. Halifax, Nova Scotia: Atlantic Institute for Marketing Studies, vi.



rights to obtain their medical files or differences in spending per capita on health care. In its 2008 Consumer Index release, Canada was ranked 23rd in a 30 country survey, just above the former Iron Curtain countries.<sup>4</sup>

There have been several publications entitled “Report Cards” published in Canada in the last few years. The Fraser Institute’s ‘Report Cards’ have provided statistics for a variety of procedures across hospitals comparing their performance on a procedure by procedure basis, such as, for example, a hip replacement. The consumer can look up a condition and compare death rates, volumes of procedures, rates of adverse events, and utilization rates across hospitals in the sample. To date, hospitals in the provinces of Ontario and BC, have been examined, however, only a few of the hospitals in each of the provinces could actually be identified by name as most of the hospitals refused permission to have their names linked to the reported results.

### ***The AIMS’ Approach***

People entering the Canadian health care system generally share the common goal of wanting to improve their health status. With the exception of those who enter the hospital and receive palliative care (care for the dying), hospitals are mandated to improve a patient’s health status through the care and services they offer. Some hospitals provide this care more effectively than others. The *AIMS*’ approach focuses on the quality of care patients receive (outcomes) because of the treatments they have been given in the hospital.

Assessing and comparing how the treatments provided to patients affects their health care status is fraught with problems. Patients require specific levels of treatment and may respond to the same treatment in different ways. Some patients will follow the advice of health care professionals; others won’t. There can also be varying opinions on diagnoses, the most effective courses of treatment, and potential care outcomes. These factors make it very difficult to identify the degree to which changes in patients’ health care status (outcomes) is related to how well a hospital administered the appropriate treatment, and which factors are outside a hospital’s control. This situation may explain in part why there is a considerable lack of consensus on how to measure the effectiveness of care.

Even though there may be a lack of consensus on effectiveness measurements, there are a variety of methods to assessing and comparing how well hospitals deliver quality health care. *AIMS* looked at two distinct approaches. The first approach involves measuring how well each patient received the right treatment. Each individual case is examined and a judgement is made as to the degree to which the appropriate care was given, (separating out the impact of factors outside hospitals’ control). Results are then compared. While this approach might appear ideal, it is difficult to assess whether patients received the right care.

The second approach examines the degree to which hospitals may have a negative impact on patients’ health. It is often much easier to identify mistakes or shortcomings during treatments. *AIMS* selected this second approach for the *HRC: QCIF* based upon a review of potentially available information by an Advisory Group specifically selected for their knowledge regarding measurement and quality of care in the Canadian health care system. Two broad categories of care were identified upon which to focus: the time it takes to access treatments (wait times) and the errors (adverse events) that can take place during treatments and procedures. Both of these categories are important indicators of quality of care and hospitals exercise some degree of control over each of them. Hospitals with lower wait times and fewer errors generally perform better than those with more.

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<sup>4</sup> Health Consumer Powerhouse AB & Frontier Centre for Public Policy. (2008). *Euro-Canada Health Consumer Index 2008*. Retrieved March 02, 2008 from <<http://www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf>>, 2.

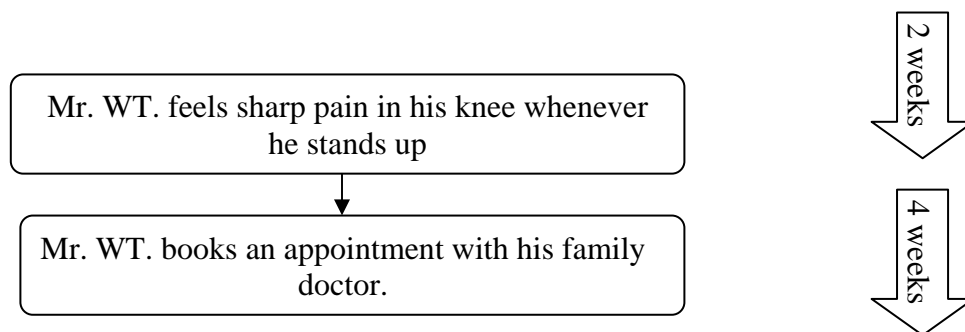
# DATA SELECTION

There is no common set of procedures for wait times, let alone common measures, methods of reporting, or levels of reporting across provinces. There is also a lack of patient safety information made readily available publicly. As a result, AIMS decided to simply ask hospitals if they had commitments to these areas, were gathering data, whether their records were demonstrating improvement, and what opinions they have about these issues. (It might have been the case that they had data collected that we could access and use for our report card, but that were not already made public through other means.)

## Wait Times

The impact of lengthy wait times is significant for patients, their families, and the health care system. The longer patients have to wait for treatments, the more time they and/or their caregivers miss from work, and the greater the pain, suffering patients may endure in addition to the increased risk of death in some cases. “Waiting” also translates into dollars in terms of lost wages, lost tax revenues, and potentially extra medical costs. A conservative estimate of the cost of wait times for four major procedures (joint replacements, cataract surgery, coronary graft bypass surgery and magnetic resonance imaging (MRI) in 2007 was \$14.8 billion for patients who waited longer than medically recommended, and \$4.4 billion in lost government revenues <sup>5</sup>. (Although governments might think that reducing wait times is costly, lengthier wait times are also not without a price)

For the purpose of this HRC QCIF report, wait times were defined as the length of time between the recommendation for a treatment and when it starts. <sup>6</sup> The First Ministers agreed at their conference in 2004 to “reduce wait times in four key areas involving surgery: hip and knee replacements, sight restoration, cancer and cardiac revascularization” <sup>7</sup> An example of the ‘wait’ a patient might experience in the current Canadian health care system could look like: <sup>8</sup>

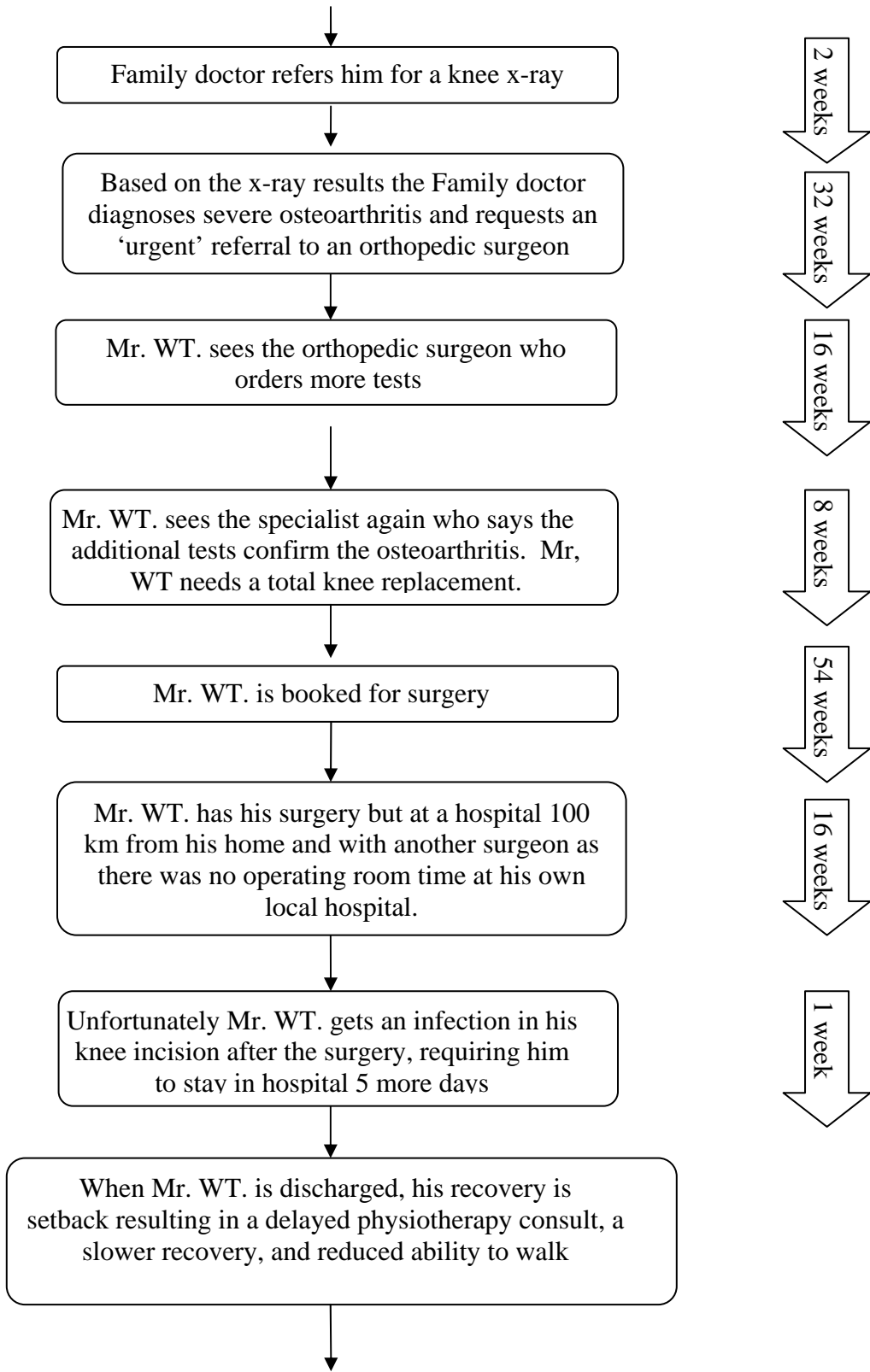


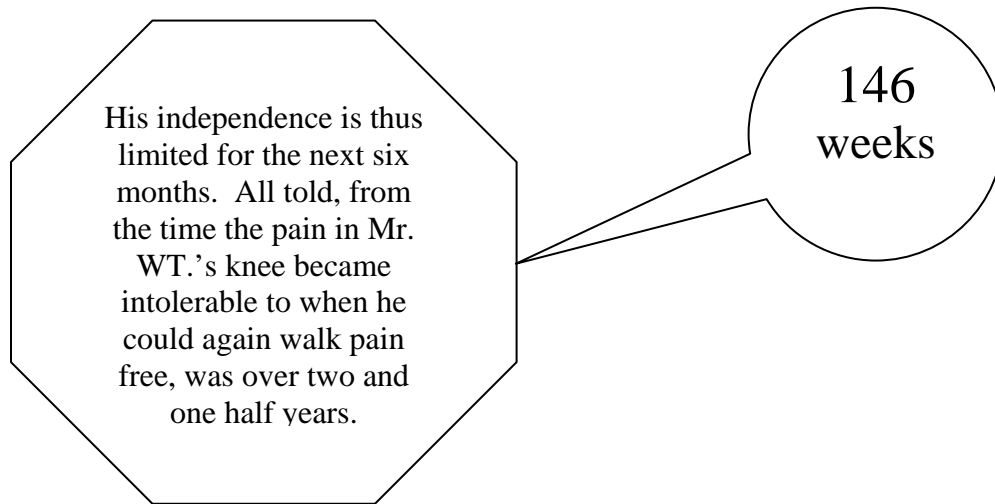
<sup>5</sup> The Centre for Spatial Economics. (2008). *The economic cost of wait times in Canada*. Ottawa: The Canadian Medical Association, 1.

<sup>6</sup> The Centre for Spatial Economics. (2008), 2.

<sup>7</sup> Canadian Institute for Health Information (2008). Wait time priority procedures continue to increase. *Surgical volumes trends, 2008 – Within and beyond wait time priority areas*. Retrieved November 10, 2008 from <[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_25jun2008\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_25jun2008_e)>.

<sup>8</sup> Canadian Institute for Health Information. (2006). *Waiting for health care in Canada: What we know and what we don't know*. Retrieved November 12, 2008 from <[secure.cihi.ca/cihiweb/products/Waittimes\\_presentation\\_e.ppt](http://secure.cihi.ca/cihiweb/products/Waittimes_presentation_e.ppt)>.





### *Adverse Events*

The first national study on adverse events in Canada found that 7.5% of the 2.5 million adult medical/surgical patients' admissions to acute care hospitals in 2000 experienced one or more adverse events. Experts considered about one-third of these events to be highly preventable and although most patients recovered from the errors, almost 21% of patients died. Somewhere between 9250 and 23,750 deaths from adverse events in Canada could have been prevented.<sup>9</sup> This percentage is greater than the number of deaths from motor vehicle accidents, breast cancer, and HIV combined.<sup>10</sup>

Adverse Events have been defined as “unintended injuries or complications that are caused by health care management rather than the patient’s underlying disease, and that lead to death, disability at the time of discharge or prolonged hospital stay”.<sup>11</sup> For the purposes of this paper, three sub-categories of adverse events were studied:

- **Preventable Deaths** – Deaths that occur as an outcome of undergoing treatments which are considered preventable. Deaths could have occurred as a result of an error in a surgical operation or the administration of a toxic amount of medication, for example.
- **Patient Safety** – Errors that can take place that have a negative impact on a patient’s health (other than death), but that are considered part of the risk involved in a treatment. For example, falling out of bed and fracturing a hip or being transfused with the wrong type of blood while in hospital.

<sup>9</sup> Baker, G.R., Norton, P.G., Flintoft, V., Blais, R., Brown, A., Cox, J., et al. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal*, 170(11), 1684.

<sup>10</sup> Canadian Institute for Health Information. (2004). *Health Care in Canada*. Ottawa: Author, 42.

<sup>11</sup> Baker, G.R., Norton, P.G., Flintoft, V., Blais, R., Brown, A., Cox, J., et al. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal*, 170(11), 1678.

- **Red Flags** – Errors that take place that have a negative impact on a patient’s health while undergoing treatment that is not associated with the risks of the treatment. A hospital-acquired infection or an unplanned return to the operating room due to surgical complications, are examples of red flags.

The *AIMS Hospital Report Card: Quality of Care Indicator Framework* looked at data on how well hospitals perform by gathering information about wait times and the mistakes that can occur (See Appendix 1 for the full list of indicators that were considered for use by AIMS for this HRC. The nine indicators highlighted in bold were the final indicators selected.)

Identifying and collecting information for the AIMS’ Hospital Report Card: QCIF proved complicated and difficult. In addition to attempting to collect indicator and outcome data, the AIMS’ experience also served to underscore:

- 1) The tremendous complexity in detecting what information is publically available;
- 2) Which sources within Canada have the required data.

Identifying the data collection problems is important to gain insight into what information is currently available, and what issues must be addressed in the future to improve the amount and quality of information available to the public about the performance of their health care system.

### *Selection of Hospitals*

There were three major factors that determined which hospitals were to be included in the first Report Card:

- **Statistical Issues** – In order to compile quality indicators, hospitals have to reach certain statistical thresholds by performing a treatment many times (such as total hip replacements or cataract surgery). These minimum volumes restricted the selection of hospitals that would perform a large range of procedures enough times to assess and compare performance across the hospitals with reasonable levels of accuracy.
- **Data Limitations** – In order to compile indicators reflecting the quality of care patients receive, certain information has to be available, consistent, and accurately reported across the selected hospitals. There are differences among provinces in the information defined, collected, analyzed, and reported, if it is available at all. (The absence of available data severely restricted the hospitals that could be included in a nationwide comparison.)
- **Comparability** – Even if information is consistently reported, of a reasonable quality, and relevant for indicating the quality of care, hospitals are not easily comparable due to many factors that are outside their control. Some hospitals treat patients who are sicker and therefore more difficult to treat. Hospitals function differently according to the provinces in which they reside and the budgets allotted to them (i.e. variable staffing and equipment). Just like it would not make sense to compare death rates between an acute care facility and one specializing in palliative care (dying patients), caution must be taken in selecting hospitals that are similar enough that when adjustments are made, similar treatment results can be expected.

Because of the size of Canada many hospitals were located in small population centres such as Prince Edward Island, and thus had low volumes of patients upon which to compare their performance. This survey sample was generated by starting with those hospitals for which there was already an important indicator, the Hospital Standardized Mortality Ratio (HSMR). “The Hospital Standardized Mortality Ratio is a measurement tool that may help inform efforts to improve care. It compares a hospital’s mortality rate with

the average national experience and allows facilities to track changes over time.”<sup>12</sup> (Deaths in palliative care, paediatrics and in specialized hospitals are not included in the calculations.) The HSMR is a very useful indicator since hospitals can potentially improve patient outcomes and see their ranks change within short time periods.

Two additional comparative factors were used to ensure as much similarity as possible among the hospitals in the sample: a focus on teaching hospitals, and those that had over 300 acute care adult beds. This selection process reduced the nationwide sample to 17 large teaching hospitals across nine provinces since PEI and the Territories did not meet these latter two criteria.

The 17 hospitals selected based on the previously cited factors were:

1. St. Paul’s Hospital Providence Healthcare, (BC)
2. Royal Alexandria Hospital, Capital Health (AB)
3. University of Alberta Hospital, Capital Health (AB)
4. Regina General Hospital (SK)
5. Health Sciences Centre (MB)
6. St. Boniface General Hospital (MB)
7. Kingston General Hospital (ON)
8. London Health Sciences Centre (ON)
9. Mt. Sinai Hospital (ON)
10. St. Joseph’s Healthcare Hamilton (ON)
11. Sunnybrook Health Sciences Centre (ON)
12. The Ottawa Hospital (ON)
13. University Health Network (ON)
14. McGill University Health Centre (QC)
15. Saint John General Hospital (NB)
16. St. John’s Health Sciences Centre (NL)
17. Queen Elizabeth II Health Sciences Centre, Capital Health (NS)

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<sup>12</sup> Canadian Institute for Health Information. (2008). Introduction to the hospital standardized mortality ratio (HSMR) (elearning). *About CIHI: Education*. Retrieved November 08, 2008 from <[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=WORK\\_1131\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=WORK_1131_E)>.

# DATA COLLECTION

In Canada, the provincial governments are responsible for the management and delivery of health care services in accordance with the Canada Health Act in order to receive designated shares of federal funding. Public funds are not only used for federal and provincial contributions to the health care system, but they are also used to gather and compile information to manage the system's performance.

Because health services in Canada is a provincial responsibility there are differences in definitions, standards, data, organizational structures, and the data reporting levels of service providers across the country. Some patients see a variety of health care providers (family doctors, specialist physicians, physiotherapists, nurse practitioners, for example) across several jurisdictions for some procedures. Using a variety of practitioners adds to the complexity of who is responsible for which part of a patient's change in health care status. Of the information that is collected, there is a little or no obligation for reporting to the public. More often than not if there is "public reporting" it is to CIHI, Statistics Canada, or corresponding departments of health only.

There are very few sources of patient outcome data that are consistently collected regionally, provincially, or nationally. What information is typically available relies on individual health records (which are public information), and, funded by the provincial and federal governments, provided to CIHI. In turn, CIHI then analyses the data and provides very general statistical information and reports. As well, CIHI employs private consulting companies (such as The Hay Group) to undertake more in depth analyses.

## *Patient Safety and Wait Times Data*

Two surveys were designed and emailed to the 17 selected hospitals. Significant issues arose regarding the requests from identifying the appropriate department in each hospital to which to make the Survey request, to the person, persons, or departments who would actually give permission to release the requested information. Furthermore, there was no consistency as to the "holders" of the requested data (in other words, which Department(s) had the data). The result was weeks of delays in actually even obtaining a response as to whether the hospital would or would not participate in the Surveys (See Appendix 2 a & b).

## *Obtaining Indicator Data*

### 1. Canadian Institute of Health Information (CIHI):

CIHI's operations are largely managed and financed by the provincial and federal governments, and rely on the Discharge Abstract Data Base (DAD) when compiling information on the quality of care. Each time a patient is discharged from a hospital, an abstract is coded, filed, and submitted to the database. This process provides a valuable resource that can be used to evaluate the treatments patients received while under a hospital's care.<sup>13</sup>

CIHI's indicators represent the largest bank of health care data in the country. Hospitals voluntarily agree to collect and submit data for analysis by CIHI to provide performance measures on the quality of care patients

<sup>13</sup> Canadian Institute for Health Information. (2008). Discharge abstract database. *Health Services*. Retrieved November 10, 2008 from <[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=services\\_dad\\_e#request](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=services_dad_e#request)>.



received at those hospitals. The data submitted is public information – that is, the data is about procedures, care, and treatments that patients received when in hospital. The patients themselves do not give permission to provide this information. Rather the hospitals decide to submit information on the patients' behalf. When contacted, CIHI was generally unwilling to aggregate statistics at the hospital or regional level for AIMS, and stated that such a request would have to be paid for (a reasonable request) and would require one, to one and a half years per indicator to complete an analysis.

## 2. The Hay Group

The Hay Group, a private consulting company, produces a wide range of performance related information for participating Canadian hospitals each year. To do so, they collaborate with the hospitals and the Canadian Institute for Health Information, accessing the DAD (patients' discharge files), and analysing hospital indicator data which it purchases from CIHI. Indicators are compiled for comparisons ranging from lengths of stay to quality of care indicators.

For the purposes of the HRC nine indicators for which data is already compiled by The Hay Group were selected by the AIMS' Advisory Group. A request was made to the Hay Group for access to the results of the 17 participating teaching hospitals for the indicators. AIMS was informed that this information was not public and that permission would have to be granted by each participating hospital to access that hospital's results (See Appendix 3). The Hay Group indicator analyses are, apparently, only available to those hospitals that participated in the analyses. The nine indicators selected for review in consultation with the Advisory Group were:

- hospital standardized mortality rate
- cardiac arrest after major surgery
- acute myocardial infarction after major surgery
- rate of reported misadventures for surgical patients
- admission via the ER
- accidental puncture and lacerations
- death in low mortality case mix – observed over expected
- surgical site infections\*
- re-admission via Emergency of surgical cases with wound infections\*

*\*NOTE: The last two indicators (marked with an “\*”) have been eliminated by CIHI/Hay due to a lack of consistency in data collection and reporting practices by the participating hospitals. The end result, therefore, were requests from AIMS for data on seven indicators.*

## 3. Provincial Ministers of Health

At the same time as permission requests were being sent to the hospitals in the sample, letters were also distributed to the related provincial Ministers of Health (Appendix 4). In the letters, AIMS requested that the Ministers grant permission to access the data regarding these nine indicators from The Hay Group. As health services are managed and delivered provincially, a lot of data is gathered and reported at the regional and provincial levels. In the request to the Ministers of Health, AIMS stressed that the provision and management of health services in Canada is a provincial responsibility and thus they have the authority to make available information regarding the quality of hospital performance within their jurisdictions. Secondly, the public has a right to access data concerning the performance of publicly funded services, and these nine indicators' data are collected at the public's expense through CIHI.



#### 4. Freedom of Information and Privacy (FOIP) Act

The third approach (of last resort) by AIMS was to obtain this public information by contacting the hospitals in the various provinces from whom we had received rejection letters and request the same information through a Freedom of Information request. The precise definitions, precedents, and acts vary from province to province, including what is considered to be a public record. Thus the “red tape” process to initiate data requests and have hospitals comply varies over a period of many months. Alberta has defined “FOIP” as: “a formal method of requesting information held by public bodies which is not available by other means.”<sup>14</sup> To ‘FOIP’ CIHI itself for the indicator data was additionally complex as CIHI is an ‘arms length’ agency from the federal government and thus not covered by Freedom of Information requests. Requests were started to the various provinces, with the exception of Nova Scotia as Capital Health<sup>15</sup> provided the requested information voluntarily covering their performance results from the Hay Group data base as well as wait time data.

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<sup>14</sup> Government of Alberta. (2006). How do I make a FOIP request? *Freedom of information and protection of privacy*. Retrieved September 20, 2008 from [http://foip.alberta.ca/faq/foip\\_request.cfm](http://foip.alberta.ca/faq/foip_request.cfm).

<sup>15</sup> Capital Health was the first respondent in the Canadian wide survey to grant AIMS permission to access their performance data for these indicators held by the Hay Group after the Hay Group specified that a specific hospital’s permission to access these records had to be granted. Capital Health also fully participated in the Wait Times Survey, provided Wait Time data, and expressed a strong interest in being involved in a transparent process to improve the information that the public had available to assess the quality of care they receive.

# FINDINGS

Access to information and essentially a lack of cooperation from the vast majority of the hospitals, CIHI, The Hay Group, and Ministers of Health were quickly identified as major barriers to the provision of the requested public information.

Eight of the seventeen hospitals contacted (47 percent) never acknowledged AIMS' request to complete the Surveys on Patient Safety or Wait Times. Two or 11.8 percent of the hospitals acknowledged our requests but after asking for clarification, either declined, or never responded further. Five hospitals (29 percent) formally declined to participate. Only one hospital in our national sample, Capital Health in Nova Scotia, agreed to participate, not only providing access to any requested information, but communicating with AIMS to ensure the data was understandable. One other facility, declined to participate, but responded to questions about Wait Time data from their surgical department via data already posted on their website. .

With respect to the requesting of data regarding the seven indicators, The Hay Group and CIHI declined to provide any information unless express written permission was obtained from each hospital. Permission requests were then sent out to the 17 hospitals (See Appendix 3). The letters sought permission to access their list of indicator information from The Hay Group and secondly, to publicly identify the hospitals by name. Only two facilities (11.7 percent) voluntarily gave formal written permission to access their information: Only one facility granted permission to publish their name in the HRC (Capital Health in Nova Scotia).

Of the hospitals that replied but did not give permission, reasons included:

“While we appreciate the time you are putting into this research, the answer from --- is No thank you - we do not give permission to have Hay data released to AIMS for this research project.”

“As you know the Hay Group benchmarking report does not provide hospital specific information publicly. This tool is used internally and the results are at this time not publicly posted...At this time we will not be able to provide you the information you request without research ethics board approval.”

With respect to the requests made to the provincial Ministers of Health to grant permission to access the indicator information for their corresponding hospitals, few complied. These refusals are direct contrast to what most of the provincial department of health websites herald for their accountability and openness:

“What is Accountability? The Manitoba Government is committed to results-oriented, open, accountable government. The people of Manitoba have the right to know what health services are being delivered and what results are being achieved. This is known as accountability.”<sup>16</sup>

Regarding their regional Health Authorities, British Columbia states on their government department of health website:

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<sup>16</sup> Manitoba Health. (1999). What is accountability? *Achieving accountability*. Retrieved November 08, 2008 from <<http://www.gov.mb.ca/health/rha/accounte.pdf>>, 3.

“B.C.’s health authorities are committed to building a high-quality, patient-centered and sustainable health care system that is: accountable with clearly articulated and conscientiously monitored performance measures and targets.”<sup>17</sup>

No provincial Health Minister (or department thereof) gave AIMS the requested permission. Instead responses generally indicated that the information was the property of the hospital, not the government. For a sample of responses see Appendix 5.

In summary, from the responses that were received, a circular argument was very evident. Eighty-eight percent of the hospitals would not give permission to access this public data, The Hay Group wouldn’t provide any hospital information unless each hospital gave written permission, and the Ministers of Health said that the data belonged to the hospitals and was therefore “private” – a real “Catch 22”.

## Concluding Observations

There are critical deficiencies in the information available to the public about the quality of care they receive for their tax dollars. Given the amount of taxpayer money spent on health care, data collection activities by hospitals and governments, and assessments of the health care system, there is virtually no specific information that is reasonably publicly accessible about the outcomes from the spending of that money. These deficiencies make it nearly impossible to hold the public health care system accountable. As a result, patients are poorly informed about the quality and risk to care they may receive.

These gaps in public information and specific weaknesses in the information system need to be addressed. Reducing wait times and errors are key ingredients to improving the health care system’s performance. A necessary first step is to identify the degree of significance of the problem(s) and where in the system the problems are located. Comparing outcomes across hospitals also makes it much easier to identify potential best practices; a critical ingredient to finding pragmatic ways to improve the quality of care.

This Framework report developed an approach that can be used to identify what the public needs to know, and more importantly, identifies what the public does not *yet* know. In particular, the following areas require immediate attention and improvement to address this gap. Thus the public will be provided with uncomplicated access to important information related to the quality of care:

- **Quantity and Quality of Indicators** – Consistently collecting similarly defined indicators across more procedures and health care providers (provincially, nationally, and internationally) will enable broader, more accurate comparisons. This analysis will improve the public’s ability to identify strengths, weaknesses, and best practices, and to hold the system accountable for the spending of the public’s dollars.
- **Transparency** – Although patients’ rights to privacy are paramount, there remain multiple opportunities to improve the level of transparency of public information in Canada’s health care sector. CIHI, (largely funded through government contributions), receives information from hospitals on behalf of their patients, without the patients’ consent - but is not considered a publicly accountable organization. CIHI uses public tax dollars to hire a private consulting group to assess and compare hospital performance based on this public patient care information, but these results are not considered public. Patients have a right to know the results of publicly funded studies using their

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<sup>17</sup> Ministry of Health Services. (n.d.). About BCs health authorities. *British Columbia Health Authorities*. Retrieved November 12, 2008 from < <http://www.health.gov.bc.ca/socsec/about.html> >.

private information, and taxpayers have a right to know how and by whom their tax dollars are being spent.

- **Wait Times** – A First Ministers’ commitment in 2004 to establish wait time benchmarks by December 31, 2005 in four priority areas is not enough. Different provinces continue to use different definitions of wait times and different methods for measuring and reporting for various parts and levels of their respective health care systems. This shell game makes it impossible to compare hospitals nationwide, identify best practices, recognize performance, and hold the system accountable for wait time improvements leading to better quality of care. Effectively reducing wait times will require agreement on a nation-wide set of reporting standards that can compliment the provincial ones already in existence, as well as expanding the procedures covered, and obligations to make the results public.<sup>18</sup>
- **Patient Safety** – Like other aspects of life, adverse events happen in health care: incorrect treatments, medication errors, falls resulting in injuries, infections, surgical misadventures, and a host of other risks. Collecting information on where and when these errors occur and the degrees of severity are important steps in their reduction and subsequent improvement in the quality of health care. Publicly releasing the indicator data related to patient safety that are compiled by The Hay Group would be an important start.

In conclusion, how can the public hold the health care system accountable without better access to information concerning how well public funds are being used to deliver quality health care? Without publicly comparable and consistently collected information, it is not possible to identify and distinguish best from worst practices or generate the right mix of incentives for future improvements in performance. It is also not possible to recognize those in the system who do perform well and deliver Canadians the best quality of care possible with the resources they have at their disposal.

These information gaps reveal that the public does not have the information they need to identify where they can be best assured of receiving quality care. With almost a one in 12 (??) chance of suffering an “adverse event” while in hospital, and a one in five chance of dying if you do, not knowing about quality of care can and will hurt you.

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<sup>18</sup> Gutkin, C. (2005). Waiting for wait times. *Canadian Family Physician*, 51, September, 1304-1303.

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## Appendix 1 – List of Indicators/ Indicators Selected for AIMS’ First Hospital Report Card

The following factors influenced the overall selection of indicators that could be used to assess and compare how effectively hospitals care for their patients:

- **Patient Outcomes** – The indicator had to be useful for measuring how much of a change in a patient’s health was due to the treatments provided while in a hospital’s care.
- **Indicates Quality** – The indicator chosen had to be useful for indicating the level of quality of care hospitals achieve. A change in the indicator had to reflect a change in quality such that a rise or fall had to be clearly associated with a rise or fall in quality rather than caused by some other factor. The indicator has to indicate and reflect quality well.
- **Available** – The first two criteria generated a long list of indicators that could be potentially used for this *Hospital Report Card*, but comparing and assessing hospitals means that they have to be available. CIHI estimates that for each indicator, typically 1 to 1.5 years is required to assess the raw data and compile meaningful statistics that can be used to indicate the quality of care. From the ideal list, only a small number of indicators are currently available for use, and even fewer publicly available.
- **Wide Ranging** – The list of indicators had to cover as many procedures as possible. It is possible that one hospital might perform one type of treatment better than another, and this situation means that making general statements about how well a hospital performs overall should include as many treatments as possible. Failing to include an indicator would likely result in some areas of hospital treatments being ignored, or being unrecognized. In a public report this situation would serve to direct a hospital’s attention away from these ignored areas to those that are documented simply because their ratings would improve.

The following list of indicators represents the grand list that could be used for this Survey. The nine indicators that were finally selected for data collection for the Report Card are indicated in bold; the *one* indicator for which data that is publicly available in bold italics.

### **Wait Times**

- Hip replacement
- Knee replacement
- Cataract replacement
- Coronary Artery Bypass Graft
- Radiation Therapy
- Outpatient/Ambulatory
- Emergency Room/Department

### **Mortality Rates**

- ***Hospital Standardized Mortality Rate (65 procedures, 87 hospitals)***
- 30-Day Acute Myocardial Infarction in-hospital
- 30-Day Stroke in-hospital
- Caesarean Section
- Hip Fracture/Replacement
- Abdominal Aortic Aneurysm (AAA) Repair

- Coronary Artery Bypass Graft (CABG)
- Craniotomy
- Pancreatic Resection
- Percutaneous Transluminal Coronary Angioplasty (PTCA)
- Acute Myocardial Infarction Rate without Transfers
- Congestive Heart Failure (CHF)
- Gastrointestinal Haemorrhage
- Pneumonia
- Death within 48 hours of surgery

***Adverse Events***

- **Accidental puncture or laceration**
- **Acute Myocardial Infarction**
- **Admission via the ER**
- Birth trauma – injury to neonate
- **Cardiac Arrest After Major Surgery**
- Complications of anesthesia
- **Death in Low-mortality DRGs**
- Decubitus Ulcer
- Failure to Rescue
- Foreign Body left during Procedure
- Iatrogenic Pneumothorax
- Obstetric Trauma – vaginal with instrument
- Obstetric Trauma – vaginal without instrument
- Obstetric Trauma – Caesarean Delivery
- Postoperative Hip Fracture
- Postoperative Haemorrhage or hematoma
- Postoperative Physiologic and Metabolic derangements
- Postoperative Respiratory Failure
- Postoperative Pulmonary Embolism or deep Vein Thrombosis
- Postoperative Sepsis
- Postoperative Wound Dehiscence
- **Re-admission via Emergency Room of surgical cases with wound infection**
- **Rate of Reported Misadventures for Surgical Patients**
- Blood Transfusion reaction
- Ventilator developed pneumonia
- PYLL (potential years of lost life)

***Red Flags***

- **Selected Infections due to medical care**
- Medication errors
- Unplanned readmissions
- Hospital acquired infection
- Emergency readmission within 28 days
- Unplanned return to operating room theatre



## Appendix 2 a & b – Wait Times and Patient Safety Surveys

### Appendix 2a: Patient Wait Times Hospital Survey

#### Date

#### Address of Hospital

Atlantic Institute for Market Studies  
2000 Barrington Street  
Suite 1302, Cogswell Tower  
Halifax, NS B3J 3K1  
[www.aims.ca](http://www.aims.ca)

Subject: *Wait Times in Canadian Hospitals – Survey*

Dear Sir or Madam:

In response to concerns over the quality of, and patient access to, health care in Canada, a First Ministers Conference in 2004 identified wait times as an area of concern. Their report, *A Ten Year Plan to Strengthen Health Care*<sup>19</sup>, identified four priority areas for non-emergency services (cancer, sight restoration, joint replacement and cardiac care) and commitments were made to establish and monitor benchmarks for each of these nationwide. Unfortunately, much of the data that are reported are at an aggregate level and do not examine more closely hospitals' unique challenges nor the initiatives hospitals are undertaking to monitor and reduce wait times, thereby increasing the quality of care.

The Atlantic Institute for Market Studies (AIMS) is a non-profit independent public policy institute in Halifax and recipient of the Templeton Freedom Award and the Sir Antony Fisher award (four times). AIMS is conducting a brief survey of a sample of hospitals across Canada to learn more about the length of wait times patients face in each of these priority areas, including Emergency Room services, as well as the initiatives hospitals are undertaking to address wait times issues. Your responses to this very brief questionnaire will help identify:

- What is being done by hospitals to measure, respond to, and improve wait times
- The portion of total wait times in the health care system that takes place in hospitals
- Problems that exist across the country in establishing consistently applied definitions and measures of wait times
- Hospital specific initiatives that are often missed in more general surveys and studies

We would appreciate learning more about the conditions your hospital is facing on this issue and would like to ask for your response **by June 20, 2008**. If we have contacted the wrong department in your hospital, we would be grateful if you would provide us with the correct contact information and forward this document to the correct personnel.

If you have any questions or concerns about this survey, please feel free to contact Barrie Hebb or Deborah Vandewater, the project leads on this AIMS initiative.

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<sup>19</sup> Canadian Intergovernmental Conference Secretariat, *A 10-Year Plan to Strengthen Health Care*, [online], cited December 2, 2005, from <[http://www.scics.gc.ca/cinfo04/800042005\\_e.pdf](http://www.scics.gc.ca/cinfo04/800042005_e.pdf)>

Thank you for your time and consideration,

Atlantic Institute for Market Studies  
2000 Barrington Street  
Suite 1302 Cogswell Tower  
Halifax, NS B3J 3K1  
Tel: 902.429.1143  
[barriehebb@aims.ca](mailto:barriehebb@aims.ca)  
[deborahvandewater@aims.ca](mailto:deborahvandewater@aims.ca)

<b>Name and Location of Facility:</b>	
<b>Name and Title of person/persons completing the question:</b>	
<b>Number of beds:</b>	
Medical	
Surgical	
Obstetrical	
Mental Health	
Paediatrics	
Rehabilitation	
Long Term Care	
Other	
<b>Do you have a “vision” statement focusing upon wait times? If yes, what is it?</b>	

*We would like to know more about the wait time issue and the length of wait times patients in hospitals across the country face. We would like to ask your hospital to participate in this brief survey to gather more information on wait times and those activities your hospital is currently engaged in that serve to reduce them.*

1. Does your hospital routinely gather information on wait times in each of the following areas?

<b>Area</b>	<b>Yes</b>	<b>No</b>
Cancer		
Sight Restoration		
Joint Replacement		
Cardiac Care		
Emergency Room		

2. If you answered yes for any or all of these areas, could you provide us with the wait time information you collect in each of these areas? Has wait time performance improved or worsened over the last 12 months compared to previous years?
3. Recognizing that there are differences across Canada, how does your hospital measure and define wait times? (e.g., from the date the procedure is booked to when the treatment is started? Or from the time the procedure is agreed upon by the patient and doctor to the start of the treatment(s)?)
4. Has your hospital developed any strategies or action plans to reduce wait times in these priority areas? Or in other areas that your hospital has identified as a priority? If yes, could we receive a copy or synopsis?
5. Please feel free to share with us any additional information or data you think is relevant in assessing wait times in your hospital specifically or hospitals more generally.

*We would like to thank you for taking the time to complete this survey.*

*Please return your comments to: [barriehebb@aims.ca](mailto:barriehebb@aims.ca), or by mail to*

**Atlantic Institute for Market Studies  
2000 Barrington Street  
Suite 1302, Cogswell Tower  
Halifax, NS B3J 3K1**

## **Appendix 2b: Patient Safety Hospital Survey**

Date

Risk Management/Quality Assurance Department  
Hospital X  
Addressee, Title  
Hospital  
Address  
City  
PC

Atlantic Institute for Market Studies  
2000 Barrington Street, Suite 1302  
Cogswell Tower  
Halifax NS B3J 3K1  
[www.aims.ca](http://www.aims.ca)

Dear

**SUBJECT: *Patient Safety in Canadian Hospitals – Survey***

The Atlantic Institute for Market Studies (AIMS) is a non-profit independent public policy institute in Halifax, winner of the Templeton Freedom Award and four time recipient of the Sir Antony Fisher Award. As part of our research efforts to explore how the priority of patient safety in hospitals is being addressed by health care institutions, AIMS is gathering information on this topic from selected hospitals across Canada.

As Health Canada states: “*ensuring patient safety is a fundamental element of high quality health care. Providing safe, quality health care to Canadians is a priority for all governments, health care professionals, organizations and institutions*”.

Following an extensive review of literature, studies and research agencies, we have developed a very brief questionnaire, which is attached. Your responses will help identify:

- What is being done by hospitals to measure, respond to, and improve patient safety
- Problems that exist across the country in establishing consistently applied definitions and measures of patient safety
- Hospital specific initiatives that are often missed in more general surveys and studies

We would appreciate learning more about the conditions your hospital is facing on this issue and would like to ask for your response **by June 20, 2008**. If we have contacted the wrong department in your hospital, we would be grateful if you would provide us with the correct contact information and forward this document to the correct personnel.

This project is being led by Ms. Deborah Vandewater and Mr. Barrie Hebb.

We are grateful for your assistance,

Atlantic Institute for Market Studies  
2000 Barrington Street

Suite 1302 Cogswell Tower  
 Halifax, NS B3J 3K1  
 Tel: 902.429.1143 x229  
[barriehebb@aims.ca](mailto:barriehebb@aims.ca)  
[deborahvandewater@aims.ca](mailto:deborahvandewater@aims.ca)

<b>Name and Location of Facility:</b>	
<b>Name and Title of person/persons completing the question:</b>	
<b>Number of beds:</b>	
Medical	
Surgical	
Obstetrical	
Mental Health	
Paediatric	
Rehabilitation	
Long Term Care	
Other	
Do you have a “vision” statement focusing upon quality and patient safety improvement? If yes, what is it?	

*We would like to know more about how patient safety issues are addressed in hospitals across the country. We would like to ask your hospital to complete this brief survey to help us gather information on patient safety and hospitals’ activities to improve it.*

1. What patient safety goals have been developed for your organization?
2. How is information concerning patient safety gathered, validated and deemed appropriate?
3. How is patient safety performance monitored in your facility?
4. What patient safety performance information do you collect? (e.g., fractured hips, medication errors, hospital acquired infections, accidental puncture/laceration, hospital-acquired decubitus ulcer, foreign body left during procedure, blood transfusion reaction, ventilator developed pneumonia).

5. Has your hospital embarked upon any initiatives to support and develop improvements in the quality and safety of care patients receive?
6. Has patient safety performance improved or worsened over the last 12 months compared to previous years? What metrics do you collect to address this question? Can you provide us with data?
7. Please feel free to provide us with any additional information you think may be relevant concerning this issue in your hospital or hospitals in general.

*We would like to thank you for taking the time to complete this survey*

*Please return your comments to: [barriehebb@aims.ca](mailto:barriehebb@aims.ca) or by mail to*

**Atlantic Institute for Market Studies  
2000 Barrington Street  
Suite 1302, Cogswell Tower  
Halifax, NS B3J 3K1**

## Appendix 3 – Letters to Hospitals for Permission to release Hay data to AIMS

Date

(insert addressee)

Re: Hospital Performance Indicators Request

Dear (insert),

The Atlantic Institute for Market Studies (AIMS) is a non-profit economic and social public policy research institute based in Halifax, Canada. AIMS has earned recognition as a unique voice on public policy issues advocating accountability, transparency, and fostering public participation through its publications, events, commentaries and research. AIMS is a four-time recipient of the Sir Antony Fisher prize and most recently received the Templeton Freedom award.

AIMS is currently conducting research on the quality of care patients receive at a sample of hospitals across the country. Although there is some information available on health care quality in Canada, much of what is reported is at the regional, provincial, or national level. Further, what is available at the hospital level is often scattered through a maze of various reports in complex language making it difficult for the public to assess the current status of health care providers and engage in discussions on health policy. To be more precise, there are several complementary goals we have in this area of research:

- **Consent:** information on hospital performance is necessary for patients to access in order to give genuine consent to treatment, all of which involve some level of risk that patients have a right to know as accurately as possible.
- **Hospital Performance:** Quality of care indicators summarized at regional, national or provincial levels leave out the specific challenges that hospitals face and the creative solutions that leaders in this sector have initiated to improve patient care.
- **Public Policy:** Without accurate information about hospitals, the quality of care they provide and the challenges they face, the public is less able to have meaningful public discussions on health policy, the resources that ought to be directed to healthcare from other public priorities, or solutions for the challenges the system faces.

We have been gathering performance measures on the quality of care that patients receive at hospitals across the country, some of which are already publicly available. There are several, however, which have been collected and are available from the Hay Group which we would like to access and include in our research. We have contacted Mark Hundert, National Director at Hay Group Health Care Consulting, who notified us that we would have to approach each hospital individually to obtain permission to access data for that hospital.

We would like to obtain the following indicators:

### **List of Indicators from Hay Group Benchmarking Comparison**

- 6.1 Hospital Standardized Mortality Rate (HSMR)
  - 6.1.2 Cardiac arrest after major surgery
  - 6.1.3 Acute Myocardial Infarction after major surgery

- 6.1.4 Surgical site infections – proportion of infections per 1000 surgical cases
- 6.1.5 Re-admission – via ER – of surgical cases with wound infection
- 6.1.7 Rate of Reported misadventures for surgical patients
- 6.3.4 Admission via the ER
- 7.2 Accidental puncture and lacerations
- 7.3 Death in low mortality case mix – observed over expected

We intend to use these indicators in addition to those already publicly available to provide a publicly available report on the quality of patient health care in a sample of hospitals across Canada. We would like your hospital to give us permission to access the list of indicators from the Hay Group for your hospital. Secondly, we would like your permission to publicly identify your hospital's performance indicators.

We would be happy to send you a copy of the report one week before our study is released publicly.

We appreciate your time and consideration. We also welcome your views on performance indicators that you may feel we should be aware of, the specific challenges your hospital faces and/or creative solutions planned or underway to improve the quality of care. If you have any questions about this request, please feel free to contact our project managers, Deborah Vandewater and Barrie Hebb,

Sincerely,

Barrie B. F. Hebb, Research Economist  
The Atlantic Institute for Market Studies.

And

Deborah Vandewater

I have read the above and consent, on behalf of (insert), to allow the Atlantic Institute for Market Studies to receive from the Hay Group a complete copy of the indicators listed above from the Hay comparative reports related to (insert). I understand that the Atlantic Institute for Market Studies will not receive any information which can identify any particular patient.

**Full Name (Print)**  
**Signature**  
**Date**

On behalf of (insert) I agree to (please check the appropriate box):  allow  not allow the Atlantic Institute for Market studies to publicly identify (insert)'s performance for each indicator.

**Signature**  
**Date**

Please return this letter, by fax or mail, to AIMS:  
2000 Barrington Street  
Suite 1302, Cogswell Tower  
Halifax, NS B3J 3K1  
Telephone: (902) 429-1143  
Fax: (902) 425-1393



## Appendix 4 – Letter to Provincial Ministers of Health

**The Atlantic Institute for Market Studies  
2000 Barrington Street  
Suite 1302, Cogswell Tower  
Halifax, N.S. B3J 3K1**

July 22, 2008

Minister  
Address  
Address  
Address

Dear ...Minister of Health

Subject: AIMS Hospital Report: Permission to Access Hospital Data from Canadian Institute for Health Information (CIHI) and Hays Consulting

In support of providing information to the public on expectations for hospital care, AIMS (a not for profit public policy research agency) is requesting your agreement to allow the release of information hospitals have submitted to CIHI and the Hay Group (?). Our understanding from these agencies is that hospitals have submitted information related to patient care and other related information.

Our initial investigation is that the present format of public data is difficult for the average consumer to understand. There is currently no single, easily accessible, location available where citizens can find out how well their hospitals perform in terms of improving patient health through treatments. Yet, this type of information is important for consent, public service performance, continuous quality improvement and recognition.

AIMS researchers, Barrie Hebb and Deborah Vandewater, are currently gathering information on the quality of care that patients receive for a sample of teaching hospitals across Canada. This research focuses on the effectiveness of treatment by health service providers and the change in patients' health status.

We have been able to access some publicly available information related to the quality of care at the hospital level (preventable deaths and wait times), but there are nine additional indicators that we would like to access within your jurisdiction and are experiencing difficulty obtaining. The nine indicators are used internationally to help assess quality performance at the hospital level and have been compiled using the Discharge Abstract Database (DAD), which is composed of individuals' medical records. The Canadian Institute for Health Information (CIHI) has access to this database and has shared the information with the private Hay Group to compile the nine indicators for the hospitals in our sample.

The following are the indicators we are interested in accessing from the **Hay Group Benchmarking Comparison**:

**6.1 Hospital Standardized Mortality Rate (HSMR)**

**6.1.2 Cardiac arrest after major surgery**

**6.1.3 Acute Myocardial Infarction after major surgery**

**6.1.4 Surgical site infections – proportion of infections per 1000 surgical cases**

**6.1.5** Re-admission – via ER – of surgical cases with wound infection

**6.1.7** Rate of Reported misadventures for surgical patients

**6.3.4** Admission via the ER

**7.2** Accidental puncture and lacerations

**7.3** Death in low mortality case mix – observed over expected

We have contacted both CIHI and the Hay Group concerning these indicators and have been told that we cannot access them. Instead, representatives at the Hay Group Health Care Consulting, has told us that it is up to each individual hospital to grant us permission to access that hospital's individual performance for each and every indicator. CIHI has notified us that they are unwilling to use the DAD to compile indicators, even on a cost recovery basis, and that each one would take 1.5 years to compile.

Given that these nine indicators already exist for the hospitals in our sample, are impossible to replicate, and are related to assessing the quality of care, we would like to request your Department of Health to grant us permission to access these nine indicators from the Hay Group for the hospitals within your jurisdiction., especially considering that these indicators are available to participating hospitals for use in comparing performance. The indicators are based on individual medical records shared with CIHI, a non-governmental non profit organization (arms length), without expressed permission from individual patients, and with the Hay Group. If these indicators can be shared with some non-governmental organizations, there is a basis for extending that more widely to not only engage a wider audience, but to inform them about the performance of a public service.

This request is being made for each province within our sample across the country. Due to our research objectives, we would appreciate receiving a response from your department by August 22, 2008.

If you have any questions, please feel free to contact AIMS project managers for this initiative, Deborah Vandewater or Barrie Hebb. Information on AIMS can be obtained in our web site which is....

Thank you for your time and consideration,

Barrie B F Hebb, BA.h., MA  
902.429.1143, x 229

Deborah Vandewater, RN, MN, GNCI

## Appendix 5 – Sample Responses from Provincial Ministers of Health

Provincial Health Department	Response
Newfoundland	No Response
Nova Scotia	The nine indicators you are requesting are not in the Department’s custody or control and the Department of Health does not have the authority to grant permission to obtain this information.
New Brunswick	No Response
Quebec	Pasque cette base de donnases n’est pas . . . (provided ????? of their provincial level measures.
Ontario	The Ontario Minister of Health is not the custodian . . . go to the hospitals, October 20 <sup>th</sup>
Manitoba	Manitoba Health and Healthy Living does not participate in this private study, and therefore, can not authorize access to privately held information.
Saskatchewan	Saskatchewan’s regional health authorities are responsible for the daily delivery of health programs and services, and are the trustees of hospital records. As such, I would encourage you to contact each RHA separately for the indicators you are seeking.
Alberta	We are not able to honour your request to compel the Hay Group or the Canadian Institute of Health Information to provide the information to you.
British Columbia	As the Ministry of Health Services is not a party to this arrangement, we are unable to approve the release of the indicators you have requested.







## Appendix 6 – Sample Responses from hospitals

Hospital	Province	Freedom of Information applicable?	Details of Response
St. Paul's Hospital Providence Healthcare	BC	Yes	Granted Permission with FOI Request
Royal Alexandria Hospital, Capital Health	AB	Yes	Minister of Health declined to give permission. Capital Health has not yet responded to FOI request
University of Alberta Hospital, Capital Health	AB	Yes	Minister of Health declined to give permission. Capital Health has not yet responded to FOI request
Regina General Hospital	SK	Yes	Granted Permission with FOI Request
Health Sciences Centre St. Boniface General Hospital	MB	Yes	Granted Permission with FOI Request
Kingston General Hospital	ON	No	Declined Permission
London Health Sciences Centre	ON	No	Declined Permission
Mt. Sinai Hospital	ON	No	Declined Permission
St. Joseph's Healthcare Hamilton	ON	No	Declined Permission
Sunnybrook Heath Sciences Centre	ON	No	Declined Permission
The Ottawa Hospital	ON	No	Declined Permission
University Health Network	ON	No	Granted Permission with FOI Request
McGill University Health Centre	QC	Yes	Quebec Hospitals are not required to participate in CIHI's data collection. The specific CIHI measures were requested from McGill, with no response to date
Saint John General Hospital	NB	Yes	Granted Permission with FOI Request, but waived FOI application fee.
St. John's Health Sciences Centre	NL	Yes	Granted Permission with FOI Request, but waived FOI application fee.
Queen Elizabeth II Health Sciences Centre, Capital Health	NS	Yes	Granted Permission without FOI Request







It should also be noted that the Hay Group responded with the following when asked how we could access the data for those hospitals who gave permission:







*“You should note that responding to the request is complicated in that some of the metrics requested are based on the performance of all the hospitals in the data base; since all the hospitals have not provided permission to provide you with data, we have been advised that metrics based on their performance should not be released*

**Appendix 7 – AIMSHRC: QUALITY OF CARE INDICATOR FRAMEWORK**

Hospital/Facility	Wait Times	Adverse Events			Indicators (from The Hay Group)								Sum	Overall Ranking
		Preventable Deaths	Patient Safety	Red Flags	Accidental puncture and lacerations	Cardiac arrest after surgery	Acute MI (heart attack) after major surgery	Rate of reported misadventures for surgical patients	Admission via the ER	Hospital Standardized Mortality Rate <sup>20</sup>	Death in low mortality case mix			
<b>Exceeds Benchmark:</b>  <b>Meets Benchmark:</b>  <b>Fails Benchmark:</b> 													=  =  = 	
St. Paul's Hospital Providence Healthcare, BC	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	101	NAFCA		
Royal Alexandra Hospital, Capital Health, AB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	104	NA		
University of Alberta Hospital, Capital Health, AB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	99	NA		
Regina General Hospital, SK	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	71	NAFCA		
Health Sciences Centre, MB	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NA	NAFCA		

<sup>20</sup> Three year average data from HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada (Ottawa: CIHI, 2007).pp 76-94

Hospital/Facility	Wait Times	Adverse Events			Indicators (from The Hay Group)							Sum	Overall Ranking
<b>Exceeds Benchmark:</b>  <b>Meets Benchmark:</b>  <b>Fails Benchmark:</b> 		Preventable Deaths	Patient Safety	Red Flags	Accidental puncture and lacerations	Cardiac arrest after surgery	Acute MI (heart attack) after major surgery	Rate of reported misadventures for surgical patients	Admission via the ER	Hospital Standardized Mortality Rate	Death in low mortality case mix	=  =  = 	
St. Boniface General Hospital, MB	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	103	NAFCA		
Kingston General Hospital, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	95	NA		
London Health Sciences Centre, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	112	NA		
Mt. Sinai Hospital, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
St. Joseph's Healthcare Hamilton, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	90	NA		
Sunnybrook Health Sciences Centre, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	104	NA		

Hospital/Facility	Wait Times	Adverse Events			Indicators (from The Hay Group)								Sum	Overall Ranking
		Preventable Deaths	Patient Safety	Red Flags	Accidental puncture and lacerations	Cardiac arrest after surgery	Acute MI (heart attack) after major surgery	Rate of reported misadventures for surgical patients	Admission via the ER	Hospital Standardized Mortality Rate	Death in low mortality case mix			
<b>Exceeds Benchmark:</b>  <b>Meets Benchmark:</b>  <b>Fails Benchmark:</b> 												=  =  = 		
The Ottawa Hospital, ON	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	90	NA		
University Health Network, ON	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	87	NAFCA		
McGill University Health Centre, QC	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
Saint John General Hospital, NB	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	74	NAFCA		
St. John's Health Sciences Centre	NA	NA	NA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	114	NAFCA		
Queen Elizabeth II Health Sciences Centre, Capital Health, NS	NAFCA	NA	NAFCA	NA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	NAFCA	102	NAFCA		

NA: Data not available

NAFCA: Not available for comparative analysis – these data points are from hospitals which gave permission for the release of data but could not be released because other hospitals refused permission



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## Selected Publications from the AIMS Library

### Publications on Health Care

*A Third Option for the Health Care Debate: Think Community and Courage* by Dianne Kelderman and Dr. David Zitner

*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 Phillippe

*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

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

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*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

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