

## **4. How does Canada compare to Europe?**

An objective look at Canada's healthcare system in the broader context of the OECD is overdue. The Euro-Canada Health Consumer Index marks the first major step toward a remedy. The EU states, plus Switzerland, against which Canada is compared, span a wide range with respect to wealth, population size and history. While all states provide solid public healthcare, the degree to which private care is available varies. (The Swiss system is basically privately funded but strictly publicly regulated, a unique solution in Europe).

Since the index does not take the source of funding into consideration when measuring outcomes, this tool is especially suited to a discussion of how Canadian healthcare might be improved and brought up to the standard enjoyed in most of Europe, while avoiding the belaboured conflict about combining public and private care providers. It is worth stressing that the Index does reward outcomes and consumer-friendliness, not private or public solutions per se.

### **4.1 Patient rights and information**

Canada's score in this category is very poor, with 12 out of 27 points. Only one country (Latvia) has a worse showing, and Poland scores the same as Canada. This is in some ways an abstract category in that health consumers seeking immediate care are less inclined to worry about whether they have a patient charter of rights than about wait times and outcomes. On the other hand, poor results in the other categories often have at their root a culture that is disdainful of the rights of healthcare consumers and is lacking in transparency. Transparency, in turn, allows consumers to hold their healthcare providers accountable, and it is the only real mechanism for empowering consumers.

#### **4.1.1 Patients' rights law**

At the national level, Canadian healthcare is largely governed by the Canada Health Act (1984). As healthcare is constitutionally a provincial responsibility, the CHA lays out the terms under which it will transfer money to the provinces for health spending. The Act determines treatments that are provided at public expense, imposes restrictions on additional fees and mandates portability and accessibility. Accessibility, though, is expressed solely in terms of the right of all patients to uniform treatment without regard to age, lifestyle or other circumstances. The right to timely, appropriate or effective treatment is not mandated.

Individual provinces are considering various bills of rights for patients, but to date there is no province with a clearly enshrined right to timely and effective treatment that provides practical remedies, without which patient guarantees are meaningless. In this regard, Canada falls well behind the great majority of European countries in the index. Canada scores the lowest mark. Red. ○

#### **4.1.2 Patient organizations involved in decision-making?**

There is no statutory requirement to involve patient advocacy (or other stakeholder) groups in the policy-making process. Nonetheless, in practice, broad, national groups (such as the Canadian Cancer Society and the Canadian Diabetes Association) as well as more disease-specific patient groups are invited

to share information with policy-making bodies, and they commonly endorse or criticize decisions made by regional, provincial and federal bodies regarding healthcare and their areas of interest.

While a full score is awarded to countries in which patient and consumer groups are formally included in the formation of health policy, Canada gets partial marks – Amber – for doing this in common practice. 🟡

#### **4.1.3 No-fault malpractice insurance**

Canada does not have no-fault medical malpractice insurance. Patients seeking compensation after an adverse event are required to look for legal redress through various avenues, which are generally adversarial in tone. There is a growing awareness that this system does not cultivate efficiency or patient safety and recommendations were made at the federal level to change this, with no success to date. Until no-fault insurance becomes the norm, Canada gets the lowest score – Red – for this indicator. 🔴

#### **4.1.4 Right to a second opinion**

Canada provides no guaranteed right to a second opinion. While many patient advocacy groups speak of a “right to a second opinion,” this right is not based in law in any province. Many provinces and regional health authorities encourage consumers to request a second opinion if they are not confident in the diagnosis or recommendations of their physician, but they provide no recourse for patients if such a request is denied.

Further, since a second opinion, like a first, from a specialist requires a referral and often a lengthy wait, even those regions that seek to provide second opinions have great difficulty in translating this into reality. The literature indicates that the accessibility of second opinions remains much worse than that of specialist referrals in general. Canada accordingly gets the lowest mark for this indicator. 🔴

#### **4.1.5 Access to own medical record**

Canadian law considers medical records the property of the practitioner, with the patient retaining the right to access the contents. In practice, this means that unless a physician can demonstrate that allowing the patient or his proxy access to a record will harm the patient or a third party, the contents of the record must be made available to patients. Practitioners can require that records be examined only in their presence, or charge a fee for the transfer of information, making the exercise of this right occasionally problematic.

Because Canadians have the nominal right to access their records but the exercise of this right is subject to various conditions, Canada scores Amber on this indicator. 🟡

#### **4.1.6 Readily accessible register of legitimate doctors**

All provincial medical associations provide a directory of physicians within their province. Medical associations will also provide minimal information about complaints that were investigated and borne out, although often that such a

complaint was filed and substantiated is the extent of the information available to the public (and not, for instance, the nature of the complaint and the disciplinary action taken). Because many provinces' registries depend upon self-reporting from physicians and accurate information about specialties is harder to obtain, Canada scores Amber. 🟡

#### **4.1.7 EPR (Electronic Patient Records) in primary care**

Electronic Patient Records, or simply Electronic Records, are not common in Canada. Information about how widely they are used in primary care and in which provinces, regions or practices they are most widespread is lacking. Nevertheless, Infoway Canada, a group representing the Deputy Ministers of Health for all provinces and territories as well as the federal government, has set as its goal that 50 per cent of Canadians should have EPRs by 2010. Since the cut-off for the EHCI/Euro-Canada Index for the lowest criteria is less than 50% penetration of EPRs, Canada clearly is in the bottom category for this indicator and scores Red. 🔴

#### **4.1.8 Provider catalogue with quality ranking**

Canada does not have meaningful choice in healthcare providers, so there is no demand for a provider catalogue. Choice of provider is limited to choices between family practitioners who are accepting new patients. Most referrals are made to facilities or specialists chosen by the physician. Score: Red. 🔴

#### **4.1.9 Web or 24/7 phone access to basic medical information**

All provinces provide a minimum level of information through a phone line (and less commonly, web access) to a portion of their residents. There is a great range in the quality and accessibility of the information offered, with some provinces providing 24-hour access to an RN who can provide basic advice, while others simply refer callers to call centres staffed by workers with significantly less medical training than RNs have. Canada receives an Amber score for this indicator. 🟡

### **4.2 Waiting times**

Waiting times are the weak spot in Canadian healthcare. Canadian health consumers with a complicated condition can be subject to up to four lengthy waits: the first, to see their family doctor, or to find a general practitioner if they do not have a regular doctor; the second, to see the appropriate specialist for their ailment; the third, for diagnostic procedures to determine appropriate treatment; and the fourth, for treatment. It is not unusual for these cumulative delays to exceed a year.

This is reflected in Canada's standing in this sub-discipline of the index: Canada gets only six out of 15 points, sharing the lowest score with Ireland and Sweden for waiting times.

#### **4.2.1 Family doctor same-day service**

An estimate of how many Canadians are confident in their ability to see their family doctor on a same-day basis can be derived from two other common measures. Roughly 86 per cent of Canadians report that they have a family doctor. A separate study showed that three-quarters of Canadians with a family doctor found that their doctor was able to see them on the same or the subsequent day for a minor health problem.

On the positive side, this means that more than half of Canadians believe they can gain rapid access to their GP for minor problems. Conversely, there is no policy to this effect, so this is to the credit of individual doctors and family practices, and even if the majority of Canadians can receive this level of service, a significant proportion still do not. Canada scores Amber for this indicator. 🟡

#### **4.2.2 Direct access to specialists**

Access to almost all specialists in Canada is by referral by a primary care provider. Obstetricians and midwives are significant exceptions. Many regions offer screening clinics to facilitate access to specific specialists such as mental health services, but self-referral is impossible. Canada scores Red for this indicator. 🔴

#### **4.2.3 Heart bypass, angioplasty, knee and hip replacement waits**

Canadawide, 84 per cent of patients received non-urgent angioplasties within 90 days of the decision to treat, and 53 per cent of patients who required a non-urgent bypass underwent surgery within 90 days. These are both average levels of service.

Data for knee and hip replacement waits exclude Quebec and Newfoundland, which do not report waiting times in a useable manner. Other provinces report either median waiting times or the percentage of cases seen within each given interval. All median times are well over 90 days, and in jurisdictions that report by interval, none comes close to treating 50 per cent of patients within 90 days. Based on orthopaedic surgery, then, Canada scores Red.

Combining the metrics for cardiac surgery and orthopaedic surgery yields a failing grade of Red, since orthopaedic surgery wait times are very poor, while cardiac wait times scarcely meet the criteria for Amber. The greater frequency of orthopaedic surgery also supports this evaluation. 🔴

#### **4.2.4 Cancer treatment**

Because cancer treatment can be broken down into three varieties (surgery, radiation and chemotherapy) and no province provides wait-time data for all three categories, an exact percentage of patients who wait more than three weeks for treatment is impossible to derive. What is clear is that despite the federal government's establishment of a four-week benchmark (strive to treat, not a guarantee of any sort) for all forms of cancer, the majority of hospitals have failed to achieve this, much less the three-week benchmark used by the Index and usually or only a handful of cancer sites.

Based on the available information, which includes the numbers published by provinces for the treatments they do track, complementary information from the Canadian Cancer Society and statements from the Canadian Association of Radiation Oncologists, it is clear that Canada earns a failing grade on this indicator. ○

#### **4.2.5 MRI scans**

The spread of values found in waiting times for non-urgent MRIs is significant, with 10 per cent of patients waiting more than three months and 25 per cent being seen within one week. The median score nationwide, however, is more than three weeks. ○

### **4.3 Outcomes**

Outcomes are the bottom line for healthcare. The “widgets” produced by the healthcare system are good medical outcomes, defined appropriately for each diagnosis. The good news for Canada is that in this sub-discipline, the Canadian healthcare system makes its best showing with 12 out of a maximum 15 points.

#### **4.3.1 AMI mortality**

EHCI figures use the 28-day mortality rate for AMIs, while Canada uses 30 days as the benchmark. For the most recent years available (2004-2005), the in-hospital 30-day mortality rate was 11.1%, an excellent score, which gives Canada a Green for this indicator. ●

#### **4.3.2 Infant mortality**

Canada’s current infant mortality rate (2003 in federal reporting) was 5.3 deaths per 1,000 live births. The reporting of extremely premature babies as viable and the increasing incidences of multiple births have led some analysts to suggest that a more meaningful measure would be the death rate per thousand live births of 500 grams or more, but by this measure, Canada’s rate would be 4.5 per 1,000 or still an Amber score. ⚠

#### **4.3.3 Cancer 5-year survival rates**

The most recent data on five-year survival rates are for cases dating from 1997. The data exclude Quebec, due to irregular data-reporting methods. By weighting survival rates according to the number of cases of each type of cancer under consideration, a composite rate of 53% is the result, or an Amber score. ⚠

#### **4.3.4 Potential Years of Life Lost (PYLL) per 100,000 people**

PYLL measures one aspect of the cost to society of illness and accidents: the years of life forfeited by those who die prematurely. The healthier a society and the better performing its healthcare system, the lower this number will be.

The OECD Health Data 2007 lists PYLL as 5,501, which gives Canada a score of Green. ●

#### **4.3.5 MRSA infections**

MRSA, or Methicillin-resistant *Staphylococcus aureus*, is a superbug whose prevalence is linked to the overuse of antibiotics and poor hygiene practices. Hospitals with well-administered protocols for dealing with infectious patients, hygiene among patients and staff, and invasive procedures have lower rates of MRSA infection.

The most recent data available on MRSA rates in Canada is from 2001 and gives a prevalence of 6 per cent. Countries with more recent data have shown a steady increase in recent years, so Canada's actual incidence of MRSA is likely higher. Based on the latest available data, Canada gets a score of Amber for this indicator. 🟡

#### **4.4 Generosity**

The Generosity of the public health offering can be measured according to the breadth of services provided and the rate at which insured services are offered. For sight restoration surgery, Canada (with Belgium) is at the top of the list. For other measures of Generosity, though, especially infant vaccination and dental care, Canada's system fails to measure up with a score of seven out of 12 maximum points.

##### **4.4.1 Cataract operation rates per 100,000 citizens**

Canada's rate of cataract operations is 992 per 100,000 people. This is partly a result of the selection of this surgery as a priority during recent efforts to shorten waiting lists. As with all measurements, there is a difference between provinces. All provinces except P.E.I. and Newfoundland exceeded the level for the highest rating (700 operations per 100,000 people). Canada therefore scores Green for this indicator. 🟢

##### **4.4.2 Infant 4-disease vaccination percentage**

Canadian health policy recommends four doses of the vaccinations against diphtheria, pertussis, tetanus and polio by the age of two. As of 2004, the percentage of infants who were immunized on schedule against each disease was 78, 74, 73 and 89 respectively, with an arithmetic mean of 78.5, well below the cut-off for the lowest score in the index, according to the Public Health Agency of Canada's Canada Communicable Disease Report, 2006.

Statistics Canada, by contrast, reports an 86% rate of the polio vaccine and 85% of the combined DPT for infants. This is a significant discrepancy, but even if the higher value were accepted without question, Canada does not approach Amber, the cut-off for which is 92%. 🟠

##### **4.4.3 Kidney donations per million people**

The level of kidney donations reflects a complex range of factors internal to the healthcare system. A high level of donation requires everything from appropriate training for anaesthesiologists to work in ICUs, dedicated donation teams that involve doctors, nurses and counsellors and a high number of ICU beds per million people, since if pressure on ICU beds is high, brain-dead patients are not

allowed to remain in the ICU for the extra 24-36 hours necessary. This means that the level of kidney donations is an excellent indicator on how healthcare services perform, not an indicator on the volume of traffic victims.

Canada's rate of renal transplants per million people, with living and deceased donors combined, is 35.1, which is a score of Amber. 🟡

#### **4.4.4 Is dental care part of the offering from public healthcare systems?**

Dental care is not included in Canadian medicare. The CHA requires coverage of dental procedures that require hospitalization, which is well under 1 per cent of all dentistry. Most provinces and municipalities provide dental care in limited form to children living in poverty and to recipients of income assistance. Public spending on dental care is well below 5 per cent of total spending. Canada scores Red for this indicator. 🔴

### **4.5 Pharmaceuticals**

Effective use of pharmaceuticals has the potential to significantly reduce the need for more drastic interventions and to improve the quality of life for consumers. The availability of pharmaceuticals is a crucial measure of how well a healthcare system serves its consumers. Whether most people can afford drugs is one aspect of this. Others are the speed with which new drugs are made available to consumers and the degree to which information about new drugs is accessible to the public. In this category, Canada wins five out of 12 points, placing above only Bulgaria, Latvia and Lithuania.

#### **4.5.1 Prescription subsidy percentage**

Pharmaceutical subsidies vary significantly from province to province. Some provinces, such as B.C. and Manitoba, pay 100 per cent of pharmacy costs once a household has spent more than 4 per cent of income on prescription costs. Alberta and Quebec require all residents to purchase supplementary insurance, which covers all prescription costs after a certain deductible (and the cost of the insurance). It is debatable whether such coverage ought to be counted as public, though, since the private purchase of supplementary coverage is available to all Canadians. Other provinces do not extend prescription coverage to residents who are not enrolled in some form of social assistance or are considered dependents or disabled, a small fraction of the population. In total, 38 per cent of prescription funding comes from public sources, which gives Canada a score of Red for this indicator. 🔴

#### **4.5.2 Layman-adapted pharmacopoeia**

No province provides a consumer-oriented (i.e., friendly to the non-health professional) reference book that is readily available and easily searchable. Most provinces provide public access to the books intended for healthcare staff, but often they are not available online (or without charge), and they do not lend themselves to searching for specific drugs by the consumer. Thus, Canada scores Red for this indicator. 🔴

### **4.5.3 Speed of deployment of novel cancer drugs**

According to the Karolinska Report (2007), Canada's use of new cancer drugs varies not only according to the drug in question but also according to province. Taken together, the look at the major new cancer drugs and the delay between their approval and first use in Canada is close to the EU average, with some delays shorter and some longer. Canada thus scores Amber for this indicator. 🟡

### **4.5.4 Access to new drugs**

The average number of days between the approval of a drug for use in a province and its inclusion in the formulary is provided by an OECD study. Weighting each period according to the share of population of each province yields an adjusted average wait of 384 days between approval and inclusion. While two provinces (P.E.I. and Nfld) took slightly fewer than 300 days, no province comes close to the cut-off for a full score, which is fewer than 150 days. For speed of access to new drugs, Canada scores Red. 🔴