EURO-CANADA
HEALTH CONSUMER INDEX

PRESENTED BY

Health Consumer Powerhouse

FRONTIER CENTRE FOR PUBLIC POLICY

Health Consumer Powerhouse
Frontier Centre for Public Policy

Euro-Canada Health Consumer Index 2008

Health Consumer Powerhouse

Frontier Centre for Public Policy

FC Policy Series No. 38

Number of pages: 46

You are welcome to quote this report
referring to the source.
© Health Consumer Powerhouse AB,
&
Frontier Centre for Public Policy

ISSN 1491-78

Contents

Canada Joins the Euro Health Consumer Index and Empowers the Healthcare Consumer!

The Health Consumer Powerhouse (HCP), Stockholm/Brussels, and the Frontier Centre for Public Policy (FCPP), Winnipeg, are pleased to introduce the inaugural Euro-Canada Health Consumer Index. This marks the induction of Canada into a comprehensive benchmarking exercise that analyzes the consumer responsiveness among 29 national European healthcare systems.

Why Canada, you ask? A most natural step, we answer. In Canada, as in large parts of Europe, healthcare is under debate. The Canadian healthcare system – publicly financed and governed – has much more in common with most European systems than it does with the American one, the traditional comparison. All the countries included in the Index share Canada's commitment to accessible and effective healthcare, and by comparing the performance of Canada's healthcare institutions with the extremely varied systems of the 29 European states, we can gain much insight into how Canada is succeeding and how it might improve in the future.

This comparison shows that Canada places in the bottom quarter of the Index but spends more money to achieve worse results than any other country in the lowest quartile. These findings send a different and provocative message about Canadian healthcare that should call for debate and action.

The lesson from the HCP's four years of healthcare benchmarking is that comparisons count. Weak – or excellent – performances among the national healthcare systems are highlighted. Transparency is essential to competition. Governments, patients and consumers have a better foundation for taking action. Well-performed rankings become accepted as measurements that set the standard for further reform and improvement.

The Canadian healthcare system has its roots in the British National Health Service (NHS), which, since the Index's start, has been a notoriously mediocre performer. To the Canadian federal and provincial governments looking for a reform agenda, our advice is that starting fresh is a good idea, because it provides healthcare consumers with a pivotal position regarding funding, choice and influence. To support further debate, later this year we will publish province-to-province Canadian rankings that will provide a more detailed picture of Canadian healthcare.

Brussels, Ottawa, Winnipeg

January 21, 2008

Johan Hjertqvist
President
Health Consumer Powerhouse
Brussels/Stockholm

Peter Holle
President
Frontier Centre for Public Policy
Winnipeg

1. Executive Summary

Canada has been brought into the annual pan-European Index, which has been published by the HCP since 2005. It was done on terms that treated Canada like any European state. The starting point was the Euro Health Consumer Index (EHCI), with 29 nations, which was published on October 1, 2007. Austria emerged as the overall winner. By then, research regarding Canadian data was partially conducted for the expansion of the EHCI into the trans-Atlantic Euro-Canada Health Consumer Index (ECHCI). In the following, Canada is consequently looked upon as one out of 30 national healthcare systems.

In this first edition of the Euro-Canada Health Consumer Index, Canada places 23rd out of 30. With respect to clinical Outcomes, Canada compares well with the best performing healthcare systems. In terms of Generosity, with the exception of the provision of sight restoration surgery, Canada performs poorly, and in the areas of Patients' rights and information, Waiting times and accessibility, and the Provision of pharmaceuticals, Canada's performance is in the bottom tier. These factors, combined with a very high level of spending on healthcare, contribute to putting Canada at the bottom of the Bang-for-the-Buck (BFB) scale.

The scoring was done in such a way that the likelihood that two states would end up sharing a position in the ranking was almost zero. It must therefore be noted that Austria, the Netherlands, France, Switzerland and Germany were very difficult to separate and that very subtle changes in single scores modified the internal order of these top five countries.

The Central and Eastern European member states are doing surprisingly well considering their much smaller healthcare spending in Purchasing Power adjusted dollars per capita. However, adjusting from a planned to a consumer-driven economy takes time. Estonia, the smallest ship to turn around, seems to lead this sub-group and is a clear winner in the academic exercise of the value-for-money adjusted Index – the Bang-for-the Buck score.

All public healthcare systems share one problem: Which technical solution should be used to funnel typically 7 per cent to 10 per cent of the national income into healthcare services? In this context, there are two major approaches.

The Bismarck healthcare system: A system based on social insurance where there are multitudes of insurance organizations that are *independent of* healthcare providers.

The Beveridge healthcare system: A system in which financing and provision are handled within one organizational system, *i.e.,* financing bodies and providers are wholly or partially within one organization.

For more than half a century, particularly since the formation of the NHS, the largest Beveridge-type system in Europe, there has been intense debate over the relative merits of the two systems.

When looking at the results of the Index, it is hard to avoid noticing that the top five countries, which fall within 36 points of each other on a 1,000-point scale, have dedicated Bismarckian healthcare systems. There is a gap of 30 points to the first Beveridge country, which is in sixth place. The introduction of Canada in the first Euro-Canada Index marks the inclusion of another major Beveridge system.

The Canadian system scores respectably on Outcomes, but rather poorly in other measures, something it has in common with other similar systems. As pressure increases for healthcare reform, policy-makers would do well to consider ways in which to make the advantages of a Bismarck system, especially the separation between providers and insurers, and the variety of insurers, available to consumers. These are key qualities among the most successful European healthcare systems.

Thus, while not arguing that the Bismarck-type healthcare system is in every way superior, it seems that for total customer value, the Bismarck model runs rings around Beveridge!

2. Introduction

The HCP is a centre for visionary thinking and actions that promote consumer-related healthcare in Europe. Tomorrow's health consumer will not accept any traditional borders. In order to become a powerful actor, and to build the necessary reform pressure from below, the consumer will need access to knowledge in order to compare health policies, consumer services and quality outcomes. HCP wants to add to this development.

In this first issue of a Euro-Canada Index, Canada's Frontier Centre for Public Policy is committed to evaluating health policy across Canada. The FCPP is an independent, non-partisan think-tank based in Winnipeg, with activities in many areas of public policy, including healthcare. All the countries included in the EHCI share Canada's commitment to accessible and effective healthcare, and by comparing the performances of Canada's healthcare institutions with the extremely varied systems of the 29 European states, we can gain much insight into how Canada is succeeding and how it can improve.

2.1 Background

Since 2004, HCP has published the Swedish Health Consumer Index (www.vardkonsumentindex.se, also in an English translation). By ranking the 21 county councils by 12 indicators concerning the design of systems policy, consumer choice, service level and access to information, we introduced benchmarking as an element in consumer empowerment.

For the first pan-European index (Euro Health Consumer Index, EHCI) in 2005, HCP aimed to follow the same approach, *i.e.,* selecting a number of indicators that describe to what extent the national healthcare systems are user-friendly, thus providing a basis for comparing different national systems.

Though it is still a somewhat controversial standpoint, HCP advocates that quality comparisons within the field of healthcare are a win-win situation. For the consumer, better information will create a better platform for informed choice and action. For governments, authorities and providers, the sharpened focus on consumer satisfaction and quality outcomes will support change. This applies not only to evidence of shortcomings and method flaws, but it also illustrates the potential for improvement. With such a view, the brand new ECHCI was designed to become an important benchmark that supports interactive assessment and improvement.

The first EHCI included 12 European countries. In 2006, the EHCI expanded, and on October 1, 2007, the HCP launched the third consecutive EHCI, which evaluated all 27 EU members, Switzerland and Norway. The 2008 Euro-Canada Health Consumer Index (ECHCI) adds Canada to this mix.

2.2 Project Manager

Ms Rebecca Walberg, the Director for Health Policy at the Frontier Centre for Public Policy, is the lead researcher for the Canadian component of the Euro-Canada Index.

Arne Björnberg, PhD is the project manager for the EHCI 2007 and the inaugural ECHCI.

Dr. Björnberg is an experienced research director in Sweden. His experience includes serving as CEO of the Swedish National Pharmacy Corporation (Apoteket AB), Director of Healthcare & Network Solutions for IBM Europe, Middle East & Africa, and CEO of the University Hospital of Northern Sweden (Norrlands Universitetssjukhus, Umeå).

Dr. Björnberg was also the project manager for the EHCI 2005 and 2006.

Ms Raluca Nagy, HCP, was the researcher for the EHCI 2007.

3. Index Scope

The aim was to select a limited number of indicators within a definite number of evaluation areas, which in combination can present an interesting tale of how the healthcare consumer is served by the respective systems.

3.1 Indicator areas (sub-disciplines)

The 2007 index was, just as in 2006, built up as a "pentathlon," with indicators grouped into five sub-disciplines. After surrendering to the "lack of statistics syndrome" and after scrutiny by our expert panels, 27 indicators made it into the EHCI 2007.

The indicator areas for the Index thus became:

Sub-discipline	Number of indicators
Patient rights and information	9
Waiting times for treatment	5
Outcomes	5
Generosity	4
Pharmaceuticals	4

3.2 Scoring

The performances of the national healthcare systems were graded on a three-grade scale for each indicator: Green = good (●), Amber = so-so (◐) and Red = not so good (○). A Green score earns 3 points, an Amber score earns 2 points and a Red score (or a not available) earns 1 point.

In the EHCI 2005, the green **3's**, amber **2's** and red **1's** were added up to make the country scores.

For the EHCI 2006 index, a different methodology was used. For each of the five sub-disciplines, the country score was calculated as a percentage of the maximum possible (*e.g.,* for Waiting times, the score for a state was calculated as a percentage of the maximum 3 x 5 = 15).

Thereafter, the sub-discipline scores were multiplied by the weight coefficients given in the following section and added up to make the final country score. These percentages were then multiplied by 100, and rounded to a three-digit integer.

3.2.1 Weight coefficients

The possibility of introducing weight coefficients was discussed for the EHCI 2005, *i.e.,* selecting certain indicator areas as being more important than others and multiplying their scores by numbers other than 1. In the EHCI 2005, the five sub-disciplines were given implicit weights, which were created by the sheer number of indicators under each sub-discipline. For example, in the 2005 index, this meant that Patient rights and information was given a weight of 1.75, compared with 1.0 for medical Outcomes and 1.25 for Accessibility/Waiting times.

As with the EHCI 2006, explicit weight coefficients for the five sub-disciplines were used. The accessibility and Outcomes sub-disciplines were decided upon as the main candidates for higher weight coefficients based mainly on discussions with expert panels and the experience detailed in a number of patient survey studies. Here, as for the whole of the index, we welcome input on how to improve the index methodology.

Following the EHCI 2006, the scores for the five sub-disciplines in the Euro-Canada index were given the following weights:

Sub-discipline	Relative weight
Patient rights and information	1.5
Waiting times for treatment	2.0
Outcomes	2.0
Generosity	1.0
Pharmaceuticals	1.0
Total sum of weights	**7.5**

Consequently, as the percentages of full scores were added and multiplied by 100, the maximum theoretical score attainable for a national healthcare system in the 2006 index was 750, and the lowest possible score was 250.

These weight coefficients have remained unchanged for the ECHCI. To improve the ease of understanding the index, in 2007, we decided that the perfect healthcare system would get a score of 1,000. Consequently, in the 2007 index, the sum of percentages was therefore multiplied by 133 (.33). *That change did not affect the ranking order of the participating countries.*

It should be noted that since not many countries excel in one sub-discipline and do very poorly in others, the final ranking of countries presented becomes remarkably stable if the weight coefficients are varied within reasonable limits.

The project experimented with other scores for Green, Amber and Red, such as 2, 1 and 0 (which would really punish low performers) and 4, 2 and 1 (which would reward real excellence). The final ranking was remarkably stable during these experiments.

3.2.2 Regional differences

The Health Consumer Powerhouse is well aware that many European states and Canada have decentralized healthcare systems. This is the case as well in the U.K. It is often argued that Scotland and Wales have separate health services and should be ranked separately, while Canada has ten provincial systems that overlap in many ways, but they are not identical. From a comparison standpoint, systems devolution might raise new challenges, but publicly funded and governed systems have many more features in common than those that are isolated or hard to compare.

Grading healthcare systems does present a certain risk of encountering the syndrome of "If you stand with one foot in an ice bucket and the other on the hot plate, on average you are pretty comfortable." This problem would be quite pronounced if there were a desire to include the United States as one country in a health consumer index. As equity in healthcare has traditionally been high on the agenda in both Canada and Europe, it was judged that regional differences are small enough to make statements about the national levels of healthcare services relevant and meaningful.

Many Canadian indicators are readily available at the national level. For those indicators present only at the provincial level, a national value was obtained by weighting each province's performance according to its share of the total population. It should be noted that even with the large spread in values from province to province for some indicators, the overall score was easy to evaluate. For example, cataract surgery, where even the provinces that carried out relatively few scored high overall, or pharmaceutical coverage, where even the more generous provincial plans required a level of individual spending that qualified for the lowest score in the index.

The forthcoming Canadian province-to-province index will taker a closer look at these differences and their impact on healthcare performance. It became clear while evaluating Canada for this Index that there is much room for the provinces to learn from each other's best practices. Extending the Index framework to each province will highlight these potential areas for easy improvements, as well

as indicate where the provincial systems consistently fail to meet the needs of healthcare consumers.

3.3 Indicator definitions and data sources for the ECHCI 2008

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
Patient rights and information	Patients' Rights Law	Is national healthcare legislation explicitly expressed in terms of patients' rights?	Yes	Various kinds of patient charters or similar bylaws	No	Patients' Rights Law (Annex 1) http://www.healthline.com/galecontent/patient-rights-1 http://www.adviceguide.org.uk/index/family_parent/health/nhs_patients_rights.htm www.dohc.ie http://www.sst.dk/Tilsyn/Individuelt_tilsyn/Tilsyn_med_faglighed/Skaerpet_tilsyn_med_videre/Skaerpet_tilsyn/Liste.aspx http://db2.doyma.es/pdf/261/261v1n2a13048764pdf001.pdf
	Patient organizations involved in decision-making?		Yes, statutory	Yes, by common practice in advisory capacity	No, not compulsory or generally done in practice.	Patients' Perspectives of Healthcare Systems in Europe, a survey commissioned by HCP 2006. Personal interviews. Survey of major patient advocacy groups within Canada.
	No-fault malpractice insurance	Can patients get compensation without the assistance of the judicial system to prove that medical staff made mistakes?	Yes	Fair. Less than 25% invalidity covered by the state.	No	Swedish National Patient Insurance Co. (All Nordic countries have no-fault insurance) www.hse.ie www.higa.ie Health Care Renewal In Canada: Clearing the Road to Quality, Health Council of Canada, 2006.
	Right to second opinion		Yes	Yes, but difficult to access due to bad information, bureaucracy or doctor negativism.	No	Patients' Perspectives of Healthcare Systems in Europe, a survey commissioned by HCP 2006. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, PatientView 2005. Personal interviews. Review of legislation and health ministry mandates on a province by province basis.
	Access to own medical record	Can patients read their medical records?	Yes	Yes, but restricted or with an intermediary	No	Patients' Perspectives of Healthcare Systems in Europe, a survey commissioned by HCP 2006. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, PatientView 2005. Personal interviews. www.dohc.ie McInerney v. MacDonald, 1992 (Canadian Supreme Court). Infoway Canada www.infoway-inforoute.ca

	Readily accessible register of legitimate doctors	Can the public readily access the info: "Is doctor X a *bona fide* specialist?"	Yes	Yes, but awkward, costly or not frequently updated.	No	Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. National physician registries http://www.sst.dk/Tilsyn/Individuelt_tilsyn/Tilsyn_med_faglighed/Skaerpet_tilsyn_med_videre/Skaerpet_tilsyn/Liste.aspx http://www.pkn.dk/offentliggjorteafgoerelser/afgoerelser/afgoerelsermednavn.html; www.medicalcouncil.ie; provincial Colleges of Physicians and Surgeons in Canada
	Electronic Patient Record (EPR) penetration in primary care	What percentage of GPs uses EPRs?	Greater than 80%	50% - 80%	Less than 50%	http://ec.europa.eu/public_opinion/flash/fl126_fr.pdf http://www.europartnersearch.net/ist/communities/indexmapconso.php?Se=11 www.icgp.ie Commonwealth Fund International Health Policy Survey of Primary Care Physicians. Infoway Canada Annual Report, 2006-7.
	Provider catalogue with quality ranking	Dr. Foster in the U.K. remains the standard European qualification for a Yes (Green score). The "750 best clinics" published by LaPointe in France warrants a Yellow.	Yes	Not really but attempts are underway	No	http://www.drfoster.co.uk/home.aspx http://www.sundhedskvalitet.dk/ http://www.sykehusvalg.no/sidemaler/VisStatiskInformasjon____2109.aspx http://www.higa.ie/ http://212.80.128.9/gestion/ges161000com.html
	Web or 24/7 telephone healthcare info	Information that can help a patient make decisions of the sort, "After consulting the service, I will take a paracetamol and wait and see." or "I will hurry to the emergency department of the nearest hospital."	Yes	Yes but not generally available	No	Patients' Perspectives of Healthcare Systems in Europe, a survey commissioned by HCP 2006. Personal interviews http://www.nhsdirect.nhs.uk/ www.hse.ie www.ntpf.ie Survey of information provided by provincial health ministries.
Waiting times	Family doctor same-day service	Can I count on seeing my primary care doctor today?	Yes	Yes but not quite fulfilled	No	Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, PatientView 2005. Personal interviews http://www.nhs.uk/England/Doctors/Default.aspx http://www.msc.es/estadEstudios/estadisticas/docs/BS_2006_total_mar.pdf Statistics Canada, Canadian Community Health Survey, 2005 (CANSIM table 105-3024), and Statistics Canada document 82-575-X.
	Direct access to specialist care	Without referral from family doctor (GP)	Yes	Theoretically not, but quite often in reality	No	Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. Personal interviews with healthcare officials http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf http://www.ic.nhs.uk/; http://www.oecd.org/dataoecd/5/27/26781192.pdf

	Major non-acute operations	A "basket" of coronary bypass/PTCA and hip/knee joint (values must be verified for all types of operations)	90% fewer than 90 days	50% - 90% Fewer than 90 days	More than 50% take more than 90 days	OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. www.frittsykehusvalg.no www.sst.dk http://sas.skl.se Personal interviews with healthcare officials www.ntpf.ie CIHI Provincial Wait Times Report 2006.
	Cancer radiation/chemo-therapy	Time to get radiation/chemotherapy after treatment decision	90% fewer than 21 days	50% - 90% fewer than 21 days	More than 50% take more than 21 days	OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. www.frittsykehusvalg.no www.sst.dk; http://sas.skl.se http://www.sst.dk/Nyheder/Seneste_nyheder/Ventetider_straalebehl_uge23_24.aspx?lang=da Personal interviews with healthcare officials. Access to Health Care Services Report 2005, Health Canada.
	MRI (magnetic resonance imaging) scan examination		Typically fewer than 7 days	Typically fewer than 21 days	Typically more than 21 days	Patients' Perspectives of Healthcare Waiting times in Europe, a survey commissioned by HCP 2007. www.frittsykehusvalg.no www.sst.dk http://www.sst.dk/Nyheder/Seneste_nyheder/Ventetider_straalebehl_uge23_24.aspx?lang=da http://sas.skl.se Personal interviews with healthcare officials. Health Services Access Survey 2005, Statistics Canada.
Outcomes	Heart infarct mortality less than 28 days after getting to hospital		Less than 18%	Less than 25%	Greater than 25%	MONICA data. Personal interviews with healthcare officials. European Society of Cardiology has data, but will not reveal country IDs. For some states, extreme mortality values. http://www.folketinget.dk/samling/20051/almdel/SUU/spm/503/svar/endeligt/20060822/300535.PDF http://www.gardianul.ro/2007/07/04/societate-c12/doar_2_dintre_rom_nii_care_fac_infarct_sunt_tratati_corect-s97335.html "Healthy Canadians" Comparable Indicators Report 2006, Statistics Canada.
	Infant deaths per 1,000 live births		Fewer than 4	Fewer than 6	More than 6	WHO Europe Health for All mortality database. Latest available statistics http://www.who.int/whosis/whostat2007_1mortality.pdf www.cso.ie OECD Health Data 2007
	Cancer 5-year survival rates	All cancers except skin	Greater than or equal to 60%	50% – 60%	Less than or equal to 50%	Eurocare 4, "A pan-European comparison regarding patient access to cancer drugs" Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm. http://www.breastcancer.org/press_cancer_facts.html http://info.cancerresearchuk.org/ www.ncri.ie http://www.sst.dk/publ/publ2005/plan/kraeftplan2/Kraeftepidemiologi_rapport.pdf "Healthy Canadians" Comparable Indicators Report 2006, Statistics Canada.
	Avoidable deaths – Potential years of life lost PYLL/100,000		Less than 3,500	3,500 – 4,500	Greater than 4,500	OECD. Latest available statistics. For non-OECD, WHO SDR/100000 (all causes) http://www.institute.nhs.uk/safer_care/safer_care/reducing_avoidable_deaths_in_hospital.html Statistics Canada.

	MRSA (Methicillin-resistant Staphylococcus aureus) infections		Less than 5%	Less than 20%	Greater than 20%	EARSS, latest available data 2005/2006 CMAJ, July 10, 2001. 165(1):21-6.
Generosity of public healthcare systems	Cataract operation rates per 100,000 citizens (age-adjusted)		Greater than 700	400 - 700	Fewer than 400	OECD Health Data 2006 www.actapress.com/PDFViewer.aspx?paperId=19351 (Germany)
	Infant 4-disease vaccination %	Diphtheria, tetanus, pertussis and poliomyelitis, arithmetic mean	Greater than or equal to 97%	92% - 97%	Less than 92%	EU Health Portal, 2004 data (some countries 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4078380 www.hpsc.ie Public Health Agency of Canada, CCDR 2006, Statistics Canada, Statistical Report on the Health of Canadians, 1999.
	Kidney transplants per million people	Living and deceased donors	Greater than or equal to 40	30 – 40	Fewer than 30	Council of Europe Newsletter 11/2006. Canadian Organ Replacement Register, CIHI 2007.
	Is dental care part of the offering from public healthcare systems?	Public spending on dental care as a percentage of total public healthcare spending	Greater than 9% of healthcare spending	5% - 9% of total healthcare spending	Less than 5% of total healthcare spending	EU Manual on Dental Health, EU Dental Liaison Committee http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Dental/index.htm www.hse.ie www.dohc.ie OECD Health Data 2005
Pharmaceuticals	Prescription subsidy percentage		Greater than 90%	60% - 90%	Less than 60%	WHO Health for All database 2005 http://www.laegemiddelstyrelsen.dk/statistik/overvaagning/udgifter/2007-1/2007-1.asp OECD Health Data 2005
	Layman-adapted pharmacopoeia	Can the public easily access a pharmacopoeia for persons who are not experts in healthcare? (World Wide Web or widely available)	Yes	Yes, but not easily accessible or frequently consulted.	No	Patients' Perspectives of Healthcare Systems in Europe, a survey commissioned by HCP 2006. Personal interviews. LIF Sweden. http://www.doctissimo.fr/html/sante/sante.htm http://www.legemiddelverket.no/custom/templates/gzInterIFrame____1548.aspx. http://medicamente.romedic.ro/ www.vademecum.es Survey of provincial health ministries in Canada.
	Speed of deployment of novel cancer drugs	How quickly are new cancer drugs made available through public healthcare?	Quicker than EU average	Close to EU average	Slower than EU average	"A pan-European comparison regarding patient access to cancer drugs" 2007 Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm. "Market uptake of new oncology drugs," Annals of Oncology vol. 18 Supplement 3, June 2007.
	Access to new drugs	Period between registration and inclusion of drugs in subsidy system	Less than 150 days	Less than 300 days	Greater than 300 days	Phase 6 Report Feb. 2007. PATIENTS W.A.I.T. Indicator Commissioned by EFPIA. IMS Global Consulting. "A pan-European comparison regarding patient access to cancer drugs" Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm. Pharmaceutical Pricing and Reimbursement Policies in Canada, Valérie Paris and Elizabeth Docteur, OECD 2006.

3.3.1 Additional data gathering - survey

In addition to public sources, as was also the case for the 2006 index, an e-mail survey for organizations for patients was commissioned from PatientView for all the European countries. (Woodhouse Place, Upper Woodhouse, Knighton, Powys, LD7 1NG, Wales Tel: 0044-(0)1547-520-965 E-mail: info@patient-view.com)

In 2007, the European survey included the five Waiting times and the Register of legitimate doctors indicators. Four hundred and eighteen organizations responded to the survey, and the lowest number of responses from any single country was four.

3.3.2 Additional data gathering – feedback from national ministries/ agencies

Over the years, HCP has established relations with several ministries of health in order to involve them in data gathering and evaluation.

On June 20, 2007, preliminary score sheets were sent to ministries of health or state agencies in all 29 European states, giving them the opportunity to supply more recent data and/or higher quality data than what was available in the public domain. Canadian federal and provincial health agencies will be invited to participate in subsequent editions of the ECHCI.

Country	Responded in 2006	Responded in 2007
Austria		√
Belgium	√	
Bulgaria	not applicable	√
Cyprus	√	
Czech Republic	√	
Denmark		√
Estonia	√	√
Finland	√	√
France		√
Germany		
Greece		
Hungary	√	√
Ireland		√
Italy		
Latvia	√	
Lithuania		√
Luxembourg		√
Malta	√	√
Netherlands	√	
Norway	not applicable	
Poland	√	√
Portugal	√	
Romania	not applicable	√
Slovakia		√
Slovenia	√	
Spain		√
Sweden		
Switzerland		
United Kingdom		√

This procedure was prepared for during the spring by extensive mail, e-mail, telephone contact and visits to ministries and agencies. Feedback was received from official national sources as illustrated in the adjoining table.

Score sheets sent to national agencies contained only the scores for that country. Corrections were accepted only in the form of actual data, not by national agencies just changing a score (frequently from Red to something better, but surprisingly often, honesty prevailed and scores were revised downwards).

The majority of the data concerning Canada was checked against another source. Where this was not possible, experts in the public and private sectors were consulted to verify that values corresponded to their observations of the reality of healthcare in Canada. In future iterations of the Euro-Canada Index, authorities at the federal and provincial levels will be invited to correct their scores, subject to the same scrutiny. The creation of the intra-Canada index, which will compare provincial healthcare systems, will involve contact with

ministries of health in each province as well as with regional representatives of national groups, such as associations of healthcare professionals and patient advocacy groups.

3.4 Threshold value settings

It was not our ambition to establish a global, scientifically based principle for threshold values to score Green, Amber or Red on the different indicators. Threshold levels were set after studying the actual parameter value spreads in order to avoid having indicators showing all Green or completely Red.

The HCP believes that the involvement of patients' organizations in healthcare decision-making is a good idea. This indicator was included in 2006, with no country scoring Green. In this Index, a Green score is attained only by Estonia and Ireland.

Setting threshold values is typically done by studying a bar graph of country data values on an indicator sorted in ascending order. The usually "S"-shaped curve yielded by that is studied for notches in the curve, which can distinguish clusters of states, and such notches are often taken as starting values for scores.

A slight preference is also given to threshold values with even numbers. An example of this is the new **Cancer 5-year survival** indicator, where the cut-offs for Green and Amber were set at 60% and 50% respectively, with the result that only four states scored Green.

3.5 Symmetry of in-data

It is important to note that there is absolutely no symmetry in the data used for the scores in the index.

The project consequently used the latest available statistics. This means that the Index compares cancer survival data from 1997 from one country with 2005 data from other countries. We tested official policy decisions in a patient survey and by interviews with healthcare officials. In cases where real-life practice did not coincide with official policy decisions, scores were modified accordingly.

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. O

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. O

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. O

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. 

5. Where does one find the most consumer-friendly healthcare?

5.1 General overview

The situation is commented upon in the following quote from the 2005 WHO European Health Report:

"Good health is a fundamental resource for social and economic development. Higher levels of human development mean that people live longer and enjoy more healthy years of life.

While the health of the 879 million people in the WHO European Region has in general improved over time, inequalities between the 52 Member States in the Region and between groups within countries have widened. In addition to the east–west gap in health, differences in health between socioeconomic groups have increased in many countries.

Reducing inequality is increasingly vital. As most countries have declining birth rates and growing elderly populations, it is particularly important to help children to avoid ill health and to become resilient enough to remain in good health long into old age."

This and several other reports provide thorough descriptions of the public health situation.

Availability of reports on the performance of healthcare systems, expressed in customer value terms such as quantitative and qualitative output, service and information levels and value for money spent, is not as good. The statistics on healthcare systems tend to focus on quantitative resource inputs such as staff numbers, beds and bed occupancy, and at best, statistics on procedures such as needle time or percentage of patients receiving thrombolysis treatment.

For a country like the United States, where healthcare financing and provision has been looked upon as a service industry, statistics on performance quantity and quality are abundant. Canada is in many ways much closer to several of the European models than it is to American medicine, although outcomes and consumer-related information are somewhat more accessible.

5.2 The Index outcomes

As is illustrated by the Index Matrix, the Index consists of 27 indicators in five sub-areas that describe 30 national healthcare systems. The aim was to select indicators that are relevant for describing a healthcare system that is viewed from the consumer/patient's angle.

The performances of the national healthcare systems were graded on a three-grade scale for each indicator: Green = good (●), Amber = so-so (◐) and Red = not so good (○), equalling 3, 2 and 1 points respectively

EURO-CANADA HEALTH CONSUMER INDEX 2008 1/2

● = 3 points
◑ = 2 points
○ or n.a. = 1 point

Sub-discipline	Indicator	Canada	Austria	Belgium	Bulgaria	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	Germany	Greece	Hungary	Ireland	Italy	Latvia
Patient rights and information	Healthcare law based on Patients' Rights	○	◑	●	◑	●	○	●	◑	●	●	○	●	●	○	◑	○
	Patient org. involved in decision-making?	◑	○	○	○	○	◑	◑	●	◑	◑	◑	○	○	●	○	◑
	No-fault malpractice insurance	○	○	○	○	○	○	●	○	●	◑	○	○	○	○	○	○
	Right to second opinion	○	●	●	◑	◑	◑	●	●	◑	●	●	◑	◑	◑	◑	○
	Access to own medical record	◑	●	●	◑	◑	●	●	◑	●	●	◑	◑	●	◑	◑	◑
	Register of legit doctors	◑	●	○	◑	◑	◑	●	●	●	●	◑	◑	○	●	●	○
	Electronic Patient Record (% of GPs)	○	◑	◑	○	n.a.	○	●	◑	●	○	○	○	○	◑	◑	○
	Provider catalogue with quality ranking	○	○	○	○	◑	●	●	○	○	◑	○	○	○	○	○	○
	Web or 24/7 telephone HC info	◑	○	○	○	○	○	◑	●	◑	○	◑	○	○	○	○	○
Waiting times	Family doctor same day access	◑	●	●	◑	●	●	●	◑	○	●	●	○	●	◑	◑	◑
	Direct access to specialist	○	●	●	○	●	○	○	◑	○	●	●	●	○	○	○	○
	Major non-acute operations <90 days	○	◑	●	◑	◑	○	◑	○	◑	◑	●	◑	○	○	○	○
	Cancer therapy < 21 days	○	●	●	◑	●	●	◑	○	●	●	●	◑	◑	○	◑	◑
	MRI scan < 7days	○	●	●	◑	◑	◑	○	○	○	◑	◑	○	○	○	○	○
Outcomes	Heart infarct mortality	●	●	◑	n.a.	○	○	○	○	◑	◑	◑	○	○	◑	◑	○
	Infant deaths/1,000 live births	◑	◑	◑	○	●	●	◑	◑	●	●	◑	◑	○	◑	◑	○
	Cancer 5-year survival	◑	●	◑	○	n.a.	○	◑	○	◑	●	◑	○	○	◑	◑	○
	Avoidable deaths – years of Life Lost	●	●	◑	○	◑	◑	◑	◑	◑	◑	●	●	○	●	●	○
	MRSA infections	◑	◑	○	○	○	◑	●	●	●	○	◑	○	○	○	○	◑
"Generosity" of public healthcare systems	Cataract operations per 100,000	●	◑	●	○	n.a.	n.a.	◑	◑	●	●	●	◑	●	◑	●	n.a.
	Infant 4-disease vaccination	○	○	◑	◑	●	●	◑	●	●	●	◑	○	●	○	◑	●
	Kidney transplants per million pop.	◑	●	◑	○	n.a.	●	◑	●	●	●	◑	○	◑	◑	◑	◑
	Dental care in public healthcare system	○	●	○	○	○	◑	○	○	◑	◑	●	●	●	◑	○	○
Pharmaceuticals	Rx subsidy %	○	◑	◑	○	○	◑	◑	○	○	●	●	◑	◑	●	●	○
	Layman-adapted pharmacopeia?	○	○	○	○	○	○	●	●	◑	◑	○	○	○	◑	○	○
	New cancer drugs deployment speed	◑	●	◑	○	◑	○	◑	◑	◑	◑	◑	◑	○	◑	◑	○
	Access to new drugs (time to subsidy)	○	●	○	○	●	○	●	●	◑	○	●	◑	○	●	○	○
	TOTAL SCORE	550	806	701	445	629	612	712	633	719	786	767	561	513	592	580	435
	RANK	23	1	10	29	13	15	9	12	8	3	5	22	25	16	18	30

Canada Austria Belgium Bulgaria Cyprus Czech Republic Denmark Estonia Finland France Germany Greece Hungary Ireland Italy Latvia

EURO-CANADA HEALTH CONSUMER INDEX 2008 2/2

● = 3 points
◑ = 2 points
○ or n.a. = 1 point

Sub-discipline	Indicator	Canada	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom
Patient rights and information	Healthcare law based on Patients' Rights	○	●	○	○	●	●	◑	◑	◑	◑	◑	◑	○	●	◑
	Patient org. involved in decision-making?	◑	○	◑	○	◑	◑	○	◑	○	○	○	◑	◑	○	◑
	No-fault malpractice insurance	○	○	○	○	○	●	○	○	○	○	○	○	●	○	○
	Right to second opinion	○	●	●	●	●	◑	◑	◑	●	◑	●	◑	◑	●	○
	Access to own medical record	◑	●	●	○	●	●	◑	◑	●	●	●	●	●	◑	◑
	Register of legit doctors	◑	◑	○	◑	●	○	○	○	○	○	◑	○	○	○	◑
	Electronic Patient Record (% of GPs)	○	○	◑	n.a.	●	●	○	◑	○	○	n.a.	◑	●	◑	●
	Provider catalogue with quality ranking	○	○	○	○	◑	◑	○	○	○	○	○	○	○	○	●
	Web or 24/7 telephone HC info	◑	○	○	●	◑	○	○	●	○	○	○	○	◑	◑	●
Waiting times	Family doctor same day access	◑	○	●	●	●	●	◑	○	●	●	●	◑	○	●	◑
	Direct access to specialist	○	○	◑	○	○	○	○	○	○	●	○	○	○	●	○
	Major non-acute operations <90 days	○	◑	○	◑	◑	◑	○	○	◑	○	○	○	○	●	○
	Cancer therapy < 21 days	○	◑	●	●	◑	●	◑	◑	◑	◑	◑	◑	◑	●	◑
	MRI scan < 7days	○	◑	◑	○	◑	◑	○	◑	○	◑	○	○	○	◑	○
Outcomes	Heart infarct mortality	●	○	◑	○	●	n.a.	○	○	n.a.	○	●	◑	●	●	●
	Infant deaths/1000 live births	◑	○	●	◑	◑	●	○	●	○	○	◑	●	●	◑	◑
	Cancer 5-year survival	◑	◑	◑	◑	◑	◑	○	◑	○	○	○	◑	●	●	○
	Avoidable deaths – years of Life Lost	●	○	●	◑	●	●	○	◑	○	○	◑	◑	●	●	◑
	MRSA infections	◑	◑	◑	○	●	●	○	○	○	◑	◑	○	●	n.a.	○
"Generosity" of public healthcare systems	Cataract operations per 100,000	●	n.a.	●	◑	●	◑	○	○	○	n.a.	n.a.	●	●	◑	◑
	Infant 4-disease vaccination	○	◑	◑	◑	●	○	●	●	●	●	○	◑	●	◑	○
	Kidney transplants per million pop.	◑	○	○	n.a.	●	●	○	◑	○	○	○	●	●	◑	◑
	Dental care in public healthcare system	○	◑	○	●	○	○	●	○	●	○	●	○	◑	○	○
Pharmaceuticals	Rx subsidy %	○	○	●	◑	●	◑	◑	◑	○	●	●	●	◑	●	●
	Layman-adapted pharmacopeia?	○	○	○	○	●	◑	○	◑	●	○	○	◑	●	○	○
	New cancer drugs deployment speed	◑	○	●	○	◑	○	○	◑	○	○	○	●	◑	●	○
	Access to new drugs (time to subsidy)	○	○	○	○	◑	●	○	◑	○	○	○	◑	●	●	●
	TOTAL SCORE	550	496	687	568	794	724	447	570	508	532	564	624	740	770	581
	RANK	23	27	11	20	2	7	28	19	26	24	21	14	6	4	17

Canada Lithuania Luxembourg Malta Netherlands Norway Poland Portugal Romania Slovakia Slovenia Spain Sweden Switzerland United Kingdom

5.3 Results Summary

This third attempt at creating a comparative index for national healthcare systems, and the first to include Canada, confirmed that there is a group of EU member states that all have good healthcare systems as seen from the customer/consumer's point of view.

The scoring was done in such a way that the likelihood that two states should end up sharing a position in the ranking is almost zero. It must therefore be noted that Austria, the Netherlands, France, Switzerland and Germany were very difficult to separate and that very subtle changes in single scores modified the internal order of these five top countries.

Austria emerged as the winner, with a generous healthcare system that provides good access for patients and very good medical results. Austria scored 806 out of 1,000 points and was followed closely by the Netherlands, France, Switzerland and Germany, which is in fifth place with 767 points. Canada, unfortunately, ends up in 23rd place out of 30 states with a score of 550.

Consumer and patient rights are improving. In a growing number of European countries, there is healthcare legislation explicitly based on patient rights, and a functional access to one's medical record is becoming standard. Still, very few countries have hospital/clinic catalogues with quality rankings. Canada ranks very poorly in this sub-discipline in particular.

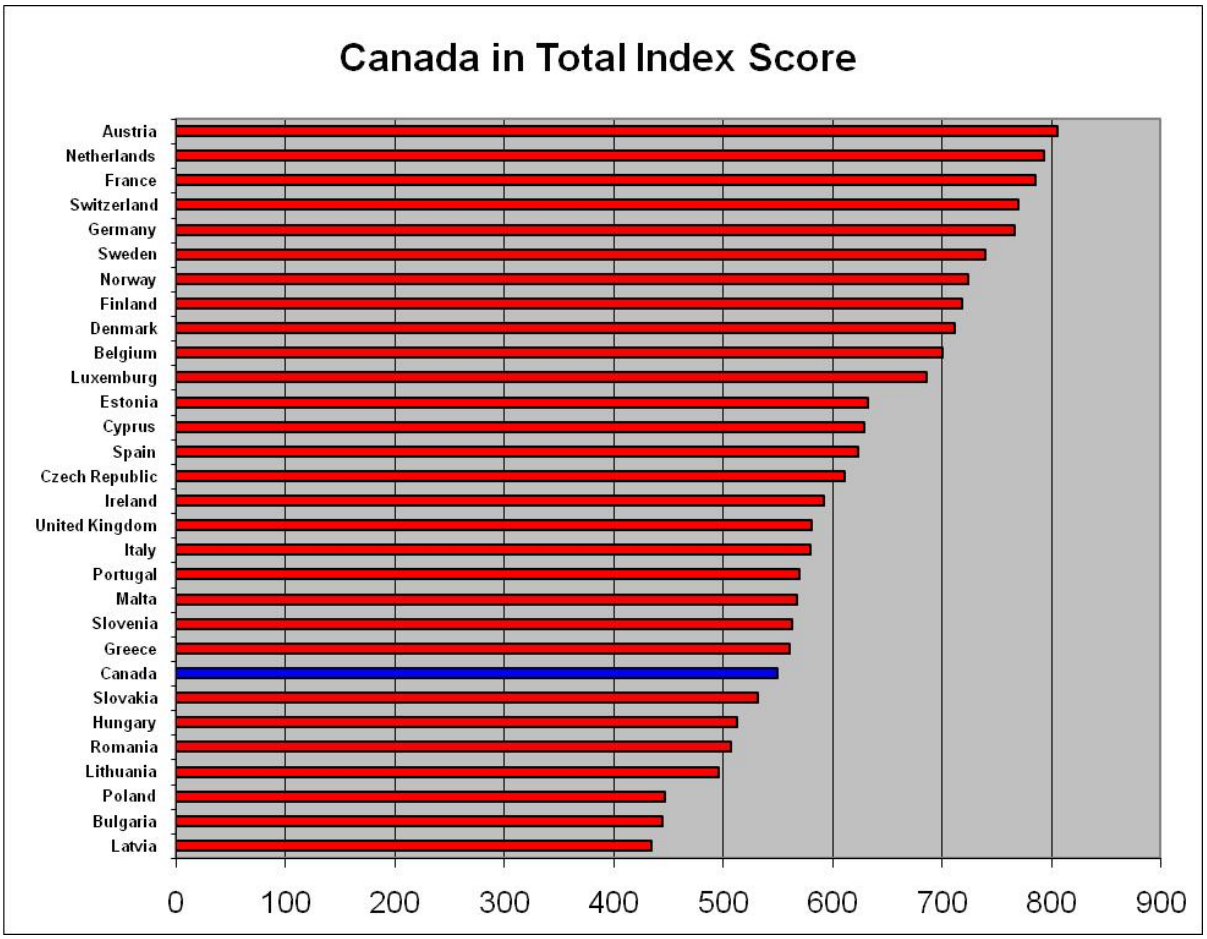
Generally, European healthcare continues to improve but medical outcomes are still appallingly poor in many countries. This is particularly true regarding the number one killer: cardiovascular diseases. Canada, on the other hand, achieves one of its three Green scores for cardiac outcomes.

In some respects, progress is not only slow but also lacking. MRSA infections in hospitals seem to spread and are a significant health threat in one out of two measured countries. Half of the governments systematically delay consumer access to new medicines and not just for reasons of poor national wealth.

Some eastern European EU member systems are doing surprisingly well considering their much smaller healthcare spending in Purchasing Power adjusted dollars per capita. However, readjusting from politically planned to consumer-driven economies does take time.

If healthcare officials and politicians take to looking across borders, and to "stealing" improvement ideas from their EU colleagues, there will be a good chance for a national system to come much closer to the theoretical top score of 1,000. As a prominent example, if Sweden could achieve a German or Austrian waiting-list situation, it would beat current winner Austria by a margin of 75 points!

As more data become available, subsequent versions of the EHCI and the Euro-Canada index will have in all likelihood a modified set of indicators.



5.3.1 Country scores

No country excels across the entire range of indicators. The national scores seem to reflect national and organizational cultures and attitudes rather than mirroring how many resources a country spends on healthcare. In all likelihood, the cultural aspects have deep historical roots. Turning a large corporation around takes a couple of years – turning a country around can take decades!

Countries with pluralistic financing systems, *i.e.,* those that offer a choice of health insurance solutions that also provide the citizen with a choice between providers regardless of whether these are public, private, non-profit or for-profit, generally score high on Patient Rights and Information issues. Under this sub-set of indicators, countries like Denmark and the Netherlands score high on openness and patients' access to their medical information. Scores of countries like Canada, Germany, France, Italy and Greece suffer from what seems to be an expert-driven attitude to healthcare, where patients access healthcare information with healthcare professionals as intermediaries rather than accessing the information directly.

In an attempt to summarize the main features of the scoring of each country included in the Index, the following table gives a somewhat subjective synopsis. To the care consumer – *i.e.,* most of us – describing and comparing healthcare will require some simplifications. (A medical information system dealing with scientific evidence such as individual diagnosis or medication guidelines requires very strict criteria; the Index must be seen as consumer information, and it cannot be considered scientific research.)

Country	**Scoring Synopsis**
Austria	A worthy winner, with very good medical results and excellent accessibility to healthcare. Austria leads the EU on overall cancer survival. Slightly autocratic attitude to patient empowerment?
Belgium	Champion for accessibility, suffers on outcome quality.
Bulgaria	Not bad considering its modest healthcare expenditure.
Canada	Solid outcomes, moderate to poor provision levels, and very poor scores with regard to patients' rights and accessibility. At the top of the bottom quartile in the overall matrix, Canada's very high level of healthcare spending means that when adjusted for bang for the buck, it is 30th out of 30 in the index.
Cyprus	Problematic. No other member state has as high a proportion of privately funded healthcare. The score nevertheless confirms the European Observatory HiT report finding that Cypriot healthcare is on par with the average.
Czech Republic	Takes care of its citizens – almost Japanese level of visits to doctors per citizen (15 times/year on average). Good on diabetes care (hope for the 2008 Index). Could reconsider resource distribution between healthcare staff and equipment/pharmaceuticals.
Denmark	Champions at Patient Rights and Information. Danes are very satisfied with their primary care but outcomes are not great.
Estonia	Estonia, with its population of 1.5 million, keeps proving that a small country can make a dramatic change faster than bigger nations can. It takes more than a dozen years to change a top-down planned economy to a customer-driven one. Good on MRSA infections and efficient financial administration of pharmaceuticals. In top of the value-for-money adjusted scores!
Finland	Not too different from Sweden. Very good outcomes. If Finland improves the waiting list situation, it can be a top contender.
France	The WHO (2000) world's #1 on healthcare system performance, and a top scorer in the EHCI. Technically efficient and quite generous. Reasonably good outcomes quality but slightly authoritarian. You want healthcare information – ask your doctor!
Germany	The customer rules! Could be great but lacks the cutting edge for quality. You want healthcare information – ask your doctor!
Greece	Doctors rule.
Hungary	It takes more than a dozen years to change a top-down planned economy to a customer-driven one. Sixty years of publicly financed healthcare has resulted in quite good coverage.
Ireland	The Health Service Executive reform seems to have started improving a historically dismal performance. Still severe waiting-list problems and less than fantastic outcomes.
Italy	Technically not too bad, but CERGAS, an institute for healthcare management, in Milan confirms that autocratic attitudes from doctors (and other Italians in superior positions, in and out of uniform) prevent Italy from scoring high in a consumer index.

Latvia	Too lacking in resources and organizational culture to be a consumer-adapted system. The country consists of more than downtown Riga!
Lithuania	A healthcare system in a state of thorough reformation – hope for better score in 2008.
Luxembourg	Has what it takes in the form of financial resources. Should be a top scorer. Luxembourgers have been shopping for care in bigger neighbouring countries, and this might have handicapped the development of superior domestic healthcare.
Malta	Technically, Maltese healthcare performs not too bad.
Netherlands	Hangs on to the Silver medal. Runner-up on Patient Rights after new champs Denmark. Openness, many financing options and good on outcomes quality. Scrap GP gate keeping, do away with waiting times and become Really Great!
Norway	Generally, not too bad. In recent years, access problems have been "solved" by pouring money over them – very expensive healthcare!
Poland	It takes more than a dozen years to change a top-down planned economy to a customer-driven one. Poor access to new drugs – a cost-saving measure?
Portugal	Not as advanced as Spanish neighbours. Good improvement in infant mortality.
Romania	Not doing too badly – shares with several of its neighbours the problem of unofficial payments to doctors. Good healthcare obtained this way unfortunately does not score in the EHCI.
Slovakia	Not as financially stable as Czech neighbours, and not very consumer-oriented.
Slovenia	Similarities to the Austrian system – does reasonably well in the BFB-adjusted score.
Spain	Rising year by year. It seems that going for private healthcare is necessary if patients want real excellence.
Sweden	Excels at medical outcomes. Really bad (and worsening!) at accessibility and service.
Switzerland	In a consumer index, a system based on individual responsibility since time began does score high. Good but expensive.
United Kingdom	Mediocre overall performer. Good on heart problems. Star performer on healthcare information! The new Freedom of Information Act will probably improve scores on openness indicators, but that will take time. The NHS shares some fundamental problems with other centrally planned healthcare systems such as Sweden.

5.3.2 Results in "pentathlon"

The Index is made up of five sub-disciplines. As no country excels across all aspects of measuring a healthcare system, it can therefore be of interest to study how the 30 countries rank in each of the five parts of the "pentathlon." The scores within each sub-discipline are summarized in the following table:

Sub-discipline	Austria	Belgium	Bulgaria	Canada	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	Germany	Greece	Hungary	Ireland	Italy	Latvia	Lithuania	Luxemburg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom
Patient rights and information	17	16	14	12	15	16	25	20	22	20	15	14	14	16	15	11	16	15	14	22	20	12	16	14	13	15	15	18	16	19
Waiting times	14	15	9	6	13	10	9	7	8	13	14	9	8	6	7	7	8	11	10	10	11	7	7	9	11	8	7	6	14	7
Outcomes	13	9	5	12	8	9	10	9	12	11	11	8	5	10	10	6	7	12	8	13	12	5	9	5	6	10	10	15	12	9
Generosity of public systems	9	8	5	7	6	9	7	9	11	11	10	7	11	7	8	7	6	7	8	10	7	8	7	8	6	6	9	11	7	6
Pharmaceuticals	9	6	4	5	7	5	10	9	7	8	9	7	5	10	7	4	4	8	5	10	8	5	8	6	6	6	10	10	10	8

As the table indicates, the top position of the Austrian healthcare system is to a great extent a product of good accessibility and very good medical quality, which are the two sub-disciplines carrying the highest weight coefficients.

Denmark is on top on **Patient rights and information**. What is strongly indicated is that the Swedish healthcare system could be a real top contender were it not for the accessibility situation, which by Belgian, Austrian, French or German standards can only be described as abysmal. Finally, some countries, most probably Switzerland, would do better if healthcare data were more readily available.

5.4 National and organizational cultures

Some indicators seem to reflect national and organizational culture rather than formal legislative or financial circumstances. Waiting times, usually considered to be of vital interest to healthcare consumers, seem to be one such area. As was observed by Siciliani & Hurst of the OECD Health Group, the existence of waiting times is strongly correlated with regulations that force the patient to access specialist care by going through a primary care procedure to get a referral to a specialist (the gatekeeping function). In general, countries with gatekeepers exhibit waiting lists – countries where patients are allowed direct access to specialists do not.

In general, countries with a long tradition of plurality in healthcare financing and provision, *i.e.,* those with consumer choice between different insurance providers that do not discriminate between providers that are private for-profit, non-profit or public, show common features in the waiting-list situation and in their readiness to let people seek healthcare in countries other than their homelands.

Canada's healthcare culture falls squarely in the gatekeeping category, with significant waiting lists for treatments, consultations and diagnostics. The absence of any choice amongst providers worsens this situation.

6. Bang-For-the-Buck Adjusted Scores

After assessing 30 often very different national healthcare systems, it became apparent the index tried to compare states with a significant spread of financial resources. The annual healthcare spending in PPP-adjusted (Purchasing Power Parity) U.S. dollars varies from around $600 in Bulgaria and Romania to $4,000 – $5,000 in Norway, Switzerland and Luxembourg. Continental Western Europe and Nordic countries generally fall between $2,500 and $3,000. As an attempt to show these differences, the EHCI 2007 and Euro-Canada Index added a value-for-money adjusted score: the Bang-For-the-Buck adjusted score (BFB score).

6.1 BFB adjustment methodology

It is not obvious how to do such an adjustment. If scores were adjusted in proportion to healthcare spending per capita, all less affluent states would be elevated to the top of the scoring sheet.

This, however, would be decidedly unfair to the financially stronger states. Even if healthcare spending is PPP adjusted, it is obvious that even PPP dollars go a lot further in purchasing healthcare services in member states where the monthly salary of a nurse is €200 than in states where nurses' salaries exceed €3,500. For this reason, the PPP adjusted scores were calculated as follows:

Healthcare spending per capita in PPP dollars was taken from the WHO HfA database (latest available numbers, most frequently 2004) as illustrated in the table below:

Country	Total health expenditure, PPP$ per capita	Square root
Austria	3,124	55,89
Belgium	3,044	55,17
Bulgaria*	648	25,46
Canada	3,326	57,67
Cyprus	1,437	37,90
Czech Republic	1,361	36,89
Denmark	2,881	53,67
Estonia	771	27,77
Finland	2,235	47,28
France	3,159	56,20
Germany	3,005	54,82
Greece	2,162	46,50
Hungary	1,323	36,37
Ireland	2,596	50,95
Italy	2,392	48,91
Latvia	734	27,10
Lithuania	786	28,04
Luxembourg	5,089	71,34
Malta	1,739	41,70
Netherlands	3,041	55,15
Norway	3,966	62,98
Poland	805	28,37
Portugal	1,813	42,58
Romania*)	566	23,79
Slovakia	777	27,87
Slovenia	1,801	42,44
Spain	2,094	45,76
Sweden	2,825	53,15
Switzerland	4,077	63,85
United Kingdom	2,546	50,46
Arithmetic mean		44,77

* For Bulgaria and Romania, the WHO HfA database (January 2007) seems to contain errors for healthcare spending. It is given as $214 and $314 respectively, which are unreasonably low numbers. The European Observatory HiT report (http://www.euro.who.int/Document/E90023brief.pdf) on Bulgaria quotes the WHO, giving the number $648, also confirming the fact that this is slightly higher than the Romanian figure. The number for Romania was taken from a report from the Romanian MoH (http://www.euro.who.int/document/MPS/ROM_MPSEURO_countryprofiles.pdf), also quoting the WHO.

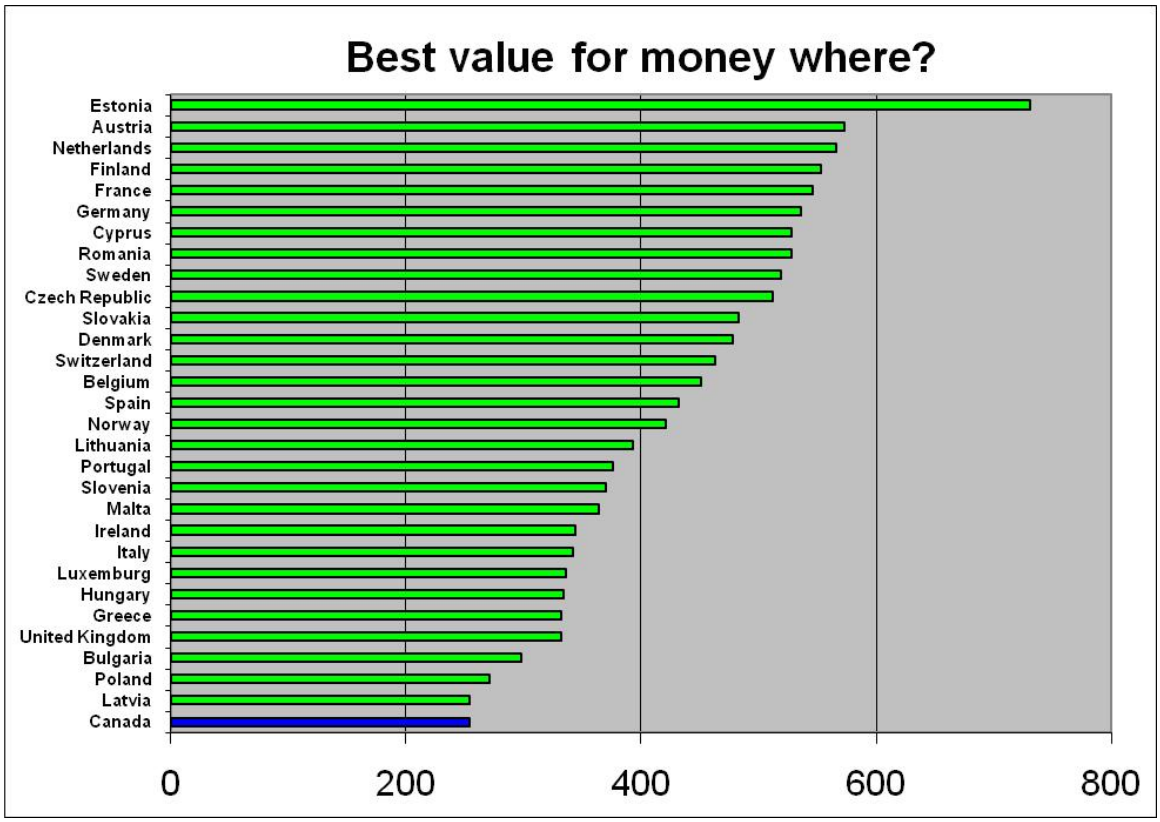
The square root of this number was calculated for each country. The reason for this was that domestically produced healthcare services are cheaper roughly in proportion to healthcare spending. The basic scores were divided by this square root. For this exercise, the basic scoring points of 3, 2 and 1 were replaced by 2, 1 and 0. In the basic index, the minimum score is 333 and the maximum is 1,000. Using 2, 1 and 0 does not change the relative positions of the 30 countries (or at least very marginally), but it is necessary for a value-for-money adjustment – otherwise, the 333 "free" bottom points

have the effect of just catapulting the less affluent countries to the top of the list.

The score thus obtained was multiplied by the arithmetic mean of all the square roots (creating the effect that scores are normalized back to the same numerical value range as the original scores).

6.2 Results in the BFB score sheet

The outcome of the BFB exercise is shown in the table below. Even with the square root exercise described in the previous section, many less affluent nations are dramatically elevated in the scoring sheet.



The BFB scores, naturally, should be regarded as somewhat of an academic exercise. Not least, the method of adjusting the square root of healthcare spending certainly lacks scientific support. However, it does seem that the supreme winner in the BFB score, Estonia, is doing very well within its financial capacity. Naturally, it is easier to reform a country with 1.5-million people than one with more than 40 million – nevertheless, Estonian reform work since 1990 deserves admiration!

What the authors find interesting is seeing which countries top the list in the BFB scores and *also* do reasonably well in the original scores. Examples of such countries are Austria, the Netherlands, Finland, France and Germany.

Canada, which spends more on healthcare than any country in the index except Norway, Luxembourg and Switzerland, performs very poorly in four of the five matrix disciplines. When the quality of care delivered is compared with the cost of providing that care, Canada falls to the very bottom of the list in terms of value for money.

7. How the ECHCI was built

7.1 Strategy

Canadians will be well served by better understanding the range of possibilities for healthcare that exist in Europe. The Index will make it possible for consumers to approach healthcare as critically as they do other vital services, and this can only benefit everyone involved. Responsive, consumer friendly healthcare with excellent outcomes is possible – it is being achieved in the top performing states in Europe, and can be achieved in Canada as well.

In April 2004, HCP launched the Swedish Health Consumer Index (www.vardkonsumentindex.se also in a translation to English). By ranking the 21 county councils (the regional parliaments responsible for funding, purchasing and providing healthcare) by 12 indicators concerning the design of systems policy, consumer choice, service level and access to information, we introduced benchmarking as an element in consumer empowerment. The presentation of the third annual update of the Swedish index on May 16, 2006, again confirmed for Swedes the low average ranking of most councils, revealing the still weak consumer position.

There is a pronounced need for improvement. The very strong media impact of the index throughout Sweden confirmed that the image of healthcare is rapidly moving from rationed public goods to consumer-related services that are measurable by common quality perspectives.

For the Euro Health Consumer Index, the Health Consumer Powerhouse aimed to follow the same approach, *i.e.,* selecting a number of indicators that described to what extent the national healthcare systems are user-friendly, thus providing a basis for comparing different national systems.

The index does not take into account whether a national healthcare system is publicly or privately funded and/or operated. The purpose of the EHCI is health consumer empowerment, not the promotion of political ideology. Aiming for dialogue and co-operation, the ambition of HCP is to be seen as a partner in developing healthcare around Europe.

In the initial years of index building, opinion brokers and policy-makers – like journalists, experts and politicians – will be the key audience for the index. Gradually, the health consumer could become the main user along with service providers, payers and authorities. Such a development will require user-friendly services and a deep knowledge of consumer values. Interactivity with users and other parts of the European healthcare society will be another key characteristic.

The Euro-Canada Health Consumer Index is a step toward bringing consumer-friendly healthcare to Canada. Primarily, the very existence of the Index will produce an atmosphere in which Canadians can see how their system succeeds and fails. Canada lacks a culture in which consumers have high expectations of healthcare services, and significant reform is unlikely without this.

7.2 The starting point: Euro Health Consumer Index 2007

7.2.1 Preliminary selection of indicator areas for study

The aim was to select a limited number of indicators within a definite number of evaluation areas that when taken together show how the healthcare consumer is being served by the respective systems.

The work on the EHCI 2007 began with the 2006 index with the desire to retain the main structure so that the possibility of making comparisons over time would not be destroyed. In addition to the indicator changes described in section 5.1 above, the following indicators were considered for inclusion. The Euro-Canada Index was developed in harmony with the EHCI 2007, using parallel methods and data gathering.

7.3 Production phases

EHCI 2007 was constructed under the following plan:

7.3.1 Phase 1

Mapping of existing data

Initially, the major work was to evaluate to what extent relevant information was available and accessible for the selected countries. The basic methods were:

- Web search
- Telephone and e-mail interviews with key individuals
- Personal visits when required

Web search

a) Relevant bylaws and policy documents

b) Actual outcome data in relation to policies

Information providers

a) National and regional health authorities

b) Institutions (EHMA, Cochrane Institute, Picker Institute, University of York Health Economics, others)

c) Patients' associations ("What would you *really* like to know?")

d) Private enterprise (IMS Health, pharmaceutical industry, others)

Interviews (to evaluate findings from earlier sources, particularly to verify the real outcomes of policy decisions)

a) Phone and e-mail

b) Visits to key information providers

7.3.2 Phase 2

- Data collection was undertaken to assemble information to be included in the EHCI 2007.
- Identification of vital areas where additional information needed to be assembled was performed.
- Collection of raw data for these areas
- Visits by the EHCI researchers to health ministries and/or state agencies for supervision and/or quality assurance of healthcare services.

7.3.3 Phase 3

- Score update sheet sent out by e-mail.

On June 20, 2007, all 29 states received their preliminary score sheets (with no reference to other states' scores), which asked for updates/corrections by July 31. The e-mail was sent to contacts at ministries/state agencies as advised by the states during the spring of 2007. Two reminders were sent out: one on July 19 and one on August 3. Corrections were accepted until September 10, by which time replies had been received as listed in section 5.5.2 above.

- EHCI construction
- Web-solution building
- Consulting European patient advocates and citizens through HCP surveys performed by external research facilities (PatientView, U.K.).

The 2007 survey was dedicated to the Waiting times and **Readily accessible register of legitimate doctors** indicators. Four hundred and eighteen patient organizations responded. The lowest number of organizations responding from any one country was four. The consistency between responses from different organizations was surprisingly good, as was the consistency with data from public sources. This survey was therefore used as the main data source for the Waiting times indicators.

For the **Readily accessible register of legitimate doctors** indicator, the survey responses showed a slightly negative bias. For states such as Bulgaria and Italy, where web-based registries of legitimate specialists (Bulgaria did not include speciality qualifications) are readily accessible, most organizations said that this information was difficult to access. In cases like these, it was decided to be generous in the awarding of country scores.

7.3.4 Phase 4

Project presentation and reports

- A report describing how the EHCI was constructed
- The presentation of EHCI 2007 at various events on October 1 and the following weeks in Brussels and other cities.

Online launch on www.healthpowerhouse.com

7.3.5 Phase 5

The inclusion of Canada

- A partnership between HCP and FCPP was created in order to integrate Canada into the EHCI 2007.
- FCPP staff studied HCP's methodology and prior indexes.
- A list was compiled of equivalent or comparable metrics to allow Canada to be evaluated in parallel with the 29 countries in the EHCI 2007.
- Data collection and verification.

Much information about the EU member states has already been harmonized and prepared in a consistent format. Some Canadian data were not quite in identical format, for example the calculation of infant mortality, and where this was the case, every effort was made to ensure that the comparison between Canada and the 29 European countries was fair.

All Canadian data were collected from publicly available sources, including government data from all three levels of government, public and private institutions for the study of healthcare and health policy and existing literature and research. The results of this data collection were further examined in the context of existing literature, as well as the experience of practitioners, consumers and administrators, to verify that they correspond reasonably well with the reality of healthcare "facts on the ground." Data were obtained from publications online, published periodicals, government documents and correspondence with sources.

The first Euro-Canada Index had its virtual release at www.healthpowerhouse.com and www.fcpp.org and it was launched January 21, 2008, in Ottawa and Brussels and throughout Canada in subsequent days and weeks.

Additionally, the first intra-Canadian index, which compares the healthcare systems of all 10 provinces, will be released later in 2008. The extension of index methodology into assessing the strengths and weaknesses of provincial healthcare regimes will shed further light on Canada's best and worst health policy practices.

8. How to interpret the Index Results

The first and most important consideration on how to treat the results is with great care, and not to leap to drastic conclusions!

Our indexes are an attempt to measure and rank the performances of healthcare systems from a consumer viewpoint. The results definitely contain information quality problems. There is a shortage of multi-country uniform procedures for data gathering.

Again, we find it far better to present our results to the public and to promote constructive discussion rather than to stay with the very common opinion that as long as healthcare information is not 100 per cent complete one had

better keep it in the closet. Again, we want to stress that the index displays consumer information, not medically or individually sensitive data.

It is clear, though, that Canada has much room for improvement. The first change, and the one which will enable improvements in all other indicators, is in the area of patients' rights. Without a culture that encourages healthcare consumers to demand and receive the best, outcomes, accessibility, and generosity are unlikely to improve. A crucial first step will be the provision of meaningful guarantees. Patients' Bills of Rights can be a useful approach to this, but only if the bills include remedies for situations wherein consumers cannot access appropriate care. There are some attempts underway in Canada to create such legislation, and this will be well worth following in both the interprovincial index and in future editions of the Euro-Canada Index.

A consumer-sensitive culture would also be more transparent. Canadians must have the right to access their own medical records (which should be in electronic format), and they should have ready access to specialists, diagnostics and treatment.

Given Canada's abysmal rating for value for money in the Bang-for-the-Buck exercise, a simple increase in health budgets is not the answer. Much more can be done with the money being spent on healthcare in Canada. Accessibility and Generosity, especially as it pertains to the preventative measure of vaccination, are two areas that are particularly ripe for reform.

9.References

9.1 Main sources

The main sources of information for the indicators are given in Table 5.5 above. For all indicators, this information was supplemented by interviews and discussions with healthcare officials in the public and private sectors.

9.2 Useful links

Useful complementary information was obtained from these Web sites.

http://www.aesgp.be/

http://www.wrongdiagnosis.com/a/amputation/stats-country_printer.htm

http://www.easd.org/

http://www.diabetes-journal-online.de/index.php?id=1

http://www.drfoster.co.uk/

http://www.rivm.nl/earss/

http://www.eudental.org/index.php?ID=2746

http://europa.eu/abc/governments/index_en.htm

http://europa.eu/pol/health/index_en.htm

http://ec.europa.eu/public_opinion/index_en.htm

http://europa.eu.int/youreurope/index_sv.html

http://www.eurocare.it/

http://www.ehnheart.org/content/default.asp

http://www.euro.who.int/observatory

http://www.escardio.org/

http://epp.eurostat.cec.eu.int/portal/page?_pageid=1090,30070682,1090_33076576&_dad=portal&_schema=PORTAL

http://ec.europa.eu/health-eu/index_en.htm

http://www.who.dk/eprise/main/WHO/AboutWHO/About/MH#LVA (Health ministries of Europe addresses)

http://www.hospitalcompare.hhs.gov/

http://www.hope.be/

http://www.activemag.co.uk/hhe/error.asp?m=2&productcode=&ptid=3&pid=2&pgid=34&spid= (Hospital Healthcare Europe – subscription page)

http://www.idf.org/home/

http://www.eatlas.idf.org/

http://www.hospitalmanagement.net/

http://www.lsic.lt/html/en/lhic.htm (Lithuanian Health Info Centre)

http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/

http://www.medscape.com/businessmedicine

http://www.oecdbookshop.org/oecd/display.asp?TAG=XK4VX8XX598X398888IX8V&CID=&LANG=EN&SF1=DI&ST1=5LH0L0PQZ5WK#OtherLanguages (OECD Health Data 2005)

http://www.oecd.org/department/0,2688,en_2649_33929_1_1_1_1_1,00.html (OECD Health Policy & Data Department)

http://www.medscape.com/medline/abstract/15176130 (Patient Ombudsmen in Europe)

http://aitel.hist.no/~walterk/wkeim/patients.htm (Patients' Rights Laws in Europe)

http://www.patient-view.com/hscnetwork.htm

http://www.pickereurope.org/

http://www.vlada.si/index.php?gr1=min&gr2=minMzd&gr3=&gr4=&id=&lng=eng (Slovenia health ministry)

http://www.lmi.no/tf/2004/Engelsk/Chapter%206/6.20.htm (Tall og fakta)

http://www.100tophospitals.com/

http://www.worldcongress.com/presentations/?confCOde=NW615

http://www.who.int/healthinfo/statistics/mortestimatesofdeathbycause/en/index.html

http://www.who.int/topics/en/

http://www.who.int/healthinfo/statistics/mortdata/en/

http://www.euro.who.int/hfadb (WHO Health for All database)

http://www.who.dk/healthinfo/FocalPoints (addresses for health statistics contacts in Europe)

http://www.who.int/genomics/public/patientrights/en/

http://www.waml.ws/home.asp (World Association for Medical Law)

http://www.wrongdiagnosis.com/risk/geography.htm

http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html

http://www.statcan.ca/english/freepub/82-573-GIE/index.htm

http://secure.cihi.ca/cihiweb/splash.html

http://www.umanitoba.ca/centres/mchp/

http://www.cancer.ca/ccs/internet/niw_splash/0%2C%2C3172%2C00.html

http://www.diabetes.ca/

http://www.gov.bc.ca/health/

http://www.health.gov.ab.ca/

http://www.health.gov.sk.ca/

http://www.gov.mb.ca/health/

http://www.health.gov.on.ca/

http://www.msss.gouv.qc.ca/en/

http://www.gnb.ca/0051/index-e.asp

http://www.gov.ns.ca/health/

http://www.health.gov.nl.ca/health/

http://www.gov.pe.ca/health/index.php3

http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3479403/

10. FAQs

Why is the ECHCI 2008 produced, and for whom?

The HCP and FCPP provide the ECHCI to empower consumers of healthcare services. When you make public comparisons, things start to happen. When you do them systematically, experience show that things grow better.

Improved insight into European healthcare standards will support patient mobility within the EU. Evaluating Canada in this context will provide ample opportunities for Canadian policymakers and consumers to consider new and effective ways to deliver accessible and excellent healthcare.

Why add Canada, a non-European country?

The Canadian healthcare system – publicly financed and governed - has much more in common with Europe than its American counterpart, to which it is traditionally compared. All the countries included in the Index share Canada's commitment to accessible and effective healthcare, and by comparing the performance of Canada's healthcare institutions with those of the extremely varied 29 European states, we can develop a better understanding of the performance of Canada's model and how it might be improved in the future.

What will this index bring to Canada?

The Euro-Canada Health Consumer Index is a step towards bringing consumer friendly healthcare to Canada. Primarily, the very existence of the Index will provide an objective basis by which Canadians can see how where their system is succeeding and failing. Canada lacks a culture in which consumers have high expectations of healthcare services, without which significant reform is unlikely.

Ultimately, Canadians will be well served by a better understanding of the range of possibilities for healthcare that exist in Europe. Responsive, consumer friendly healthcare with excellent outcomes is possible – it is being achieved in the top performing states in Europe, and can be achieved in Canada as well.

You talk of "consumers" – does this mean that you want to privatize Canadian healthcare?

No, to us the term "healthcare consumer" expresses the evolution where the weak, uninformed patient becomes transformed into the powerful, informed actor – the consumer. This transformation is essential in meeting the higher, more sophisticated service expectations among modern people and building pressure for consumer-oriented change from below.

The Index is neutral on whether there are public and private funding solutions to healthcare, i.e. there are no criteria to measure how the healthcare system is funded. Public-private or left-right distinctions are not considered in the Index's analysis.

It is called a Consumer Index – can consumers easily understand this information?

Rankings of consumer services – for example, in housing, mobile phones or cars – are increasingly becoming important news. Healthcare consumers have a clear interest in learning more so they can make the best possible choices.

Although the index contains a great deal of relatively complex information, it is presented in a matrix in a consumer friendly way that shows the differences in the consumer orientation of healthcare.

How can the consumer use the index?

The index highlights the strong and weak points of the national healthcare system. Such insights can provide a foundation for making informed choices. For example, can I ask for a second opinion? Is it necessary to go abroad to find treatment? In the new era of patient mobility and "health tourism" cross-border consumer comparisons will have growing importance.

This is now the fourth year of this kind of indexes. What concrete difference have the index findings made?

The indexes have significantly contributed to healthcare investments in a number of countries. For instance, following our 2006 EHCI, the Danish government added more money to improve Danish healthcare. In Ireland, its poor ranking the same year caused a media outcry and intense political debate that resulted in pressure for reform. In Sweden, significant steps toward public ranking of healthcare were taken following the release of our report.

One big difference the Index has made has been to improve the transparency of information required to make such comparisons. Ireland, for instance, suffered in the 2006 index by furnishing out-of-date and incomplete information. As a result, it – and many other countries – have been much more forthcoming in supplying this information. This in turn improves the reliability of the Index.

The European Commission has declared that transparency and competition are essential elements for making European healthcare more efficient.

What will be the next step?

The FCPP will continue to work with the HCP to produce evaluations of Canada's performance as compared with European healthcare systems. Additionally, the first Canadian Health Consumer Index, in which provincial performances are assessed along lines similar to those of the Euro-Canada Index but tailored to Canadian health issues, will be released later in 2008. HCP is also working on pan-European disease-specific indexes, such as heart disease and diabetes.

Who is behind the EHCI?

The index was initiated and produced by the Health Consumer Powerhouse, which holds the copyright to the Indexes. The HCP is a private healthcare analyst and information provider, registered in Sweden, with offices in Brussels and Stockholm. The Frontier Centre for Public Policy, an independent and non-partisan Canadian think-tank, has partnered with HCP to produce the Euro-Canada Index.

How was the ECHCI 2008 funded?

The pan-European Indexes are HCP flagship products which are now being introduced into Canada. HCP accepts non-restricted research and educational grants from institutions and companies and sells healthcare-related information in the competitive-intelligence market. The HCP does not, however, accept grants from any entities measured in the indexes.

Regarding the Euro-Canada Index 2008 HCP has sold limited rights to use the index methodology and brand to FCPP.

The FCPP is funded by private sector donors and charitable foundations that support public policy research. It does not accept any government grants. A strict separation is maintained between funders, the centre's board of directors and all research activity.

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

Yes, no doubt! Healthcare is the largest industry in the world and there is a pressing need to find relevant and comprehensive ways of assessing its performance, not just measuring the input of resources (staff, beds, medication et cetera) as has been traditionally done without regard to outcomes.

The advantage of a more outcomes focussed method is that it focuses on measures that affect the ability of the consumers to use their healthcare services and on the differences between countries. It also helps consumers understand what more they can and should reasonably expect from their providers.

How reliable are index data?

The data are as reliable as the data that could be found using the methods described. HCP and FCPP have brought the data together from public statistics and our investigations and research. The access to public data in many fields is not only slow but also appallingly poor. This means that for one country the latest data might be quite recent, while for another it might be several years old. The HCP has a system to assess and validate all data, but there might be uncertain data which should be used selectively and with great care.

Some of the data used for the indicators are relatively dated and other sources are current. Why such a variation?

The Index always uses the most recent data. Highlighting the fact that such information anyhow can be rather dated is one purpose of the entire exercise. This is consumer information, and our view is that presenting data – even where inconsistent – is better than saying nothing at all. This poor quality of public data represents a major challenge of governments and institutions rather than part of an index weakness.

Differing weights are given to indicators. Why?

Numerous surveys show that patients generally say that medical outcomes and accessibility to healthcare are the most important aspects of healthcare services. This is true even for countries, where waiting-list problems are moderate.

What is measured – public health or healthcare performance?

Healthcare performance. Governments, EU and WHO deliver data on public health – which is undeniably important at the policy level. For consumers, we find that an assessment of what the national healthcare system delivers to patients as more relevant. We are not measuring public health in general, which is related closely to diet, smoking habits, obesity et cetera and cultural factors.