

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

DISCUSSION PAPER

Access to Healthcare in Canada

MAY 2002

This paper is one of a series of nine public discussion documents designed to help Canadians make informed decisions about the future of Canada's healthcare system. Each of these research-based papers explores three potential courses of action to address key healthcare challenges. Canada may choose to pursue some, none, or all of these courses of action; in addition, many other options are available but not described here. These research highlights were prepared for the Commission on the Future of Health Care in Canada, by the Canadian Health Services Research Foundation.

Thank you for your interest in shaping the future of Canada's healthcare system.

This discussion document and survey on Access to Healthcare is one of a series of nine such documents the Commission on the Future of Health Care in Canada has developed in partnership with the Canadian Health Services Research Foundation. They were designed to enable Canadians to be better informed about some of the key challenges confronting their health care system and to express their preferences on proposed solutions. We have worked hard to summarize relevant, factual information and to make it as balanced and accessible as possible.

Each of our nine documents follows an identical format. We begin by briefly summarizing a particular health issue. Next, we identify three possible courses of action to address the issue and their respective pros and cons. Last, we ask you to complete a brief survey relating to the courses of action.

To make it easier to provide us with your responses, the survey questions are included on the final pages of this document. Please detach and forward these pages to us by fax at: (613) 992-3782, or by mail at:

Commission on the Future of Health Care in Canada
81 Metcalfe, Suite 800
Ottawa, Ontario
Canada K1P 6K7

You can also complete the survey on-line through our interactive website at:
www.healthcarecommission.ca.

There are no "right" or "wrong" answers, and the results are intended to be informational only. They are designed to illustrate how each person's response fits within the context of others who have responded, not to have scientific validity in and of themselves. The survey results are only one of many ways the Commission is studying and analyzing this issue. To order other titles in this series, please write to us at the address above, or call 1-800-793-6161. Other titles include:

- Homecare in Canada
- Pharmacare in Canada
- Sustainability of Canada's healthcare system
- Consumer choice in Canada's healthcare system
- The Canada Health Act
- Globalization and Canada's healthcare system
- Human resources in Canada's healthcare system
- Medically necessary care: what is it, and who decides?

We are grateful for your contribution to shaping Canada's healthcare system and hope that this document will be as informative to you, as we know your survey responses will be valuable to us.

Sincerely,



Roy Romanow

Access to Healthcare in Canada

The accessibility of healthcare services is one of our major preoccupations. The media is full of stories about long waits for surgery and other specialist care, and hospitals, with patients lying on stretchers in the hallways, turning ambulances away from the door.

The facts, however, are notoriously slippery. There's little hard evidence on how long people wait for care and what impact that has on their health.

Under the Canada Health Act we're supposed to have universal access to health services, but too often we don't. Many services fall outside medicare coverage, so some people can't afford them. In other cases, the services are available; we just have to wait for them — sometimes longer than we'd like. Some people live far from the big cities where much of the care is delivered. Others face language or cultural barriers that make it harder to obtain the care they need.

With a problem so complex, there can be no single or simple solution. This paper focuses on three of the many potential courses of action for Canada. They are:

I. Central management of waiting lists — Canadians generally receive prompt care for urgent conditions. But many fear long waits for elective procedures may hurt their health. Could we manage waiting lists better to make sure that the sickest patients get to the front of the line, and nobody waits too long?

II. A bill of rights for patients — More and more, patients are becoming “healthcare consumers” who have certain expectations of the system they support through taxes, premiums and out-of-pocket purchases. Some jurisdictions are developing bills of rights to clarify the relationships between patients, providers and the healthcare establishment. Could a bill of rights improve consumer access to health services?

III. Complementary and alternative medicine — Is it fair to spend most of our medicare dollars on services typically delivered by doctors and hospitals? In light of the growing popularity of complementary and alternative medicines, would it make sense to expand medicare coverage to a broad range of products and services now largely outside the conventional medical system?

I Waiting Lists

Canadians worry that waiting lists are growing, that waiting times are too long, and that services may not be available when they need them. Emergency and urgent care are usually provided right away, but waiting times for planned procedures such as a hip replacement are shrouded in mystery.

That's because most specialists create their own waiting lists, so there may be hundreds of lists for any given health procedure. Some are long, some short; some move quickly, others slowly. Each specialist judges whom to include, and in what order of priority.

Without a single co-ordinated list, we don't know who is waiting and for how long. Patients and their family doctors usually don't know which specialist to choose to get care quickly. We do know that different people who are equally sick wait different lengths of time for the same service: waiting for a hernia operation in Saskatoon might take you a week or a year, depending not on how urgent your case is, but to which doctor you are sent.

We could reduce waiting lists by having a lot of extra capacity in the health system, but it would be costly. In fact, a short wait isn't necessarily bad; if the date is booked, uncertainty is removed and patients have time to get their affairs in order and prepare for the treatment. A waiting list can even be a good thing if it means those with a more urgent need get care before people who are less sick.

The problem is, we don't co-ordinate our waiting lists. That means we don't know if people are waiting too long and we can't ensure those who are sickest get to the front of the line. We don't know if the amount of service provided and the amount needed are mismatched, or if we're just not operating efficiently. We don't even know if waiting times are really as bad as people think. When three provinces studied waiting lists in the 1990s none found waits much longer in 1998 than in 1992-93. However, more recent evidence from one province suggests waits may be slowly on the rise. Until waiting lists are better managed, we can't be sure.

Course of action: Waiting lists for healthcare should be centralized and then coordinated by regional or provincial authorities, not by individual providers or institutions.

Patients are often put on waiting lists for "elective" care: it's medically necessary, but not an emergency. If we managed waiting lists centrally, everyone in a province or region waiting for the same treatment would be tracked on one list. Physicians would use standard, objective measures to assess if the patient would benefit from the treatment, and how urgent the need was (considering risk of death, pain and disability, impact on their lives). Maximum waiting times would be set for each level of urgency. The list would be managed to make sure no one waited longer than the maximum and that the most urgent cases were treated first. Patients would be monitored and moved up or down the list as changes to their health required. The outcomes of both waiting and treatment would be measured.

A centralized management system can let patients and doctors choose between a preferred specialist with a longer waiting time or the next available provider. In either case, they know about how long they'll have to wait, and can make an informed choice.

The primary model for managed centralized waiting lists is the Cardiac Care Network of Ontario. It was launched in response to public concerns that heart patients were dying while waiting for care. Yet there was not enough reliable information available to know if that was true. Investigation showed that not only had waiting times for coronary artery bypass surgery in Ontario greatly increased, they also varied enormously, from 30 days in one city to 73 days in another. After the network was introduced, waits for coronary artery bypass surgery shortened. As well, sicker people got to the front of the line. The network's approach is being built on by the Western Canada Waiting List Project, which is developing tools to manage waiting lists for a number of procedures.

ARGUMENTS FOR

Proper centralized management of waiting lists can eliminate unfairness. Objective criteria to include and rank patients, combined with monitoring of people on the list, means more urgent cases go first and the list includes only those it should.

The Cardiac Care Network successfully reduced waiting times. Waits for adult cardiac surgery in 1999-2000 were lower than in any of the previous six years. Average wait times that year were 34 days for elective patients (compared to 62 in 1995), eight days for semi-urgent cases (down from 13 in 1995) and three days for those ranked urgent (which was the same as 1995).

Just adding more money doesn't fix waiting lists in the long run. Sometimes adding more resources even makes lists grow, because if doctors think waiting lists are shorter, they may take patients they would not have considered sick enough to treat in a more financially stressed system. In addition, when new money is used to get rid of a backlog, more urgent patients recently added to the list may have to wait while less-sick patients who have waited longer are treated.

Centralized waiting lists can provide the information needed for good planning and management. Governments, health authorities and hospitals can invest money where it will make the most difference.

ARGUMENTS AGAINST

Successful management of waiting lists requires additional money for administration and probably also for patient care. The Cardiac Care Network costs \$1.75 million a year to administer, money that might otherwise be spent directly on patient care. In addition, most managed waiting lists have led to more money for care; without it they might not have been so effective. At the very least, extra money clears backlogs so central waiting lists can get off to a good start. Furthermore, care that is easy to track on waiting lists can get a higher profile and pull money from less-easily measured, but equally important types of care.

We don't know if the success of the Cardiac Care Network can be repeated in other provinces and other services. The state of cardiac care in Ontario in the 1990s may have been unique. Did the network succeed because of centralized management of waiting lists, good partnerships, more money, or because cardiac care lends itself to such a system? Experts believe all these factors played a part. The Western Canada Waiting List project found it more difficult to create standard measures for diagnostic services like MRI.

Relying solely on standardized approaches may be too rigid. Some people will be exceptions to the rules. If physicians find "objective" measures of priority don't allow for occasional over-ruling by clinical judgement and other factors, their confidence in the system will be undermined.

Value-laden issues may be unresolvable. Non-medical factors, like age or employment status, are considered when people are put on a waiting list (should a single parent get care faster than a retired person?). Centralized waiting lists can also lead to fears that governments will ration care by arbitrarily deciding how sick people have to be before they get treated. At the same time, managing waiting lists may force us to make some tough decisions about which condition will get priority in the healthcare system. The best management system in the world may be rejected by doctors and patients alike if they are not happy with the way it handles these issues.

SURVEY QUESTIONS

Please refer to page 11 for the survey questions for this section.

A Patients' Bill of Rights

In today's information-rich society, where patients are apt to see themselves as "healthcare consumers" with options and rights, some jurisdictions are setting down those rights in formal bills of rights or charters. These vary from vague pledges of quality care to legally enforceable performance standards. Most express shared values and sentiments about the healthcare system. Some — though by no means all — promise access to specific services within guaranteed time limits.

In Canada, patients already have significant rights under the Canada Health Act, including the right to a broad range of publicly funded health services. The courts have also been used to interpret and extend those rights. So what role would bills of patients' rights play in improving access to health services? Would they ensure faster and better care, or will we just see finger-pointing, jurisdictional squabbles and litigation?

New Brunswick is the first jurisdiction in Canada to consider a formal charter, which is still being drafted. While affirming people's right to medically needed care, the charter also reminds them of a duty to "live a healthy lifestyle." It gives no standards or wait-time guarantees, and neither the rights nor the responsibilities it outlines are legally enforceable. Instead, advocates will monitor the use of the charter and handle complaints. To give effect to the charter commitments, reforms to New Brunswick's system are also planned.

That charter is not yet in place, but others are. Nearly 30 years ago, the American Hospital Association adopted a bill of rights that promised patients respect, privacy, autonomy and a clear role in treatment decisions. The tendency of managed-care insurance plans in the U.S. to restrict choice and access to some services has led federal and state legislators to pass or consider bills of rights for patients.

In 1991, the United Kingdom experimented with a charter of rights for patients served under the public National Health Service (NHS). However, because the NHS had such profound problems, the government abandoned the charter and launched an ambitious 10-year reform plan. After a massive infusion of cash, the NHS has adopted a series of service commitments, including very specific maximum wait-time guarantees.

Course of action: All governments should agree to a common Patient's Bill of Rights that defines standards of care, including access guarantees.

New Zealand's 1996 code of rights for consumers of health and disability services could be a good model for Canada. The 10-point code sets out the rights of patients and the duties of all providers, including many (such as naturopaths) outside the medical mainstream.

The rights, however, are general. For instance, they include the right to respect, dignity, information and access to "services of an appropriate standard." This means health professionals must comply with legal, professional, ethical and other standards, and deliver services "with reasonable care and skill...in a manner that minimizes the potential harm to, and optimizes the quality of life of...consumer(s)."

The United Kingdom's 2000 National Health System Guide takes a more specific approach to patient rights. It guarantees maximum waiting times for health services: by 2005, NHS patients will wait no more than three months for an outpatient appointment and no more than six months for admission to hospital. For chest pain or suspected cancer, referrals will come within two weeks.

ARGUMENTS FOR

A bill of patient rights can convey a sense of fairness. Patients benefit from a clear statement of the services they can expect, and when and how those services will be delivered. When rights are set out in plain terms, particularly if they have the force of law, patients know they're protected and being treated fairly.

Patients dissatisfied with their health services can feel empowered. Bills of patient rights are typically backed by a range of enforcement mechanisms, such as ombudsmen, mediators and complaints commissioners. These give patients an easy and inexpensive alternative to going to court or complaining to a professional body if they have a problem with the care they've received.

Bills of patient rights can also serve an educational function. Listing patient rights (and, as in New Brunswick, their responsibilities as well) can help patients, providers and health administrators better understand what patients are entitled to, as well as the limitations of the healthcare system.

Effective patient bills of rights can help improve the healthcare system. Providers are given measurable standards for clinical care and health improvement. Publishing assessments of their performance on those standards can result in informed debate and keep governments accountable for system improvements.

ARGUMENTS AGAINST

A patient bill of rights doesn't cause change — cash does. The British experience demonstrated that a bill of rights, standing alone, is doomed to failure. Promises about delivery must be backed by mechanisms to turn promises into actions. In the case of the NHS, that has meant a gigantic overhaul of the system, including annual budget increases of 6.3 percent for 10 years.

A bill of rights may be too rigid. Providers, constrained by the rules and budgets of the health system — not to mention external factors, such as a bus crash in the area — may not be able to meet patient expectations, even with the best intentions.

Professionals may resist, especially if they were not involved in developing the bill of rights. Experience in New Zealand and the U.K. suggests healthcare providers may resist bills of rights. Some feel patient charters foster a culture of blame and a tendency to deliver services at the minimum standard, rather than constructive improvements and accountability. What's more, with their focus on individual rights, charters may undermine efforts to fix system-wide problems.

There is no evidence that a bill of rights needs to be common across Canada. Canada is so big, and resources vary so much among communities that standards for access would have to be set so low as to be meaningless.

SURVEY QUESTIONS

Please refer to page 11-12 for the survey questions for this section.

Complementary and Alternative Medicines and Providers

While the healthcare debate focuses largely on access to conventional services, another vast galaxy of health products and practices is being ignored. Known collectively as complementary and alternative medicine, they include products like herbs, vitamins and minerals, and practices such as chiropractic, naturopathy, homeopathy, massage, acupuncture, reflexology and traditional Aboriginal healing. They're considered complementary when they're used in addition to regular forms of healthcare, and alternative if they're used instead of it.

Some provinces now subsidize a few complementary and alternative therapies, but the coverage is uneven and limited. Would it make sense to extend full public medicare insurance? Would public funding improve access to these therapies, relieve pressure on mainstream medicine and improve the health of Canadians?

A 1997 survey found 70 percent of respondents felt complementary and alternative treatments should be covered by provincial health plans, although they were not asked where the funds should come from. Another study in the same year found 60 percent of respondents felt payment should be private. Most of those who favoured public funding argued the money should be redirected from other healthcare spending.

Opinions aside, what are the facts? We don't have many. We don't know, for instance, whether public funding would increase use of complementary and alternative treatments or whether it would affect use of other therapies such as drugs and surgery. We don't know whether access to non-conventional care is a problem; many people are already using it, even without medicare coverage (70 percent of Canadians reported using one or more natural health products in 1999, up from 56 percent just two years earlier and 25 percent had consulted a complementary or alternative practitioner). It's estimated that Canadians spend \$3.8 billion a year on complementary and alternative medicine products, services and related items and use is equally popular among high- and low-income people.

Canadians with insurance coverage spend about the same on these treatments as those without. Provincial insurance plans offer piecemeal coverage for a few of the more established non-conventional treatments. There are no comprehensive figures on the nature and scope of private insurance coverage.

The economics of these therapies are puzzling because the science is far from conclusive. Some of these treatments have been around for millennia, but research on them is in its infancy. Most experts feel that until we have more proof these products and services are effective, assessing their value is nearly impossible and we need that proof before considering covering them under medicare.

Course of action: Complementary and alternative medicines and providers should be covered as part of the publicly funded healthcare system.

There is no model for comprehensive public coverage of complementary and alternative medicines because the lines are too blurred. However, if governments were to consider such a policy, a reasonable place to start would be with the professions that are regulated in some provinces now (which usually means they are licensed by a "college" that sets professional standards and handles patient complaints). These include chiropractors, osteopaths and massage therapists and naturopathic practitioners.

Complementary and alternative products could be covered by medicare — provided they were regulated and their safety and effectiveness had been proved. However, such a move isn't likely unless we first create an insurance program for conventional drugs, which aren't currently covered by the Canada Health Act.

ARGUMENTS FOR

Consumers should have equitable access to safe and effective therapies. Canadians often turn to complementary and alternative therapies when mainstream remedies don't work. As long as these treatments are safe and effective, they should be publicly supported. Existing insurance coverage is uneven; coverage under medicare would be consistent and fair.

Public funding requires regulation, which can improve access to complementary and alternative medicines. Canadians will benefit from regulations that require more consumer information, good manufacturing processes and professional standards for non-conventional care.

Public insurance coverage would bring complementary and alternative medicine providers closer to the healthcare mainstream. This would protect their right to practice, improve their career development opportunities, and ensure they meet proper standards for professionalism.

U.S. advocates for broader insurance coverage argue it makes good economic sense over the long term. Many of the therapies are less expensive than conventional treatments and it is argued that their focus on health maintenance can help prevent illnesses. American research suggests regular users of complementary and alternative care reduce their use of prescription medications and physicians. In a Canadian study, 18 percent of adults preferred to use a natural health product over conventional drugs.

ARGUMENTS AGAINST

The costs could be prohibitive. There has been no comprehensive analysis of the implications of full public funding of complementary and alternative medicines in Canada. U.S. research, however, suggests that insurance coverage leads to more visits to both conventional and alternative practitioners and in a Canadian study, 27 percent of consumers preferred to visit both doctors and alternative practitioners, which would not cut costs.

We can't agree on standards of proof for the effectiveness of complementary and alternative medicines. To justify a substantial investment of public funds, governments need credible proof that complementary and alternative medicine works. Critics point to the shortage of randomized clinical trials, the "gold standard" of Western medical evidence, which might demonstrate the merits of the treatments. The research that does exist is often inconclusive and by no means comprehensive. Proper scientific testing would also be very expensive.

Funding complementary and alternative medicines practice like conventional therapies could bring the two streams closer. But not all health practitioners, whether working in the mainstream or complementary and alternative medicine therapies, favour such integration. Complementary and alternative medicine still faces considerable suspicion from some Western physicians because of its lack of a scientific evidence base. For their part, some complementary and alternative practitioners fear integration will lead to dominance by mainstream medicine, and that their focus on "wellness" and patient involvement could be lost.

SURVEY QUESTIONS

Please refer to page 12 for the survey questions for this section.

Acknowledgements

This document was produced by the Canadian Health Services Research Foundation, in partnership with the Commission on the Future of Health Care in Canada. The topics and courses of action reflect key issues raised frequently in the Commission's consultations to date, for which the Foundation was able to find relevant research evidence to help inform the debate.

This document has been reviewed by the following experts for accuracy and fairness, but final responsibility lies with the Canadian Health Services Research Foundation:

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A complete bibliography of the research used to prepare these documents can be found at www.healthcarecommission.ca.

SURVEY INSTRUCTIONS

Please detach the following page and forward to us by fax at:
(613) 992-3782

Or by mail at:
Commission on the Future of Health Care in Canada
81 Metcalfe, Suite 800
Ottawa, Ontario
Canada K1P 6K7

For information:
Call toll free at 1-800-793-6161
www.healthcarecommission.ca

Thank you

Survey Questions

For each of the following questions, please indicate your opinion by selecting the appropriate box.

WAITING LISTS

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Centralized management of waiting lists for elective care will improve healthcare in Canada. | <input type="checkbox"/> |
| 2. Government should increase healthcare spending in order to centrally manage waiting lists for elective care. | <input type="checkbox"/> |
| 3. Government should spend enough money to completely eliminate waiting lists, even though the system would then have a lot of unused resources much of the time. | <input type="checkbox"/> |
| 4. I would prefer to see the next available specialist rather than wait longer for a particular specialist. | <input type="checkbox"/> |
| 5. I would be willing to travel up to five hours to get faster care in another location. | <input type="checkbox"/> |
| 6. Do you believe that central authorities or individual doctors should manage waiting lists? | <input type="checkbox"/> |

A PATIENT'S BILL OF RIGHTS

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. A common Patient's Bill of Rights that defines standards of care, including access guarantees such as maximum waiting times for elective care, will improve healthcare in Canada. | <input type="checkbox"/> |
| 2. A Patient's Bill of Rights would raise public expectations for healthcare services to a level beyond that which the healthcare system could meet. | <input type="checkbox"/> |
| 3. Governments should only introduce a Patient's Bill of Rights once they have first added significant resources to the system and done extensive education with healthcare providers. | <input type="checkbox"/> |
| 4. A Patient's Bill of Rights should describe performance standards, or make explicit guarantees of timely treatment. | <input type="checkbox"/> |
| 5. A Patient's Bill of Rights should include patient responsibilities. | <input type="checkbox"/> |
| 6. Organizations in the health system should be measured against the targets in the Patient's Bill of Rights, and held accountable for meeting those targets. | <input type="checkbox"/> |

COMPLEMENTARY AND ALTERNATIVE MEDICINES AND PROVIDERS

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Covering complementary and alternative medicine under medicare will improve healthcare in Canada. | <input type="checkbox"/> |
| 2. Which comes closest to your own view? Government should increase healthcare spending in order to cover complementary and alternative medicine under medicare. | <input type="checkbox"/> |
| or People who want to use CAMs should pay for them themselves. | <input type="checkbox"/> |
| 3. Which comes closest to your own view? We need scientific proof that each CAM product and service works before paying for it through the healthcare system. | <input type="checkbox"/> |
| or The healthcare system should pay for any product or service that healthcare practitioner organizations feel appropriate. | <input type="checkbox"/> |
| 4. Which comes closest to your own view? Doctors should be the only people licensed to provide CAMs services. | <input type="checkbox"/> |
| or Practitioner organizations should decide who is licensed to provide CAMS. | <input type="checkbox"/> |
| 5. There have been times when I would have used a CAM, but it was too expensive. | <input type="checkbox"/> |

ANALYSIS INFORMATION

Please complete the following information for analysis purposes. Thank you.

Gender: Male Female

Age: under 18 19-29 30-49 50-65 over 65

Province or Territory in which you reside: _____

Continued ...

Your annual household income from all sources before taxes is: (Optional)

Choose one:

- Less than \$20000
- \$20000 to \$39999
- \$40000 to \$59000
- \$60000 to \$79000
- \$80000 to \$99000
- More than \$100K

The highest level of schooling you have completed is: (Optional)

Choose one:

- Elementary School or less
- Secondary School
- Community College/CEGEP/Trade School
- Prof./Trade Certification
- Bachelor Degree
- Graduate Degree

Are you a healthcare professional? (Optional)

- Yes
- No

Approximately how many times in the last year have you personally used the healthcare system? (eg. seen a doctor or specialist, spent time in the hospital, received care in a hospital emergency room, etc.) (Optional)

Choose one:

- 0-3
- 4-6
- 7-9
- More than 10

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