PUTTING IT IN CONTEXT: Canadians' views on the financial sustainability, quality and accessibility of healthcare in Canada

A BACKGROUNDER

Healthcare is consistently a top issue for Canadians. At a time when healthcare spending is rising faster than the rate of economic growth, Canadians are concerned about their ability to get the care they need, when they need it. This backgrounder provides insight into public perceptions about the financial sustainability, quality and accessibility of healthcare based on recent public opinion polling.[1, 2] In addition, the backgrounder places these perceptions into the context of research evidence and federal, provincial and territorial initiatives. The Canadian Health Services Research Foundation believes an informed public is possible and desirable. This resource can be used to facilitate informed debate on ways to improve the financial sustainability, quality, and accessibility of healthcare in Canada.

WHAT DO CANADIANS THINK ABOUT THE FINANCIAL SUSTAINABILITY OF THE HEALTHCARE SYSTEM?

The number of Canadians who believe that healthcare in Canada is financially unsustainable has increased over the past decade.

- 19% of Canadians polled in 2000 agreed with the statement "Health costs will rise gradually, but the increase will be manageable due to growth in the economy", while only 7% agreed in 2010.[3]
- 29% of Canadians polled in 2000 agreed with the statement "The demand for health care will increase, but we will be able to contain costs by operating the health care system more efficiently", while only 14% agreed in 2010.[3]

IN CONTEXT

- In Canada, public healthcare spending as a proportion of GDP has risen from 1975 to 2008. Across the provinces, expenditures grew by 1 to 3% over that period (except in Newfoundland and Labrador, where expenditures decreased).[4] However, there have been dramatic increases in certain healthcare costs, including prescription drugs (paid for by a combination of public and private insurance and out-of-pocket payments) and cost related to higher healthcare service utilization and technological innovation.[5, 6] As a percentage of GDP, the cost of prescription drugs more than tripled between 1980 and 2006.[7]

WHAT DO CANADIANS THINK ABOUT PUBLIC HEALTH INSURANCE IN CANADA?

Canadians support the current single-tier system of public health insurance paid for through the tax system, but the vast majority think that coverage should be broadened to cover more types of care.

- 91% of Canadians surveyed in 2006 agreed that publicly insured services should be extended to include access to home care, long-term care, mental healthcare and drug benefits to prevent creation of a "second tier of healthcare".[8]

- 94% of Canadians polled in 2007 strongly or somewhat agreed that if a health professional prescribes a new medication or vaccine, it should be covered by a prescription drug plan.[9]

IN CONTEXT

- Neither home care nor long-term care is defined as medically necessary under the Canada Health Act. Extensive variation exists across and within provinces and territories in terms of the type and level of home- and long-term care services that are publicly provided, application of co-payments and user fees, eligibility criteria, residency requirements, access, wait times and service delivery.[10, 11]

- Outpatient mental health services from a psychologist or counsellor are not defined as medically necessary either, despite the fact that the World Health Organization states that improving mental health is a crucial aspect of the overall health and well-being of individuals.[12] Efforts to improve the mental health of Canadians are underway in Canada. The Mental Health Commission of Canada released a framework for a mental health strategy in Canada in 2009,[13] and is working to develop a mental health strategy that will outline a plan of action for improving the mental health of Canadians; whether this will lead to extended public coverage for and a wider availability of mental health services remains to be seen.

- Access to outpatient prescription drugs also varies widely. Each province decides who is eligible for public coverage (e.g. based on age, disease or income), the level of co-payments or deductibles, and which drugs enter the formulary. In 2010, while 30.2% of prescription drugs were covered by private insurance, 14.7% of prescription drugs were paid for out of pocket by Canadians. National pharmacare programs that would provide national, first-dollar coverage of prescription drugs and reduce or eliminate inequities have been proposed but have not been fully implemented in Canada. For example:

  - The Commission on the Future of Healthcare in Canada headed by Roy Romanow proposed that federal funds should reimburse provinces up to 50% of drug costs under provincial plans to cover catastrophic costs for those who pay over $1500 annually. Based on 2001 figures, the commission estimated such a plan would cost between $749 million and $1.1 billion annually.[15]

  - The Standing Senate Committee on Social Affairs, Science and Technology headed by Michael Kirby proposed that federal funds reimburse provincial and territorial plans 90% of drug costs to cover individuals who spend more than $5000 a year on drugs to ensure no family spends more than 3% of its income on drugs.[16] The committee estimated this plan would cost $500 million in its first year.

  - A federal-provincial-territorial ministerial task force on the National Pharmaceuticals Strategy in 2006 put forth two main options for a pharmacare plan, with four variations for a national catastrophic drug plan.[17] One option proposed coverage of drug costs in excess of 4.3% of family income. Such a plan was estimated to require $6.6 billion annually for those with private insurance and $9.4 billion annually for those without, split between the federal government and the provinces/territories.

  - Marc-André Gagnon and Guillaume Hubert proposed a series of options for public universal drug plans in 2010.[18] Depending on the choice of pharmaceutical pricing and reimbursement policies related to drug costs, they estimate that national pharmacare plans would save Canadians between 10% and 42% of annual drug expenditures. If established with a rigorous drug assessment process (that would determine whether new drugs are more efficient than older drugs), they claim their proposals would also help contain inflation in the cost of drugs in Canada.

WHAT DO CANADIANS THINK ABOUT THE PRIVATIZATION OF HEALTHCARE SERVICES?

Most Canadians oppose further allowances for private financing of healthcare. However, when public financing of healthcare impedes timely access many Canadians are open to private payment options.

- 55% of Canadians polled in 2009 believed more healthcare should be publicly provided, while only 12% believed more services should be privately provided.[19]
- A bare majority (54%) of Canadians polled in 2010 agreed that they should have the right to buy private health care within Canada if they do not receive timely access to services in the public system.[20]
- Eighty-four percent of Canadians polled in 2006 strongly or somewhat agreed that patients should have the ability to seek treatment elsewhere if they have to wait longer than what is considered medically acceptable in the publicly funded system; 84% thought this should be covered under the provincial health insurance plan while only 33% thought it should be covered through the purchase of private insurance.[21] It is not clear whether the lower endorsement of privatization in 2010 is the result of genuine changes in attitudes across time or an artefact of wording changes to polling questions.

IN CONTEXT

- Although healthcare in Canada is largely taxpayer financed (about 70%), health services are also paid for through private insurance or out-of-pocket (about 30%).
- While some argue that for-profit hospitals and long-term care facilities can provide medical services more efficiently and with a lower price tag, the vast majority of studies shows the exact opposite. For instance:
  - Parallel private systems do not cut public waiting lists.[22] In fact, research shows they appear to lengthen waits for healthcare in the public system. A 2004 OECD study[23] on how private financing affects publicly funded healthcare systems found that countries with parallel public and private healthcare systems have the longest waiting times. OECD data from 2005 indicate that countries with parallel public and private health insurance (e.g., Australia, the UK, Spain, Italy and Ireland) also experience significant problems with wait times.[24]
  - Some evidence suggests the quality of care in private for-profit facilities is inferior to that provided in public facilities.[25] For example, a systematic review of American literature indicated that patients undergoing dialysis in for-profit facilities were more likely to die than those in non-profit ones.[26]
  - Parallel private systems may also bleed resources away from the public system. For example, doctors and nurses cannot be in two places at once, so it is possible that the more care they provide in the for-profit sector, the less they can provide in the public sector, thereby creating longer waits for publicly provided care.[27] Indeed, wait times for publicly provided cataract surgery by surgeons who worked in both systems between 1997 and 1999 in Alberta and Manitoba were 11 to 16 weeks longer than for those who only worked in the public system.[28]

WHAT DO CANADIANS THINK ABOUT WAYS TO PAY FOR HEALTHCARE?

To address health system sustainability and affordability, most Canadians point to the need to make the system more efficient and effective. There is also some support for the development of a contribution-based Canada health plan or registered health savings plan. Support for increasing taxes is mixed. Reducing spending on other government programs to address health system sustainability is an unpopular option.

- Most Canadians (91%) agree that the best way to slow the growing costs associated with healthcare is to make the system more efficient and effective.[3]
- 49% of Canadians surveyed in 2010 agreed that they would be willing to pay 10% more in taxes if they knew all of the money would go to healthcare. Only 31% agreed that they would support reducing the amount of money spent on education and social services in order to have more money spent on healthcare. However, when forced to choose among three options for addressing affordability of the healthcare system, most respondents (46%) agreed that "patients should be responsible for paying a portion of the cost of the healthcare they receive," while only 32% agreed that the best solution would be for "governments to raise taxes to cover the cost of healthcare"; even fewer (22%) agreed the best solution would be for governments to "cut spending on other programs like education, transportation and support for the unemployed and pension benefits for retirees".[3]
- 69% and 65% of Canadians, respectively, surveyed in 2010 agreed that developing a contribution-based Canada Health Plan or developing a Registered Health Savings Plan (similar to the Registered Retirement Savings Plan)[i] would be good or very good ideas to ensure enough government tax revenue to pay for future healthcare. Fewer Canadians supported raising taxes over time (35%) or taxing Canadians an additional amount on their annual income tax return (35%).[3]

IN CONTEXT

- To increase the financial sustainability of healthcare, governments can implement policies to contain spending, improve efficiency (value for money) within systems, increase public revenues or reallocate public revenues from other social programs to healthcare, or some combination thereof.[6] In terms of increasing revenue, caution must be exercised to avoid negative fiscal consequences. For example, the economic impacts of a payroll tax increase can include job loss[29] and reduced disposable income of individuals, when considered in isolation. In addition, revenue-generating strategies will have uneven effects on different groups—the poor, the disabled, children and the elderly, among others. Revenue generating strategies that rely on citizens to save money only have the potential to work for citizens who can afford to save, for instance, and thereby threaten fair and equitable access to healthcare. The challenge for governments is to find a way to finance an increase in health-related services that minimizes potential negative effects, while maintaining incentives to improve the overall quality of care. Changing the way services are funded will not inevitably produce a more efficient, effective health care system: that requires reform of the delivery system, such as by improving how providers are organized and funded.[30]

WHAT DO CANADIANS THINK ABOUT ACCESS TO FAMILY DOCTORS AND SPECIALISTS?

The vast majority of Canadians report having access to a family doctor, and rate the services provided by their doctor as excellent or good. Many Canadians, however, rate timely access to both doctor and specialist care poorly.

- 87% of Canadians polled in 2009 claimed to have a family doctor. This varied somewhat across the provinces, with fewer respondents from Quebec citing that they had a family doctor (75%).[31]
- 88% of Canadians polled in 2009 rated the service provided by their family doctor as excellent or good, and this rating was relatively consistent across the provinces.[31]
- 49% of Canadians polled said that timely access to family doctors had worsened over the years 2005 to 2007.[9]
- 57% of Canadians polled in 2009 assigned an "A" or "B" and 42% assigned a "C" or "F" grade to their families' ability to get prompt access to a family doctor in their community. The same poll showed 48% of Canadians assigned an "A" or "B" and 52% assigned a "C" or "F" grade to their families' ability to get prompt access to a medical specialist.[32]

[i] Participants' knowledge about the potential success of such plans is unknown and no information evaluating the success or potential success of such plans was provided in the surveys. The only information provided about the potential contribution-based Canada health plan was that it would "raise revenue and set aside financial resources for individuals who need health care the same way that the Canada Pension Plan works for people who want to retire". The only information provided about the potential Registered Health Savings Plan was that it would be "similar to the Registered Retirement Savings Plan that would allow individuals to save money on a tax-free basis that would be available for them to pay for health services or prescription drugs that are not included in the public health coverage."

IN CONTEXT

- Canada has one of the lowest ratios of practising doctors per 1,000 population among OECD countries.[33] However, evidence suggests that the problem with access to doctors is sometimes not one of supply (not enough doctors) but one of distribution and deployment (where doctors set up practice and what they choose to practice).[34] The proportion of practicing doctors per 100,000 population in Canada increased by 4.1%, more than triple the rate of population growth (1.2%), from 2008 to 2009.[35] Policy efforts could help to alleviate problems such as geographic variation in doctor retention, rising doctor retirement rates, and workload differences where, for example, young doctors are less likely to keep the long hours of their predecessors.[36] The Northern and Rural Recruitment and Retention (NRRR) Initiative in Ontario offers taxable grants ranging from $80,000 to $117,600, paid over a four-year period, to each eligible physician who establishes a full-time practice in an eligible northern or rural community of the province.[37] In February 2011, the federal government announced $39.5 million in funding to support new family medicine positions and training across Canada, including initiatives to support residency training for recent graduates who want to pursue careers in rural and remote areas within Canada.[38] In Manitoba, for instance, the federal funds will support the training of 15 additional family medicine residents through expanding the Northern and Remote Family Medicine Residency Program. In Newfoundland and Labrador, the federal funds will support up to 16 new family medicine residents. In addition, the 2011 federal budget included Canada student loan forgiveness for rural doctors and nurses.

- Expanding the role of nurse practitioners as the first point of contact for patients has helped improve access to primary healthcare for many Canadians. Nurse practitioners—who are educated to conduct health assessments, perform a variety of therapeutic procedures, prescribe drugs, and diagnose and manage common illnesses and injuries through ordering and interpreting diagnostic tests—can deliver those services and produce equivalent patient outcomes.[39] Evidence suggests that Canadians are very satisfied with nurse practitioner care. For example, a 2009 poll revealed that more than three in four respondents would be comfortable seeing a nurse practitioner in lieu of their family doctor.[40]

- By expanding team-based approaches to care, we can also expand the first point of access and create multiple access points for patients to seek care. Teams can include family physicians, nurse practitioners, registered nurses, social workers, dieticians and other professionals. Team-based approaches to care are expanding in Canada. It has been estimated that more than 2.7 million Ontarians experienced improved access to care since the inception of over 200 Family Health Teams in Ontario.[41] Barriers associated with jurisdictional, regulatory and funding issues as well as professional expectations related to scope of practice have impeded expansions in team-based approaches to care, however.[42] The role of pharmacists across Canada is also expanding, with pharmacists in some jurisdictions now able to initiate and adapt prescriptions, administer inoculations and provide emergency prescription refills, thereby improving the safe accessibility of drugs.[43]

- Doctors and nurse practitioners can also help address high demand for appointments by doing as much as possible for patients while they are in the office for any given visit. This practice, called “max-packing,” helps eliminate the need for extra appointments and is a helpful way to provide higher quality care to patients because it anticipates their future needs.[44] Max packing directly contrasts with the “one problem per visit” approach taken by some family doctors[45] that can be encouraged by fee-for-service payment methods.[46]

- Improved access can also be achieved by integrating health services and improving transitions between them. For example, Rapid Access Breast Clinics in Providence Health Care in British Columbia serve to coordinate and organize diagnostic testing for breast cancer screening and have cut the average breast cancer diagnosis time in half.[47] Their success has been attributed to factors including streamlined transitions between diagnostic testing—all diagnostic testing in a single location, accessible through a single access point—and to nurse navigators, who are responsible for facilitating and organizing the entire diagnostic and surgical (if necessary) process for each individual patient.

- Changing the way appointments to primary healthcare providers are booked has also shown promise in improving patient access and reducing non-urgent emergency room visits in Canada. Through the advanced access initiative (also known as same-day scheduling or open access), physicians clear the backlog of pre-booked appointments to accommodate same-day booking.[48] The practice of one family physician who shifted to advanced access booking in the Cape Breton District Health Authority experienced a 28% drop in non-urgent (level 4 and 5) visits to emergency wards.[49]

- Specialist outreach clinics, whereby specialist physicians make planned, regular visits from their standard practice location (usually hospitals or their own private offices in urban areas) to see patients in primary care or rural hospital settings, has been shown to significantly improve access to specialist care for patients and create greater efficiency in the use of hospital-based services.[50, 51] Telemedicine and expanding the roles of general practitioners in providing specialist care services can also improve access to specialist services.[51]

WHAT DO CANADIANS THINK ABOUT ACCESS TO EMERGENCY ROOM SERVICES?

Canadians rate access to emergency room services as particularly poor.

- 54% of Canadians assigned an "A" or "B" grade to access to emergency rooms in 2009, while 27% assigned a "C" and 18% assigned an "F" grade.[32]

IN CONTEXT

- Emergency room overcrowding is a system-wide issue, with many contributing factors such as length of stay of admitted patients, complexity of patient cases, problems with human resources, and poor integration within and between hospitals and from hospitals to communities.[52] Research suggests that simply increasing the number of doctors will not resolve the backlog, but other solutions exist and are being advanced in Canada. For example:

    - Adding nurse practitioners and/or physician assistants to emergency departments can help achieve access within wait-time benchmarks. One study demonstrated that nurse practitioners and physician assistants can reduce length of stay in the ER by half and reduce cases of patients leaving without being seen by one-third.[53]

    - Management initiatives that improve patient flow by prioritizing care for the most urgent cases and streamlining care for less urgent cases can also improve access. For example, St. Paul's Hospital in Vancouver experienced a 50% reduction in wait times after implementing streamlined procedures that include a rapid assessment zone, a special diagnostic and treatment unit and a computerized data collection system, along with increases in the number of doctors and nurses.[54]

    - A rising number of alternate level of care patients reside in Canada's hospitals. This problem results from insufficient resources to support more appropriate care placement (e.g. long-term care facilities or home care) and an increased number of patients requiring complex care.[55] Pockets of excellence exist across Canada where the number of alternate level of care patients in hospitals has been reduced, which creates capacity in hospitals and improves emergency room utilization. One example is the *Home First* program at Halton Healthcare Services in Ontario. Through the program, in-hospital alternate level of care days declined from 28% to 3-5% when clinicians were required to consider home as the first discharge option (with appropriate community support, such as home care) rather than long-term care.[56]

WHAT DO CANADIANS THINK ABOUT THE OVERALL QUALITY OF THEIR HEALTHCARE?

Canadians are confident that if they become seriously ill they will have access to high-quality, safe medical care. At the same time, many believe they are not receiving high-quality healthcare. A small majority of respondents to one survey in 2010 felt the healthcare system was in a "state of crisis".

- 80% of respondents polled in 2007 were somewhat or very confident that if they became seriously ill they would have access to high-quality, safe medical care.[55]
- 57% of respondents polled in 2007 agreed that "Canadians are receiving quality health care", representing similar results to those obtained in 2002.[58]
- 51% of respondents surveyed in 2009 believed healthcare services in their communities would get "much better" or "somewhat better" over the next two to three years rather than "somewhat worse" or "worse," representing similar results to those obtained in 2005 (47%).[32]
- 52% of respondents surveyed in 2010 claimed healthcare is in a "state of crisis", while only 43% judged it to be "basically in good shape."[20]
- 60% of Canadians surveyed in 2007 agreed that "there are some good things in our health system, but fundamental changes are needed to make it work better."[55]

IN CONTEXT

- Quality in healthcare means many things: *effectiveness* of the healthcare sector in improving health outcomes; *access* to healthcare services; the *capacity* of systems to deliver appropriate services; the *safety* of care delivered; the degree to which healthcare in Canada is *patient-centred*; and equity in healthcare outcomes and delivery.
- In order to take stock of existing data and metrics on healthcare quality in Canada, the Canadian Health Services Research Foundation (CHSRF), in collaboration with the Canadian Institute for Health Information (CIHI), the Canadian Patient Safety Institute (CPSI), and Statistics Canada, commissioned *Quality of Healthcare in Canada: A Chartbook*.[57] The Canadian chartbook examined international, national and provincial/territorial data and showed that, in recent years, the amount of available data and information relevant to the quality of healthcare in Canada—produced by national, provincial, territorial, academic, professional and patient organizations—has grown. The chartbook sought to draw these disparate pieces of data together to build a broad and coherent picture of the quality of healthcare in Canada. It shows, for instance:
  - Canada's mortality rate dropped by 13.6% over the five-year period from 1997–98 to 2002–03.[60] Canada has also seen significant decline in mortality rates from major killers such as cancer and heart disease in recent years (1992–2005).[57] It is possible that such improvements are related to improvements in the effectiveness of healthcare.
  - In terms of capacity, Canada has a relatively low level of practicing physicians per person (about 1 per 1000) and its use of information technology appears less developed than in many comparable countries.[57]
  - Canada does not include an explicit focus on patient-centredness or responsiveness in the concepts underpinning quality measurement and reporting.[57]
  - There is no comprehensive, pan-Canadian data set on equity, but it is possible to draw some conclusions from the data that are available. Notably, there are concerns about the deficiencies in the health status of aboriginal people and their ability to access high-quality healthcare. There is also a clear correlation between low income/socio-economic status and poor health status in Canada. An international survey found that because of cost concerns, 16% of Canadians did not fill a prescription or skipped doses, and that 29% did not seek needed dental care.[57]
- The 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-year Plan to Strengthen Health Care* set out to improve access to healthcare in several areas, for example by improving wait times for priority

procedures and improving pharmaceuticals management. A report released by the Health Council of Canada in 2011[43] illustrates that some progress has been made in improving healthcare quality in these (and other) areas. For example:

- There were improvements in the number of people who received hip and cataract surgery within provincial benchmarks for acceptable wait times. For example, Saskatchewan, New Brunswick, Nova Scotia and Prince Edward Island had at least a 10% increase in the proportion of patients who received hip replacements within the benchmark. However, this improvement varied substantially across provinces between 2008 and 2010; in some provinces, wait-times worsened (e.g., Manitoba) and other provinces did not have data available to assess the improvement (e.g., Newfoundland and Labrador).[59] Few improvements were realized in wait times for knee surgeries, with less than 75% of patients receiving the surgery within the wait-time benchmark of 182 days. Despite mixed progress on improving wait times, provinces have made significant advances in measuring and evaluating wait times; before the onset of the accord, this information was generally not available.
- Long waits persist for MRIs in many jurisdictions and there are no pan-Canadian benchmarks for MRI and CT scan wait times.[41]
- There has been some progress in implementing a national pharmaceutical strategy.[43] However, some provinces have implemented drug information systems that can improve the quality of patient care by reducing the probability of adverse drug interactions and abuse. Pharmacists' scope of practice has also expanded in some provinces, enabling them to prescribe drugs or change prescription formulations, perform inoculations, and fill emergency prescriptions.
- Most jurisdictions have improved 24/7 access to a health care provider by using a combination of after-hours services in physicians' offices, emergency departments and tele-triage services.[43]

- Medication errors persist as a relatively common and potentially life-threatening occurrence in Canada, with estimates that adverse drug events account for 24% of total adverse events.[62] The main causes of medication errors have been shown to be inappropriate prescribing by professionals, skipped doses or incorrect dosage use by patients, and the lack of systems for continuous and adequate tracking of problems.[63] The *Safer Healthcare Now!* campaign, Canada's largest patient-safety initiative, launched in 2005, has led to a reduction in adverse events such as hospital-acquired infections and harm associated with medication errors.[64]

There are gaps between public perception and the current state of healthcare financial sustainability, quality and accessibility. Meaningful and sustainable improvement to healthcare requires shifts in the way healthcare is funded and delivered as well informed public engagement on how such changes should be executed. Citizens can make an important contribution to improving healthcare if they are supported in doing so.

MORE INFORMATION ON THE POLLING DATA CITED AND CHSRF KNOWLEDGE EXCHANGE PRODUCTS:

- The poll results cited in this brief are from Ipsos-Reid, The Strategic Counsel, Environics, Pollara, and Harris/Decima. Polls were conducted by telephone, on line, or a combination of both, and sample sizes ranged from 1002 to 3483. Although measures were taken to minimize error, such as through weighting data to better reflect regional, age and gender composition of the Canadian population, all polls are subject to error, including but not limited to coverage error and measurement error. Reported margins of error are often larger within regions and for sub-groupings of the population. For more information about the polls reported here, refer to the references cited and to *Soroka, S. N. (2011). Public Perceptions and Media Coverage of the Canadian Healthcare System. A report to the Canadian Health Services Research Foundation and Soroka, S.N.*

& Fournier, P. (2011). The Sources of Attitudes on the Canadian Healthcare System. A report to the Canadian Health Services Research Foundation. For more information on CHSRF's Mythbusters and other knowledge exchange products, see www.chsrf.ca.

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