RESEARCH PAPER

Canadians' Views about Health System Performance

Point de vue des Canadiens sur le rendement du système de santé

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Abstract

Objectives and methods: The re-negotiation of the 10-year 2004 First Ministers' Accord provides an opportunity to review medicare's fundamentals. We used the published results from 13 Commonwealth Fund international health surveys to assess Canadians' views of health system performance and compared these to the views of respondents from Australia, the United Kingdom and the United States.

Results: Although a majority of Canadians wish to see fundamental change to their health system, medicare performs relatively well in an international context on key dimensions of access.

Conclusion: Canadians see a need for improvement in the healthcare system, particularly access to prescription medications.

Résumé

Objectifs et méthode : La renégociation de l'Accord décennal des premiers ministres (2004), est l'occasion de réviser les principes de base de l'assurance maladie. Nous avons utilisé les résultats publiés dans le cadre de 13 enquêtes internationales sur la santé, menées par le Fonds du

Commonwealth, afin d'évaluer le point de vue des Canadiens sur le rendement du système de santé, et nous avons comparé ces résultats à ceux obtenus en Australie, au Royaume-Uni et aux États-Unis.
Résultats : Bien que la majorité des Canadiens souhaitent voir des changements fondamentaux dans le système de santé, le rendement de l'assurance maladie sur les principaux aspects de l'accessibilité est relativement bon comparé au contexte international.
Conclusion : Les Canadiens expriment le besoin d'un changement dans le système de santé, particulièrement dans l'accès aux médicaments sur ordonnance.

The 2004 First Ministers' Accord on Health Care Renewal set the framework for Canadians' experience of medicare for a decade. It involved a generous financial settlement for the provinces and included actions designed to address the contemporary problems of long waits for a select list of elective procedures and diagnostic imaging examinations. The fiscal and political environment for the 2014 re-negotiations is very different from that of a decade ago. Although the federal government committed during the 2011 election campaign to continue current levels of indexation of the federal transfers to the provinces, the current (Conservative) government is probably less sympathetic to expanding the medicare promise than a Liberal or NDP government would be.

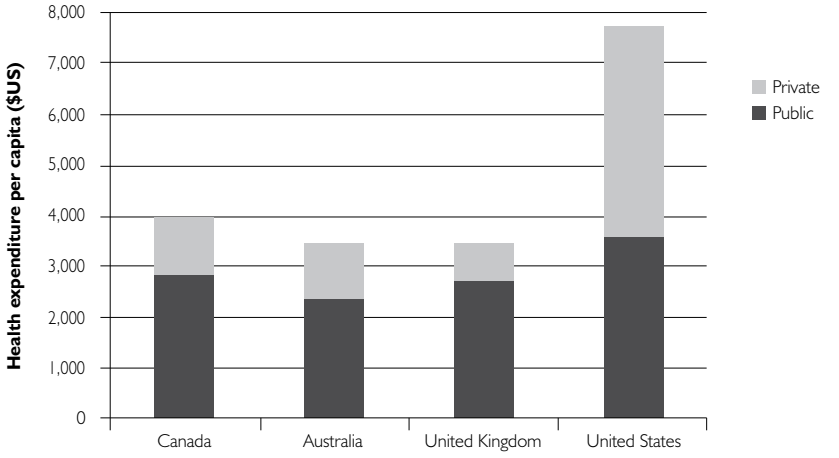
As 2014 approaches, many organizations are advancing their proposals for change. But how much change to medicare do Canadians want? And are Canadians' concerns the same as they were a decade ago?

The Commonwealth Fund has conducted an International Health Policy survey on healthcare systems annually in Australia, Canada, New Zealand, the United Kingdom and the United States since 1998, expanding to France, Germany, Italy, the Netherlands, Norway, Sweden and Switzerland more recently. The surveys initially sampled consumer views, but later surveys also sampled provider views. These surveys present the opportunity to track how Canadians' views have changed on critical issues, such as how much change to their healthcare system is perceived as necessary and dimensions of satisfaction with healthcare.

This paper uses the published results of 13 years of consecutive Commonwealth Fund International Health Policy surveys from 1998 to 2010 ("the surveys") to assess these issues in the Canadian context. It compares Canadians' views with those of respondents from three other countries: Canada's nearest neighbour, the United States of America; the United Kingdom, a country almost the polar opposite of the United States in health system design and funding; and Australia, a country positioned midway between the United States and the United Kingdom in system design.

The health systems of these countries are quite different in levels of health expenditure and the proportion funded from private sources (see Figure 1).

FIGURE 1. Per capita health expenditure, selected countries, by source of finance, 2008 (adjusted to $US purchasing power parity)



Source: OECD Health Data 2011

The United States is an outlier in almost all comparative analyses of health expenditure (Anderson et al. 2003) and the only one of the four countries without universal health coverage. As shown in Figure 1, it has substantially greater spending per capita. Australia and the United Kingdom spend roughly comparable amounts, with Canada spending about 20%–25% more than these two countries. The role of private funding (including private insurance and out-of-pocket payments) is significantly different across the four countries. Just over half (54%) of healthcare funding in the United States comes from private sources, in contrast to just under one-third in Canada (30%) and Australia (32%) and under one-fifth in the United Kingdom (18%). Public sector spending per capita is more consistent across countries (Canada's expenditure is 5% greater than that of the United Kingdom and 20% greater than Australia's).

The scope of public financing also differs among the four countries. In Canada, medicare provides universal coverage, free at point of service, for hospital and physician services ("insured services" under the *Canada Health Act*). Other health services (including pharmaceuticals) have variable coverage across the country, with different groups being subsidized for different services in different provinces. Australia has universal coverage for physician and hospital services as well as pharmaceuticals, although there are mandated co-payments for pharmaceuticals and physician fees are not regulated, so patients may face out-of-pocket costs for these services. In contrast to Canada and Australia, which have health systems based on fee-for-service for physician services, the United Kingdom has a national health service that incorporates a somewhat broader scope of coverage beyond physician and hospital services than the other two countries.

The United States has multiple arrangements for different population segments: Medicare, covering physician and hospital access for the elderly; Medicaid, which varies by state, for the poor; a national health service–type system for veterans; and employer-based private insurance. A significant percentage of the population is left uncovered: this group is the object of the recent health reforms in the United States, which will come into force from 2014 onward.

The absence of universal coverage and the consequent greater role of private sector funding in the United States create financial barriers to access for the uninsured or marginally insured (American College of Physicians 2008). In contrast, the lower level of spending in the other three countries is associated with time barriers to access (Siciliani and Hurst 2005). Both these issues were explored in the surveys.

Method

The surveys used a cross-sectional observational study design, in which respondents were asked about their experiences with their country's healthcare system in recent years, as well as future concerns. The questionnaires were designed by researchers at the Commonwealth Fund and Harris Interactive, with advice and review by experts in each country. Questionnaires were slightly modified by experts in each country to account for differences in terminology. Four of the 13 surveys present the views of providers of healthcare: executives of large hospitals in 2003 (Blendon et al. 2004) and physicians in 2000 (Blendon et al. 2001), 2006 (Schoen et al. 2006) and 2009 (Schoen, Osborn, Doty et al. 2009). The other surveys address the experiences and views of different consumer groups: the elderly in 1999 (Donelan et al. 2000); sicker adults in 2002 (Blendon et al. 2003), 2005 (Schoen et al. 2005) and 2008 (Schoen, Osborn, How et al. 2009); and randomly sampled ("ordinary") adults in the remaining years, 1998 (Donelan et al. 1999), 2001 (Blendon et al. 2002), 2004 (Schoen et al. 2004), 2007 (Schoen et al. 2007) and 2010 (Schoen et al. 2010).

Table 1 provides a summary of the main characteristics of the surveys, identifying the subsection of the population targeted by the survey and the number of individuals sampled in each country for each survey year.

TABLE 1. Characteristics of Commonwealth Fund surveys, selected countries

Survey Year	Survey Population	Published Results	Interview Method	Survey Sample			
				Canada	Australia	United Kingdom	United States
1998	Adults aged 18 and older	Donelan et al. 1999	Telephone (except UK, where face-to-face)	1,006	1,001	1,043	1,010
1999	Non-institutionalized adults aged 65 and older	Donelan et al. 2000	Telephone	700	701	714	700
2000	Stratified sample of generalist and specialist physicians	Blendon et al. 2001	Mail, telephone and Internet	533	517	500	528
2001	Adults aged 18 and older	Blendon et al. 2002	Telephone	1,400	1,412	1,400	1,401

TABLE 1. Continued

Survey Year	Survey Population	Published Results	Interview Method	Survey Sample			
				Canada	Australia	United Kingdom	United States
2002	Adults with health problems who met at least one of four criteria*	Blendon et al. 2003	Telephone	750	844	750	755
2003	Random sample of executives from largest general or paediatric hospitals in each country	Blendon et al. 2004	Telephone	102	100	103	205
2004	Adults aged 18 and older	Schoen et al. 2004	Telephone	1,410	1,400	3,061	1,401
2005	Adults with health problems who met at least one of four criteria*	Schoen et al. 2005	Telephone	751	702	1,770	1,527
2006	Primary care physicians	Schoen et al. 2006	Telephone and mail	578	1,003	1,063	1,004
2007	Adults aged 18 and older	Schoen et al. 2007	Telephone	3,003	1,009	1,434	2,500
2008	Adults with health problems who met at least one of four criteria*	Schoen, Osborn, How et al. 2009	Telephone	2,635	750	1,200	1,205
2009	Primary care physicians	Schoen, Osborn, Doty et al. 2009	Telephone and mail	1,401	1,016	1,062	1,442
2010	Adults aged 18 and older	Schoen et al. 2010	Telephone	3,302	3,552	1,511	2,501

* Criteria used to identify respondents: (a) Reported their health as fair or poor; (b) reported that they had had serious illness, injury or disability that required intensive medical care in the past two years; or (c) reported that in the past two years they had undergone major surgery or (d) had been hospitalized for something other than a normal, uncomplicated delivery.

The surveys were comprehensive, asking numerous questions about different aspects of the healthcare system. This paper focuses first on overall attitudes to the need for system redesign and on those questions particularly affecting consumers – specifically, questions relating to timely access and financial barriers to healthcare.

Results

The surveys asked respondents an overall question about the extent of health system change they thought was necessary (see Table 2 and Figure 2). Three standard choices were given:

- On the whole, the system works pretty well, and only minor changes are necessary to make it work better ("minor change").
- There are some good things in our healthcare system, but fundamental changes are needed to make it work better ("fundamental change").
- Our healthcare system has so much wrong with it that we need to completely rebuild it ("complete rebuild").

Figure 2 reveals substantial dissatisfaction across all countries, over all time periods and all groups (see Table 2 for numeric results for all groups). In only one survey group (United Kingdom, 2010, randomly selected adults) did a majority respond that only minor change was necessary. Canadians are less inclined to think that the health system has so much wrong with it that it needs a complete rebuild compared to Australians and residents of the United States. About a fifth to a third of Canadians, a significant minority, think that only minor change is necessary to the system; the proportion who think that only minor change is necessary appears to be increasing. However, since 2000, on average, 50%–60% of Canadians see much merit in the health system but still look to "fundamental change."

FIGURE 2. Extent of change necessary in healthcare system (percentage distribution), 1998–2010

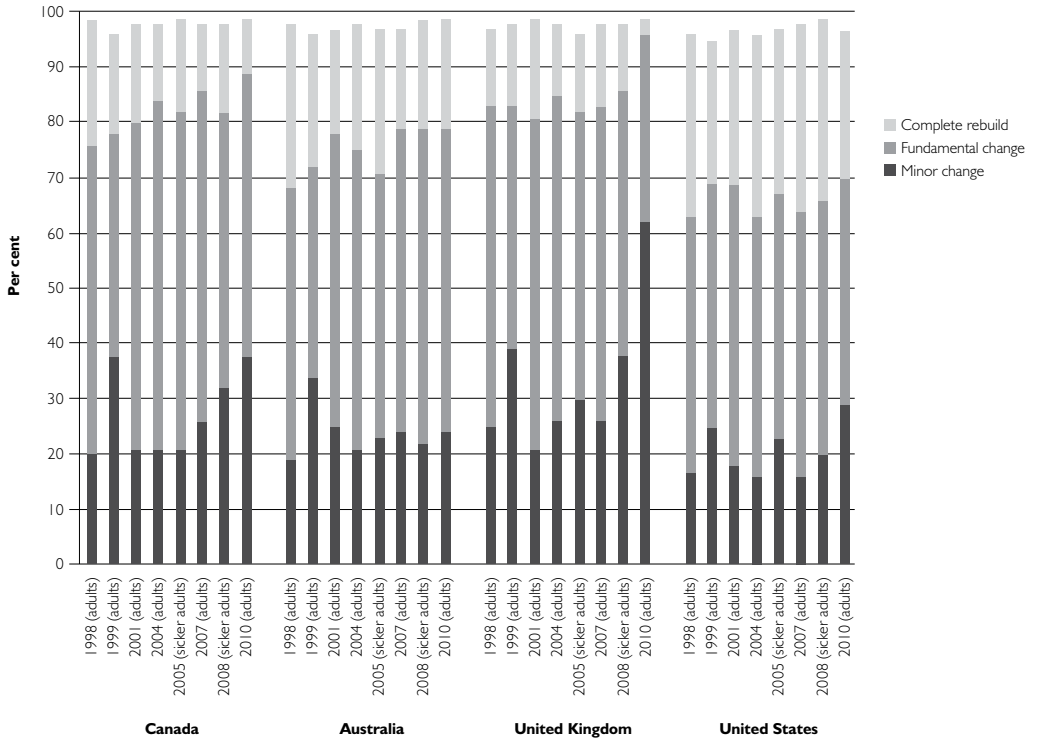


TABLE 2. Respondents' views of extent of change necessary in healthcare system

			Canada	Australia	UK	US
Survey Year	**Survey Group**	**Providers**				
2000	Physicians	Minor change	24	27	23	17
		Fundamental change	72	66	70	71
		Complete rebuild	4	7	12	12
2009	Physicians	Minor change	33	23	47	17
		Fundamental change	62	71	50	67
		Complete rebuild	4	6	3	15
		Consumers				
1998	Ordinary	Minor change	20	19	25	17
		Fundamental change	56	49	58	46
		Complete rebuild	23	30	14	33
1999	Elderly	Minor change	38	34	39	25
		Fundamental change	40	38	44	44
		Complete rebuild	18	24	15	26
2001	Ordinary	Minor change	21	25	21	18
		Fundamental change	59	53	60	51
		Complete rebuild	18	19	18	28
2004	Ordinary	Minor change	21	21	26	16
		Fundamental change	63	54	59	47
		Complete rebuild	14	23	13	33
2005	Sicker	Minor change	21	23	30	23
		Fundamental change	61	48	52	44
		Complete rebuild	17	26	14	30
2007	Ordinary	Minor change	26	24	26	16
		Fundamental change	60	55	57	48
		Complete rebuild	12	18	15	34
2008	Sicker	Minor change	32	22	38	20
		Fundamental change	50	57	48	46
		Complete rebuild	16	20	12	33
2010	Ordinary	Minor change	38	24	62	29
		Fundamental change	51	55	34	41
		Complete rebuild	10	20	3	27

Financial burdens of healthcare

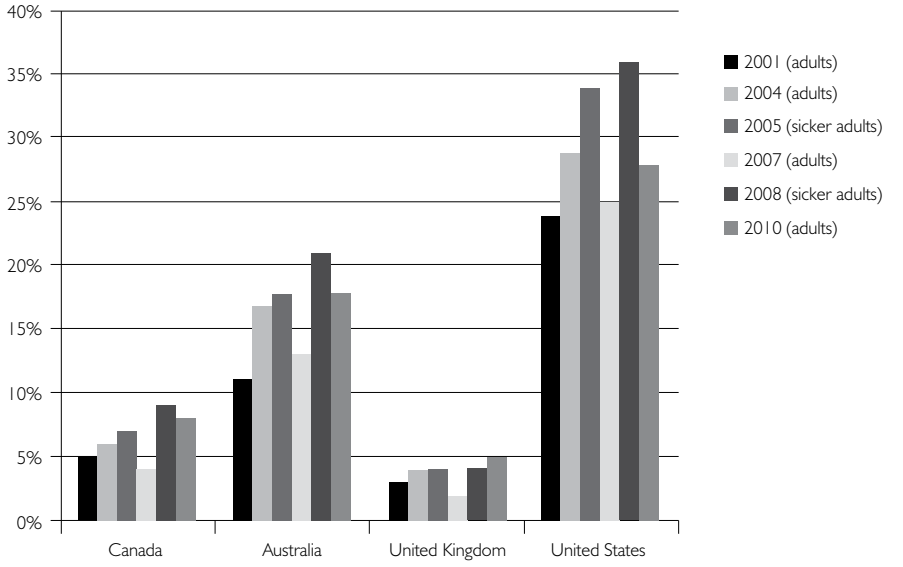
Financial barriers to access to a broad range of health services (physicians, dental care) were assessed through questions about deferral of needed care and difficulties paying for care (Table 3 see online at: *http://www.longwoods.com/content/22750*).

The surveys indicate clear trends about financial concerns and barriers to healthcare: the United States is consistently poorer in providing affordable healthcare and the United Kingdom is consistently the best, with Canadians reporting close to the UK pattern, other

than for dental care, which is not covered under medicare, where Canadians reported higher levels of deferred care.

In general, respondents from the United States were the most likely to report affordability concerns. Respondents from the United States across all the surveys were the most likely to have gone without care from a physician because of cost (see Figure 3) and to have high out-of-pocket expenses and significant difficulty affording prescription medication. Conversely, respondents in the United Kingdom were the least likely to report access problems due to cost. Canadians' experience was relatively good, somewhat worse than the United Kingdom's but not as poor as either Australia's or, particularly, that of the United States.

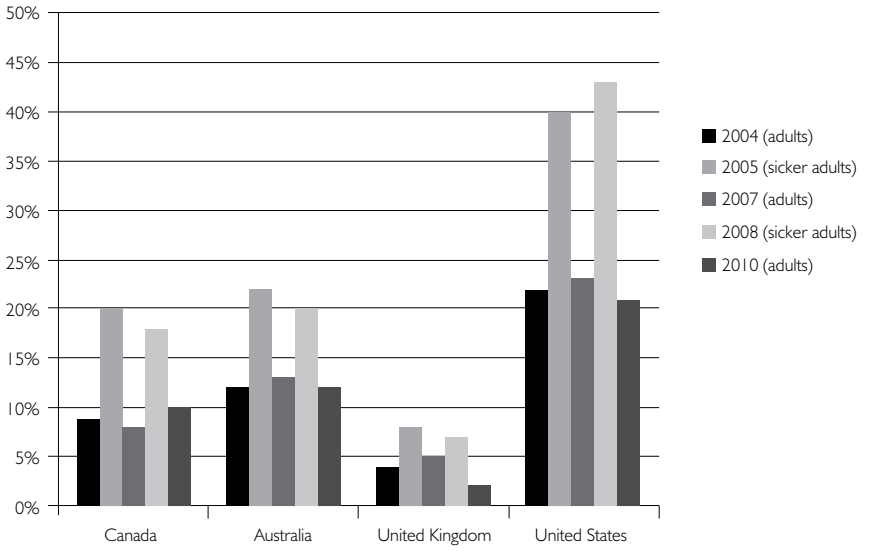
FIGURE 3. Percentage of respondents who had a medical problem but did not visit doctor owing to cost



The 2005 and 2008 surveys targeted sicker adults, those most likely to have high medical costs and thus, potentially facing greater financial barriers when accessing care. Again, the United States performed noticeably poorly in terms of barriers to physician care (Figure 3) and pharmaceuticals (Figure 4) for this group.

Pharmaceuticals are not covered by medicare in Canada and are subject to mandated co-payments in Australia. Respondents in the 2005 and 2008 surveys of sicker adults showed a different pattern from that of "ordinary adults" in those two countries, reporting higher rates of unfilled prescriptions or missed doses (Figure 4). "Ordinary adults" in both countries reported higher unfilled/missed dose rates than those in the United Kingdom, probably reflecting differences in pharmaceutical coverage. The proportion of Canadians responding that they did not fill a prescription was generally about twice that reporting not accessing medical care.

FIGURE 4. Percentage of respondents who did not fill a prescription or skipped a dose owing to cost



PROVIDERS' VIEWS

The views held by US consumers, that they are faced with considerable financial barriers, were shared by US providers. Well over half the United States' physicians surveyed in 2000 thought that patients often have difficulty affording out-of-pocket expenses, and nearly half reported that patients could not afford necessary prescription drugs. Canadian providers reported the least concern that their consumers have financial difficulty paying out-of-pocket expense, with 20% reporting this as a problem. Only 10% of United Kingdom and Australian providers reported that a major problem was consumers' inability to afford prescription drugs, one-fifth the proportion reported by United States physicians.

In contrast to the relatively low levels of problems with financial barriers to access reported in the countries with universal coverage, all four countries reported high levels of concern about future affordability, almost always above one-fifth of those surveyed (see Table 4).

TABLE 4. Financial barriers to healthcare: future concerns

		Concerns of the Future	Canada	Australia	UK	US
Survey Year	**Survey Group**	**Providers**				
2000	Physicians	Percentage concerned that in the future patients will not be able to afford the care they need	32%	34%	23%	54%
		Consumers				
1998	Ordinary	Percentage worried that they won't be able to afford needed medical care for future illnesses	22%	25%	14%	23%
2001	Ordinary		20%	26%	15%	29%
1998	Ordinary	Percentage worried that they won't be able to pay for long-term care of family member for future illnesses	31%	37%	17%	36%
2001	Ordinary		26%	30%	23%	35%

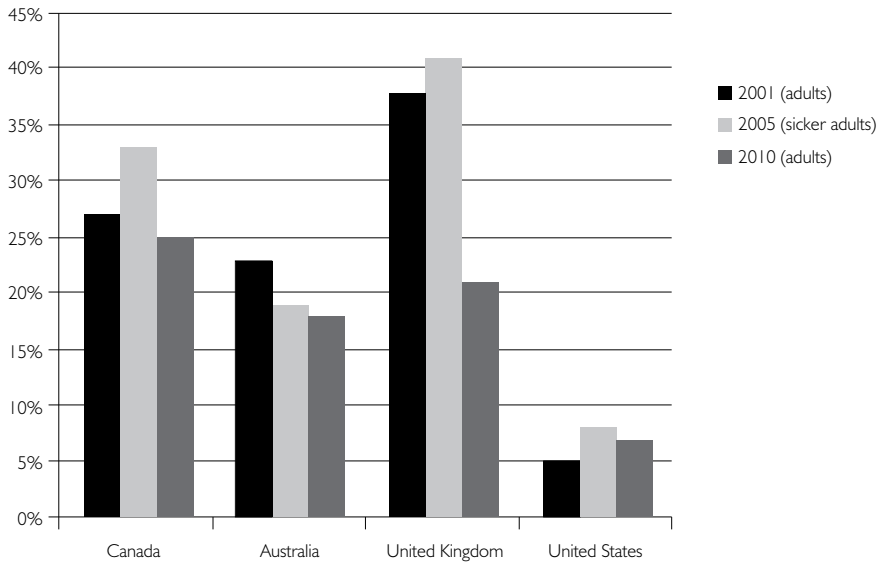
Access barriers to healthcare

Access barriers represent another impediment to individuals' ability to access timely healthcare, with the survey results for this dimension reported in Tables 5 and 6, available online at: *http://www.longwoods.com/content/22750*. The findings in relation to access barriers from the surveys are not as stark as those about financial constraints. However, clear trends can be identified about the impact of the health system structure on access. While results are mixed, respondents in Canada, followed by respondents in the United Kingdom, were the most likely to report problems with access to healthcare. On this dimension the United States is generally in front, with better outcomes in terms of access compared to the other three countries.

Unlike the poor findings in terms of financial barriers, US respondents consistently reported the lowest level of concerns and problems with waiting times for non-emergency care, the lowest percentage who reported waiting for an extended period of time for elective surgery and the highest percentage waiting less than a month for elective surgery.

Reported extended elective surgery waits have improved over time, especially in the United Kingdom, where over one-third of respondents reported waiting more than four months for elective surgery in earlier surveys, dropping to around 20% in the most recent survey (Figure 5). As a result, Canada appears to have shifted from second-highest reported extended waits to the highest.

FIGURE 5. Percentage of respondents whose wait for elective or non-emergency surgery was more than four months



All countries reported that waiting times for emergency care was a problem, with at least one in four respondents in each of the countries identifying this. Canada had the highest per-

centage who reported waiting in emergency rooms for more than two hours and that waiting for emergency care was a problem.

Sicker respondents in the United States were particularly disadvantaged in terms of financial barriers to healthcare. However, the surveys indicate that sicker respondents in the United States consistently reported the lowest waiting times for non-emergency care out of the five countries. No country is consistently the worst at providing sick respondents with timely healthcare. However, in both the United Kingdom and Canada, relatively higher percentages of people reported waiting times as a major problem, waiting extended periods for elective surgery. Correspondingly lower proportions reported waiting less than a month for elective surgery.

PROVIDERS' VIEWS

Providers surveyed in the United States share similar views to those of their consumers, reporting lower concern about the impact of waiting times on patients' ability to access care, although executives surveyed in 2003 reported the second-highest percentage stating that waiting times were getting longer and the second-lowest percentage stating that they were getting shorter.

Providers surveyed in Australia, Canada and the United Kingdom all expressed concern about waiting times for patients. UK health providers were the most concerned about patients waiting more than six months for elective surgery (22% reporting "very often" and 35% reporting "often") and that patients experience long waits for diagnostic tests (57%). However, providers in the United Kingdom appeared most confident about trends, with the highest percentage reporting that waiting times were shortening and the lowest percentage stating that they had lengthened. Nearly three-quarters of Canadian providers in 2000 reported that patients will wait longer than they should for medical care in the future. Canadian providers reported the highest percentage stating that waiting times had lengthened and the lowest percentage stating that they had shortened.

ACCESS TO SPECIALISTS AND IN-HOURS AND OUT-OF-HOURS CARE

The ability of people to access specialists and healthcare "in hours" as well as "out of hours" is another critical measure of access. In different countries, the ability to access timely healthcare varies in terms of hours in which healthcare is needed. In-hours care refers to care accessed within standard working hours, typically 9 a.m. to 5 p.m. weekdays, with slight variations in these hours. Out-of-hours care refers to care needed in the evenings and on weekends and holidays. Table 6 highlights questions regarding access to specialists, in-hours care and out-of-hours care.

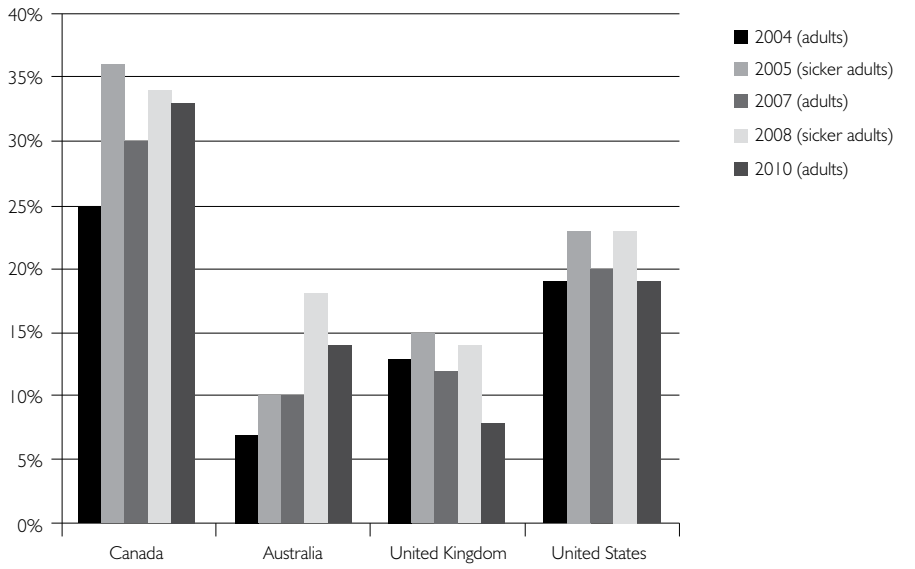
Canadians generally reported the highest percentage of respondents finding it "extremely difficult" and "very difficult" to see a specialist when needed. The UK respondents also reported high percentages who had difficulty accessing specialists. Respondents in the United States were the most likely to report less difficulty seeing a specialist. Australians sat between the United Kingdom and the United States. Providers in the United States agreed with consumers, having the lowest proportion (29%) reporting that limitations on, or long waits for, specialist referrals was a major problem. UK providers reported the highest proportion, at 84%.

A clear trend emerged in terms of national respondents in each country's ability to get in-hours care. Australians reported the easiest ability to get same-day appointments with a doctor and the lowest percentages reporting that they had to wait six days or more. Canadian respondents reported the lowest percentages of those who were able to get same-day appointments and the highest waiting six days or more.

Lastly, a barrier to timely healthcare is the ability to access care out of hours on weekends, evenings and holidays without going to a hospital emergency room. Residents of all countries reported access difficulties on this dimension. About 55%–65% of respondents in Canada, Australia and the United States reported it was "very difficult" or "somewhat difficult" getting care on nights, weekends or holidays without going to the hospital emergency room. Respondents from the United States were somewhat less likely to report out-of-hours access difficulties (38%–55%).

About one-third of respondents in Australia, the United Kingdom and the United States in 2004 and 2007 (ordinary adults) who attended emergency rooms in the previous 12 months reported waiting more than two hours in the emergency room for care; Canadian performance was worse on this dimension, at 46%–48%.

FIGURE 6. Percentage of respondents who waited six days or more to see doctor when sick or needing medical attention



Discussion and Conclusion

We have synthesized data from 13 surveys conducted by the Commonwealth Fund to assess Canadians' perceptions of health system functioning, comparing these with the views of residents of Australia, the United Kingdom and the United States. Although similar questions

were asked across all surveys, the sample populations differed across the surveys (providers, sicker consumers, "ordinary" consumers). We have focused particularly on access barriers, both financial and wait times.

The results are reported as the views of "Canadians." But the Canadian healthcare system is managed differently in different provinces, to the extent that it has been described as a "set of centralized provincial systems" (DiMatteo 2009). The published data do not distinguish the Canadian results by province and so it is not possible, from this data source, to compare provincial variation in perceptions. However, given the differences among the provinces in spending levels and organizational arrangements, it is reasonable to assume that there is provincial variation and thus Canadians' experience of healthcare as reported here might be affected by the size of the samples in different provinces (larger provinces will predominate).

When asked to describe their views of needed change in the health system, more than half the Canadian respondents to these international surveys over the last decade answered that "there are some good things in our healthcare system, but fundamental changes are needed to make it work better." Canadian responses were, in that sense, similar to those from respondents in Australia, the United Kingdom and the United States. However, a significant but increasing minority of Canadian respondents thought that "on the whole, the system works pretty well and only minor changes are necessary to make it work better."

A response that "fundamental changes are needed" gives little guidance about the direction of change. Are respondents suggesting, as some commentators have proposed, that there should be a greater level of private funding in the Canadian health system? Or is that an anathema? Unfortunately, the data source used here does not allow us to tease out the "whys" in detail. But we can use the surveys to identify where the health system seems to be failing Canadians (at least, relative to people in other countries).

First, it's important to recognize that the Canadian health system is not just medicare. Medicare is a financing arrangement; the core criteria for medicare relate to physicians and hospitals, not the myriad other aspects of the system.

One aspect where Canadians' experience, as reported in these surveys, appears to be poor is in terms of access to medications:

- One-fifth of sicker Canadians didn't have prescriptions filled or skipped a dose because of cost.
- Around one-quarter of primary care physicians reported that their patients often had difficulty paying for prescriptions.

The United Kingdom fared much better on this dimension.

This weakness in pharmaceutical coverage may be influencing respondents to see "fundamental change" as necessary. Medicare, at its foundation, did not make explicit provision to eliminate financial barriers to access to pharmaceuticals. As a result, provinces have highly variable programs of addressing drug coverage, and people with significant chronic conditions

and pharmaceutical needs may face financial hardship to pay for care, relocate to ensure better long-term coverage, and be admitted or stay longer in hospitals simply to obtain drug treatment under hospital medicare coverage. The absence of systematic coverage of pharmaceuticals is a significant weakness for the Canadian healthcare system and needs to be remedied. A potential policy response might be limited catastrophic coverage (Evans 2009) or some form of universal pharmacare, which may even be cost neutral or lead to savings in total pharmaceutical expenditure (Gagnon 2010). The precise way in which pharmaceuticals will be covered should be negotiated as part of the 2014 Accord renewal.

Canada's poorer performance on wait times as reported in these surveys may also lead to a perceived need for "fundamental change." Despite the medicare promise of "reasonable access" (the term used in section 12 of the *Canada Health Act*), Canadians reported waiting at almost every point of the care journey:

- One-third of Canadians reported waiting more than six days to see a physician; the next poorest performer was the United States, at 19%.
- Canadians reported waiting longer for emergency care than respondents in other countries. Almost half reported waiting more than two hours, compared to around one-third waiting this long in other countries.
- More than half of Canadian respondents reported waiting more than four weeks to see a specialist, again the worst performance of the countries reported here.
- About one-quarter of respondents in the 2010 survey reported waiting more than four months for elective surgery, this now being worse than other respondents in other countries.

As Chief Justice Beverley McLachlin noted, "access to a waiting list is not access to health care" (*Chaoulli v. Quebec* 2005). A commitment to improve access, with some funding to support that, was a feature of the 2004 Accord, although clearly problems still exist, and there is some evidence of inequity in access to services covered by medicare, such as specialists (Curtis and MacMinn 2008). Respondents might be looking to see "fundamental changes" as necessary to improve access. These changes should start with better reporting and accountability.

Tracking of wait times in Canada is patchy and inconsistent, and "much of the wait time picture remains clouded in mystery" (Wait Time Alliance 2010). Patients want clearer, better information about waits (Bruni et al. 2010). There is no standardization of definitions among provinces, and in some cases there is no standardization within provinces (Sanmartin et al. 2003). Public wait time reporting is almost exclusively limited to the five "priority areas" originally established as part of the 2004 Accord: joint replacement (hip and knee), cataract surgery, coronary artery bypass graft, diagnostic imaging (MRI and CT) and radiation therapy. There is no evidence that these conditions are serving as indicators for whole-system performance, and a continued focus on a limited range of conditions seems inappropriate.

Although measuring provides the base, measurement without active intervention is futile. Incentives on services to manage waiting lists through targets with sanctions and rewards

are effective in bringing down long waits (Siciliani and Hurst 2005; Hauck and Street 2007; Propper et al. 2008, 2010) but carry a gaming risk (Kreindler 2010). The English waiting time targets are much more aggressive than Canada's, covering the whole wait of a patient, in a much shorter time. Implementation has been driven aggressively, and waiting times in England have dramatically improved (Appleby 2011). Quebec has given some force to its waiting time targets by introducing a "guarantee" that where targets are not achieved, the patient has redress through funded access to alternative provision (Prémont 2007). A guarantee, of course, is necessary only if there is extensive failure to achieve the announced targets.

The 2014 Accord should go farther than the 2004 Accord in ensuring accountability and action with respect to waiting times. Provinces should be required to commit in the new Accord to adopting common definitions of waiting times for the full patient journey. The new Accord should include new waiting time targets for a broad range of services and a requirement/commitment for provinces to publish consistent data on achievement of those targets at least quarterly.

It is also important to note that relatively few Canadians answered that "our healthcare system has so much wrong with it that we need to completely rebuild it." What respondents in these surveys seem to be saying is that, overall, the Canadian system is good. Certainly, medicare appears to have addressed financial barriers to access to hospitals and physicians, and financial barriers in Canada are not of the same magnitude as in the United States.

The results from the Commonwealth Fund surveys (the data source used in this study) are consistent with other surveys of public opinion about the health system in Canada. Mendelsohn (2002), who reviewed findings from public opinion surveys for the Romanow Commission of the future of healthcare in Canada, concluded "Canadians have reached a mature, settled public judgment, based on decades of experience, that the Canadian health care model is a good one that should be preserved." Incremental improvements identified in public opinion surveys reviewed by Mendelsohn related to primary care, home care and, to a lesser extent, access to pharmaceuticals.

Soroka (2007) provided a more recent review of public opinion surveys and reached conclusions similar to Mendelsohn's earlier findings: strong support for the medicare framework, with recognition of the need for expansion of universal coverage into some specific areas. Coverage of home care was again supported, with weaker support for pharmaceutical coverage.

So the negotiations leading up to the renewal of the federal–provincial–territorial funding agreement in 2014 should be focused on addressing the problems that have been identified in surveys such as those reviewed here, rather than a "complete rebuild" of medicare. The Commonwealth Fund surveys reinforce the earlier findings that medicare is accepted as continuing to provide the right framework to eliminate financial barriers to access to medical and hospital care. The "fundamental changes" that might be necessary need to build on medicare's strengths, recognizing – as the stem of the relevant answer did – that "there are some good things in our healthcare system." And this is certainly the case when Canada's system is viewed in an international context.

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RESEARCH PAPER

Canadians' Views about Health System Performance

Point de vue des Canadiens sur le rendement du système de santé

STEPHEN DUCKETT AND ANNALISE KEMPTON

TABLE 3. Financial barriers to healthcare

		Deferral or Not Getting of Care Due to Cost	Canada	Australia	UK	US
Survey Year	**Survey Group**	**Consumers**				
1998	Ordinary	Did not fill a prescription for financial reasons/cost	7%	12%	6%	17%
1999	Elderly		4%	1%	3%	7%
2001	Ordinary		13%	19%	7%	26%
2002	Sicker		19%	23%	10%	35%
2004	Ordinary	Did not fill a prescription or skipped dose due to cost	9%	12%	4%	22%
2005	Sicker		20%	22%	8%	40%
2007	Ordinary		8%	13%	5%	23%
2008	Sicker		18%	20%	7%	43%
2010	Ordinary		10%	12%	2%	21%
2002	Sicker	Skipped dose of a prescription drug to make drug last longer	8%	9%	6%	16%
1998	Ordinary	Did not get medical care due to financial reasons/cost	2%	10%	3%	53%
2002	Sicker		9%	16%	4%	28%
2004	Ordinary		17%	29%	9%	40%
2001	Ordinary	Had a medical problem but did not visit doctor due to cost	5%	11%	3%	24%
2004	Ordinary		6%	17%	4%	29%
2005	Sicker		7%	18%	4%	34%
2007	Ordinary		4%	13%	2%	25%
2008	Sicker		9%	21%	4%	36%
2010	Ordinary		8%	18%	5%	28%
2001	Ordinary	Did not get recommended test treatment or follow-up due to cost	6%	15%	2%	22%
2002	Sicker		10%	16%	5%	26%
2004	Ordinary		8%	18%	2%	27%
2005	Sicker		12%	20%	5%	33%
2007	Ordinary		5%	17%	3%	23%
2008	Sicker		11%	25%	6%	38%
2001	Ordinary	Did not get dental care due to cost	26%	33%	19%	35%
2002	Sicker		35%	44%	21%	40%

TABLE 3. Continued

		Difficulties Paying for Care				
		Providers				
2000	Physicians	Percentage reporting that a "major" problem is that patients cannot afford necessary prescription drugs	17%	10%	10%	48%
2000	Physicians	Perceptions of patients' problems – percentage reporting that patients "often" have difficulty affording out-of-pocket cost	20%	34%	26%	63%
2006	Physicians	Physicians' perception of patient access is that patients often have difficulty paying for medications	24%	15%	13%	51%
2009	Physicians		27%	23%	14%	58%
		Consumers				
2004	Ordinary	Nothing spent in the past year on medical bills not covered by insurance / out-of-pocket medical costs in the past year	22%	10%	57%	11%
2005	Sicker		22%	10%	65%	15%
2007	Ordinary		21%	13%	52%	10%
1998	Ordinary	Nothing spent in the past year on medical bills not covered by insurance / out-of-pocket medical costs in the past year	27%	7%	44%	8%
1999	Elderly	No out-of-pocket spending on prescription medicine (elderly)	24%	10%	92%	20%
2001	Ordinary	Nothing spent in the past year on medical bills not covered by insurance / out-of-pocket medical costs in the past year	35%	4%	43%	7%
2001	Ordinary	No out-of-pocket spending on prescription drugs	19%	6%	40%	10%
2001	Ordinary	More than $1,000 spent on out-of-pocket medical costs	5%	8%	2%	26%
2004	Ordinary		12%	14%	4%	26%
2005	Sicker		14%	14%	4%	34%
2007	Ordinary		12%	19%	4%	30%
2008	Sicker		20%	25%	4%	41%
2010	Ordinary		12%	21%	1%	35%
1998	Ordinary	More than $100 spent on medical bills not covered by insurance in the past year	5%	11%	0%	19%
1998	Ordinary	Spent more than $750 out of pocket for medical care in the past year	10%	19%	1%	29%
1999	Ordinary	Spent more than $100 prescription drugs per month (elderly)	4%	0%	0%	16%
2001	Ordinary	Spent more than $200 on prescription drugs	26%	23%	7%	44%
1998	Ordinary	Percentage who had problems paying medical bills in the past year	5%	10%	3%	18%
1999	Elderly		3%	4%	1%	6%
2001	Ordinary		7%	11%	3%	21%
2007	Ordinary		4%	8%	1%	19%
2010	Ordinary		6%	8%	2%	20%

TABLE 5. Waiting times for non-emergency and emergency healthcare

		Waiting Times for Non-Emergency Healthcare	Canada	Australia	UK	US
Survey Year	**Survey Group**	**Providers**				
2000	Physicians	Long waiting times for surgical or hospital care	64%	67%	78%	8%
2000	Physicians	Percentage concerned that patients in the future will wait longer than they should for medical treatment	74%	54%	68%	43%
2003	Executives	Patients "very often" wait six months or more to be admitted for elective surgery	9%	12%	22%	0%
2003	Executives	Patients "often" wait six months or more to be admitted for elective surgery	22%	14%	35%	1%
2006	Physicians	Percentage reporting that patients often experience long waits for diagnostic tests	51%	6%	57%	9%
2000	Physicians	Physicians' perception of patient access is that patients get sicker because they are not able to get the healthcare they need	12%	7%	18%	18%
2003	Executives	Waiting times for elective surgery in the past two years have gotten longer	44%	11%	8%	27%
2003	Executives	Waiting times for elective surgery in the past two years have gotten shorter	9%	21%	86%	14%
		Consumers				
1998	Ordinary	Reason people didn't get medical care – waiting times	38%	39%	51%	10%
1998	Ordinary	Will wait too long to get non-emergency care	20%	25%	12%	14%
2001	Ordinary	Percentage "very worried" that they will wait too long to get non-emergency care in the future	17%	19%	15%	14%
2002	Sicker	Most frequently cited problem – waiting times	27%	31%	39%	3%
1999	Elderly	Percentage of the elderly who needed non-emergency surgery and said waiting a long time was a serious problem	11%	9%	13%	4%
1998	Ordinary	Waiting more than four months for elective surgery	10%	13%	29%	1%
1999	Elderly	Percentage of the elderly who needed non-emergency surgery and waited five weeks or more	40%	19%	51%	7%
2001	Ordinary	Waiting time for elective or non-emergency surgery was more than four months	27%	23%	38%	5%
2005	Sicker		33%	19%	41%	8%
2010	Ordinary		25%	18%	21%	7%
2007	Ordinary	Waiting time for elective or non-emergency surgery was more than six months	14%	9%	15%	4%
2001	Ordinary	Waiting time for elective or non-emergency surgery was less than one month	37%	51%	38%	63%
2005	Sicker		15%	48%	25%	53%
2007	Ordinary		32%	55%	40%	62%
		Waiting Times for Emergency Healthcare				
		Providers				
2003	Executives	Percentage reporting an average wait of two or more hours in hospital emergency room or department	46%	23%	58%	39%
		Consumers (those who attended emergency rooms in previous 12 months)				
2002	Sicker	Percentage reporting waiting time for emergency care was a big problem	37%	31%	36%	31%
2004	Ordinary	Waited two or more hours in emergency room before being treated	48%	29%	36%	34%
2007	Ordinary		46%	34%	32%	31%

TABLE 6. Access to specialists and in-hours and out-of-hours care

		Access to Specialists	Canada	Australia	UK	US
Survey Year	**Survey Group**	**Providers**				
2000	Physicians	Limitations on or long waits for specialist referrals is a major problem	66%	56%	84%	29%
		Consumers				
1998	Ordinary	Difficulties seeing specialist and consultants	47%	35%	29%	39%
1999	Elderly	Percentage of the elderly who felt it was "extremely," "very" or "somewhat" difficult to see a specialist when needed	23%	10%	23%	14%
2001	Ordinary	Extremely/very difficult to see a specialist when needed	16%	12%	13%	17%
2001	Ordinary	Extremely or very difficult to see a specialist when needed, below average income	20%	14%	16%	30%
2001	Ordinary	Extremely or very difficult to see a specialist when needed, above average income	14%	11%	9%	8%
2002	Sicker	Percentage reporting it is very or somewhat difficult to see a specialist	53%	41%	38%	39%
2002	Sicker	Reason that it was difficult to see a specialist was due to wait for an appointment, long waiting times for type of care	86%	74%	75%	40%
2005	Sicker	Waited more than four weeks to see a specialist doctor	57%	46%	60%	23%
2008	Sicker		58%	53%	53%	22%
2010	Ordinary		59%	46%	28%	20%
2002	Sicker	The reason it was difficult to see a specialist was that the facilities or services were not available locally or lack of doctors available	24%	18%	15%	13%
		Barriers to Access, In-Hours Care				
		Consumers				
2001	Ordinary	Percentage of patients able to get same-day appointment when sick	35%	62%	42%	36%
2004	Ordinary	Same-day appointment to see doctor when sick or need medical attention	27%	54%	41%	33%
2005	Sicker		23%	49%	45%	30%
2007	Ordinary		22%	42%	41%	30%
2008	Sicker		26%	36%	48%	26%
2002	Sicker	Percentage reporting waiting time for an appointment with regular physician was a big problem in the past two years	24%	17%	21%	14%
2004	Ordinary	Wait of six days or more to see doctor when sick or needing medical attention	25%	7%	13%	19%
2005	Sicker		36%	10%	15%	23%
2007	Ordinary		30%	10%	12%	20%
2008	Sicker		34%	18%	14%	23%
2010	Ordinary		33%	14%	8%	19%
		Barriers to Access, Out-of-Hours Care				
		Consumers				
1998	Ordinary	Site of care was the hospital emergency room on weekends and evening	62%	55%	34%	64%
2001	Ordinary	Very or somewhat difficult to get care in evening or on weekends	41%	34%	33%	41%
2004	Ordinary	Percentage saying "very" or "somewhat" difficult getting care on nights, weekends, holidays without going to the hospital emergency room	59%	54%	43%	63%
2005	Sicker		54%	59%	38%	61%
2007	Ordinary		66%	64%	55%	66%
2008	Sicker		56%	62%	44%	60%
2010	Ordinary		65%	59%	38%	63%