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Services de santé, gestion et recherche de politique

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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision makers.

We publish original scholarly and research papers that support health policy development and decision making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision makers or researcher–decision maker collaborations that address knowledge application and exchange.

While *Healthcare Policy/Politiques de Santé* encourages submissions that are theoretically grounded and methodologically innovative, we emphasize applied research rather than theoretical work and methods development. The journal maintains a distinctly Canadian flavour by focusing on Canadian health services and policy issues. We also publish research and analysis involving international comparisons or set in other jurisdictions that are relevant to the Canadian context.

* * *

Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

Bien que *Politiques de Santé/Healthcare Policy* encourage l'envoi d'articles ayant un solide fondement théorique et innovateurs sur le plan méthodologique, nous privilégions la recherche appliquée plutôt que les travaux théoriques et l'élaboration de méthodes. La revue veut maintenir une saveur distinctement canadienne en mettant l'accent sur les questions liées aux services et aux politiques de santé au Canada. Nous publions aussi des travaux de recherche et des analyses présentant des comparaisons internationales qui sont pertinentes pour le contexte canadien.

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EDITORIAL

A Call for Bigger Thinking and Meaningful Improvements in Health and Well-Being: Time to Move on From Small-Scale Changes

Effective reforms to provinces' and territories' healthcare delivery systems are needed to generate meaningful changes in population-based health and well-being outcomes in Canada. These reforms include transformations that slow the decline of health and improve the quality of life – such as those relevant to long-term care and aged care – and are expansive enough to include prevention and health promotion.

From the perspectives of many, including mine, the adoption of effective policy reforms can be frustratingly slow but is long overdue (Sutherland 2021). For instance, why can't people and their healthcare providers access a single electronic medical record shared across providers, sectors and settings for both publicly and privately insured services? The technology exists, and the business case is strong (CCA 2023). Even highly visible and expensive reforms by provinces' and territories' ministries of health have struggled to gain traction – for example, using higher payments to improve access to primary care (Farmer 2023; Islam et al. 2023).

Even when the policy path is clear, solutions well-articulated and expected outcomes beneficial to thousands, effective reforms have been slow in coming. This is the case with surgical waitlists. Provinces and territories have been slow to develop policies that have been shown to be effective at improving wait times and access to elective surgery, such as centralizing waitlists (Blythe and Ross 2022; Office of the Auditor General of Ontario 2021).

These examples highlight that reforms to provinces' and territories' healthcare delivery systems that meaningfully raise population-based health and well-being outcomes are uncommon. Opportunities abound and span all aspects of healthcare, including service delivery models, clinical governance, procurement, clinical information integration, payment policy and provincial or territorial health insurance programs. Recent reforms are modestly incremental, targeting dental services for uninsured children and the elderly through the Canadian Dental Care Plan (Government of Canada 2024). The other is the much-ballyhooed national pharmacare program, now scaled down to include only diabetes therapies and reproductive care and already panned as a "pilot" for expanding drug insurance programs (Picard 2024b).

Governments face policy choices. They are not making the hard choices for meaningful and effective reforms in healthcare that raise population-based health and well-being outcomes. Lack of policy innovation by provinces and territories could be overlooked by the public if provincial and territorial health systems were high-performing. However, they are not. Incrementalism is not cutting it.

I am not the first to say that reforms are needed (Drummond and Sinclair 2021; Picard 2024a). The health systems that governments regulate and fund clearly need big ideas and innovation. Here are some ideas.

Thinking Big

Re-writing the Canada Health Act *for expansion*

A re-imagined *Canada Health Act* (*CHA*) (1985) would build from provinces' and territories' forays into other sectors not covered by the *CHA*. They would expand their insurance programs to include publicly funded access to under-insured and uninsured physical and mental health services, therapies and products.

Currently, the *CHA* (1985) outlines the minimums required by provinces and territories – free access to medically necessary hospital, physician and diagnostic services. Beyond this minimum guarantee of access and public administration, provinces and territories have latitude regarding which other providers, sectors, settings, services or technologies are publicly insured. Provinces and territories already selectively offer programs that insure select groups of residents, such as drug insurance for the aged, long-term care for residents who lack the ability to privately pay and access to human immunodeficiency virus drugs.

Significant reform that expands provincial and territorial health insurance programs would encompass and subsume what is currently privately paid or commercially insured services, technologies and products, including drugs, vision and hearing care, physical therapies and mental healthcare services. This reform would remove financial barriers to accessing physical and mental health services from audiologists, physiotherapists, dentists and counsellors. Expansion of provincial insurance programs of this magnitude has been unheard of since the introduction of provincial insurance programs decades ago.

Yes, expanding provincial and territorial health insurance programs would be complex because of the number of stakeholders involved – each vested and invested in the current structure and process of healthcare delivery. Each of the physician associations, nursing unions, allied health providers, healthcare organizations, pharmaceutical and technology companies, patients and caregivers would deserve a say.

Yes, publicly insuring healthcare services, technologies and therapies that are currently under-insured and uninsured would be expensive.

The governments' bold policy reforms into publicly funding under-insured and uninsured physical and mental health services, technologies and therapies would signify that provincial and territorial governments are focused on reducing wealth-based disparities in health and well-being among their residents. However, it is also not a panacea and involves big trade-offs. Serious problems that governments largely ignore would remain unaddressed, including the effectiveness or appropriateness of services or products and quality problems that plague current healthcare delivery models.

Re-writing the CHA *for compulsory health insurance in a government-regulated market*

With changes to the *CHA* (1985) and other legislative efforts, the market for health insurance could be opened by provinces and territories. This reform would allow private health insurers to offer health insurance to residents in a government-regulated health insurance market where public or private insurance is compulsory for individuals. This reform may or may not include services currently mandated by the *CHA* (1985).

Regulated health insurance markets exist in other high-income countries. In the Netherlands, "coverage schemes" (p. 3) are health insurance programs provided by private insurers and are compulsory for residents (noting there is a separate single-payer system for long-term care) (OECD and European Observatory on Health Systems and Policies 2021). Germany also has compulsory health insurance, with many health insurers referred to as "sickness funds" (Blümel et al. 2020: xxii). The Netherlands and Germany are acknowledged by many experts to have better-performing health systems than Canada (Schneider et al. 2021).

Hybrid variants of Dutch and German health insurance models have been implemented elsewhere. Optional private health insurance runs alongside the public system in Australia and Ireland. In these latter countries, private health insurance is not compulsory for residents. The well-publicized experience of Australia has shown that this approach is not a panacea (Angeles et al. 2023), although Australia's health system reportedly consistently performs better than Canada's on important markers of access (Schneider et al. 2021). There is also the case of the US, where many consider the health insurance market to be a failure for population-level health and well-being outcomes, noting the important distinction that neither is health insurance compulsory nor do public insurers – such as state-based Medicaid programs (https://www.medicaid.gov/) – have a mandate or budget to provide health insurance to all residents.

A government-regulated mandated health insurance model is not inconceivable in Canada. Many Canadians already experience multi-payer insurance with workplace-based extended health benefits.

Such an abrupt change, however, would be dizzyingly complex owing to the constitutional entanglements, technically challenging to legislate and enact. It is not clear whether provinces, territories or the federal government have the skills to develop and manage a regulated health insurance market – which may or may not operate alongside the public system. There is scant relevant international evidence to guide large-scale reforms in the context of provinces and territories.

Would this be expensive? More expensive for whom is the trickier question, but we would likely experience higher total healthcare spending, public and private. The publicly borne costs would depend on how far governments developed regulated and compulsory health insurance markets – whether the current publicly funded provincial health systems were maintained in parallel, whether governments stepped away from public provision of health services and "paid" private health insurers premiums that are now spent on healthcare or yet-to-be-conceived other options.

A heavily regulated and compulsory market for private health insurance that does, or does not, include services described in the *CHA* (1985) might shake off the stasis that has gripped provincial health systems.

Thinking big is not without outsized risks, but painfully slow incrementalism has left provinces' health systems standing last in league tables, above only the US.

Thinking Medium

Compulsory insurance for physical and mental health services outside the CHA

In this hybrid reform, provinces' residents would be obligated to carry "extended" health insurance to cover the currently under-insured or uninsured healthcare services and products, such as drugs, dental, vision and mental health services. As noted earlier, many Canadians already experience multi-payer care for physical and mental health services not insured by provinces and territories but offered by their employer.

Through compulsory extended health insurance, reforms could increase access to under-insured or uninsured services and products by removing financial barriers. Necessary steps would include minimizing or eliminating premiums among residents with low income and wealth. Obviously, public spending would increase. For this more limited option, the juice might be worth the squeeze if health and well-being outcomes improved meaningfully, especially among those currently unable to access the needed physical and mental health services and products due to affordability.

Being Bold for the Sake of Improving Performance

If the past is a guide, Canada's provinces and territories have conditioned the public to be accustomed to a *small or no change* approach to health policy reforms. There is a need for provincial and territorial premiers, ministers of health and their deputy ministers to innovate in their health systems. Out-of-the-box thinking is needed, and reforms are overdue for an aging population's health and well-being outcomes.

In This Issue

This issue's first Discussion and Debate article (Crépault et al. 2024) is focused on the contentious issue of relaxing restrictions on promoting cannabis. Crépault et al. (2024) note that the cannabis industry has been opposed to aspects of restrictions on promoting cannabis, which leaves the industry less able to displace illegal producers and retailers. They argue that the federal government should not relax restrictions on promoting cannabis due to the cannabis-related harms among youth.

In a rejoinder to the Discussion and Debate article on restrictions on promoting cannabis, Hall (2024) similarly posits that relaxing restrictions on promoting cannabis could lead to an increase in the prevalence of problematic patterns of cannabis use and cannabis-related harms. However, this rejoinder draws a line with experiences in other regulated substances and activities – including alcohol, tobacco and gambling – noting that governments become dependent on their revenues. This parallel leads Hall (2024) to conclude that it is likely that governments will incrementally relax the regulation of cannabis over time.

This issue also features a Discussion and Debate article exploring provinces and territories' potential use of private surgical centres to expand access to elective day surgeries. Crump et al. (2024) argue that new data collection is needed from private surgical centres that measure access, quality and cost to patients. They further argue that additional information is needed to evaluate whether private surgical centres are providing high-value care to their patients relative to the public spending for those services.

A rejoinder to Crump et al. (2024) offers similar advice that additional information regarding access, quality and cost would be helpful. However, Falk (2024) arrives at his conclusion from the perspective that hospitals are not providing the needed services in a timely manner, additional elective surgical capacity is long overdue and patients are experiencing undue suffering while waiting.

The issue's first research paper is by Campbell et al. (2024) who explore policies regarding methadone prescribing regulation for opioid use disorder. Based on a comparative policy analysis, Campbell et al. (2024) show that British Columbia and Ontario have served as *hubs* for policy responses from other provinces owing to geographical, political and professional factors. They also show that western provinces' restrictive policies regarding methadone may have contributed to their province's higher rates of harm.

The next paper in this issue by de Moissac et al. (2024) describes the healthcare needs and experiences of French-speaking 2S/LGBTQI+ (two-spirit, lesbian, gay, bisexual, transgender, queer and intersex) adults in Manitoba. The study applied a community-based participatory design during the first wave of the COVID-19 pandemic and found that gender and sexual identity were often hidden from healthcare providers. The study also outlined that participants reported twofold discrimination based on their ethnolinguistic and sexual identities, with de Moissac et al. (2024) arguing for policies to redress these inequities.

Arsenault-Lapierre et al. (2024) used a repeated cross-sectional design to compare patterns of health service utilization among new cases of dementia between rural and urban community-dwelling individuals. The study found that rural dwellers used less ambulatory care and more hospital-based care than urban community-dwelling individuals with dementia. Arsenault-Lapierre et al. (2024) provide a number of policy recommendations, such as expanding hospital-at-home programs, to provide alternatives to hospital-based care.

JASON M. SUTHERLAND, PhD
Editor-in-Chief

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ÉDITORIAL

Appel à une réflexion plus approfondie et à des améliorations pour la santé et le bien-être : il est temps de passer à autre chose que des changements à petite échelle

DES RÉFORMES EFFICACES DES SYSTÈMES DE SANTÉ DES PROVINCES ET DES territoires sont nécessaires pour générer des changements significatifs dans les résultats en matière de santé et de bien-être de la population au Canada. Ces réformes comprennent des transformations qui ralentissent le déclin de la santé et améliorent la qualité de vie – comme celles qui concernent les soins de longue durée et les soins aux personnes âgées – et sont suffisamment étendues pour inclure la prévention et la promotion de la santé.

Selon plusieurs personnes, y compris moi-même, l'adoption de réformes politiques efficaces semble extrêmement lente, mais elle est attendue depuis longtemps (Sutherland 2021). Par exemple, pourquoi les gens et les fournisseurs de soins de santé ne peuvent-ils pas accéder à un seul dossier médical électronique partagé entre les fournisseurs, les secteurs et les établissements pour les services assurés publics et privés? La technologie existe et l'analyse de rentabilité est solide (CAC 2023). Même les réformes très visibles et coûteuses ont du mal à gagner du terrain – par exemple, en utilisant des paiements plus élevés pour améliorer l'accès aux soins primaires (Farmer 2023; Islam et al. 2023).

Même lorsque la voie politique est claire, que les solutions sont bien articulées et que les résultats attendus sont bénéfiques pour des milliers de personnes, les réformes efficaces tardent à venir. C'est le cas des listes d'attente en chirurgie. Les provinces et les territoires ont tardé à élaborer des politiques qui soient efficaces pour améliorer les temps d'attente et l'accès aux chirurgies non urgentes, comme la centralisation des listes d'attente (Blythe et Ross 2022; Bureau de la vérificatrice générale de l'Ontario 2021).

Ces exemples montrent que les réformes des systèmes de santé qui améliorent sensiblement les résultats en matière de santé et de bien-être de la population sont rares. Les possibilités abondent et couvrent tous les aspects des soins de santé, dont les modèles de prestation de services, la gouvernance clinique, l'approvisionnement, l'intégration de l'information clinique, la politique de paiement et les programmes d'assurance maladie provinciaux ou territoriaux. Les réformes récentes sont légèrement progressives, ciblant les services dentaires pour les enfants non assurés et les personnes âgées par l'entremise du régime canadien de soins dentaires (Gouvernement du Canada 2024). Il y a aussi le controversé régime national d'assurance-médicaments, qui est désormais réduit pour comprendre uniquement les thérapies du diabète et les soins en matière de reproduction. Ce régime est déjà considéré comme un « projet pilote » pour l'expansion des programmes d'assurance-médicaments (Picard 2024b).

Les gouvernements doivent faire des choix politiques. Ils ne semblent pas portés à faire les choix difficiles qui apporteraient des réformes significatives et efficaces pour améliorer les résultats en matière de santé et de bien-être de la population. Le manque d'innovation stratégique des provinces et des territoires pourrait être toléré par la population si les systèmes de santé provinciaux et territoriaux étaient très performants. Cependant, ce n'est pas le cas. Les réformes graduelles ne suffisent pas.

Je ne suis pas le premier à dire que des réformes sont nécessaires (Drummond et Sinclair 2021; Picard 2024a). Les systèmes de santé que les gouvernements réglementent et financent ont clairement besoin de grandes idées et d'innovations. En voici quelques-unes.

Voir grand

Élargir la Loi canadienne sur la santé

Une refonte de la *Loi canadienne sur la santé* (*LCS*) (1985) reposerait sur les incursions des provinces et des territoires dans d'autres secteurs non couverts par la *LCS*. Ils élargiraient leurs programmes d'assurance pour inclure l'accès à des services, des thérapies et des produits de santé physique et mentale qui sont actuellement sous-assurés ou non assurés.

À l'heure actuelle, la *LCS* (1985) décrit les éléments minimums requis pour les provinces et les territoires – accès gratuit aux services hospitaliers, médicaux et diagnostiques médicalement nécessaires. Au-delà de cette garantie minimale, les provinces et les territoires ont toute latitude quant aux autres fournisseurs, secteurs, établissements, services ou technologies qui sont assurés par le secteur public. Les provinces et les territoires offrent déjà sélectivement des programmes qui assurent certains groupes de résidents, comme l'assurance-médicaments pour les personnes âgées, les soins de longue durée pour les résidents qui n'ont pas la capacité de payer à titre privé ou l'accès aux médicaments contre le virus de l'immunodéficience humaine.

Une réforme visant à élargir les programmes provinciaux et territoriaux d'assurance maladie engloberait les services, les technologies et les produits qui sont actuellement payés par le secteur privé ou assurés par le secteur commercial, notamment les médicaments, les soins de la vue, les soins en audiologie, la physiothérapie et les services de santé mentale. Cette réforme éliminerait les obstacles financiers à l'accès aux services de santé physique et mentale des audiologistes, physiothérapeutes, dentistes et autres conseillers. Il n'y a eu aucune expansion de cette ampleur depuis l'introduction des programmes d'assurance maladie provinciaux, il y a des décennies.

Oui, une expansion des programmes d'assurance maladie provinciaux et territoriaux serait complexe en raison du nombre d'intervenants concernés – chacun étant impliqué dans la structure et les processus en place pour la prestation des soins de santé. Chaque association de médecins, syndicat d'infirmières, fournisseur de services de santé, organisation de soins de santé, société pharmaceutique ou technologique, patient ou soignant mériterait d'avoir son mot à dire.

Oui, il serait coûteux d'assurer publiquement les services de santé, les technologies et les thérapies qui sont actuellement sous-assurés ou non assurés.

Une réforme audacieuse des politiques gouvernementales en matière de financement public des services, technologies et thérapies de santé physique et mentale sous-assurés ou non assurés demande que les gouvernements provinciaux et territoriaux se penchent sur la réduction des disparités en matière de santé et de bien-être liées au statut économique. Cependant, cela n'est pas non plus une panacée et implique de gros compromis. Les problèmes graves que les gouvernements ignorent en grande partie demeureraient sans solution, pensons notamment à l'efficacité et à la pertinence des services ou des produits, ou encore aux problèmes de qualité qui nuisent aux modèles actuels de prestation des soins de santé.

Réécriture de la LCS *pour une assurance maladie obligatoire sur un marché réglementé par l'État*

Avec des changements apportés à la *LCS* (1985) et d'autres mesures législatives, les provinces et les territoires pourraient ouvrir le marché de l'assurance maladie. Cette réforme permettrait aux assureurs privés d'offrir une assurance aux résidents d'un marché réglementé par le gouvernement où l'assurance publique ou privée serait obligatoire pour les particuliers. Cette réforme pourrait inclure ou non les services actuellement prescrits par la *LCS* (1985).

Des marchés réglementés d'assurance maladie existent dans d'autres pays à revenu élevé. Aux Pays-Bas, les « régimes de couverture » (p. 3) sont des programmes d'assurance maladie privés obligatoires pour les résidents (il existe un système à payeur unique distinct pour les soins de longue durée) (OCDE et Observatoire européen des systèmes et politiques de santé 2021). L'Allemagne dispose également d'une assurance maladie obligatoire, avec de nombreux assureurs appelés « caisses d'assurance maladie » (Blümel et al. 2020: xxii). Les Pays-Bas et l'Allemagne sont reconnus par de nombreux experts pour avoir des systèmes de santé plus performants que le Canada (Schneider et al. 2021).

Des variantes des modèles d'assurance maladie néerlandais et allemands ont été mises en œuvre ailleurs. En Australie et en Irlande, l'assurance maladie privée optionnelle côtoie le système public. Dans ces pays, l'assurance maladie privée n'est pas obligatoire. L'expérience très médiatisée de l'Australie a montré que cette approche n'est pas une panacée (Angeles et al. 2023), bien que le système de santé de l'Australie semble constamment mieux performer que celui du Canada en ce qui concerne les marqueurs importants de l'accès (Schneider et al. 2021).

Il y a aussi le cas des États-Unis, où beaucoup considèrent le marché de l'assurance maladie comme un échec face aux résultats de santé et de bien-être de la population. Il est important de noter ici que l'assurance maladie n'est pas obligatoire et que les assureurs publics – tels que les programmes d'État de Medicaid (https://www.medicaid.gov/) – n'ont ni le mandat ni le budget pour fournir une assurance maladie à tous les résidents.

Un modèle d'assurance maladie obligatoire réglementé par le gouvernement n'est pas inconcevable au Canada. De nombreux Canadiens bénéficient déjà d'une assurance multiniveau avec des prestations complémentaires de santé en milieu de travail.

Cependant, un changement aussi brutal serait d'une complexité vertigineuse en raison des enchevêtrements constitutionnels, techniquement difficiles à légiférer et à promulguer. Il n'est pas clair si les provinces, les territoires ou le gouvernement fédéral ont les compétences nécessaires pour développer et gérer un marché réglementé de l'assurance maladie, lequel peut fonctionner ou non de concert avec le système public. Il existe peu de données probantes internationales pertinentes pour orienter les réformes à grande échelle dans le contexte des provinces et des territoires.

Cela coûterait-il cher? Plus cher « pour qui » est la question la plus délicate, mais nous aurions probablement des dépenses totales plus élevées, au public comme au privé. Les coûts assumés par le secteur public dépendraient de la mesure dans laquelle les gouvernements ont développé des marchés d'assurance maladie réglementés et obligatoires, en plus de considérer si les systèmes de santé publics sont maintenus en parallèle, si les gouvernements se sont éloignés de la prestation de services de santé et des primes d'assurance maladie privée « payées » qui seraient maintenant consacrées aux soins de santé ou à d'autres fins.

Un marché fortement réglementé et obligatoire de l'assurance maladie privée qui inclut ou non les services prévus par la *LCS* (1985) pourrait secouer la stase qui grippe les systèmes de santé provinciaux.

Voir grand n'est pas sans risques, mais la lente et douloureuse progression a laissé les systèmes de santé des provinces au dernier rang des classements, juste au-dessus des États-Unis.

Voir moyen

Assurance obligatoire pour les services de santé physique et mentale en dehors de la LCS

Dans le cadre de cette réforme hybride, les résidents des provinces seraient tenus de souscrire une assurance maladie complémentaire pour couvrir les services et produits de santé actuellement sous-assurés ou non assurés, tels que les médicaments, les soins dentaires, les soins de la vue et les services de santé mentale. Comme il a été mentionné précédemment, de nombreux Canadiens reçoivent déjà des soins à plusieurs niveaux pour des services de physiothérapie et de santé mentale non assurés par les provinces et les territoires, mais offerts par leur employeur.

Grâce à l'assurance maladie complémentaire obligatoire, les réformes pourraient accroître l'accès aux services et produits sous-assurés ou non assurés en supprimant les obstacles financiers. Les mesures nécessaires comprendraient la minimisation ou l'élimination des primes pour les résidents à faible revenu. Évidemment, les dépenses publiques augmenteraient. Pour cette option plus limitée, le jeu pourrait en valoir la chandelle si les résultats en matière de santé et de bien-être s'améliorent de manière significative, en particulier chez ceux qui ne peuvent actuellement pas accéder aux services et produits de santé physique et mentale nécessaires en raison des coûts.

Être audacieux pour l'amélioration de la performance

Si le passé est garant de l'avenir, les provinces et les territoires du Canada ont conditionné la population à s'habituer à une approche de *changements modestes ou inexistants* dans les réformes des politiques de santé. Il faut que les premiers ministres provinciaux et territoriaux ainsi que les ministres et sous-ministres de la Santé apportent des innovations dans les systèmes de santé. Une réflexion originale est nécessaire et les réformes se font attendre depuis longtemps pour améliorer les résultats en matière de santé et de bien-être d'une population vieillissante.

Dans ce numéro

Le premier article de la section Discussions et débats (Crépault et al. 2024) porte sur la question controversée de l'assouplissement des restrictions sur la promotion du cannabis. Crépault et al. (2024) font remarquer que l'industrie du cannabis s'oppose à certains aspects des restrictions sur la promotion, ce qui laisse l'industrie moins en mesure de supplanter les producteurs et les détaillants illégaux. Les auteurs soutiennent que le gouvernement fédéral ne devrait pas assouplir les restrictions sur la promotion du cannabis en raison de ses effets néfastes chez les jeunes.

Dans une réplique à cet article, Hall (2024) avance aussi que l'assouplissement des restrictions sur la promotion du cannabis pourrait entraîner une augmentation de la prévalence des schémas problématiques de consommation de cannabis et des effets néfastes. Cependant, cette réplique établit un lien avec l'expérience d'autres substances et activités réglementées – notamment l'alcool, le tabac et le jeu –, en notant que les gouvernements deviennent dépendants de leurs revenus fiscaux. Ce parallèle amène Hall (2024) à conclure qu'il est probable que les gouvernements assouplissent progressivement la réglementation du cannabis au fil du temps.

La section Discussions et débats comprend aussi un article qui explore l'utilisation possible des centres chirurgicaux privés par les provinces et les territoires pour élargir l'accès aux chirurgies de jour non urgentes. Crump et al. (2024) soutiennent qu'il faut recueillir de nouvelles données auprès des centres chirurgicaux privés pour mesurer l'accès, la qualité et les coûts pour les patients. Ils soutiennent en outre que des renseignements supplémentaires sont nécessaires pour évaluer si les centres chirurgicaux privés fournissent des soins de grande valeur à leurs patients par rapport aux dépenses publiques pour ces services.

Une réplique à Crump et al. (2024) présente des conseils similaires, selon lesquels des informations supplémentaires concernant l'accès, la qualité et les coûts seraient utiles. Cependant, Falk (2024) arrive à sa conclusion en constatant que les hôpitaux ne fournissent pas les services nécessaires en temps opportun, qu'une capacité chirurgicale supplémentaire est attendue depuis longtemps et qu'entre-temps les patients éprouvent des souffrances inutiles.

Le premier article de recherche, de Campbell et al. (2024), se penche sur les politiques concernant la réglementation de la prescription de méthadone pour les troubles liés à la consommation d'opioïdes. D'après une analyse comparative des politiques, Campbell et al. (2024) montrent que la Colombie-Britannique et l'Ontario ont servi de plaque tournante pour les réactions stratégiques d'autres provinces en raison de facteurs géographiques, politiques et professionnels. Ils montrent également que les politiques restrictives des provinces de l'Ouest concernant la méthadone peuvent avoir contribué aux taux plus élevés d'effets néfastes dans ces provinces.

L'article suivant, rédigé par de Moissac et al. (2024), décrit les besoins et les expériences en matière de soins de santé chez les adultes 2S/LGBTQI+ (bispirituels, lesbiennes, gais, bisexuels, transgenres, queers et intersexes) d'expression française au Manitoba. Grâce à une enquête participative communautaire qui a eu lieu pendant la première vague de la pandémie de COVID-19, l'étude a permis de constater que le genre et l'identité sexuelle des membres de cette communauté étaient souvent dissimulés face aux fournisseurs de soins de santé. L'étude souligne aussi que les participants ont signalé une double discrimination fondée à la fois sur leur identité ethnolinguistique et sur leur identité sexuelle, ce qui amène de Moissac et al. (2024) à plaider pour des politiques visant à corriger ces inégalités.

Arsenault-Lapierre et al. (2024) ont employé un plan de cohortes transversales annuelles répétées pour comparer les modèles d'utilisation des services de santé parmi les nouveaux cas de démence entre les personnes vivant en milieu rural et celles vivant en milieu urbain. L'étude a révélé que les habitants des régions rurales et atteints de démence utilisaient moins de soins ambulatoires et plus de soins hospitaliers que leurs homologues en milieu urbain. Arsenault-Lapierre et al. (2024) formulent un certain nombre de recommandations stratégiques, comme l'expansion des programmes hospitaliers à domicile, pour offrir des solutions de rechange aux soins hospitaliers.

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DISCUSSION AND DEBATE

Five Years After Cannabis Legalization, Is It Time to Ease Restrictions on Promotion?

Cinq ans après la légalisation du cannabis, est-il temps d'assouplir les restrictions sur la promotion?

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Abstract

In the spring of 2024, the federal government is expected to report on its legislative review of the *Cannabis Act* (2018). One of the most contentious issues is whether to relax restrictions on cannabis promotion. This commentary describes the tension between the public health aims of legalization and the secondary aim of displacing the illicit market. We maintain that among jurisdictions that have legalized cannabis, Canada stands out as having the stated primary objective of safeguarding public health, and its restrictions on promotion are evidence-based and innovative. These measures must be preserved, even in the face of growing industry pressure to loosen them.

Résumé

Au printemps 2024, le gouvernement fédéral devrait présenter un rapport sur son examen législatif de la *Loi sur le cannabis* (2018). Une des questions les plus controversées est de savoir s'il faut assouplir les restrictions sur la promotion du cannabis. Ce commentaire décrit la tension entre les objectifs de la légalisation en matière de santé publique et l'objectif secondaire d'un remplacement du marché illicite. Nous arguons que, parmi les administrations qui ont légalisé le cannabis, le Canada se distingue par son objectif principal déclaré, qui est de protéger la santé publique, et par ses restrictions sur la promotion qui sont novatrices et qui se fondent sur des données probantes. Ces mesures doivent être préservées, même face à la pression croissante de la part de l'industrie pour les assouplir.

Introduction

The federal government is expected to report on its legislative review of the *Cannabis Act* (2018) in the spring of 2024. Crucial to this review is assessing the degree to which the Act meets its main goal of strictly regulating the production, distribution and sale of cannabis in order to protect public health and safety and minimize cannabis-related harms. One of the most contentious issues is whether to relax restrictions on promotion. The cannabis industry has been lobbying against these restrictions for years, arguing that they prevent legal producers and retailers from competing with illegal ones (Laba 2020; Raycraft 2022). Some go further, suggesting that these restrictions actually endanger public health by pushing cannabis users to the illicit market and its unregulated products (Cannabis Council of Canada 2022). Even the federal government's own Competition Bureau has added its voice, agreeing that marketing restrictions should be eased (Competition Bureau Canada 2023). However, these arguments are at odds with the evidence that the promotion of psychoactive substances is associated with increased consumption, especially among youth, and is detrimental to public health.

Discussion

There is a strong public health case for cannabis legalization. It can be summarized as follows (Crépault et al. 2016):

- Cannabis is not benign. Harm is concentrated among people who use cannabis frequently and/or heavily and especially those who began doing so early in life. Importantly, these risk factors are modifiable.

- Prohibition exacerbates these health harms and, through the criminalization of users, causes social harms.
- Legalization gives governments the opportunity to address the modifiable risk factors for cannabis-related harm via evidence-informed regulation. Ultimately, the population-level benefits of legalization depend on the implementation of regulations that prevent increases in problematic use – especially among young people, who are at greater risk of experiencing harm from cannabis use.

In the years prior to the introduction of the *Cannabis Act* (2018), leading organizations in the public health and substance use sectors coalesced around a vision for a public health approach to cannabis (CAMH 2014; Chapados et al. 2016; CPHA 2017). The goal was the establishment of a regulatory system in which Canadian adults who use cannabis are no longer criminalized and have access to quality-controlled products and reliable information, but with strong safeguards against early use and inducements to problematic use. Central to these safeguards were limits on retail availability; controls on price; a ban on advertising, marketing and promotion; and strict labelling requirements. Significantly, these elements were all included in the "public health approach" recommended by the federal government's Task Force on Cannabis Legalization and Regulation (Health Canada 2016: 2).

In the *Cannabis Act* (2018) itself, the legislation's first listed purposes are "to protect public health and public safety and, in particular, to (a) protect the health of young persons by restricting their access to cannabis; (b) protect young persons and others from inducements to use cannabis". To support these objectives, the government opted for strict regulations around cannabis promotion (Health Canada 2024). Promotion of cannabis products and accessories is generally prohibited, apart from informational promotion at the point of sale (i.e., in stores, either brick-and-mortar or online); permissible promotion must not appeal to young people, may not depict people, animals or cartoons and may not use testimonials. Products must be sold in plain, standardized packaging that includes mandatory health warnings and leaves little room for branding. These regulations are evidence-informed and innovative – the kind of approach that is often recommended for psychoactive substances (Babor et al. 2023; WHO 2017) but seldom implemented.

Despite these measures, Canadians' level of exposure to cannabis promotion is high. A federal government survey (Health Canada 2022) found that 49% of Canadians noticed cannabis advertisements or promotions in 2022. Some of this exposure would have come from legal promotion; for example, some respondents reported noticing promotion inside or outside a cannabis store (13% and 24%, respectively). But respondents also reported exposure to cannabis promotion through social media (14%), on TV or radio (10%) and on public billboards or posters (10%) – striking figures in view of the fact that all of these forms of promotion are illegal under the *Cannabis Act* (2018) and its regulations. Indeed, researchers have documented widespread violations of existing promotion rules by licensed cannabis producers and retailers, including lack of age restrictions, passing branded content as education, lifestyle advertising, omission of risks, unsubstantiated medical claims and brand glamorization, among others (Asquith 2021; Fournier and Gagnon 2023; Sheikhan et al. 2021).

The cannabis industry has made various proposals to ease federal restrictions on promotion, which it considers emblematic of the Act's "'nanny state' over-regulation" (Cannabis Council of Canada 2021: 8). These range from recommendations to loosen plain packaging and labelling rules to allow producers and retailers to provide "evidence-based information" about the characteristics and effects of cannabis products (Cannabis Council of Canada 2022) to suggestions that the rules for cannabis should be brought in line with those for alcohol (Laba 2020; Lagerquist 2020). Such proposals are presented as necessary elements toward "eliminating the illicit market, one of legalization's key public health objectives" (Cannabis Council of Canada 2022; see also Legislative Review Secretariat 2023: 70–77) but, in fact, prioritize commercial interests over public health (Barry and Glantz 2016; CAMH 2023).

The purpose of promotion – and marketing in general – is to increase consumption among existing customers and to draw in new consumers by increasing brand/product recognition and appeal. Alcohol, tobacco and early cannabis research have shown that the promotion of these substances is associated with increased consumption, especially among youth (Jernigan et al. 2017; Lovato et al. 2011; Whitehill et al. 2020). When the industry argues that the Act's restrictions limit the ability of cannabis producers and retailers to compete with the illicit market, it ignores these known harms.

The industry also overemphasizes the current harms of the illicit market. While legal, regulated products are indeed preferable from a health perspective to illicit, unregulated ones, the population-level harms we can expect from further commercialization – increased consumption and problematic use – would in all probability exceed any harms of continued illicit cannabis use. It should also be noted that the proportion of Canadians accessing cannabis in the illicit market has been steadily decreasing and continues to do so: the share of the illicit market has decreased from 86% in early 2019 to just 30% in 2022 (Statistics Canada 2023). And, importantly, the industry offers no evidence to support its claims that easing restrictions on cannabis promotion would further accelerate the reduction of the illicit market.

Overall, early evidence of legalization's impacts on public health suggests a complex picture. There are unequivocal wins; notably, decreases in arrests and convictions; areas of ambiguity, such as adolescent use remaining at the high-prevalence levels seen prior to legalization and mixed effects in cannabis-impaired driving; and areas of concern, especially increased use in adults and a rise in pediatric emergency room visits and hospitalizations (Fischer et al. 2023; Hall et al. 2023; Rubin-Kahana et al. 2022). Given that the negative outcomes relate to health-related effects from increased cannabis use, it is important to not make policy changes that will further exacerbate these harms. More research (and time) will be needed to determine the long-term public health and safety impacts of the *Cannabis Act* (2018). But in the area of adolescent use, promotion restrictions are likely helping: early research on Canada's plain packaging suggests that it successfully achieves the goal of making products less appealing to young people (Goodman et al. 2021).

There are certainly aspects of Canadian cannabis policy that can be improved. One important area is ensuring compliance with the *Cannabis Act* (2018) to counter the widespread flouting of promotion regulations noted earlier and the continued existence of illicit production and sales. In addition, there is no standard tetrahydrocannabinol (THC) unit in Canada, which makes it difficult for consumers to estimate and understand their THC intake; this could be remedied by setting a standard THC unit and requiring its use on cannabis packages and labels. The Centre for Addiction and Mental Health and the Canadian Institute for Substance Use Research recently made 10 recommendations to the expert panel conducting the legislative review (Box 1), and the first recommendation is to maintain the Act's restrictions on advertising, marketing and promotion. Canada's current regulations in this area are a rare instance where public health evidence and best practices have been designed as recommended.

BOX 1. CAMH/CISUR recommendations to the expert panel conducting the *Cannabis Act* (2018) legislative review

- The *Cannabis Act*'s (2018) regulations around advertising, marketing and promotion, including packaging and labelling requirements, should be maintained in their entirety. The federal government should also ensure compliance, including at points of sale and online.
- Health Canada should launch a consultation to determine the optimal standard THC unit. Once set, the use of the standard unit should be added to labelling requirements.
- The federal excise tax on cannabis should not be reduced. The federal government should move toward an excise tax based on THC for dried and fresh cannabis in order to incentivize the consumption of less potent products.
- The limit of 10 mg of THC per package for edibles should be maintained. In addition, Health Canada should investigate whether different kinds of legally available edibles appeal to youth.
- The federal government should ensure widespread dissemination of the lower-risk cannabis use guidelines, as well as the versions adapted for particular subpopulations.
- Evidence-informed education campaigns around cannabis should be led by Health Canada and developed free of industry involvement.
- Though this does not fall under the *Cannabis Act* (2018), we encourage provinces and territories with private retail systems to introduce limits on cannabis retail density and clustering and to regulate cannabis availability with public health as the main criterion.
- The federal government should work with the provinces and territories to address illegal storefronts.
- The federal government should continue to address the over-policing and over-incarceration of racialized people and communities.
- The federal government should expunge all convictions for personal possession of cannabis.

Source: CAMH and CISUR 2022: 2–3.
CAMH = Centre for Addiction and Mental Health; CISUR = Canadian Institute for Substance Use Research; THC = tetrahydrocannabinol.

Conclusion

Many jurisdictions have legalized recreational use of cannabis, but Canada stands out as having done so with the stated primary objective of safeguarding public health. Displacing the illicit market is an objective of the *Cannabis Act* (2018), but a secondary one, subordinate to its public health aims. The Act not only serves as a model for regulating cannabis in other jurisdictions but also sets a precedent for the regulation of other legal substances in Canada.

Should restrictions on cannabis promotion be eased? If the federal government remains serious about protecting young people from inducements to use cannabis and from cannabis-related harms, then the answer is no.

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Commentary: The Conflict Between Protecting Public Health and Raising Tax Revenue

Commentaire : Conflit entre la protection de la santé publique et augmentation des recettes fiscales

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Abstract

When Canada created a legal market for cannabis, it gave priority to public health by restricting marketing using branding and promotion via social and other media sources. These restrictions to protect the public from harmful use are under increasing pressure from the legal cannabis industry, which claims that they prevent them from outcompeting and replacing the illicit market. Public health advocates are reasonably concerned that these restrictions will not hold given our experience with alcohol, tobacco and gambling where governments' fiscal dependence on tax revenue favours the liberalization of regulation.

Résumé

Au moment de créer un marché légal pour le cannabis, le Canada a accordé la priorité à la santé publique en restreignant la commercialisation au moyen de l'image de marque ou de la promotion sur les médias sociaux et autres. Ces restrictions visant à protéger le public contre une consommation nocive sont soumises à une pression croissante de la part de l'industrie légale du cannabis, qui prétend que ces mesures les empêchent de supplanter et de remplacer le marché illicite. Les défenseurs de la santé publique craignent, avec raison, que ces restrictions ne tiendront pas, compte tenu de l'expérience vécue avec l'alcool, le tabac et les jeux de hasard, alors que la dépendance des gouvernements à l'égard des recettes fiscales favorise une libéralisation de la réglementation.

Introduction

The Canadian government gave a high priority to protecting public health when it legalized a cannabis market for adult use, as Crépault et al. (2024) note, by adopting evidence-informed ways to regulate cannabis sales that would minimize uptake among youth (Babor et al. 2023; CPHA 2017; Crépault et al. 2016). The *Cannabis Act* (2018) accordingly regulated cannabis retail sales to minimize the promotion of cannabis to youth by, for example, banning the use of brand names, only allowing promotions at the point of sale and requiring plain packaging and health warnings on cannabis products.

Discussion

Crépault et al. (2024) argue that the goal of protecting public health should take precedence over reducing the size of the illicit market for cannabis, a common objective of legalization. A legal cannabis market reduces the role of criminal organizations in cannabis supply and protects public health by ensuring that adults can obtain cannabis products of known quality and potency. It can also provide tax revenue to cover the costs of regulation and fund programs to prevent youth uptake and treat persons who develop cannabis-related problems (Crépault et al. 2016).

The cannabis industry has argued that Canada's public health–oriented cannabis regulations put them at a disadvantage as new market entrants in competing effectively with a well-established illegal cannabis market (Laba 2020; Raycraft 2022). They also claim that the danger posed to public health by illicitly produced cannabis of uncertain quality and safety justifies policy changes to allow the promotion of legal products (Cannabis Council of Canada 2022). These arguments seem to have persuaded the Canadian government's Competition Bureau to support an easing of cannabis marketing restrictions (Competition Bureau 2023).

The cannabis industry also cites evidence from recent reviews that cannabis legalization in Canada has had modest effects on the prevalence of cannabis use and cannabis-related harm (Fischer et al. 2023; Hall et al. 2023; Rubin-Kahana et al. 2022). Legalization has, as intended, produced a large reduction in arrests and convictions for cannabis use (Hall et al. 2023). The proportion of Canadian adults who report that they obtain their cannabis from the illicit market has decreased from 86% in early 2019 to 30% in 2022 (Statistics Canada 2023). Legalization has not, so far, increased the prevalence of adolescent cannabis use, but it has not reduced it either (Fischer et al. 2023; Rubin-Kahana et al. 2022). Surveys indicate that cannabis use has modestly increased among adults but arguably at a similar rate to that preceding legalization (Fischer et al. 2023). Rates of adult and pediatric emergency department visits and hospitalizations for cannabis-related health problems have increased (Hall et al. 2023), but the evidence is more mixed on whether legalization has increased the prevalence of cannabis-impaired driving (Fischer et al. 2023).

Given the modest adverse effects of legalization to date in Canada and concerted cannabis industry lobbying, it would not be surprising if some relaxation of marketing regulations was allowed. However, as Crépault et al. (2024) remind us, our experience with the past liberalization of alcohol policy suggests that the relaxation of marketing restrictions (e.g., by allowing brand names and social media advertisements) will incentivize the promotion of more frequent use of cannabis products of higher potency by a larger proportion of adults and, thereby, is likely to increase the prevalence of problematic patterns of cannabis use and cannabis-related harms.

Even if existing marketing restrictions are not reduced at this time, the future of the public health–oriented regulation of cannabis use in Canada remains at risk in the longer term.

First, most immediately, a future centre-right government is likely to give a different priority to the policy goals embodied in the *Cannabis Act* (2018) than the centre-left liberal government that enacted it. Centre-right governments often disparage the public health regulation of alcohol and tobacco as expressions of "the nanny state" while, nonetheless, supporting the use of criminal penalties for the use of illegal drugs. They also prefer to maximize tax revenue from alcohol and tobacco so that they can cut income taxes. For example, a recently elected centre-right coalition government in New Zealand has decided to repeal public health–oriented legislation designed to reduce the prevalence of tobacco smoking in the New Zealand population to less than 5%. The new government derided these policies as *nanny-state* measures and argued that their abolition will enable them to raise sufficient tax revenue from tobacco sales to permit cuts to direct taxes (Dyer 2023).

Second, in the longer term, governments of all political hues in high-income countries have a problem with fiscal dependence on revenue from alcohol, tobacco and gambling taxes. Given the popularity of reductions in personal income tax, we can expect future Canadian governments to develop a similar fiscal dependence on cannabis taxes and, thus, incrementally relax the regulation of cannabis sales in ways that maximize tax revenue.

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DISCUSSION AND DEBATE

The Eye-Opening Truth About Private Surgical Facilities in Canada

La vérité sur les établissements chirurgicaux privés au Canada

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Abstract

This paper examines the contentious issue of using contracted surgical facilities (CSFs) for scheduled eye surgeries within Canada's publicly funded healthcare system. Despite the debate over the use of CSFs, there is a stark lack of Canadian-focused empirical evidence to guide policy decisions. This paper uses the Organisation for Economic Co-operation and

Development's healthcare system performance conceptual model – access, quality and cost/expenditures – as a framework to explore the debates surrounding CSFs. It highlights the mixed evidence from international studies and proposes recommendations for policy makers to ensure equitable access, maintain high-quality care and achieve cost-effectiveness. The paper underscores the necessity for informed policy making supported by robust empirical research, stakeholder engagement and continuous policy evaluation to address the challenges posed by the integration of CSFs into Canada's healthcare landscape.

Résumé

Ce document examine la question litigieuse de l'utilisation des établissements chirurgicaux sous contrat (ECC) pour des chirurgies oculaires planifiées au sein du système de santé public du Canada. Malgré le débat sur l'utilisation des ECC, il y a un manque flagrant de données sur le contexte canadien pour guider les décisions politiques. Ce document emploie le modèle conceptuel de performance de l'Organisation de coopération et de développement économiques – accès, qualité et coût/dépenses dans le système de santé – comme cadre pour explorer le débat entourant les ECC. Il met en évidence les preuves mitigées tirées d'études internationales et propose des recommandations aux décideurs pour assurer un accès équitable, maintenir des soins de haute qualité et atteindre la rentabilité. Le document souligne la nécessité d'élaborer des politiques éclairées appuyées par de solides recherches, par la mobilisation des intervenants et par une évaluation continue pour relever les défis posés par l'intégration des ECC dans le paysage des soins de santé au Canada.

Introduction

The demand for "elective" (i.e., scheduled) eye surgery in Canada outstretches the available supply of surgical resources, including operating rooms, ophthalmologists, anesthesiologists and nursing care. The insufficient supply of scheduled eye surgeries is evident by the length of time it takes patients to receive their surgery. For example, in Alberta patients wait, on average, 17.7 weeks for non-urgent cataract surgery and 13.0 weeks for "[o]ther interventions on the eye" from decision to surgery to the delivery of the actual service (Government of Alberta n.d.). In Ontario, the average wait time is 20.2 and 10.1 weeks,[1] respectively (Ontario Health 2023). Whether these wait times are appropriate is beyond the scope of this article; they are merely provided as evidence that the demand for these surgeries outstrips the availability of supply.

The demand for eye surgery is not expected to abate. The demand for cataract surgery in Ontario is estimated to more than double in the next 25 years (Hatch et al. 2012). This growing demand can be explained by an aging population, reduced thresholds of visual impairment warranting surgery, increased frequency of repeated eye surgery and higher expectations of patients for better vision (Erie 2014).

The insufficient supply of resources for scheduled eye surgeries is an issue for health ministries and regional health authorities because the length of time spent waiting for these surgeries is widely reported in the media and used as an indicator for the performance of provincial health systems. Some provincial policy makers have turned to contracting with private, for-profit surgical facilities (i.e., contracted surgical facilities [CSFs]) (Government of Alberta 2022; Monga 2023). The use of CSFs is a contentious issue in Canada, and it is often difficult to parse fact from fiction. In this article, we aim to frame the issues underlying the contention, highlight relevant empirical evidence and recommend solutions to make more informed decisions regarding the use of CSFs in the Canadian context.

What Is the Debate Over CSFs?

The use of CSFs to provide publicly funded surgeries is not new in Canada. Several provinces have contracted scheduled eye surgeries with CSFs for years. Health regions in Alberta and British Columbia, for example, have been contracting out cataract surgery since the 1990s (Adams 2003; Armstrong 2009; Kent 2020). Since that time, provincial governments have passed legislation that specifies how CSFs can comply with the *Canada Health Act* (1985) (Allin et al. 2020).

More recently, several health authorities (i.e., provincial health ministries or health regions) have announced additional agreements with CSFs to perform scheduled eye surgeries paid for by the respective provincial health insurance plans, and remain free to patients. These agreements have been motivated by the growing backlog of patients waiting for their scheduled eye surgeries.

Heated debates over the use of CSFs – for all types of surgery, not just eye surgeries – in Canada's publicly funded healthcare system have been going on for decades. The issue was given consideration during the Commission on the Future of Health Care in Canada (i.e., The Romanow Commission) (Deber 2002). To characterize these debates, we have adopted the framework for healthcare system performance measurement developed by the Organisation for Economic Co-operation and Development. While originally designed to facilitate comparisons of healthcare quality across systems (Arah et al. 2006), it has been updated to more broadly compare health system performance (Carinci et al. 2015). It is one of the few frameworks that includes the importance of core services (e.g., elective surgery) in defining health system performance and, therefore, provides an appropriate foundation upon which we can frame the debate (Busse et al. 2019). The framework defines performance through the following three dimensions:

1. *Access*. Do patients have equitable access to scheduled surgeries, irrespective of their medical complexity, ability to pay or geographic location? Some argue that CSFs *cream skim* or *cherry-pick* patients, taking those that are less complicated and leaving the more difficult patients for the public system (Armstrong et al. 2000; Friends of Medicare 2019; Mehra 2017). Proponents of their use, however, argue that CSFs open surgical capacity in publicly administered hospitals to deal with more urgent or complicated procedures (Scholl and Bhandari 2022).

2. *Quality.* Are the desirable outcomes from scheduled surgeries achieved? Are they provided in an appropriate and safe manner? Are the providers of these surgeries *patient-centred*? Critics of CSFs argue that there is a profit motive that leads these providers to cut corners, which results in poorer quality of care (Armstrong et al. 2000; Friends of Medicare 2022).
3. *Cost/expenditures.* Establishing whether health authorities receive good value for their spending on CSFs is complex as the concept of value incorporates measures of access, quality and price over short-term and long-term horizons. Relevant to elective surgery, this includes the cost of labour or, more specifically, the cost of nursing services. Proponents claim that CSFs are more cost-efficient at delivering surgeries (Miller and Shingler 2022). Critics argue that CSFs "poach" nurses from public hospitals, ultimately weakening publicly funded healthcare models (ONA 2023; Payne 2023a). Feeding this debate is the perception that CSFs offer better pay and daytime shifts to nurses compared with public hospitals (Payne 2023b). Others counter this argument claiming that this could put pressure on provincial governments to seek nursing staff from agencies or pay up at the negotiating table with unions ("Health Coalition Vows to Fight" 2022; The Canadian Press 2023), which possibly eliminates any cost savings offered by CSFs.

What Does the Empirical Evidence Tell Us?

Despite the history with and debate over CSFs for scheduled eye surgeries, there is no Canadian-focused empirical evidence regarding whether CSFs offer the same access, quality or value to the taxpayer that public hospitals do. As a result, policies are being made in a vacuum – void of any evidence – leaving only opinion and rhetoric to fill.

There are some empirical studies regarding the use of CSFs for scheduled eye surgeries from other countries with universal healthcare systems. There have been no systematic reviews conducted on this topic, and there have been no studies conducted in a Canadian setting. With the weak base of evidence, one must be cautious when generalizing the results of these studies to the Canadian context. Differences in insurance systems, performance measurements and restrictions on healthcare providers make direct generalizations difficult (Holom et al. 2018).

Below, we have attempted to summarize the studies we could find comparing public versus private delivery of scheduled eye surgeries in universal healthcare systems. This is not intended to be a comprehensive review, rather it is intended to demonstrate the mixed evidence that has been published on the topic.

- *Access.* Browne et al. (2008) reported that patients undergoing cataract surgeries at private facilities in the UK's National Health Service (NHS) tended to be healthier with less severe cataracts compared to those undergoing the same surgery in public hospitals. Similarly, Solborg Bjerrum et al. (2015) observed that patients receiving surgery in Denmark's private facilities were younger and healthier. These results, however, cannot be assumed to demonstrate cherry-picking by private facilities; as Browne et al. (2008) noted in their paper, having the less complicated patients treated at private facilities was the underlying intent of contracts.

- *Quality*. Two studies reported that patients who underwent cataract surgery at private facilities in western Australia and Denmark were at greater risk for post-operative endophthalmitis compared to those undergoing the same surgery at a public hospital (Li et al. 2004; Solborg Bjerrum et al. 2013). Browne et al. (2008) observed that patients treated for cataracts at private facilities in the NHS experienced greater post-operative improvements and lower incidence of complications. Pager and McCluskey (2004) reported that cataract patients in Australia were more satisfied with the pre-operative information and post-operative experience surveys if they underwent surgery in a private facility.
- *Cost/expenditures*. Kruse et al. (2019) reported that private facilities in the NHS provided more "value" (p. 1357) – defined as patient-related outcomes relative to costs – for cataract care as compared with public hospitals. However, these findings were disputed a year later by Tulp et al. (2020), who reported no evidence that private facilities in the NHS outperform public hospitals on quality or price for eye surgery.

In terms of nurses leaving the public system for CSFs, there is very little empirical evidence investigating such occurrences. Chan et al. (2013) conducted a qualitative study on nurses in Hong Kong who had made such a move, revealing multifactorial motivations. However, this study only involved 12 nurses, and the prevalence of nurses leaving the public system for CSFs was not discussed.

What Are the Recommendations?

The limited empirical evidence on the use of CSFs to perform scheduled eye surgeries in Canada has exposed the vacuity to the recent request for proposals made by health authorities. This leads to the pertinent question: How are contracts with CSFs to be evaluated? If CSFs are to be used, we offer a number of recommendations for addressing the concepts of access, quality and value.

- *Access*. Health regions should designate who receives eye surgeries from CSFs. This should safeguard against potential *cream skimming* by providers and ensure equitable access for all patients. To facilitate this, health regions could administer a centralized referral system from primary care to ophthalmology. Patients would be seen by the ophthalmologist with the shortest wait times, irrespective of where they performed their surgery. Alberta Health Services has begun testing such a system for referrals to urology and orthopedics (Alberta Surgical Initiative n.d.).

- *Quality.* CSFs should be required to provide timely and reliable data on the quality of eye surgeries they perform. This means that CSFs would have to collect and report the same safety and quality measures collected by public hospitals, including reporting to the National Ambulatory Care Reporting System or Discharge Abstract Database. Reports should be publicly available analogous with public healthcare facilities. The responsibility and costs for implementing this data collection should be borne by the CSFs and be part of their qualification to bid on contracts with health authorities.

  Provinces should create an infrastructure to collect surgical outcomes that are important to patients, such as patient-reported outcomes and experience measures. To ensure that these outcomes can be compared across settings and time, the federal government should offer provinces a targeted transfer of funds for developing this infrastructure, just as it has for previous priorities (CMA 2023). The federal government should also mandate the standards by which this data collection needs to be done, again, as it has been done for previous priorities (e.g., wait times) (Government of Canada 2012). The responsibility for collecting and reporting these data should fall to health regions, hospitals and CSFs though possibly funded federally. Such a system would be analogous to how hospital and emergency utilization data are currently collected and reported (Lucyk et al. 2015).
- *Cost/expenditures.* Health authorities should measure how much scheduled eye surgeries in public hospitals cost. Very few public hospitals in Canada measure their costs for specific activities, such as eye surgery, although the feasibility of the practice has been established at the Kensington Eye Institute (Sadri et al. 2021). The price paid to CSFs by health authorities for scheduled eye surgeries should be made publicly available. This cost information would allow for an apples-to-apples comparison between the two facility types. When coupled with our recommendation for collecting patient-reported outcomes, health authorities would be able to start understanding whether expanding the supply of eye surgeries using CSFs is a good return on investment.

Conclusion

The increasing demand for scheduled eye surgeries, a trend likely to be seen across many surgical specialties where elective surgery is an effective treatment option, necessitates that health authorities considering contracting out some elective treatments to CSFs develop and implement policies to manage this increased supply. Contracting out surgical services to CSFs is not a new concept, yet provinces should be proactive in determining how to mandate new reporting and data collection methods and how to measure the value of this policy option. We offer several recommendations that could equip health authorities to negotiate smarter contracts with CSFs, rewarding better performance or value. Health authorities will also need to monitor the number of nurses attracted to CSFs and assess the impact it has on the public system. If this proves to be problematic, policy makers and nursing unions may need to focus on creating more competitive working conditions for nurses in the public system. The potential impact of these changes on healthcare costs will need to be empirically studied.

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Note

1. Ontario Health reports specific eye surgeries, rather than Alberta's global "[o]ther intervention on the eye" (Government of Alberta n.d.). We are referencing the average wait time for non-urgent glaucoma (eye pressure-lowering surgery).

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Commentary: Pricing Cataract (and Other Straightforward) Surgeries – A Policy Perspective to Build Capacity, Value and Innovation

Commentaire : Établissement du prix des chirurgies de la cataracte (et autres chirurgies simples) – point de vue stratégique pour renforcer la capacité, la valeur et l'innovation

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Abstract

Aligning with Crump and colleagues' (2024) conclusions on cataract surgery, this article champions a level playing field for expanding surgical capacities for straightforward surgeries. It is agnostic toward for-profit or not-for-profit models. It argues for experimenting with new ambulatory facilities to meet urgent needs, emphasizing Ontario's successful two-decade experience with models such as the Kensington Eye Institute. The discussion advances a three-tiered pricing framework, advocating for transparent, structured pricing to reduce wait times and improve public health outcomes. This approach seeks to balance annual commitments, quarterly adjustments and spot market needs, promoting innovation, cost-efficiency and quality care.

Résumé

Conformément aux conclusions de Crump et de ses collègues (2024) sur la chirurgie de la cataracte, cet article préconise des règles équitables pour une expansion des capacités chirurgicales pour les chirurgies simples. L'article met de côté les modèles à but lucratif ou sans but lucratif. Il préconise l'expérimentation de nouvelles installations ambulatoires pour répondre aux besoins urgents, en mettant l'accent sur les vingt ans d'expérience de l'Ontario avec des modèles tels que celui du Kensington Eye Institute. La discussion propose un cadre de tarification à trois niveaux, préconisant une tarification transparente et structurée pour réduire les temps d'attente et améliorer les résultats en matière de santé publique. Cette approche vise à équilibrer les engagements annuels, les ajustements trimestriels et les besoins du marché au comptant, en favorisant l'innovation, la rentabilité et la qualité des soins.

Introduction

I agree with most of the conclusions that Crump et al. (2024) reach in their strong article on cataract surgery. We should experiment in a limited and transparent way with new ambulatory facilities applied to other surgical and diagnostic procedures that require urgent added capacity and that have clear appropriateness criteria. Like the authors, I am largely agnostic as to whether such an expansion should occur in for-profit or not-for-profit (NFP) facilities. However, I arrive at a similar endpoint by somewhat different paths.

Discussion

Cataract capacity serves the health needs of our population. These surgeries are valuable to people regardless of who performs them. They are a bargain as they provide direct benefit and also support the health status of the population. Take the example of a 75-year-old woman whose vision has significantly deteriorated due to cataracts. These cataracts have greatly affected her daily activities, making it unsafe for her to drive, and she has been waiting for nine months for the needed corrective surgery. This wait has not only reduced her mobility but also limited her ability to engage in activities such as reading, especially during the winter. Delaying such a surgery makes no sense given the low price at either a for-profit or an NFP facility.

In Ontario, the cost of corrective cataract surgery – which is around $1,000 – is covered by the Ontario Health Insurance Plan (OHIP). This includes approximately $400 for the surgeon and a facility fee that ranges between $400 and $800.

- Should we invest $1,000 in such a surgery? Yes.
- Should we accept extended wait times? No.

Allowing my apocryphal 75-year-old to live in partial blindness undermines the health and wellness principles. From a social determinants of health (SDOH) perspective, it undermines health status. We need to eliminate unnecessary wait times for such critical yet straightforward procedures. The same logic can be extended to many joint surgeries and other procedures (without appropriateness concerns). From an SDOH perspective, capacity should be brought on line quickly and ramped up and down as needed. There is little concern about appropriateness, and it is easy to add in year or even in quarter, the volume adjustments for these procedures. Operating rooms are usually available.

Next, I will take a pricing perspective. Crump et al. (2024) argue well for price transparency. I would like to go beyond this and unpack pricing and costs in some detail. My goal here is to suggest a perspective on how to manage pricing well at a system level. I will close by recommending a new pricing system for cataract and other similar surgical procedures.

What price should we pay for a routine cataract (or routine knee or hip) surgery?

I quoted a sum of $1,000 earlier as a placeholder: $400 for the surgeon and $600 for the facility. This number is actually both too high and too low. Some providers will lose money at this price, and some will gain. The argument is often made that providers should be paid a fair compensation and that the definition of "fair" is that they be paid their costs. This argument is now being made by the for-profits as a reason for a higher fee.

THIS ARGUMENT IS NONSENSE

Imagine an airline insisting that you cover their costs with the price of your ticket, an appliance manufacturer listing their costs as the basis for the price, your childrens' school itemizing the teachers' and other staff salaries or drivers' licence renewals based on staffing costs. But healthcare is different, you say. No, it is not – not for straightforward surgeries and other well-defined services.

The late Harvard professor, Clayton Christensen, and co-authors discuss pricing in their excellent book *The Innovator's Prescription* (Christensen et al. 2008), which was the healthcare follow-up to the professor's earlier book, *The Innovator's Dilemma* (Christensen 1997). Christensen et al. (2008) argue that "value-added processes or VAPs" (p. 76) (such as cataracts) are best paid for on a fixed-fee basis, "… to fix problems after definitive diagnoses have been made" (p. 77). Christensen et al. (2008) compare VAPs with facilitated networks and solution shops. Facilitated networks are paid on a membership basis (think Netflix or your gym membership or healthcare-capitated primary care services). "The solution shop activities within a hospital are generally those involved in diagnosing patients' problems" (Christensen et al. 2008: 76). The three streams differ in several ways, one of which is how they are best paid. Building on Christensen and colleagues' (2008) work, I believe that fixed pricing for VAPs is aided by certain clinical criteria, the two most important being the following:

1. The risk of inappropriate treatment is low. This can be due to clear inclusion criteria and/or low negative consequences if inappropriate treatment is given.
2. The complexity and comorbidity criteria can be established to create a relatively homogeneous diagnostic population.

Christensen and colleagues' (2008) make a compelling case that paying for VAPs with a fixed price encourages innovation and quality improvement.

During my career over the past two decades, I have repeatedly seen the same thing in the Ontario system with respect to cataracts. Prices and costs for cataracts have declined as facilities and surgeons innovated. They created special chairs that convert to operating room (OR) tables, they introduced nursing anesthesia that allows multiple room coverage, they consolidated surgical packs from many sutures and instruments to fewer in number and they got faster and faster. Post the World War II period, cataract surgery costs have declined consistently (Shapiro et al. 2001). When first invented, the procedure required six hours of OR time and weeks immobilized in a hospital bed. Today, it is done in under 90 minutes door to door and often in under 10 minutes in the actual OR. Crump et al. (2024) are correct in that a transparent price is important. I am saying that this should come with an understanding of what is driving prices and an expectation that we can and should manage to bring prices down over time. We have done so in the past when we have been diligent.

The Kensington Eye Institute (KEI) was created in 2006 under Premier McGuinty using wait time monies allocated using the 'retired brain surgeon model' of funding (Kensington Health n.d.). Alan Hudson, former Toronto Hospital president and neurosurgery chief, was addressing long wait times by allocating funds to existing facilities around the province for several surgical procedures (almost all were what Christensen et al. [2008] would later call VAPs). He found that the pace of change for ophthalmological surgery was too slow and that he needed a more aggressive provider to push the hospitals, expand capacity and reduce prices. He worked with the Kensington Community Foundation and created the NFP KEI. The KEI, today, does 10,000 to 15,000 cataracts every year and has been doing so for more than a decade. They have stopped telling me what they charge because I kept talking about it, but my guess is that they are somewhere in the low $400s.

I used to take my business school class to KEI once a year (Christensen et al.'s [2008] was my textbook) to look at how a VAP works. It is not a hospital, but it is the site of the chief of academic ophthalmology for the University of Toronto. We saw the innovations I mentioned earlier being demonstrated. And those innovations quickly spread to other competing hospital-based providers.

Could volumes have stayed at the Toronto Western Hospital, where most of these surgeries were done before KEI, and been done as effectively? I do not believe so. There were those who argued that case at the time. I know almost no one who would argue that today. My perspective is that by creating the new service and ratcheting down the reimbursement, Hudson and McGuinty created reference pricing and a model of clinical excellence, which they used to manage other providers. KEI, today, shows all of the attributes that Crump et al. (2024) talk about. They transparently report their quality, access and prices. When they upsell consumers, they do so transparently.

My third perspective is health system policy. We need to encourage consistent improvement and innovation in our system, and new models may help with this. Hudson and McGuinty brought on the new capacity at a lower price point. Ontario Premier Doug Ford and Ontario Health Minister Sylvia Jones appear to be bringing it on at a higher price point.

The Canadian Broadcasting Corporation (CBC) reports (Crawley 2023) that a freedom of information request produced figures stating that the facility fee for cataracts was $1,264 at a new private facility as opposed to $508 for public hospitals. I have no reason to doubt the CBC's numbers. And Minister Jones did not dispute them directly (Crawley 2023).

I note that it is not unreasonable to pay higher fees to a new service supplier to encourage market entry. Windmills and solar power producers get guaranteed tariffs that are much higher than those of the existing electricity producers, and policy makers believe that there are good reasons for this. In healthcare, we do pay special fees to new facilities that can be quite significant.

There would not be great excitement for more volumes at the lower public fee level of $508 (about $900 with the surgeon fee), but there would be some takers. My friends at KEI will, I hope, forgive me for saying that they would probably take 2,000 to 5,000 more cataracts at that price. (Please note that a couple of thousand at that price is $1.8 million, which is not even a rounding error on the rounding error of the hospital budget in Ontario and is a truly inexpensive price to take thousands of Ontarians out of partial blindness.)

How did Minister Jones and her team arrive at $1,264 for the facility fee? This is not at all clear. What is clear is that many legacy providers would be very interested in more cataracts at this price. Jones is playing a business class fare, and there is no reason to believe that there is improved service or quality. In fact, there is good reason to believe that the lack of reporting suggests an immaturity of systems and the poor processes call into question clinical quality. This is not to suggest that these organizations may not be of good quality, rather to underscore Crump et al.'s (2024) point that this needs to be transparently reported.

So how should governments price cataracts and other VAPs?

The answer to this question is not academic. Even though Hudson was a renowned academic (Trypuc et al. 2006a, 2006b), his buying of cataracts was practical and pragmatic. We need such an approach now. The new volumes are targeted for Windsor, London, and other areas, and the price for cataracts may be higher there for practical reasons. Running a low-cost, high-quality facility such as KEI requires at least two ORs and preferably four to spread fixed costs and the anesthetist's time. In my experience, a single-room facility will have trouble getting below $800. So a number of the hospitals in southwestern Ontario may struggle with lower prices and certainly would not be able to make a $508 number in a new and growing facility. Judgement needs to be exercised to set prices and then reduce them over time.

Southwestern Ontario may be somewhat more expensive than KEI, but it is absolutely fair that if customers are willing to travel as far for their cataracts as they would for a Mirvish production (https://www.mirvish.com/), they should be able to get a cataract done at an NFP facility for under $1,000 in the public system (plus the $400 surgeon fee that is flat across the province).

As Crump et al. (2024) argue, these prices should be radically transparent. VAP services and prices should be posted and discussed. Quality should be assured, and Accreditation Canada (https://accreditation.ca/) is a respected and excellent group to do this. Contracts with all providers should be in place to limit upselling (corrective lenses, tests not covered by OHIP and changed eye colour). No one should be allowed to sell access through the back door; access for VAP should be guaranteed for all.

Competition among these providers will result in a win by providers already in the public system, in my opinion, as they have a lower cost to serve. When you have a pricing discussion with them, they will argue that their costs are higher, but watch how they behave, not how they negotiate for higher prices. Very few providers (if any) should ever be compensated based on historic costs; doing so causes price inflation in healthcare services as it does in other industries.

The ministry should be an active buyer of all VAP surgical services. Within the Crump framework (Crump et al. 2024) of pricing, access and quality transparency allow me to suggest a specific model.

Proposed pricing framework for VAP surgeries

Create three tranches of buying:

1. A total of 75% annual volumes committed at the start of each fiscal year based on negotiations and existing accountability agreements (such as the Hospital Service Accountability Agreement) (Middlesex Hospital Alliance n.d.)
    a. In my opinion, this will end up at about $1,200: divided $800 and $400.

2. Then, 20% to be priced quarterly using a bond auction methodology where the clearing price is given to all bidders.
    a. In my opinion, this will end up at about $900: divided $550 and $350.

3. And, 5% spot market (or “buy it now”), which the ministry offers and raises when needed.
    a. This will likely clear at a surprisingly low number: perhaps $600; divided $400 and $200.

Note that I bundled surgeon and facility fees. For more complex VAPs, such as knees and hips, I would bundle rehabilitation services and home care as well. There is a lot of international literature on bundling and some good experience in Ontario from the quality-based procedures program (https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/QBP-Connect).

There has to be some attention paid to travel time. I might offer patients willing to travel a free hotel (and a Mirvish show?) so that the bigger city price advantage can influence local monopolies. Such a care guarantee also helps solve regional shortages and addresses the access issues raised by Crump et al. (2024).

Conclusion

Please note that none of my perspectives was anything other than agnostic about for-profit and NFP providers. I have huge respect for our public hospitals, but I do think they need to be challenged. Many of the same arguments against privates were advanced when KEI came on as an NFP. Those arguments were not true then. In particular, the argument that staff will be hired away by new competitors is one that I am skeptical about as a reason for wholesale rejection of all non-hospital options (Miller and Shingler 2022). Yes, there are huge human resource issues in healthcare, and we need to fix them. But allowing people to deteriorate in semi-blindness because we cannot organize ourselves to provide a $1,000 procedure in a timely way is not okay.

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RESEARCH PAPER

Methadone Prescribing Regulation for Opioid Use Disorder in Canada: Evidence for an East–West Policy Divide

Règlement sur la prescription de méthadone pour les troubles liés à la consommation d’opioïdes au Canada : preuves d’un fossé entre l’Est et l’Ouest

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Abstract

Opioid agonist therapy (OAT) is a key element in the response to opioid-related harms in Canada. In May 2018, Health Canada rescinded the requirement for obtaining a federal exemption for methadone prescribing. This comparative analysis examined provincial OAT policies and policy changes in response to this federal policy change. Policies and changes were regionalized; despite having lower rates of opioid-related harms, eastern provinces had looser regulatory regimes compared with western provinces, which became even looser after the federal policy change. Diverse knowledge and policy networks need to be fostered to bridge this east–west divide in substance use care policy.

Résumé

Le traitement par agonistes opioïdes (TAO) est un élément clé de la réponse aux effets néfastes des opioïdes au Canada. En mai 2018, Santé Canada a annulé l'exigence d'obtenir une exemption fédérale pour la prescription de méthadone. Cette analyse comparative porte sur les politiques et les changements de politiques concernant le TAO en réponse à l'annulation de l'exigence fédérale. Les politiques et les changements ont été régionalisés; malgré des taux plus faibles d'effets néfastes liés aux opioïdes, les régimes de réglementation des provinces de l'Est, qui étaient déjà plus souples que ceux de l'Ouest, le sont devenus encore plus après le changement de la politique fédérale. Il faut favoriser la diversité des réseaux de connaissances et de politiques pour combler ce fossé Est–Ouest dans la politique sur les soins offerts aux toxicomanes.

Introduction

Opioid-related harms continue to escalate in Canada, impacting people of all ages, communities and socio-economic groups. Between 2016 and 2022, there was a near doubling in the number of people dying due to opioid toxicity from 2,830 to 5,360 people, even with the 2022 data only available until September (Government of Canada 2023). Hospitalizations for opioid poisoning have continued to stay elevated, averaging 14 per day in 2022 (Government of Canada 2023).

These harms are not distributed evenly across the country. There are substantially higher mortality and hospitalization rates in western provinces and territories, including British Columbia (BC), Alberta (AB), Saskatchewan (SK) and Yukon (YT) (Government of Canada 2023). For example, apparent opioid-related deaths in AB were 32.4 per 100,000 in 2022, nearly twice the national mean. Specific regions in BC have mortality rates of 42.9 per 100,000 (including other illicit substances) (Government of Canada 2023), which is comparable with some of the hardest-hit regions in the US (CDC 2023). These devastating trends in the western provinces have been driven primarily by the contamination of the drug supply by fentanyl and other potent synthetic opioids (Belzak and Halverson 2018). Although eastern provinces have also had significant and growing opioid-related harms, the overall rates are substantially lower. For example, Quebec's (QC) mortality rate in 2020 was 3.7 per 100,000 (Government of Canada 2023). The drug supplies in the eastern and Atlantic provinces are less likely to be affected by non-prescription opioids and fentanyl contamination. In Nova Scotia (NS), as of 2021, mortality rates due to prescription opioids were more than triple those of non-prescription opioids (3.0 versus 0.9 deaths per 100,0000) (Open Data Portal 2024).

Opioid agonist therapy (OAT) is a key element in the response to opioid-related harms. It is an effective, safe and widely used treatment for opioid use disorder (OUD), or opioid addiction, that involves treatment with long-acting opioid medications such as methadone, buprenorphine or slow-release oral morphine in order to manage withdrawal and cravings (Neale et al. 2019). As in many other jurisdictions internationally, despite its effectiveness and the important initiatives undertaken to expand access, Canadians continue to have limited access to OAT due to a number of intersecting structural forces, such as stigma related to drug use, insufficient training of prescribers and stringent regulation of prescribing (Pijl et al. 2022).

Medications for OUD are among the most highly regulated pharmaceuticals (Sud et al. 2022). Opioid agonists are considered controlled substances and, until recently, providers were required to obtain a Canadian federal Section 56 Exemption from the *Controlled Drugs and Substances Act* (1996) in order to prescribe, sell, provide or administer methadone (CRISM 2017). In addition to having to comply with this federal regulation, health professionals must also comply with the distinct provincial/territorial prescribing and dispensing regulations for education, training and monitoring under the oversight of the provincial/territorial medical, nursing and pharmacy regulatory colleges (CRISM 2017; Pijl et al. 2022). These provincial/territorial regulations have, to a great extent, been influenced by federal exemption requirements. In contrast, opioid analgesics for the management of chronic pain such as hydromorphone, morphine or even transdermal fentanyl have not been subject to the same complex regulations. This complex, multi-level regulation has made medications for OUD challenging and onerous to prescribe and dispense, and likely acted as a deterrent for health professionals to be engaged in OUD care.

After a focused consultation on this issue, in May 2018, in an attempt to reduce this complexity and address the growing opioid-related harms across Canada, Health Canada rescinded the requirement for the Section 56 Exemption for methadone (Health Canada 2017). This Canadian policy change is in keeping with some international examples of federal OAT deregulation (Sud et al. 2023). For example, in the late 1990s, France instituted federal policy reform, particularly in response to the growing rates of transmission of the human immunodeficiency virus related to injection drug use, which substantively increased access to buprenorphine in primary care (Gamage et al. 2023). At the end of 2022, the US abolished the requirement for a federal waiver from the Drug Enforcement Agency for buprenorphine prescribing (*Mainstreaming Addiction Treatment Act* 2021). Similar to Canada, variation in continuing state-level regulation may very much determine the impacts of this US federal policy change.

Given this multi-level and federalist nature of methadone regulation in Canada, the removal of the federal methadone exemption requirement provides an opportunity to compare regulatory policy responses to OAT within and across the provinces and territories. In addition to the differing regulations, the diverse epidemiology of opioid-related harms means that such comparisons are essential for understanding variable policy trajectories and responses as well as possible opportunities for cross-jurisdictional learning. Therefore, the aim of this study is to document, compare and analyze the OAT policies and policy changes in response to the removal of the federal methadone exemption requirement within each territory's and province's particular health system contexts.

Methods

Study design

We conducted a two-stage comparative analysis of provincial/territorial OAT regulations using documentary data sources (Blank et al. 2017). First, the changes in the content of health policies regulating methadone for OAT before and after the May 2018 federal policy change were documented, inductively categorized, organized on a timeline and then compared across jurisdictions. Second, we investigated cross-referencing of provincial/territorial guidance documents to identify any cross-provincial or national relationships.

Data sources

We drew from publicly available policies, guidelines, reports and education/training materials relevant to provincial and territorial methadone prescription requirements for OAT. To obtain documents for analysis, an online search was performed in two stages. The first involved accessing the official medical regulatory college websites of each province and territory to obtain guidelines, policies and public releases of information. Subsequently, a general online search was performed using keywords including province or territory name, methadone and provider type (physician), and keywords were combined using Boolean operators. Documents published in English or French describing provincial/territorial requirements for methadone prescribing for OAT were included in the analysis. Exclusion criteria included documents not from a direct provincial/territorial or scientific source (e.g., news articles), those only referencing the use of methadone for analgesia and those outlining changes implemented before 2014, about five years prior to the federal removal of the exemption requirement. We elected to focus on medical regulations rather than pharmacy regulations as these would be the most directly impacted by the removal of the exemption. Likewise, during the study period, there was significant interprovincial variability in nurse practitioner prescribing rights and, thus, clear pre- and post-exemption removal patterns could not be discerned and were not included in this study.

Data analysis

DESCRIBING PROVINCIAL OAT PRESCRIBING REQUIREMENTS

For each province and territory, a timeline was constructed from 2014 onwards documenting all changes relevant to methadone prescribing requirements. Once timelines were constructed, clinicians and policy makers with OAT expertise from each province were consulted to review the respective timelines for accuracy and relevance. Of note, we were unable to obtain expert review for YT. From the policy documents and our constructed timelines, we inductively identified five broad categories of requirements: (1) initial education and training;

(2) mentorship or preceptorship; (3) regular renewal of licence and continuing education and training; (4) registration with the relevant college; and (5) auditing or practice review. These categories were identified across all provincial/territorial policies, and they align with previous literature on OAT prescribing requirements (Eibl et al. 2017; Priest et al. 2019; Sachidanandan et al. 2022). Requirements in each category were coded as either mandatory or recommended.

Initial education and training refers to any mandated action that must be taken by the healthcare professional to increase knowledge or aptitude regarding methadone prescribing in order to obtain initial prescribing permission. This may include different kinds of educational programs such as webinars or accredited provincial programs. Mentorship or preceptorship refers to any shadowing, residency, preceptor-based courses or ongoing relationships with mentors.

Regular renewal and continuing education and training refers to any requirement for a prescriber to undergo education or training to qualify for re-application to their college for continuing approval to prescribe methadone. These are additional, ongoing education requirements above and beyond the initial education and training requirements.

Registration with the relevant college refers to a mandated requirement for physicians to apply and obtain approval from their medical college to prescribe methadone.

Auditing and practice review refers to any regulation by which physician practices are subject to formal review, either by peers or a regulatory body. Any province that was explicitly stated to invoke ongoing auditing or practice review was identified as such. Any province where auditing/practice review was not commented on – or where most other educational/collegial requirements were removed – was assumed to have no official requirements for standard auditing or practice review.

MAPPING EDUCATION AND GUIDELINE USAGE ACROSS PROVINCES AND TERRITORIES

To further explore any cross-jurisdictional patterns, we examined individual provincial/territorial medical regulatory college OAT standards for references to documents, policies, training programs and standards from other provinces and territories. We inductively categorized and then visualized these references in terms of their content (education/training program, clinical guideline, regulatory standard) and strength (identified as an alternative to consider, a recommendation, a requirement or wholesale adoption).

Institutional ethics

Research ethics board approval was not required as this study only used data from publicly available documentary sources.

Results

Relevant documents for all provinces and territories except the Northwest Territories and Nunavut were identified and included in the analysis.

2014 to May 2018: Pre-removal of exemption

Prior to the removal of the Section 56 Exemption, all provinces and territories required prescribers to undergo initial education and training related to methadone prescribing as well as college registration (Table 1). All provinces except QC and Prince Edward Island (PEI) also required mentorship or preceptorship. All provinces except QC required regular renewal or continuing education and training. Notably, several of the eastern provinces (QC, New Brunswick [NB] and Newfoundland and Labrador [NL]) did not have any auditing or practice review requirements even prior to the removal of the exemption.

While there were fewer high-level differences in the categories of requirements across jurisdictions before the removal of the exemption, western provinces demonstrated tighter education and preceptorship regulation compared with eastern provinces. For instance, providers in AB were required to take a methadone maintenance treatment (MMT) course, gain experience in an OAT setting or evidence of training, potentially undergo an interview with a registrar of the College of Physicians and Surgeons of Alberta or equivalent, complete requirements specific to initiation (preceptorship until determined competent with documentation of competence, complete a course within two years and 40 hours of continuing medical education every five years and maintain association with providers) and have requirements specific to maintenance (attend an MMT/equivalent course again within five years and maintain association/collaboration with another provider). SK had near identical requirements. In contrast, eastern provinces such as NL, NB, NS and Ontario (ON) required an online course (or similar), eight-hour to two-day preceptorships and completion of additional training every three to five years. The province with the fewest requirements before exemption removal was QC, only requiring a one-day professional development course and naming of a mentor willing to support, if needed.

June 2018 onwards: Post-removal of exemption

After the removal of the exemption, several provinces, including ON, NB, NL, NS and PEI, removed all or the majority of their pre-exemption requirements. In other provinces, including BC, YT, AB, SK and Manitoba (MB), there was little to no change in requirements following removal of the exemption. It should be noted that all provinces without mandatory education or training still strongly recommended ongoing training and education to providers.

BC had unique requirements where new prescribers (and those who have not prescribed for over three years) post-exemption removal were required to complete education and preceptorship and report to the provincial college, while those who previously held an exemption under Health Canada did not have these requirements and could continue to prescribe with no specific requirements. As regulations for new prescribers are particularly important to consider with respect to increasing the system capacity to prescribe, these changes were included in the table as required education and training, required mentorship/preceptorship and required college registration for BC.

TABLE 1. Requirements for methadone prescribing regulation across jurisdictions pre- and post-removal of the Section 56 Exemption

Jurisdiction	Initial education and training		Mentorship or preceptorship		Regular renewal or continuing education and training		College registration		Auditing or practice review	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
British Columbia[a]	●	●*	●	●*	●		●	●*		
Yukon	●	●	●	●	●	●	●	●		
Alberta	●	●	●	●	●	●	●	●	●	●
Saskatchewan[b]	●	●	●	●	●	●	●	●	●	●
Manitoba	●	●	●	●	●	●	●	●	●	●
Ontario[c]	●		●		●		●	●	●	●
Quebec[d]	●						●			
New Brunswick	●		●		●		●			
Newfoundland and Labrador	●		●		●		●			
Nova Scotia	●		●		●		●		●	
Prince Edward Island	●	●			●		●		●	

● Indicates required to prescribe in jurisdiction.
a Removed requirement for Section 56 Exemption in 2016.
b Requires continuing medical education with no regular renewal.
c Removed education/training requirements in March 2021.
d Required to name a mentor willing to support, if necessary.
* Applies only to those with no previous Section 56 Exemption before removal or no prescribing within the past three years.

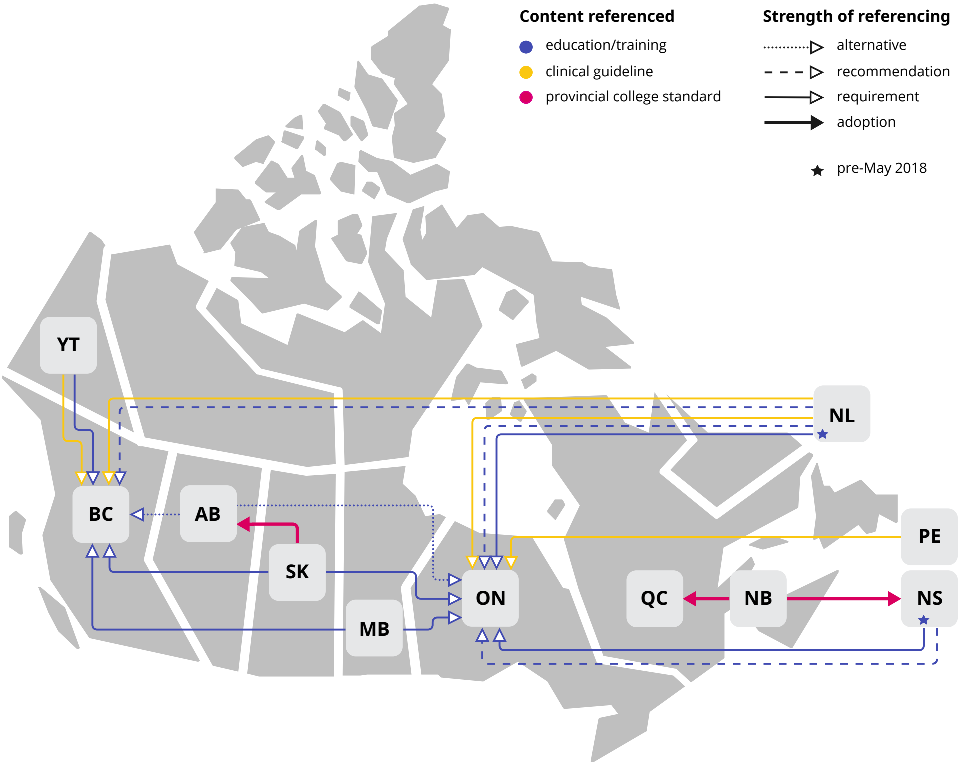
Cross-jurisdictional referencing

BC and ON were the two major "nodes" from which other provinces drew references (Figure 1). We identified seven references to BC documents and nine to ON documents, while documents from these provinces did not reference documents from any other province. More specifically, their major education and guideline providers, the British Columbia Centre on Substance Use and the Centre for Addiction and Mental Health (CAMH), are highly referenced by other provinces. Generally, BC operates as a reference node for western provinces and territories (YT, AB, SK, MB and also NL), while ON does so for eastern and some western provinces.

We identified college standards from two provinces (SK and NB) that explicitly adopted another province's standards, which would not only include training requirements and guidelines but also other requirements such as preceptorship, registration and auditing. In both cases, these adoptions occurred within geographically regionalized west versus east networks.

The removal of the federal exemption had a minimal impact on this cross-jurisdictional referencing. For two provinces (NS and NL), we identified a change in the type of referencing after the removal of the exemption. While both provinces had previously *required* physicians to undertake the training from Ontario's CAMH, this was downgraded to a *recommendation* contemporaneous with the exemption removal (also seen in Table 1).

FIGURE 1. Cross-jurisdictional methadone document referencing across Canadian provinces and territories before removal of the Section 56 Exemption



AB = Alberta; BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland and Labrador; NS = Nova Scotia; ON = Ontario; PE = Prince Edward Island; QC = Quebec; SK = Saskatchewan; YT = Yukon.

Discussion

Regionalized and hierarchical policy responses

Analysis and comparison of methadone policies and changes across provinces and territories demonstrated multiple important patterns relevant to the larger context of opioid-related harms in Canada. On the one hand, western provinces and territories (BC, AB, SK, MB and YT) had tighter prescribing regulations before the removal of the federal exemption, many of which were maintained post-removal. Eastern provinces (QC and the Atlantic provinces), on the other hand, had relatively loose regulatory regimes before the removal of the exemption, which became even looser after the removal. ON – both geographically and also in terms of policies – sits in between these two regions with several pre-exemption removal restrictions removed but some maintained. The cross-jurisdictional referencing of prescribing policies was similarly regionalized and was also hierarchical: documents referencing resources of another province tended to be within the same geographic region and tended to reference resources from more populous provinces.

While this study was not designed to determine the reasons for these regional and hierarchical patterns, they are likely affected by geographical, political and/or professional factors. Regulatory colleges of the more populous provinces have much larger dues-paying registrants than their counterparts in less populous provinces. For example, BC has 11,743 registered physicians while SK has 2,387 (CMA 2019). This means that the regulators in the more populous provinces are better resourced to develop and enact the regulatory policies for methadone prescribing. This greater resourcing is also true with respect to health systems and, in this case, health education institutions. Likewise, values specific to different jurisdictions play important roles in drug policies, including OAT regulations. For example, our previous cross-national research has identified important differences in OAT policies based on value orientations around drug use with jurisdictions with more restrictive OAT policies being more oriented toward abstinence-based approaches while jurisdictions with less restrictive OAT policies being more oriented toward harm reduction (Chiu et al. 2023).

Missed opportunities and locked-in policy trajectories

Considering this east–west regionalization of the policy response against the epidemiology of opioid-related harms in Canada raises some additional important questions. There are higher rates of harm and specifically fentanyl use in western provinces, and increasing access to and utilization of OAT (particularly using methadone) is an essential policy response. Removal of the federal exemption provided a window of opportunity for provinces and territories to address these high rates of harm and improve access to care. For example, previous efforts to decrease regulatory control of methadone have been associated with increases in treatment availability and use (Kurdyak et al. 2018). It might, therefore, be expected that western provinces would have elected to relax methadone regulations. However, our findings show the opposite – eastern provinces such as QC that already had more relaxed regulations and lower rates of opioid-related harms relaxed their methadone regulations even further, while western provinces mostly stood pat in the face of growing harms.

This raises the possibility that restrictive policies around methadone may, in fact, be important *contributors* to higher rates of harm in western provinces compared with eastern provinces, while looser regulation in the eastern provinces could, in fact, be relatively protective. Poorer access to care, more use of the contaminated drug supply and greater opioid-related harms may all be knock-on effects of tighter regulatory control of methadone. The failure of western provinces to respond to the policy opportunity of the federal exemption removal may indicate that they are locked into a policy trajectory of restrictive methadone prescribing. This may then be reinforced by the regionalization of cross-jurisdictional referencing and communication. This phenomenon of regionalized policy communication is also seen in established horizontal intergovernmental relations between provinces/territories enacted through institutions such as the Western Premiers' Conference (a forum of the premiers from the three territories and the provinces of BC, AB, SK and

MB) and the Council of Atlantic Premiers (Atkinson et al. 2013). While these relationships are particularly evident in macro-level policy arenas such as trade and labour, their influence on health or social policy is less known (Berdahl 2011). Therefore, further exploration of whether and how political and geographical factors may influence drug policy and treatment regulation is warranted.

Applications to policy practice

Moving forward, developing more diverse policy and knowledge networks across the east–west division may facilitate a corresponding greater diversity and appropriateness of policy responses to opioid-related harms. For instance, ON is a populous, central and "intermediate" province with a balance of policy restriction and relaxation following the removal of the federal exemption. Likewise, cross-jurisdictional referencing demonstrated ON's high influence across both eastern and western provinces. These factors suggest that it could play an important mediating response across these regional networks. Other institutions with national reach and connectivity such as the Federation of Medical Regulatory Authorities of Canada and the Canadian Research Initiative in Substance Misuse may play important mediating roles as well. As initiators and implementors of this policy change, Health Canada would be particularly well-placed to support cross-jurisdictional policy learning, including through its federal Opioid Response Team. A first step in this direction could be through supporting a comprehensive evaluation of the healthcare and population health impacts of this policy change at national and subnational levels.

In addition, this analysis further emphasizes the need to recognize the substantial variation of the Canadian opioid crisis across provinces, in terms of both epidemiology and policy responses. While the earliest national reporting on the opioid crisis began in the Atlantic provinces, over time attention has shifted to western provinces with a focus specifically on fentanyl-related harms (Webster et al. 2020). Such a focus may not do justice to other provinces that face unique challenges and particularities regarding opioid-related harms and thus need policy responses specific to their jurisdictions.

Limitations

This study is limited by the absence of available data for the Northwest Territories and Nunavut, as well as the lack of expert review for YT. While both policy wise and epidemiologically, YT does seem to pattern with the western provinces, it is possible that the territories may constitute a distinct pattern that may not fit the east–west divide identified here.

We did not include the analysis of policy development nor motivations for the implementation of these policies. Thus, we are unable to explain why the described patterns in prescribing policy exist. Future work should aim to examine the underlying reasons for the observed patterns, as well as investigate how they can be improved to better respond to opioid-related harms. Additionally, it will be important to determine the impact of these policy changes on important outcomes, such as access to treatment for OUD, and on opioid-related harms. While there will be challenges in doing such impact evaluations given the variability in (and sometimes paucity of) relevant data systems across provinces and territories, approaches to evaluating policy impacts such as interrupted time series analyses could be conducted to support such efforts, and doing so would be in keeping with the pressing need for ongoing and accelerated policy learning in response to the crisis of opioid-related harms.

Given these limitations, it is important to characterize our major findings of an east–west policy divide as provisional and defeasible. Further investigation as outlined above may identify important nuances and revisions of this characterization of policy trajectories.

Conclusion

This study demonstrated greater restriction of methadone prescribing in western provinces compared with eastern provinces as well as regionalized and hierarchical cross-jurisdictional referencing. Greater restriction in the west despite higher rates of harm indicates potential contributory effects of these policies on opioid-related harms, as well as inflexible policy trajectories reinforced by regionalized cross-jurisdictional referencing. There is an ongoing need to explain these policy patterns, develop pathways for alternative policy development and consider the impacts of these policy changes on access to OAT.

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RESEARCH PAPER

Healthcare Service Utilization and Perceived Gaps: The Experience of French-Speaking 2S/LGBTQI+ People in Manitoba

Utilisation des services de santé et lacunes perçues : l’expérience des francophones 2S/LGBTQI+ au Manitoba

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Abstract

Ethnolinguistically diverse 2S/LGBTQI+ (two-spirit, lesbian, gay, bisexual, transgender, queer and intersex) populations have unique healthcare needs and experience health inequities compared to their cisgender or heterosexual peers. This community-based participatory study sought to describe the profile and healthcare needs and experiences of official language minority French-speaking 2S/LGBTQI+ adults in Manitoba. Participants ($N = 80$) reported that gender and sexual identity were often concealed from service providers; many respondents faced discrimination based on their ethnolinguistic and sexual identities. Service gaps are identified pertaining to mental and sexual health; locating 2S/LGBTQI+-friendly, patient-centred care in French is difficult. Policy and practice should address systemic inequity and discrimination experienced by this equity-seeking population.

Résumé

Les populations ethnolinguistiquement diversifiées et qui s'identifient à la communauté 2S/LGBTQI+ (bispirituels, lesbiennes, gais, bisexuels, transgenres, queers et intersexes) ont des besoins uniques en matière de soins de santé et vivent des inégalités par rapport à leurs pairs cisgenres ou hétérosexuels. Cette étude participative communautaire vise à décrire le profil ainsi que les besoins et les expériences en matière de soins de santé chez des adultes 2S/LGBTQI+ d'expression française en situation minoritaire au Manitoba. Les participants ($N = 80$) ont indiqué qu'ils dissimulaient souvent leur genre et leur identité sexuelle devant les fournisseurs de services; de nombreux répondants ayant été victimes de discrimination fondée sur l'identité ethnolinguistique et sexuelle. Les lacunes en matière de services ont trait à la santé mentale et à la santé sexuelle; il est difficile de trouver en français des soins axés sur le patient qui soient adaptés aux besoins des personnes 2S/LGBTQI+. Les politiques et les pratiques devraient s'attaquer aux iniquités et à la discrimination systémiques dont sont victimes ces personnes en quête d'équité.

Introduction

The 2S/LGBTQI+ (two-spirit, lesbian, gay, bisexual, transgender, queer and intersex) populations persistently experience poorer mental and physical health than the general population as illustrated by a higher incidence of chronic conditions such as asthma, obesity, cardiac disease, arthritis, cancer (Casey 2019; Dai and Hao 2019; Hsieh and Ruther 2016) and psychological distress (Edkins et al. 2018; Gilmour 2019; Pakula et al. 2016; Parent et al. 2019). Systemic inequity experienced within healthcare settings may contribute to this reality (Konnoth 2020). Considering that homosexuality was only depathologized in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1973 (APA 2013) and in the International Classification of Diseases (ICD) in 1990 (WHO 2019), the international medical and psychiatric community's stigmatization of 2S/LGBTQI+ people has only recently begun to be remediated (Drescher 2015). However, a recent study of Manitoban 2SGBQ+ (two-spirit, gay, bisexual and queer) men concluded that discrimination continues to be a barrier to healthcare service use for this population: many experienced discrimination firsthand from healthcare professionals and did not have access to a general practitioner, and only a quarter of those who did felt they could speak openly about their sexual orientation to providers (McLeod et al. 2021).

The COVID-19 pandemic exacerbated the pre-existing discrimination and chronic minority stress (Meyer 1995, 2003) already experienced by 2S/LGBTQI+ populations worldwide (Brennan et al. 2020; Egale 2020; Goldbach et al. 2021; McLeod et al. 2021; Salerno et al. 2020), particularly for dually minoritized 2S/LGBTQI+ individuals belonging to diverse ethnicities (Goldbach et al. 2021; Prada et al. 2023; Whittington et al. 2020). Strikingly, 2S/LGBTQI+ people in Canada face numerous barriers to service access, especially mediated through stigma and discrimination, including services related to housing (Lyons et al. 2021), mental health (Ferlatte et al. 2019) and the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) prevention and treatment (McLeod et al. 2021). Barriers include stigma (especially stigma experienced when an individual has numerous intersecting minoritized identities), financial insecurity and perceived discrimination on behalf of the service (including healthcare) providers. Considering the Manitoban landscape more specifically, 2S/LGBTQI+ people in rural Manitoba report experiencing discrimination, stigmatization and lack of provider awareness and sensitization to 2S/LGBTQI+ identities and experiences as barriers to their healthcare access (Henriquez and Ahmad 2021). Indeed, perceived invisibility brought on by systemic barriers to service utilization among 2S/LGBTQI+ people in Canada – as in Manitoba – is directly linked to them performing poorly on indicators of psychological and physiological health, and this can be especially pronounced in rural or remote areas (Henriquez and Ahmad 2021; Souleymanov et al. 2023). While experienced by many 2S/LGBTQI+ people, barriers can be especially salient and deleterious for transgender and gender non-binary people (Rutherford et al. 2021).

In parallel, the impact of language barriers on healthcare access and quality of care for official-language minority (OLM) populations in Canada – such as francophones outside Quebec – are well-documented (Bowen 2015; Ohtani et al. 2015; Schwei et al. 2016). Such barriers lead to increased wait times, greater distances to travel and, at times, bullying by service providers, discouraging patients from even asking for services in French (de Moissac and Bowen 2017). Often, they result in unmet healthcare needs (Alimezelli et al. 2013; Bahi and Mulatris 2018; Benoit et al. 2012; de Moissac and Bowen 2017), leading to poorer health outcomes for these populations (Bouchard et al. 2018; Chartier et al. 2012). As such, healthcare providers are becoming increasingly cognizant of the value of language access services in providing appropriate patient-centred, culturally congruent care, especially among vulnerable populations (Schwei et al. 2016). Since 1989, the active offer of services in French, defined as "[t]he set of measures taken by designated public bodies to ensure that French language services are evident, readily available, easily accessible, and publicized, and that the quality of these services is comparable to that of services offered in English"

(Francophone Affairs Secretariat n.d.), has been encouraged to remediate this issue. However, systemic and structural barriers persist, including nationwide shortages of bilingual healthcare professionals serving OLM communities (de Moissac et al. 2015; de Moissac and Bowen 2017; Drolet et al. 2014), reducing access to care in the official language of the minority in Manitoba and across Canada.

Hence, both 2S/LGBTQI+ and OLM identities have been shown to independently hinder patient health, their care and treatment outcomes. When these minority identities intersect, they exacerbate inequities that such populations face (Pachankis and Goldfried 2013; Ramirez and Galupo 2019). Such populations are generally not well-served by healthcare systems as "[c]lients may enter services having felt unable to locate their experiences within a seemingly mutually exclusive relationship between mainstream sexual minority and [their minority community's] social narratives" (Choi and Israel 2016: 351). Cultural and social connection through holistic care is essential, allowing 2S/LGBTQI+ patients to integrate all parts of their identity in a narrative that coheres with their goals and values (Choi and Israel 2016).

While a thrust has recently been observed in Canada to investigate racialized 2S/LGBTQI+ subpopulations (Hart et al. 2021; Husbands et al. 2022; Lee-Foon et al. 2020), such research remains under-represented compared with that investigating 2S/LGBTQI+ populations more broadly. For instance, Bowleg's (2012) critique of public health research seldom considering multiple intersecting identities – including gender, sexuality and ethnic diversity – when investigating 2S/LGBTQI+ and other minoritized populations calls for its meaningful inclusion in all future public health inquiry. Indeed, most research conducted on ethnically diverse 2S/LGBTQI+ populations pertains to visible minority populations in the US (for example: Choi and Israel 2016; Cyrus 2017; Page et al. 2022); few report on Canadian (Gates-Gasse and Lassonde 2015) or OLM populations (Sherbourne Health, Rainbow Health Ontario and Government of Ontario 2020). According to the 2021 national census data, one in 300 Canadians aged 15 and older are transgender or non-binary; over half of the non-binary people live in one of Canada's six largest urban centres (Statistics Canada 2022). As for French-speaking OLM populations in the province of interest (Manitoba), over 36,000 Manitobans reported French as a first official language (2.7%) and over 110,000 identified as bilingual (8.3%) (Auclair et al. 2023). Hence, a quantitative needs analysis – a first in western Canada – was conducted among the OLM (French-speakers) 2S/LGBTQI+ (inclusive of all people who do not identify as cisgender or heterosexual) population in Manitoba (hereafter named "Community"), to explore their socio-demographic profile, health and social needs and experiences. A first publication stemming from these data described this population's socio-demographic profile and needs (Prada et al. 2023). In our paper, we discuss access to healthcare and experiences of discrimination. The data will inform healthcare providers, policy makers, researchers and other community stakeholders on this vulnerable population's experience with healthcare.

Methods

This community-based participatory study was initiated by the community partner – Collectif LGBTQ* du Manitoba (https://collectiflgbtq.ca/) – a grassroots organization advocating for French-speaking 2S/LGBTQI+ Manitobans that sought funding, enlisted researchers and was closely involved throughout this project. While a primarily quantitative approach was employed, participants were also invited to qualify through certain responses. Inclusion criteria were being at least 18 years of age (age of majority in this province), residing in Manitoba and self-identifying as French-speaking and 2S/LGBTQI+. The survey was available in French only; average proficiency in this language was required to participate. Of note, inclusion criteria for language proficiency in French was used rather than mother tongue, as many members within the francophone community of interest do not have French as a mother tongue (such as immigrants) but are more fluent in this language than in the official language of the majority (English). Ethics approval was obtained from the research ethics board of Université de Saint-Boniface, Winnipeg, MB (ETH 2020 04 Juin 2020). Informed consent was obtained from all participants prior to survey completion.

Data collection occurred over three weeks in June 2020, during the first wave of the COVID-19 pandemic. Recruitment strategies included convenience and snowball sampling, namely, through e-mails sent via local francophone 2S/LGBTQI+ and community partner networks; promotion on social media (both organic and paid); and press releases sent to media province-wide, both in French and English.

The 38-question survey, co-constructed by the research team and Community members and inspired by a similar study in Ontario (Gates-Gasse and Lassonde 2015), comprised four sections: (1) socio-demographic and ethnolinguistic profile; (2) social support and health-care needs; (3) perceptions of discrimination and marginalization; and (4) priorities for the future (Prada et al. 2021). The questions were mostly multiple-choice, although participants could select the "other" option to be able to specify further. Open questions were also asked. For questions pertaining to challenges, service use and barriers to use, lists were provided to participants who were invited to choose all options applicable to them. The barriers in the questionnaire were inspired by other research done on 2S/LGBTQI+ populations and linguistic minorities (of which some of the authors have extensive experience), as well as in consultation with Collectif LGBTQ* du Manitoba. The study tool was pilot-tested among four Community members for clarity of questions, as well as ease and time of survey completion, then made available in print (Prada et al. 2023) and online through the Canadian-based data host LimeSurvey.

All statistical analyses were performed using SPSS version 24.0 for Windows (SPSS, Inc., Chicago, IL). The data were described as proportions and were further analyzed according to age groups (18–34, 35–54 and 55 years or over), as needs and service utilization differ with age. Furthermore, historical events may also have had some impact on the experience of discrimination and access to services (Prada et al. 2023). Chi-squared or Fisher's exact tests were computed to identify statistically significant differences between age groups ($p < 0.05$).

Results

Socio-demographic and ethnolinguistic profile

A total of 80 respondents participated; approximately half were aged between 18 and 34 years, a third were between 35 and 54 years and 19% were 55 years or older (Table 1, available online at www.longwoods.com/content/27239). Nearly half identified as women and a third as men. The highest proportion of respondents identified as gay, lesbian or bisexual. Most lived in an urban setting, alone or with their partner or spouse. Most were single or in a same-sex common-law relationship or marriage and reported post-secondary education and full-time employment. One in five were considered low-income (personal annual income < $20,000). Most respondents reported having no known functional limitations, although the most frequently reported limitation was psychological.

For their ethnolinguistic profile, three-quarters of the respondents identified as White. Two-thirds identified as bilingual (French and English), and three-quarters indicated French as their maternal language still spoken at home. Self-reported proficiency in both French and English for oral, writing and comprehension was generally advanced.

Healthcare service utilization and perceived gaps

Healthcare service utilization trends, per age group, are presented in Table 2 (available online at www.longwoods.com/content/27239). Healthcare services most used by respondents included those provided by family physicians or nurse practitioners, walk-in clinics, private healthcare services, hospitals and other clinics or healthcare centres; more than half of the respondents received services from the designated francophone healthcare centre. Few consulted these services only in French, save at this designated health centre. Furthermore, 69.2% had consulted psychological services, and 29.2% had consulted sexual health services, most often in English. Few reported using addictions-related services (9.2%), assisted procreation or adoption services (9.2%) or services for people living with HIV or AIDS (4.6%). Some statistically significant differences emerged between age groups: the 35- to 44-year-old age group was most likely to have consulted assisted procreation or adoption services as well as services for people living with HIV/AIDS, while no 18- to 34-year-old participants reported having used either of these services. Furthermore, although not statistically significant, participants 55 years of age and older were most likely to have accessed services in French than all other groups, save for hospital services.

Among service users, high satisfaction levels were generally reported for private healthcare services and services provided by family physicians or nurse practitioners. Respondents generally felt less satisfied with services received from walk-in clinics, hospitals, clinics or healthcare centres and mental health supports. One participant qualified these findings:

> I used some of these services only once, and then stopped. In some cases, it's because the service wasn't offered in French, or because I felt that my sexual orientation was not taken into account or misunderstood. (Participant #49, 55–64 years of age)

A considerable number of participants reported experiencing difficulties locating community information and health-related 2S/LGBTQI+-friendly services in French, finding a family physician or locating other healthcare services. In terms of services received in French, many indicated that it was difficult or very difficult for them to locate and access services in French and that the active offer of services in that language was only sometimes or rarely practised:

> There is a general lack of service access for francophones, and when it's focused on an even smaller [2S/LGBTQI+] community, we can feel even more targeted/stigmatized. (Participant #13, 35–44 years of age)

> Often, as a gay man, the situation can become quite complex as the types of services geared to our community and that understand us without judgement are only offered in English. (Participant #49, 55–64 years of age)

Participants perceived gaps in services pertaining to both their sexual or gender identities and their ethnolinguistic identities. Their most reported unmet needs are social activities and psychological, physical and sexual healthcare services. Approximately half of the respondents indicated an unmet need for French-language, 2S/LGBTQI+-friendly services pertaining to senior lodging, adoption, assisted fertility, surrogacy or midwifery and long-term care. Between 30 and 40% of the participants also expressed a need for such services relating to substance use and addictions (including drugs, alcohol and gambling) and assistance in finding lodging. Some statistically significant differences emerge between age groups. For example, respondents 55 years of age and older more frequently reported needs for services relating to senior lodging, home meals and healthcare services.

Barriers to service utilization

Barriers to healthcare service utilization, per age group, are presented in Table 3 (available online at www.longwoods.com/content/27239). Participants were invited to select from a list of possible obstacles to service utilization in their preferred language, even when in need. Among the six most-reported barriers, five pertained to the language of service. Many chose to utilize services in English rather than in French because it was easier to do so in English; although not statistically significant, this was reported most often by younger participants. Others were unaware that such services existed, found that the service provider's proficiency in French was inadequate or felt that their own proficiency in French was inadequate. Almost one in four respondents reported that such services were unavailable in French.

Sexual or gender identity-related barriers to service access are largely related to anticipated discrimination from service providers. Some also reported fear of getting "outed" or identified as 2S/LGBTQI+ or services not being sufficiently geared to the person's sexual or gender identity-related needs as corroborated by one participant:

> I sometimes choose to not obtain certain services in French out of concern for lack of discretion from the service provider and their associates. (Participant #153, 35–44 years of age)

Other barriers to service utilization included inaccessibility of services because of distance and limited transportation options.

Discrimination and identity concealment

Perceptions of discrimination and identity concealment trends, per age group, are presented in Table 4 (available online at www.longwoods.com/content/27239). Many respondents reported experiencing discrimination based on their sexual orientation or their use of French. Some also reported discrimination regarding their linguistic identity, mental health concerns or age.

Although most respondents indicated always or often feeling respected by service providers regarding their sexual orientation or gender identity, half of the participants indicated rarely or never disclosing their sexual orientation or gender identity to service providers compared with 18.5% indicating always or often doing so. The most frequently reported motivations for concealing participants' sexual orientation or gender identity included the following: the opportunity did not present itself or the context of the interaction did not lead to this topic; their sexual orientation or gender identity had no bearing on their access to services; or this information did not concern service providers. More than a third of the participants also reported discomfort discussing this topic or concern that the service provider may have been uncomfortable discussing this with them.

Discussion

This study – the first of its kind in western Canada – provides insight into the unique experiences and needs of OLM French-speaking 2S/LGBTQI+ adults pertaining to healthcare access and utilization. The data were collected during the first wave of the COVID-19 pandemic.

The most reported barrier to healthcare service use, even when in need, pertained to limited access to, or absence of, services in French. The dearth of active offer and consequent difficulty locating and accessing services in French reported by most participants are corroborated by previous literature showing that OLM individuals often feel disadvantaged compared with the anglophone majority (Ngwakongnwi et al. 2012). Furthermore, although many OLM francophones across Canada have advanced fluency in English, some may have little or no fluency in languages other than French, including young children, the elderly and the newcomers from Quebec or French-speaking countries. Furthermore, fluency in a second language (English) may be jeopardized when in a position of vulnerability, such as when in pain, under the influence of medication or in psychological distress (de Moissac and Bowen 2017). Finally, accessing services in French can also be motivated by other factors, such as a desire to improve or maintain linguistic competency (Office of the Commissioner of Official Languages 2023) or to create or reinforce ties with members of the French-speaking community. As such, given the dearth of 2S/LGBTQI+-friendly French-language services highlighted by current data, participants were less likely to experience patient-centred care. Language barriers should be addressed to ensure quality of care and patient safety to level the inequity that OLM populations continue to face in healthcare settings (Savard et al. 2021; Seeleman et al. 2015; Zhao et al. 2021).

Furthermore, anticipated and experienced discrimination relating to both their OLM and sexual or gender identities were reported by many respondents. Although most indicated feeling respected by service providers, over half of them reported regularly or always concealing their sexual or gender identity or not using certain services for fear of discrimination. A recent study among Manitoban 2SGBQ+ men echoes this finding: there, only a quarter of respondents felt that they could speak openly about their sexual orientation with their healthcare provider, and over 65% indicated having experienced discrimination in healthcare settings within the previous two years (McLeod et al. 2021). While little research has been conducted among transgender and gender non-binary people in Manitoba, results from the Trans PULSE Canada survey conducted throughout the COVID-19 pandemic likewise revealed the numerous obstacles to healthcare experienced by transgender and gender non-binary people in Canada, and that these barriers may have been heightened through this global health crisis (Tami et al. 2022). Alarmingly, it is those transgender and gender non-binary people in Canada – vulnerable given their poor mental health – who may be most prone to primary healthcare avoidance, compared to their cisgender 2S/LGBQ+ (two-spirit, lesbian, gay, bisexual and queer) peers (Rutherford et al. 2021). As the French-speaking community in Manitoba is perceived by many as small and tight-knit, fear of being "outed" as an 2S/LGBTQI+ person may be particularly salient for members of the Community. Considering that identity concealment impedes appropriate treatment (Casey 2019; Foy et al. 2019; Hsieh and Ruther 2016), this finding highlights the importance of healthcare professionals proactively addressing these topics with patients. The responsibility lies on the provider, not the patient, to broach such sensitive topics (McLeod et al. 2021). Clinicians must also be proactively cognizant of their internalized biases or prejudice, which may hinder treatment (Wynn and West-Olatunji 2009).

Many participants underscored their unmet need for psychological support services. It is troubling that mental health supports were most often accessed in English as mental healthcare that is congruent with patients' cultural and linguistic needs is essential to treatment efficacy (Chartier et al. 2012; Choi and Israel 2016; Vu et al. 2011). Present findings suggest that 2S/LGBTQI+ people are more inclined to seek professional psychological support than non-2S/LGBTQI+ peers (Pachankis and Goldfried 2013). Previous reports have emphasized the clinical efficacy of targeted strategies for ethnically diverse 2S/LGBTQI+ populations, including mindfulness (Li et al. 2019), family intervention, group therapy and cognitive behavioural therapy (Igartua and Montoro 2015). Proactively addressing issues, such as stigma, internalized homophobia or heteronormativity (Brewster et al. 2013), and focusing on the holistic integration of a 2S/LGBTQI+ patient's ethnic, historical and cultural identities (Choi and Israel 2016) are also vital.

Furthermore, while respondents underscored their unmet need for 2S/LGBTQI+ sexual health services in French, few used services for people living with HIV/AIDS. These findings are of concern as 2S/LGBTQI+ populations have unique sexual health needs, and approximately six Canadians contract HIV daily – namely, men who have sex with men (Public Health Agency of Canada 2020). With a 52% increase in HIV transmission between 2018 and 2021 in Manitoba (Manitoba HIV Program 2022), comprehensive, multi-layered preventative services promoting 2S/LGBTQI+ sexual health continue to be vital (Manitoba HIV Program 2022; McLeod et al. 2021) and should take into account the unique linguistic needs of this Community.

Findings predominantly reflect the experiences and needs of individuals self-reporting select sexual and gender identities (namely gay, lesbian or bisexual). Also, participants were mostly younger, White, born in Canada and from urban areas, and few reported living with a disability. Such homogeneity is not consistent with recent Canadian statistics on 2S/LGBTQI+ populations (Statistics Canada 2022). Compared to Manitoba's broader francophone population (French as its mother tongue), a significantly higher prevalence of participants reported low income and living alone. In contrast, a considerably lower proportion reported being elders or residing in rural areas (Auclair et al. 2023). This suggests that their profile and needs may, in fact, be distinct from their larger OLM communities. Furthermore, despite heterogeneous recruitment strategies, some sub-populations remain under-represented, such as visible minorities and Indigenous Peoples. Although not the focus of this article, given the low proportion of non-White respondents, analysis of findings pertaining to Métis and Black participants appear to suggest that their plight is worse than that of White respondents, as reported elsewhere (Goldbach et al. 2021; Whittington et al. 2020). Also, the fact that more than half of the respondents reported no disability is unexpected as the literature reports higher incidence of illness and disability among 2S/LGBTQI+ populations compared to the larger population (Casey 2019; Egale 2020; Martin-Storey et al. 2019; Statistics Canada n.d.). Future targeted studies ought to intentionally include such equity-seeking populations (El-Hage and Lee 2016). The data from the 2021 national census – the first to include more holistic and accurate questions on gender and sexual identity – will be helpful to future study (Statistics Canada 2020, 2022).

Implications for policy and practice

Members of this Community face compounded healthcare inequities given their intersecting OLM ethnolinguistic and 2S/LGBTQI+ minority identities. As such, a community-led, community-informed approach targeting policy and professional practice to proactively ensure equity, diversity and inclusion (EDI) competency while caring for ethnolinguistically diverse 2S/LGBTQI+ people is vital (Prada et al. 2021, 2023). Such efforts must also be cognizant of the larger prejudicial systems that equity-seeking groups occupy, and empower the client to address these larger issues (macro) while also addressing individual morbidity (micro) (Buchanan and Wiklund 2020). As some 2S/LGBTQI+ people feel healthcare professionals misunderstand their experiences and needs and others are hypervigilant to experiences of stigmatization in healthcare settings (Foy et al. 2019), increasing awareness and providing professional development for service providers on the specific needs and experiences of 2S/LGBTQI+ OLM populations is crucial (Prada et al. 2023). Furthermore, regular evaluation and adaption of healthcare policies to address systemic inequity and discrimination, especially those faced by dually minoritized populations, should be conducted. Healthcare professionals must also endeavour to reinforce the provider–patient alliance (McLeod et al. 2021) by proactively initiating conversations on sexual and gender identity with all patients and actively offering services in French. Understanding that cultural and social connections are essential to forging positive social identities, any clinical strategy that brings the patient to feel they must mute one of their identities to receive treatment will fail to provide adequate, patient-centred care (Choi and Israel 2016). These issues must be addressed at systemic, policy and individual provider levels. Otherwise, the obstacles hindering service utilization by members of this Community will continue to reinforce the stigmatization and inequity they face.

Strengths and Limitations

This study is the first to report on OLM 2S/LGBTQI+ populations in western Canada. Considering this Community represents a small minority within an even smaller minority, the sample size ($N = 80$) is adequate; heterogeneous recruitment efforts allowed the research team to overcome recruiting obstacles inherent to the COVID-19 pandemic. Furthermore, its community-based paradigm through the close involvement of Community members at every step of this study further enhances its validity, as it was executed by and for this Community.

Limits include the relatively homogeneous sample, which is inconsistent with the recent statistics on 2S/LGBTQI+ people in Canada (Statistics Canada 2022); results may only be generalizable to analogous populations. However, as this study was founded in community-based participatory research principles (Gélineau et al. 2012; Godrie 2017), we sought a basic understanding of the specific context in which our sample lived; thus, the findings allow us (community partners in collaboration with researchers) to enact change. As data were collected during the COVID-19 pandemic, related stressors may have confounded results. Furthermore, given the descriptive nature of the data collected, causal relationships cannot be inferred.

Conclusion

The intersecting identities of OLM French-speaking 2S/LGBTQI+ Manitobans impact their access to and experiences with healthcare services. The data highlight limited active offer of 2S/LGBTQI+-friendly services in French and twofold discrimination based on gender or sexual and ethnolinguistic identities. Given the current insufficiency of healthcare provision to this population, particularly with respect to mental and sexual health, policies and practices must be adapted to the linguistic and 2S/LGBTQI+ needs to ensure accessible, culturally competent and 2S/LGBTQI+-affirming treatment and prevention service provision and, in doing so, reduce systemic and structural inequities faced by this Canadian population.

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RESEARCH PAPER

Rural–Urban Differences in Healthcare Use in Persons With Dementia Between 2000 and 2019: A Quebec Population-Based Study

Différences entre régions rurales et urbaines dans l'utilisation des soins de santé chez les personnes atteintes de démence entre 2000 et 2019 : une étude québécoise axée sur la population

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Rural–Urban Differences in Healthcare Use in Persons With Dementia Between 2000 and 2019

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Abstract

Background: Rural persons with dementia face medical services gaps. This study compares the health service utilization of rural and urban community-dwelling individuals with incident dementia.

Methods: This study used a repeated annual cross-sectional cohort design spanning a period from 2000 to 2019 analyzing age-adjusted rates for 20 indicators of service use and mortality one year after diagnosis in Quebec administrative databases.

Results: Of 237,259 persons, 20.1% were rural. Most rural persons had more emergency department visits and hospitalizations, shorter stays, less alternate level of care and fewer family physicians' and cognition specialists' visits. All groups had similar long-term care and mortality rates.

Conclusion: Policy implications of these disparities are discussed.

Résumé

Contexte : Les personnes qui vivent en milieu rurales atteintes de démence font face à des lacunes dans les services médicaux. Cette étude compare l'utilisation des services de santé entre les personnes atteintes de démence dans les collectivités rurales et celles des collectivités urbaines.

Méthodes : Cette étude emploie un plan de cohortes transversales annuelles répétées pour la période allant de 2000 à 2019 et analyse les taux ajustés selon l'âge de 20 indicateurs d'utilisation des services et de mortalité un an après le diagnostic dans les bases de données administratives du Québec.

Résultats : Parmi 237 259 personnes, 20,1% vivaient en milieu rural. La plupart des personnes en milieu rural ont eu plus de visites à l'urgence et d'hospitalisations, des séjours plus courts, moins de soins de niveau différent et moins de visites de médecins de famille ou de spécialistes de la cognition. Tous les groupes avaient des taux de soins de longue durée et de mortalité similaires.

Conclusion : Les répercussions politiques de ces disparités sont discutées.

Introduction

Dementia is an increasing public health concern that continues to grow due to the aging population (WHO 2023). Persons with dementia (PWDs) are high users of health services, requiring tailored medical services. Compared to older persons without dementia, PWDs visit emergency departments (EDs) and hospitals more frequently (Bronskill et al. 2020), receive more potentially inappropriate medications (Maltais et al. 2022) and have higher mortality rates (Prince et al. 2012).

The variable availability of health services across regions may impact the provision of adequate care to PWDs, with rural areas facing challenges due to limited access to specialized and primary care services (Casey et al. 2001). Consequently, rural PWDs encounter more barriers to healthcare than urban PWDs (Sibley and Weiner 2011).

Existing literature highlights disparities in healthcare use between rural and urban PWDs. Our systematic review (Arsenault-Lapierre et al. 2023) reveals that in comparison to urban PWDs, rural PWDs have higher mortality rates and more hospitalizations with shorter stays but are less likely to consult specialists. However, these findings may be confounded by the limited scope of most of the studies that were included, capturing only a few years of data and one or two care indicators (i.e., visits to the family physicians, visits to specialists, ED visits, hospitalization, etc.) (Arsenault-Lapierre et al. 2023). In addition, diverse definitions of rurality in the original studies hinder cross-jurisdictional comparisons (Arsenault-Lapierre et al. 2023). Functional measures accounting for the social and economic influence of large urban centres on the surrounding regions may offer a more nuanced approach suitable in the health provision context (du Plessis et al. 2002; Hart et al. 2005; Nelson et al. 2021). More importantly, existing studies have looked at PWDs at various stages of the disease. Around the time of diagnosis, PWDs tend to use (appropriately or inappropriately) health services more than at any other stage of the disease (National Academies of Sciences, Engineering and Medicine et al. 2018; Sivananthan and McGrail 2016).

Understanding the scope of service use by rural and urban PWDs across multiple indicators throughout the continuum of care is necessary for decision makers to plan more equitable health services. This study aims to compare healthcare service use between rural and urban community-dwelling persons with incident dementia in Quebec between 2000 and 2019.

Methods

Setting

Quebec is Canada's second largest province and home to 1.5 million adults aged 65 years and over (Institut de la statistique du Québec 2023). Over the course of the past two decades, Canadian dementia guidelines (Gauthier et al. 2012; Ismail et al. 2020) and federal and provincial healthcare reforms and policies, such as the Canadian dementia strategy (PHAC 2019) and the Quebec Alzheimer Plan (Bergman et al. 2009), have shaped the capacity of primary care to detect, diagnose and manage dementia, whereas other countries have based their dementia strategy in specialist care (Arsenault-Lapierre et al. 2020). Since 2009, the province introduced the Quebec Alzheimer Plan (Bergman et al. 2009) in two phases: first, in 2014, a pilot phase was launched in 42 interdisciplinary primary care teams, followed by an extension phase in 2016 to the whole province (Arsenault-Lapierre et al. 2020;

Guillette et al. 2021; Vedel et al. 2019). The data included in this study span these population changes and pivotal health policies and reforms.

Design and data source

We conducted an annual repeated cohort study from 2000 to 2019. We extracted data from the linked population-based administrative databases from the Québec Integrated Chronic Disease Surveillance System at Institut national de santé publique du Québec. These databases include services provided by the publicly funded universal healthcare system (health insurance registry, hospitalizations, fee-for-service physician claims and drug services) and mortality rates. These databases are linked to individual-level demographics for 99% of the Quebec population, except for the drug services databases, which cover 90% of older adults aged 65 years or more (Blais et al. 2014). Therefore, these databases offer an opportunity to study geographical differences in healthcare service use and mortality at a near population-based level.

Population

We included all community-dwelling older adults aged 65 years and over with incident diagnosis of dementia occurring between April 1 and March 31 for each cohort year. Dementia diagnosis was identified through a validated algorithm, developed in Ontario from the ICES database and adopted by the Public Health Agency of Canada (Appendix 1, available online at www.longwoods.com/content/27281). It has high specificity (99.1%) and sensitivity (79.3%) (Jaakkimainen et al. 2016). With this algorithm, a dementia diagnosis is defined by one of the following criteria: (a) one hospitalization with a dementia code, (b) three or more physician visits with a dementia code and (c) a dementia-specific drug, whichever occurred first. We focused on the incident dementia population as the needs and healthcare use at this time are frequently high and tend to be more homogeneous than in the prevalent population (Sivananthan and McGrail 2016). We determined the community-dwelling status by the absence of evidence in the linked health administrative databases of living in or waiting for admission to a long-term care facility (Godard-Sebillotte et al. 2019). More details are provided in Appendix 2 (available online at www.longwoods.com/content/27281). Individuals with missing postal codes were excluded from analyses.

We used an area-level equity stratification linking an individual's residential postal code to a statistical area classification (SAC) type (CIHI 2018a). This stratification with SAC types, developed by Statistics Canada, provides a functional stratification – i.e., rather than being based only on the size of the population, the degree of social and economic influence that the census metropolitan areas and census agglomerations have on regions outside of census metropolitan areas and census agglomerations is considered (du Plessis et al. 2001).

The most urban group is SAC type 1 that corresponds to census metropolitan areas. SAC types 2 and 3 correspond to census agglomerations (Appendix 3, available online at www.longwoods.com/content/27281); SAC type 4 corresponds to a census area with strong metropolitan influence; SAC type 5 corresponds to a census area with moderate metropolitan influence; and the most rural groups are SAC types 6 and 7 that correspond to a census area with weak or null metropolitan influence. Finally, there is SAC type 8 that refers to territories outside of census agglomerations. There are no data for SAC type 8 as they fall outside each provincial jurisdiction, including Quebec (Statistics Canada 2022). As routinely done by researchers and surveillance specialists, we grouped SAC types 2 and 3, as well as SAC types 6 and 7, to keep the number of categories small and the number of persons within each category large enough to draw meaningful conclusions and reduce noise (Institut national de santé publique du Québec 2019; Vanasse et al. 2010). We used the last issue of the Postal Code Conversion File Plus (a SAS [statistical software suite] control program), to assign the SAC type based on postal codes. This program uses population-weighted random allocation for postal codes that link to more than one geographical area. The distribution of this product is shared between Statistics Canada and Canada Post Corporation.

Outcomes

We selected 20 indicators grounded in a validated Quality of Dementia Care Framework (Sourial et al. 2022) that spans the continuum of care (ambulatory care, acute care and pharmacological care). The operational definitions of all indicators used are provided in Appendices 4 and 5 (available online at www.longwoods.com/content/27281). We measured all indicators during the year following the diagnosis, until death or admission to long-term care and thus expressed as person-year rates.

We grouped four indicators into *ambulatory care*: visits to a primary care physician, continuity of ambulatory care (using the Usual Provider Continuity index, which describes the proportion of visits to the regular physician out of all visits), diagnosis of dementia in primary care and visits to a cognition specialist.

We grouped four indicators into *general acute care*: at least one ED visit, ED visits, at least one hospitalization and days hospitalized.

We grouped four indicators into *potentially avoidable acute care*: at least one hospitalization for an ambulatory care sensitive condition (ACSC) (Feng et al. 2014) relative to the aging/dementia population, 30-day readmissions, at least one hospitalization with alternate level of care (ALC) and months in ALC. ALC is also referred to as delayed discharge.

We grouped three indicators into *dementia-specific pharmacological care*: cholinesterase inhibitor prescriptions, memantine prescriptions and dementia medication prescribed in primary care (cholinesterase inhibitor and/or memantine).

We grouped three indicators into *potentially inappropriate pharmacological care*: benzodiazepine, antipsychotic and antidepressant prescriptions. Some of these medications are considered potentially inappropriate for PWDs by Canadian dementia care guidelines (Gauthier et al. 2012; Ismail et al. 2020). Not all antidepressants are inappropriate; however, information on different classes of antidepressants was not accessible. This limitation is discussed in the interpretation of our results.

We used one indicator for *long-term care* (long-term care admission) and one indicator for *mortality*.

Analysis

Indicators were summarized as rates adjusted for person-time (until death, admission to long-term care or end of the cohort year). Indicators were adjusted for age using direct standardization with the distribution of the 2011 Canada census as the reference population (Anderson and Rosengerb 1998).

We performed descriptive analyses of the baseline characteristics (mean age and standard deviation and percentage of women) of each group based on SAC type. To assess the geographical differences, we stratified age-standardized person-year rates for all indicators over the 20 cohort years using SAC types. These stratified rates were then graphed (one per indicator) and visually analyzed. A visual analysis allowed for determining differences without over-relying on statistical tests as any small difference would have been statistically significant due to quasi-population-level data (Faber and Fonseca 2014). The presence or absence of geographical differences was determined by iterative rounds of collective consensus with 10 experts, including health services researchers and clinicians (public health physicians, nurses, pharmacists, geriatricians and epidemiologists). This methodology was used in a previous study with similar design and methods (Sourial et al. 2020).

Results

Between 2000 and 2019, we present results for 257,919 incidents of PWDs (see Table 1 for socio-demographic characteristics). Of these, 65.7% lived in the most urban area (SAC type 1), 14.2% lived in other urban areas (SAC types 2 and 3), 5.3% lived in a rural area with strong metropolitan influence (SAC type 4), 10.8% lived in a rural area with a moderate metropolitan influence (SAC type 5) and 4.0% lived in the most rural areas (SAC types 6 and 7). In each subsequently more rural geographical location group, the mean age decreased slightly (from 81.4 years old on average in the most urban group to 80.9 years old on average in the most rural group) as the proportion of women decreased (from 63.6% in the most urban group to 59.5% in the most rural group). There was minimal missing information (0.2%) due to lack of postal code.

In terms of *ambulatory care*, between 2000 and 2019 we observed that the most rural group (SAC types 6 and 7) had the lowest rates of visits to a family physician of all groups (Figure 1). For example, the most urban group had more visits to family physicians compared with the most rural group, 17 out of the 19 cohort-years and up to 1.7 visits per person-year. A table of the differences between each group for each indicator is presented in Appendix 6 (available online at www.longwoods.com/content/27281). We observed that the most urban group (SAC type 1) had higher rates of visits to cognition specialists (i.e., compared with the most rural group, the most urban group had more visits to cognition specialists, up to one visit per person-year), lower rates of dementia diagnosis in primary care (the most rural group

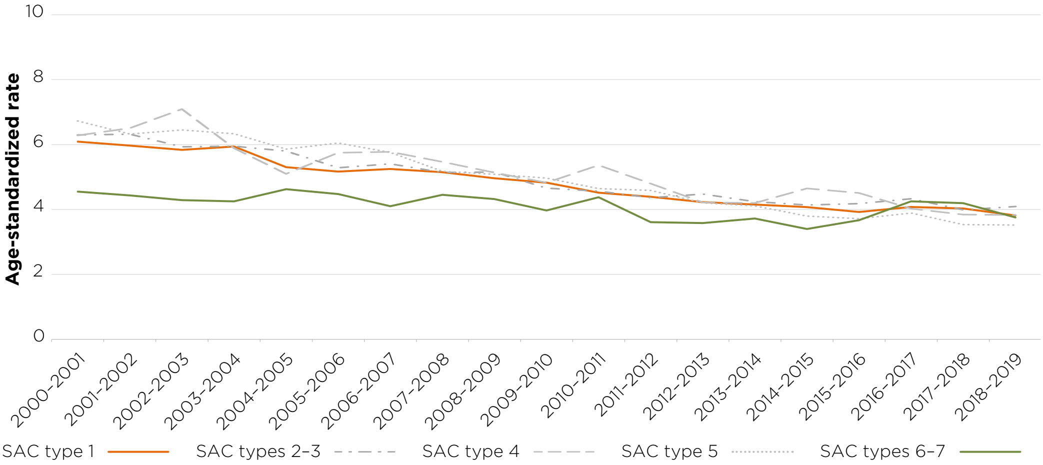
TABLE 1. Description of persons with a newly identified diagnosis of dementia per geographical location

SAC type	*N*	Percentage (%)	Mean age	% of women
SAC type 1 (most urban)	169,351	65.7	81.4	63.6
SAC types 2 and 3	36,689	14.2	81.3	62.9
SAC type 4	13,700	5.3	80.6	55.8
SAC type 5	27,759	10.8	81.1	59.2
SAC types 6 and 7 (most rural)	10,420	4.0	80.9	59.5
Missing postal code	393	0.2		

SAC = Statistical Area Classification.
The cumulative number (*N*) and relative proportion (%) of persons with newly identified dementia between 2000 and 2019, their mean age (in years) and the percentage (%) of women per SAC type.
The most urban group is SAC type 1, which corresponds to census metropolitan areas; SAC types 2 and 3, correspond to census agglomerations; SAC type 4 corresponds to a census area with strong metropolitan influence; SAC type 5 corresponds to a census area with moderate metropolitan influence; and the most rural/remote groups are SAC types 6 and 7, which correspond to a census area with weak or null metropolitan influence. The number and relative proportion of persons for whom the postal code is missing is also given.

had more diagnosis in primary care for the entire cohort-years, and this difference was up to 21.1 person-year, compared with the most urban group) and lower continuity of ambulatory care compared with the other groups. Due to a technical issue, the identification numbers of the physicians were not saved in the prescription drugs database during the year 2011–2012; therefore, it was not possible to determine if the dementia diagnosis was in primary care for that cohort. Data for that year and the indicator are thus missing. The figures for these indicators are available in Appendix 7 (available online at www.longwoods.com/content/27281).

FIGURE 1. Age-standardized rates (per person-year) of the number of visits to a family physician

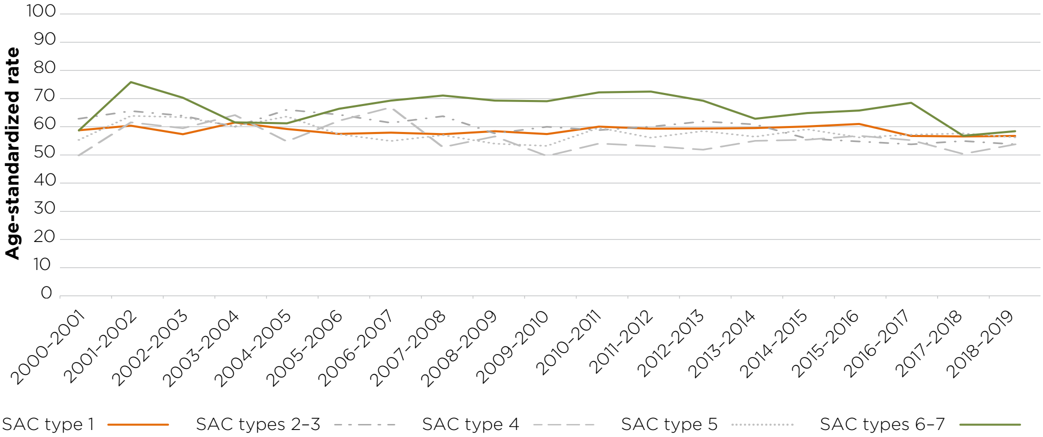


SAC = Statistical Area Classification. SAC type 1 is the most urban group, which corresponds to census metropolitan areas; SAC types 2 and 3 correspond to census agglomerations; SAC type 4 corresponds to a census area with strong metropolitan influence; SAC type 5 corresponds to a census area with moderate metropolitan influence; and the most rural groups, SAC types 6 and 7, correspond to a census area with weak or null metropolitan influence.
Operational definitions are available in Appendix 3. Other figures of age-standardized rate for ambulatory care indicators are presented in Appendix 7.

In terms of *acute care*, between 2000 and 2019 we observed that the most rural group (SAC types 6 and 7) had the highest rates of ED visits (Figure 2) and hospitalizations

(Appendix 7) but the shortest length of stays of all groups (Appendix 7). For example, compared with the most urban group, the most rural group had more ED visits, 18 years out of 19, up to 15.5 person-year and more hospitalization, 17 years out of 19, up to 17.0 person-year. The most urban group had more days of hospitalization, 18 years out of 19 and up to 24 per person-year, compared with the most rural group.

FIGURE 2. Age-standardized rates (per 100 person-year) of at least one ED visit

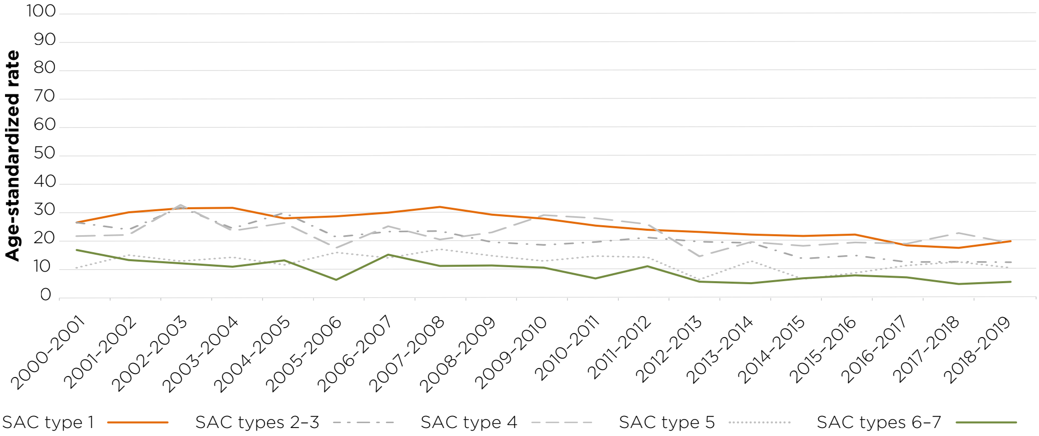


ALC = alternate level of care; SAC = Statistical Area Classification. For further details on each SAC type, refer to Figure 1 footnote (p. 84).
Complete operational definitions are available in Appendix 3. Other figures of age-standardized rate for acute care indicators are presented in Appendix 7.

In terms of *potentially avoidable acute care*, between 2000 and 2019 the most rural group (SAC types 6 and 7) had the lowest rate of hospitalizations with ALC (or delayed discharge) (Figure 3) but highest rates of 30-day readmissions of all groups (Appendix 7). For example, the most urban group had more hospitalizations with ALC for all cohort years, and up to 22.4 person-year, compared with the most rural group; and the most rural group had more 30-day readmissions, 18 out of 19 cohort-years, up to 22.6 person-year, compared with the most urban group. Due to the already low rate of hospitalization, with ensuing large variations between each cohort, the results were inconclusive for the rates of number of months in ALC or hospitalization for an age-related condition that could have been treated in primary care (Appendix 7). Of note, approximately 45% of each group were hospitalized each year.

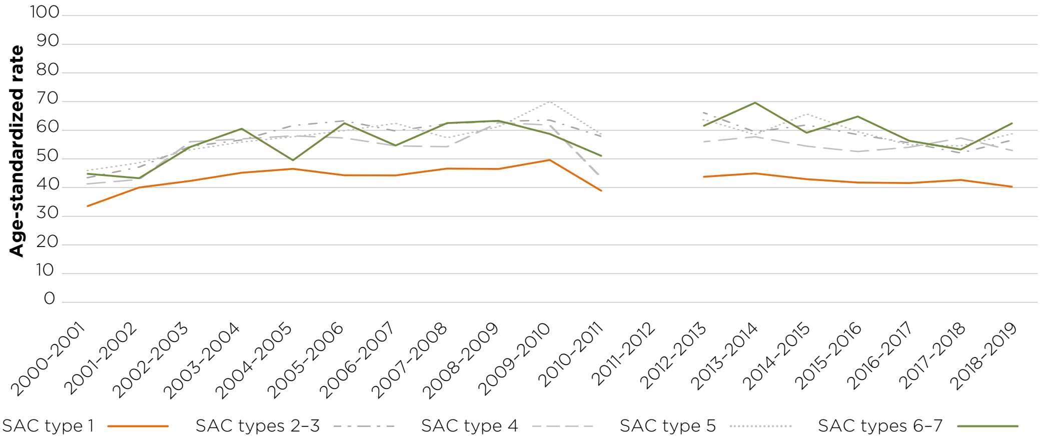
In terms of *dementia-specific pharmacological treatments*, we observed no differences between the groups in the rates of cholinesterase inhibitors or memantine between 2000 and 2019 (Appendix 7). However, the most urban group (SAC type 1) had the lowest rates of dementia medications prescribed in primary care (Figure 4). For example, compared with the most urban group, the most rural group had more prescriptions in primary care for all cohort years, up to 24.6 person-year. Due to a technical issue in the prescription drugs database, the identification numbers of the physicians were not saved during the year 2011–2012; therefore, it was not possible to determine who prescribed the dementia-specific medication for that cohort. Data for that year and the indicator are thus missing.

FIGURE 3. Age-standardized rates (per 100 person-year) of at least one hospitalization with ALC (or delayed discharge)



ALC = alternate level of care; SAC = Statistical Area Classification. For further details on each SAC type, refer to Figure 1 footnote (p. 84).
Complete operational definitions are available in Appendix 3. Other figures of age-standardized rate for potentially avoidable acute care indicators are presented in Appendix 7.

FIGURE 4. Age-standardized rates (per 100 person-year) of dementia prescriptions (cholinesterase inhibitors or memantine) prescribed in primary care

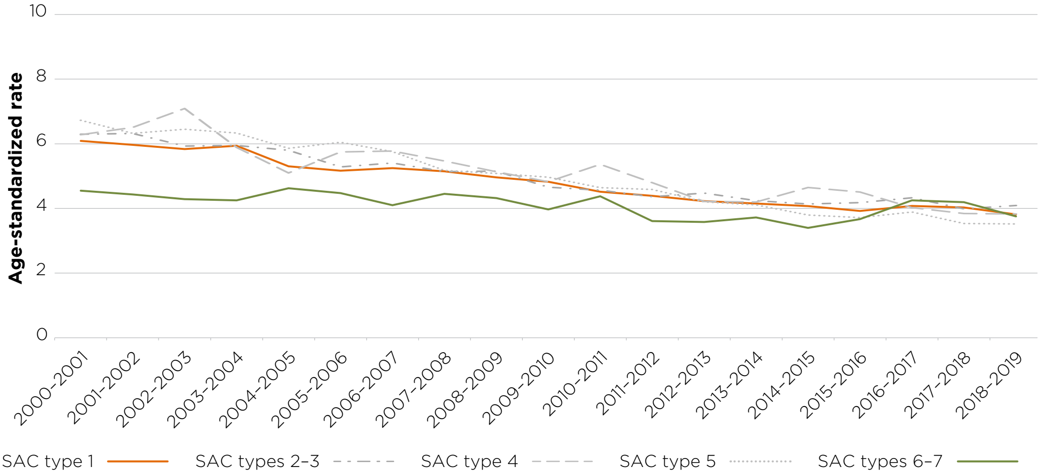


SAC = Statistical Area Classification. For further details on each SAC type, refer to Figure 1 footnote (p. 84).
Complete operational definitions are available in Appendix 3. Missing data for the year 2011–2012 are due to a technical issue in the prescription drugs database. Other figures of age-standardized rate for dementia-specific medications indicators are presented in Appendix 7.

In terms of *potentially inappropriate pharmacological treatments*, between 2000 and 2019 we observed no differences between the groups for rates of antipsychotic and antidepressant prescriptions (Appendix 7), but the most rural group (SAC types 6 and 7) had the highest rates of benzodiazepine prescriptions (Figure 5). For example, compared with the most urban group, the most rural group had higher rates of benzodiazepine prescriptions, 19 years out of 19 and up to 17.7 person-year.

Finally, during the two-decade period, we observed no differences between the groups in rates of *long-term care* or *mortality* (Appendix 7).

FIGURE 5. Age-standardized rates (100 per person-year) of benzodiazepine prescriptions



SAC = Statistical Area Classification. For further details on each SAC type, refer to Figure 1 footnote (p. 84). Complete operational definitions are available in Appendix 3. Other figures of age-standardized rate for potentially inappropriate indicators are presented in Appendix 7.

Discussion

We observed differences in the use of health services for incident PWDs living in rural and urban communities in Quebec. Despite no differences in long-term care admissions and mortality rates, disparities emerged in ambulatory care, acute care and pharmacological care.

In our study, PWDs from the most rural group had the lowest rates of visits to family physicians and cognition specialists as well as higher continuity of care. This aligns with prior studies (Crouch et al. 2019; Koller et al. 2010) but not all (Forbes et al. 2006; Koller et al. 2010). Conflicting results may stem from our focus on incident cases, portraying PWDs in earlier disease stages. Nevertheless, limited resources in rural areas likely contribute to our findings (Charlton et al. 2015; Fédération médicale étudiante du Québec 2020; Gauthier et al. 2009).

We found that rural PWDs had higher rates of ED visits, possibly linked to the practice of rural family physicians in Quebec who often practise in both primary care clinics and the ED (Fleet et al. 2015). Thus, rural family physicians in Quebec may auto-refer patients to the ED for follow-up. Investigating the impact of this practice is essential for future research.

We found higher hospitalizations in rural PWDs, which aligns with existing literature (Forbes et al. 2006). Increased accidents (Smith et al. 2008) and comorbidity (Weeks et al. 2004) in the general rural population may contribute to higher use of acute care services. The shorter length of stay in the rural PWDs of this study may be influenced by the long travel distances; rural PWDs may be hospitalized more often but for shorter periods to spare them long and sometimes unsafe commutes (Martinez et al. 2004), especially when several consultations or tests are required. The limited availability of dementia-related support services in rural areas, including day programs and respite services for both PWDs and caregivers (Bayly et al. 2020), may also contribute to these findings (Martinez et al. 2004).

The most rural PWDs in our study had higher 30-day readmission rates and lower rates of hospitalizations with ALCs (or delayed discharge). Variability in coding preferences and even the availability of hospital beds (Ravaghi et al. 2020) warrant further investigation before conclusion. Due to the low hospitalization rates in each group, we could not determine differences in the length of stay for hospitalizations with ALCs or the rates of hospitalizations with sensitive care conditions for the aging or dementia population. Moreover, there is not enough literature for more detailed comparisons, indicating the need for additional research.

We found no group difference in dementia-specific prescription rates. However, we found lower dementia-specific prescription initiation rates in rural primary care settings. Canadian dementia guidelines (Gauthier et al. 2012; Ismail et al. 2020) and Quebec Alzheimer Plan (Bergman et al. 2009) do support the management of dementia in primary care, across the continuum of care, as opposed to other countries that have based their dementia strategy in specialist care (Arsenault-Lapierre et al. 2020). Nuanced comparisons are limited due to insufficient literature that considers the locus of prescription, emphasizing the need for further research.

We observed no group differences in antidepressant and antipsychotic prescriptions, contradicting previous literature (Bohlken et al. 2015; Sivananthan et al. 2015). This may be due to our focus on incident cases or due to different healthcare insurance systems. Selecting incident cases reduces the inclusion of advanced disease stages explaining the disparity. Rural–urban distinctions may become more pronounced in later disease stages. In addition, rural–urban differences in potentially inappropriate medications have been shown in the general older population in Quebec (Gosselin et al. 2020) and may reflect practice effects. Rural physicians may have limited exposure to new knowledge and fewer chances to consult with geriatricians to manage behavioural and psychological symptoms of dementia.

Finally, we found no group differences in mortality and long-term care admissions, contradicting previous literature, which found higher mortality (Singh and Siahpush 2014) and long-term care admission rates (Crouch et al. 2019) in rural PWDs.

Policy implications

The findings of this study have several policy implications that warrant attention from various stakeholders, including healthcare providers, policy makers, clinicians and professional organizations. Some of our results suggest that services offered in rural settings are of better quality, as they align with the Quebec Alzheimer Plan recommendations (i.e., higher rates of dementia diagnosis in primary care, higher rates of anti-dementia medication prescribed in primary care and higher continuity of care, with the same mortality rates). However, the sheer lack of resources in rural settings needs to be considered carefully. Importantly, PWDs in rural areas, in our study and globally, still have limited access to family physicians and specialists. The perpetual movement of the physician workforce, caused by measures put in place by the Quebec government to promote a better distribution of medical services across the province in rural and especially remote areas (Fédération médicale étudiante du Québec 2020) means that individual access varies abruptly as people come and go (Gauthier et al. 2009). Governmental incentive measures and professional organizations need to align and formalize interprofessional collaborations to improve access to primary care. Through structuring elements that allow a patient's affiliation to a clinic rather than a physician and that expand the scope of practice of these interdisciplinary resources, the impact of resource instability could be mitigated, a broader range of primary care needs could be supported and rural communities' dependence on distant resources could be reduced (Gauthier et al. 2009). This is especially relevant for the dementia care policy in Canada, which relies on interdisciplinary care (Bergman et al. 2009; PHAC 2019). Another solution would be to invest and support in virtual care, which has been demonstrated as useful in rural areas (Iyer et al. 2024).

The higher utilization of acute care services of rural PWDs in our study underscores the significance of strategic investments in health and social services in rural settings to better support PWDs and their care partners at home and avoid caregiver burden, which can lead to ED visits or hospitalizations not medically needed. Decision makers, managers, clinicians and community organizations could pursue several avenues to decrease ED visits and hospitalizations. First, home services and other community services are especially relevant to dementia care (Morgan et al. 2002). Supporting primary care partnerships with community services, such as Alzheimer societies, has been explored in rural Ontario as well as in Saskatchewan, where half of the population lives outside metropolitan areas (Government of Saskatchewan n.d.). These services have strategically located First Link resource centres in smaller communities and adapted a range of services to be accessible virtually to rural communities, including support groups, education sessions, socialization programs and a telephone helpline (Alzheimer Society of Saskatchewan 2021). In addition, decision makers should support the development of hospital-at-home schemes (Leff and Montalto 2004) in rural settings as an alternative to in-patient care when hospitalizations are medically required. Hospital-at-home schemes could also decrease the travel burden for PWDs and care partners.

Finally, to address the higher rates of benzodiazepine prescriptions in rural settings, medical associations, continuing education providers and academic institutions could develop and implement educational programs focusing on pharmacological dementia care, especially in rural areas. Ensuring that healthcare providers are well-informed about the latest dementia management guidelines, or initiatives such as Choosing Wisely, can lead to improved diagnosis, treatment and overall care outcomes. These recommendations should be addressed in dementia care policies, such as the Canadian dementia strategy and provincial Alzheimer's plans, with precise action plans aiming at reducing these rural–urban inequities.

Limitations

Our study has limitations to consider. First, it is a descriptive study, precluding causal inferences. Rather, it provides a comprehensive (20 indicators over 20 years across the care continuum) observational portrait of rural–urban health service use differences in incident dementia cases. Second, measurement of rurality using area-level indicators – like SAC type – though widely used, may be imprecise at the individual levels, particularly in large rural territories and rapidly changing urban areas (CIHI 2018b). However, this measure helps assess how urban centres affect nearby areas.

Third, our analysis – based on administrative databases – may underestimate medical visits, especially in rural settings where salaried physicians (Bosco and Oandasan 2016) and non-physician professionals (Forbes et al. 2006) are common. However, administrative databases allow us to measure the use of health services by the vast majority (90%) of PWDs in Quebec (Blais et al. 2014). The dementia diagnosis algorithm used (Jaakkimainen et al. 2016) excludes specific subtypes of dementia, such as Lewy body dementia, potentially biasing health service use patterns.

Additional research is necessary to grasp the extent of rural–urban disparities in health service utilization among PWDs. Future studies should encompass all subtypes for a more precise representation of the studied population. In addition, exploring other questions in future research mandates the scrutiny of normalcy assumptions, especially given the typically smaller size of the rural groups compared with urban ones. Finally, consideration of how rurality intersects with socio-economic status and sex in PWDs' health service use is essential as these multi-dimensional determinants may overlap and impact health service utilization.

Conclusion

This study reveals important similitudes and differences in health service use between rural and urban community-dwelling PWDs in Quebec. Ignoring geographical disparities may exacerbate health inequity. By providing an estimation of the scope of the differences in health service use in rural and urban regions, this research could guide decision makers involved in implementing Alzheimer's plans to develop more equitable health policies.

Ethics Approval

This study is part of the continuous chronic disease surveillance mandate granted to the Institut national de santé publique du Québec by the provincial Minister of Health and Social Services and approved by the provincial Ethics Committee of Public Health, allowing surveillance activities without participant consent. In addition, it was approved by the McGill Faculty of Medicine Institutional Review Board (A10-B66-19A).

Availability of Data and Materials

The data that support the findings of this study are available from the Institut national de santé publique du Québec but restrictions apply to the availability of these data, which were used under licence for the current study and so are not publicly available. Data are, however, available from the authors upon reasonable request and with permission of the Institut national de santé publique du Québec.

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