Healthy Canadians

A Federal Report on Comparable Health Indicators 2004

Canada

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Health Canada
Ottawa, Ontario K1A 0K9
Tel.: (613) 954-5995
Fax.: (613) 941-5366
E-mail: publications@hc-sc.gc.ca

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November 2004

Message from the Minister of Health

Canadians cherish their publicly funded health care system as part of their national identity and want to know how the system is performing. They are entitled to better and more comparable information on the timeliness and quality of health care services and their health status.

Extensive work has been done since the first set of comparable health indicator reports in 2002. I am pleased to release *Healthy Canadians — A Federal Report on Comparable Health Indicators 2004.* This report is the Government of Canada's response to the commitments of enhanced transparency and accountability in the health care system made by First Ministers in February 2003.

Building on the spirit of collaboration demonstrated throughout the 2002 reporting process, health ministries from all 14 jurisdictions — including the federal government — are reporting on a set of jointly agreed-upon indicators that address the themes of timely access, quality, and health and wellness.

Comparing across jurisdictions allows Canadians to see their governments' progress in renewing and strengthening the health care system. These reports provide a basis upon which areas for improvement can be highlighted and informed decisions can be made.

Indicators that respond to the needs and interests of Canadians have been identified and developed. I would like to thank the citizens who participated in public consultations on health indicators, as well as stakeholders, health ministries, advisory committees, Statistics Canada, the Canadian Institute for Health Information and l'Institut de la statistique du Québec, for their invaluable contributions to the development of this report.

At their September 2004 meeting, First Ministers reiterated the significant progress that has been made since the 2003 Health Accord and agreed on new initiatives, such as reducing wait times, that will build upon this progress. Numerous efforts are under way throughout Canada and across jurisdictions to make health care more responsive and sustainable. However, there is still more work to be done. For instance, indicators under the theme of Sustainability and the priority area of Home Care are currently under development. I am hopeful that additional indicators will be developed over the longer term in order to improve reporting in future years.

I am optimistic that these reports will inform discussions of health system renewal and support a health care system that successfully adapts to the changing needs of Canadians.

Sincerely,

Ujjal Dosanjh
Minister of Health

Table of Contents

Annexes

Executive Summary

The September 2000 First Ministers' Communiqué on Health *gave direction to federal, provincial and territorial health ministers to collaborate on the development of a comprehensive framework of health indicators. Ministers committed to reporting on comparable health indicators that measure health status, health outcomes and quality of health care service. In September 2002, all 14 jurisdictions, including the federal government, released their reports on 67 comparable indicators.*

The February 2003 *First Ministers' Accord on Health Care Renewal* (the Accord) directed health ministers to further develop indicators to supplement the work on comparable indicator reporting. This has resulted in a suite of 70 indicators (available at: <http://www.statcan.ca/english/freepub/82-401-XIE/2002000/index.htm> or <http://www.cihi.ca/comparable-indicators>) which address a number of themes and priority areas identified in the Accord. The current report — *Healthy Canadians — A Federal Report on Comparable Health Indicators 2004* — is the federal government's report on the 18 health indicators selected by federal, provincial and territorial governments for detailed reporting in 2004. These indicators are based on extensive input from a range of stakeholders and experts, as well as on results of public focus group testing.

Much of the data in this report comes from national data sources provided by Statistics Canada, Health Canada and the Canadian Institute for Health Information. This report also includes limited data on First Nations and Inuit populations.

The following highlights some of the findings in the report.

Timely Access ...

- Canadians are experiencing difficulties accessing health care services — of those requiring services, 16.4% reported difficulty accessing routine or on-going care, 15.8% reported difficulty accessing health information or advice, and 23.8% indicated that they had difficulty getting immediate care for a minor health problem.
- In 2003, Canadians reported waiting three weeks to receive the diagnostic services they needed — unchanged since 2001.

- In 2002, the majority of Canadian households (65.2%) spent, out-of-pocket, a portion of their after-tax income on prescription drugs.

Quality ...

- Hospitalization rates for conditions that could be treated in community-based settings have been declining in recent years in Canada, from a rate of 503 admissions per 100,000 population in 1995–96 to 346 in 2001–02.

- Most Canadians (84.9%) say they were satisfied with the way overall health care services were provided in Canada in 2003.

Health Status and Wellness ...

- In 1999–2000, 5.1% of Canadians aged 20 and over were living with diagnosed diabetes.

- The proportion of Canadian teenagers and adults who rate their health as “excellent” or “very good” has been declining. In 2003, 59.6% of Canadians aged 12 years and over reported that they were in “excellent” or “very good” health, compared to 63.3% in 1994–95.

- Smoking among teenagers is declining — in 1994–95, 20.9% of 12- to 19-year-olds reported that they were current smokers, compared to 14.8% in 2003. After a brief increase, the proportion of teenaged smokers who reported that they were daily smokers has also declined, from 13.6% in 1994–95 to 9.1% in 2003.

- Canadians are becoming more active, reporting an overall increase in activity levels from 39.3% in 1994–95 to 51.0% in 2003.

- Self-reported data show that almost one half (46.9%) of Canadians are overweight or obese. A similar proportion of people are in the normal weight range (47.8%), and 2.8% are underweight.

- Canada’s seniors are taking action to prevent getting the flu — the majority (62.1%) got a flu shot during the 12 months before they were surveyed.

Current plans are to develop additional indicators over the longer term, in order to improve reporting in future years.

I

Introduction

The purpose of this report is to inform Canadians on the performance of their health care system, and to assist individuals, governments and health care providers to make more informed choices. Public reporting of comparable indicators is an important component of government accountability to Canadians. This initiative demonstrates that federal, provincial and territorial governments are committed to increased accountability and have invested in strengthening their capacity to report on the performance of the health system.

Background

In 2000, the *First Ministers' Communiqué on Health* directed health ministers in all provinces and territories and the federal government to collaborate on the development of a comprehensive framework of health indicators. The framework was to focus on reporting to Canadians on health status, health outcomes and quality of health care services. Indicators were developed that would allow for comparison across all federal/provincial/territorial jurisdictions in Canada. In September 2002, all 14 jurisdictions, including the federal government, released their reports on 67 comparable indicators. This marked the first time that health ministries from all jurisdictions were concurrently reporting to their constituents on a set of jointly agreed-upon indicators addressing health status, health outcomes and quality of service. The First Ministers committed to reporting to the public every two years.

In February 2003, the *First Ministers' Accord on Health Care Renewal* (the Accord) directed health ministers to develop additional indicators by September 2003, and to include "review by experts and stakeholders, to ensure these new indicators measure progress on achieving the reforms set out" in the Accord. In particular, the Accord focused on several themes: Timely Access, Quality, Health Status and Wellness, and Sustainability.

The Accord reflects the First Ministers' agreement that:

- Each jurisdiction will provide comprehensive and regular public reporting on the health programs and services that it delivers, as well as on health system performance, health outcomes and health status.

- These reports will include the indicators set out in the September 2000 Communiqué, as well as additional comparable indicators to be developed by health ministers on the specific themes mentioned above.

- Jurisdictions will develop the necessary data infrastructure and collect the data needed for high quality reporting.

The Accord focused indicator development and reporting activities on several specific program and service areas for the health system, such as primary health care and home care services, identifying the development of these services as important strategies for health system reform and sustainability.

Federal/Provincial/Territorial Process

The Federal/Provincial/Territorial Conference of Deputy Ministers of Health directed its Advisory Committee on Governance and Accountability (Advisory Committee) to prepare the plan for comparable reporting, in compliance with the terms of the 2003 Accord. The policy direction for this work was approved by the Deputy Ministers and a working group was established to undertake the technical work associated with the initiative. The working group included representatives from each federal, provincial and territorial jurisdiction, as well as from the Canadian Institute for Health Information, Statistics Canada and l'Institut de la statistique du Québec.

Selection of Indicators

The selection of indicators involved a variety of groups, processes and events. Consultations with stakeholders were undertaken in the form of an invitational workshop with national stakeholder groups in June 2003. Stakeholders were also invited to contribute input by written submissions or via a Web site. Public opinion was collected through a number of focus groups held in January 2004 in five major cities across Canada. This feedback helped to determine the indicators that are important and meaningful to Canadians, as well as to provide information on the public's preferences for the format and presentation of health indicators. Results from public consultations held in some provinces on the 2002 comparable health indicator reports were also considered in the selection of indicators for 2004. A review and rationalization of indicators in two areas (burden of illness and wait times) from the September 2000 *Communiqué on Health* was undertaken, and input from other advisory committees was also considered.

Ultimately, the Advisory Committee on Governance and Accountability recommended a list of 70 indicators to the Deputy Ministers for reporting to the public in November 2004, including a subset of 18 indicators for detailed reporting by all jurisdictions in their printed reports. Data on all indicators, for all jurisdictions, are available on Web sites hosted by the Canadian Institute for Health Information (http://www.cihi.ca/comparable-indicators) and Statistics Canada (http://www.statcan.ca/english/freepub/82-401-XIE/2002000/index.htm).

Additional indicators for reporting will be developed over the longer term, with the goal of improving reporting in future years.

About the 2004 Healthy Canadians Report

This report reflects some significant changes from the 2002 *Healthy Canadians* report:

- ***Themes and priority areas of the 2003 Health Accord*** — The 2004 report reflects the themes and priority areas identified in the 2003 Health Accord (see box, next page).
- ***Focus on 18 featured indicators*** — This report focuses on 18 featured indicators. These indicators are those shown by public opinion research to be of greatest interest or use to Canadians and which could be reported on by most jurisdictions. The full set of 70 indicators is available for access by researchers, administrators and the public at: <http://www.statcan.ca/english/freepub/82-401-XIE/2002000/index.htm> or <http://www.cihi.ca/comparable-indicators>.
- ***Data on other federal health responsibilities:***
  - The federal government is responsible for delivering health care services to specific groups — for example, First Nations and Inuit, veterans, military personnel, inmates of federal penitentiaries and members of the Royal Canadian Mounted Police.
  - Much of the data currently collected on these populations do not correspond to the comparable indicator reporting requirements for 2004. More specifically:
    - No data are available for most of the populations that are under federal responsibility, and

  - There are only limited data available on Aboriginal peoples. Every effort has been made to clearly identify these reporting limitations for each graph and table included in the report.
- Information routinely collected for the Canadian population is not necessarily available for Aboriginal populations. Jurisdictions have varying capacities to collect, analyze and publish data. For example, the ability to accurately identify First Nations and Inuit clients in hospital databases, and to track utilization and outcomes, varies by province and region.

2003 Health Accord — Themes and Priority Areas

The 2003 Health Accord is an action plan for reform of Canada's health care system and reflects commitment by the federal, provincial and territorial governments to work together, along with health care providers and with Canadians, to shape the future of Canada's public health care system. The Accord identifies four broad themes and six priority areas for reporting to Canadians, as listed below; descriptions are included in Section III.

Four Themes ...

1. Timely Access
2. Quality
3. Health Status and Wellness
4. Sustainability*

Six Priority Areas ...

- Primary Health Care
- Home Care*
- Catastrophic Drug Coverage and Pharmaceutical Management
- Diagnostic and Medical Equipment
- Health Human Resources
- Healthy Canadians

A seventh priority area, Other Programs and Services, was added by the Advisory Committee to deal with follow-up work on indicators arising from the 2000 *Communiqué on Health.*

Some of the priority areas fall under a number of themes. For example, Primary Health Care falls under the themes of Timely Access and Quality.

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*The theme of Sustainability and the priority area Home Care are under development and, therefore, are not covered in this report.

How this Report is Organized

This report begins with a snapshot of the federal government's role in health (Section II, *Overview of the Federal Government's Role in Health*).

Section III, *Measuring Performance*, presents an overview of national level data and highlights information on health care delivery that falls under federal jurisdiction. It reports on the 18 featured indicators, including a brief description of each indicator, the data collected for each (the results) and a brief commentary on the results. Limited information on Aboriginal populations is included, and no data are available on other populations under federal responsibility for health care.

Section IV, *Health Information — Challenges and Next Steps*, presents some of the current issues related to collecting and reporting on health information and sets out direction from the 2003 Health Accord for improving data collection and reporting on Aboriginal populations.

The report is supplemented by four annexes: Annex 1 — lists the 18 featured indicators and the federal government's ability to report on these indicators for the national population and for Aboriginal populations; Annex 2 — provides the descriptions, definitions, and corresponding data tables and sources for the 18 indicators; Annex 3 — lists the 70 indicators approved by the Deputy Ministers for public reporting in 2004; and Annex 4 — lists exclusions and limitations for the data sources used in this report.

Notes:

- Unless specifically noted, the data presented in this report have been audited; all unaudited data are noted as "not audited."
- All differences highlighted in this report have been found to be statistically significant ($p<0.05$).*

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*Statistical significance implies that an observed difference is probably true and not due to chance. The term "$p<0.05$" means that the probability is less than 5% that the observed difference is due to chance alone.

Overview of the Federal Government's Role in Health

The Government of Canada plays a pivotal role in preserving and supporting our publicly funded health care system. It assists the provinces and territories in ensuring that Canadians have access to medical care based on need, not on ability to pay. Federal funding is contingent on the five conditions of the Canada Health Act*: universality; accessibility; portability; comprehensiveness; and public administration. In addition, the government has program and regulatory responsibilities in such areas as health protection and promotion, health security, disease prevention and research.*

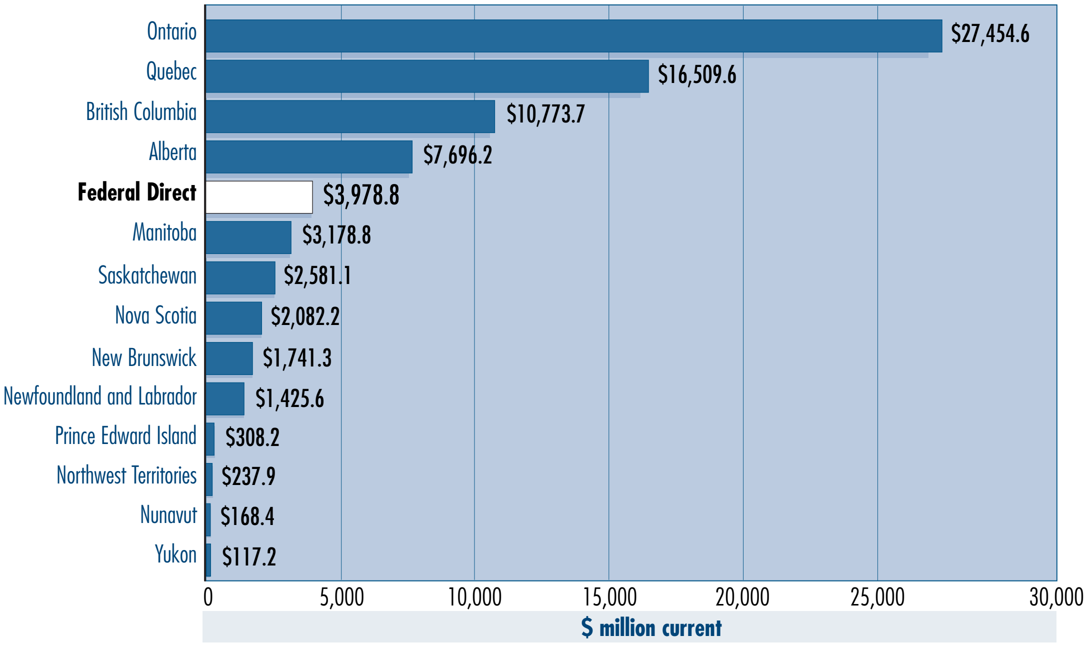
The Government of Canada is also the fifth largest provider of health services to Canadians, serving approximately 990,000 people at a cost of almost $4.0 billion annually. It ensures access to health services for First Nations and Inuit, military personnel and veterans, the Royal Canadian Mounted Police, and inmates in federal penitentiaries.

Federal Health Services at a Glance

Several federal government departments either provide health services directly or ensure that health services are provided to specific populations. A summary of the services provided by federal departments follows.

Total Public Sector Health Care Spending

By jurisdiction, 2001



Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2003.*

Health Canada — First Nations and Inuit health programs account for about $1.4 billion annually and serve approximately 695,983 First Nations clients, as well as 39,360 Inuit clients. The department provides:

- a limited range of medically necessary health-related goods and services not provided through private or provincial/territorial health plans, including drugs, medical transportation, dental care, medical supplies and equipment, crisis intervention counselling and vision care; and
- community-based health programs, including on-reserve disease prevention and health promotion programs; community nursing services; health education; drug, alcohol and substance abuse programs; mental health and child development programs; environmental health services; and limited hospital services.

Veterans Affairs Canada — Provides health care to war and Canadian Forces veterans who meet service and income requirements or who have been awarded disability pensions resulting from military service. The department provides a comprehensive range of health care benefits not provided provincially, and includes institutional care for eligible clients in community care facilities. In fiscal year 2002–03, 133,400 clients were eligible for health care benefits, resulting in expenditures of $636.6 million in health care programming.

Correctional Service of Canada — Provides inmates with essential health care services (physical and dental) as well as reasonable access to non-essential mental health care that will contribute to their rehabilitation and successful reintegration into the community. Services are provided through a network of health units at all penitentiaries, including five regional hospitals and dedicated mental health treatment centres. Community specialists and diagnostic and hospital services are used as required. The operating expenditures for delivery of these health services to approximately 12,600 inmates in fiscal year 2002–03 were $118.4 million. This figure includes all medical costs — salaries, medication, hospitalization, medical tests/examinations, and physician, specialist and dental appointments.

Department of National Defence — Provides for the health care needs of Canadian Forces members at home and abroad. Health care services are provided through a network of Canadian Forces health care clinics or by purchasing services from the provinces/territories. A comprehensive range of health services is provided to 60,000 Regular Forces members and 33,000 Reserve members (while on duty). Health expenditures in fiscal year 2002–03 were approximately $306.0 million.

Royal Canadian Mounted Police (RCMP) — Provides health care to all uniformed members of the RCMP. A comprehensive range of health services is provided to ensure that members of the RCMP are emotionally and medically fit to perform their duties safely. Members receive personal health care from providers of their choice from within their immediate community, who meet RCMP criteria. Approximately 15,980 members are eligible to receive health benefits. In fiscal year 2002–03, health expenditures were approximately $38.0 million.

The Canada Health Act excludes ...

… inmates of federal penitentiaries and members of the Canadian Forces and the Royal Canadian Mounted Police from the definition of "insured persons" for whom health services are provided under provincial health care plans.

Definitions Related to Aboriginal Populations

Health information about First Nations and Aboriginal populations presented in this report is drawn from several sources and refers to a number of different populations, as defined below:

Aboriginal: A person who reports identifying with at least one Aboriginal group (North American Indian, Métis or Inuit). This group includes all those who report being a Treaty Indian or a Registered Indian as defined by the *Indian Act* of Canada, as well as members of an Indian Band or members of a First Nation.[1]

First Nations peoples: A term that came into common usage in the 1970s to replace the word "Indian," which some people found offensive. Although the term First Nation is widely used, no legal definition exists. Among its uses, the term "First Nations peoples" refers to the Indian peoples in Canada, both Status and Non-Status.[2]

North American Indians: People who identify themselves as being Indians from North America. They may or may not be Registered or Status Indians.[1]

Inuit: The Aboriginal people of Arctic Canada. Inuit live primarily in Nunavut, the Northwest Territories and northern parts of Labrador and Quebec. The word "Inuit" means "the people" in Inuktitut, the Inuit language, and is the term by which Inuit refer to themselves.[2]

Reserve: A tract of land, the legal title to which is held by the Crown, set apart for the use and benefit of an Indian band. Some bands use more than one reserve.[2]

On-reserve: A term used to describe people, services or objects that are part of a reserve and relate to First Nations people.[2]

Off-reserve: A term used to describe people, services or objects that are not part of a reserve, but relate to First Nations people.[2]

Non-reserve: A term used to describe Aboriginal people/populations who are not affiliated with a reserve. For example, Inuit people do not live on reserves.[1]

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[1] Statistics Canada.
[2] Indian and Northern Affairs Canada.

III

Measuring Performance

This section presents information about the 18 indicators selected for discussion. As described earlier, these indicators reflect both the themes and priority areas identified in the 2003 Health Accord.

An overview of the themes and priority areas is followed by highlights of each of the 18 indicators. In addition, a number of graphs are included in this section that reflect comparisons of various health indicators among the G7 countries. These are intended to help readers understand the Canadian data in a broader international context. Detailed data tables are included for each indicator in Annex 2 of this report.

Themes and Priority Areas of the 2003 Health Accord

Themes ...

The four themes of the Health Accord are:

Timely Access — Indicators under this theme measure access to essential services and the waiting time involved in receiving these services.

Quality — Indicators under this theme measure several aspects of quality of health care services, including patient safety, patient satisfaction and health outcomes.

Health Status and Wellness — Indicators under this theme measure the health of the entire population. They are influenced by many factors, including education, economic status and living conditions.

Sustainability — Indicators under this theme measure several aspects of health care, including the state of health human resources, equipment, information systems and value for money from the system.

G7 countries ...

... are the original seven most industrialized countries in the world: Canada, France, Germany, Italy, Japan, United Kingdom and United States.

Priority Areas ...

Each priority area is described below, followed by an example of an indicator.

Primary Health Care — This is the first level of care and the initial point of contact that a patient has with the health system. When Canadians need non-emergency care, they most often turn to primary health care services. This could include visits to family physicians, nurses, nurse practitioners and mental health workers; telephone calls to health information lines; and advice received from pharmacists. *Example: Difficulty obtaining routine or on-going health services.*

Catastrophic Drug Coverage and Pharmaceutical Management — Although the federal government, provinces and territories provide some level of public drug benefit coverage to certain segments of the population, out-of-pocket spending on prescription drugs is growing faster than any other category of health expenditures. Canadians with serious health conditions or illnesses may face undue hardship due to very high prescription drug costs. *Example: Prescription drug spending as a percentage of income.*

Diagnostic and Medical Equipment — Early access to diagnostic equipment can lead to early detection, diagnosis and treatment — and often to favourable health outcomes. Diagnostic and medical equipment normally includes such high technology machines as magnetic resonance imagers (MRIs), computed tomography (CT) scanners, radiation therapy equipment and lithotripters. It also includes other diagnostic and therapeutic equipment such as ultrasound and x-ray machines, and additional medical and surgical equipment that enhances the quality of patient care or the working conditions of health care personnel. *Example: Self-reported wait times for diagnostic services.*

Health Human Resources — The health care system relies on trained health professionals such as physicians, nurses and pharmacists to deliver health care. Ensuring that all health providers are qualified, and anticipating and maintaining an appropriate supply of health professionals are key to making sure that Canadians have proper access to health providers. *Example: Patient satisfaction with physician care.*

Healthy Canadians — An effective health system requires a balance between individual responsibility for personal health and a collective responsibility for the health care system. Coordinated approaches to deal with the issue of obesity and to promote physical fitness and the enhancement of public and environmental health are necessary to improve the health status of Canadians. Continuing efforts to promote healthy living, immunization and other initiatives to reduce disparities in health status are also essential. *Example: Prevalence of diabetes.*

Other Programs and Services — This priority area encompasses timely access and quality indicators that were part of the first comparable reporting process arising from the 2000 *First Ministers' Communiqué on Health*, and includes measures of public perception of the health care system and indicators of quality service outcomes. *Example: Patient satisfaction with hospital care.*

Home Care — This priority area encompasses an array of services that enables individuals to receive care and treatment at home and/or to live as independently as possible, when they might otherwise have to be in hospital. This could include professional nursing care, personal care and home support, such as cleaning and laundry. Home care also offers support to persons providing full-time care for an incapacitated individual. *Indicators for this priority area are currently under development.*

Report on 18 Indicators

Highlights of the 18 featured indicators include a brief description of each indicator (i.e., what it measures), the results of the measurement (including a graphic representation of results) and a brief comment about the results. The theme and priority area that the indicator relates to are also identified. Several graphs that compare Canadian data to that of other G7 countries are also included. These graphs may not necessarily reflect the same data as those in the 18 featured indicators, but they are included to provide readers with international context. Detailed data tables for each of the 18 featured indicators are presented in Annex 2 of this report.

1 Difficulty obtaining routine or on-going health services

2 Difficulty obtaining health information or advice

3 Difficulty obtaining immediate care

Theme: Timely Access

Priority Area: Primary Health Care

Description: Grouped in this category are indicators that measure the percentage of people who reported having difficulty obtaining routine or on-going health services, health information or advice, and immediate care for a minor health problem at any time of the day in the 12 months prior to the survey.

Results: Among Canadians who required selected health services in 2003, 16.4% reported difficulty accessing routine or on-going health services in the 12 months prior to the survey, 15.8% reported difficulty accessing health information or advice, and 23.8% had difficulty accessing immediate care for a minor health problem.

Comment: Canadians are reporting difficulty accessing routine health services, health information or advice, and immediate care for a minor health problem.

Percent of Population Reporting Difficulty Accessing Health Services, Information or Advice, and Immediate Care

By type of service (age standardized), Canada, 2003*

Type of service	Percent reporting difficulty accessing service
Routine or on-going health services	16.4
Health information or advice	15.8
Immediate care for a minor health problem	23.8

Source: Statistics Canada, Health Services Access Survey, 2003.

Notes: Includes household population aged 15 and over reporting difficulty accessing these services in the 12 months prior to the survey, for self or a family member.
Based on the population requiring these services in the 12 months prior to the survey, for self or a family member.
Age standardized to the 1991 Canadian population.
For additional exclusions/limitations see Annex 4.

*Data for the Health Services Access Survey exclude the territories.

4

Prescription drug spending as a percentage of income

Theme: Timely Access

Priority Area: Catastrophic Drug Coverage and Pharmaceutical Management

Description: This indicator measures the percentage of Canadian households that spend more than a certain proportion (specifically, 0%, 1%, 2%, 3%, 4% or 5%) of their after-tax income out-of-pocket on prescription drugs.

Results: The proportion of households in Canada that spend, out-of-pocket, more than 1%, 2%, 3%, 4% or 5% of their after-tax income on prescription drugs generally increased over the six-year period from 1997 to 2002. For example, in 1997, 18.1% of Canadian households spent more than 1% — by 2002, 19.1% were spending over 1%. And, while 2.7% spent over 5% on prescription drugs in 1997, 3.0% were doing so in 2002. In 2002, 65.2% of Canadian households spent a portion (in other words, more than 0%) of their after-tax income on prescription drugs (see page 51, Annex 2).

Comment: The percentage of Canadian households spending at least a portion of their after-tax income on prescription drugs has remained fairly constant in recent years.

After-tax income …

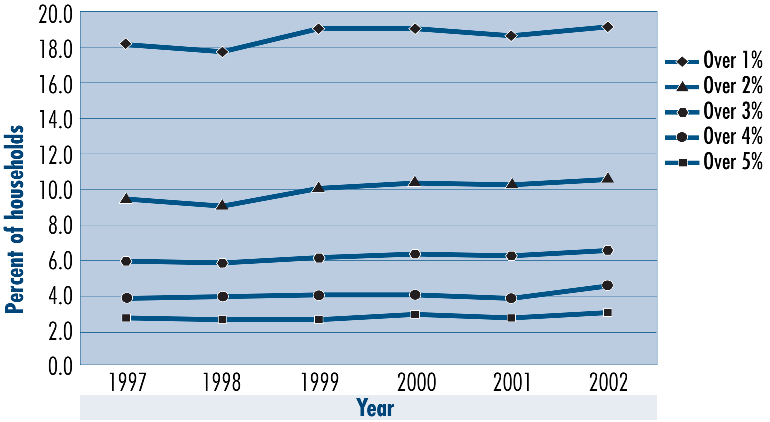
… is total income minus personal taxes.

Out-of-pocket …

… refers to a full or partial expenditure that is not reimbursed through a drug plan or other health insurance plan.

Prescription Drug Spending as a Percentage of Income

By percent of after-tax income, Canada, 1997 to 2002



Source: Statistics Canada, Survey of Household Spending, 1997, 1998, 1999, 2000, 2001 and 2002.

Notes: Prescription drug spending only includes prescription drugs purchased by households. Over-the-counter drugs and drugs paid for by governments or insurance companies are not included.
Premiums for health care plans are not included.
For additional exclusions/limitations see Annex 4.

5 Self-reported wait times for diagnostic services

This indicator includes two sub-indicators:

- Median wait time for diagnostic services
- Distribution of wait times for diagnostic services

Theme: Timely Access

Priority Area: Diagnostic and Medical Equipment

Description: This indicator measures the median wait time reported by people requiring a diagnostic service and the proportion of people who report waiting for a required diagnostic service for three different time periods (less than one month, one to three months, and more than three months). The wait time refers to the time in weeks between the time when the patient is referred for a service and when the patient actually receives the service during the 12 months prior to the survey. Patients who had not yet received the service (or who are still waiting) are excluded from the definition of this indicator.

Results: In 2003, the self-reported median wait time for diagnostic services was three weeks, unchanged from 2001 (see page 52, Annex 2). Results from 2003 show that 57.5% of Canadians reported waiting less than one month for a diagnostic service, while 31.1% reported waiting one to three months and 11.5% reported waiting longer than three months.

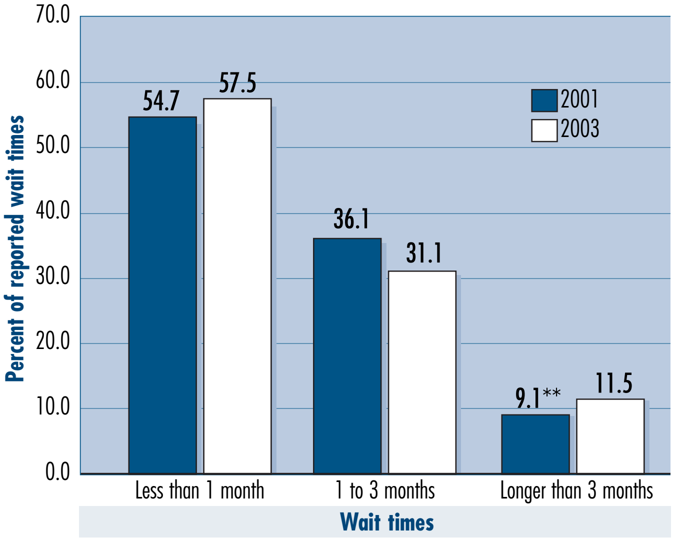
Comment: Canadians report waiting three weeks to receive the diagnostic services they need — unchanged in 2003 from 2001.

Median wait time …

… is measured in weeks, and indicates that half of patients wait less and half wait more than the median number of weeks. For example, a median wait time of three weeks means that half of patients wait less than three weeks and half wait more than three weeks.

Self-reported Wait Times for Diagnostic Services

Distribution of wait times, Canada, 2001 and 2003*



Source: Statistics Canada, Health Services Access Survey, 2001 and 2003.
Notes: Based on household population aged 15 and over reporting a need for a diagnostic test in the 12 months prior to the survey.
Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.
For additional exclusions/limitations see Annex 4.

*Data for Health Services Access Survey exclude the territories.
**Use with caution (high sampling variability).

6 Hospitalization rate for ambulatory care sensitive conditions

Theme: Quality

Priority Area: Primary Health Care

Description: This indicator measures hospitalization rates per 100,000 population for chronic conditions that can often be cared for in the community, such as diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Fewer hospitalizations for ambulatory care sensitive conditions are desirable.

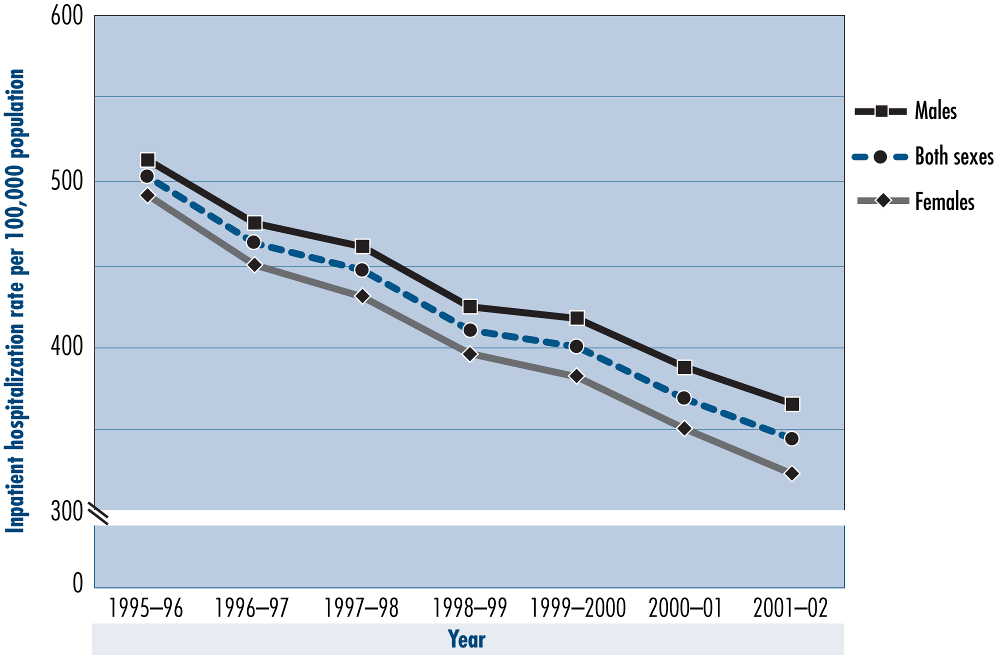
Results: The hospitalization rate for ambulatory care sensitive conditions has been declining in recent years for both men and women in Canada, from a rate of 503 admissions per 100,000 population in 1995–96 to 346 in 2001–02.

Age standardization …

… is a procedure for adjusting rates (e.g., death rates) to minimize the effects of differences in age composition when comparing rates for different populations.

Hospitalization Rate for Ambulatory Care Sensitive Conditions

By sex (age standardized), Canada, 1995–96 to 2001–02



Sources: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, Census; Institut de la statistique du Québec.

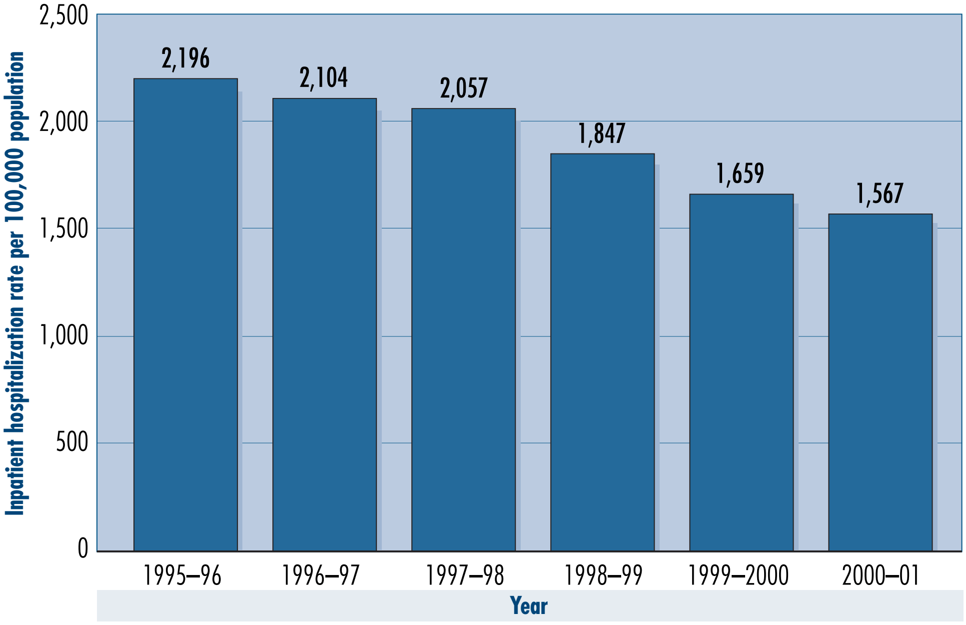
Notes: Age standardized to the 1991 Canadian population.
For additional exclusions/limitations see Annex 4.

The rate has also been declining for both men and women in First Nations populations — from 2,196 admissions per 100,000 population in 1995–96 to 1,567 in 2000–01.

Comment: Some hospitalizations for chronic conditions are being avoided by providing adequate care in the community. While the rate has been declining for all Canadians, it remains four to five times higher among First Nations populations.

Hospitalization Rate for Ambulatory Care Sensitive Conditions (not audited)

First Nations (on- and off-reserve) (age standardized), 1995—96 to 2000–01*



Sources: Health Canada, First Nations and Inuit Health Branch; Manitoba Health; Saskatchewan Health; British Columbia Ministry of Health Planning.

Notes: Age standardized to the 1991 Canadian population.
See notes on applicable table in Annex 2.

*First Nations data are for British Columbia, Saskatchewan and Manitoba only.

7 Patient satisfaction with overall health care services

Theme: Quality

Priority Area: Primary Health Care

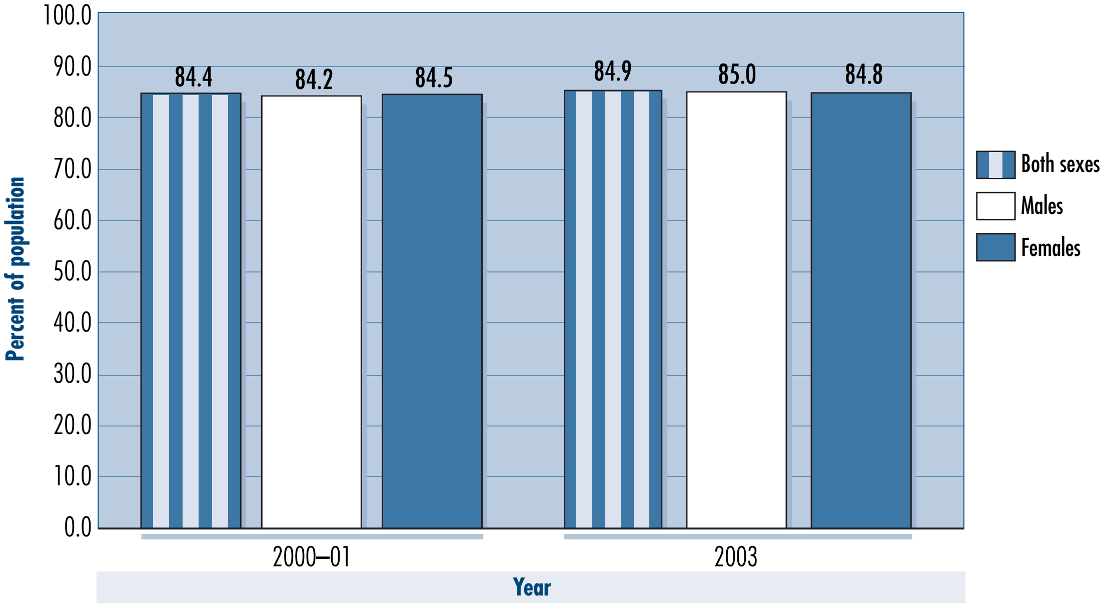
Description: Patient satisfaction with overall health care services refers to the percentage of the population who used health care services in the 12 months prior to the survey, and who reported that they were either "very satisfied" or "somewhat satisfied" with the way the services were provided.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Results: Most Canadians (84.9%) reported being satisfied with the way overall health care services were provided in Canada in 2003. No changes are discernible from 2000–01 when survey respondents were first asked this question.

Patient Satisfaction with Overall Health Care Services

Percent who were "very satisfied" or "somewhat satisfied" with the way services were provided, by sex (age standardized), Canada, 2000–01 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving health care services in the 12 months prior to the survey.
For additional exclusions/limitations see Annex 4.

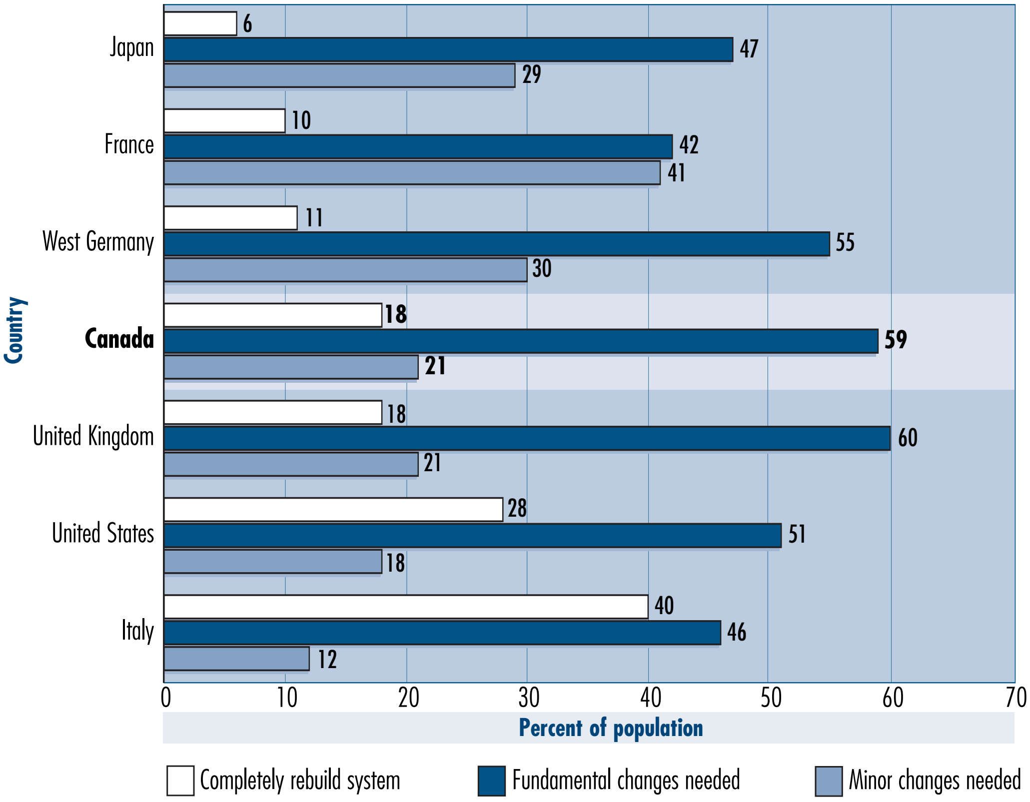
In terms of satisfaction with their health care system and suggested reforms, the populations of Canada and the United Kingdom have similar views. In 2001, 21% of both the Canadian population and the United Kingdom population said that minor changes were needed.

Comment: Canadians are generally satisfied with the health care system, although a comparison across G7 countries suggests that improvements to the system may be needed for Canadians to attain the high satisfaction levels reported in Japan and France.

The international data presented on this indicator are an indirect measure of the public's satisfaction with their respective health care systems. For example, a response of "minor changes needed" indicates the highest level of satisfaction.

Health Care Satisfaction (not audited)

Expressed need for reforms as a reflection of the public's satisfaction with their health care system, selected countries



Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for France, Italy and Japan are from 1988–1991; data for West Germany are from 1994; data for Canada, U.K. and U.S.A. are from 2001.
For additional exclusions/limitations see Annex 4.

8 Patient satisfaction with community-based care

Theme: Quality

Priority Area: Primary Health Care

Description: Patient satisfaction with community-based care is the percentage of the population who used community-based services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

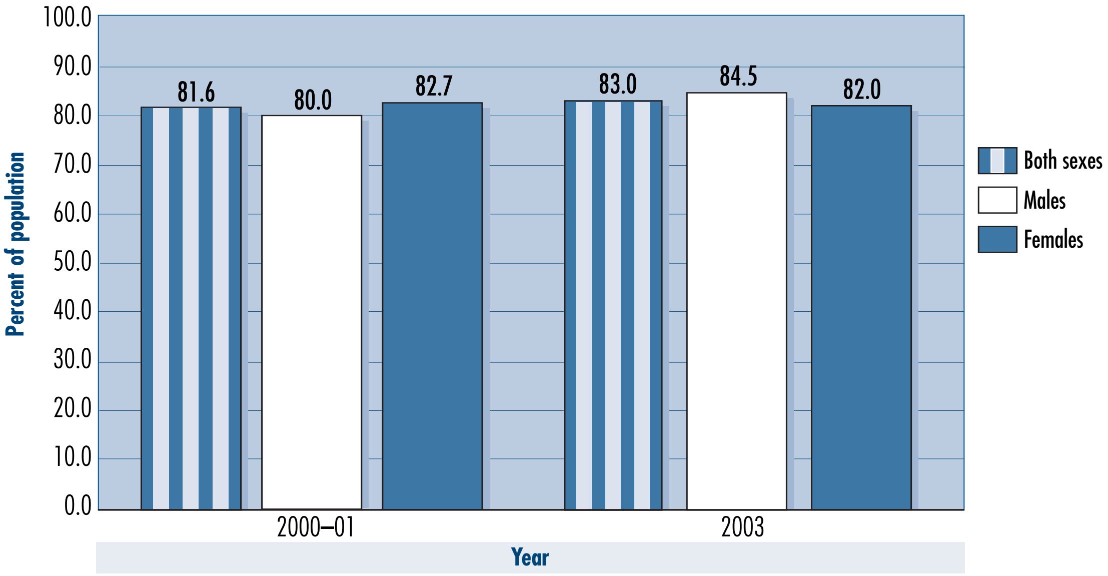
Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Results: In 2003, 83.0% of Canadians reported being satisfied with the way community-based care was provided. The proportion of men reporting satisfaction increased from 80.0% in 2000–01 to 84.5% in 2003.

Comment: Canadians generally appear to be satisfied with the way community-based care is provided, and satisfaction with this care has increased for men over the last few years.

Patient Satisfaction with Community-based Care

Percent who were "very satisfied" or "somewhat satisfied" with the way care was provided, by sex (age standardized), Canada, 2000–01 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving community-based health care in the 12 months prior to the survey, excluding that received through a hospital or doctor's office.
For additional exclusions/limitations see Annex 4.

9 Patient satisfaction with telephone health line or tele-health services

Theme: Quality

Priority Area: Primary Health Care

Description: Patient satisfaction with telephone health line or tele-health services refers to the percentage of the population who used a telephone health line or tele-health service in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the services were provided.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Results: In 2003, 83.7% of Canadians reported being "very satisfied" or "somewhat satisfied" with the way telephone health line or tele-health services were provided. In addition, 86.0% of men and 82.7% of women expressed satisfaction with these services.

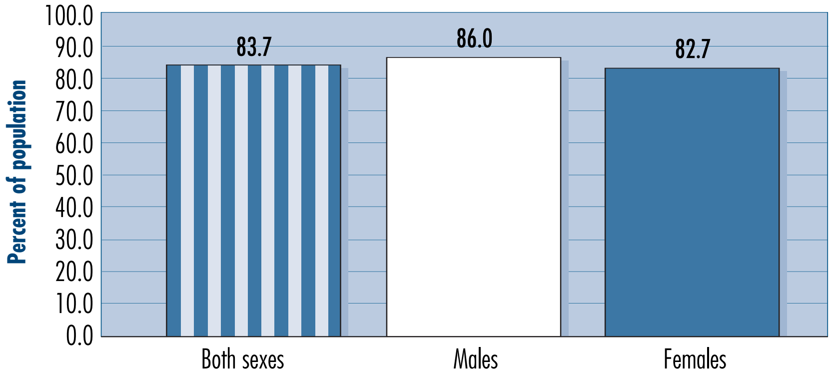
Comment: A high proportion of Canadians are satisfied with the way telephone health line or tele-health services are provided.

Telephone health line or tele-health services …

… are phone-based services which offer health information provided by a nurse or other health specialist. There must be live interaction. Therefore, automated services are excluded from the definition of this indicator.

Patient Satisfaction with Telephone Health Line or Tele-health Services

Percent who were "very satisfied" or "somewhat satisfied" with the way services were provided, by sex (age standardized), Canada, 2003



Source: Statistics Canada, Canadian Community Health Survey, 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported using telephone health line services in the 12 months prior to the survey. There are no telephone health line or tele-health services in Nunavut and Yukon.
For additional exclusions/limitations see Annex 4.

10 Patient satisfaction with hospital care

Theme: Quality

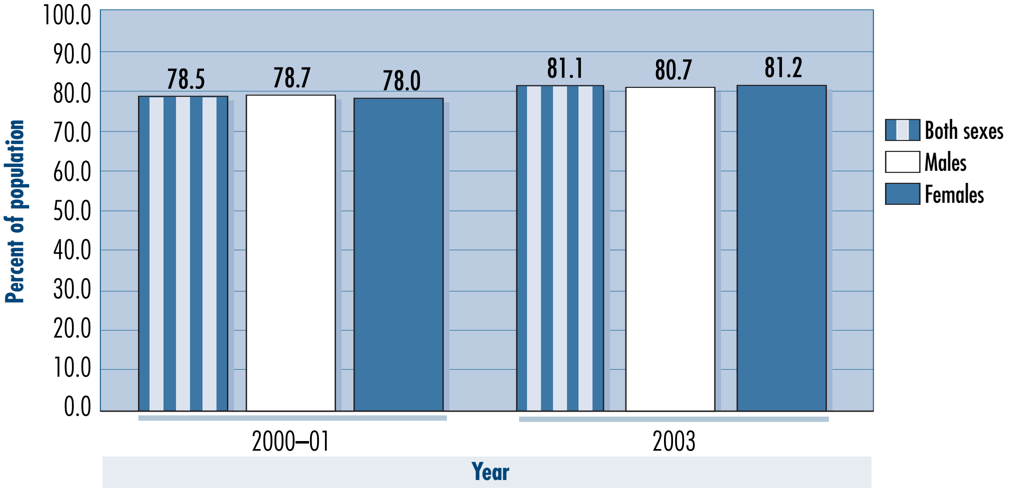
Priority Area: Other Programs and Services

Description: Patient satisfaction with hospital care measures the percentage of the population who used hospital services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Results: Among Canadians, patient satisfaction with the way hospital care was provided increased from 78.5% to 81.1% between 2000–01 and 2003. The proportion of women reporting satisfaction increased to 81.2% in 2003 from 78.0% in 2000–01.

Comment: Over the past several years, satisfaction with the way hospital care is provided has increased among Canadians, particularly among women.



Patient Satisfaction with Hospital Care

Percent who were "very satisfied" or "somewhat satisfied" with the way care was provided, by sex (age standardized), Canada, 2000–01 and 2003

Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving hospital care in the 12 months prior to the survey.
Refers to the most recent care received from a hospital.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

11 Patient satisfaction with physician care

Theme: Quality

Priority Area: Health Human Resources

Description: Patient satisfaction with physician care refers to the percentage of the population who used physician services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

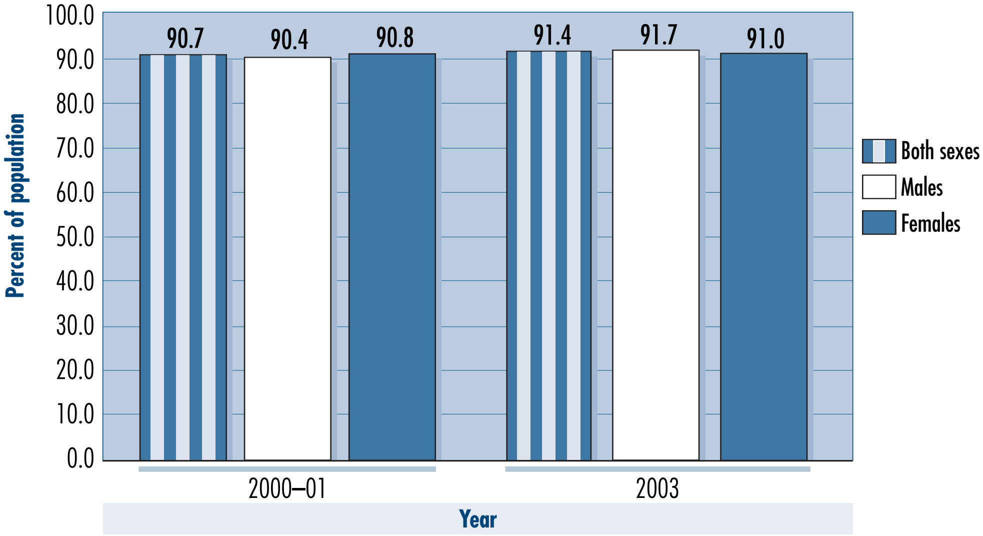
Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Results: In 2003, the vast majority of Canadians (91.4%) said they were "very satisfied" or "somewhat satisfied" with the way physician care was provided. Among men, patient satisfaction has increased to 91.7% in 2003 from 90.4% in 2000–01.

Comment: In general, Canadians are satisfied with the way physician care has been provided.

Patient Satisfaction with Physician Care

Percent who were "very satisfied" or "somewhat satisfied" with the way care was provided, by sex (age standardized), Canada, 2000–01 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving health care services from a family doctor, general practitioner or medical specialist in the 12 months prior to the survey. This excludes services received during a hospital visit and refers to most recent care received from a physician.
For additional exclusions/limitations see Annex 4.

12 Health adjusted life expectancy (HALE)

This indicator includes two sub-indicators:

- Health adjusted life expectancy (HALE) for overall population
- Health adjusted life expectancy (HALE) by income

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

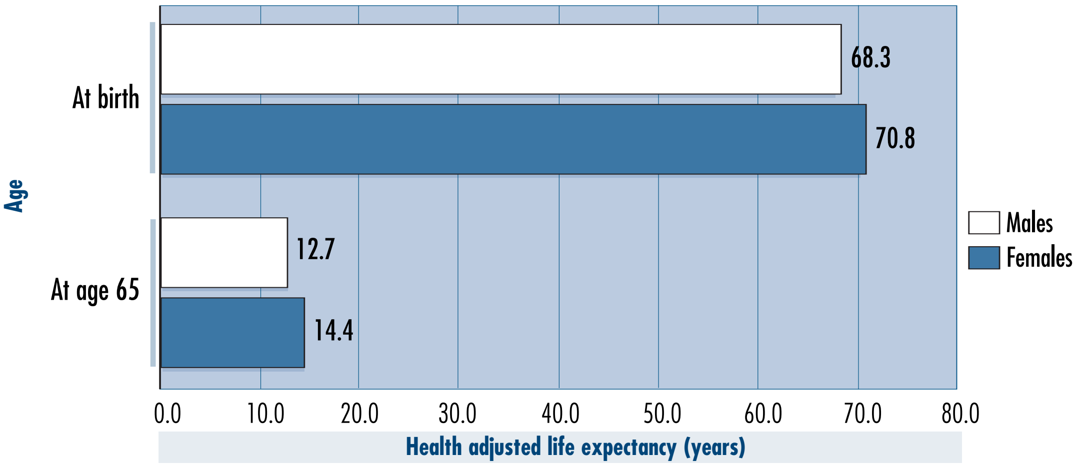
Description: Health adjusted life expectancy (HALE) is an indicator of overall population health. It represents the number of expected years of life equivalent to years lived in good health, based on the average experience in a population. Trends in HALE should be examined in conjunction with trends in life expectancy (LE). If HALE increases more over time than LE, it can be concluded that added years of life expectancy are indeed more often years in good health. HALE can be measured for the general population as a whole, as well as for different household income levels.

Advisory to Readers: HALE is a relatively new indicator and embodies a number of assumptions which are important for its interpretation.

Results: In 2001, women had a higher health adjusted life expectancy (HALE) than men, both at birth and at age 65. The difference in HALE between women and men is more evident at birth, with women's at 70.8 years and men's at 68.3 years.

Health Adjusted Life Expectancy

By sex, at birth and age 65, Canada, 2001



Source: Statistics Canada, Canadian Vital Statistics, Death Database; National Population Health Survey, 1996–97; Canadian Community Health Survey, 2000–01; 2001 Census.

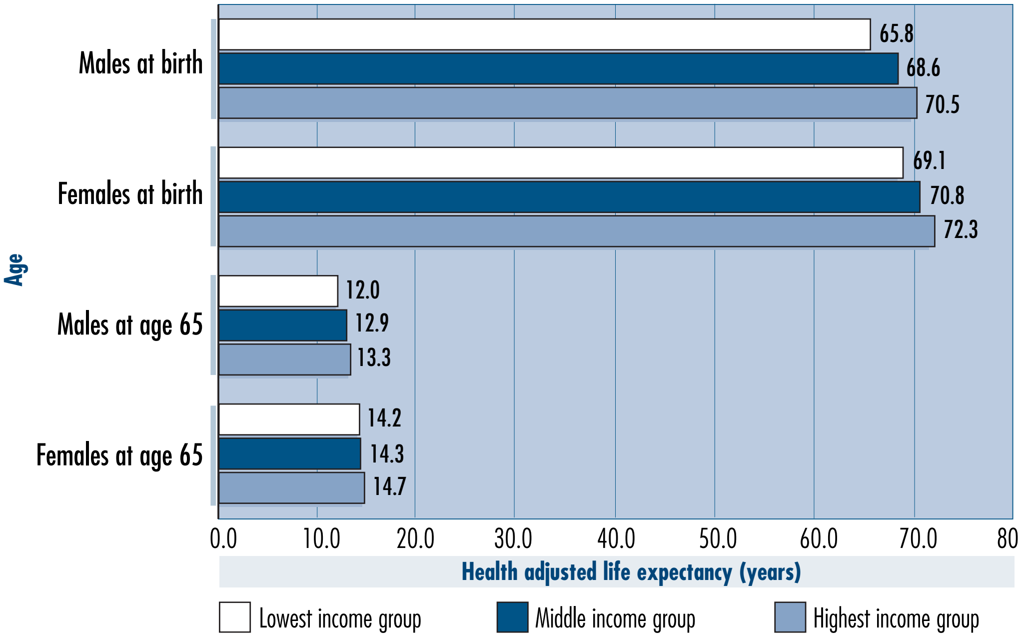
Note: For additional exclusions/limitations see Annex 4.

Sex and level of income at birth play a very important role in determining HALE. While women generally have a higher HALE than men, women in the highest income group at birth have a HALE of 72.3 years — higher than any other group. Men in the highest income group at birth have a HALE of 70.5 years. The differences between men and women are smaller at age 65 in the highest income group, with men's HALE 1.4 years lower than that of women in the same group. Comparisons of HALE across income groups show that, at birth, women in the highest income group have a HALE that is 3.2 years higher than women in the lowest group. The same comparison for men shows that men in the highest category have a HALE 4.7 years higher than those in the lowest income group.

Comment: HALE at birth is lower for men than for women. Canadians in higher income groups generally live longer, healthier lives than their counterparts in the other income groups. Differences in HALE by income group at age 65 are very marginal for both men and women.

Health Adjusted Life Expectancy

By sex and income level, at birth and age 65, Canada, 2001



Source: Statistics Canada, Canadian Vital Statistics, Death Database; National Population Health Survey, 1996–97; Canadian Community Health Survey, 2000–01; 2001 Census.

Note: For additional exclusions/limitations see Annex 4.

13 Prevalence of diabetes

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator shows the percentage of individuals aged 20 years and older with all types of diabetes.

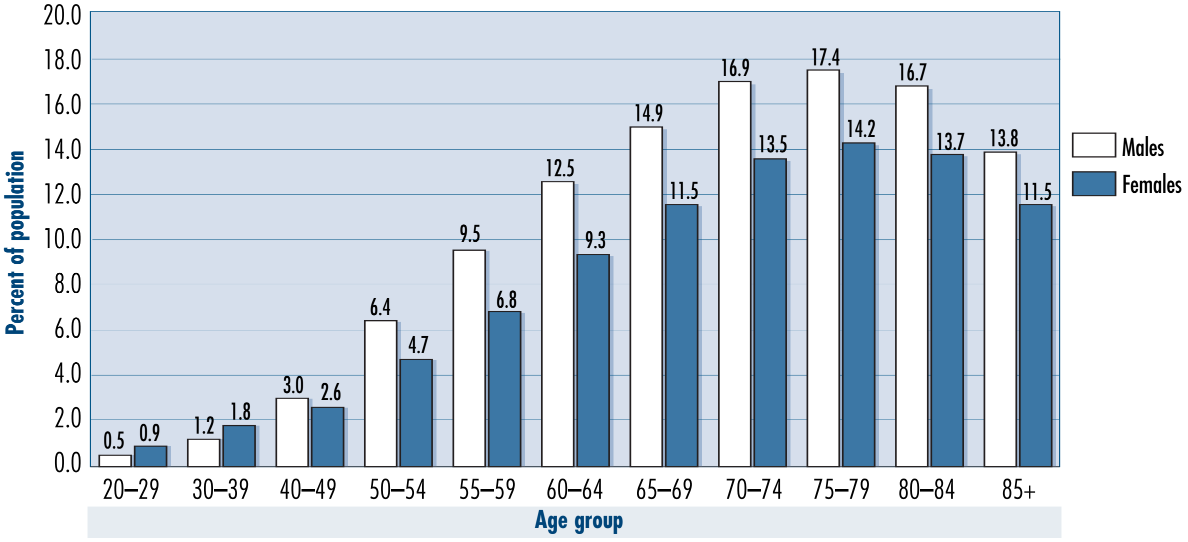
Results: With the exception of the child-bearing years (ages 20 to 39), when there is a greater risk for gestational diabetes, the prevalence of diabetes was higher among men than women in 1999–2000. The rate for men was 5.4% compared to 4.9% for women (see page 65, Annex 2). For both sexes, prevalence increased with age, peaking in the 75 to 79 age group at 15.5% (17.4% for males and 14.2% for females). Overall, 5.1% of Canadians aged 20 and older were living with diagnosed diabetes.

The prevalence of self-reported diabetes among the North American Indian population is about four times higher than the Canadian rate.

All diabetes types are included in the definition of this indicator: diabetes type 1, diabetes type 2, and gestational diabetes.

Prevalence of Diabetes

Percent of population aged 20 years and over with diagnosed diabetes (all types), by sex and selected age group, Canada, 1999–2000*



Source: Health Canada, National Diabetes Surveillance System (NDSS).

Notes: Data presented for this indicator are final and include Northwest Territories and Nunavut. This was not the case in the 2002 *Healthy Canadians* report.
Readers should interpret these data with caution; see Annex 4.

*Excludes New Brunswick and Newfoundland and Labrador.

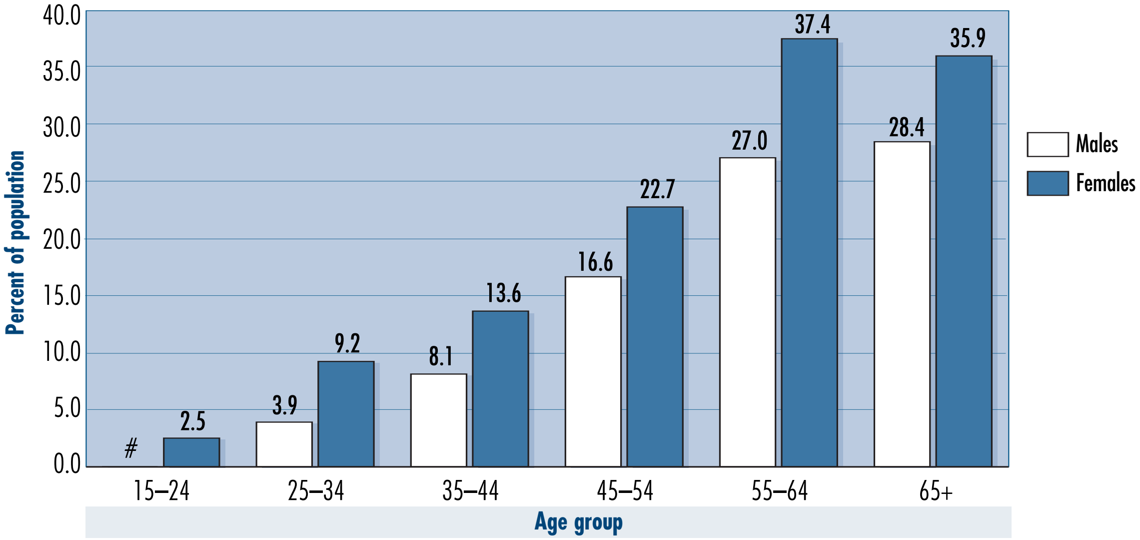
Findings of the First Nations Regional Longitudinal Health Survey also illustrate a high prevalence of diabetes among First Nations on-reserve adults 20 years of age and older (see page 65, Annex 2). For data exclusions/limitations see Annex 4.

Comment: The prevalence of diabetes increases with age and is more common among Canadian men. North American Indians — especially those living on-reserve — report a much higher prevalence rate of diabetes than the general Canadian population and thus suffer disproportionately from the disease.

Prevalence …
… is the number of existing instances of a given disease, at a given time, or over a specified period of time, in a defined population.

Self-reported Diabetes (all types) (not audited)

Percent of population, by sex and selected age group, North American Indian (on-reserve**), 2001*



Source: Statistics Canada, Aboriginal Peoples Survey, 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: See notes on applicable table in Annex 2.
For additional exclusions/limitations see Annex 4.

*Age groups differ from agreed upon data specifications for reporting in 2004.
**Selected participating reserves.
Data suppressed to protect confidentiality.

14 Self-reported health

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: Self-reported health measures the percentage of the population aged 12 and over who rated their health as either "excellent" or "very good."

Results: The percentage of Canadians aged 12 years and over who reported their health as "excellent" or "very good" has declined in recent years. In 2003, 59.6% reported that they were in "excellent" or "very good" health, compared to 63.3% in 1994–95 (see page 67, Annex 2). For all years shown, a greater proportion of males than females rated their health as "excellent" or "very good."

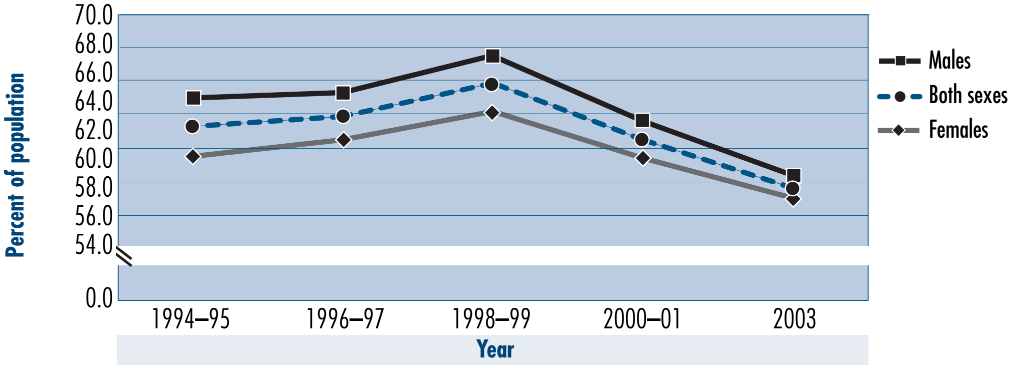
For all age groups, the Inuit population has higher rates of "excellent or very good" self-rated health. The proportion of those rating their health as "excellent or very good" drops much more sharply with age for the North American Indian on-reserve population than is the case for the Inuit population.

Canada ranks second among the G7 countries in terms of self-reported health status — 88.8% of Canadian men and 87.3% of Canadian women rated their health as "good or better" in 2001.

Comment: The proportion of Canadians who feel that they are in "excellent or very good" health is lower than it was in the mid-1990s. The Inuit population has higher rates of "excellent or very good" self-reported health than North American Indians living on-reserve in Canada.

Self-reported Health

Percent reporting "excellent" or "very good" health, by sex (age standardized), Canada, 1994–95 to 2003

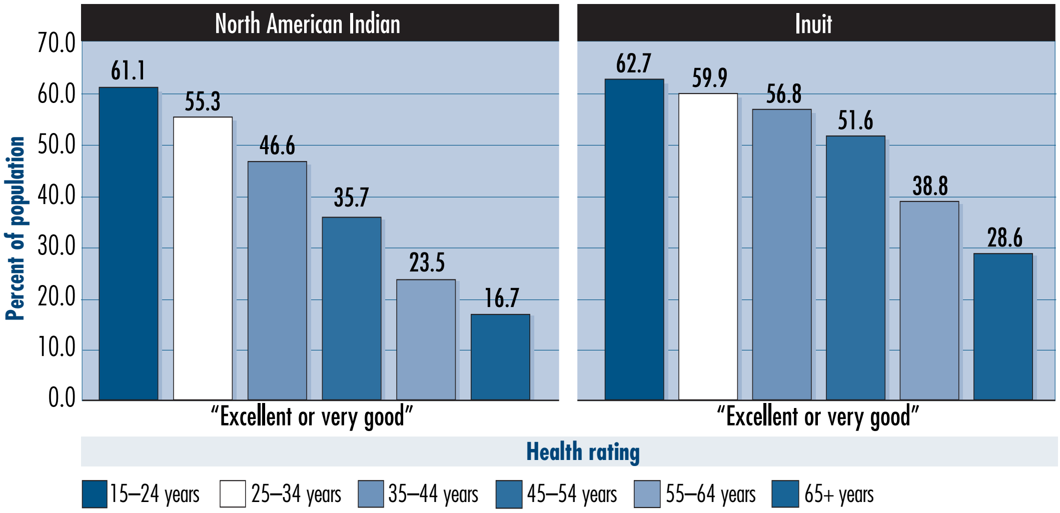


Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 12 and over who rate their own health status as being excellent or very good.
For additional exclusions/limitations see Annex 4.

Self-reported Health (not audited)

By selected age group, North American Indian (on-reserve**) and Inuit (non-reserve), 2001*



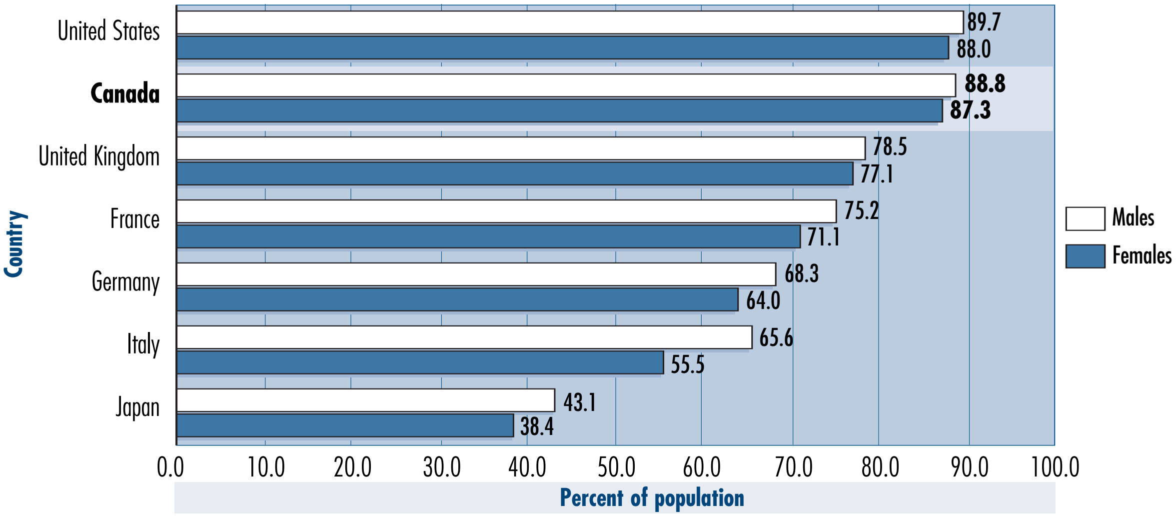
Source: Statistics Canada, Aboriginal Peoples Survey, 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: See notes on applicable table in Annex 2.
For additional exclusions/limitations see Annex 4.

*Age groups differ from agreed upon data specifications for reporting in 2004.
**Selected participating reserves.

Self-reported Health (not audited)

Percent reporting "good or better" health, by sex, selected countries



Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Germany are from 1998; data for Italy, Japan and Canada are from 2001; data for France, U.K. and U.S.A. are from 2002.
For additional exclusions/limitations see Annex 4.

15 Teenage smoking rates

This indicator includes two sub-indicators:

- Teenage smoking rates: Proportion current teenage smokers
- Teenage smoking rates: Proportion daily smokers

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

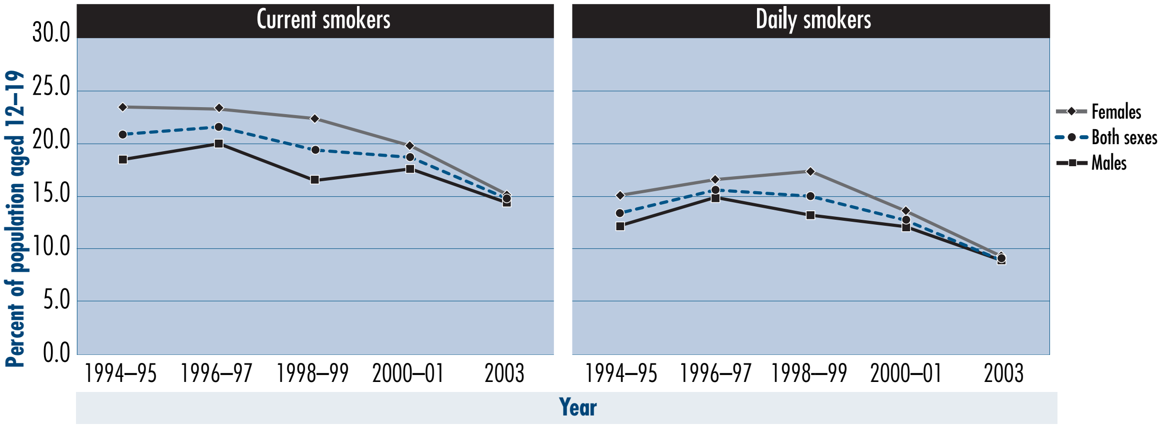
Description: This indicator shows the percentage of the population aged 12 to 19 years (as a proportion of the total population in this age group) who reported that they were current smokers (which includes occasional and daily) and the percentage who reported that they were daily smokers.

Results: The data show that the percentage of current smokers aged 12 to 19 years dropped from 20.9% in 1994–95 to 14.8% in 2003 (see page 70, Annex 2). After a brief increase, the proportion of daily smokers also declined, from 13.6% in 1994–95 to 9.1% in 2003.

In 2001, Inuit teenagers aged 15 to 19 years reported higher smoking rates (69.1%) than did their North American Indian

Teenage Smoking Rates

Percent of population aged 12–19 years reporting they are current and daily smokers, by sex, Canada, 1994–95 to 2003



Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

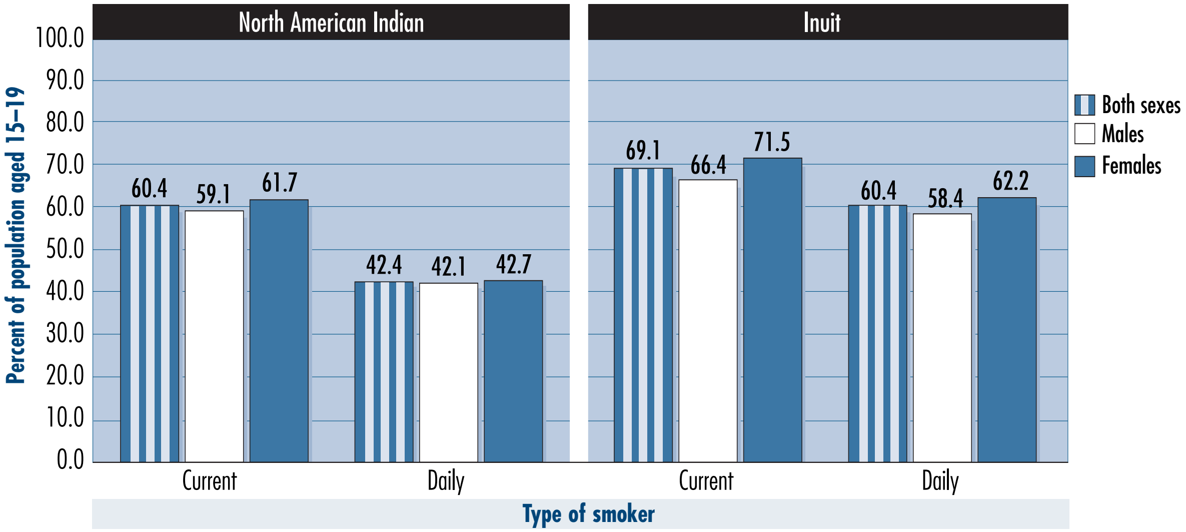
Notes: Current smokers include daily smokers and occasional smokers (see Annex 2).
For additional exclusions/limitations see Annex 4.

counterparts (60.4%). Caution should be used when comparing this to the Canadian teen smoking rate, as the Aboriginal rates include only teens aged 15 to 19 years. At the same, the overall Aboriginal rates are substantially higher than for the general teen population.

Comment: In general, teenage smoking rates have been falling in Canada for the last several years. North American Indian and Inuit teenagers have higher smoking rates than the Canadian teenage population as a whole.

Teenage Smoking Rates (not audited)

Percent of population aged 15–19 years reporting they are current or daily smokers, by sex, North American Indian (on-reserve**) and Inuit (non-reserve), 2001*



Source: Statistics Canada, Aboriginal Peoples Survey, 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: Current smokers include daily smokers and occasional smokers (see Annex 2).
See notes on applicable table in Annex 2.
For additional exclusions/limitations see Annex 4.

*Age groups differ from agreed upon data specifications for reporting in 2004.
**Selected participating reserves.

16 Physical activity

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

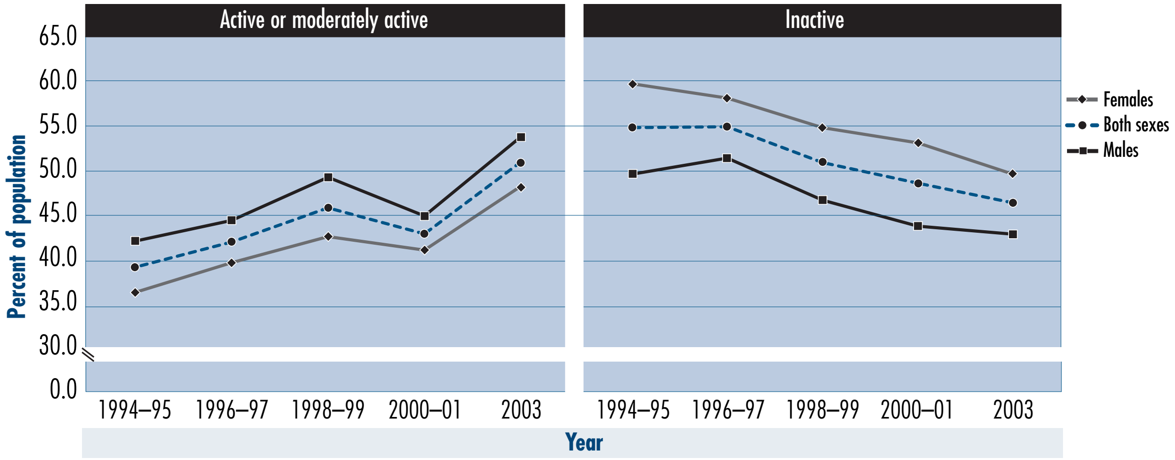
Description: Physical activity measures the percentage of the population aged 12 years and older who reported themselves as being active and those who reported themselves as being inactive.

Results: The proportion of Canadians who reported themselves as being active or moderately active increased to 51.0% in 2003 from 39.3% in 1994–95. For each year shown (from 1994–95 to 2003), a higher proportion of Canadian males than females reported being active (see page 72, Annex 2). In 2003, for example, 53.8% of males reported being active compared to 48.3% of females. The proportion of Canadians who said they were inactive has declined over the same time period — 46.4% reported being inactive in 2003 compared to 54.8% in 1994–95.

Comment: Overall, Canadians are becoming more active. The percentage of the population who consider themselves to be inactive has been declining.

Physical Activity

Percent reporting being active or moderately active and inactive, by sex (age standardized), Canada, 1994–95 to 2003



Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Includes household population aged 12 and over reporting level of physical activity, based on their responses to questions about frequency, duration and intensity of their leisure-time physical activity.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

17 Body mass index

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the population aged 18 years and older (excluding pregnant women) with a calculated body mass index (BMI) falling into one of four categories: underweight, normal weight, overweight or obese. The category "obese" is further broken down into three classes: obese I, obese II and obese III.

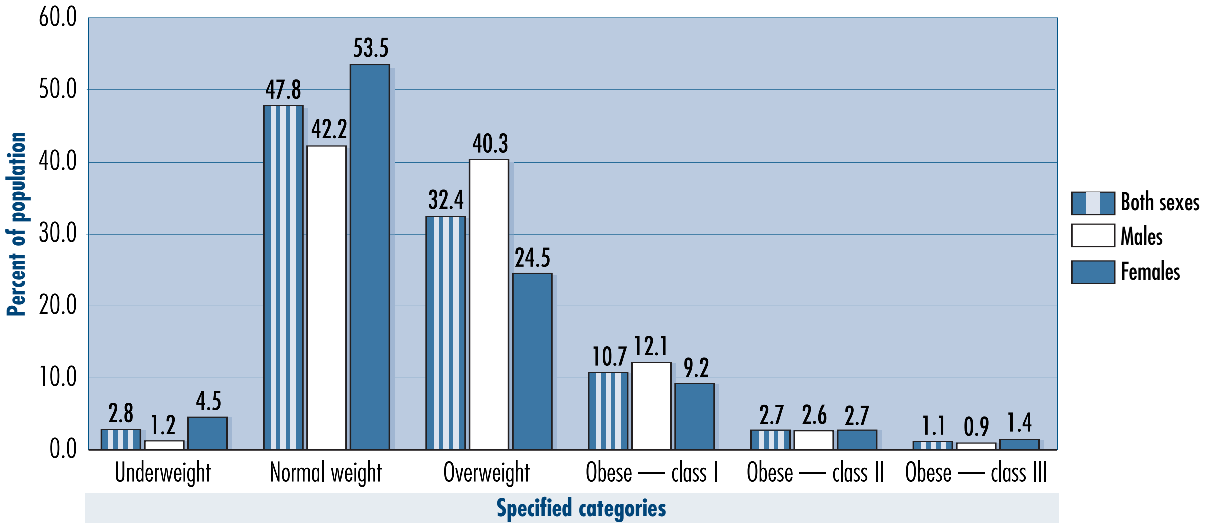
Results: Canadian data show that, in 2003, 14.5% of adult Canadians had a calculated BMI indicating they were obese, and 32.4% were considered overweight. At the same time, 47.8% of Canadians were in the normal weight range, and 2.8% were considered underweight.

Body mass index (BMI) …

… is the ratio of a person's weight in relation to their height. It is calculated as weight (in kilograms) divided by height (in metres) squared.

Body Mass Index

Percent having a calculated BMI in specified categories, by sex (age standardized), Canada, 2003



Source: Statistics Canada, Canadian Community Health Survey, 2003.

Notes: Age standardized to the 1991 Canadian population.
Includes household population aged 18 and over excluding pregnant women and persons less than 3 feet (0.914 metres) or greater than 6 feet, 11 inches (2.108 metres) tall.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

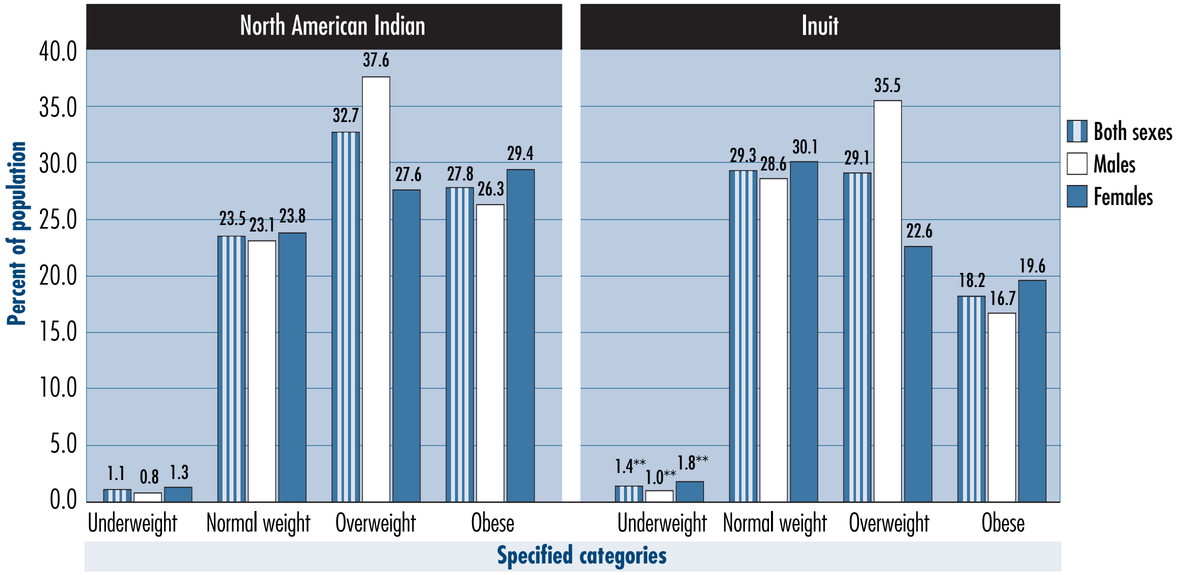
Also in 2003, a very small percentage of North American Indians and Inuit were underweight. A greater proportion of Inuit were in the normal weight range (29.3%) than their North American Indian counterparts (23.5%). Finally, a greater proportion of North American Indians were considered to be overweight (32.7%) or obese (27.8%) than Inuit (29.1% and 18.2%, respectively).

Findings of the First Nations Regional Longitudinal Health Survey illustrate a similar trend of overweight and obesity for First Nations on-reserve adults 18 years of age and older (see page 73, Annex 2). For additional exclusions/limitations see Annex 4.

It has been suggested that the obesity criteria used for Canadians in general may not be applicable to Inuit people. Although there was an increasing trend in blood pressure and lipid levels with obesity in

Body Mass Index (not audited)

Percent of adults (aged 18 and over) having calculated BMI in specified categories, by sex, North American Indian (on-reserve) and Inuit (non-reserve), 2001*



Source: Statistics Canada, Aboriginal Peoples Survey, 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: See notes on applicable table in Annex 2.
For additional exclusions/limitations see Annex 4.

*Selected participating reserves.
**Use with caution (high sampling variability).

the Inuit, the magnitude of the response differed with respect to high-density lipoproteins and triglyceride levels as compared to a sample of the general population. From this study it was unclear whether the standard BMI criteria would be appropriate to predict health risk for the Inuit.[3]

Data from the Organisation for Economic Cooperation and Development (OECD) reveal that, in Canada in 2001, 16.0% of men and 13.9% of women reported having a BMI that classified them as obese.

Comment: Almost one half of Canadians are overweight or obese, and a similar proportion is in the normal weight range. Canadians rank in the middle among the G7 countries in terms of the proportion of the population that is obese.

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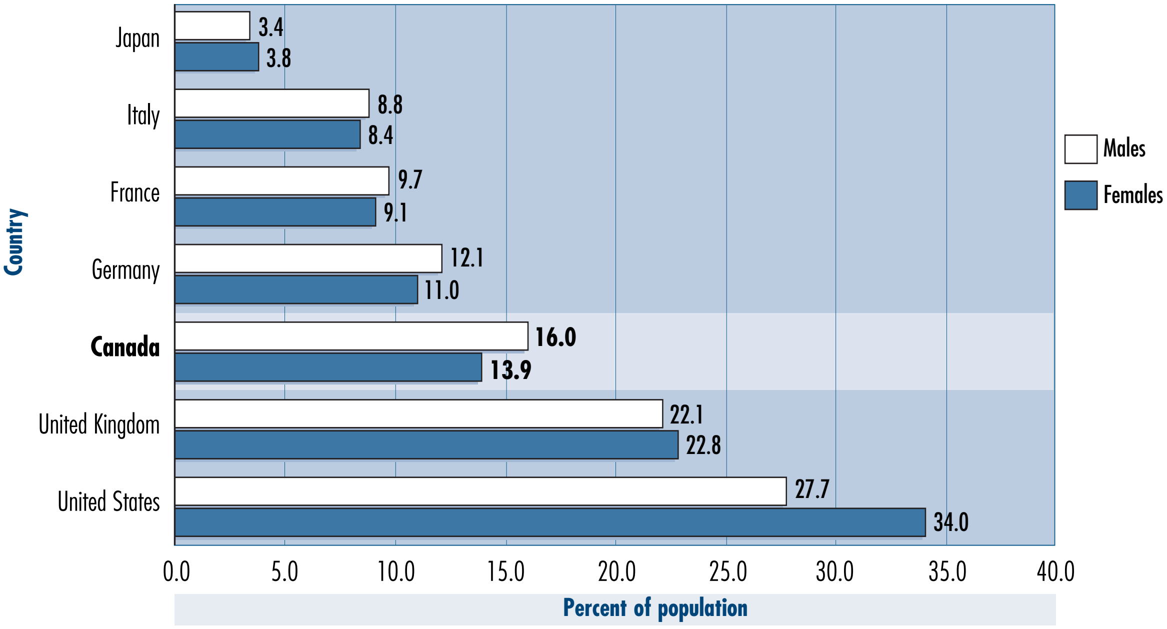
[3] Young TK. Obesity, central fat patterning and their metabolic correlates among the Inuit of the Central Canadian Arctic. *Human Biology* 1996; 68(2):245–63.

Body Weight and Composition (not audited)

Percent of population who are obese (BMI >30), by sex, selected countries



Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Germany and U.S.A. are from 1999; data for Italy are from 2000; data for Canada are from 2001; data for France, Japan and U.K. are from 2002.
For additional exclusions/limitations see Annex 4.

18 Immunization for influenza, aged 65 plus ("Flu Shot")

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the adult population aged 65 and older who reported that they had received a flu shot in the 12 months before they were surveyed.

Results: Data from Statistics Canada show that 62.1% of the Canadian population aged 65 and over were immunized for influenza in the 12 months before they were surveyed, while another 10.3% had received flu shots one or more years before the survey. In contrast, 20.6% reported that they had never been immunized.

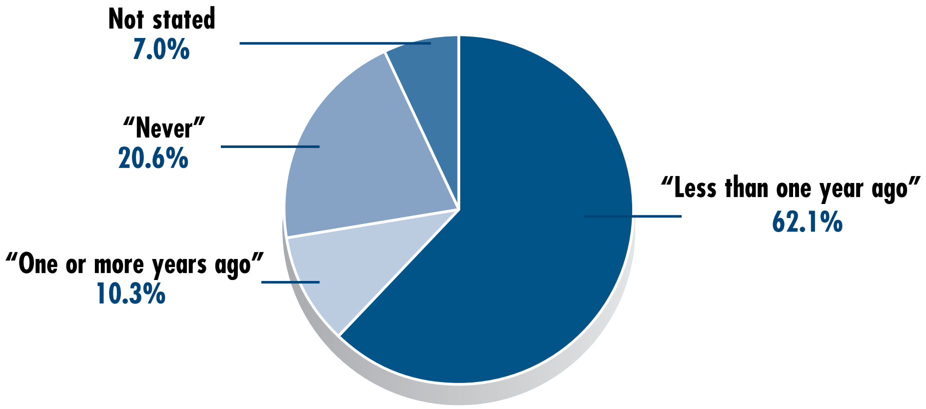
Canada ranks in the middle of the G7 countries in terms of the percentage of the population aged 65 and older who had been immunized against influenza in the 12 months preceding the survey — 63.0% of Canadians reported having had a flu shot in 2000.

Comment: Most Canadian seniors are taking steps to prevent influenza by getting regular flu shots.

Data for this indicator exclude residents of institutions.

Influenza Immunization

Percent of population aged 65 and over who were immunized in selected timeframes, both sexes (age standardized), Canada, 2003

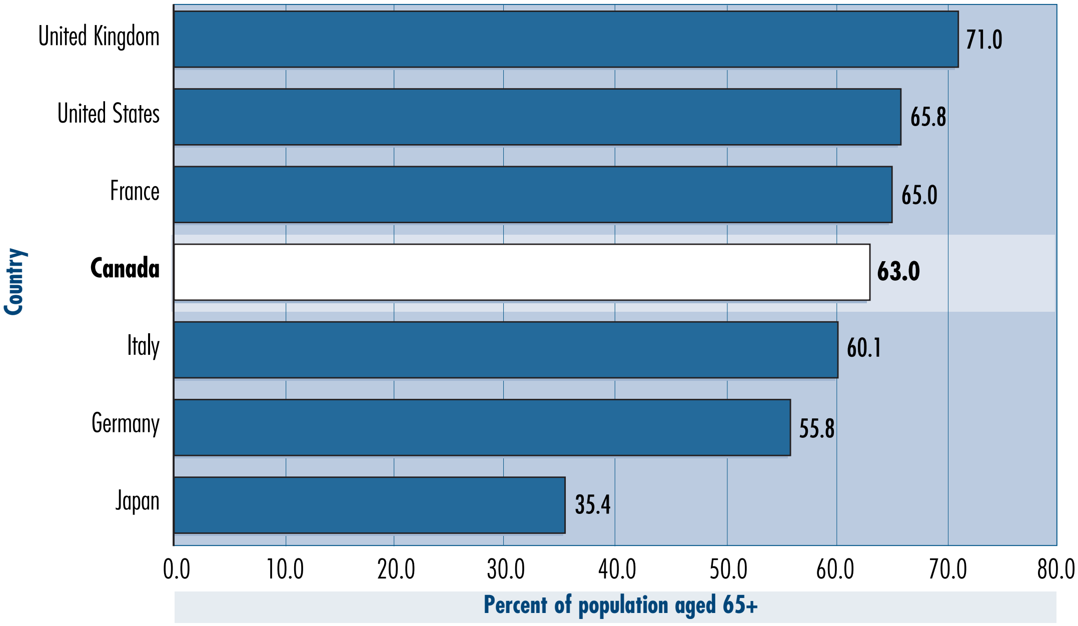


Source: Statistics Canada, Canadian Community Health Survey, 2003.

Notes: Age standardized to the 1991 Canadian population.
Includes household population aged 65 and over reporting when they had their last influenza immunization (flu shot).
For additional exclusions/limitations see Annex 4.

Influenza Inoculation (not audited)

Percent of population aged 65 and over having been immunized during the past 12 months, selected countries



Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Canada are from 2000; data for France and Germany are from 2001; data for Italy, Japan and U.S.A. are from 2002; data for U.K. are from 2003.
For additional exclusions/limitations see Annex 4.

IV

Health Information — Challenges and Next Steps

Health information and integrated health information systems will continue to play a key role in supporting the health objectives of Canadians as individuals and as a society. Recognizing this, the federal government has, in recent years, invested substantial resources in improving health information systems to better respond to the needs of Canadians.

Since 1999, the federal government has invested over $280.0 million in the modernization of health information in Canada. This has strengthened our ability to make evidence-based decisions and has allowed improved reporting on both the health of Canadians and the health care delivery system. Similar investments have also been made in collecting data on Aboriginal peoples. In the 2003 federal budget, $6.0 million was committed over four years to enhance the gathering and analysis of health data on Aboriginal populations.

Investments in health information have yielded notable dividends, including supporting the First Ministers' Health Accord reporting commitments; allowing the development of new data sources; improving data quality; enhancing the development of national data standards; and providing increased accountability by making health information available to the public. For example, data on all of the new indicators included in this report have been provided by Statistics Canada. Similarly, with the exception of seven indicators that were obtained from provincial sources, all remaining indicators were derived from national datasets, which are available from the Canadian Institute for Health Information and Health Canada.

Although significant progress has been made, more work is needed to further the accomplishments to date and to improve the capacity to collect, develop, identify and report on national data in a consistent and comparable way. Thus, while the current national datasets are attractive in terms of comparability across jurisdictions, requiring minimal investment on the part of governments, they are not adequate sources for some of the new indicators that need to be developed from scratch (for example, indicators for home care and catastrophic drug coverage). Comparable health indicator reporting in support of the First Ministers' Health Accord commitments has, among other things, reinforced the role of the national information organizations as major data providers. It has not, however, increased the demand for harmonized provincial and territorial health administrative data systems.

Further development is also required for the 2003 Health Accord theme of Sustainability and for the priority area of Home Care to allow for the reporting of comparable data across Canada. As reporting on this theme and priority area is not yet possible, neither one is covered in this report.

To fill some of the gaps identified above, a process has been initiated by the Advisory Committee on Governance and Accountability for the further development of indicators for long-term reporting (2006 and beyond). While some of these indicators can be developed within a relatively short timeframe, others may require development over the longer term. For example, for those indicators where no data are currently available, a longer and more involved development period will be required. The first step in this process is under way and involves a feasibility study on the process needed to develop valid, more reliable and appropriate indicators to achieve the goals described in the 2003 Health Accord.

There are also several challenges to obtaining quality data on Aboriginal populations. Two main issues persist: the inability to consistently track treatment and outcome data specific to Aboriginal clients once they are in a provincial system; and the difficulty in distinguishing between Aboriginal groups (indicating the need for Aboriginal-specific identifiers). The Health Information and Analysis Initiative (HIAI) is a two-year Health Canada initiative implemented in 2002–03 as part of its commitment to improve the data-gathering effort on the health status of First Nations and Inuit populations. Since this initiative began, Health Canada has published two editions of the *Statistical Profile on the Health of First Nations*, created policies on privacy and data quality assurance and developed data dictionaries of the major data holdings.

Much of the information included on the Aboriginal population in this report comes from the Aboriginal Peoples Survey 2001, conducted by Statistics Canada in partnership with national Aboriginal organizations, with a response rate of 84%. This represents a notable improvement in data quality in Aboriginal reporting from the 2002 report; however, minor limitations still exist. For example, due to a high number of refusals by First Nations communities in Quebec to participate in the survey, no provincial-level data for the Quebec reserve population is available. Overall, data for on-reserve and non-reserve populations were published separately, with no aggregate data to reflect the whole Aboriginal population in Canada. For all Aboriginal data, every effort has been made to identify the data limitations, and provide sources for further information where available.

A number of unique circumstances affect the delivery of health care to Aboriginal populations, including the fragmentation of Aboriginal health care delivery between federal, provincial/territorial and community governments; remoteness of Aboriginal communities; and issues surrounding community self-governance. In order to reduce the health disparities between Aboriginal and non-Aboriginal peoples, the Aboriginal Health Reporting Framework initiative was launched with the 2003 *First Ministers' Accord on Health Care Renewal*. In it, the First Ministers directed health ministers to:

> "… consult with Aboriginal peoples on the development of a comparable Aboriginal Health Reporting Framework. They further agree to consult with Aboriginal peoples in this effort, to use comparable indicators, and to develop the necessary data infrastructure. This reporting will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as on service levels and outcomes."

The Aboriginal Health Reporting Framework should create a clearer picture of the health and well-being of Aboriginal peoples across Canada. This will provide improved information for decision makers at all levels — Aboriginal, provincial, territorial and federal governments. It will also supply a baseline against which to measure progress, and assist in directing new investments to the areas where they will have the most impact.

The responsibility for the development of the Aboriginal Health Reporting Framework has been given to a task group made up of representatives from the federal government, the provinces and territories and the five national Aboriginal organizations. It is hoped that the development of the framework will help resolve some of the Aboriginal health data issues across Canada.

Statement of Responsibility

Deputy Minister of Health
Health Canada

Management's Responsibility for Health Indicator Reporting

Health Canada is responsible for the preparation and presentation of the *Healthy Canadians* report which includes "18 featured, comparable health indicators," as identified and defined by the Conference of Deputy Ministers of Health.

To the best of our knowledge, the information in this report is complete, accurate (unless otherwise noted and explained), and limitations on the data are adequately disclosed, bearing in mind the needs of the intended users of this report. Information is provided where departures from agreed upon specifications are necessary or further explanation was required to assist in data interpretation.

Information on one indicator (prevalence of diabetes) and the health information systems that provide the data for reporting it in *Healthy Canadians* are the responsibility of Health Canada. This responsibility consists of maintaining the required information systems and adequate controls to ensure that the information generated by the systems is accurate. Health Canada health information systems provide a national picture of the health status and health outcomes of Canadians. This requires working in close collaboration and agreement with provincial and territorial governments and other jurisdictions that provide the data voluntarily.

In preparing this report, Health Canada also relied on information provided from external parties, including Statistics Canada for 16 of the health indicators and the Canadian Institute for Health Information (CIHI) for one of the indicators (ambulatory care sensitive conditions). Health Canada is reasonably confident that the information obtained from these external sources is accurate and free of significant misrepresentation. Health Canada takes all reasonable steps to assure itself of the quality of the information provided by external sources, including Statistics Canada and CIHI for inclusion in *Healthy Canadians.*

The Auditor General of Canada was engaged to provide third party verification in the form of an audit opinion on this report.

Ian Green, Deputy Minister

Auditor General of Canada
Vérificatrice générale du Canada

AUDITOR'S REPORT

To the Minister of Health

I have audited the 18 national health indicators presented in the Federal Government report on comparable health indicators of November 2004, as prepared by Health Canada. The report is published pursuant to the 2003 First Ministers' Accord on Health Care Renewal, which builds on the 2000 First Ministers' Meeting Communiqué on Health. The Conference of Deputy Ministers of Health identified and defined the specific indicators to be reported to Canadians. Health Canada is responsible for reporting the national health indicators.

My responsibility is to express an opinion on the completeness, accuracy and adequacy of disclosure of the 18 health indicators presented in the 2004 Federal Government report on comparable health indicators, based on my audit. However, my responsibility does not extend to assessing the performance achieved, nor the relevance or sufficiency of the health indicators selected for reporting. My work on the analysis and discussion of the health indicators presented in this report was limited to reading such information to ensure that it was not inconsistent with the result of the audited indicators. I did not audit data from international sources or data about Aboriginal populations. As well, my audit was limited to information related to the most recent year for which each indicator was reported.

I conducted my audit in accordance with the standards for assurance engagements established by the Canadian Institute of Chartered Accountants. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the federal health indicators presented are free of significant misstatement. To this end, I audited these health indicators to determine whether they meet the criteria of completeness, accuracy and adequate disclosure, as presented in Annex A of my report. My audit includes examining, on a test basis, evidence supporting the health indicators and disclosures. My audit also includes assessing significant judgments made in the 2004 Federal Government report by management of Health Canada.

In my opinion the health indicators included in the Federal Government report present fairly, in all significant respects, the required information that is complete, accurate and adequately disclosed, using the criteria in Annex A. Further, in my opinion, the report adequately discloses and explains any departures from the criteria; specifically, why data for some areas of federal responsibility for health services are not provided.

My work included auditing the national data for the indicator of “Hospitalization rate for ambulatory care sensitive conditions.” I was unable to form an opinion on this indicator in my 2002 report because a study on data quality had not been completed. This study has now been completed and I am able to form an opinion that, in the 2004 Federal Government report on comparable health indicators, this indicator presents fairly, in all significant respects, the required information that is complete, accurate and adequately disclosed, using the criteria in Annex A.

I am encouraged by the work undertaken by Health Canada in preparing this report.

Sheila Fraser

Sheila Fraser, FCA
Auditor General of Canada
Ottawa, November 18, 2004

ANNEX A

Audit criteria

Health Canada has acknowledged the suitability of the following criteria:

Complete

According to the 2003 First Ministers' Accord on Health Care Renewal, the Conference of Deputy Ministers approved 70 indicators, including a subset of 18 indicators that all jurisdictions are to feature in their 2004 reports. All health indicators reported comply with the definitions, technical specifications and standards of presentation as approved. All 18 featured health indicators are reported.

Accurate

The health indicators reported adequately reflect the facts, to an appropriate and consistent level of accuracy, including the ability to make comparisons between jurisdictions and between the 2002 and 2004 reports within each jurisdiction, where applicable.

Adequate disclosure

The health indicators are defined and their significance and limitations on the data are explained. The report states and properly describes departures from what was approved by the Conference of Deputy Ministers and explains plans for the future resolution of the departures.

Annex 1

List of 18 Featured Indicators

Note: *In all, there are 70 indicators for public reporting in 2004. Eighteen of these indicators were designated for detailed (featured) reporting by all federal, provincial and territorial jurisdictions for 2004. Data for all indicators, for all 14 jurisdictions, are available on Web sites hosted by the Canadian Institute for Health Information (http://www.cihi.ca/comparable-indicators) and Statistics Canada (http://www.statcan.ca/english/freepub/82-401-XIE/2002000/index.htm).*

Priority Area and Indicator (and sub-indicator)		Indicator Count	Sub-indicator Count	Federal report includes data for:	
				Canada	First Nations
Theme: Timely Access					
Primary Health Care					
Difficulty obtaining routine or on-going health services	Difficulty obtaining routine or on-going health services	1	1	✔	*
Difficulty obtaining health information or advice	Difficulty obtaining health information or advice	2	2	✔	*
Difficulty obtaining immediate care	Difficulty obtaining immediate care	3	3	✔	*
Catastrophic Drug Coverage and Pharmaceutical Management					
Prescription drug spending as a percentage of income	Prescription drug spending as a percentage of income	4	4	✔	N/A
Diagnostic and Medical Equipment					
Self-reported wait times for diagnostic services	Median wait time for diagnostic services	5	5	✔	
	Distribution of wait times for diagnostic services		6		
Theme: Quality					
Primary Health Care					
Hospitalization rate for ambulatory care sensitive conditions	Hospitalization rate for ambulatory care sensitive conditions	6	7	✔	✔
Patient satisfaction with overall health care services	Patient satisfaction with overall health care services	7	8	✔	*
Patient satisfaction with community-based care	Patient satisfaction with community-based care	8	9	✔	
Patient satisfaction with telephone health line or tele-health services	Patient satisfaction with telephone health line or tele-health services	9	10	✔	N/A

Priority Area and Indicator (and sub-indicator)		**Indicator Count**	**Sub-indicator Count**	**Federal report includes data for:**	
				Canada	**First Nations**
Theme: Quality *(continued)*					
Other Programs and Services					
Patient satisfaction with hospital care	Patient satisfaction with hospital care	10	11	✔	N/A
Health Human Resources					
Patient satisfaction with physician care	Patient satisfaction with physician care	11	12	✔	*
Theme: Health Status and Wellness					
Healthy Canadians					
Health adjusted life expectancy (HALE)	Health adjusted life expectancy (HALE) for overall population	12	13	✔	
	Health adjusted life expectancy (HALE) by income		14		
Prevalence of diabetes	Prevalence of diabetes	13	15	✔	✔
Self-reported health	Self-reported health	14	16	✔	✔
Teenage smoking rates	Teenage smoking rates: proportion current teenage smokers	15	17	✔	✔
	Teenage smoking rates: proportion daily smokers		18		
Physical activity	Physical activity	16	19	✔	
Body mass index	Body mass index	17	20	✔	✔
Immunization for influenza, aged 65 plus ("Flu Shot")	Immunization for influenza, aged 65 plus ("Flu Shot")	18	21	✔	

*Data available in Annex 2, but do not match the 2004 comparable reporting requirements. Available data address similar issues as 2004 indicators.

N/A — Indicator not applicable for the federal jurisdiction.

Annex 2

Data Tables for the 18 Featured Indicators

1 Difficulty obtaining routine or on-going health services

2 Difficulty obtaining health information or advice

3 Difficulty obtaining immediate care

Description: Grouped in this category are indicators that measure the percentage of people who reported having difficulty obtaining routine or on-going health services, health information or advice, and immediate care for a minor health problem at any time of the day in the 12 months prior to the survey.

Definitions:

1. Percent who required routine or on-going health services for self or a family member in the past 12 months and experienced difficulties obtaining them, based on the population 15 years of age and over.
2. Percent who required health information or advice for self or a family member in the past 12 months and experienced difficulty obtaining it at any time of the day, based on the population 15 years of age and over.
3. Percent who required immediate care for a minor health problem for self or a family member in the past 12 months and experienced difficulty obtaining it at any time of the day, based on the population 15 years of age and over.

Canada

Percent of Population Reporting Difficulty Accessing Health Services, Information or Advice, and Immediate Care

By type of service (age standardized), Canada, 2003*

Type of service	Percent reporting difficulty accessing service
Routine or on-going health services	16.4
Health information or advice	15.8
Immediate care for a minor health problem	23.8

Source: Statistics Canada, Health Services Access Survey, 2003.

Notes: Includes household population aged 15 and over reporting difficulty accessing these services in the 12 months prior to the survey, for self or a family member.
Based on the population requiring these services in the 12 months prior to the survey, for self or a family member.
Minor health problem includes fever, vomiting, major headaches, sprained ankle, minor burns, cuts, skin irritation, unexplained rash, etc.; non-life-threatening health problems or injuries due to a minor accident.
Age standardized to the 1991 Canadian population.
For additional exclusions/limitations see Annex 4.

*Data for Health Services Access Survey exclude the territories.

First Nations

The First Nations data for this indicator are derived from the results of the National Aboriginal Health Organization public opinion poll, “What First Nations Think About Their Health and Health Care” (2004), with approximately 1,200 respondents. The questions do not match the 2004 federal/provincial/territorial reporting requirements but do address similar issues.

First Nations — Difficulty Obtaining Health Care and Information (not audited)

In 2002, 17% of survey respondents reported that access to appointments with nurses was “somewhat” or “very” difficult. Thirty-three percent reported that access to appointments with doctors was “somewhat” or “very” difficult.

Thirty-six percent of First Nations survey respondents reported that they sought information on personal health issues such as nutrition, fitness and quitting smoking over the past year (30% of males and 39% of females).

Eighteen percent of First Nations living on-reserve reported an occasion when they had not obtained needed health care in the previous 12 months. Of those, 22% reported they did not receive care because the wait time was too long, followed by those who reported that the care was not available in their area (14%) or at the time required (13%).

Source: National Aboriginal Health Organization, “What First Nations Think About Their Health and Health Care,” 2004.

Note: For additional exclusions/limitations see Annex 4.

4 Prescription drug spending as a percentage of income

Description: This indicator measures the percentage of Canadian households that spend more than a certain proportion (specifically, 0%, 1%, 2%, 3%, 4% or 5%) of their after-tax income out-of-pocket on prescription drugs.

Definition: Percent of households spending over given percentages (0%, 1%, 2%, 3%, 4% and 5%) of total after-tax income out-of-pocket on prescription drugs.

Canada

Prescription Drug Spending as a Percentage of Income

Percent of households, Canada, 1997–2002

Spending category	1997	1998	1999	2000	2001	2002
More than 0%	66.8	64.8	65.7	64.9	65.4	65.2
More than 1%	18.1	17.7	19.0	19.0	18.6	19.1
More than 2%	9.4	9.0	10.0	10.3	10.2	10.5
More than 3%	5.9	5.8	6.1	6.3	6.2	6.5
More than 4%	3.8	3.9	4.0	4.0	3.8	4.5
More than 5%	2.7	2.6	2.6	2.9	2.7	3.0

Source: Statistics Canada, Survey of Household Spending, 1997, 1998, 1999, 2000, 2001 and 2002.

Notes: After-tax income is total income minus personal taxes.
Prescription drug spending only includes prescription drugs purchased by households. Over-the-counter drugs and drugs paid for by governments or insurance companies are not included.
Premiums for health care plans are not included.
If prescription drugs are covered by a plan but the household pays a certain percentage, the cost to the household is included in the figures above.
For additional exclusions/limitations see Annex 4.

There are a number of reasons why households may spend more than the maximum paid under a provincial prescription drug plan. These reasons include:

- The Survey of Household Spending is a household survey. Thus, multiple families or a number of non-related persons (room-mates, for example) could be in one household.
- In some cases, insurance premiums for a provincial prescription drug plan may have been reported as prescription drug spending.
- Households could live in more than one province in a survey year, but would be coded as living in the province at the time they were surveyed.
- People who change insurers may not request the required documentation from their previous insurer to ensure that they do not spend more than the maximum.
- Prescription drug spending while persons are temporarily outside of their home province may not be covered under the provincial plan.
- Spending could be on prescription drugs not covered under the provincial formulary.

5 Self-reported wait times for diagnostic services

- Median wait time for diagnostic services
- Distribution of wait times for diagnostic services

Description: This indicator measures the median wait time reported by people requiring a diagnostic service and the proportion of people who report waiting for a required diagnostic service for three different time periods (less than one month, one to three months and more than three months). The wait time refers to the time in weeks between the time when the patient is referred for a service and when the patient actually receives the service in the 12 months prior to the survey. Patients who had not yet received the service (or who are still waiting) are excluded from the definition of this indicator.

Definitions:

- **Reported median wait time for diagnostic services.**
  Wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and receiving the service, during the 12 months prior to the survey. The median is the 50th percentile of the distribution of wait times: half the patients wait less and half wait longer than the median number of weeks. Patients who have not yet received the service are excluded from the indicator calculation. *Note: Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.*
- **Distribution of reported wait times for diagnostic services.**
  Wait time refers to the length of time, in weeks, between the patient being referred for a diagnostic service and receiving the service. The indicator is the percent of those requiring a diagnostic service who waited less than one month, between one to three months or more than three months to receive the service, during the 12 months prior to the survey. Patients who have not yet received the service are excluded from the indicator calculation.

Canada

Self-reported Wait Times for Diagnostic Services

Median wait time, Canada, 2001 and 2003*

	2001	2003
Weeks	3.0**	3.0

Source: Statistics Canada, Health Services Access Survey, 2001and 2003.

Notes: Based on household population aged 15 and over who reported a need for a selected diagnostic test in the 12 months prior to the survey.
Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.
For additional exclusions/limitations see Annex 4.

*Data for Health Services Access Survey exclude the territories.
**Use with caution (high sampling variability).

Self-reported Wait Times for Diagnostic Services

Distribution of wait times, Canada, 2001 and 2003*

	2001	2003
Less than one month	54.7	57.5
One to three months	36.1	31.1
Longer than three months	9.1**	11.5

Source: Statistics Canada, Health Services Access Survey, 2001and 2003.

Notes: Based on household population aged 15 and over who reported a need for a selected diagnostic test in the 12 months prior to the survey.
Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.
For additional exclusions/limitations see Annex 4.

*Data for Health Services Access Survey exclude the territories.
**Use with caution (high sampling variability).

6 Hospitalization rate for ambulatory care sensitive conditions

Description: This indicator measures hospitalization rates per 100,000 population for chronic conditions that can often be cared for in the community, such as diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease.

Definition: Age-standardized inpatient hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital.

Canada

Ambulatory Care Sensitive Conditions

By sex (age standardized), Canada, 1995–96 to 2001–02

Year	Both sexes	Males	Females
1995–96	503	513	492
1996–97	463	475	450
1997–98	447	461	431
1998–99	411	425	397
1999–2000	401	418	383
2000–01	370	389	352
2001–02	346	367	325

Sources: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, Census; Institut de la statistique du Québec.

Notes: Hospitalization rates are per 100,000 population.
Age standardized to the 1991 Canadian population.
For additional exclusions/limitations see Annex 4.

First Nations

Health Canada's First Nations and Inuit Health Branch, using provincial data from British Columbia, Saskatchewan and Manitoba, estimates that ambulatory care sensitive conditions are four to five times higher for First Nations and Inuit populations than for the Canadian population as a whole. Due to reporting difficulties, this ratio includes all First Nations (on- and off-reserve) and not only those on reserves. About one third of the First Nations residing on-reserve have varying degrees of remoteness. It should be noted that these numbers allow for more than one admission for the same person per year.

Ambulatory Care Sensitive Conditions (not audited)

First Nations (on- and off-reserve) (age standardized), 1995–96 to 2000–01*

Year	Both sexes
1995–96	2,196
1996–97	2,104
1997–98	2,057
1998–99	1,847
1999–2000	1,659
2000–01	1,567

Sources: Health Canada, First Nations and Inuit Health Branch; Manitoba Health; Saskatchewan Health; British Columbia Ministry of Health Planning.

Notes: Age standardized to the 1991 Canadian population.
Hospitalization rates are per 100,000 population.
Caution should be exercised in generalizing the characteristics of the three provinces included in this data to the entire First Nations population in Canada.
For more information on data limitations, visit:
<http://www.hc-sc.gc.ca/fnihb/sppa/hia/publications/statistical_profile.htm>.

*First Nations data are for British Columbia, Saskatchewan and Manitoba only.

7 Patient satisfaction with overall health care services

Description: Patient satisfaction with overall health care services refers to the percentage of the population who used health care services in the 12 months prior to the survey, and who reported that they were either "very satisfied" or "somewhat satisfied" with the way the services were provided.

Definition: Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the overall health care services received.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Canada

Patient Satisfaction with Overall Health Care Services

By sex (age standardized), Canada, 2000–01 and 2003

	Percent of population who were very satisfied or somewhat satisfied with the way services were provided	
	2000–01	**2003**
Both sexes	84.4	84.9
Males	84.2	85.0
Females	84.5	84.8

Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving health care services in the 12 months prior to the survey.
For additional exclusions/limitations see Annex 4.

First Nations

The First Nations data for this indicator are derived from the results of the National Aboriginal Health Organization public opinion poll, "What First Nations Think About Their Health and Health Care" (2004), with approximately 1,200 respondents. The questions do not match the 2004 federal/provincial/territorial reporting requirements but do address similar issues.

Rating of Health Care Received Over the Last Year (not audited)

First Nations on-reserve, 2002

	Percent of survey respondents
Positive rating	67

Source: National Aboriginal Health Organization, "What First Nations Think About Their Health and Health Care," 2004.

Notes: "Positive rating" refers to ratings of "excellent" or "good" for quality of health care services received.
For additional exclusions/limitations see Annex 4.

International

The following table does not match the 2004 federal/provincial/territorial reporting requirements but does address similar issues.

Health Care Satisfaction (not audited)

Selected countries

Country	Percent of population expressing need for reforms as a reflection of satisfaction with their health care system		
	Completely rebuild system	Fundamental changes needed	Minor changes needed
Japan	6	47	29
France	10	42	41
West Germany	11	55	30
Canada	18	59	21
United Kingdom	18	60	21
United States	28	51	18
Italy	40	46	12

Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for France, Italy and Japan are from 1988–91; data for West Germany are from 1994; data for Canada, U.K. and U.S.A. are from 2001.
For additional exclusions/limitations see Annex 4.

8 Patient satisfaction with community-based care

Description: Patient satisfaction with community-based care is the percentage of the population who used community-based services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

Definition: Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with community-based services received. The Canadian Community Health Survey definition for "community-based care" includes any health care received outside of a hospital or doctor's office (e.g., home nursing care, home-based counselling or therapy, personal care, community walk-in clinics).

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Canada

Patient Satisfaction with Community-based Care

By sex (age standardized), Canada, 2000–01 and 2003

	Percent of population who were very satisfied or somewhat satisfied with the way care was provided	
	2000–01	**2003**
Both sexes	81.6	83.0
Males	80.0	84.5
Females	82.7	82.0

Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving community-based health care in the 12 months prior to the survey, excluding that received through a hospital or doctor's office.
For additional exclusions/limitations see Annex 4.

9 Patient satisfaction with telephone health line or tele-health services

Description: Patient satisfaction with telephone health line or tele-health services refers to the percentage of the population who used a telephone health line or tele-health service in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the services were provided.

Definition: Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the telephone health line or tele-health service received.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Canada

Patient Satisfaction with Telephone Health Line or Tele-health Services

By sex (age standardized), Canada, 2003

	Percent of population who were very satisfied or somewhat satisfied with the way services were provided
Both sexes	83.7
Males	86.0
Females	82.7

Source: Statistics Canada, Canadian Community Health Survey, 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported using telephone health line services in the 12 months prior to the survey.
There are no telephone health line or tele-health services in Nunavut and Yukon.
Telephone health line includes health hotline or tele-health services provided by a nurse or other health specialist. There must be live interaction. Therefore, automated services are excluded for this indicator.
For additional exclusions/limitations see Annex 4.

10 Patient satisfaction with hospital care

Description: Patient satisfaction with hospital care measures the percentage of the population who used hospital services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

Definition: Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the way hospital services were provided.

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Canada

Patient Satisfaction with Hospital Care

By sex (age standardized), Canada, 2000–01 and 2003

	Percent of population who were very satisfied or somewhat satisfied with the way care was provided	
	2000–01	**2003**
Both sexes	78.5	81.1
Males	78.7	80.7
Females	78.0	81.2

Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving hospital care in the 12 months prior to the survey.
Refers to the most recent care received from a hospital.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

11 Patient satisfaction with physician care

Description: Patient satisfaction with physician care refers to the percentage of the population who used physician services in the 12 months prior to the survey, and who reported being "very satisfied" or "somewhat satisfied" with the way the care was provided.

Definition: Percent of population 15 years old and older who rate themselves as either very satisfied or somewhat satisfied with the care received from a physician — family doctor or medical specialist (excluding services received in a hospital).

Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole.

Canada

Patient Satisfaction with Physician Care

By sex (age standardized), Canada, 2000–01 and 2003

	Percent of population who were very satisfied or somewhat satisfied with the way care was provided	
	2000–01	**2003**
Both sexes	90.7	91.4
Males	90.4	91.7
Females	90.8	91.0

Source: Statistics Canada, Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 15 and over who reported receiving health care services from a family doctor or other physician during the 12 months prior to the survey, excluding those services which may have been received during a hospital visit.
Refers to the most recent care received from a physician.
For additional exclusions/limitations see Annex 4.

First Nations

The First Nations data for this indicator are derived from the results of the National Aboriginal Health Organization public opinion poll, "What First Nations Think About Their Health and Health Care" (2004), with approximately 1,200 respondents. The questions do not match the 2004 federal/provincial/territorial reporting requirements but do address similar issues.

First Nations — Patient Satisfaction with Physician Care (not audited)

Of the 67% who provided a positive rating* for the quality of health care they received, 15% reported they did because they had a "good/approachable" doctor.

Source: National Aboriginal Health Organization, "What First Nations Think About Their Health and Health Care," 2004.

Note: For additional exclusions/limitations see Annex 4.

*Positive rating refers to ratings of "excellent" or "good" for quality of health care services received.

12 Health adjusted life expectancy (HALE)

- Health adjusted life expectancy (HALE) for overall population
- Health adjusted life expectancy (HALE) by income

Description: Health adjusted life expectancy (HALE) is an indicator of overall population health. It represents the number of expected years of life equivalent to years lived in full health, based on the average experience in a population. Trends in HALE should be examined in conjunction with trends in life expectancy (LE). If HALE increases more over time than LE, we can then conclude that added years of life expectancy are indeed more often years in better health. HALE can be measured for the general population as a whole, as well as for different household income levels.

Definitions: Health adjusted life expectancy (HALE) is an indicator of overall population health. It combines measures of both age- and sex-specific health status, and age- and sex-specific mortality into a single statistic. HALE represents the number of expected years of life equivalent to years lived in full health, based on the average experience in a population. In this sense, HALE is not only a measure of quantity of life but also a measure of quality of life.

Advisory to Readers: HALE is a relatively new indicator, and embodies a number of assumptions which are important for its interpretation.

Canada

Health Adjusted Life Expectancy

By sex and income terciles, at birth and age 65, Canada, 2001

Age group	Sex	Income group	2001
At birth	Males	All income groups	68.3
		Lowest	65.8
		Middle	68.6
		Highest	70.5
	Females	All income groups	70.8
		Lowest	69.1
		Middle	70.8
		Highest	72.3
At age 65	Males	All income groups	12.7
		Lowest	12.0
		Middle	12.9
		Highest	13.3
	Females	All income groups	14.4
		Lowest	14.2
		Middle	14.3
		Highest	14.7

Source: Statistics Canada, Canadian Vital Statistics, Death Database; National Population Health Survey, 1996–97; Canadian Community Health Survey, 2000–01; 2001 Census.

Notes: For additional exclusions/limitations see Annex 4.
For additional notes on HALE, consult: <http://www.statcan.ca/hale>.

13 Prevalence of diabetes

Description: This indicator shows the percentage of individuals aged 20 years and older with all types of diabetes.

Definition: The prevalence rate of diagnosed diabetes among health service users per 100 population.

Canada

Prevalence of Diabetes (all types)

By sex and selected age groups, Canada, 1997–98 to 1999–2000*

	Percent of population aged 20 years and older								
	1997–98			1998–99			1999–2000		
Age group	**Both sexes**	**Males**	**Females**	**Both sexes**	**Males**	**Females**	**Both sexes**	**Males**	**Females**
20–29	0.6	0.4	0.7	0.7	0.5	0.8	0.7	0.5	0.9
30–39	1.2	1.0	1.4	1.3	1.1	1.6	1.5	1.2	1.8
40–49	2.4	2.6	2.2	2.6	2.9	2.4	2.8	3.0	2.6
50–54	4.9	5.7	4.1	5.3	6.2	4.5	5.6	6.4	4.7
55–59	7.1	8.3	6.0	7.7	9.0	6.5	8.1	9.5	6.8
60–64	9.4	10.7	8.1	10.3	11.9	8.9	10.9	12.5	9.3
65–69	11.5	12.9	10.2	12.5	14.1	11.0	13.2	14.9	11.5
70–74	12.9	14.5	11.7	14.1	15.9	12.7	15.0	16.9	13.5
75–79	13.2	14.8	12.1	14.5	16.3	13.2	15.5	17.4	14.2
80–84	12.5	14.0	11.6	13.8	15.4	12.8	14.8	16.7	13.7
85+	10.1	11.5	9.5	11.3	12.8	10.6	12.2	13.8	11.5
Total	**4.3**	**4.5**	**4.1**	**4.8**	**5.0**	**4.6**	**5.1**	**5.4**	**4.9**

Source: Health Canada, National Diabetes Surveillance System (NDSS).

Notes: Diabetes prevalence data reported in 2004 are for the same time period (1999–2000) as in *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002.* However, the data in this (2004) report are final and include data for Northwest Territories and Nunavut.
Where available, new data will be featured in future reports.
All diabetes types are included: diabetes type 1, diabetes type 2 and gestational diabetes.
For additional exclusions/limitations see Annex 4.

*Excludes New Brunswick and Newfoundland and Labrador.

First Nations and Inuit

Age groups for this indicator do not match the 2004 federal/provincial/territorial reporting requirements.

Self-reported Prevalence of Diabetes (all types) (not audited)

By sex and selected age groups, North American Indian (on-reserve) and Inuit (non-reserve), 2001*

Age group	North American Indian			Inuit		
	Both sexes	Males	Females	Both sexes	Males	Females
15–24	1.6	#	2.5	..	..	..
25–34	6.7	3.9	9.2	..	..	..
35–44	10.9	8.1	13.6	..	..	..
45–54	19.3	16.6	22.7	..	..	..
55–64	32.0	27.0	37.4	..	..	..
65+	32.6	28.4	35.9	..	..	..
Total	**11.5**	**8.9**	**14.0**	**2.3**	**1.8****	**2.8****

Source: Statistics Canada, Aboriginal Peoples Survey (APS), 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: North American Indian identity population includes those who reported identifying as North American Indian (either as a single response or in combination with Métis and/or Inuit).
Caution should be exercised in generalizing the characteristics of the reserves that participated in APS to the entire on-reserve population in Canada. Any aggregation of APS reserve data is only representative of the reserves that participated in APS and cannot be considered representative of the total on-reserve population.
For additional exclusions/limitations see Annex 4.
For more information on the APS, visit: <http://www.statcan.ca/english/freepub/89-591-XIE/free.htm>.

*Selected participating reserves.
**Use with caution (high sampling variability).
.. Indicates no data available.
Data suppressed to protect confidentiality.

Additional First Nations information is available from the First Nations Regional Longitudinal Health Survey (RHS) 2002–03 (Adult Survey).

Self-reported Prevalence of Diabetes (all types) (not audited)

By selected age group, First Nations (on-reserve), 2002–03

Age group	Percent
20–34	4
35–54	17
55+	36

Source: National Aboriginal Health Organization, First Nations Regional Longitudinal Health Survey (RHS), 2002–03 (Adult Survey).

Notes: For additional exclusions/limitations see Annex 4.
For more information on the RHS, visit: <http://www.naho.ca/fnc/rhs>.

14 *Self-reported health*

Description: Self-reported health measures the percentage of the population aged 12 and over who rated their health as either "excellent" or "very good."

Definition: Percent of the population aged 12 and older who report that their health is very good or excellent.

Canada

Self-reported Health

By sex (age standardized), Canada, 1994–95 to 2003

		Percent of population with very good or excellent self-reported health		
Year		**Total**	**Percent with very good self-reported health**	**Percent with excellent self-reported health**
1994–95	**Both sexes**	63.3	37.6	25.7
	Males	65.0	38.4	26.7
	Females	61.5	36.8	24.6
1996–97	**Both sexes**	63.9	38.6	25.4
	Males	65.3	38.8	26.5
	Females	62.5	38.4	24.1
1998–99	**Both sexes**	65.9	39.7	26.2
	Males	67.6	38.9	28.7
	Females	64.2	40.5	23.7
2000–01	**Both sexes**	62.5	36.3	26.2
	Males	63.6	36.0	27.5
	Females	61.4	36.6	24.9
2003	**Both sexes**	59.6	36.6	23.0
	Males	60.3	36.6	23.7
	Females	59.0	36.7	22.3

Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Based on household population aged 12 and over who rate their own health status as being "excellent" or "very good."
For additional exclusions/limitations see Annex 4.

First Nations and Inuit

Age groups for this indicator do not match the 2004 federal/provincial/territorial reporting requirements.

Self-reported Health (not audited)

By selected age groups, North American Indian (on-reserve) and Inuit (non-reserve), 2001*

	North American Indian (On-reserve)	**Inuit (Non-reserve)**
Age group	**Percent of population with "excellent" or "very good" self-reported health**	
15–24	61.1	62.7
25–34	55.3	59.9
35–44	46.6	56.8
45–54	35.7	51.6
55–64	23.5	38.8
65+	16.7	28.6

Source: Statistics Canada, Aboriginal Peoples Survey (APS), 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: The North American Indian identity population includes those who reported identifying as North American Indian (either as a single response or in combination with Métis and/or Inuit). The Inuit identity population includes those who reported identifying as Inuit (either as a single response or in combination with North American Indian and/or Métis).
Non-reserve population includes Aboriginal people who do not live on Indian reserves, with the exception of the Northwest Territories, in which case the total (on- and non-reserve) Aboriginal population is included.
Caution should be exercised in generalizing the characteristics of the reserves that participated in APS to the entire on-reserve population in Canada. Any aggregation of APS reserve data is only representative of the reserves that participated in APS and cannot be considered representative of the total on-reserve population.
For additional exclusions/limitations see Annex 4.
For more information on the APS, visit: <http://www.statcan.ca/english/freepub/89-591-XIE/free.htm>.

*Selected participating reserves.

International

The following table does not match the 2004 federal/provincial/territorial reporting requirements but does address similar issues.

Self-reported Health (not audited)

By sex, selected countries

Country	Percent of population reporting "good or better" health	
	Males	Females
United States	89.7	88.0
Canada	88.8	87.3
United Kingdom	78.5	77.1
France	75.2	71.1
Germany	68.3	64.0
Italy	65.6	55.5
Japan	43.1	38.4

Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Germany are from 1998; data for Italy, Japan and Canada are from 2001; data for France, U.K. and U.S.A. are from 2002.
For additional exclusions/limitations see Annex 4.

15 Teenage smoking rates

- Teenage smoking rates: proportion current teenage smokers
- Teenage smoking rates: proportion daily smokers

Description: This indicator shows the percentage of the population aged 12 to 19 years (as a proportion of the total population in this age group) who reported that they were current smokers (which includes occasional and daily) and the percentage who reported that they were daily smokers.

Definition: Percentage of population aged 12–19 (inclusive) reporting they are current smokers (current includes daily and occasional smokers) at the time of the interview and percentage of population aged 12–19 (inclusive) reporting that they are daily smokers at the time of the interview.

Canada

Teenage Smoking Rates

By sex, Canada, 1994–95 to 2003

		Percent of population aged 12–19 years reporting they are current smokers		
Year		**Total**	**Percent who are daily smokers**	**Percent who are occasional smokers**
1994–95	**Both sexes**	20.9	13.6	7.3
	Males	18.5	12.2	6.3*
	Females	23.5	15.1	8.4*
1996–97	**Both sexes**	21.6	15.8	5.9
	Males	20.0	14.9	5.1
	Females	23.3	16.6	6.7
1998–99	**Both sexes**	19.4	15.2	4.2
	Males	16.5	13.2	3.3*
	Females	22.4	17.4	5.0*
2000–01	**Both sexes**	18.7	12.9	5.8
	Males	17.6	12.1	5.5
	Females	19.8	13.6	6.2
2003	**Both sexes**	14.8	9.1	5.7
	Males	14.4	8.9	5.5
	Females	15.2	9.3	6.0

Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

Notes: Current smokers include daily smokers and occasional smokers.
For additional exclusions/limitations see Annex 4.

*Use with caution (high sampling variability).

First Nations and Inuit

Age groups for this indicator do not match the 2004 federal/provincial/territorial reporting requirements.

Teenage Smoking Rates (not audited)

By sex, North American Indian (on-reserve) and Inuit (non-reserve), 2001*

	North American Indian			Inuit		
	Percent who report that they are current smokers			Percent who report that they are current smokers		
	Total	Daily smokers	Occasional smokers	Total	Daily smokers	Occasional smokers
Both sexes	60.4	42.4	18.0	69.1	60.4	8.6
Males	59.1	42.1	17.1	66.4	58.4	8.0**
Females	61.7	42.7	19.2	71.5	62.2	9.2**

Source: Statistics Canada, Aboriginal Peoples Survey (APS), 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: Teen includes all persons aged 15 to 19 years.
The North American Indian identity population includes those who reported identifying as North American Indian (either as a single response or in combination with Métis and/or Inuit).
The Inuit identity population includes those who reported identifying as Inuit (either as a single response or in combination with North American Indian and/or Métis).
Non-reserve population includes Aboriginal people who do not live on Indian reserves, with the exception of the Northwest Territories, in which case the total (on- and non-reserve) Aboriginal population is included.
Caution should be exercised in generalizing the characteristics of the reserves that participated in APS to the entire on-reserve population in Canada. Any aggregation of APS reserve data is only representative of the reserves that participated in APS and cannot be considered representative of the total on-reserve population.
Current smokers include daily smokers and occasional smokers.
For additional exclusions/limitations see Annex 4.
For more information on the APS, visit: <http://www.statcan.ca/english/freepub/89-591-XIE/free.htm>.

*Selected participating reserves.
**Use with caution (high sampling variability).

16 Physical activity

Description: Physical activity measures the percentage of the population aged 12 years and older who reported themselves as being active and those who reported themselves as being inactive.

Definitions:

- Percentage of the population aged 12 and over who report a physical activity index of "active."
- Percentage of the population aged 12 and over who report a physical activity index of "inactive."

Canada

Physical Activity

By sex (age standardized), Canada, 1994–95 to 2003

		Percent of population who report being "active"			
Year		**Percent who report being active**	**Percent who report being moderately active**	**Total**	**Percent of population who report being "inactive"**
1994–95	**Both sexes**	18.5	20.8	39.3	54.8
	Males	21.6	20.6	42.2	49.6
	Females	15.4	21.1	36.5	59.7
1996–97	**Both sexes**	20.1	21.9	42.1	54.9
	Males	23.0	21.5	44.5	51.4
	Females	17.3	22.5	39.8	58.1
1998–99	**Both sexes**	22.1	23.8	45.9	50.9
	Males	24.7	24.6	49.3	46.7
	Females	19.6	23.1	42.7	54.8
2000–01	**Both sexes**	21.4	21.6	43.0	48.6
	Males	24.0	21.1	45.0	43.8
	Females	18.9	22.3	41.2	53.1
2003	**Both sexes**	26.7	24.3	51.0	46.4
	Males	30.3	23.5	53.8	42.9
	Females	23.2	25.1	48.3	49.6

Source: Statistics Canada, National Population Health Survey, 1994–95 to 1998–99; Canadian Community Health Survey, 2000–01 and 2003.

Notes: "Active" — includes those individuals reporting combined active (≥3.0 kcal/kg/day) and moderately active (1.5–2.9 kcal/kg/day) levels of physical activity.
"Inactive" — includes those individuals reporting an inactive level of physical activity (<1.5 kcal/kg/day).
Age standardized to the 1991 Canadian population.
Includes household population aged 12 and over reporting a level of physical activity, based on their responses to questions about frequency, duration and intensity of their leisure-time physical activity.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

17 Body mass index

Description: This indicator measures the percentage of the population aged 18 and over (excluding pregnant women) with a calculated body mass index (BMI) falling into one of four categories: underweight, normal weight, overweight or obese. The category "obese" is further broken down into three classes: obese I, obese II and obese III.

Definition: Percent of adults who report a [computed] body mass index in specified categories, ranging from underweight to obese.

Body mass index (BMI) is based on self-reported height and weight, and calculated for persons 18 years of age and over, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI is not considered a suitable indicator for this group. BMI is calculated as weight (in kilograms) divided by height (in metres) squared.

Canada

Body Mass Index

By sex (age standardized), Canada, 2003

	Percent of population being underweight (BMI under 18.5)	Percent of population being normal weight (BMI 18.5–24.9)	Percent of population being overweight (BMI 25.0–29.9)	Percent of population being obese (BMI 30.0 or higher)			
				Obese total	Obese I (BMI 30.0–34.9)	Obese II (BMI 35.0–39.9)	Obese III (BMI 40.0 or higher)
Both sexes	2.8	47.8	32.4	14.5	10.7	2.7	1.1
Males	1.2	42.2	40.3	15.6	12.1	2.6	0.9
Females	4.5	53.5	24.5	13.3	9.2	2.7	1.4

Source: Statistics Canada, Canadian Community Health Survey, 2003.

Notes: Age standardized to the 1991 Canadian population.
Includes household population aged 18 and over excluding pregnant women and persons less than 3 feet (0.914 metres) or greater than 6 feet, 11 inches (2.108 metres) tall.
Results should be treated with caution because a proportion of the difference may be explained by the mode in which the data were collected from the respondent (i.e., by phone or in person).
For additional exclusions/limitations see Annex 4.

First Nations and Inuit

Body Mass Index (not audited)

By sex, North American Indian (on-reserve) and Inuit (non-reserve), 2001*

	North American Indian				Inuit			
	Underweight	Normal weight	Overweight	Obese	Underweight	Normal weight	Overweight	Obese
Both sexes	1.1	23.5	32.7	27.8	1.4**	29.3	29.1	18.2
Males	0.8	23.1	37.6	26.3	1.0**	28.6	35.5	16.7
Females	1.3	23.8	27.6	29.4	1.8**	30.1	22.6	19.6

Source: Statistics Canada, Aboriginal Peoples Survey (APS), 2001 — Custom tabulations produced for Health Canada, First Nations and Inuit Health Branch.

Notes: Crude (non-age standardized) percentages.
Data excludes unstated or invalid responses for height.
Counts for the Inuit "underweight" category have a high coefficient of variation, and should be interpreted with caution.
The North American Indian identity population includes those who reported identifying as North American Indian (either as a single response or in combination with Métis and/or Inuit).
The Inuit identity population includes those who reported identifying as Inuit (either as a single response or in combination with North American Indian and/or Métis).
Non-reserve population includes Aboriginal people who do not live on Indian reserves, with the exception of the Northwest Territories, in which case the total (on- and non-reserve) Aboriginal population is included.
Caution should be exercised in generalizing the characteristics of the reserves that participated in APS to the entire on-reserve population in Canada. Any aggregation of APS reserve data is only representative of the reserves that participated in APS and cannot be considered representative of the total on-reserve population.
Population excludes those with invalid or unstated ages, persons under the age of 18, pregnant women, and those whose height is less than 3 feet (0.914 metres) or greater than 6 feet, 11 inches (2.108 metres) tall.
This table shows the prevalence of the four international body mass index (BMI) categories: underweight (18.5 or less); normal weight (18.6 to 24.9); overweight (25 to 29.9); and obese (30 or more).
For additional exclusions/limitations see Annex 4.
For more information on the APS, visit: <http://www.statcan.ca/english/freepub/89-591-XIE/free.htm>.

*Selected participating reserves.
**Use with caution (high sampling variability).

Additional First Nations information is available from the First Nations Regional Longitudinal Health Survey (RHS) 2002–03 (Adult Survey).

Distribution of Body Mass Index (BMI) Scores (not audited)

By selected age group, First Nations (on-reserve), 2002–03

	Percent of population			
Age group	**Underweight (BMI <18.5)**	**Normal weight (BMI 18.5–24.99)**	**Overweight (BMI 25–29.99)**	**Obese (BMI ≥30)**
18–34	1.4	36.0	35.8	26.7
35–54	0.6	18.3	38.6	42.5
55+	1.1	19.0	38.6	41.3
Total (18+)	**1.0**	**26.1**	**37.4**	**35.5**

Source: National Aboriginal Health Organization, First Nations Regional Longitudinal Health Survey (RHS) 2002–03 (Adult Survey).

Notes: Population aged 18 and over excluding pregnant women.
For additional exclusions/limitations see Annex 4.
For more information on the RHS, visit: <http://www.naho.ca/fnc/rhs>.

International

The following table does not match the 2004 federal/provincial/territorial reporting requirements but does address similar issues.

Body Weight and Composition (not audited)

By sex, selected countries

	Percent of population who are obese (BMI >30)	
Country	**Males**	**Females**
Japan	3.4	3.8
Italy	8.8	8.4
France	9.7	9.1
Germany	12.1	11.0
Canada	16.0	13.9
United Kingdom	22.1	22.8
United States	27.7	34.0

Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Germany and U.S.A. are from 1999; data for Italy are from 2000; data for Canada are from 2001; data for France, Japan and U.K. are from 2002.
For additional exclusions/limitations see Annex 4.

18 Immunization for influenza, aged 65 plus ("Flu Shot")

Description: This indicator measures the percentage of the adult population aged 65 and older who reported that they had received a flu shot in the 12 months before they were surveyed.

Definition: Proportion of the population 65 and over who report having a flu shot in the past year.

Canada

Immunization for influenza for 65+

By sex (age standardized), Canada, 1996–97, 2000–01 and 2003

	Year	Percent of population reported to have had influenza immunization, less than one year ago	Percent of population reported to have had influenza immunization, one year or more ago	Percent of population reported to have never had influenza immunization
Both sexes	**1996–97**	47.8	11.2	34.8
Males		47.1	10.2	34.4
Females		48.4	12.0	35.0
Both sexes	**2000–01**	62.9	7.7	23.7
Males		60.5	7.3	23.8
Females		64.8	7.8	23.7
Both sexes	**2003**	62.1	10.3	20.6
Males		61.2	9.8	20.5
Females		62.9	10.7	20.5

Sources: Statistics Canada, National Population Health Survey, 1996–97; Canadian Community Health Survey, 2000–01 and 2003.

Notes: Age standardized to the 1991 Canadian population.
Includes household population aged 65 and over reporting when they had their last influenza immunization (flu shot).
For additional exclusions/limitations see Annex 4.

International

The following table does not match the 2004 federal/provincial/territorial reporting requirements but does address similar issues.

Influenza Inoculation (not audited)

Selected countries

Country	Percent of population aged 65 and over immunized during the past 12 months
United Kingdom	71.0
United States	65.8
France	65.0
Canada	63.0
Italy	60.1
Germany	55.8
Japan	35.4

Source: Organisation for Economic Cooperation and Development, Health Data, 2004.

Notes: Data for Canada are from 2000; data for France and Germany are from 2001; data for Italy, Japan and U.S.A. are from 2002; data for U.K. are from 2003. For additional exclusions/limitations see Annex 4.

Annex 3

List of 70 Indicators

Federal Report 2004

Priority areas, indicators and sub-indicators

Primary Health Care

1. Difficulty obtaining routine or on-going health services (**Featured**)
2. Difficulty obtaining health information or advice (**Featured**)
3. Difficulty obtaining immediate care (**Featured**)
4. Proportion of population that reports having a regular family physician
5. Patient satisfaction with overall health care services (**Featured**)
6. Patient perceived quality with overall health care services
7. Patient satisfaction with community-based care (**Featured**)
8. Patient perceived quality with community-based care
9. Patient satisfaction with telephone health line or tele-health services (**Featured**)
10. Patient perceived quality with telephone health line or tele-health services
11. Proportion of population reporting contact with telephone health line
12. Hospitalization rate for ambulatory care sensitive conditions (**Featured**)
13. Proportion of female population aged 18–69 with at least one PAP test in the past three years
14. Proportion of women aged 50–69 obtaining mammography in the past two years

Home Care

15. Home care clients per 100,000 population
16. Home care clients per 100,000 population, aged 75 plus

Other Programs and Services

17. Wait times for cardiac bypass surgery
    - Median wait time for cardiac bypass surgery
    - Distribution of wait times for cardiac bypass surgery
18. Wait times for hip replacement surgery
    - Median wait time for hip replacement surgery
    - Distribution of wait times for hip replacement surgery
19. Wait times for knee replacement surgery
    - Median wait time for knee replacement surgery
    - Distribution of wait times for knee replacement surgery

20. Self-reported wait times for surgery
    - Median wait time for surgery
    - Distribution of wait times for surgery
21. Self-reported wait times for specialist physician visits
    - Median wait time for specialist physician visits
    - Distribution of wait times for specialist physician visits
22. Re-admission rate for acute myocardial infarction (AMI)
23. Re-admission rate for pneumonia
24. 30-day in hospital acute myocardial infarction (AMI) mortality rate
25. 30-day in hospital stroke mortality rate
26. 365-day net survival rate for acute myocardial infarction (AMI)
27. 180-day net survival rate for stroke
28. Patient satisfaction with hospital care (**Featured**)
29. Patient perceived quality of hospital care

Catastrophic Drug Coverage and Pharmaceutical Management

30. Prescription drug spending as a percentage of income (**Featured**)

Diagnostic and Medical Equipment

31. Wait times for radiation therapy for prostate cancer
    - Median wait time for radiation therapy for prostate cancer
    - Distribution of wait times for radiation therapy for prostate cancer
32. Wait times for radiation therapy for breast cancer
    - Median wait time for radiation therapy for breast cancer
    - Distribution of wait times for radiation therapy for breast cancer
33. Self-reported wait times for diagnostic services (**Featured**)
    - Median wait time for diagnostic services
    - Distribution of wait times for diagnostic services

Health Human Resources

34. Patient satisfaction with physician care **(Featured)**
35. Patient perceived quality of physician care

Healthy Canadians

36. Life expectancy
    - Life expectancy for overall population
    - Life expectancy by income
37. Health adjusted life expectancy (HALE) **(Featured)**
    - Health adjusted life expectancy (HALE) for overall population
    - Health adjusted life expectancy (HALE) by income
38. Infant mortality
39. Low birth weight
40. Mortality rate for lung cancer
41. Mortality rate for prostate cancer
42. Mortality rate for breast cancer
43. Mortality rate for colorectal cancer
44. Mortality rate for acute myocardial infarction (AMI)
45. Mortality rate for stroke
46. Five-year survival rate for lung cancer
47. Five-year survival rate for prostate cancer
48. Five-year survival rate for breast cancer
49. Five-year survival rate for colorectal cancer
50. Incidence rate for lung cancer
51. Incidence rate for prostate cancer
52. Incidence rate for breast cancer
53. Incidence rate for colorectal cancer
54. Potential years of life lost due to suicide
55. Potential years of life lost due to unintentional injury
56. Incidence rate for invasive meningococcal disease
57. Incidence rate for measles
58. Incidence rate for Haemophilus influenzae b (invasive) (Hib) disease

59. Incidence rate for tuberculosis
60. Incidence rate for Verotoxigenic E. Coli
61. Incidence rate for chlamydia
62. Rate of newly reported HIV cases
63. Prevalence of diabetes (**Featured**)
64. Exposure to environmental tobacco smoke
65. Self-reported health (**Featured**)
66. Teenage smoking rates (**Featured**)
    - Teenage smoking rates: Proportion current teenage smokers
    - Teenage smoking rates: Proportion daily smokers
67. Physical activity (**Featured**)
68. Body mass index (**Featured**)
69. Immunization for influenza, aged 65 plus (“Flu Shot”) (**Featured**)
70. Prevalence of depression

Annex 4

Data Source Exclusions and Limitations

The following is a list of the data sources used to report the 18 featured indicators included in *Healthy Canadians — A Federal Report on Comparable Health Indicators 2004* as well as a list of the relevant database exclusions and limitations.

Statistics Canada

Aboriginal Peoples Survey (APS) (not audited)

Exclusions/Limitations: All residents of collective dwellings (collective dwellings include lodging or rooming houses, hotels, motels, tourist homes, nursing homes, hospitals, staff residences, communal quarters (military camps), work camps, jails, missions, group homes and so on); all individuals 14 and under; individuals who did not participate in the 2001 Census; and individuals who did not identify on the 2001 Census as an Aboriginal person, and/or had Aboriginal ancestry, and/or First Nations membership, and/or registration under the *Indian Act.*

Due to a high number of refusals by First Nations communities in Quebec to participate in the survey, no provincial level data for the Quebec reserve population are available. Overall, data for on-reserve and non-reserve populations were published separately, with no aggregate data to reflect the whole Aboriginal population in Canada. Any aggregation of APS reserve data is only representative of the reserves that participated in APS and cannot be considered representative of the total on-reserve population.

Canadian Community Health Survey (CCHS)

Exclusions/Limitations: Persons living on First Nation reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, and residents of certain remote regions are excluded from the sample. Persons less than 12 years of age are not surveyed.

Health Services Access Survey (HSAS), Supplement to CCHS

Exclusions/Limitations: Persons less than 15 years of age, persons living in Nunavut, the Yukon, the Northwest Territories, on First Nation reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, and residents of certain remote regions are excluded from the sample.

National Population Health Survey (NPHS)

Exclusions/Limitations: Persons living on First Nation reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, and residents of certain remote regions are excluded from the National Population Health Survey household component sample.

The National Population Health Survey institutional component collects data on long-term residents (expected to stay six months or more) living in health care institutions with four or more beds. Institutions that exclusively provided short-term care, such as drug rehabilitation centres were excluded. Health care institutions in the territories, on Indian reserves and Canadian Forces Bases, and within correctional facilities were excluded.

Survey of Household Spending

Exclusions/Limitations: Persons living on First Nation reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, and residents of certain remote regions are excluded from the sample. Data from the territories are not available due to data quality issues.

Canadian Institute for Health Information (CIHI)

Hospital Morbidity Database (HMD)

Exclusions/Limitations: Patients not treated as inpatients in acute care hospitals (e.g., those seen only in an emergency department or chronic care institution).

A re-abstraction study designed to examine the consistency of coding for the **Hospitalization rate for ambulatory care sensitive conditions** (**ACSC**) (**12-PC**) indicator yielded a 10.8% discrepancy rate overall. In the majority of discrepant records, however, an ACSC did appear as a diagnosis on the patient record, although not as a most responsible diagnosis. Only 13 of 272 re-abstracted records did not have an ACSC recorded in any diagnosis field. Almost half of these (six) were originally coded as neurotic or depressive disorders, and all of these records were re-abstracted as a mental disorder, although the re-abstracted condition did not strictly qualify as ACSC. This suggests that the ACSC indicator is consistently coded and may be compared inter-jurisdictionally and across time, with one exception. Caution is advised when comparing 2001–02 rates with previous years' rates for provinces coding in ICD-10-CA/CCI. It is important to note that some of the differences identified may not be due to the implementation of ICD-10-CA/CCI, but may reflect other factors such as the establishment or withdrawal of programs and services specific to the conditions comprising this indicator.

Health Canada

National Diabetes Surveillance System (NDSS)*

Exclusions/Limitations: Persons younger than 20 years of age, New Brunswick and Newfoundland and Labrador.

Note to Readers: Readers should be cautious when interpreting these data.

Disclosure of Limitations:

a. Three types of diabetes are included in the database: type 1, type 2 and gestational diabetes. Note that gestational diabetes is only included when coded as diabetes mellitus (ICD9 code 250).
b. A baseline error rate of 20% to 25% exists in the published (1999–2000) data.
c. This level of error is accepted by Health Canada and by those national experts identified by Health Canada.
d. Since 1997–98, these data have been accumulating false positives. For the data published here, this may not have a significant impact. Health Canada plans to work to reduce these errors so that by the time the department publishes the 2001–02 data, this accumulation will not become significant.
e. This "baseline error rate" is likely to vary by age and sex groups.

Data are based on administrative data — therefore, their quality is constrained by the accuracy of those systems.

Data should not be used for trend analysis. Some data produced for the September 2002 Comparable Health Indicators Reports may have changed due to updated provincial and territorial numbers. For this reason, data tables provided for the November 2004 Comparable Health Indicators Reports replace all previous data tables.

Minor variations in data will occur when comparing data with other federal and provincial/territorial publications because of reporting delays, different cut-off dates and date of access to Statistics Canada's population estimates.

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*Now housed in the Public Health Agency of Canada.

National Aboriginal Health Organization (NAHO)

National Regional Longitudinal Health Survey (RHS) (Adult Survey) (not audited)

Exclusions/Limitations: Individuals under 18 years of age and residents of Nunavut.

Results are limited to participating First Nations people living on-reserve and in some non-reserve communities in the territories.

"What First Nations Think About Their Health and Health Care" (not audited)

Exclusions/Limitations: Individuals under 18 years of age and residents of Nunavut.*

Results are limited to participating First Nations people living on, or near, a First Nations community. (For this report, a First Nations community denotes an Indian reserve, within the meaning of the *Indian Act*, or federal Crown lands which have been set aside for, and/or are inhabited by, First Nations people.)

Organisation for Economic Cooperation and Development (OECD)

OECD Health Data 2004 (not audited)

Exclusions/Limitations: Users of cross-national data comparisons of health care data should be aware that there are still important gaps with respect to international agreements on statistical methods. The same term can refer to very different things among the 30 OECD countries. Despite efforts to develop homogeneity, standardized health statistics is still a goal, not a reality. The statistics contained in OECD Health Data, 2004 reflect the situation at the time of release; they are refined and improved year after year.

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*There are some inconsistencies in the exclusions presented in the NAHO document and on the NAHO Web site. For further information, contact the National Aboriginal Health Organization <http://www.naho.ca>.