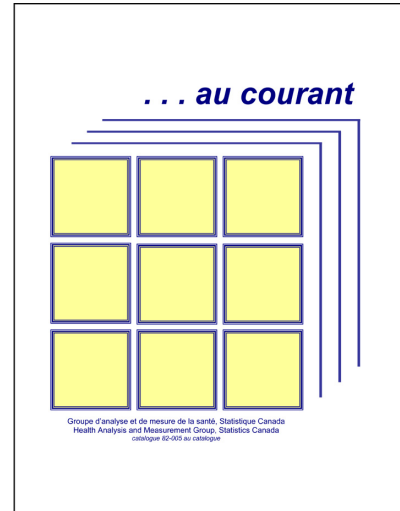




Catalogue no. 82-005-XIE

... au courant



Statistics Canada
Statistique Canada

Canada



Statistics Canada

. . . au courant

Published by authority of the Minister responsible for Statistics Canada

© Minister of Industry, 2003

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without prior written permission from Licence Services, Marketing Division, Statistics Canada, Ottawa, Ontario, Canada K1A 0T6.

February 2003

Catalogue no. 82-005-XIE

Frequency: Irregular

ISSN: 1703-2180

Ottawa

La version française de cette publication est disponible sur demande (n° 82-005-XIF au catalogue).

Note of appreciation

Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses, governments and other institutions. Accurate and timely statistical information could not be produced without their continued cooperation and goodwill.



In this issue

UP FRONT

PHI: a new name for the Canadian Burden of Disease

Jean-Marie Berthelot

IN SHORT

Cigarette smoking by birth cohort

Serge Tanguay, Kathy White, Karla Nobrega

INSIDE STORY

Health Services Access Survey

Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot, Kathy White

NEW FROM HAMG

Articles, announcements and seminars

UP FRONT...

PHI: a new name for the Canadian Burden of Disease (CBD)

The new year brings ongoing challenges to HAMG as we move into the next stage of our major initiative, formerly known as the Canadian Burden of Disease, Injury and Risk Factors (CBD). We have changed the name to Population Health Impact of Disease, Injury and Health Determinants (PHI) to better reflect both positive and negative impacts of health determinants and interventions on the health of Canadians.

During the spring of 2003 we are taking into the field several hundred health state descriptions, developed over the past months. Panels of Canadians will assess their relative preferences for these health states. Over the next several years, this collaboration of Statistics Canada, Health Canada, McGill University, the University of Ottawa, the University of Manitoba, the Institute for Clinical Evaluative Sciences (ICES) and the Montréal-Centre Regional Board of Health and Social Services will synthesize and integrate epidemiologic data about diseases and health determinants with Canadian health state preference scores. Our *In Short* article describes one small piece of this vast puzzle.

Our *Inside Story* highlights a major initiative completed in 2002: developing, implementing, and disseminating information from the Health Services Access Survey. The report, which describes the experiences of Canadians in accessing the health care system, was released in July 2002.

Jean-Marie Berthelot, Manager

IN SHORT...

Cigarette smoking by birth cohort

The Population Health Impact of Disease, Injury, and Health Determinants will combine the relative preferences of Canadians for several hundred health states with epidemiologic data about diseases, health conditions, and health determinants. A microsimulation framework that characterizes the health histories and futures of Canadians will provide answers to what-if scenarios such as "what is the potential health impact of a reduction of smoking among youth?"

An important input for this framework is a profile over time of health determinants such as smoking, diet, and physical activity: who is exposed, to what extent, and for how long. We reconstructed the smoking behaviour of birth cohorts over the past century using fourteen health surveys. We examined age of smoking initiation, smoking prevalence, and amount of cigarette use by age group, period, and cohort. At a recent seminar we provided preliminary results of this analysis: age of smoking initiation has dropped substantially over the past century, particularly among women. Although prevalence rates vary across birth cohorts, the pattern of use within each cohort is fairly similar, peaking during the middle years.

These results are of particular concern to Canadians as the baby boom generation reaches the age at which major health outcomes related to smoking—cardiovascular disease and cancer—start to peak. We will present more results in forthcoming issues.

Serge Tanguay, Kathy White, Karla Nobrega

HAMG conducts policy-relevant research and quantitative analysis of health and social issues.



Health Services Access Survey, 2001

As part of the Health Action Plan of September 11, 2000, all provincial and federal jurisdictions agreed to report on fourteen indicator areas covering health status, health outcomes, and quality of health care services. Comprehensive and timely data for two of these indicator areas were not available in all provinces: 24/7 (24 hours a day, 7 days a week) access to first contact services, and access to specialist services including waiting times. The Health Services Access Survey was developed by HAMG in part to address this information gap.

This survey is the first to provide comprehensive and comparable information at the national level on the patterns of use of health care services and self-reported difficulties in accessing health care as experienced by Canadians. Developed and conducted by Statistics Canada, it was funded by Statistics Canada, Health Canada and the provinces of Prince Edward Island, Alberta and British Columbia.

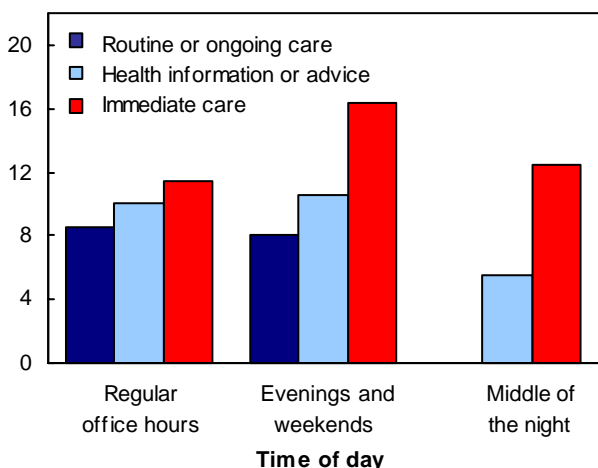
Access to two kinds of health care services were examined: first contact services (for self or family member) included routine care, health information and immediate care for a minor health problem; specialized services (for self) included specialist visits, non-emergency surgery and specific diagnostic tests. Information on waiting times was also collected for specialized services.

First contact health care services (for self or family member)

An estimated 23.2 million Canadians, or about 94% of the total population aged 15 and over, accessed first contact health care services in 2001. Of these, about 18%, or just under 4.3 million people, encountered a difficulty of some kind. This proportion varied by time of day and type of service (Figure 1). The type of difficulty varied by type of service, but long waits and problems contacting a health care provider topped the list.

Figure 1
Difficulties accessing first contact services by time of day, Canada, 2001

% reporting difficulties among those accessing this service at this time



Overall, 11% (2.5 million) of those who accessed routine care reported they had difficulties, as did 13% (1.5 million) of those who accessed health information or advice, and 19% (1.6 million) of those who needed immediate care for a minor health problem.

During regular office hours, 42% of individuals who reported difficulties accessing routine care did so because of problems getting an appointment, while during evenings and weekends, a time when most accessed walk-in clinics, 47% cited lengthy in-office waiting times.

Close to 40% of those who had difficulties getting health information during regular office hours or during evenings and weekends indicated that it was because they did not get adequate information. In the middle of the night, a time when most accessed or called emergency rooms, close to 60% cited having to wait too long to speak to someone.

About 38% of individuals who had difficulties getting immediate health care for a minor health problem during regular office hours cited in-office waiting times as the cause. This proportion increased to 57% during evenings and weekends, and 59% during the middle of the night, times when most accessed walk-in clinics and emergency rooms.

Specialized services (for self)

Over the past 12 months, about 20% of Canadians (over 5 million individuals) aged 15 and over sought a specialist visit for a new illness or condition. In addition, about 1.2 million had non-emergency surgery and almost 1.7 million had specific non-emergency diagnostic tests (MRIs, CT scans or angiographies) over a 12-month period.

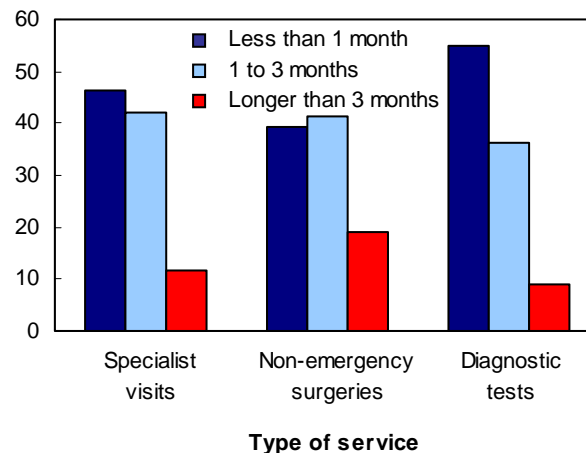
About 22% of those who visited a specialist reported difficulties accessing the service, as did 21% of those who had a non-emergency surgery and 18% of those who had a diagnostic test. The majority of those who indicated that they had problems accessing specialized services said it was because of long waits, between 55% (for non-emergency surgeries) and 72% (for diagnostic tests) of those citing difficulties.

Waiting times

Among those who reported waiting for (and accessing) specialized services, between 40% of those who waited for non-emergency surgery and 55% of those who waited for diagnostic tests waited less than one month (Figure 2).

Figure 2
Distribution of waiting times for specialized services, Canada, 2001

% of those who waited for this service



Of those who waited for specialized services, just over 5% waited 26 weeks (six months) or more for specialist visits or diagnostic tests. For non-emergency surgery, close to 10% reported waiting for 26 weeks and about 5% for 35 weeks or more.

For non-emergency surgery, the waiting time varied by type of surgery. Individuals who waited for cardiac or cancer-related surgery were more likely to receive services within one month (54%), compared with those who waited for joint replacement surgery or cataract surgery (20%).

Of the estimated 5 million people who waited for specialized services, roughly 18%, or 900,000 people, reported that waiting for care affected their lives. The majority of these people, between 44% (for non-emergency surgery) and 68% (for diagnostic tests) reported worry, anxiety or stress, and about 37% said they experienced pain. Diminished health status; problems with activities of daily living; worry, anxiety, and stress for family and friends; and loss of work or income were also cited as effects of waiting for care.

Over 20% of those who waited for specialized services felt the amount of time they waited was unacceptable. This ranged from 22% of people who waited for non-emergency surgery to 27% of those who waited for specialist visits. People who reported unacceptable waiting times reported waiting up to six times longer than those who considered their wait acceptable. For example, among people who visited a specialist, those who said their waiting times were unacceptable had waited 13 weeks (median value), compared with only two weeks among those who reported acceptable waiting times. For non-emergency surgery, those who said their waits were unacceptable had also waited 13 weeks, three times longer than those who reported acceptable waiting times.

More than half of those who reported their waits to be unacceptable also reported that waiting for care had affected their lives, compared with only 5% among those who reported that their waiting time was acceptable.

Claudia Sanmartin and Christian Houle have been recognized by Statistics Canada with Merit Awards for their role in developing and implementing this new survey. They brought together teams from Special Surveys, Health Statistics, Communications, and Dissemination Divisions to develop and implement the survey and analyse and disseminate the results.

Claudia is a senior analyst with HAMG. She has a PhD in Health Services Research from the University of British Columbia and a MSc in Health Administration from the University of Toronto. Claudia's primary research interests include the delivery of and access to health care services, including extensive work conducted in the area of waiting times for medical services, and inequalities in health.

Christian, who has a MSc in Mathematics, worked with HAMG for close to ten years as a methodologist, senior analyst, and manager of diverse projects, ranging from microsimulation of cancer treatment outcomes to record linkage of socio-demographic data and health outcomes. Since August 2002, he has been the manager of the Data Interpretation Workshop, one of Statistics Canada's flagship training programs.

In summary

For the first time, detailed information regarding the experiences of Canadians when they access health care services is available at the national level. The results of the Health Services Access Survey revealed that almost 20% of those who obtained first contact services (for self or family member) for routine care, health information or advice or immediate care for a minor health problem reported difficulties accessing these services.

About 20% of those seeking specialized services (for self) reported difficulties, the majority citing lengthy waits as a primary barrier to care. Waits for surgery varied by type of surgery. Variations in waiting times by type of service warrant further investigation to assess how current services are meeting the needs of Canadians.

This survey provides valuable information regarding the views and experiences of Canadians about waiting for care. These initial data provide a starting point for examination of access to health care services in Canada.

*Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot,
Kathy White*

See our report

Access to Health Care Services in Canada, 2001.
(Statistics Canada, Catalogue 82-575-X1E)
<http://www.statcan.ca/english/freepub/82-575-X1E/free.htm>

Related reading

Healthy Canadians. A Federal Report on Comparable Health Indicators 2002. Ottawa: Health Canada, 2002.
<http://www.hc-sc.gc.ca/iacob-dgiac/arad-draa/english/accountability/indicators.html>

Comparable Health Indicators – Canada, Provinces and Territories.

<http://www.statcan.ca/english/freepub/82-401-X1E/free.htm>

Health Services Access Survey: Methods and Limitations

In November and December 2001, telephone interviews of individuals fifteen and over living in households were conducted in all 10 provinces as a supplement to the Canadian Community Health Survey (CCHS). The total sample size for the survey was 14,210, with a response rate of 80.7%. Responses were weighted to account for the survey design, non-response, and demographic distributions. Bootstrap techniques were used to account for design effects on the variance.

The survey asked about first contact services (for self or family member) and specialist services (for self) accessed over the previous twelve months. Analysis of difficulties experienced is thus based on those actually receiving services. These self-reported data have not been externally validated; comparisons with the CCHS and other data sources must take into consideration methodologic differences explained in the report. No temporal or causal relationships can be inferred. Provincial comparisons are limited due to small sample sizes in some provinces.

Recent publications

Chen J, Hou F, Sanmartin C, Houle C, Tremblay S, Berthelot J-M. Unmet health care needs. *Canadian Social Trends*. Statistics Canada Catalogue no. 11-008 Winter 2002: 18-22.

Bélanger A, Martel L, Berthelot J-M, Wilkins R. Gender differences in disability-free life expectancies for selected risk factors and chronic conditions in Canada. *Women and Aging* 2002;14(1/2): 61-83. Also in: Laditka S, ed., *Health Expectations for Older Women: International Perspectives*. New York: The Haworth Press, 2002.

Berthelot J-M. Health-adjusted life expectancy. In: Robine J-M, Jagger C, Mathers CD, Crimmins EM, Suzman RM, eds., *Determining Health Expectancies*. Chichester: John Wiley and Sons, 2003, p. 235-46.

Announcements

Russell Wilkins recently received a Commemorative Medal for the Queen's Golden Jubilee for his significant contribution to the public service and research community during his 15 years at Statistics Canada. Russell has published widely on socioeconomic inequalities in Canada. He has been in the forefront of developing health expectancy measures, in particular, disability-free life expectancy. Russell has also developed PCCF+ software for automated geographic coding.

Our February 2002 issue highlighted work by Nancy Ross and colleagues. See the recent article in the *McGill Reporter* which recognizes the importance of these findings in influencing social policy at <http://www.mcgill.ca/reporter/03/ross>.

Dafna Kohen and Nancy Ross have been accepted into the New Investigators Network for Human Development of the Canadian Institute for Advanced Research (CIAR).

In our September 2002 issue, we highlighted the contribution of our microsimulation model to the evidence base for screening recommendations being developed by the National Committee on Colorectal Cancer Screening. These recommendations are now available at <http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ncccs-cndcc>.

Paul James, a Master's student with the Department of Epidemiology and Community Medicine at the University of Ottawa, has been working with HAMG since November. He is examining income-related differences in mortality across Canada from 1971 to 1996, with a focus on causes of death for which public health or medical interventions are available. He will be continuing his thesis with the Institute for Clinical and Evaluative Sciences (ICES) in Toronto.

Seminars and workshops

Dafna Kohen and Karla Nobrega have contributed to the development of Statistical Society of Canada Case Study 2003, "Neighbourhood Factors and Children: Hierarchical Linear Models and Small Area Statistics." Course material will be available at http://www.ssc.ca/resources/studies_e.html.

Next HAMG seminars:

February 19	Paul James	Effects of socio-economic status on avoidable mortality in Canada, 1971 to 1996
March 5	Margo Shields, Stéphane Tremblay	The health of Canada's communities
April 16	Tom Reichert (of NIH)	National Institutes of Health (NIH) Multinational Influenza Seasonal Mortality Study (MISMS)

Standards of service to the public

Statistics Canada is committed to serving its clients in a prompt, reliable and courteous manner and in the official language of their choice. To this end, the Agency has developed standards of service which its employees observe in serving its clients. To obtain a copy of these service standards, please contact Statistics Canada toll free at 1-800-263-1136.

Note of appreciation

Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses, governments and other institutions. Accurate and timely statistical information could not be produced without their continued cooperation and goodwill.

**. . . au courant is published three times a year by the Health Analysis and Measurement Group, Statistics Canada.
Aussi disponible en français.**

Rolande Bélanger	Julie Bernier	Jean-Marie Berthelot	Charlotte Clarke	William Flanagan
René Gélinas	François Gendron	Sarah Gorber	Paul James	Dafna Kohen
Christel Le Petit	Alex MacCutchan	Cameron McIntosh	Edward Ng	Karla Nobrega
Nancy Ross	Claudia Sanmartin	Selene Spence	Mietek Szyszkowicz	Stacey Todd
Stéphane Tremblay	Kathy White	Russell Wilkins		

We welcome your comments!
Jean-Marie Berthelot, Manager
Kathy White, Editor

Tel: 1-800-263-1136
Email: infostats@statcan.ca