Healthy Canadians

A Federal Report on Comparable Health Indicators 2006

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A Federal Report on Comparable Health Indicators 2006

Health Canada is the federal department responsible for helping Canadians maintain and improve their health. We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.

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Message from the Minister of Health

I am pleased to release *Healthy Canadians – A Federal Report on Comparable Health Indicators 2006*. This is the third in a series of reports prepared by the Government of Canada to respond to the First Ministers' commitments of greater transparency and accountability in the health care system.

This report provides information on themes of key concern to Canadians, namely, timely access, quality of care, and health and wellness. By tracking changes over time and making international comparisons, it provides a basis upon which areas for improvement can be highlighted and informed decisions can be made.

I am gratified to see that while there is much left to do, this report shows we are on the right path in many areas. We see there are some improvements in the areas of timely access to care, quality of care, and self-reported health status and wellness. We see an increase in the number of Canadians who are satisfied with their health, and a decrease in the number of Canadians who experienced difficulty in receiving immediate care.

Canada's new government continues to work with the provinces and territories on the priority of establishing Patient Wait Times Guarantees. As we move toward that goal, the access indicators in this report provide governments and all Canadians with important information on progress made in improving timely access to care. I would like to thank Statistics Canada and the Canadian Institute for Health Information for their invaluable contributions to the development of this report.

I am confident that this report will inform discussions of health system renewal and support continued improvements to the health care system and the health of Canadians.

Sincerely,

Tony Clement
Minister of Health

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Executive Summary

In 2000, First Ministers made a commitment to report to Canadians on the performance of our health care system. *Healthy Canadians—A Federal Report on Comparable Health Indicators 2006* is the federal government's third report on this issue.

The indicators presented in *Healthy Canadians 2006* are based on input from health partners, experts and the general population. Most of the data and information in this report come from Statistics Canada and the Canadian Institute for Health Information and pertain to the general population. In addition, limited information is presented on First Nations and Inuit populations as well as on military personnel. All data are from 2005 except where stated, and all highlighted differences are statistically significant.

Selected highlights of the data include the following:

For the General Canadian Population

- Fewer Canadians aged 15 years and older who required health services for themselves or a family member reported difficulty obtaining immediate care for a minor health problem—20.7% in 2005 compared to 23.8% in 2003.
- The median wait time for Canadians aged 15 years and older to receive the diagnostic service they needed was three weeks—unchanged from 2003. However, 10.2% said they waited over three months for diagnostic testing—very similar to the 11.5% reported in 2003.
- Fewer Canadians younger than 75 years of age were hospitalized in 2004–2005 for chronic conditions (such as diabetes or hypertension) that can be cared for in the community—392 admissions per 100,000 population, down from the 416 seen in 2002–2003.
- Most Canadians (84.4%) aged 15 years and older reported being "very satisfied" or "somewhat satisfied" with the way overall health care services were provided, unchanged from 2003.
- 65.5% of Canadians aged 12 years and older said their health was "excellent" or "very good." This is an increase from the 59.6% noted in 2003.
- Smoking among teenagers continued to decline—6.9% of 12- to 19-year-olds said they were daily smokers in 2005, compared to 12.9% in 2000–2001.
- More than half of Canadians (51.6%) aged 12 years and older said they were active or moderately active—an increase from the 43% seen in 2000–2001. More males (53.8%) than females (49.5%) said they were active or moderately active in 2005.
- Almost one third (32.5%) of Canadians aged 18 years and older said their height and weight corresponded to a body mass index (BMI) in the overweight category. In addition, 14.9% said their height and weight corresponded to a BMI in the obese category, an increase from the 14.1% observed in 2000-2001.
- More seniors (66.2%) aged 65 and older said they had received a flu shot during the 12 months before they were surveyed—an increase from the 62.9% reported in 2000–2001.

For First Nations and Inuit

- Over one third (39.9%) of First Nations aged 18 years and older and living on-reserve said their health was "excellent" or "very good" in 2002–2003.
- A minority (25.6%) of First Nations aged 12 to 19 years old and living on-reserve said they smoked daily in 2002–2003.
- Well over half (63.1%) of self-identified Inuit aged 20 years and older reported in 2001 that they smoked daily.

For Military Populations

- Most members of the Regular Force (83%) who sought medical attention from a Canadian Forces medical facility reported in 2004 that they felt their concerns were addressed at the time of their appointment.
- Most Regular Force members (65%) said their health was "excellent" or "very good" in 2004.
- Almost half (43%) of Regular Force members reported being physically active and over one quarter (28%) reported being moderately active in 2004. The number of physically active members has decreased since 2000 when 48% were physically active.

Healthy Canadians 2006 presents data on 21 health indicators which were mostly identified through consultations (including, for example, public opinion research that targeted health care professionals and Canadians) as being of greatest interest and/or use to Canadians. Health Canada added data on three additional indicators in this third federal report on the performance of Canada's health system to reflect current needs and interests of Canadians. Limitations of the data are included to help the reader assess the reliability and validity of the information presented in this report.

Healthy Canadians 2006 (as well as reports from 2002 and 2004) is available online at http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/index_e.html.

Introduction

1. Introduction

Purpose of this Report

The Government of Canada is committed to being accountable and to reporting to Canadians. Information on comparable health indicators helps federal, provincial and territorial jurisdictions and health care providers monitor trends and progress towards improving the health of Canadians.

Following similar reports published in 2002 and 2004, *Healthy Canadians—A Federal Report on Comparable Health Indicators 2006* provides Canadians with the most recent information available on the performance of our health care system. This report presents cumulative data on a number of indicators for the general population. It also includes available data on First Nations living on-reserve and recognized Inuit, and Canadian military personnel, as the federal government is responsible for delivering health services to these populations.

Background

The impetus for this report lies in the *First Ministers' Communiqué on Health*, published in 2000. This agreement articulated the commitment of health ministers in all provinces and territories and the federal government to strengthen and renew Canada's publicly funded health system. It included an action plan to improve the effectiveness of the system by encouraging work in a number of critical areas: access to care; health promotion and wellness; primary health care; home care and community care; pharmaceuticals management; health information and communications technologies; health equipment and infrastructure; and the supply of well-trained health professionals. The agreement also highlighted the need for improved accountability and reporting to Canadians. It directed federal, provincial and territorial health ministers to collaborate and develop a comprehensive framework of comparable health indicators on health status, health outcomes and the quality of health care services with the expectation that comparisons could be made across jurisdictions.[1] By 2002, all jurisdictions[2] had information on some of the 67 comparable indicators and all published a first report. All jurisdictions committed to reporting to the public every two years.

In February 2003, the *First Ministers' Accord on Health Care Renewal* built on the success of the agreement by directing health ministers to develop additional indicators. These indicators were reviewed by experts and stakeholders to ensure that the indicators would measure progress on achieving the reforms articulated in the 2003 Health Accord.

The 2003 Health Accord focused on several themes—Timely Access, Quality, Health Status and Wellness, and Sustainability—and showed that First Ministers agreed to the following:

- Jurisdictions will continue to report to the public on how they spend health care dollars annually—including comprehensive and regular public reporting on their health programs and services, on health system performance, health outcomes and health status.
- Reports will include the indicators articulated in the *First Ministers' Communiqué on Health* and any other comparable indicator identified by health ministers on the above-mentioned themes.
- Jurisdictions will develop the required data infrastructure and collect the data necessary to facilitate quality reporting (i.e., data will be comparable, relevant, feasible, technically robust and reliable).

The First Ministers' meeting of 2004 built upon the 2003 Health Accord by reiterating the commitment of governments to strengthen health care in Canada. Subsequently, the 2004 Health Accord, also referred to as the *10-Year Plan to Strengthen Health Care*, was agreed to by First Ministers in September 2004. It addresses Canadians' priorities for sustaining and renewing the health care system and provides long-term funding to make those reforms a reality. The 2004 Accord also addresses issues related to reducing wait times and improving access—especially in the priority areas of cancer and heart treatments, diagnostic imaging, joint replacements and sight restoration. Under the 2004 Accord, federal investments of $41 billion over 10 years were intended to allow governments to plan ahead, to build with confidence, and to invest with certainty in renewal and positive

1. Section 5, *Health Information—Challenges and Next Steps*, provides information on the limitations of comparable health indicators.
2. Federal departments often do not have data on many indicators (e.g., wait times, hospitalizations, cancer incidence and mortality) because provinces and territories typically hold this information.

change. As part of their commitment to accountability, the First Ministers also agreed to report to their residents on the performance of the health system.

Federal/Provincial/Territorial Process

In June 2002, the Conference of Federal/Provincial/Territorial Deputy Ministers of Health tasked the Advisory Committee on Governance and Accountability to review the comparable health indicators used for reporting in 2002 against the Health Accord (Communiqué) of 2000, and to prepare the plan for comparable reporting in compliance with the terms of the 2003 Accord. Deputy Ministers approved the policy direction supporting this work. To guide the technical work and development of the 2004 report, a working group was established to provide expertise and advice on enhancing comparable reporting in accordance with the First Ministers' commitments of 2000 and 2003. The working group included representatives from Statistics Canada, the Canadian Institute for Health Information, l'Institut de la statistique du Québec, and each federal, provincial and territorial jurisdiction. The committee's earlier work and that of the Conference of Deputy Ministers, which in June 2004 agreed to the set of comparable indicators for the 2004 Federal Report, helped guide the production of *Healthy Canadians 2006*. However, the Advisory Committee on Governance and Accountability did not play a role in the selection of all the indicators for 2006. In addition, the Committee did not participate in the selection of the three additional indicators (e.g., self-rated mental health, self-perceived stress, and self-reported fruit and vegetable consumption) or the indicators in the sections on First Nations and Inuit and military personnel.

Development of *Healthy Canadians 2006*

2. Development of *Healthy Canadians 2006*

This section describes how the indicators featured in this report were selected and identifies the themes and priorities of the 2003 Health Accord that had an impact on the information presented. It also provides an overview of how the report is organized.

Most of the data used in this report—including their technical descriptions—come from Statistics Canada and the Canadian Institute for Health Information. In general, data have already been analyzed and age-standardized—age-adjusted (or age-standardized) data are required in order to control for changes in the age structure of the Canadian population over time.

Health Canada was responsible for ensuring that all data referred to in *Healthy Canadians 2006* met criteria for completeness, accuracy and adequate disclosure. The Office of the Auditor General of Canada was responsible for verifying that the featured indicators met these criteria.

Selection of Indicators

For past reports (2002, 2004), indicators were selected through consultations with various groups (e.g., subject experts, health professionals and Canadians). These consultations included written submissions and public opinion gathered in some provinces in 2002, an invitational workshop with national stakeholders held in June 2003, and focus groups held in five major cities across Canada in January 2004. To assist in the prioritization of indicators according to their importance and meaning to Canadians, the federal government relied on reviews of relevant information, input from advisory committees and targeted feedback. The Advisory Committee on Governance and Accountability then recommended 70 indicators to the Deputy Ministers for approval by the Ministers of Health in 2004.

While all indicators were considered relevant and important to this process, some did not meet the necessary criteria (e.g., comparability, availability of data). A subset of 18 indicators was therefore selected from the original 70. Most of these 18 indicators have been updated for 2006, although two (i.e., health-adjusted life expectancy and patient satisfaction with telephone health line or tele-health services) were not updated as data were not available.

The federal/provincial/territorial structure or process that was in place to provide guidance or feedback on the development of the last report (2004) was not available for *Healthy Canadians 2006*. In the absence of such a mechanism, Health Canada sought to add value to the report by addressing areas of health not covered in the 2002 and 2004 reports. Through consultations with relevant areas of Health Canada and the Public Health Agency of Canada, three additional indicators were selected for inclusion in this report: self-rated mental health, self-perceived stress, and self-reported fruit and vegetable consumption. All were selected for their relevance to current health issues and for the availability of reliable data across provinces.

The selection of indicators related to First Nations and Inuit, as well as to military personnel, was done in consultation with Health Canada's First Nations and Inuit Health Branch and the Department of National Defence. The final selection of indicators for these populations was based on relevance and the availability of data. Because of the distinctiveness of these populations compared to the general public, information on First Nations and Inuit and military personnel are presented in separate sections of the report.

Section 5, *Health Information—Challenges and Next Steps*, provides information on the limitations of comparable health indicators.

What is Included in *Healthy Canadians 2006*

To facilitate comparisons with the 2004 report, *Healthy Canadians 2006* includes:

A description of the themes and priority areas—This report, like its predecessor in 2004, incorporates the themes and priority areas identified in recent Health Accords (see "Themes and Priority Areas" on the following page).

Emphasis on 18 featured indicators—Public opinion research shows that these featured indicators, which most jurisdictions can report on, are of greatest interest or use to Canadians.[3]

Focus on specific populations—In addition to highlighting data on the general population, this report provides information on specific populations under the responsibility of the federal government.

Data presentation—In Section 4, *Measuring Performance*, data are presented in graph and/or table form. Highlights are presented in accompanying text.

Data on other federal health responsibilities—The federal government delivers health care services to specific groups such as military personnel and veterans, inmates of federal penitentiaries, and members of the Royal Canadian Mounted Police. It also delivers selected health care services to eligible First Nations and recognized Inuit, and people for whom immigration authorities are responsible (e.g., asylum seekers, refugees and persons detained for immigration purposes).

It should be noted that the data are sometimes lacking because federal departments and agencies do not always have the capacity to collect information. Moreover, available data on federal populations do not often correspond exactly to the reporting requirements of 2006's comparable indicators for the following reasons:

- While data are available for some of the populations under federal responsibility, many of the selected indicators are for services provided by the provinces and territories.
- The infrastructure needed to systematically collect consistent information across the country has yet to be implemented. For this reason, provinces and territories vary in their capacity to collect, analyze and publish data. This, in turn, affects which data on utilization and outcomes are available (for example, from hospital databases).
- Information that is regularly collected on the Canadian population is not always available for First Nations and recognized Inuit. See page 15 for definitions related to Aboriginal populations (First Nations, Inuit and Métis).

Data exclusions and limitations—Where possible, exclusions and limitations are identified for each graph and table included in the report; they are also shown in Annex 3.

Themes and Priority Areas

The 2006 report provides information on the broad themes of recent Health Accords and focuses on seven specific priority areas under those themes. This information is listed and described below. Additional descriptions of performance indicators are provided in Section 4, *Measuring Performance*.

Three Themes

1. Timely Access
2. Quality
3. Health Status and Wellness

Timely Access—measures access to essential health services across the country. *Example: waiting times.*

Quality—measures various aspects of the quality of health care services across the country. *Example: patient satisfaction with the way that services were provided.*

Health Status and Wellness—measures the health of the entire population. *Examples: physical activity* and *body mass index*.

Seven Priority Areas

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

3. Federal, Provincial and Territorial Performance Indicators Reporting Committee. Federal, Provincial and Territorial Public Consultations on Performance Indicators and Reporting: Summary of Results. April 2003.

Primary Health Care—For non-emergency care, Canadians often turn to primary health care services that represent both the first level of care and the initial point of contact patients have with the health system. This includes consultations with family physicians, nurses, nurse practitioners and mental health workers, as well as telephone calls to health information lines and advice received from pharmacists. *Example: difficulty obtaining immediate care*.

Home Care—Patients can receive care and treatment at home rather than being treated in a hospital, enabling them to live independently while reducing pressure on the health system. This priority area also includes supports to persons who provide full-time care to an incapacitated individual. Other services are needed to supplement home care in Canada, including professional nursing care, personal care and home support such as cleaning and laundry. *Example: the number of home care clients per 100,000 population. Note that home care is not featured in this report*.

Catastrophic Drug Coverage and Pharmaceutical Management—Canadians spend more money out-of-pocket on prescription drugs than on any other category of health expenditure, despite the availability of some public drug benefit coverage from federal, provincial and territorial governments to certain populations (such as eligible First Nations and recognized Inuit). Because of the high cost of prescription drugs, Canadians suffering from serious health conditions or illnesses may face significant hardship. *Example: prescription drug spending as a percentage of income*.

Diagnostic and Medical Equipment—Positive health outcomes can be achieved through early access to diagnostic equipment for disease detection, diagnosis and treatment. High technology equipment includes magnetic resonance imagers (MRIs), computed tomography (CT) scanners, nuclear medicine cameras and radiation therapy equipment. Other devices include ultrasound and X-ray machines and medical/surgical tools that enhance the quality of patient care and/or the working conditions of health care personnel. *Example: self-reported wait times for diagnostic services*.

Health Human Resources—Trained health professionals such as physicians, nurses and pharmacists are essential in the delivery of quality health care to Canadians. The health system must therefore anticipate and maintain an appropriate supply of qualified health care providers. *Example: patient satisfaction with the way physician care was provided*.

Healthy Canadians—To help Canadians maintain and improve their health status and to address issues like obesity, the health care system must strike the right balance between personal and collective responsibility. This requires coordination with governments and stakeholders to maximize the benefits of health promotion and public and environmental health activities. Such an approach will also help minimize health disparities. *Example: physical activity*.

Other Programs and Services—Following the *First Ministers' Communiqué on Health* in 2000, governments agreed to improve quality, accessibility and sustainability of health care services. Indicators have been developed to measure the public's perception of the health care system and on quality service outcomes. *Example: patient satisfaction with the way hospital care was provided*.

Organization of this Report

Section 3, *Overview of the Federal Government's Role in Health*, provides a brief description of some federal government departments and the health services they offer, the number of clients they serve and related expenditures.

In Section 4, *Measuring Performance*, national-level information is presented on the indicators featured in this report, including: the theme and priority area they address; a brief description and technical definition of what the indicators measure and what data were collected; a brief commentary on the results; as well as data sources and related notes. This section also includes information on three additional indicators (self-rated mental health, self-perceived stress, and self-reported fruit and vegetable consumption) selected by Health Canada to supplement the featured indicators. Information on the general population, First Nations and Inuit, and military personnel are presented in separate sub-sections to help limit comparisons across distinct population groups.

Section 5, *Health Information—Challenges and Next Steps*, highlights the challenges related to the collection and reporting of health information, in particular for First Nations and Inuit populations.

Three annexes supplement this report. Annex 1 lists the featured and supplementary indicators (i.e., the eighteen indicators agreed to by the provinces, territories and federal government, and the three additional ones selected by Health Canada) and provides a summary of the federal government's ability to report on data pertaining to the general public, on-reserve First Nations and recognized Inuit, and military personnel. Annex 2 lists the 70 indicators approved by the Deputy Ministers for public reporting in 2004. Annex 3 highlights exclusions and limitations for the data sources referred to in this report.

Note to Readers

Most of the data in this report regarding the general population have been audited unless specifically identified as "unaudited." In particular, data for international comparisons, First Nations and Inuit, and military personnel are unaudited.

All differences highlighted in the presentation of the 18 featured indicators, the three additional indicators and the indicators on First Nations and Inuit, and military personnel are statistically significant ($p<0.05$), and result from tests that take into account the size and complex design of the survey used.[4] Where appropriate, age standardization was performed to allow meaningful comparisons. In some instances, data from the National Population Health Survey (NPHS) and the Canadian Community Health Survey (CCHS) are presented graphically; however, the analysis is limited to the CCHS data due to differences in survey methodologies.

4. Statistical significance means that an observed difference is probably true and not caused by chance. The term "$p<0.05$" means there is less than a 5% probability that an observed difference is due to chance alone.

Overview of the Federal Government's Role in Health

3. Overview of the Federal Government's Role in Health

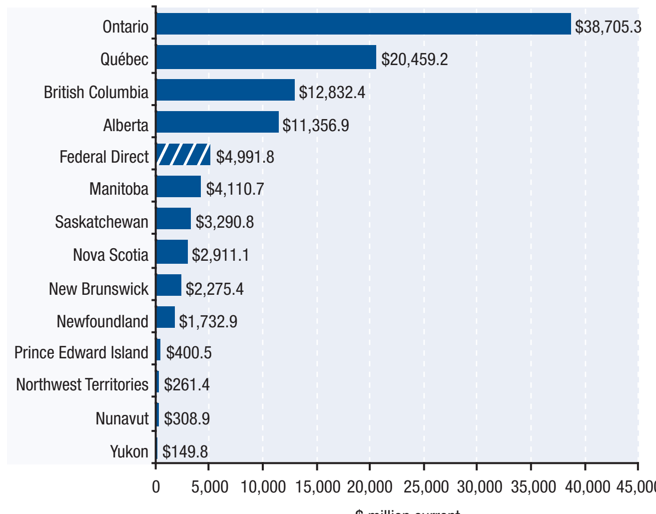
Canada's health care system is the product of a complex interplay between various partners, including the provinces and territories, health service providers and the Canadian public. While the provinces and territories are largely responsible for the delivery of health care services, the Government of Canada supports the publicly funded system through transfer payments and the *Canada Health Act*. The Act is intended to ensure that all Canadians have access to medically necessary services regardless of their ability to pay. The provinces and territories are required to comply with the five principles of the Act—universality, accessibility, portability, comprehensiveness and public administration—in order to receive full federal funding.[5]

Expenditures on Health

The Government of Canada is directly responsible for providing health services to close to one million people at an annual cost of approximately $5 billion, and is the fifth largest provider of health services to Canadians. It ensures the availability of health services for First Nations and Inuit communities, military personnel and veterans, members of the Royal Canadian Mounted Police, inmates in federal penitentiaries and persons for whom immigration authorities are responsible (e.g., asylum seekers, refugees and persons detained for immigration purposes).

Total Public Sector Health Care Spending (unaudited)

By jurisdiction, 2005

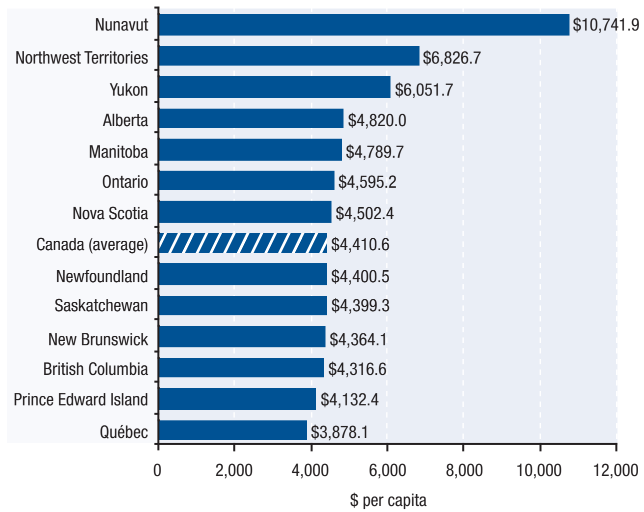


Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2005*.

Note: These figures are forecast estimates. Final figures will not be available until December 2007.

Total Health Expenditure (unaudited)

By province/territory and for Canada, per capita, 2005



Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2005*.

Note: These figures are forecast estimates. Final figures will not be available until December 2007.

5. A description of the *Canada Health Act* can be found at: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html.

Federal Health Services at a Glance

Some federal government departments provide health services directly to specific populations. A summary of the services offered by selected departments is provided below. In addition to quoted client population sizes, quoted expenditure figures were provided by the relevant departments and do not total the $5 billion noted earlier in this section, as that amount includes nearly 30 federal departments and agencies providing direct health services to Canadians.[6]

Health Canada—Provides an extensive range of ongoing programs to a number of segments of the First Nations and Inuit populations. For example, primary health care services are provided through nursing stations and community health centres in remote and/or isolated communities to supplement and support the services that provincial, territorial and regional health authorities provide. Non-Insured Health Benefits coverage of drug, dental care, vision care, medical supplies and equipment, short-term crisis intervention counselling, and medical transportation are also available to all 764,523 registered Indians and recognized Inuit in Canada, regardless of residence. Disease prevention and health promotion programs, public health education, environmental health, alcohol/drug addiction treatment and long-term community care are also provided on-reserve. Health Canada also administers targeted health promotion programs for all Aboriginal people regardless of residence (e.g., the Aboriginal Diabetes Initiative), and other programs that support the development and implementation of activities to promote healthy lifestyle choices and contribute to the prevention of chronic disease and injuries. In 2005–2006, resources of approximately $1.8 billion were made available for federal First Nations and Inuit Health Programs.

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, including institutional care for eligible clients in community care facilities. In 2005–2006, 134,000 clients were eligible for health care benefits, resulting in expenditures of $877 million.

Correctional Service of Canada—Provides inmates with essential health care services (medical, dental and mental health) 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 and at five regional hospitals and five dedicated mental health treatment centres. Community specialists and diagnostic and hospital services are used as required. In 2005–2006, health services were available to approximately 12,671 inmates, resulting in expenditures of $123.9 million. This figure includes all medical costs—salaries, medication, hospitalization, medical tests/examinations, and physician, specialist and dental appointments.

Department of National Defence—Provides health care for approximately 62,000 Canadian Forces members (Regular Forces and full-time Reservists) while they are at home or abroad in order to optimize their health and support Canadian Forces operations. A comprehensive range of clinical services is available to individuals through a network of Canadian Forces health care clinics or by purchasing services from the provinces/territories. Public health and health promotion programs are offered at a population level

The *Canada Health Act* excludes

members of the Canadian Forces, those people appointed to a position of rank within the Royal Canadian Mounted Police, those serving a prison term in a federal penitentiary, and people who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months). In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., foreign refugees) or under the workers' compensation legislation of a province or territory (see: http://hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html).

6. Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends, 1975–2005* (Ottawa: CIHI, 2005), p. 12.

primarily through Force Health Protection, Canadian Forces Health Services Group. Total health care expenditures were estimated to be $417.3 million in 2003–2004 and $456.1 million in 2004–2005.

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 medically and emotionally fit to perform their duties safely. These services include basic health care that is equivalent to the public provincial plan (as the definition of "insured persons" in the *Canada Health Act* excludes RCMP members for funding under provincial health care plans). Services also include supplemental health care (equivalent to what other workers of the same level receive through their employer's collective health care plans) as part of their collective agreement(s). In addition, members and other employees receive health care to meet the occupational requirements of the RCMP. Approximately 15,998 RCMP members are eligible to receive health benefits. In 2005–2006, health expenditures were approximately $50.9 million.

Citizenship and Immigration Canada—

Provides, through the Interim Federal Health Program, essential health/dental care, medical screening for immigration purposes, and pre-departure screening and treatment for persons for whom the immigration authorities are responsible (e.g., asylum seekers, refugees and persons detained for immigration purposes)—which represents approximately 100,000 clients. The coverage extends from pre-departure or arrival in Canada until the client qualifies for provincial health programs or is removed from Canada. Health expenditures for fiscal year 2005–2006 totalled $48 million.

Definitions Related to Aboriginal Populations

Aboriginal: A person who reports identifying with at least one Aboriginal group (North American Indian, Métis or Inuit), including Treaty or Registered Indians as defined by Canada's *Indian Act*, as well as members of an Indian Band or First Nation.[1]

First Nations peoples: Although there is no legal definition for the term First Nation, it is widely used to describe Status and Non-Status Indian peoples in Canada. The term replaced "Indian" in the 1970s because some people found this word offensive.[2]

North American Indians: Individuals who may or may not be Registered or Status Indians but who identify themselves as North American Indians.[1]

Inuit: In Inuktitut, the Inuit language, Inuit means "the people" and generally replaces the word "Eskimo" which is no longer in common usage in Canada. Most Inuit live in Nunavut, the Northwest Territories, and northern parts of Labrador and Québec.[2]

Recognized Inuit (for specific health services): Refers to Inuit recognized by one of the Inuit land claim organizations.[3]

Reserve: An area of land, whose legal title the Crown holds, which is designated for the use and advantage of an Indian band. Certain bands use more than one reserve.[2]

On-Reserve: Refers to people, services or objects relating to First Nations people that are part of a reserve (e.g., on-reserve businesses).[2]

Off-Reserve: Refers to people, services or objects relating to First Nations people that are not part of a reserve (e.g., off-reserve housing).[2]

Non-Reserve: Refers to Aboriginal people/populations who are not affiliated with a reserve, such as Inuit (who do not live on reserves).[1]

Status Indian (Registered First Nation): Refers to individuals recognized by the federal government as persons registered under the *Indian Act*.[2]

Non-Status Indian: People of First Nation ancestry who are not registered under the *Indian Act*.[2]

1 Statistics Canada.
2 Indian and Northern Affairs Canada.
3 Health Canada.

Measuring Performance

4. Measuring Performance

Healthy Canadians–A Federal Report on Comparable Health Indicators 2006 provides Canadians with the most recent information available on the performance of our health care system. The first part of this section presents information on each of the 18 featured indicators as well as the additional three, and reflects both the themes and priority areas that were identified in recent Health Accords. It includes a number of graphs that compare various health indicators among the G7 countries. These may help readers understand Canadian data in a broader international context. Moreover, where data are available, comparisons over time and between countries are presented.

The second part of the section presents available data on First Nations living on-reserve and recognized Inuit, and Canadian military personnel, as the federal government is responsible for delivering health services to these populations.

G7 countries …

… are the original seven largest industrialized economies in the world: Canada, France, Germany, Italy, Japan, United Kingdom and United States.

Routine or ongoing care…

…corresponds to health care provided by a family or general physician including an annual check-up, blood tests or routine care for an ongoing illness (for example, prescription refills).

Measuring Performance—General Population

1. Self-reported difficulty obtaining routine or ongoing health services

2. Self-reported difficulty obtaining health information or advice

3. Self-reported difficulty obtaining immediate care

Theme: Timely Access

Priority Area: Primary Health Care

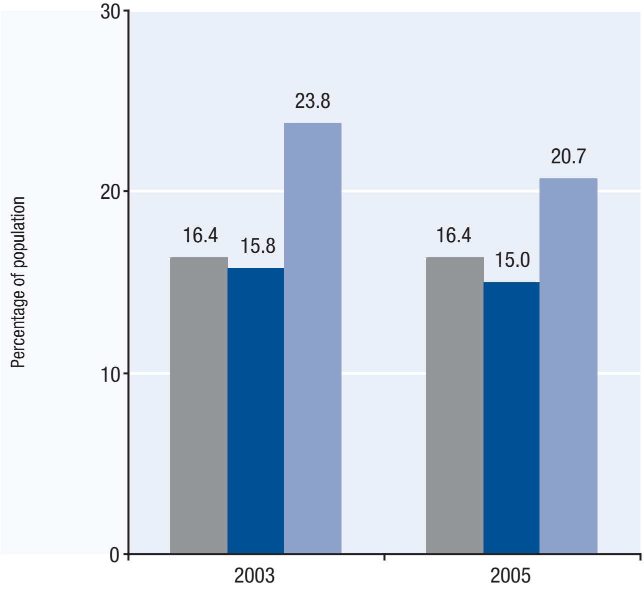
Description: Grouped in this category are indicators measuring the percentage of the population 15 years of age and older who required health services for self or a family member in the 12 months prior to being surveyed and who experienced difficulties obtaining routine or ongoing health services, health information or advice, and immediate care for a minor health problem at any time of the day.

Minor health problem …

…includes fever, vomiting, major headaches, sprained ankle, minor burns, cuts, skin irritation, unexplained rash, and other non-life threatening health problems or injuries due to a minor accident.

Self-Reported Difficulty Accessing Health Services, Health Information or Advice, and Immediate Care

Percentage of population reporting difficulty obtaining various health services (age-standardized), Canada,* 2003 and 2005



Difficulty obtaining routine or ongoing health services
Difficulty obtaining health information or advice
Difficulty obtaining immediate care

Sources: Statistics Canada, Health Services Access Survey, supplement to the Canadian Community Health Survey, 2003, 2005.

Notes: Includes household population aged 15 and older reporting difficulties accessing these services in the 12 months prior to the survey, for self or a family member.

*For 2003, Canadian totals do not include the Yukon Territory, Northwest Territories and Nunavut. For 2005, the Canada total includes the Yukon Territory, Northwest Territories and Nunavut.

Age-standardized to the 1991 Canadian population.

For additional exclusions/limitations see Annex 3.

Results: A decrease was seen in the percentage of Canadians aged 15 years and older who required health services and who reported difficulties obtaining immediate care for a minor health problem – to 20.7% in 2005 from 23.8% in 2003. Data pertaining to difficulty obtaining routine or ongoing health services and difficulty obtaining health information or advice are essentially unchanged from 2003. Most Canadians requiring routine or ongoing health services, health information or advice, and immediate care for a minor health problem do not report difficulties obtaining them.

4. Self-reported 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 reporting out-of-pocket expenditures on prescription drugs over given percentages (i.e., 0%, 1%, 2%, 3%, 4% and 5%) of total after-tax income.

Advisory to Readers: Information on spending as reported by households represents an estimate and not the actual amount.

After-tax income …

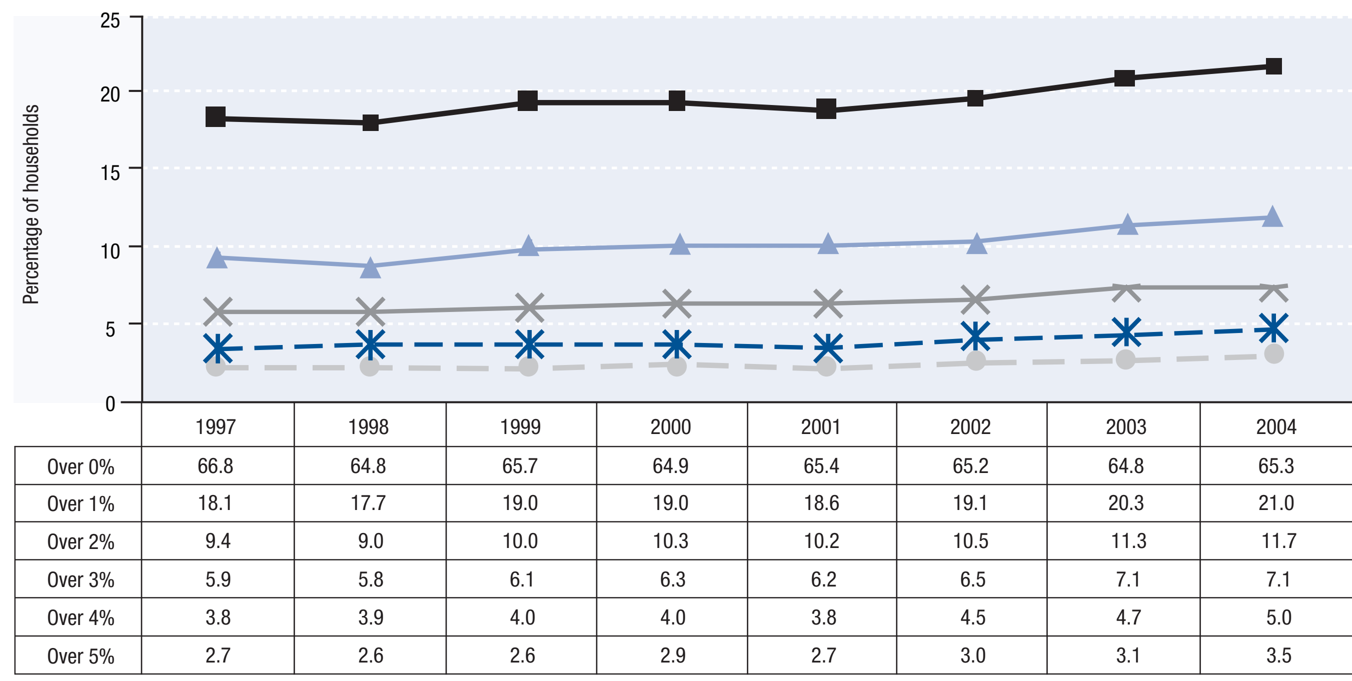
… is total income minus personal taxes.

Out-of-pocket …

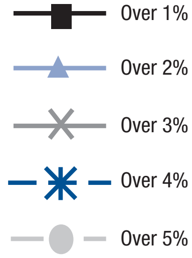
… refers to a full or partial expenditure that is not reimbursed through a drug plan or other health insurance plan.

Self-Reported Out-of-Pocket Prescription Drug Expenditures as a Percentage of After-Tax Income

By percentage of after-tax income, Canada, 1997 to 2004



	1997	1998	1999	2000	2001	2002	2003	2004
Over 0%	66.8	64.8	65.7	64.9	65.4	65.2	64.8	65.3
Over 1%	18.1	17.7	19.0	19.0	18.6	19.1	20.3	21.0
Over 2%	9.4	9.0	10.0	10.3	10.2	10.5	11.3	11.7
Over 3%	5.9	5.8	6.1	6.3	6.2	6.5	7.1	7.1
Over 4%	3.8	3.9	4.0	4.0	3.8	4.5	4.7	5.0
Over 5%	2.7	2.6	2.6	2.9	2.7	3.0	3.1	3.5



Source: Statistics Canada, Survey of Household Spending, 1997, 1998, 1999, 2000, 2001, 2002, 2003 and 2004.

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 3.

Results: The percentage of Canadian households reporting out-of-pocket expenditures on prescription drugs over given percentages (i.e., 1%, 2%, 3%, 4% and 5%) of total after-tax income has gradually increased from 1997 to 2004. However, since the last *Healthy Canadians* report published in 2004 – which included data up to and including 2002 – an increase was observed only in the number of households reporting out-of-pocket expenditures on prescription drugs *over 1%* of their after-tax income. The increase was from 19.1% in 2002 to 21.0% in 2004.

5. Self-reported wait times for diagnostic services

Theme: Timely Access

Priority Area: Diagnostic and Medical Equipment

Description: This indicator includes two sub-indicators that report on wait times for diagnostic services. They are:

a) **Self-reported median wait time for diagnostic services,** which measures the median number of weeks people aged 15 years and older waited for diagnostic services; and

b) **Distribution of reported wait times for diagnostic services,** which measures the percentage of people aged 15 years and older that had a diagnostic service and that waited less than one month, between one and three months, or more than three months to receive the service, during the 12 months prior to being surveyed.

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.

Median wait time …

… 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.

Advisory to Readers: Patients who had not yet received the service were excluded from the indicator calculation.

Diagnostic tests only include the following: non-emergency Magnetic Resonance Imaging (MRI) devices that do not use X-rays to detect and treat illness inside the body; computed tomography (CT or CAT) scans that use X-rays for illness detection and treatment; and angiographies that use X-rays to examine the inner opening of blood-filled structures such as veins and arteries.

Self-Reported Wait Times for Diagnostic Services

Median wait times, Canada,* 2001 to 2005

	2001	2003	2005
Number of weeks	3**	3	3

Sources: Statistics Canada, Health Services Access Survey, 2001, and Health Services Access Survey, supplement to the Canadian Community Health Survey, 2003, 2005.

Notes: Based on household population aged 15 and older reporting having had a diagnostic test in the 12 months prior to the survey.

As with the 2004 Federal Report, these data are not age-standardized.

Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.

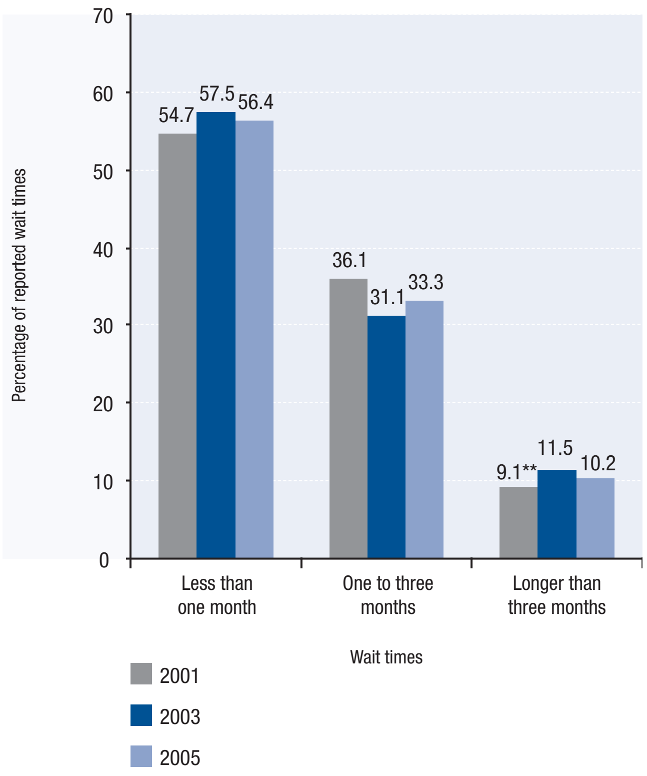
*For 2001 and 2003, the Canada totals do not include the Yukon Territory, Northwest Territories and Nunavut. For 2005, the Canadian total includes the Yukon Territory, Northwest Territories and Nunavut.

**Since the variability of this indicator is relatively high (with a coefficient of variation between 16.6% and 33.3%), it should be used with caution.

For additional exclusions/limitations see Annex 3.

Self-Reported Wait Times for Diagnostic Services

Distribution of wait times, Canada,* 2001 to 2005



Sources: Statistics Canada, Health Services Access Survey, 2001, and Health Services Access Survey, supplement to the Canadian Community Health Survey, 2003, 2005.

Notes: Based on household population aged 15 and older reporting having had a diagnostic test in the 12 months prior to the survey.

As with the 2004 Federal Report, these data are not age-standardized.

Diagnostic tests include non-emergency MRIs, CT scans and angiographies only.

*For 2001 and 2003, the Canada totals do not include Yukon Territory, Northwest Territories and Nunavut. For 2005, the Canadian total includes the Yukon Territory, Northwest Territories and Nunavut.

**Since the variability of this indicator is relatively high (with a coefficient of variation between 16.6% and 33.3%), it should be used with caution.

For additional exclusions/limitations see Annex 3.

Results: From 2001 to 2005, median self-reported wait times for diagnostic services have remained constant at three weeks. In 2005, most Canadians (56.4%) aged 15 years and older who had a diagnostic service reported waiting less than one month for their test. However, 10.2% of Canadians reported that they had waited over three months for diagnostic testing.

6. Hospitalization rate for ambulatory care sensitive conditions

Theme: Quality

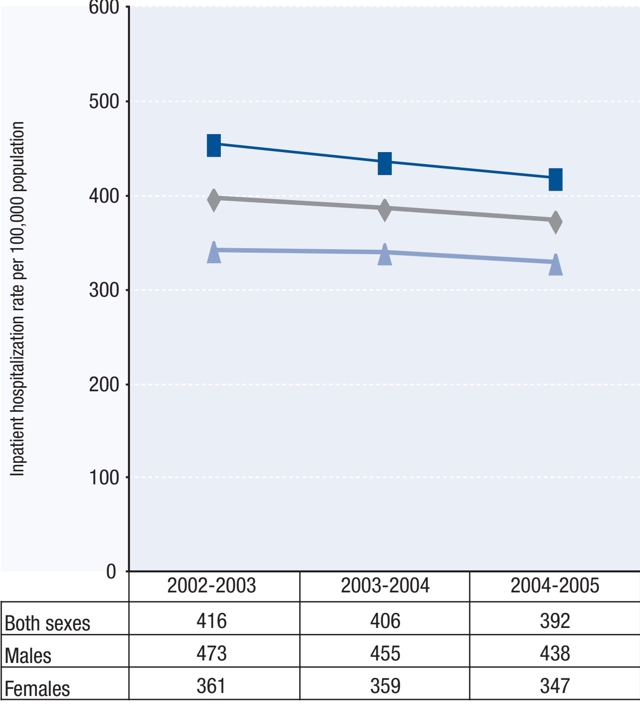
Priority Area: Primary Health Care

Description: This indicator measures the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population under age 75 years, such as angina, asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, epilepsy, and hypertension.

Advisory to Readers: Health care professionals think that managing these chronic conditions before a patient is hospitalized improves the patient's health, contributes to better overall community health status, and often saves money because community-based care usually costs less than hospitalizations.

Ambulatory Care Sensitive Conditions

Hospitalization rate for ambulatory care sensitive conditions, by sex (age-standardized), Canada, 2002-2003 to 2004-2005



	2002-2003	2003-2004	2004-2005
Both sexes	416	406	392
Males	473	455	438
Females	361	359	347

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

Notes: Beginning with 2002-2003, the calculation of ambulatory care sensitive conditions is based on a new definition due to a change from ICD-9 to ICD-10 classifications, and therefore comparison with rates reported for previous years is not recommended.

Age-standardized to the 1991 Canadian population.

Excludes patients not treated as inpatients in acute care hospitals, patients 75 years of age and older, and patients who died before discharge.

For additional exclusions/limitations see Annex 3.

Results: In 2004-2005, hospitalization rates for chronic conditions that can be cared for in the community had declined in both males and females to 392 admissions per 100,000 population from the 416 admissions per 100,000 population observed in 2002-2003. Canadian males continue to have significantly higher rates of hospitalizations than females (438 admissions versus 347 admissions per 100,000 population in 2004-2005).

7. Self-reported patient satisfaction with overall health care services

Theme: Quality

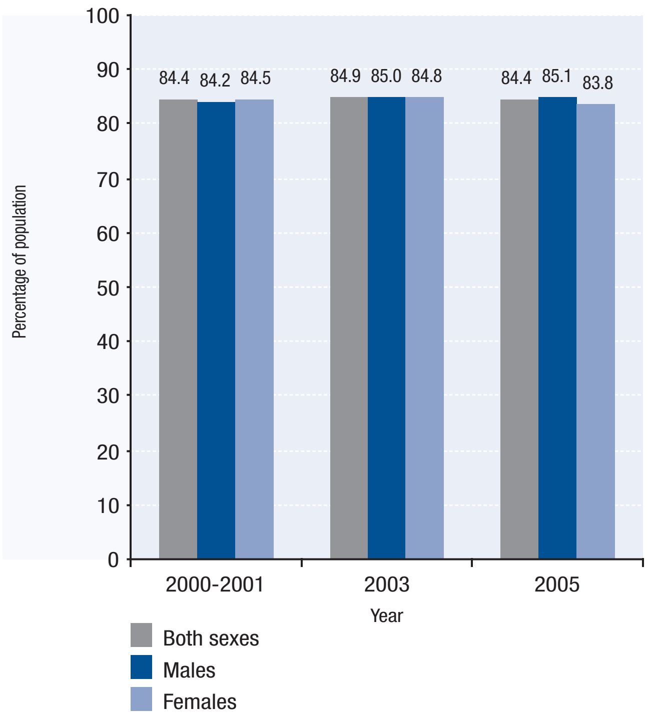
Priority Area: Primary Health Care

Description: This indicator measures the percentage of the population aged 15 and older who used health care services in the 12 months prior to being surveyed, and who reported 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.

Self-Reported Patient Satisfaction with Overall Health Care Services

Percentage of population who were "very satisfied" or "somewhat satisfied" with the way overall health care services were provided, by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

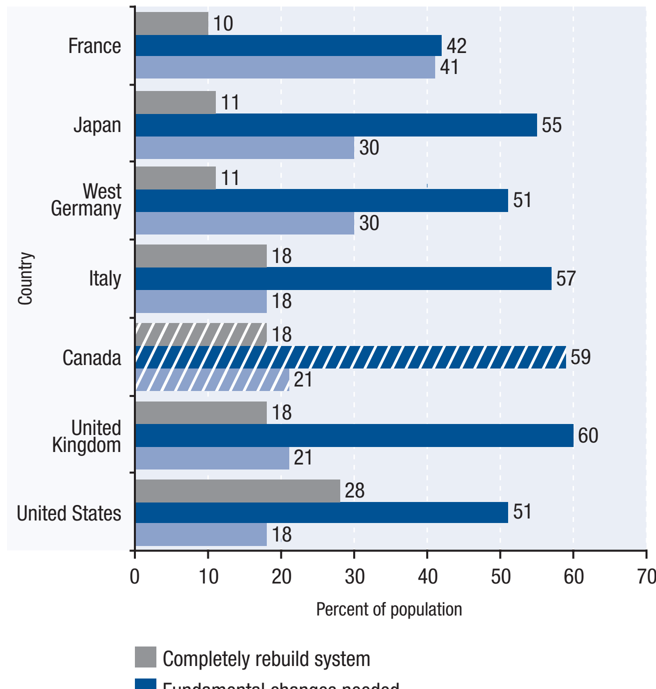
Notes: Age-standardized to the 1991 Canadian population.

Based on household population aged 15 and older who reported receiving health care services in the 12 months prior to the survey.

For additional exclusions/limitations see Annex 3.

Health Care Satisfaction (unaudited)

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



Source: Organisation for Economic Co-operation and Development, *Health Data, 2006*.

Notes: Data for France are from 1988-1991; data for West Germany and Japan are from 1994; data for Canada, Italy, the U.K. and the U.S. are from 2001.

For additional exclusions/limitations see Annex 3.

International data presented here 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.

Results: In 2005, 84.4% of Canadians reported being "very satisfied" or "somewhat satisfied" with the way overall health care services were provided. Referring to the graph on page 25, patient satisfaction with the quality of health care services has remained fairly constant across the three time periods.

The reader should note that reference years for OECD data differ according to the country, potentially affecting the interpretation of results. Considering G7 countries with the most recent data (i.e., from 2001), the United States had a high percentage of respondents (28%) who felt that their health care system should be completely rebuilt, followed by Canada, the United Kingdom and Italy (each reporting 18%). An even greater number of respondents thought that fundamental changes were needed to reform the health care system: 60% in the United Kingdom, 59% in Canada, 57% in Italy, and 51% in the United States.

8. Self-reported patient satisfaction with community-based care

Theme: Quality

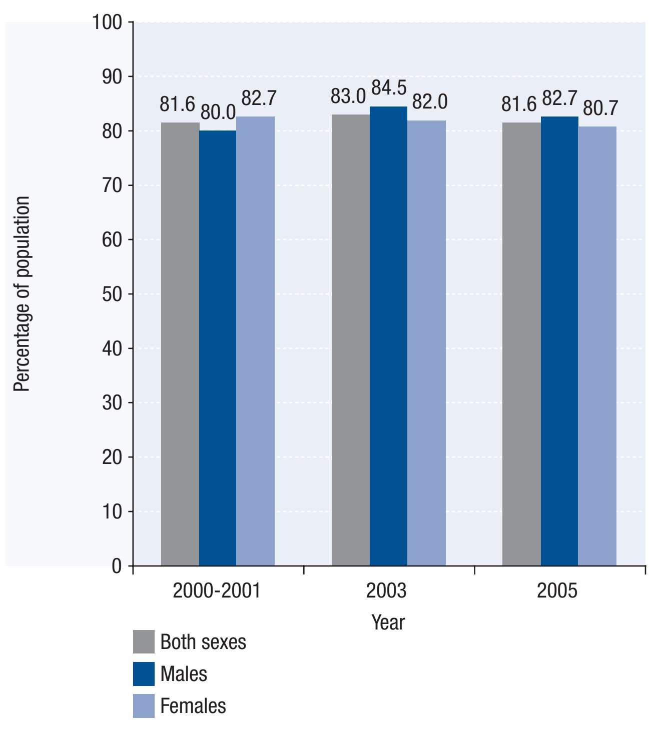
Priority Area: Primary Health Care

Description: This indicator measures the percentage of the population aged 15 and older who rated themselves as either "very satisfied" or "somewhat satisfied" with the way community-based care was provided in the 12 months prior to being surveyed. "Community-based care" included any health care services 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 with allied health service providers).

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.

Self-Reported Patient Satisfaction with Community-Based Care

Percentage of population who were "very satisfied" or "somewhat satisfied" with the way community-based care was provided, by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

Notes: Age-standardized to the 1991 Canadian population.

Based on household population aged 15 and older who reported receiving community-based health care in the 12 months prior to the survey, excluding care received through a hospital or doctor's office.

For additional exclusions/limitations see Annex 3.

Results: In 2005, 81.6% of Canadians who used community-based health care reported being "very satisfied" or "somewhat satisfied" with the way community-based care was provided. This number is fairly constant with the numbers reported in previous years.

9. Self-reported patient satisfaction with telephone health line or tele-health services

Theme: Quality

Priority Area: Primary Health Care

Description: This indicator measures the percentage of the population aged 15 and older who used a telephone health line or tele-health service in the 12 months prior to being surveyed, and who reported being "very satisfied" or "somewhat satisfied" with the way the services were provided.

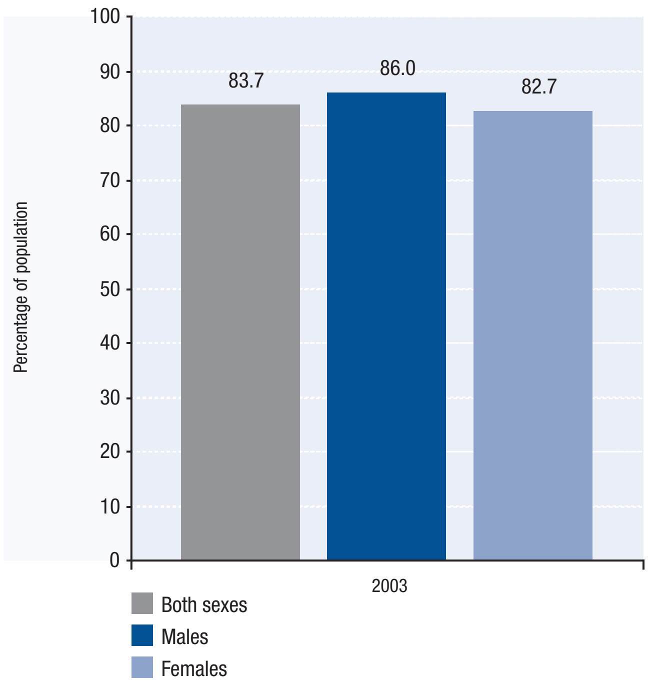
Advisory to Readers: The actual meaning of the indicator is patient satisfaction with *the way* the service was provided and not with the service as a whole. Also, new data for this indicator were not available; therefore the same information from the *Federal Report on Comparable Health Indicators 2004* is reported here.

Telephone health line or tele-health services …

… are phone-based services which offer health information provided by a nurse or other allied health service provider. As there must be live interaction for a service to be included in this indicator, automated services are excluded from this definition.

Self-Reported Patient Satisfaction with Telephone Health Line or Tele-Health Services

Percentage of population who were "very satisfied" or "somewhat satisfied" with the way telephone health line or tele-health service was 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 older who reported using telephone health line or tele-health services in the 12 months prior to the survey.

There are no telephone health line or tele-health services in Nunavut, Yukon and the Northwest Territories.

Because only live interactions were counted, any respondent who accessed information through taped messages was excluded. However, respondents were not necessarily informed of this exclusion when responding to the question. This may be an issue for some jurisdictions that have taped public messages (e.g., where to get a flu shot).

For additional exclusions/limitations see Annex 3.

Results: In 2003, 83.7% of Canadians who used a telephone health line or tele-health service reported being "very satisfied" or "somewhat satisfied" with the way the service was provided.

10. Self-reported patient satisfaction with hospital care

Theme: Quality

Priority Area: Other Programs and Services

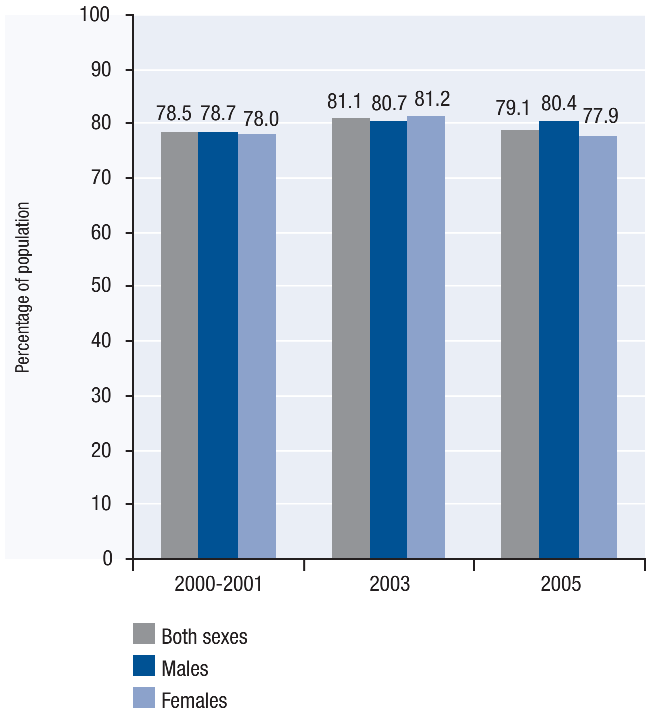
Description: This indicator measures the percentage of the population aged 15 and older who used hospital care in the 12 months prior to being surveyed, and who reported being "very satisfied" or "somewhat satisfied" with the way hospital services were provided.

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.

Results: In 2005, 79.1% of Canadians who used hospital care reported being "very satisfied" or "somewhat satisfied" with the way their most recent hospital care was provided. This figure is fairly constant with those from previous years, with similar rates of satisfaction from both males and females in every period.

Self-Reported Patient Satisfaction with Hospital Care

Percentage of population who were "very satisfied" or "somewhat satisfied" with the way their most recent hospital care was provided, by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

Notes: Age-standardized to the 1991 Canadian population.

Based on household population aged 15 and older who reported receiving hospital care in the 12 months prior to the survey.

Results should be treated with caution because a proportion of the difference may be explained by the mode used to collect the data from the respondent (i.e., by phone or in person).

When there are multiple hospital visits, these data refer to the most recent care received from a hospital.

For additional exclusions/limitations see Annex 3.

11. Self-reported patient satisfaction with physician care

Theme: Quality

Priority Area: Health Human Resources

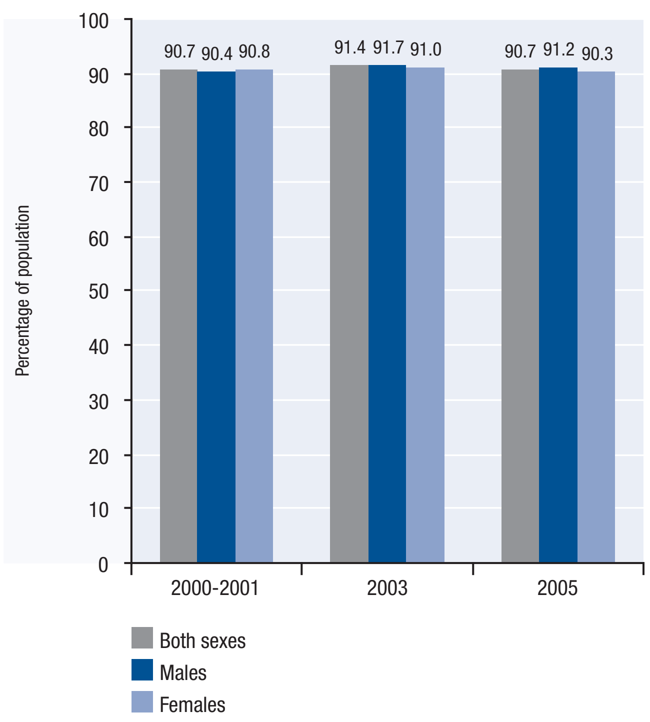
Description: This indicator measures the percentage of the population aged 15 and older who received care from a physician (i.e., a family doctor or medical specialist) in the 12 months prior to being surveyed, and who reported being "very satisfied" or "somewhat satisfied" with the way physician care 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. Also, physician care excluded services received from a family physician or medical specialist located in a hospital.

Results: In 2005, 90.7% of Canadians who received care from a physician reported they were "very satisfied" or "somewhat satisfied" with the way physician care was provided. Satisfaction has remained consistently high, with similar rates of satisfaction from males and females in every period.

Self-Reported Patient Satisfaction with Physician Care

Percentage of population who were "very satisfied" or "somewhat satisfied" with the way physician care was provided, by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

Notes: Age-standardized to the 1991 Canadian population.

Based on household population aged 15 and older 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 the most recent care received from a physician.

For additional exclusions/limitations see Annex 3.

12. Health adjusted life expectancy (HALE)

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator includes two sub-indicators:

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

HALE measures the number of years *in full health* that an individual can expect to live given current morbidity and mortality conditions. It takes into account life expectancy, which is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), if the age- and sex-specific mortality rates for a given observation period (such as a calendar year) were held constant over the estimated life span. However, HALE is a more comprehensive indicator than that of life expectancy because it introduces the concept of *quality* of life.

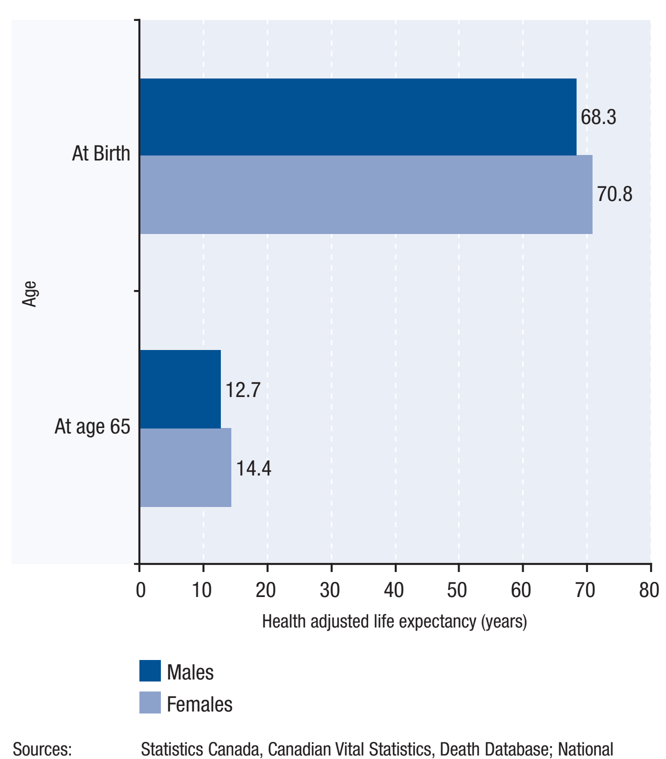
HALE uses the Health Utility Index (HUI) to weigh years lived in good health higher than years lived in poor health. Thus, HALE is not only a measure of *quantity* of life but also a measure of *quality* of life.

Advisory to Readers: HALE is a relatively new indicator embodying a number of assumptions which are important for its interpretation. One such assumption is using an indicator of the self-reported health status of a sample of individuals, each at a moment in time, to represent the double average, first, of that individual's health status over a period of time, such as a year, and then over-all of the individuals in the population (e.g., of a province). A second and related assumption is that there is a reciprocity between health and time such that, for example, five years lived at a heath state of 0.5 (quite poor health) as measured by the indicator is the same thing as 2.5 years lived in full health.

Because new data for this indicator were not available, the same information from the *Federal Report on Comparable Health Indicators 2004* is reported here.

Health Adjusted Life Expectancy

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



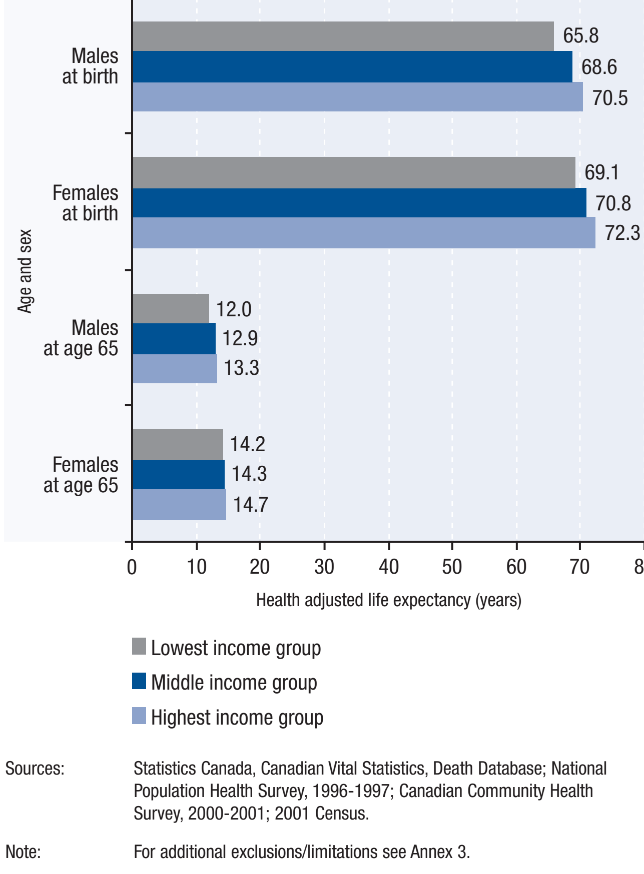
Males
Females

Sources: Statistics Canada, Canadian Vital Statistics, Death Database; National Population Health Survey, 1996-1997; Canadian Community Health Survey, 2000-2001; 2001 Census.

Note: For additional exclusions/limitations see Annex 3.

Health Adjusted Life Expectancy

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



Sources: Statistics Canada, Canadian Vital Statistics, Death Database; National Population Health Survey, 1996-1997; Canadian Community Health Survey, 2000-2001; 2001 Census.

Note: For additional exclusions/limitations see Annex 3.

Results: In 2001, women had a higher health adjusted life expectancy (HALE) than men, both at birth and at age 65. This difference is more apparent at birth, with women living to 70.8 years in full health and men living to 68.3 years in full health.

Sex and income are important for determining HALE. Canadians in higher income groups generally live longer, healthier lives than those in lower income groups. Men in the highest income group at birth have a HALE of 70.5 years while women in the highest income group at birth have a HALE of 72.3. 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. Similarly, men in the highest group have a HALE 4.7 years higher than men in the lowest income group.

13. Prevalence of diabetes

Prevalence …

… is the number of existing cases of a given disease at a given period of time in a defined population.

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the prevalence rate of diagnosed diabetes among health service users aged 20 years and older per 100 population.

Advisory to Readers: The prevalence rate includes all forms of diagnosed diabetes including type 1 diabetes and type 2 diabetes. Gestational diabetes is excluded when it is correctly coded. Efforts are made to exclude gestational diabetes when it is incorrectly coded by ignoring records 120 days before or 90 days after a gestational event.

Data for this indicator come from health professional administrative databases and do not represent self-reported information. Data include First Nations individuals although they are only identified in British Columbia.

Prevalence rate …

… is the number of people with the condition at the specified point in time divided by the number of people in the population at risk (often expressed as a percentage).

Type 1 diabetes, previously known as insulin-dependent diabetes, typically occurs in childhood or adolescence and requires multiple daily injections for survival. Insulin treatment begins immediately after diagnosis.

Type 2 diabetes, previously known as non-insulin dependent diabetes, usually begins after age 30 and is more common in First Nations and Inuit populations. Risk factors for type 2 diabetes include obesity and lack of exercise. Eating healthy foods, maintaining a healthy weight and engaging in regular physical activity can decrease the risk for developing type 2 diabetes.

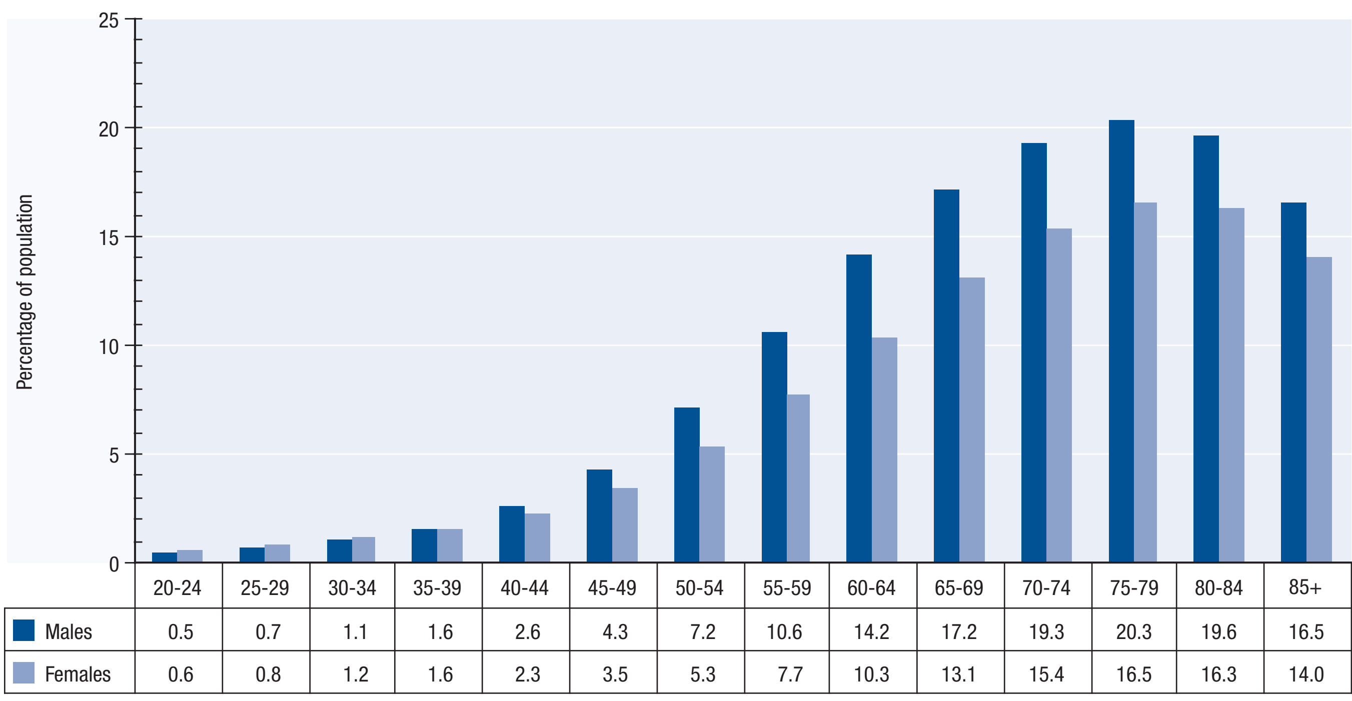
Effective management of diabetes includes maintaining a healthy weight, doing regular physical activity, taking medications when needed, monitoring blood sugar and seeking medical help to identify complications.

Results: In 2001-2002, the year for which the most recent data were available, 5.3% of Canadians aged 20 and older received a health service related to a diagnosis of diabetes by a physician. The true prevalence of diabetes is likely higher as some people with diabetes are unaware of their condition. The diagnosed prevalence of diabetes overall was higher in men (6.0%) than in women (4.8%). However, among adults under the age of 45, prevalence rates were comparable for men and women. Rates increased with age for both sexes, peaking in the 75 to 79 age group then decreasing in the oldest age groups. This phenomenon, while possibly due to mortality associated with diabetes, could also be the result of problems with the data. For example, seniors often have multiple conditions, yet only one condition is listed per physician visit.

Diabetes is a major public health problem because of its impact on people with heart, kidney, vision and vascular complications, and because of its impact on the health care system. The increase in diabetes is in part attributed to an aging population and to the high prevalence of people who are obese and overweight.

Prevalence of Diabetes (unaudited)

Percentage of population aged 20 years and older with diagnosed diabetes (all types), by sex and selected age group, Canada, 2001-2002



	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Males	0.5	0.7	1.1	1.6	2.6	4.3	7.2	10.6	14.2	17.2	19.3	20.3	19.6	16.5
Females	0.6	0.8	1.2	1.6	2.3	3.5	5.3	7.7	10.3	13.1	15.4	16.5	16.3	14.0

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

Notes: Readers should interpret these data with caution: see Annex 3.

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 (ICD-9 code 250). An adjustment is in place to exclude incorrectly coded gestational diabetes.

14. Self-reported health

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

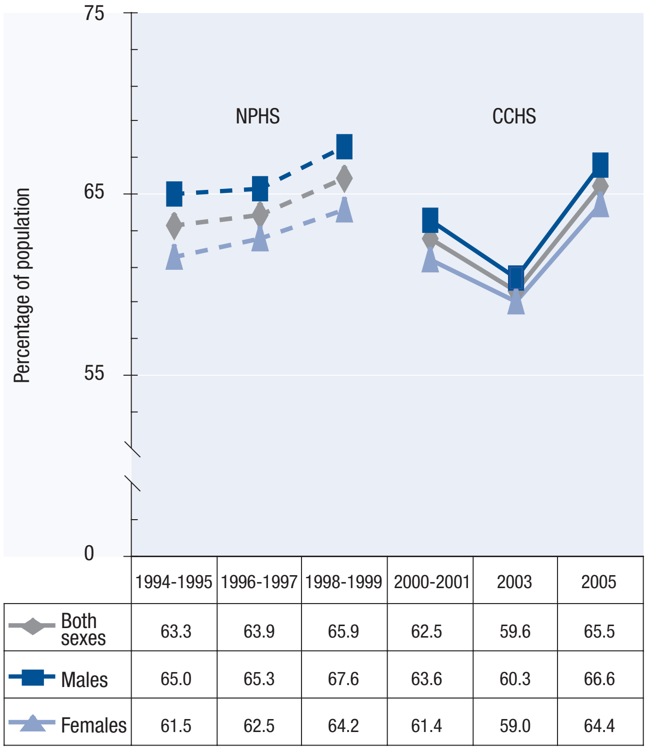
Description: This indicator measures the percentage of the population aged 12 and older who rated their overall health as either "excellent" or "very good."

Advisory to Readers: Studies indicate that when individuals rate their health, they tap into information that can predict the incidence of chronic diseases, loss of ability to function, and, ultimately, survival. Self-reported health is considered predictive of mortality even when more objective measures such as clinical evaluations are taken into account. Inconsistencies may occur between self-reported health data from population surveys and best estimates from epidemiological studies (such as under-reporting of undiagnosed conditions, over-reporting of some conditions, or lack of information on condition severity).

Results: In 2005, 65.5% of Canadians aged 12 years and older reported their health as "excellent" or "very good," an increase from the 59.6% noted in 2003. Since 2000-2001, a larger percentage of males than females rated their health as "excellent" or "very good."

Self-Reported Health

Percentage of population reporting "excellent" or "very good" health, by sex (age-standardized), Canada, 1994-1995 to 2005



	1994-1995	1996-1997	1998-1999	2000-2001	2003	2005
Both sexes	63.3	63.9	65.9	62.5	59.6	65.5
Males	65.0	65.3	67.6	63.6	60.3	66.6
Females	61.5	62.5	64.2	61.4	59.0	64.4

Sources: Statistics Canada, National Population Health Survey (NPHS), 1994-1995 to 1998-1999 and the Canadian Community Health Survey (CCHS), 2000-2001, 2003 and 2005.

Notes: As data from NPHS and CCHS are not comparable, the analysis refers only to CCHS data.

NPHS data series are indicated with a dashed line, CCHS data series with a solid line.

Age-standardized to the 1991 Canadian population.

Based on household population aged 12 and older who report that their health is excellent or very good.

For additional exclusions/limitations see Annex 3.

15. Self-reported teenage smoking rates

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

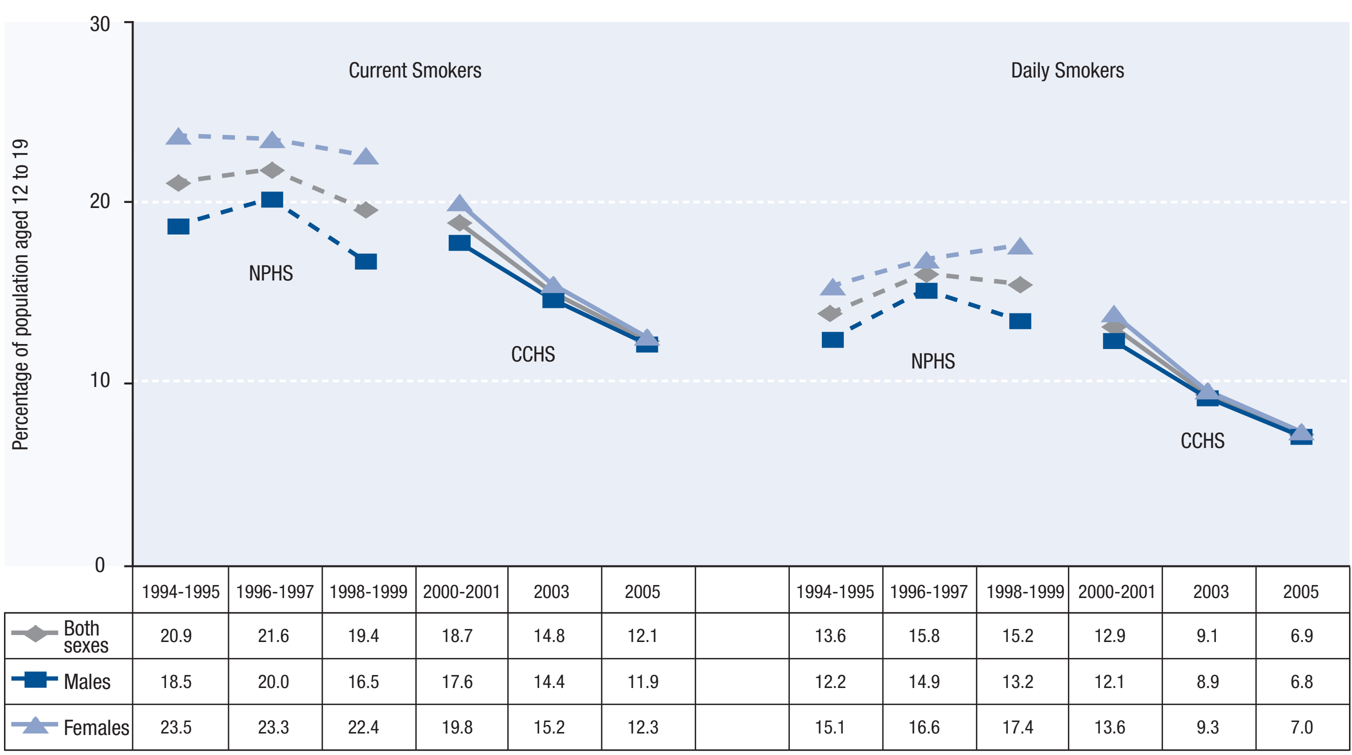
Description: This indicator measures the percentage of the population aged 12 to 19 years (inclusive) who, when interviewed, reported they were current smokers and the percentage who reported they were daily smokers at the time of the interview.

Advisory to Readers: Current smokers included daily and occasional smokers. Occasional smokers are individuals who do not smoke daily.

Results: In 2005, 6.9% of teenagers reported being daily smokers, a decrease from the 12.9% seen in 2000-2001. Among current smokers, rates have declined to 12.1% in 2005 from 18.7% in 2000-2001.

Self-Reported Teenage Smoking Rates

Percentage of population aged 12 to 19 years reporting they are current and daily smokers, by sex, Canada, 1994-1995 to 2005



	Current Smokers 1994-1995	1996-1997	1998-1999	2000-2001	2003	2005		Daily Smokers 1994-1995	1996-1997	1998-1999	2000-2001	2003	2005
Both sexes	20.9	21.6	19.4	18.7	14.8	12.1		13.6	15.8	15.2	12.9	9.1	6.9
Males	18.5	20.0	16.5	17.6	14.4	11.9		12.2	14.9	13.2	12.1	8.9	6.8
Females	23.5	23.3	22.4	19.8	15.2	12.3		15.1	16.6	17.4	13.6	9.3	7.0

Sources: Statistics Canada, National Population Health Survey (NPHS), 1994-1995 to 1998-1999 and the Canadian Community Health Survey (CCHS), 2000-2001, 2003 and 2005.

Notes: As data from NPHS and CCHS are not comparable, the analysis refers only to CCHS data.

NPHS data series are indicated with a dashed line, CCHS data series with a solid line.

Current smokers include daily smokers and occasional smokers.

For additional exclusions/limitations see Annex 3.

16. Self-reported physical activity

Theme: Health Status and Wellness

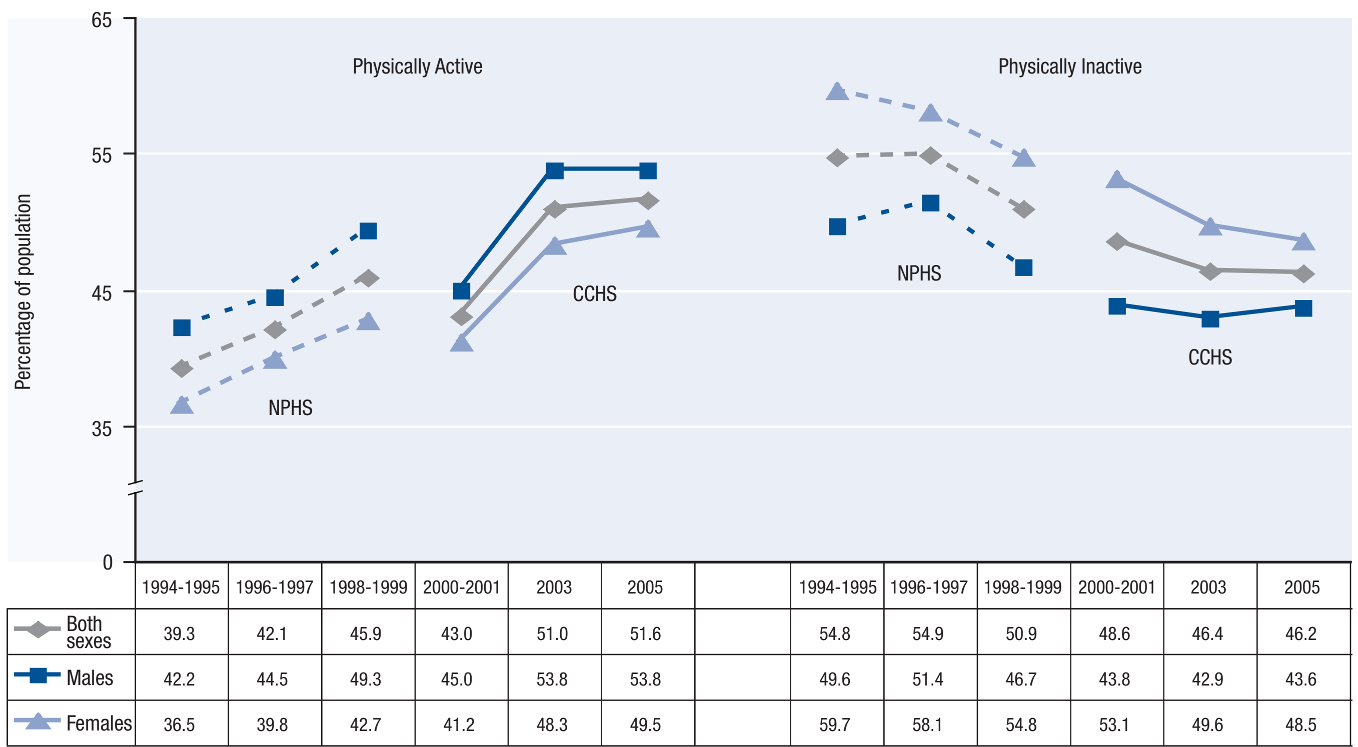
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the population aged 12 years and older who reported themselves as being either "physically active" or "physically inactive."

Advisory to Readers: The "physically active" category included those people reporting either active or moderately active levels of physical activity. Energy Expenditure (EE) is calculated using the frequency and duration per session of the physical activity, as well as the MET value of the activity. MET is a value of metabolic energy cost expressed as a multiple of the resting metabolic rate. Persons whose total EE (based on reported frequency and durations of the various physical activity indicators) was between 1.5 and 2.9 kcal/kg/day were considered "moderately active," while those with total EE that was 3.0 kcal/kg/day or over were considered "active." Persons whose total EE was less than 1.5 kcal/kg/day were considered "inactive."[7]

Self-Reported Physical Activity

Percentage of population reporting being physically active and physically inactive, by sex (age-standardized), Canada, 1994-1995 to 2005



	1994-1995	1996-1997	1998-1999	2000-2001	2003	2005		1994-1995	1996-1997	1998-1999	2000-2001	2003	2005
Both sexes	39.3	42.1	45.9	43.0	51.0	51.6		54.8	54.9	50.9	48.6	46.4	46.2
Males	42.2	44.5	49.3	45.0	53.8	53.8		49.6	51.4	46.7	43.8	42.9	43.6
Females	36.5	39.8	42.7	41.2	48.3	49.5		59.7	58.1	54.8	53.1	49.6	48.5

Sources: Statistics Canada, National Population Health Survey (NPHS), 1994-1995 to 1998-1999 and the Canadian Community Health Survey (CCHS), 2000-2001, 2003 and 2005.

Notes: As data from NPHS and CCHS are not comparable, the analysis refers only to CCHS data.

NPHS data series are indicated with a dashed line, CCHS data series with a solid line.

Results should be treated with caution as there is variation in the number of non-respondents.

Results should be treated with caution because a proportion of the difference may be explained by the mode used to collect the data from the respondent (i.e., by phone or in person).

Age-standardized to the 1991 Canadian population.

Includes household population aged 12 and older reporting level of physical activity, based on their responses to questions about frequency, duration and intensity of their leisure-time physical activity.

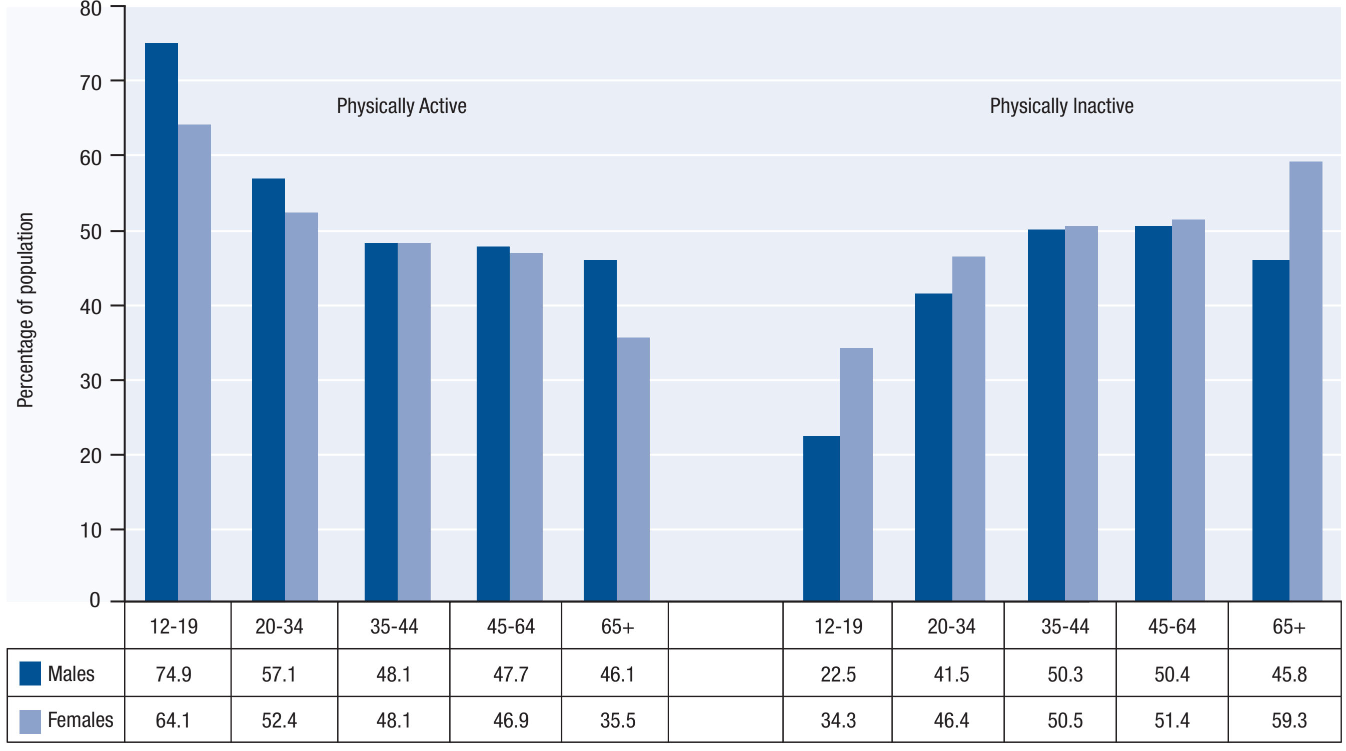
"Physically active" includes individuals reporting either active or moderately active levels of physical activity. "Physically inactive" includes those reporting a physical activity level of inactive.

For additional exclusions/limitations see Annex 3.

7. A full explanation of the derivation of the Physical Activity Index is available at http://www.statcan.ca/english/sdds/document/3226_D2_T9_V3_E.pdf.

Self-Reported Physical Activity

Percentage of population reporting being physically active and physically inactive, by sex and selected age group, Canada, 2005



	Physically Active					Physically Inactive				
	12-19	20-34	35-44	45-64	65+	12-19	20-34	35-44	45-64	65+
Males	74.9	57.1	48.1	47.7	46.1	22.5	41.5	50.3	50.4	45.8
Females	64.1	52.4	48.1	46.9	35.5	34.3	46.4	50.5	51.4	59.3

Source: Statistics Canada, Canadian Community Health Survey, 2005.

Notes: Includes household population aged 12 and older 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 used to collect the data from the respondent (i.e., by phone or in person).

"Physically active" includes individuals reporting either active or moderately active levels of physical activity. "Physically inactive" includes those reporting a physical activity level of inactive.

For additional exclusions/limitations see Annex 3.

Results: In 2005, 51.6% of Canadians reported being active or moderately active, an increase from the 43% noted in 2000-2001. Also in 2005, males (53.8%) consistently reported higher rates of active or moderately active physical activity levels compared to females (49.5%). Physical activity rates, which vary depending on age, have remained unchanged between 2003 and 2005.

17. Body mass index

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of adults who reported a height and weight corresponding to a body mass index (BMI) in specified categories ranging from underweight to obese. BMI is based on self-reported height and weight and is 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 used for adults is not considered a suitable indicator for this group.

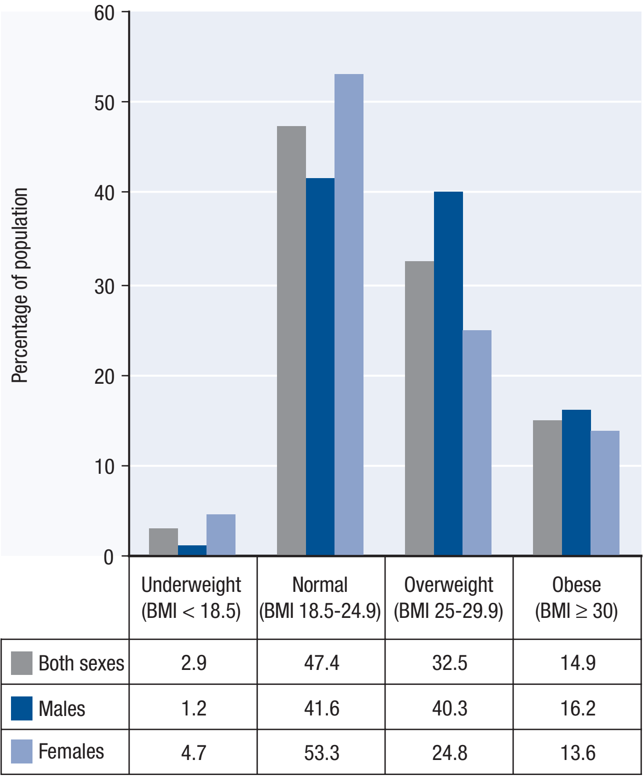
Advisory to Readers: Statistics Canada has pointed out that self-reported height and weight tend to yield underestimates of the prevalence of overweight and obese individuals in the population.[8] BMI may overestimate the health risks for young adults who have not reached full growth and for adults who are very lean, muscular, or physically fit because muscle weighs more than fat. BMI does not take bone density into account. BMI may not accurately assess the health risks for adults over 65 and members of certain ethnic and racial groups. BMI measures body weight at one point in time and may not capture the risk for people whose weight has changed (a sudden increase or decrease in weight may be a signal of additional health problems).

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.

Self-Reported Body Mass Index

Percentage of population who reported height and weight corresponding to a BMI in specified categories, by sex (age-standardized), Canada, 2005



	Underweight (BMI < 18.5)	Normal (BMI 18.5-24.9)	Overweight (BMI 25-29.9)	Obese (BMI ≥ 30)
Both sexes	2.9	47.4	32.5	14.9
Males	1.2	41.6	40.3	16.2
Females	4.7	53.3	24.8	13.6

Source: Statistics Canada, Canadian Community Health Survey, 2005.

Notes: Includes household population 18 and older who reported their height and weight.

Data exclude pregnant women and persons measuring less than 91.4 centimetres (3 feet) or greater than 210.8 centimetres (6 feet, 11 inches) in height.

Results should be treated with caution because a proportion of the difference may be explained by the mode used to collect the data from the respondent (i.e., by phone or in person).

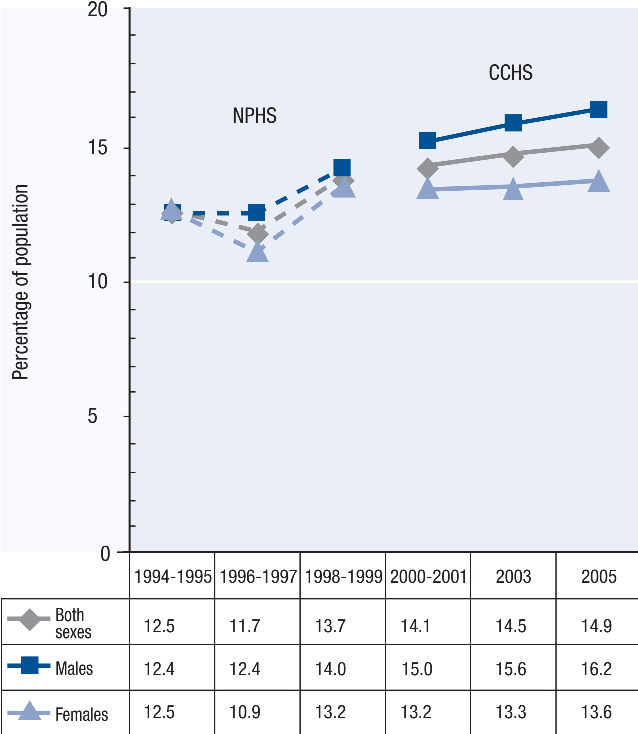
Age-standardized to the 1991 Canadian population.

For additional exclusions/limitations see Annex 3.

8. Tjepkema, M. Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Statistics Canada Catalogue no. 82-620-MWE2005001. Available at: http://www.statcan.ca/english/research/82-620-MIE/2005001/pdf/aobesity.pdf. Accessed November 7, 2006. Ottawa: Minister of Industry, 2005.

Self-Reported Body Mass Index

Percentage of population who reported height and weight corresponding to a BMI in the obese category (BMI ≥ 30), by sex (age-standardized), Canada, 1994-1995 to 2005



	1994-1995	1996-1997	1998-1999	2000-2001	2003	2005
Both sexes	12.5	11.7	13.7	14.1	14.5	14.9
Males	12.4	12.4	14.0	15.0	15.6	16.2
Females	12.5	10.9	13.2	13.2	13.3	13.6

Sources: Statistics Canada, National Population Health Survey (NPHS), 1994-1995, 1996-1997, 1998-1999 and the Canadian Community Health Survey (CCHS), 2000-2001, 2003 and 2005.

Notes: As data from NPHS and CCHS are not comparable, the analysis refers only to CCHS data.

NPHS data series are indicated with a dashed line, CCHS data series with a solid line.

Includes household population 18 and older who reported their height and weight.

Data exclude pregnant women and persons measuring less than 91.4 centimetres (3 feet) or greater than 210.8 centimetres (6 feet, 11 inches) in height.

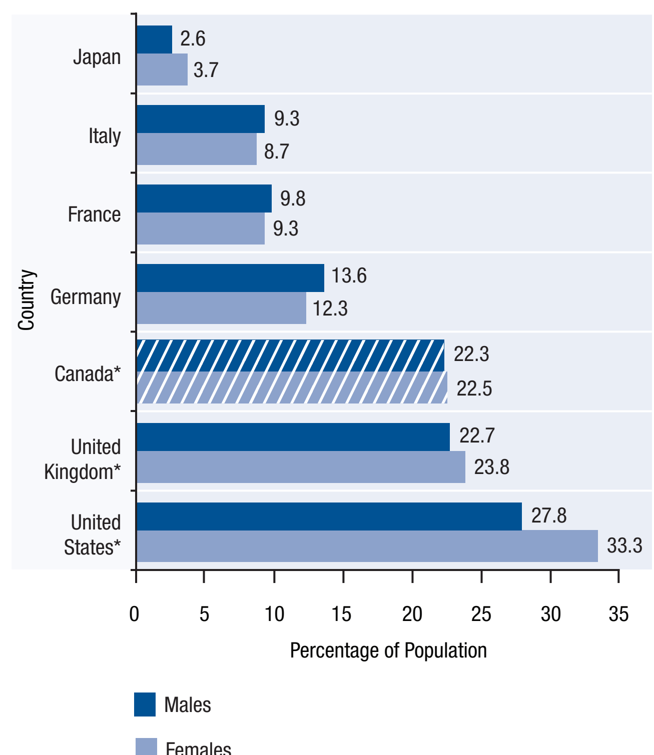
Results should be treated with caution because a proportion of the difference may be explained by the mode used to collect the data from the respondent (i.e., by phone or in person).

Age-standardized to the 1991 Canadian population.

For additional exclusions/limitations see Annex 3.

Body Weight and Composition (unaudited)

Percentage of population who are obese (BMI ≥ 30), by sex, selected countries, various years



Source: Organisation for Economic Co-operation and Development, *Health Data, 2006*.

Notes: Data for the U.S. are from 2002; data for Germany, Italy and Japan are from 2003; data for Canada, France and the U.K. are from 2004.

*Data from these countries included actual physical measures of weight and height rather than self-reported measures.

For additional exclusions/limitations see Annex 3.

Results: As shown in the first graph on BMI (page 37), nearly half (47.4%) of Canadians reported in 2005 a height and weight corresponding to a BMI in the normal weight category. More females (4.7%) than males (1.2%) reported a height and weight corresponding to a BMI in the underweight category. However, more males than females reported a height and weight corresponding to a BMI in the overweight category (40.3% and 24.8%, respectively) and obese category (16.2% and 13.6%, respectively). Overall, 32.5% of Canadians reported a height and weight corresponding to a BMI in the overweight category. According to trend data shown in the graph on page 38, 14.9% of Canadians in 2005 reported a height and weight corresponding to a BMI in the obese category, an increase from the 14.1% observed in 2000-2001.

Data from the Organisation for Economic Co-operation and Development (OECD) show that obesity rates in 2004 among Canadian men and women—which are based on actual physical measures of height and weight—were similar (22.3% and 22.5%, respectively). Among G7 countries, Canada ranked third highest in terms of the percentage of the population that is obese, with the United Kingdom and the United States reporting higher percentages of their populations as obese. The reader should note that OECD figures for the United States, the United Kingdom and Canada represent actual physical measures and not self-reported information. As previously stated, self-reported height and weight tend to yield underestimates of the prevalence of overweight and obese individuals in the population.[9]

9. Tjepkema, M. Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Statistics Canada Catalogue no. 82-620-MWE2005001. Available at: http://www.statcan.ca/english/research/82-620-MIE/2005001/pdf/aobesity.pdf. Accessed November 7, 2006. Ottawa: Minister of Industry, 2005.

18. Self-reported immunization for influenza, aged 65 plus ("Flu Shot")

Theme: Health Status and Wellness

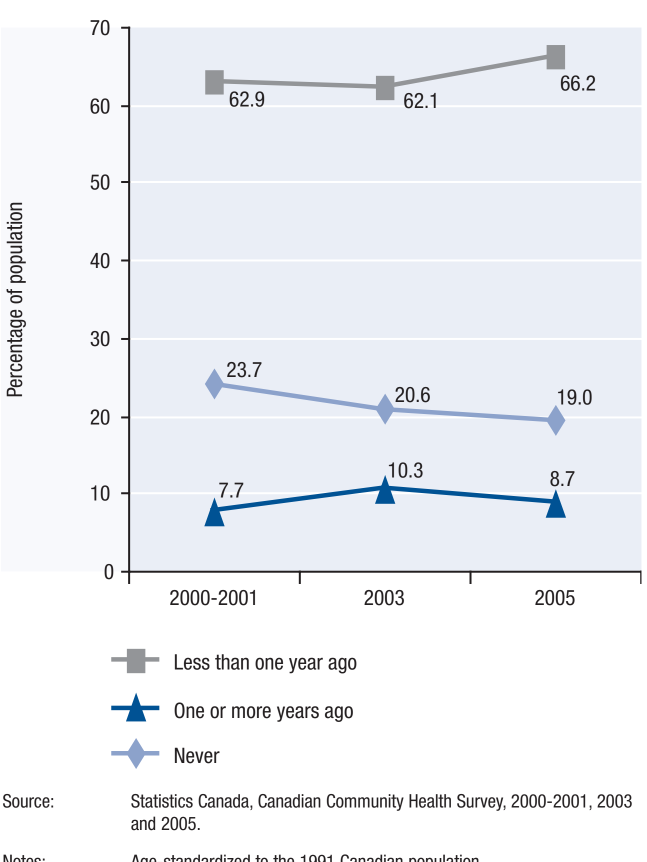
Priority Area: Healthy Canadians

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 prior to being surveyed.

Data for this indicator exclude residents of institutions.

Self-Reported Influenza Immunization

Percentage of population aged 65 and older who were immunized in selected timeframes (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

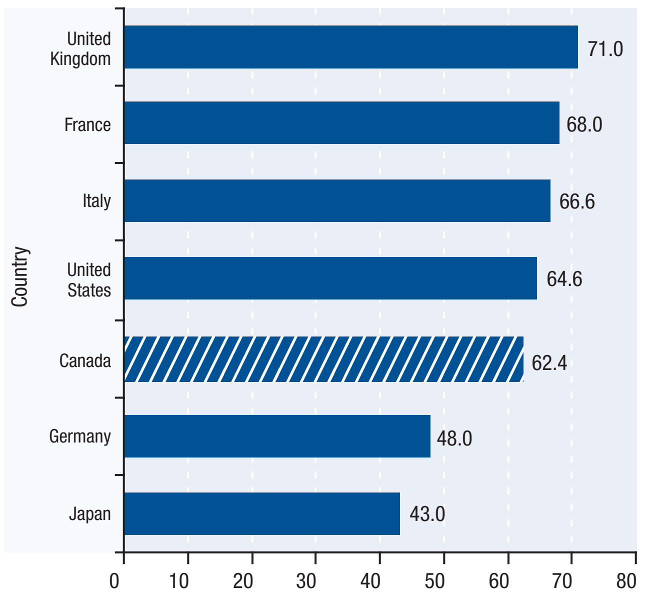
Notes: Age-standardized to the 1991 Canadian population.

Includes household population aged 65 and older reporting when they had their last influenza immunization ("Flu Shot").

For additional exclusions/limitations see Annex 3.

Influenza Immunization (unaudited)

Percentage of population aged 65 and older having been immunized during the past 12 months, selected countries, various years



Source: Organisation for Economic Co-operation and Development, *Health Data, 2006*.

Notes: Data for Canada, Japan and Germany are from 2003; data for Italy, France, the U.S. and the U.K. are from 2004.

For additional exclusions/limitations see Annex 3.

Results: In 2005, 66.2% of seniors aged 65 and older reported having received a flu shot in the 12 months prior to being surveyed, an increase from the 62.9% reported in 2000-2001. This increase in flu immunization may be due to a variety of factors, including government support for immunization through public education and information, health promotion and the provision of free flu shots.

Internationally, immunization rates among seniors appear to have been higher in the United Kingdom, the United States, France and Italy, than in Canada. According to the OECD table, which unlike reported Canadian data *does not* include age-standardized data, Canada ranked fifth in terms of the percentage (62.4%) of seniors aged 65 and older who had been immunized against influenza in the 12 months prior to being surveyed. The United Kingdom reported the highest percentage (71%) of individuals aged 65 and older who received a flu shot in the 12 months prior to being surveyed.

Measuring Performance— Additional Indicators for 2006

19. Self-rated mental health

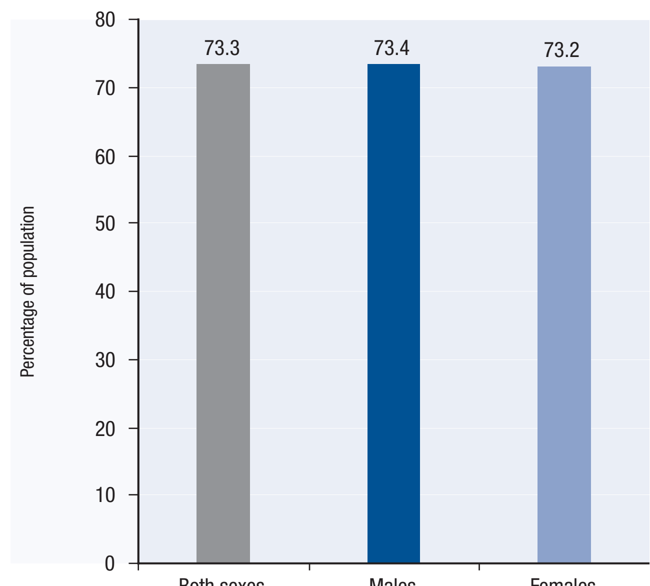
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the population aged 12 and older who rated their own mental health status as being "excellent" or "very good." Self-reported mental health provides a general indication of the possible presence of a mental disorder, mental or emotional problems, or distress, which are not necessarily reflected in self-reported (physical) health.

Self-Rated Mental Health

Percentage of population who reported "excellent" or "very good" mental health status, by sex (age-standardized), Canada, 2005



Source: Statistics Canada, Canadian Community Health Survey, 2005.

Notes: Based on household population aged 12 and older who rated their mental health status as excellent or very good.

Percentage represents the minimum possible as figures exclude surveyed individuals whose responses were "not stated."

Age-standardized to the 1991 Canadian population.

For additional exclusions/limitations see Annex 3.

Results: In 2005, 73.3% of Canadians reported "excellent" or "very good" mental health. The percentages for males (73.4%) and females (73.2%) are similar.

20. Self-perceived stress

Theme: Health Status and Wellness

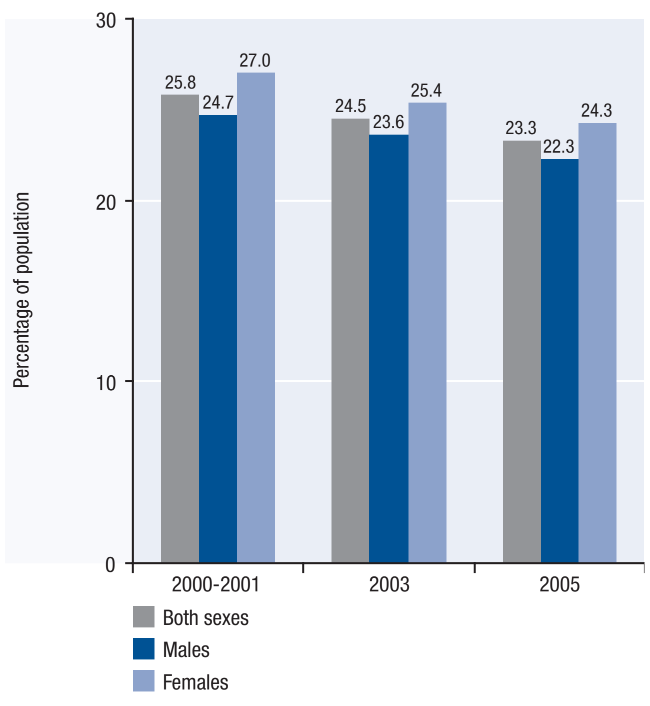
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the population aged 18 years and older who reported their level of life stress as "quite a lot."

Advisory to Readers: Results in self-perceived stress may vary according to age.

Self-Perceived Stress

Percentage of population aged 18 and over who reported their level of life stress as "quite a lot," by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



Source: Statistics Canada, Canadian Community Health Survey, 2000-2001, 2003 and 2005.

Notes: Based on household population aged 18 and older who reported their level of life stress as quite a lot.

Percentage represents the minimum possible as figures exclude surveyed individuals whose responses were "not stated."

Age-standardized to the 1991 Canadian population.

For additional exclusions/limitations see Annex 3.

Results: In 2005, 23.3% of Canadians reported their level of stress as being "quite a lot," a decrease from the 25.8% reported in 2000-2001. More females (24.3%) than males (22.3%) reported "quite a lot" of life stress in 2005.

21. Self-reported fruit and vegetable consumption

Theme: Health Status and Wellness

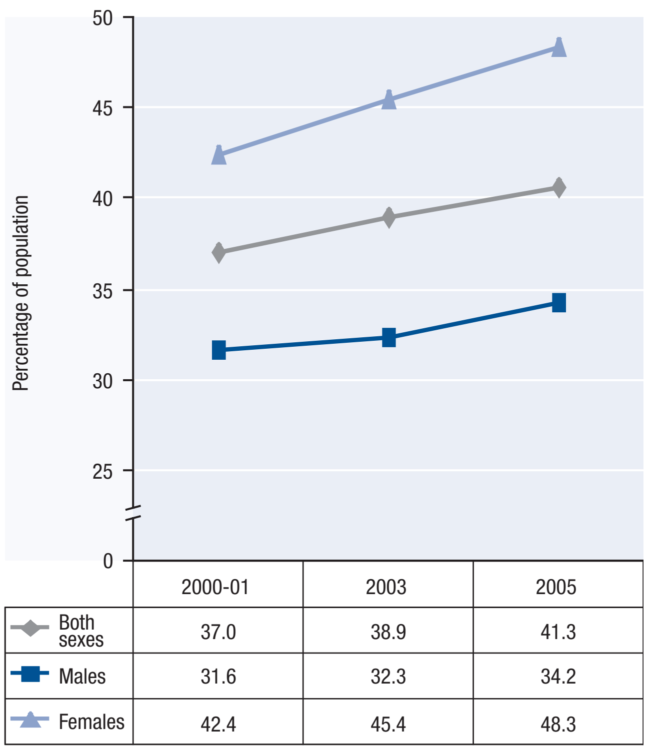
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of the population aged 12 years and older who reported eating fruits and vegetables at least five times daily.

Advisory to Readers: This variable classified individuals based on the total number of *times* they ate fruits and vegetables per day (frequency), and not the *quantity* of fruits and vegetables they consumed per day.

Self-Reported Fruit and Vegetable Consumption

Percentage of population who reported eating fruits and vegetables at least five times daily, by sex (age-standardized), Canada, 2000-2001, 2003 and 2005



	2000-01	2003	2005
Both sexes	37.0	38.9	41.3
Males	31.6	32.3	34.2
Females	42.4	45.4	48.3

Source: Statistics Canada, Canadian Community Health Survey, 2000-01, 2003 and 2005.

Notes: Based on household population aged 12 and older who reported eating fruits and vegetables at least five times daily.

Percentage represents the minimum possible as figures exclude surveyed individuals whose responses were "not stated."

The extent to which the questions may misclassify respondents in relation to fruit and vegetable consumption is unknown, and mean estimates should be interpreted with caution.

Age-standardized to the 1991 Canadian population.

For additional exclusions see Annex 3.

Results: In 2005, 41.3% of Canadians reported that they consumed fruits and vegetables five or more times per day. In the three time periods noted in the graph above, more females than males reported consuming fruits and vegetables five or more times per day. For example, in 2005, 48.3 % of females reported consuming fruits and vegetables five or more times per day compared to 34.2% of males. The percentage of Canadians reporting that they consumed fruits and vegetables five or more times per day has increased since 2000-2001.

Measuring Performance—First Nations and Inuit

This section provides information on selected indicators pertaining to First Nations living on-reserve and recognized Inuit. Direct comparisons cannot be made with the general public, however, because there may be important differences between population groups or data sources. Data presented in this section were not audited by the Office of the Auditor General of Canada.

In past *Healthy Canadians* documents, reporting on First Nations and Inuit relied heavily on the Aboriginal Peoples Survey (APS), 2001. In this version of *Healthy Canadians*, First Nations data are derived from the more recent First Nations Regional Longitudinal Health Survey (RHS) 2002-2003, which was designed to reflect cultural perspectives of First Nations on-reserve. Inuit data continue to come from the APS 2001.

Given that the data used to report on the First Nation population in previous *Healthy Canadians* documents came from different sources than the data in this report, it is not possible to describe trends in the First Nations on-reserve population. Where applicable, the limitations of displayed information are indicated in footnotes at the bottom of each graph. The reader is encouraged to consult the section entitled *Health Information Challenges and Next Steps* for an overview of some of the challenges of data collection in Aboriginal populations, in particular in First Nations populations living on-reserve. Annex 3 also provides information on data source exclusions and limitations.

Self-perceived access to health services compared to Canadians in general

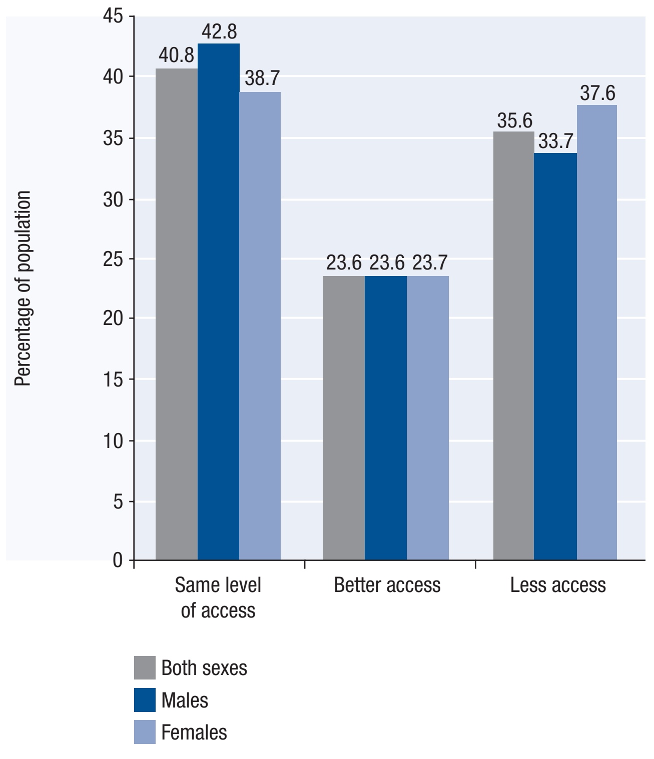
Theme: Timely Access

Priority Area: Primary Health Care

Description: This indicator measures the percentage of First Nations individuals 18 years of age and older and living on-reserve who reported perceiving the "same level of access," "better access" or "less access" to health services compared to Canadians in general.

Self-Perceived Access to Health Services Compared to Canadians in General (unaudited)

Percentage of population who reported various levels of health care relative to Canadians, by sex, First Nations adults living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: As this is measuring perceived relative access it involves the perceived access by the individual, as well as the individual's perception of the access by the general population.

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 40.8% of First Nations adults living on-reserve and rating their access to health services compared to Canadians in general reported the same level of access, 23.6% reported better access, and 35.6% reported less access. Overall, 64.4% of First Nations adults perceived their access to health care as being at least at the same level as the access to health care received by other Canadians.

Self-reported barriers to receiving health care

Theme: Timely Access

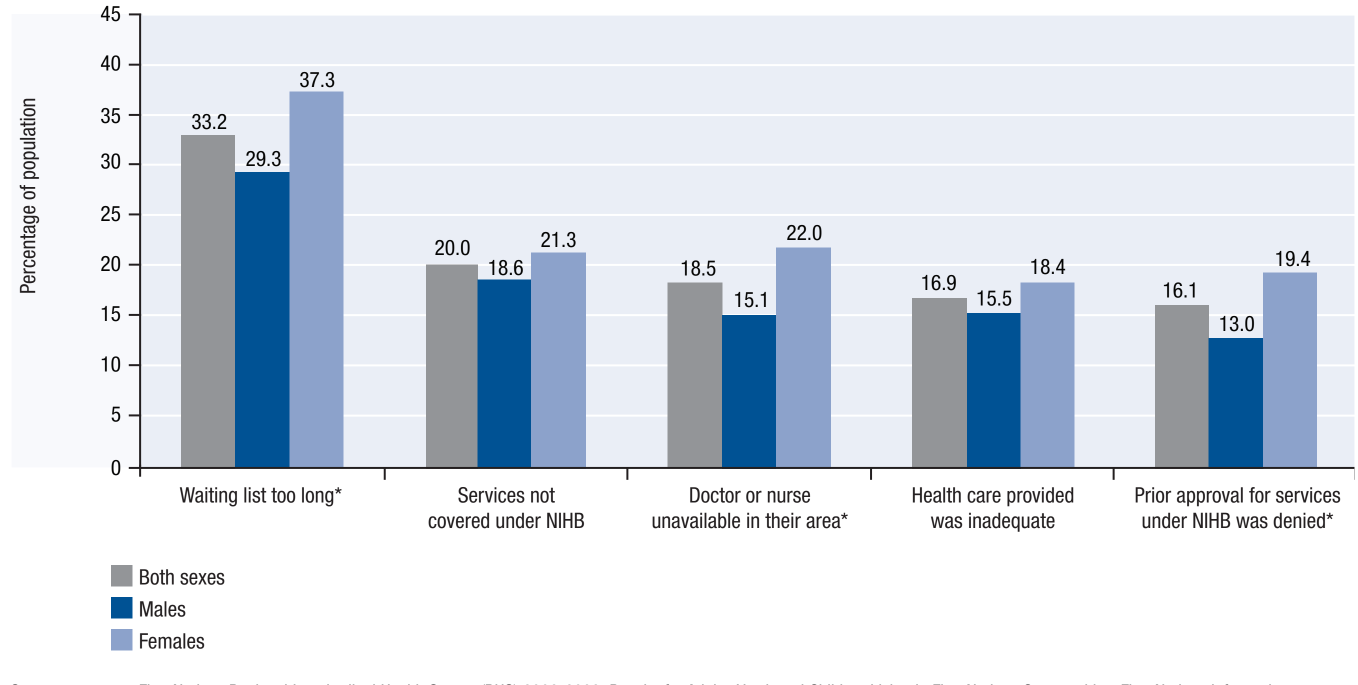
Priority Area: Primary Health Care

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported barriers to receiving health care in the 12 months prior to being surveyed.

Results: In 2002-2003, the five barriers most frequently reported by First Nations to accessing health care were: 1) the waiting list was too long (33.2%); 2) the services were not covered under the Non-Insured Health Benefits Program (NIHB)[10] (20.0%); 3) a doctor or nurse was not available in their area (18.5%); 4) the health care provided was inadequate (16.9%); and 5) prior approval for services under NIHB was denied (16.1%). Statistically significant differences were found between men and women for the following barriers: waiting list was too long (37.3% of women versus 29.3% of men); a doctor or nurse was not available in their area (22.0% of women versus 15.1% of men); and prior approval for services under the NIHB was denied (19.4% of women versus 13.0% of men).

Self-Reported Barriers to Receiving Health Care (unaudited)

Percentage of population reporting barriers to health care in the last 12 months, by sex, First Nations adults living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: This list does not include all reported barriers. Survey participants were allowed to select multiple barriers therefore percentages do not add up to 100%.

*Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

10. Non-Insured Health Benefits (NIHB) coverage of drug, dental care, vision care, medical supplies and equipment, short-term crisis intervention counselling, and medical transportation is available to registered Indians and recognized Inuit in Canada, regardless of location of residence.

Self-reported prevalence of diabetes

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported they had been told by a health care professional that they have one or more types of diabetes.

Advisory to Readers: Type 1 diabetes, previously known as insulin-dependent diabetes, typically occurs in childhood or adolescence and requires multiple daily injections for survival. Insulin treatment begins immediately after diagnosis.

Type 2 diabetes, previously known as non-insulin dependent diabetes, usually begins after age 30.

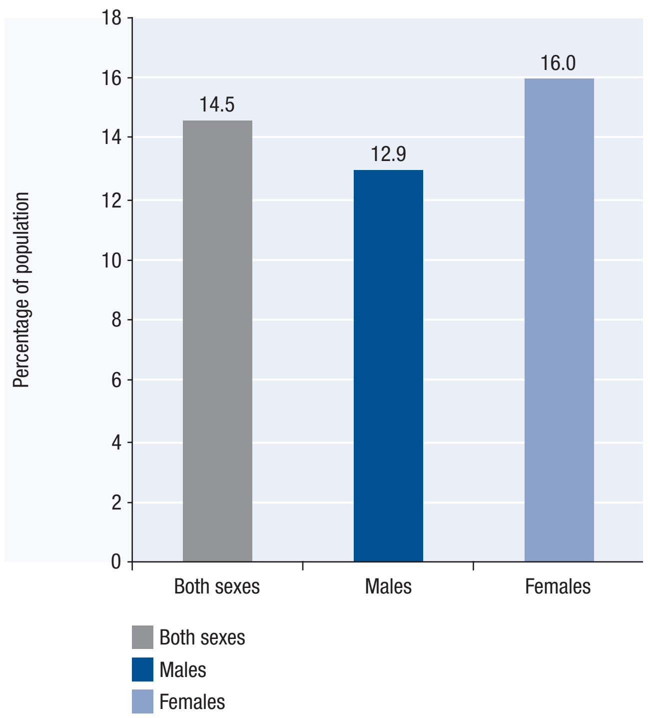
Gestational diabetes refers to diabetes that occurs in women during pregnancy. Women generally stop being diabetic after the birth of their baby.

Pre-diabetic state, sometimes referred to as “borderline” diabetes, includes impaired fasting glucose and impaired glucose tolerance. Both are determined by tests that reveal high blood glucose levels that are not high enough to be diagnosed as type 1 or type 2 diabetes.

The age noted for the prevalence of diabetes in the general Canadian population is 20 years and older, compared to 18 years and older for First Nations individuals living on-reserve. In addition, because different methodologies were used to obtain prevalence data, comparisons between these population groups should not be made.

Self-Reported Prevalence of Diabetes (any type) (unaudited)

Percentage of population reporting having diabetes, by sex, First Nations adults living on-reserve, 2002-2003

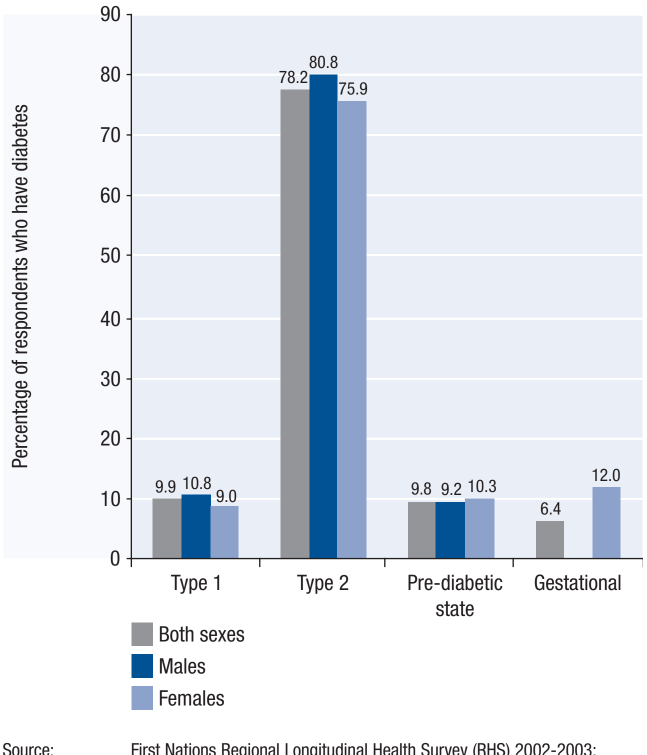


Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Self-Reported Type of Diabetes (unaudited)

Percentage of population reporting having diabetes, by sex and type of diabetes, First Nations adults living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: Diabetes categories are not mutually exclusive, as a result totals may exceed 100%.

According to the survey questionnaire, pre-diabetic state refers to high blood glucose levels that are not high enough to be diagnosed as type 1 or type 2 diabetes.

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 14.5% of First Nations adults living on-reserve reported having been told by a health care professional that they have diabetes. Of these, 9.9% were diagnosed with type 1, 78.2% with type 2, 6.4% with gestational and 9.8% with pre-diabetes.

Diabetes continues to be an important health problem in the First Nations on-reserve population.

Self-reported health

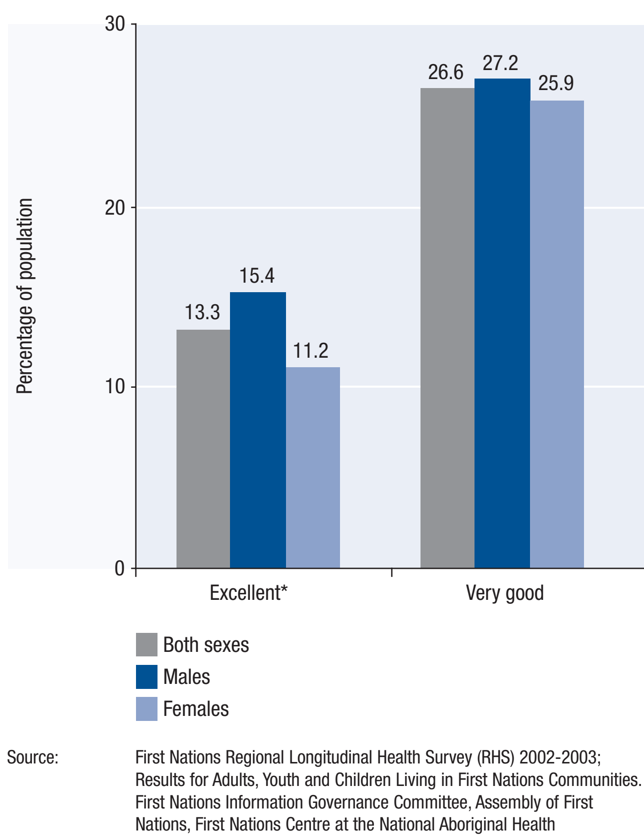
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported their health as either "excellent" or "very good."

Self-Reported Health (unaudited)

Percentage of population who reported 'excellent' or 'very good' health, by sex, First Nations adults living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 13.3% of First Nations people living on-reserve reported their health as being "excellent" and 26.6% reported their health as being "very good."

Self-reported teenage smoking

Theme: Health Status and Wellness

Priority Area: Healthy Canadians

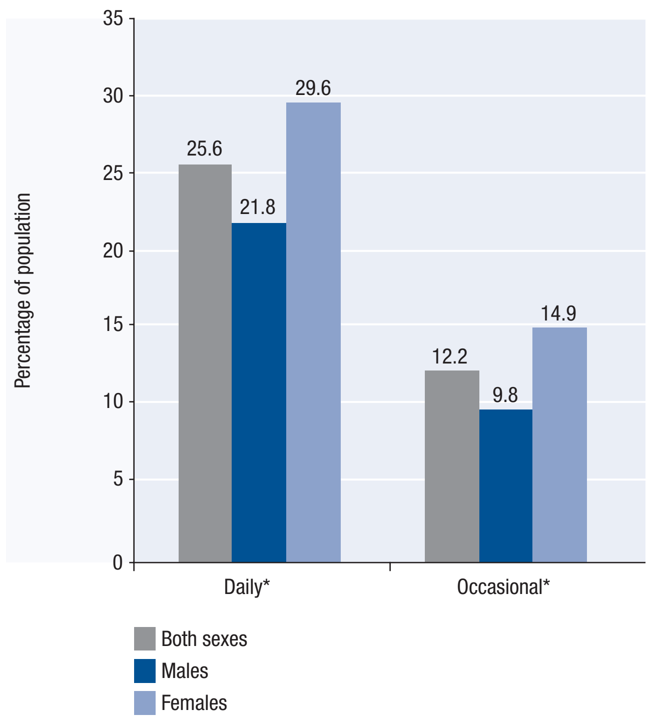
Description: This indicator measures the percentage of First Nations youth aged 12 to 17 (inclusive) years and living on-reserve who reported that they were current smokers (daily or occasional) at the time of the survey.

Advisory to Readers: Occasional smokers are smokers who do not smoke daily. Also, due to differences in the age groups covered in the Canadian and First Nations populations (12 to 19 years for Canadians in general versus 12 to 17 for First Nations), the results are not directly comparable.

Results: In 2002-2003, 62.2% of First Nations youth living on-reserve reported that they did not smoke. However, 25.6% reported that they smoked daily, with a significant difference between males (21.8%) and females (29.6%). Finally, 12.2% indicated that they smoked occasionally – of this figure, more females (14.9%) than males (9.8%) smoked occasionally.

Self-Reported Teenage Smoking (unaudited)

Percentage of population reporting they are daily or occasional smokers, by sex, First Nations youth living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: Youth are defined as individuals between 12 and 17 (inclusive) years of age.

*Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

Self-reported adult smoking

Theme: Health Status and Wellness

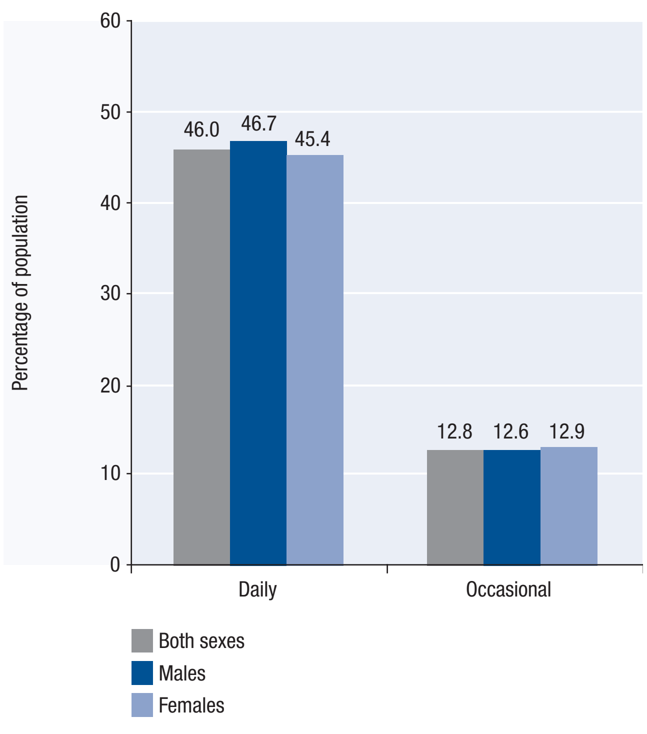
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported they were current smokers (daily or occasional) at the time of the survey, and the percentage of self-identified Inuit aged 20 years and older who reported they were current smokers (daily or occasional) at the time of the survey.

Advisory to Readers: Occasional smokers are smokers who do not smoke daily.

Self-Reported Adult Smoking (unaudited)

Percentage of population reporting they are daily or occasional smokers, by sex, First Nations adults living on-reserve, 2002-2003

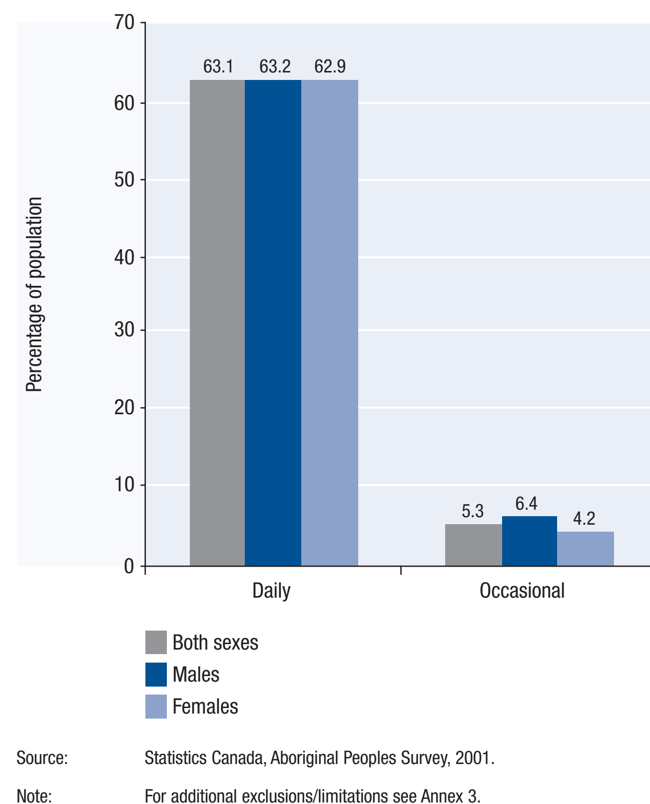


Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Self-Reported Adult Smoking (unaudited)

Percentage of population reporting they are daily or occasional smokers, by sex, Inuit adults aged 20 and older, 2001



Source: Statistics Canada, Aboriginal Peoples Survey, 2001.

Note: For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 41.2% of First Nations adults living on-reserve reported that they did not smoke, although 46.0% stated that they smoked daily and another 12.8% reported that they were occasional smokers.

In 2001, 63.1% of adult Inuit reported smoking daily, with another 5.3% reporting occasional smoking. Only 31.7% of Inuit reported being non-smokers.

Self-reported balance for physical, emotional, mental and spiritual health

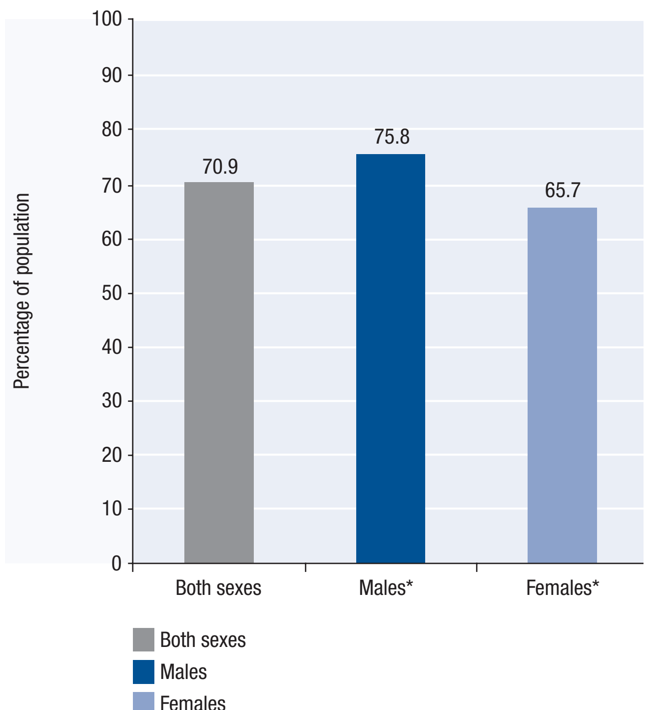
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported that their health was in balance in the four aspects of life. They were asked, "How often do you feel that you are in balance in the four aspects of your life (i.e., physical, emotional, mental and spiritual)?" Respondents then gave a rating on how balanced they felt for each of these four aspects (i.e., all of the time, most of the time, some of the time, or almost none of the time).

Self-Reported Balance for the Physical Aspect of Life (unaudited)

Percentage of population who responded "all of the time" or "most of the time," by sex, First Nations adults living on-reserve, 2002-2003



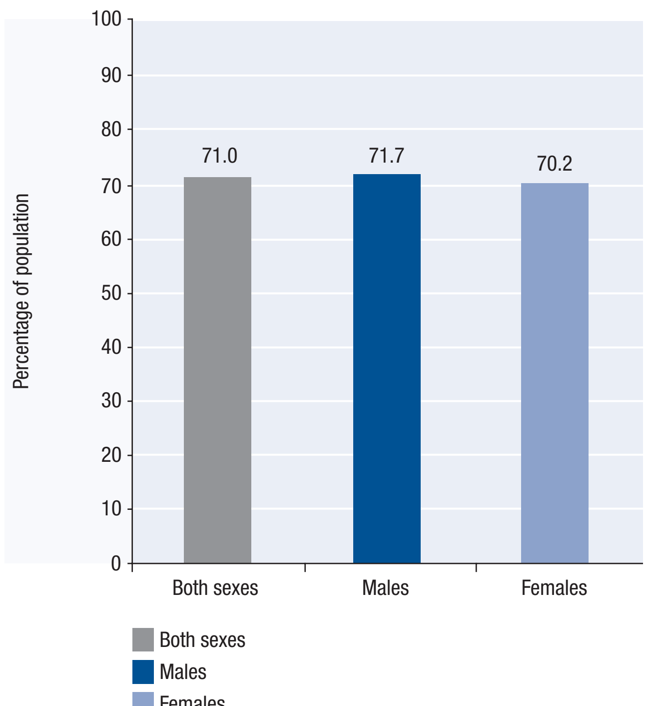
Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

Self-Reported Balance for the Emotional Aspect of Life (unaudited)

Percentage of population who responded "all of the time" or "most of the time," by sex, First Nations adults living on-reserve, 2002-2003

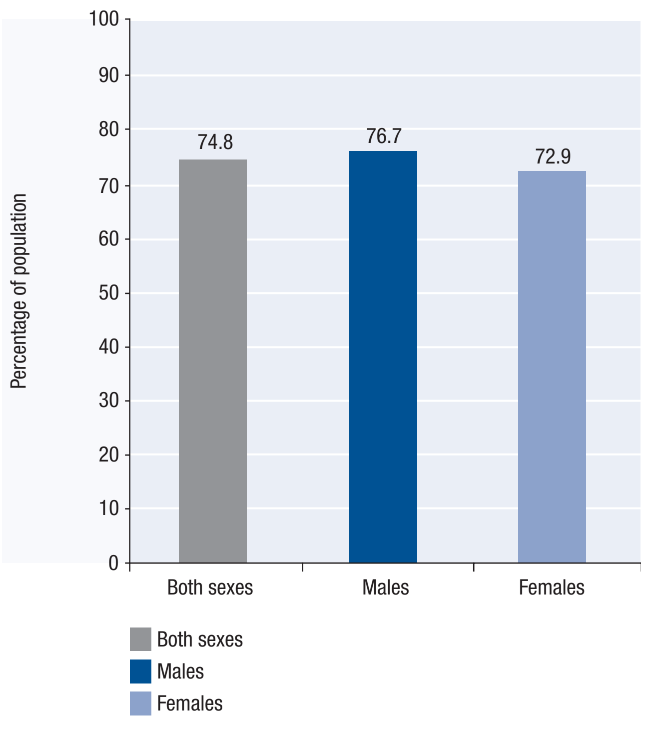


Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Self-Reported Balance for the Mental Aspect of Life (unaudited)

Percentage of population who responded "all of the time" or "most of the time," by sex, First Nations adults living on-reserve, 2002-2003



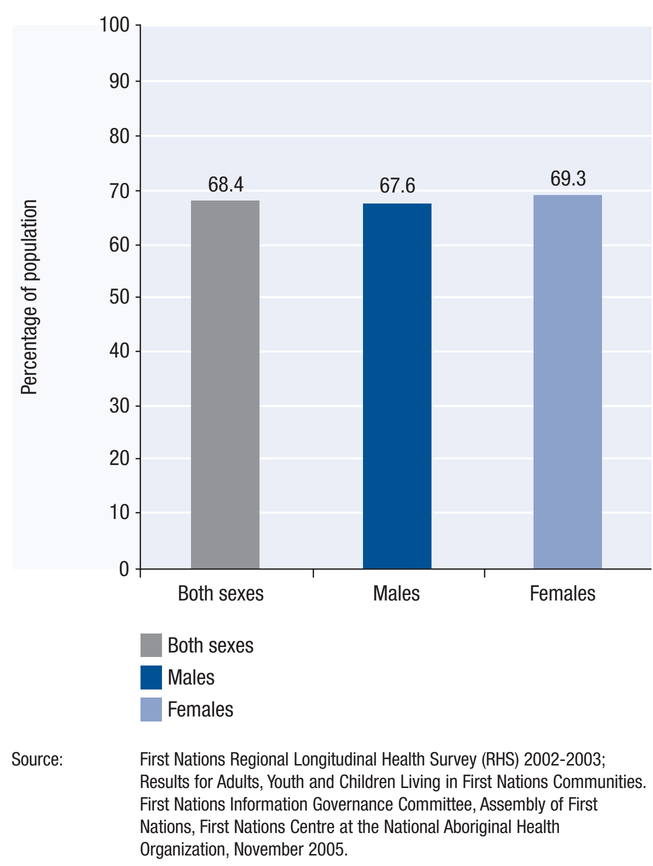
Both sexes
Males
Females

Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Self-Reported Balance for the Spiritual Aspect of Life (unaudited)

Percentage of population who responded "all of the time" or "most of the time," by sex, First Nations adults living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 70.9% of First Nations individuals living on-reserve reported being in physical balance "all of the time" or "most of the time." Regarding the emotional aspect of life, 71% reported being in balance "all of the time" or "most of the time." For the mental aspect of life, 74.8% reported being in balance "all of the time" or "most of the time." Regarding the spiritual aspect of life, 68.4% reported being in balance "all of the time" or "most of the time." Men were more likely than women to report being in balance "all of the time" or "most of the time" for the physical aspects of life.

Self-reported prevalence of arthritis or rheumatism

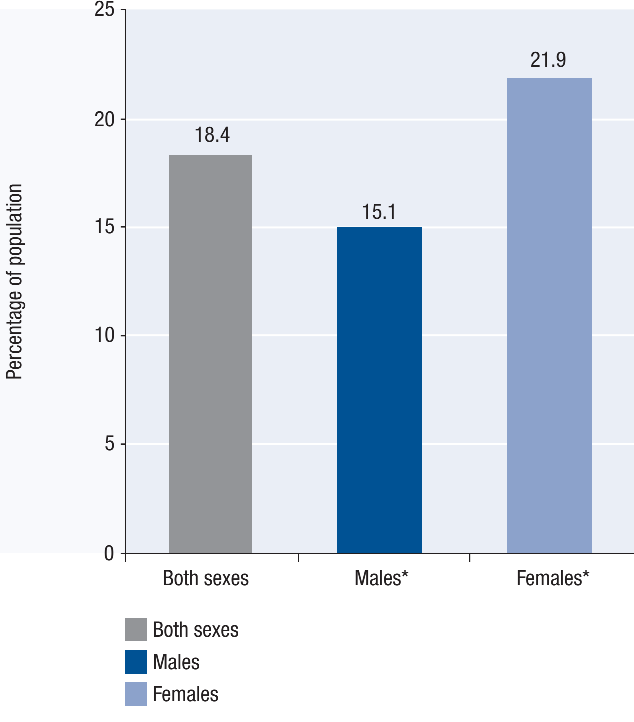
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported having been told by a health care professional that they have arthritis, and the percentage of self-identified Inuit aged 15 years and over who reported having been told by a health care professional that they have arthritis or rheumatism.

Self-Reported Prevalence of Arthritis (unaudited)

Percentage of population reporting having arthritis, by sex, First Nations adults living on-reserve, 2002-2003



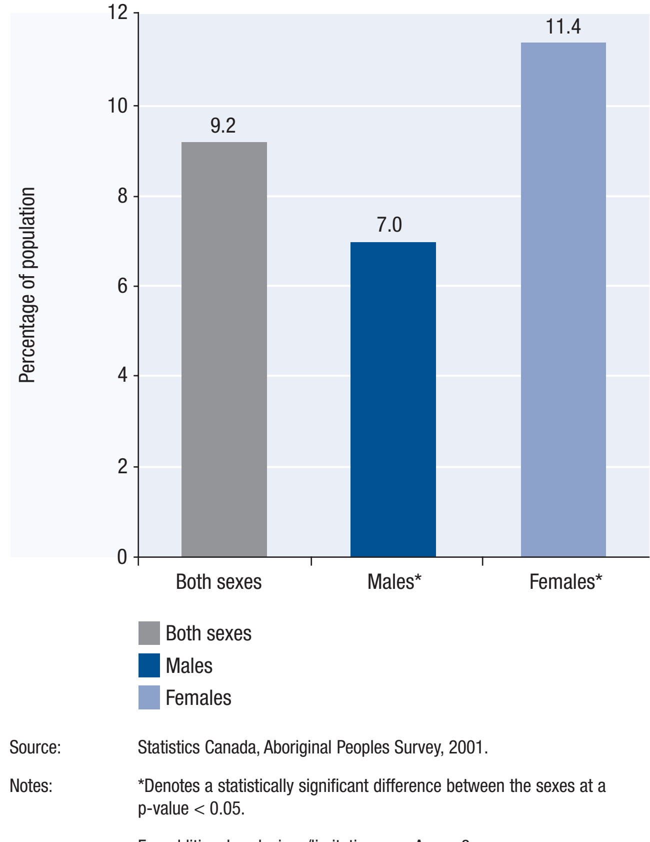
Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

Self-Reported Prevalence of Arthritis or Rheumatism (unaudited)

Percentage of population reporting having arthritis or rheumatism, by sex, Inuit adults aged 15 and over, 2001



Source: Statistics Canada, Aboriginal Peoples Survey, 2001.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05.

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 18.4% of First Nations adults living on-reserve reported having been informed by a health care professional that they have arthritis. Women (21.9%) were more likely to report arthritis than men (15.1%).

In 2001, 9.2% of Inuit adults reported having been diagnosed with arthritis or rheumatism. Inuit women (11.4%) were more likely than Inuit men (7.0%) to report arthritis or rheumatism. Of note, the Aboriginal Peoples Survey (APS) did not distinguish between arthritis and rheumatism. Therefore, APS data for Inuit are not comparable with data that present arthritis and rheumatism as separate conditions.

Self-reported prevalence of asthma—adults

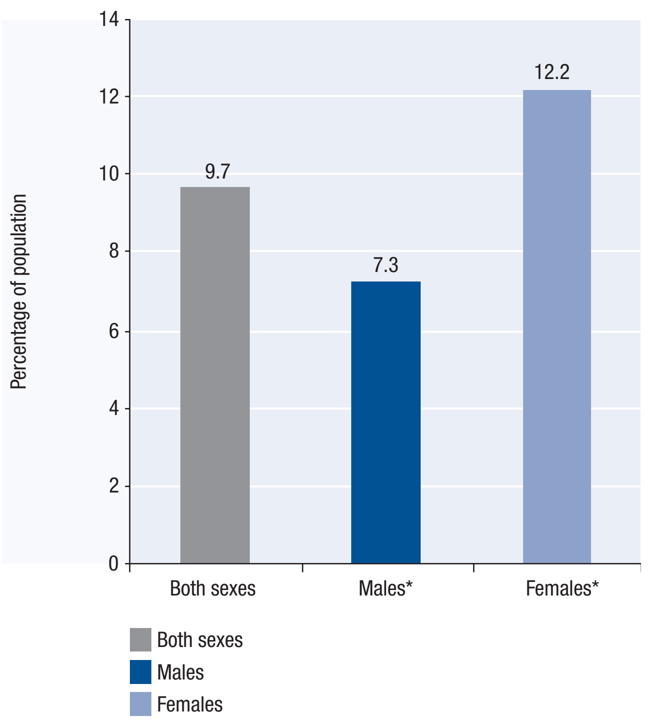
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations individuals aged 18 years and older and living on-reserve who reported having been told by a health care professional that they have asthma, and the percentage of self-identified Inuit aged 15 years and older who reported having been told by a health care professional that they have asthma.

Self-Reported Prevalence of Asthma (unaudited)

Percentage of population reporting having asthma, by sex, First Nations adults living on-reserve, 2002-2003



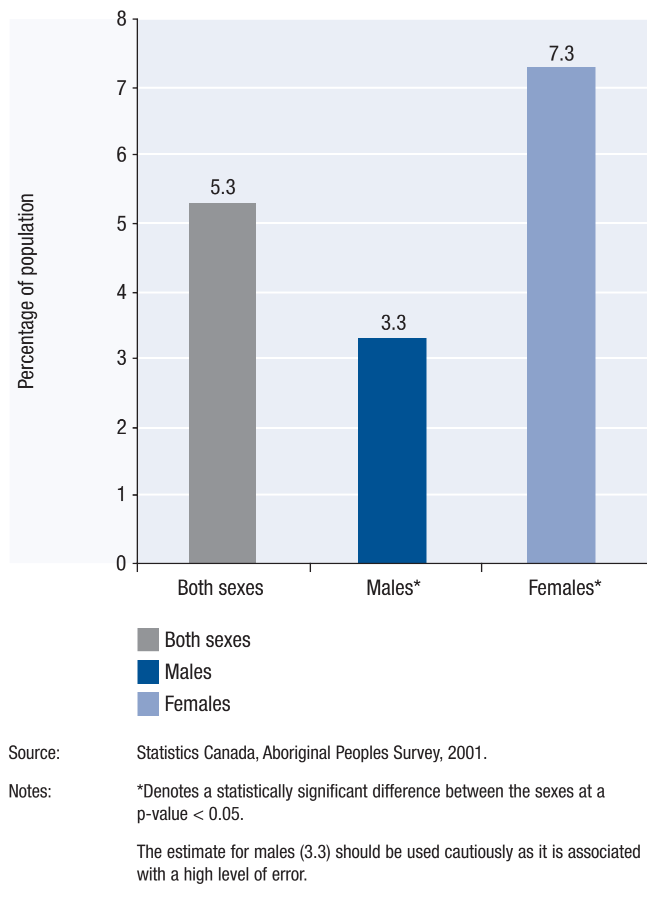
Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05 (after Bonferroni adjustment).

For additional exclusions/limitations see Annex 3.

Self-Reported Prevalence of Asthma (unaudited)

Percentage of population reporting having asthma, by sex, Inuit adults aged 15 and over, 2001



Source: Statistics Canada, Aboriginal Peoples Survey, 2001.

Notes: *Denotes a statistically significant difference between the sexes at a p-value < 0.05.

The estimate for males (3.3) should be used cautiously as it is associated with a high level of error.

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 9.7% of First Nations adults living on-reserve reported having been informed by a health care professional that they have asthma. Women (12.2%) were more likely than men (7.3%) to report this condition. While a higher proportion of First Nation adult females compared to males have asthma, no significant gender differences were found in First Nations youth and children.

In 2001, 5.3% of Inuit adults reported having been informed by a health care professional that they have asthma. Twice as many women (7.3%) compared to men (3.3%) reported this condition.

Self-reported prevalence of asthma—youth

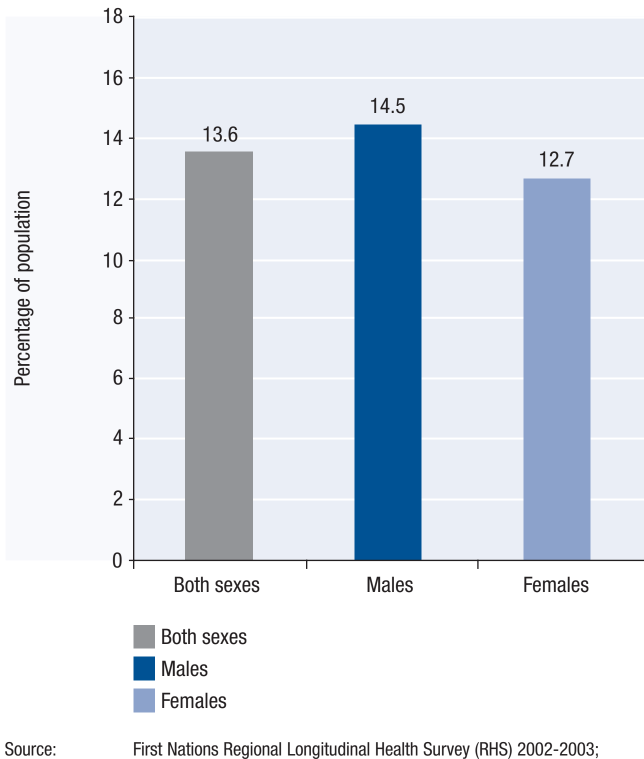
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations youth aged 12 to 17 years (inclusive) and living on-reserve who reported having been told by a health care professional that they have asthma.

Self-Reported Prevalence of Asthma (unaudited)

Percentage of population reporting having asthma, by sex, First Nations youth living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Note: For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 13.6% of First Nations youth living on-reserve reported having been informed by a health care professional that they have asthma.

Self-reported prevalence of asthma—children

Theme: Health Status and Wellness

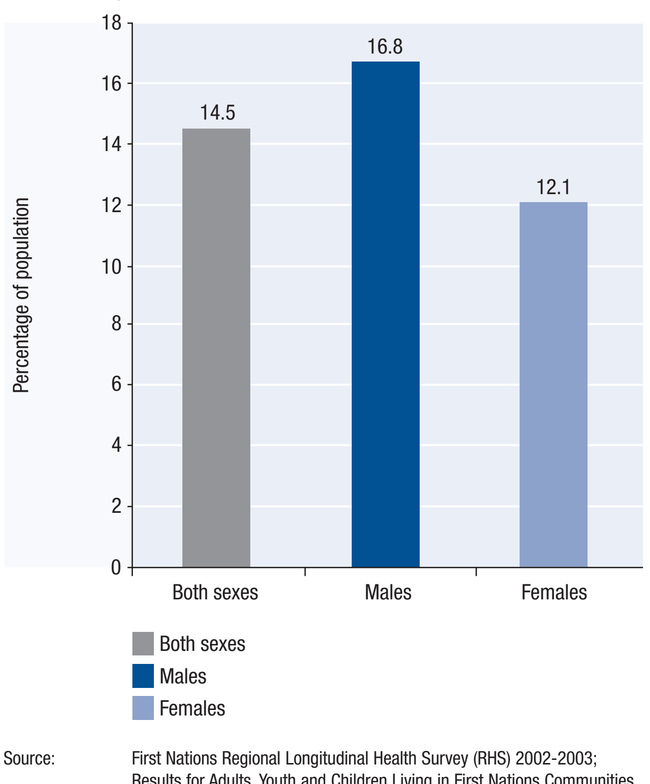
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of First Nations children under 12 years of age and living on-reserve who reported having been told by a health care professional that they have asthma.

Advisory to Readers: Children were interviewed by proxy with a person who knew them well. In most cases, this was their mother.

Self-Reported Prevalence of Asthma# (unaudited)

Percentage of population reporting having asthma, by sex, First Nations children living on-reserve, 2002-2003



Source: First Nations Regional Longitudinal Health Survey (RHS) 2002-2003; Results for Adults, Youth and Children Living in First Nations Communities. First Nations Information Governance Committee, Assembly of First Nations, First Nations Centre at the National Aboriginal Health Organization, November 2005.

Notes: #Children were interviewed by proxy with a person who knew them well. In most cases this was their mother.

For additional exclusions/limitations see Annex 3.

Results: In 2002-2003, 14.5% of First Nations children living on-reserve reported (through a proxy) being informed by a health care professional that they have asthma.

Measuring Performance—Military Personnel

This section provides indicator information pertaining to Regular Force members of the Canadian Forces (CF).[11] The CF is distinctly different from the Canadian population as a whole since it is mainly comprised of healthy workers who are predominantly male and younger than the general population. Military personnel are screened for disease prior to entry and during their career and are excluded from service if they have serious diseases or illnesses. The reader should note that, due to these fundamental differences, direct comparisons between the CF and the general Canadian population should not be made. Annex 3 provides more detail regarding exclusions and limitations. Where applicable, the limitations of displayed information are indicated in notes at the bottom of each graph. Data presented in this section were not audited by the Office of the Auditor General of Canada.

Self-reported accessibility of health services

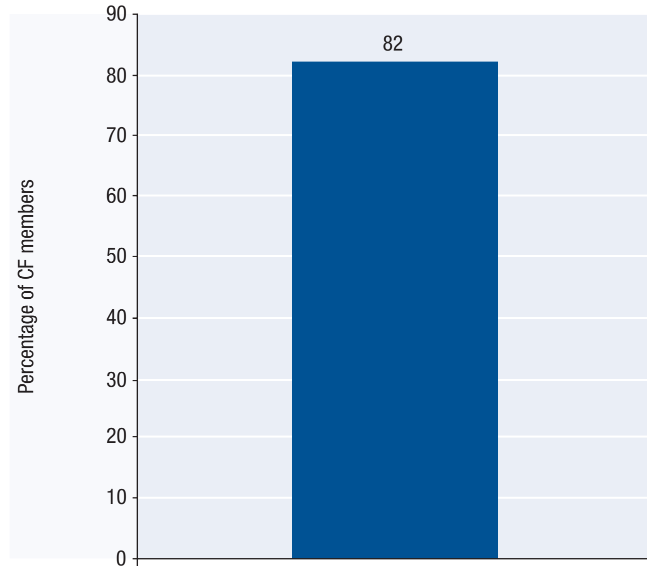
Theme: Timely Access

Priority Area: Primary Health Care

Description: This indicator measures the percentage of Regular Force members who felt that clinic hours did meet their needs and preferences regarding after-hours access, as reported in the Health and Lifestyle Information Survey (HLIS) 2004.

Self-Reported Accessibility of Health Services (unaudited)

Percentage of members reporting accessibility of health care services, Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004.

Notes: Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 82% of Regular Force members reported that local clinic hours met their needs. Of those who were not satisfied, 21% wanted earlier morning access, 54% wanted evening access and 57% wanted weekend access.

11. This information comes from the Health and Lifestyle Information Survey (HLIS), which is administered by the Department of National Defence (DND) every four years to measure a number of important items. These include CF members' physical and mental health status, behavioural risk factors, utilization of health promotion programs and health care services, and satisfaction with the CF health care system. In 2004, the survey was mailed to a stratified random sample of approximately 5000 Regular Force members and achieved a response rate of 62%. A detailed description of the 2004 survey methods and results is available on the CF Health Services website at the following address: http://www.forces.gc.ca/health/information/HLIS/engraph/HLIS_2004_e.asp

Self-reported awareness of health information services

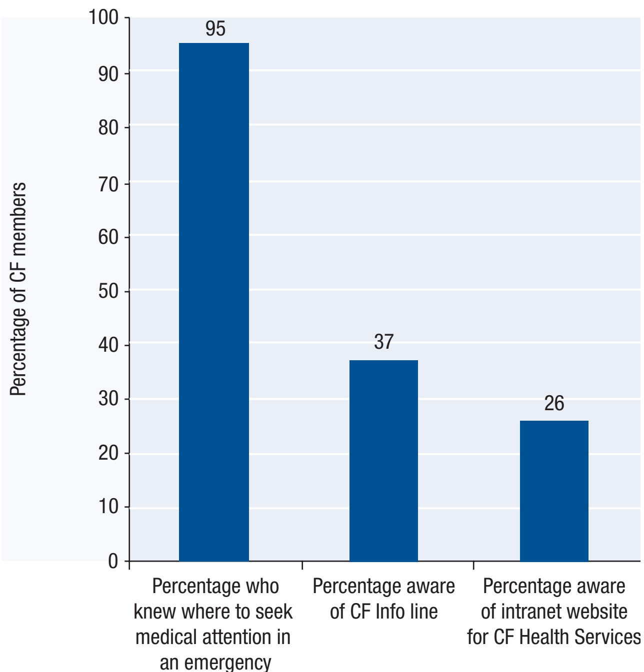
Theme: Timely Access

Priority Area: Primary Health Care

Description: This indicator measures the percentage of Regular Force members who knew where to seek medical attention in the event of an emergency, were aware of the Canadian Forces Health Info line and were aware of the Canadian Forces Health Services website, as reported in the HLIS 2004.

Self-Reported Awareness of Health Services (unaudited)

Percentage of members reporting awareness of various health information services, Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004.

Notes: Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 95% of Regular Force members knew where to seek emergency medical attention, 37% were aware of the Canadian Forces Health Info line, and 26% knew about the Canadian Forces Health Services website.

Self-reported patient satisfaction with health care services

Theme: Quality

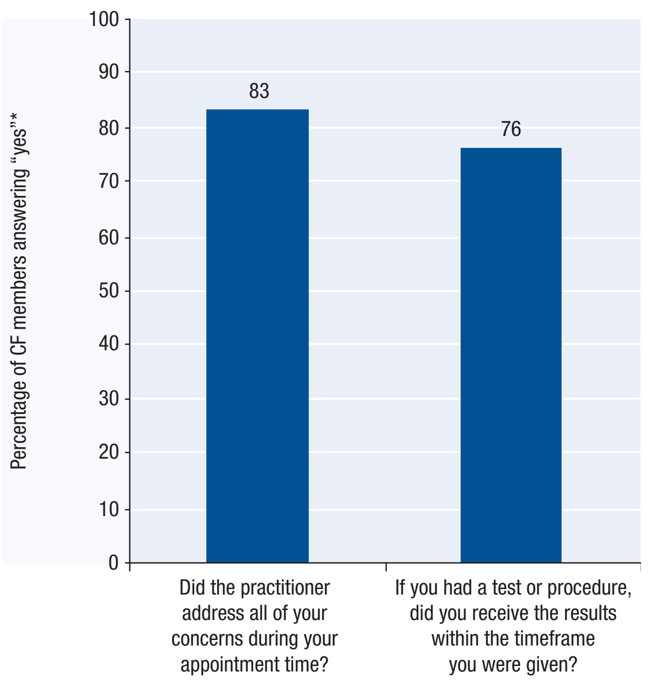
Priority Area: Primary Health Care

Description: This indicator measures the percentage of Regular Force members who felt the practitioner addressed their concerns at the time of their appointment and the percentage who felt they received results of tests/procedures within the timeframe they were given, as reported in the HLIS 2004.

Advisory to Readers: While this indicator does not deal directly with patient satisfaction, it does deal indirectly with it by asking respondents if their concerns have been addressed or if they received results from tests/procedures within the timeframe they were given.

Self-Reported Patient Satisfaction with Health Care Services (unaudited)

Percentage of members* who were satisfied with the quality and timeliness of the services they received, Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004.

Notes: *Of the 78% of Regular Force members who sought care from a CF medical facility in the last 12 months.

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

The term "practitioner" refers to physicians, physician assistants, nurse practitioners and other health professionals at CF Health Care Centres.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 83% of the Regular Force members who sought medical attention from a CF Medical Facility said that their concerns were addressed at the time of the appointment. Meanwhile, 76% reported that they received the results of tests or procedures within the time frame they were given.

Self-reported health

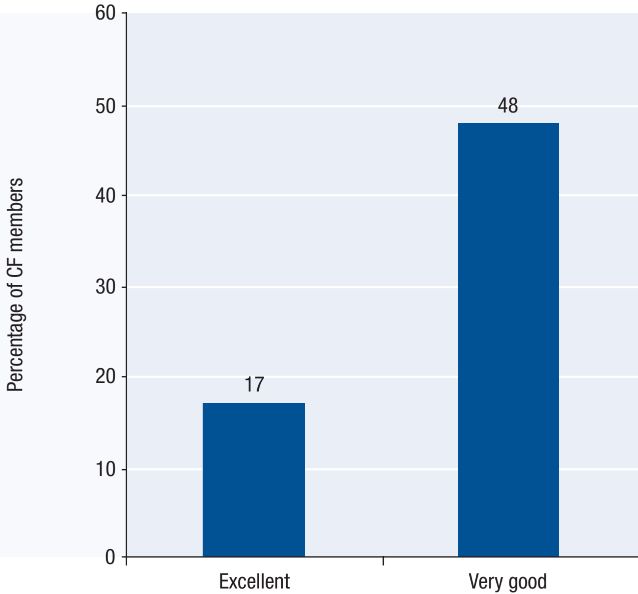
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of Regular Force members who rated their overall health as either "excellent" or "very good," as reported in the HLIS 2004.

Self-Reported Health (unaudited)

Percentage of members reporting "excellent" or "very good" health, age-standardized, Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004.

Notes: Age-standardized to the 2004 CF population.

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 17% of Regular Force members rated their health as "excellent" and 48% rated it as "very good." Most Regular Force members (65%) said their health was "excellent" or "very good."

Self-reported physical activity

Theme: Health Status and Wellness

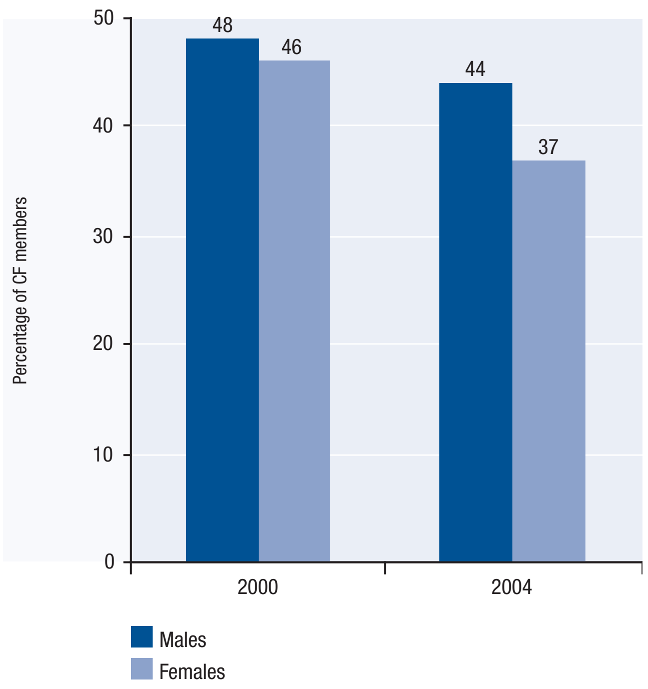
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of Regular Force members who were found to have a physical activity index of active, moderately active or inactive, as reported in the HLIS 2004.

Advisory to Readers: Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over the past 3 months. For each leisure time physical activity engaged in by the respondent, an average daily energy expenditure (DEE) is calculated by multiplying the number of times the activity was performed by the average duration of the activity by the energy cost (kilocalories per kilogram of body weight per hour) of the activity. The index is calculated as the sum of the average daily energy expenditures of all activities. Respondents are classified as follows: 3.0 kcal/kg/day or more = physically active; 1.5 – 2.9 kcal/kg/day = moderately active; less than 1.5 kcal per day = inactive.

Self-Reported Physical Activity (unaudited)

Percentage of members reporting being physically active, by sex (age- and sex-standardized), Canadian Regular Force members, 2000 and 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004 (ages 20-64, Regular Force members).

Notes: Age- and sex-standardized to the 2004 CF population. To adjust for age differences (for each sex) between HLIS 2004 respondents and the general CF population, the age distribution of the 2004 CF population was multiplied by the age-specific rates in the survey population. This calculation was done separately for males and females.

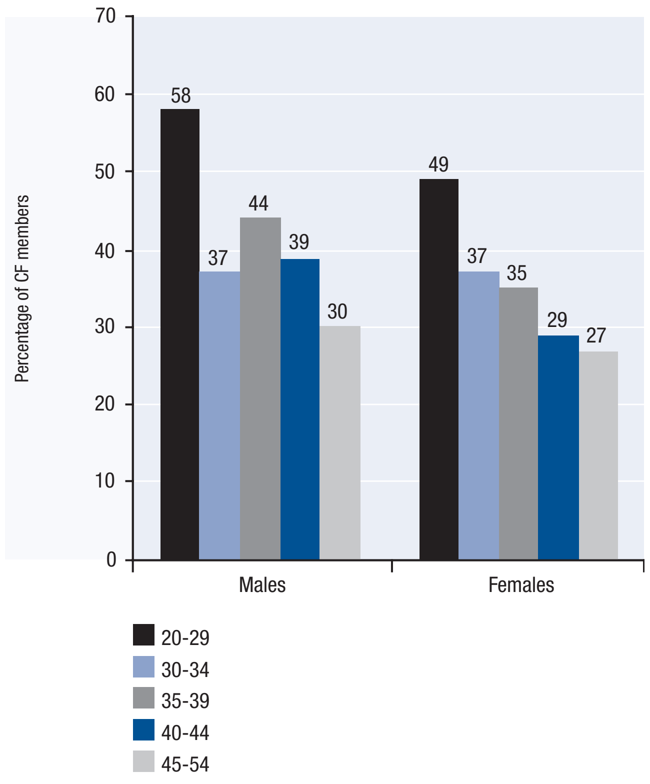
Physical Activity Index was categorized according to daily energy expenditure (DEE) (Active DEE ≥3.0 and <25.0, Moderate DEE ≥1.5 and <3.0, Inactive DEE ≥0 and <1.5).

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Self-Reported Physical Activity (unaudited)

Percentage of members reporting being physically active, by sex and selected age groups, Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004 (ages 20-64, Regular Force members).

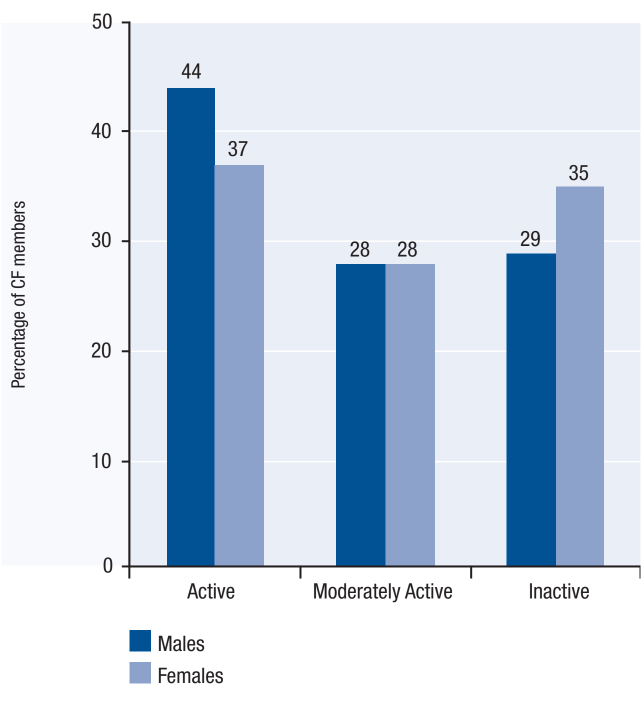
Notes: Physical Activity Index was categorized according to daily energy expenditure (DEE) (Active DEE ≥3.0 and <25.0, Moderate DEE ≥1.5 and <3.0, Inactive DEE ≥0 and <1.5).

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Self-Reported Physical Activity (unaudited)

Percentage of members reporting being physically active, moderately active or inactive, by sex and selected age groups (age- and sex-standardized), Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004 (ages 20-64, Regular Force members).

Notes: Age- and sex-standardized to the 2004 CF population. To adjust for age differences (for each sex) between HLIS 2004 respondents and the general CF population, the age distribution of the 2004 CF population was multiplied by the age-specific rates in the survey population. This calculation was done separately for males and females.

Physical Activity Index was categorized according to daily energy expenditure (DEE) (Active DEE ≥3.0 and <25.0, Moderate DEE ≥ 1.5 and <3.0, Inactive DEE ≥0 and <1.5).

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

Due to rounding to the nearest whole number, percentages may not total 100%.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 43% of Regular Force members reported being "physically active" and 28% were "moderately active." The number of physically active members has decreased since 2000 when 48% were physically active.

Self-reported body mass index

Theme: Health Status and Wellness

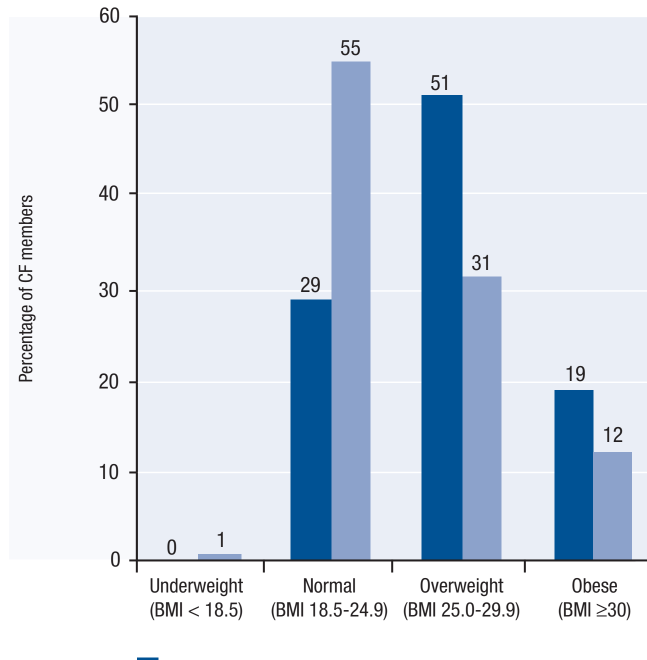
Priority Area: Healthy Canadians

Description: This indicator measures the percentage of Regular Force members who reported a [computed] body mass index (BMI) in specified categories, ranging from underweight to obese. Body mass index is based on self-reported height and weight and calculated for persons 18 years of age and older, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI used for adults is not considered a suitable indicator for this group.

Advisory to Readers: A confounding factor in the interpretation of population survey BMI data is the caveat that highly muscular adults may not be at the level of health risk indicated by their BMI categorization. Canadian Forces personnel may well have a significant number of highly muscular adults in the overweight and perhaps also the obese categories; this may be because muscle weighs more than fat. At this time, there are no national guidelines to assess the level of musculature or its interpretation on BMI categorization. Finally, as Statistics Canada has pointed out, self-reported height and weight tend to yield underestimates of the prevalence of overweight and obese individuals in the population.[12]

Self-Reported Body Mass Index (unaudited)

Percentage of members having a calculated BMI in specified categories, by sex (age- and sex-standardized), Canadian Regular Force members, 2000



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2000 (ages 20-64, Regular Force members).

Notes: Age- and sex-standardized to the 2004 CF population. To adjust for age differences (for each sex) between HLIS 2004 respondents and the general CF population, the age distribution of the 2004 CF population was multiplied by the age-specific rates in the survey population. This calculation was done separately for males and females.

Due to rounding to the nearest whole number, percentages may not total 100%.

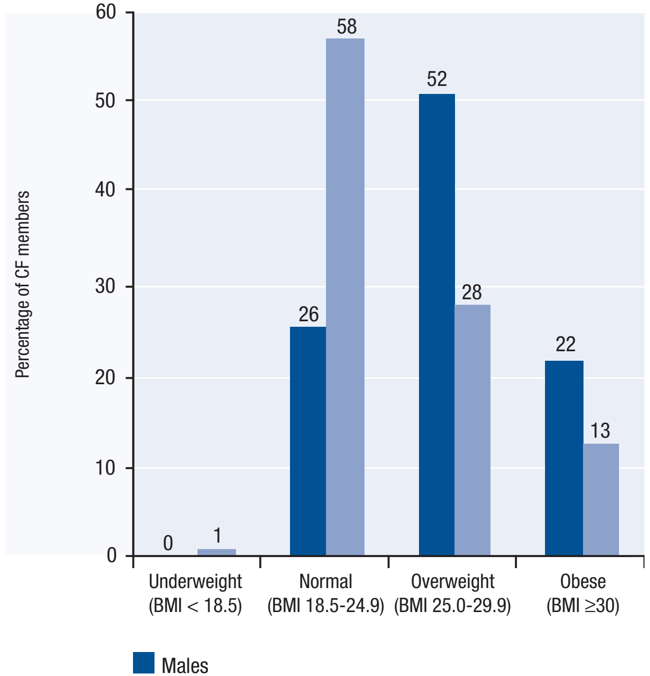
Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

12. Tjepkema, M. Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Statistics Canada Catalogue no. 82-620-MWE2005001. Available at: http://www.statcan.ca/english/research/82-620-MIE/2005001/pdf/aobesity.pdf. Accessed November 7, 2006. Ottawa: Minister of Industry, 2005.

Self-Reported Body Mass Index (unaudited)

Percentage of members having a calculated BMI in specified categories, by sex (age- and sex-standardized), Canadian Regular Force members, 2004



Source: Department of National Defence, Canadian Forces Health and Lifestyle Information Survey (HLIS), 2004 (ages 20-64, Regular Force members).

Notes: Age- and sex-standardized to the 2004 CF population. To adjust for age differences (for each sex) between HLIS 2004 respondents and the general CF population, the age distribution of the 2004 CF population was multiplied by the age-specific rates in the survey population. This calculation was done separately for males and females.

Due to rounding to the nearest whole number, percentages may not total 100%.

Although some questions from the HLIS are the same or similar to questions asked on the Canadian Community Health Survey (CCHS), the survey mode of delivery was entirely different (mail versus telephone/face-to-face) and will affect survey responses. CF rates are not comparable to other populations.

For additional exclusions/limitations see Annex 3.

Results: In 2004, 21% of Regular Force members reported a BMI that was in the obese category, an increase from 18% in 2000. While females have not shown a significant increase in obesity since 2000, the percentage of males reporting obesity increased to 22% in 2004 from 19% in 2000. Also in 2004, the percentage of Regular Force members reporting a BMI in the overweight category was 52% for males and 28% for females. The large percentage of males who are overweight may be because Regular Force members have a higher percentage of muscular adults in this category.

Immunization for influenza

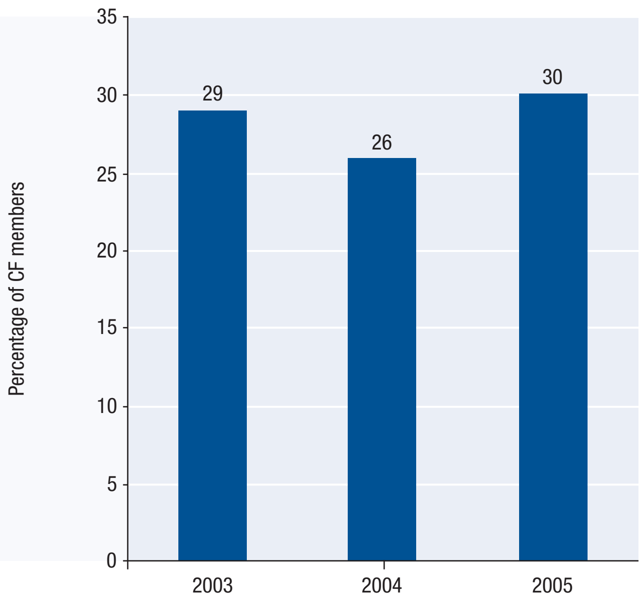
Theme: Health Status and Wellness

Priority Area: Healthy Canadians

Description: This indicator measures the percentage of Regular Force members who reported that they had received a flu shot in the 12 months prior to being surveyed.

Influenza Immunization (unaudited)

Percentage of members who were immunized against influenza, Canadian Regular Force members, 2003, 2004 and 2005



Source: Personal communication with Dr. Martin Tepper. Directorate Force Health Protection, Canadian Forces Health Services Group Headquarters, Department of National Defence, September 2006.

Results: In 2005, 30% of Regular Force members reported having received a flu shot, while 29% reported having received one in 2003, and 26% in 2004.

Health Information—Challenges and Next Steps

5. Health Information—Challenges and Next Steps

Heath information plays a vital role in monitoring the pulse of individuals and societies, helping track changes to health status and health system performance. As a result, information that is both timely and useful can help people improve their health and quality of life. It can also assist the health sector in becoming more effective through improved evidence-based decision-making.

Understanding that a sound health information system can benefit its citizens, the Government of Canada has invested significant resources to improve the collection of data to help the health sector respond better to the needs of Canadians. Since 1999, the federal government has invested more than $280 million to help modernize health information in Canada.

These investments support the First Ministers' Health Accord (2003) reporting commitments and have already generated significant benefits, such as the development of new data sources (e.g., the Canadian Institute for Health Information's Home Care Reporting System or its National Survey of the Work and Health of Nurses; Statistics Canada's Canadian Health Measures Survey). Other benefits include the improvement of data quality, the enhancement of national data standards, and improvements in transparency and accountability by giving Canadians access to health information that is relevant to them.

Historically, robust and reliable health information has not always been available, however. Although investments and progress have been made, various gaps in data availability and collection exist today.

Limited health information is available on populations under federal responsibility, such as military personnel and veterans, inmates in federal penitentiaries, members of the Royal Canadian Mounted Police, registered First Nations and recognized Inuit, and persons for whom immigration authorities are responsible (e.g., asylum seekers, refugees, and persons detained for immigration purposes). In addition, provincial administrative databases (which hold information on wait times, morbidity and mortality, for example) include data on some federal populations, although an examination of this information was outside the scope of this report.

There are limitations to using comparable health indicators to make comparisons across populations. There may be fundamental differences between some populations (e.g., military and inmate populations), and/or differences in data collection tools and techniques (e.g., potentially different survey methodologies) between federal departments, and/or a lack of standardization in related analyses that make direct data comparisons difficult, if not invalid. In addition, indicators are not always relevant to each federal population (e.g., teenage smoking is not relevant to inmates or veterans). Although some of the information available to Health Canada may not be comparable, it still merits reporting to Canadians.

Most of the information in this report comes from Statistics Canada and the Canadian Institute for Health Information. Information on the prevalence of diabetes in the general population comes from the Public Health Agency of Canada. Other information comes from the Organisation for Economic Co-operation and Development and the Assembly of First Nations.

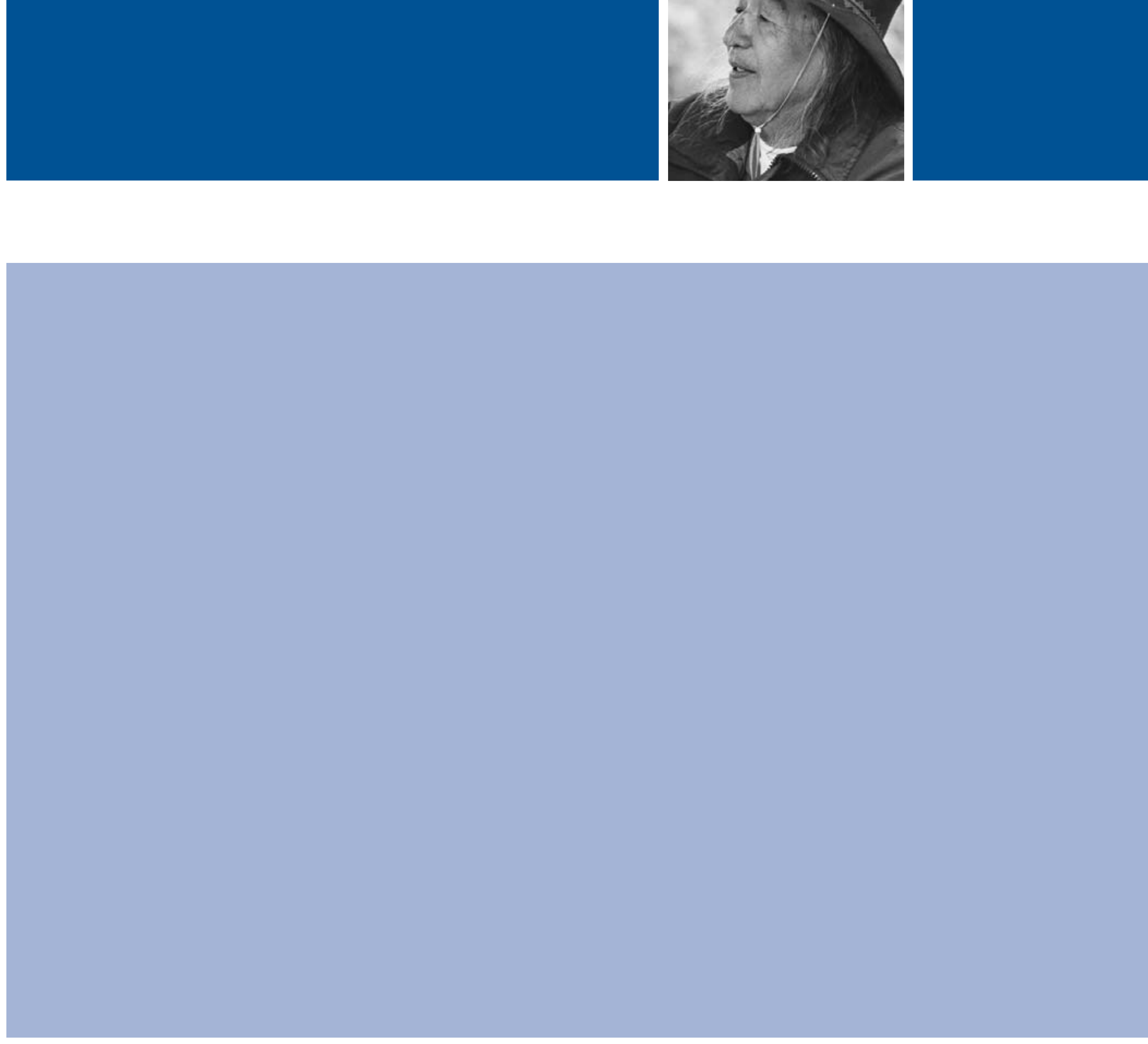
Aboriginal data currently lags behind data on the general Canadian population, and this may impede the federal government's ability to adequately understand and respond to Aboriginal health issues. Challenges exist in the collection and reporting of health information on Aboriginal peoples. As is also true for other groups within Canada, it is difficult to extract health data particular to Aboriginal peoples, let alone First Nations, Inuit or Métis, from administrative databases. For Aboriginal health reporting, this challenge is further complicated by overlapping jurisdictional responsibilities for health between federal, provincial/territorial and local governments. Still, some jurisdictions have had limited success reporting on Aboriginal populations either by using voluntary identifiers or by data linkage.

Statistics Canada was involved in the collection of Aboriginal-specific health information through the Aboriginal Peoples Survey, which was used for the previous federal report on comparable health indicators (2004). The Aboriginal Peoples Survey was useful in identifying health issues in the population, in particular for the Inuit. It struggled, however, with the collection of data from many First Nations communities (notably in Québec) that refused to participate in the survey.

For the *Federal Report on Comparable Health Indicators 2006*, the Government of Canada used data from the National Regional Longitudinal Health Survey 2002-2003. The National Aboriginal Health Organization's First Nations Centre and 10 First Nations regional organizations collectively undertook the survey, which is overseen and guided by the First Nations Information Governance Committee, a standing committee of the Chiefs' Committee on Health of the Assembly of First Nations. The National Regional Longitudinal Health Survey is a First Nations' initiative designed to reflect the First Nations cultural perspective. As such, these survey data are not comparable to data on the general population.

Various strategies are underway to help improve the development of Aboriginal data. Since 2001, Health Canada's First Nations and Inuit Health Branch has contributed over $8 million toward the development of the National Regional Longitudinal Health Survey. It also supported the development of distinction-based indicators (i.e., indicators recognizing that Aboriginal peoples are distinct from one another) by funding five national Aboriginal organizations ($375 thousand in 2005-2006).

Statement of Responsibility



Statement of Responsibility

Deputy Minister of Health
Health Canada

Management's Responsibility for Health Indicator Reporting

The featured comparable health indicators in this edition of *Healthy Canadians* reflect the themes and priority areas about health and the health care system that are important to Canadians. It builds upon previous commitments to continue public reporting of comparable health indicators.

The preparation and presentation of this report is the responsibility of Health Canada. The Department worked with Statistics Canada and the Canadian Institute for Health Information (CIHI) to acquire the data for the bulk of the indicators in this report. Through its partnership with the Public Health Agency of Canada, Health Canada is able to provide information on the prevalence of diabetes.

Health Canada takes all reasonable steps to ensure the data acquired from external sources is reliable. This approach allows the federal government to provide a reasonably accurate national portrait of the health issues of note affecting Canadians.

Health Canada is confident that the information obtained from these external sources is accurate. However, we also wish to acknowledge ongoing challenges in the collection and reporting of data on populations under federal responsibility, such as First Nations living on-reserve. Health Canada is striving to overcome these challenges by engaging in a mutually beneficial dialogue with our partners.

This report helps support the activities carried out by Health Canada and those who deliver health care by providing the information required for evidence-based decision-making. This will ultimately help strengthen Canada's health care system.

This report was compiled according to specifications outlined and approved by the Conference of Deputy Ministers for the 2004 edition of *Healthy Canadians*. Data limitations have been disclosed and explained according to the needs of intended users and to the best of our knowledge the report is complete and accurate (unless otherwise noted and explained).

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

Morris Rosenberg, Deputy Minister

Auditor's Report

AUDITOR'S REPORT

To the Minister of Health

I have audited data for the most recent year for the national health indicators presented in the 2006 Federal Government report on comparable health indicators, 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 2004 Conference of Deputy Ministers of Health identified and defined 18 of the 21 specific indicators to be reported to Canadians. Health Canada presents three new indicators in the 2006 Federal Government report. 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 21 health indicators presented in the 2006 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 additional information provided in the Federal Government report, including (i) data from international sources, (ii) spending by federal departments or by provincial or territorial governments, (iii) data about First Nations, Inuit or military populations, or (iv) information accessible by Internet links cited in the report.

Except as explained in the following paragraph, I conducted my audit in accordance with the Canadian generally accepted auditing standards. 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 2006 Federal Government report by management of Health Canada.

I was unable to audit one of the health indicators, prevalence of diabetes, because I do not have a mandate to audit provincial government data sources. Therefore, I am unable to form an opinion on the completeness and accuracy of the data or on the adequacy of disclosure for the prevalence of diabetes indicator.

In my opinion, except for the prevalence of diabetes indicator which I was unable to audit as explained in the preceding paragraph, 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.

Sheila Fraser

Sheila Fraser, FCA
Auditor General of Canada

Ottawa, Canada
14 November 2006

Annex A

AUDIT CRITERIA FOR THIRD-PARTY VERIFICATION OF *HEALTHY CANADIANS, A FEDERAL REPORT ON COMPARABLE HEALTH INDICATORS 2006*

Health Canada has acknowledged the suitability of the following criteria:

Complete

The health indicators reported comply with the requirements for the definitions, technical specifications and standards of presentation approved by the Conference of Deputy Ministers of Health on June 17-18, 2004. The definitions, technical specifications and standards of presentation for any new indicators are consistent with those approved in 2004.

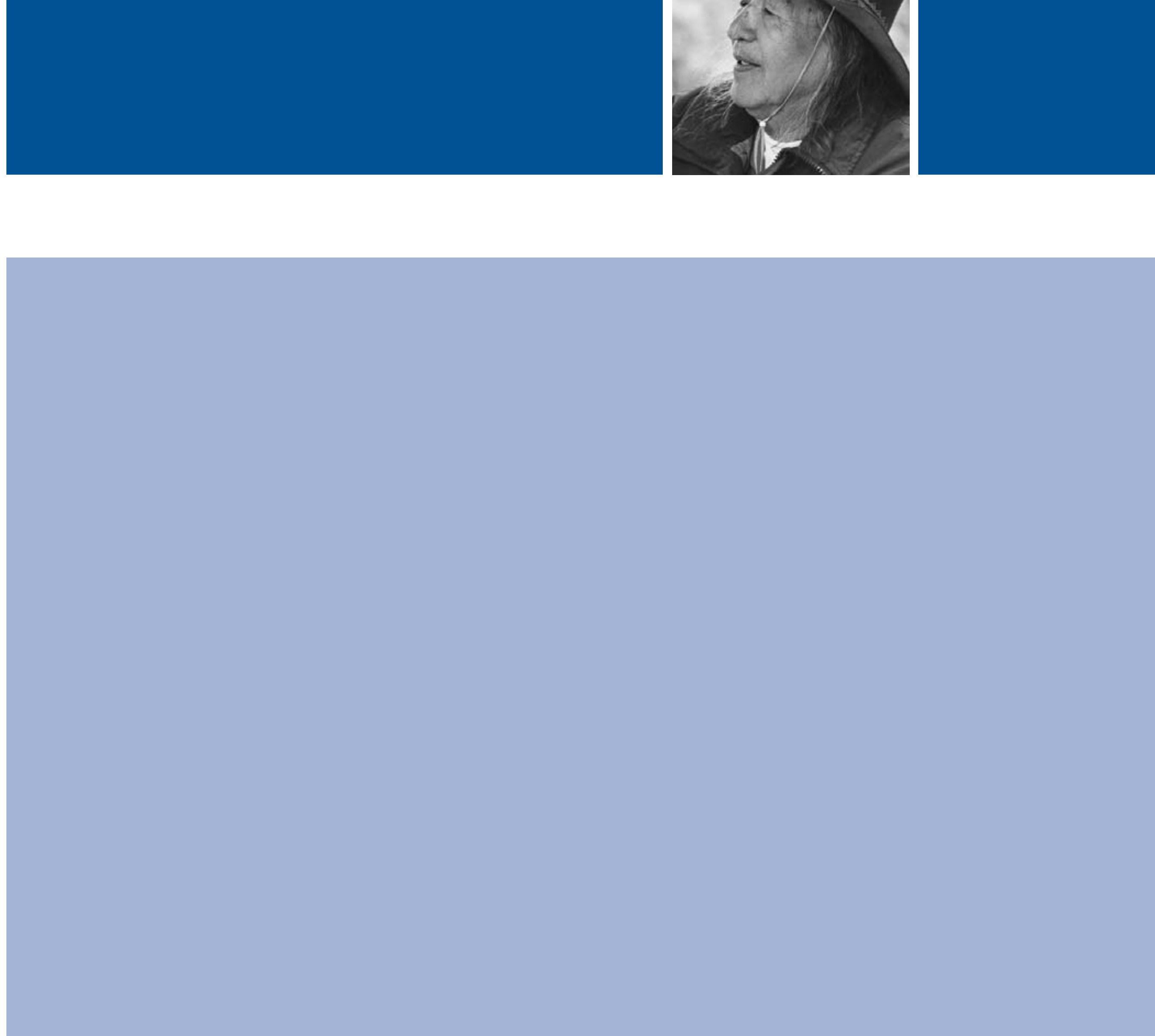
Accurate

The 2006 health indicators adequately reflect the facts and are reported at an appropriate level of accuracy to enable comparisons among the 2002, 2004 and 2006 reports on comparable indicators, where relevant.

Provides adequate disclosure

The health indicators are defined and limitations on the quality of the data are explained. The report states and properly describes departures from what was approved in 2004 by the Conference of Deputy Ministers and explains plans for future resolution of these departures.

Annexes



Annex 1: List of Featured Indicators

In 2004, all federal, provincial and territorial jurisdictions agreed to 18 indicators from a list of 70 that were developed for public reporting. While most of the featured indicators have been updated for 2006, information on *Health adjusted life expectancy* and *Patient satisfaction with telephone health line or tele-health services* was not available.

The table below shows the featured indicators, the measures they used, and the populations they encompassed. In some instances, more than one measure informs a single indicator (e.g., *median wait times* and *distribution of wait times* both inform *self-reported wait times for diagnostic services*). Indicators that have not been audited for 2006 are labelled "unaudited."

Regarding populations under federal responsibility, specific information was only available on First Nations living on-reserve, recognized Inuit and military personnel.

Added to the *Federal Report on Comparable Health Indicators 2006* are additional indicators on the general public (identified by the symbol * in the table below) and additional indicators on First Nations living on-reserve, recognized Inuit, and/or military personnel (identified by the symbol • in the table below).

Indicator	Measure	Populations
THEME: TIMELY ACCESS		
Priority: Primary Health Care		
Self-reported difficulty obtaining routine or ongoing health services	Percentage of population aged 15 years and older who reported difficulty obtaining routine or ongoing health services	General public
Self-perceived access to health services compared to Canadians in general• **UNAUDITED**	Percentage of population aged 18 years and older who reported various levels of health care relative to Canadians	First Nations on-reserve
Self-reported accessibility of health services• **UNAUDITED**	Percentage of Regular Force members who felt clinic hours met their needs	Military personnel
Self-reported difficulty obtaining health information or advice	Percentage of population aged 15 years and older who reported difficulty obtaining health information or advice	General public
Self-reported awareness of health information services• **UNAUDITED**	Percentage of Regular Force members who reported awareness of various health information services	Military personnel
Self-reported difficulty obtaining immediate care	Percentage of population aged 15 years and older who reported difficulty obtaining immediate care	General public
Self-reported barriers to receiving health care• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported barriers to receiving health care	First Nations on-reserve

• identifies additional indicators on First Nations living on-reserve, recognized Inuit, and/or military personnel

* identifies additional indicators on the general public

Indicator	Measure	Populations
THEME: TIMELY ACCESS		
Priority: Catastrophic Drug Coverage and Pharmaceutical Management		
Self-reported prescription drug spending as a percentage of income	Percentage of Canadian households who reported having spent a percentage of their after-tax income out-of-pocket on prescription drugs	General public
Priority: Diagnostic and Medical Equipment		
Self-reported wait times for diagnostic services	Reported median wait time for diagnostic services	General public
	Distribution of reported wait times for diagnostic services	General public
THEME: QUALITY		
Priority: Primary Health Care		
Hospitalization rate for ambulatory care sensitive conditions	Hospitalization rate per 100,000 population younger than 75 years of age for chronic conditions that can be cared for in the community	General public
Self-reported patient satisfaction with overall health care services	Percentage of patients aged 15 years and older who reported they were very satisfied or somewhat satisfied with the way health care services were provided	General public
Self-reported patient satisfaction with health care services• **UNAUDITED**	Percentage of Regular Force members who felt the practitioner addressed their concerns and who felt they received results of tests/procedures within the timeframe they were given	Military personnel
Self-reported patient satisfaction with community-based care	Percentage of patients aged 15 years and older who reported they were very satisfied or somewhat satisfied with the way community-based care was provided	General public
Self-reported patient satisfaction with telephone health line or tele-health services	Percentage of patients aged 15 years and older who reported they were very satisfied or somewhat satisfied with the way the telephone health line or tele-health service was provided	**NOT UPDATED FOR 2006**
Priority: Health Human Resources		
Self-reported patient satisfaction with physician care	Percentage of patients aged 15 years and older who reported they were very satisfied or somewhat satisfied with the way the physician care was provided	General public
Other Programs and Services		
Self-reported patient satisfaction with hospital care	Percentage of patients aged 15 years and older who reported they were very satisfied or somewhat satisfied with the way the hospital care was provided	General public

• identifies additional indicators on First Nations living on-reserve, recognized Inuit, and/or military personnel

* identifies additional indicators on the general public

Indicator	Measure	Populations
THEME: HEALTH STATUS AND WELLNESS		
Priority: Healthy Canadians		
Prevalence of diabetes **UNAUDITED**	Prevalence rate of diagnosed diabetes among health service users aged 20 years and older per 100 population	General public
Self-reported prevalence of diabetes• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported they were told by a health care professional they have one or more types of diabetes	First Nations on-reserve
Self-reported prevalence of arthritis• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported they were told by a health care professional they have arthritis	First Nations on-reserve
Self-reported prevalence of arthritis or rheumatism• **UNAUDITED**	Percentage of self-identified Inuit aged 15 years and older who reported they were told by a health care professional they have arthritis or rheumatism	Inuit
Self-reported prevalence of asthma• **UNAUDITED**	Percentage of First Nations aged 18 years and older and Inuit aged 15 years and older who reported they were told by a health care professional they have asthma	First Nations on-reserve and Inuit
Self-reported health	Percentage of the population aged 12 years and older who rated their health as excellent or very good	General public
Self-reported health• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported their health as excellent or very good	First Nations on-reserve
Self-reported health• **UNAUDITED**	Percentage of Regular Force members who rated their overall health as excellent or very good	Military personnel
Self-reported level of balance for physical, emotional, mental and spiritual health• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported their health was in balance for the four aspects of life – physical, emotional, mental and spiritual	First Nations on-reserve
Self-reported teenage smoking rates	Percentage of the population aged 12 to 19 (inclusive) years who reported they were current and daily smokers	General public
Self-reported teenage smoking• **UNAUDITED**	Percentage of First Nations aged 12 to 17 (inclusive) years who reported they were current smokers	First Nations on-reserve
Self-reported adult smoking• **UNAUDITED**	Percentage of First Nations aged 18 years and older who reported they were current smokers	First Nations on-reserve
Self-reported adult smoking• **UNAUDITED**	Percentage of self-identified Inuit aged 20 years and older who reported they were current smokers	Inuit
Self-reported physical activity	Percentage of the population aged 12 years and older who reported themselves as physically active or physically inactive	General public
Self-reported physical activity• **UNAUDITED**	Percentage of Regular Force members who reported they were active, moderately active or inactive	Military personnel

• identifies additional indicators on First Nations living on-reserve, recognized Inuit, and/or military personnel

* identifies additional indicators on the general public

Indicator	Measure	Populations
THEME: HEALTH STATUS AND WELLNESS		
Priority: Healthy Canadians *(cont'd)*		
Health adjusted life expectancy (HALE)	Health adjusted life expectancy for overall population	**NOT UPDATED FOR 2006**
	Health adjusted life expectancy by income	
Self-reported body mass index	Percentage of the population aged 18 years and older who reported a calculated body mass index in specified categories	General public
Self-reported body mass index• **UNAUDITED**	Percentage of Regular Force members who reported a computed body mass index in specified categories	Military personnel
Self-reported immunization for influenza, aged 65 plus ("Flu shot")	Percentage of the population aged 65 years and older who reported having received a Flu shot	General public
Immunization for influenza• **UNAUDITED**	Percentage of the population who reported having received a Flu shot	Military personnel
Self-rated mental health*	Percentage of the population aged 12 years and older who rated their mental health as excellent or very good	General public
Self-perceived stress*	Percentage of the population aged 18 years and older who reported their life stress as quite a lot	General public
Self-reported consumption of fruits and vegetables*	Percentage of the population aged 12 years and older who reported that they consumed fruits and vegetables five or more times a day	General public

• identifies additional indicators on First Nations living on-reserve, recognized Inuit, and/or military personnel

* identifies additional indicators on the general public

Annex 2: List of 70 Indicators agreed to by Federal/Provincial/Territorial Jurisdictions

Primary Health Care

1. Difficulty obtaining routine or ongoing 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 specialists 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 3: Data Source Exclusions and Limitations

The data sources noted in this section have been used to report information on the featured indicators included in *Healthy Canadians – A Federal Report on Comparable Health Indicators 2006*. Exclusions and limitations for each data source are mentioned to help the reader assess the reliability and validity of the information presented in this report.

Strengths and Limitations of Self-Reported Data

Much of the data presented in *Healthy Canadians – A Federal Report on Comparable Health Indicators 2006* is derived from self-reported data. While self-reported data are often used to provide information on a variety of health-related issues, they are subject to some known limitations. Self-reported information requires the respondent to be thoroughly honest to interviewers and accurately recollect past events. In a systematic review evaluating the accuracy of self-report utilization data, researchers showed that self-reported information may be influenced by factors such as a respondent's sociodemographic characteristics, cognitive ability or memory, stigma related to health care utilization, questionnaire design, and/or the mode of data collection (for example, whether respondents were interviewed by phone or in person).[1] In a report on adult obesity in Canada, Statistics Canada indicated that variations in the methods used to collect information on height and weight have yielded different data. For example, self-reported measures of height and weight yield lower overweight and obesity rates than do direct physical measurements.[2]

Regarding *Healthy Canadians 2006*, the reader is cautioned that some indicators that rely on self-reported information may be subject to the limitations of the mode of data collection (i.e., interviews conducted by phone or in person). These indicators include body mass index, physical activity, and patient satisfaction with hospital care.

Statistics Canada

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)

Exclusions/Limitations: For 2001 and 2003, 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. For 2005, persons less than 15 years of age, 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.

1. Bhandari, A. and Wagner, T. Self-reported utilization of health care services: Improving measurement and accuracy. (2006). *Medical Care Research and Review*, 63(2), 217-235.
2. Tjepkema, M. Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Statistics Canada Catalogue no. 82-620-MWE2005001. Available at: http://www.statcan.ca/english/research/82-620-MIE/2005001/pdf/ aobesity.pdf. Accessed November 7, 2006. Ottawa: Minister of Industry, 2005.

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 sample (cross-sectional sample, health file, household component). Persons less than 12 years of age are not surveyed.

Note: The NPHS is a longitudinal survey.

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.

Note: Only includes out-of-pocket spending on prescription drugs (i.e., does not cover drug expenses paid by a third party such as a private or public drug plan). If prescription drugs are covered by a plan but the household pays a certain percentage of the cost of the drugs, the cost to the household is included in the amount spent on prescription drugs. Over-the-counter medications are not included. The numbers for private and public premiums are not included in out-of-pocket spending and cannot be reported separately because the numbers would be too small.

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 and its predecessor, the Survey of Family Expenditures (FAMEX), are household surveys; thus, multiple families or a number of non-related persons (e.g., room-mates) 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.

Aboriginal Peoples Survey (APS) (unaudited)

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, etc.); 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*.

Inuit population is for the non-reserve population only. It does not include the small number of Inuit who live on Indian reserves. Due to a high number of refusals by First Nations communities in Québec to participate in the survey, no provincial level data for the Québec 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 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).

Regarding the Ambulatory Care Sensitive Conditions (ACSC) indicator, its definition was changed in 2002, and while data exist prior to this period, they cannot be compared to the data presented in the report.

Public Health Agency of Canada

National Diabetes Surveillance System (NDSS) (unaudited)

Exclusions/Limitations: Persons younger than 20 years of age.

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

Disclosure of Limitations:

- Two types of diabetes are included in the database: type 1 and type 2.
- Gestational diabetes is excluded when it is correctly coded. Efforts are made to exclude gestational diabetes when it is incorrectly coded by ignoring records 120 days before or 90 days after a gestational event.
- A baseline error rate of 20% to 25% exists in the published (1999-2000) data.
- This level of error is accepted by the Public Health Agency of Canada and by those national experts identified by the Agency.
- Since 1995-1996, these data have been accumulating false positives and missing false negatives. For the data published here this may not have a significant impact. Work is ongoing to monitor the magnitude of these errors.
- 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.

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.

Assembly of First Nations (First Nations Information Governance Committee)

National Regional Longitudinal Health Survey (RHS) 2002-2003 – Adult Survey (unaudited)

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

Results are limited to participating First Nations living on-reserve and in some non-reserve communities in the territories, excluding Nunavut. The Québec James Bay Cree and the Innu of Labrador did not participate. The sampling was based on the Indian Register, the accuracy of which varies from region to region, though local sampling frames were based on more up-to-date locally validated counts. In Manitoba and British Columbia, paper surveys were employed as a response to difficulties with telecommunications, with possible interview mode effects.

National Regional Longitudinal Health Survey (RHS) 2002-2003 – Youth Survey (unaudited)

Exclusions/Limitations: Individuals under 12 and over 17 years of age and residents of Nunavut.

Results are limited to participating First Nations living on-reserve and in some non-reserve communities in the territories, excluding Nunavut. The Québec James Bay Cree and the Innu of Labrador did not participate. The sampling was based on the Indian Register, the accuracy of which varies from region to region, though local sampling frames were based on more up-to-date locally validated counts. In Manitoba and British Columbia, paper surveys were employed as a response to difficulties with telecommunications, with possible interview mode effects.

National Regional Longitudinal Health Survey (RHS) 2002-2003 – Children's Survey (unaudited)

Exclusions/Limitations: Individuals over 11 years of age and residents of Nunavut.

Results are limited to participating First Nations living on-reserve and in some non-reserve communities in the territories, excluding Nunavut. The Québec James Bay Cree and the Innu of Labrador did not participate. The sampling was based on the Indian Register, the accuracy of which varies from region to region, though local sampling frames were based on more up-to-date locally validated counts. In Manitoba and British Columbia, paper surveys were employed as a response to difficulties with telecommunications, with possible interview mode effects. Children were interviewed by proxy with a person who knew them well – in most cases, this was their mother.

Department of National Defence

Canadian Forces Health and Lifestyle Information Survey (HLIS) 2004 (unaudited)

Exclusions/Limitations: Questions from the HLIS 2004 are the same or similar to questions asked on the Canadian Community Health Survey (CCHS). However, due to differences in survey mode (i.e., mail for HLIS versus telephone/face-to-face for CCHS 2003) direct comparisons cannot validly be made between Canadian Forces (CF) members and other Canadians.

The age group of less than 20 was not used due to low numbers in this category. All rates were age-standardized to the 2004 CF population. The use of sex-specific standard populations allows comparisons among the sexes (i.e., female versus female) but precludes comparisons between sexes (i.e., male versus female).

Organisation for Economic Co-operation and Development (OECD)

OECD Health Data 2006 (unaudited)

Exclusions/Limitations: All users of cross-national comparisons of health care data are advised 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 2006 reflect the situation at the time of release; they have been refined and improved year after year. The aim of the files and the accompanying sources and methods is to provide an objective working tool: the co-operation and, indeed, the criticism of the various national data providers and users will enable improvements in the future.

Reader Feedback

The federal government invites you to answer a few questions about *Healthy Canadians— A Federal Report on Comparable Health Indicators 2006*. Your answers will provide feedback on the content and usefulness of this report.

Please return the completed questionnaire to:

Applied Research and Analysis Directorate
Health Canada
2nd Floor, Richelieu Building
975 St. Joseph Blvd, A.L. 9002D
Gatineau, Québec K1A 0K9

Overall Satisfaction with the Federal Report

For each of the following questions, please place an X beside the *most appropriate* response.

1. How did you obtain your copy of *Healthy Canadians 2006*?

   - ❑ It was mailed to me as part of the initial distribution
   - ❑ I obtained my copy at work
   - ❑ I accessed it through the Internet
   - ❑ I ordered my own copy
   - ❑ Other (please specify)

   ____

2. To what extent have you read or browsed through *Healthy Canadians 2006*?

   - ❑ Have not read or browsed through the document
   - ❑ Have browsed through the entire document
   - ❑ Have browsed through the document and have read specific chapters
   - ❑ Have read the entire document

3. How satisfied are you with the following aspects of *Healthy Canadians 2006*?

   a. Length

   ❑ Too short ❑ About right ❑ Too long

   b. Clarity/readability of technical information

   ❑ Excellent ❑ Good ❑ Fair ❑ Poor

   c. Organization/format

   ❑ Excellent ❑ Good ❑ Fair ❑ Poor

   d. Use of graphs and figures

   ❑ Excellent ❑ Good ❑ Fair ❑ Poor

   e. Quality of results/comments

   ❑ Excellent ❑ Good ❑ Fair ❑ Poor

4. How can future *Healthy Canadians* reports be improved?

   - ❑ Other data sources could be used
   - ❑ Format could be simplified/more user-friendly
   - ❑ Use of different indicators
   - ❑ Other (please specify)

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Usefulness of Healthy Canadians 2006

5. The Government of Canada is committed to being accountable and reporting to Canadians on the performance of their health care system every two years. Information on comparable health indicators helps federal, provincial and territorial jurisdictions and health care providers manage for results and improve health outcomes for citizens. Overall, how successful do you think *Healthy Canadians 2006* was in achieving this goal?

   - ❑ Very successful
   - ❑ Fairly successful
   - ❑ Not successful

6. Have you used, or will you likely use, the information in *Healthy Canadians 2006* for any of the following?

- ❑ Research and/or evaluation
- ❑ Policy development
- ❑ Educational activities
- ❑ Program planning
- ❑ Public awareness activities
- ❑ For information only
- ❑ Will not use
- ❑ Other (please specify)

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7. How useful did you find each section of *Healthy Canadians 2006*? (For each section, please place an X beside the most appropriate response.)

	Very useful	Somewhat useful	Not useful
Executive Summary	❑	❑	❑
Introduction	❑	❑	❑
Overview of the Federal Government's Role in Health	❑	❑	❑
Measuring Performance General Population	❑	❑	❑
Measuring Performance Additional Indicators	❑	❑	❑
Measuring Performance First Nations and Inuit	❑	❑	❑
Measuring Performance Military Personnel	❑	❑	❑
Health Information – Challenges and Next steps	❑	❑	❑
Statement of Responsibility	❑	❑	❑
Auditor's Report	❑	❑	❑
Annex 1: List of 18 Featured Indicators	❑	❑	❑
Annex 2: List of 70 Indicators	❑	❑	❑
Annex 3: Data Source Exclusions and Limitations	❑	❑	❑

8. Do you have other suggestions for future reports of *Healthy Canadians— A Federal Report on Comparable Health Indicators*?

- ❑ Should be shorter
- ❑ Should have more detail
- ❑ Should have more provincial/ territorial information
- ❑ Other (please specify)

Reader Information

For each of the following questions, please place an X beside the most appropriate response.

9. What is your geographic region (e.g., province, territory)?

❑ Nfld.	❑ N.B.
❑ N.S.	❑ P.E.I.
❑ Yukon	❑ Québec
❑ Ont.	❑ Man.
❑ Sask.	❑ Alta.
❑ B.C.	❑ N.W.T.
❑ Nunavut	❑ Other (please specify)

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10. In which sector do you work?

- ❑ Health
- ❑ Social Services
- ❑ Education
- ❑ Environment
- ❑ Housing
- ❑ Other (please specify)

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11. What is your affiliation?

- ❑ Federal government
- ❑ Provincial government
- ❑ Local or regional government
- ❑ Library
- ❑ General public
- ❑ Academic and/or policy research institute
- ❑ Non-government (e.g., voluntary organization)
- ❑ Service provider (e.g., clinician)
- ❑ Media
- ❑ Other (please specify)

12. What is your position or role within your organization?

- ❑ Policy analyst
- ❑ Program manager
- ❑ Service deliverer
- ❑ Researcher
- ❑ Administrator
- ❑ Board member
- ❑ Other (please specify)

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