Health Canada
Performance Indicators
Focus Group Study

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A Report to Health Canada
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Executive Summary

- COMPAS was commissioned by Health Canada to conduct a series of focus groups on issues related to the federal government report entitled *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002*. In total, 10 focus groups were conducted between January 7-9, 2003, with two groups in each of Halifax, Montreal, Toronto, Winnipeg, and Vancouver. The purpose was to explore the extent to which the current approach to reporting on these #1 health indicators meets the needs of Canadians. Participants included Canadians with post-secondary education, Canadians with high school education, and Aboriginal Canadians.

Awareness & Importance of Performance Indicators

- Relatively few participants, perhaps one in five, claimed to have heard or read anything about the federal and provincial governments developing reports designed to provide clear accountability and reporting to Canadians on the health of Canadians and the state of health care in Canada.
- Participants who did remember hearing something recalled a variety of health and health care-related issues that have received coverage in the media over the past few months or years, but nothing in relation to the joint federal and provincial reports themselves. In terms of what was recalled, the two themes identified most often related to health care service cut-backs in various areas, and federal health care transfer payments and efforts to increase accountability for money spent.
- There was a virtual consensus among participants that the development of reports to provide clear accountability and reporting to Canadians is important. Only a small minority did not consider developing joint federal and provincial reports to be important.
- Fiscal accountability issues were cited most often when participants were asked to identify *why* they consider this type of reporting to be important. While participants identified a range of issues related to the financial accountability, a significant focus was on enabling Canadians to better understand where their money is being spent in the health care system. The two other reasons identified with considerable frequency were increased public awareness (e.g. about Canada's health care system, what services/ benefits are covered) and the provision to Canadians of health-related information (e.g. information about the general health of Canadians, such as statistics and information about diseases).
- The few participants who did not think this type of reporting was important were sceptical about government reports in general, and whether this would be used to facilitate change. Some noted that it is expensive and time-consuming to accumulate the data and, on a cost-benefit basis, it was unclear to them how Canadians would gain from these types of reports.
- There was less of a consensus in terms of personal interest in this type of information. That said, many people said they were interested, with some

expressing strong interest. While a variety of reasons were offered to explain why, chief among them was personal relevance. The health care system was of enhanced importance to some for reasons related to themselves, their family or their friends – people either had health conditions, knew others affected by diseases or conditions, or were at a stage in life (i.e. seniors, new parents, etc.) where they relied more heavily on the health care system.

- A significant minority said they were not interested in this type of information. By way of explanation, many pointed to a lack of personal relevance. Some simply had no interest in it. Finally, a few noted that they acquire most of what they need in terms of current affairs from the news media.

Potential Content, Presentation & Distribution of Indicators

- Participants were asked to identify what information should be included in a report designed to provide clear accountability and reporting on the health of Canadians and the state of health care in Canada. By a wide margin, the greatest level of interest was in financial information. Many participants wanted to have a clear understanding of where and how their tax dollars are spent on health care. Many other types of financial information were also cited. Also identified with considerable frequency were general health information (many dimensions to this, including healthy living), information about health care practitioners, and information about health care facilities and services (e.g. average wait times for different services/procedures). Also mentioned with some frequency were diseases and conditions, treatments, drugs and R&D, and comparative information.
- In terms of the presentation or layout of this type of information, there was a general consensus that two reports would be required – a summary report that presents an overview of the information and a full report with the details. Most participants would prefer to read the former, seen to be a short, simple document that presents the highlights.
- Across all groups, the Internet and advertising were considered to be integral components of distribution. Many saw the Internet as an excellent channel for posting/distributing the full report. Advertising was seen to be important to raise awareness among Canadians that this type of information is available.
- While the Internet was identified as a primary method of distribution, participants described a number of other ways they would like to receive this type of information (summary of findings only, not full report). These included through the mail, on CD-ROMs, as features or pull-out sections in local newspapers, and via MPs' newsletters to their constituents. In addition to the various channels of distribution, participants identified a host of locations where this type of information could be made accessible to the public – physicians' offices, medical clinics, hospital waiting areas, pharmacies, libraries, universities, and government client service offices.
- Not only did participants offer a range of suggestions on how this type of information could best be presented to Canadians, there was considerable

consistency in participants' suggestions on the design/layout of the reports, where the focus was on simplicity, clarity, ease of use, and interpretation.

Potential Use of Performance Indicators

- Participants who had earlier expressed an interest in this type of information were asked to identify what they would do with the information. Feedback was consistent across all groups. Heading the list in terms of usage of this type of information were personal education, improving their own health (and/or that of their family) and voter accountability (i.e. using the information as input into voting decisions). Also identified with some frequency were using it as a reference tool of the health care services that are available, as an advocacy and lobbying tool, to help stimulate discussion among families, friends or others, and to help demystify the health care system.
- Thinking in terms of a report produced every two years on the health of Canadians and health care in Canada, participants were asked to identify the type of information they would need to do a number of things:
    - For making informed health choices, information in support of healthy living, such as nutrition, exercise/fitness, life-style, and sleep-related information was seen to be most useful.
    - To increase their understanding of health care outcomes, current and historical statistics about the incidence and survival rates for diseases and health conditions/illnesses, quality-of-life indicators, and hospital comparisons (e.g. treatment, equipment, quality of care, etc.) were the things identified most often.
    - To help people better understand how health care services are delivered, financial information about how and where tax dollars are spent on service delivery, directories of available health care services, and statistics about the number/distribution of health care professionals were considered to be important.
    - To help governments identify and share best practices, the information seen to be useful includes consultations with hospitals and surveys of patients and health care professionals.

Performance Indicators

- Participants were asked to identify specific measures/performance indicators that they think should be included in each of three areas: health status, health outcomes, and quality of service. In response, lengthy lists of quite specific performance indicators were offered. While the lists do not lend themselves to easy summary, some of the measures identified most often include:
    - Health status:
        - Number/type of doctor visits.
        - Number/type of hospital and clinic visits.
        - Number/type of treatments/procedures.

  - Incidence rates for illnesses/diseases (including mental health and disabilities).
  - Level of prescription drug use.
  - Average life expectancy.
  - Demographic profiles of Canadians using the health care system and affected by different diseases/illnesses.
- Health outcomes:
  - Treatments for diseases/conditions (success rates for new diagnoses/treatments, use of homeopathic remedies, number/type of transplants, number/type of prostheses used, tracking outcome of preventive measures).
  - Incidence rates for illnesses/diseases.
  - Effectiveness of generic versus brand name medications.
  - Flu shots versus incidence of the flu.
  - Use of prescription drugs.
  - Number/type of doctor and hospital errors.
  - Number of sick days used by employees.
  - Number of repeat doctor visits.
  - Number/type of medical claims (e.g. insurance, EI claims).
  - Demographic profiles of Canadians using the health care system and affected by different diseases/illnesses.
- Quality of service:
  - Average waiting times for doctor/specialist appointments, different surgeries and other medical procedures.
  - Supply of health care providers (including distribution of family physicians/specialists, ratio of health care providers to patients).
  - Patient and health care workers' satisfaction (including level of attrition for health care workers, level of compassionate care (e.g. bedside manner), overall quality of doctors (i.e. training, cultural sensitivity), number and type of malpractice claims, and average time spent per patient per visit.)
  - Number/type/quality of hospitals and clinics.
  - Number/type of medical equipment.
  - Use and cost of homecare versus hospitalization.

Review of Federal Report on Health Indicators

- Most participants had a positive overall impression of the report extract. That said, perceptions tended to be moderately, not strongly positive. Reasons offered by participants for their favourable reaction were relatively consistent across the groups, and related to the presentation, tone and content of the report. These people tended to view the document as interesting, easy to understand, easy to review, and containing useful information.
- The relatively small number of participants who did not react positively to the report extract pointed to their perceptions that the report contained too much

information, that the information tended to be too general in nature or lacked personal relevance, and that there were important things missing.

- People routinely pointed to a number of design and content elements, most of which were mentioned with consistency across the groups, when asked what they liked most about the information and its presentation. The report was seen to be easy to read and understand. The language used was generally described as being clear and straightforward. Participants identified the graphs as being useful, clear and easy to understand. The layout of the report was said to make it easy to scan the document for information of interest or relevance. The use of three categories to organize the health performance indicators makes the information easier to follow and digest, while the use of bullets, white space and columns contribute to the clarity and accessibility of the information.
- In terms of what they liked least about the information and its presentation, participants identified a number of shortcomings. That said, one concern stood out vis-à-vis all others, and was articulated with consistency across the groups – the need for more explanation and interpretation of the information. Many felt that there were too many statistics without adequate explanation/ discussion of their implications. As a result, the statistics tended to blend together without meaning or definition for readers.
- When asked to focus specifically on the content of the document, and how useful it is to them, slightly over one-third viewed it as useful. While most people attributed importance to this type of information, they did not perceive it to be personally useful to them. In terms of why the content was useful to some participants, these people tended to point to its educational function, viewing the report as offering valuable health-related information. A few also said they might use this information with others (e.g. within their Aboriginal communities, when working with parolees, or in discussions with friends). Participants who did not find the content useful cited its lack of personal relevance and lack of analysis, including information that could be acted on.
- There was a consensus among participants that the set of health indicators in each of the three areas were appropriate for inclusion in this kind of report. In addition to the current set of indicators, participants identified other indicators that they felt should be considered for inclusion in this type of report.

Interest & Usage of Report

- Virtually none of the participants would have read the report in its entirety if they had seen it when it came out. However, a strong majority think they would have read it in part, scanning the sections for information of personal relevance or interest. It appears that people would have been equally likely to review the report whether it came to them in the mail or they saw it in a waiting room (i.e. family doctor, hospital, etc.).
- Reasons offered for why they would read the report, whether in whole or in part, included satisfying curiosity, obtaining useful information, and gaining a sense of the health status of Canadians and the services available to them.

- Participants were asked to consider whether the information contained in the report would do a number of things (in relation to the report's objectives). Feedback in this area was largely consistent across the focus groups. For two of these items – making more informed choices on one's own health and better understanding the delivery of health care services – the large majority of participants felt that the information in the report would not help them. Assessments of the usefulness of the information in the two other areas – better understanding outcomes and helping governments in continuous service improvement – were more positive, although somewhat mixed. For the former, many felt that the information was likely to be moderately useful. In terms of helping governments contribute to service improvement, many people also felt the information might be useful "depending on who reads it and acts on it", at least when all the reports are pulled together (provincial, territorial and federal) and when looked at over time.

Aboriginal Canadians

- Aboriginal Canadians tended to attribute less importance to the development of reports to provide clear accountability and reporting to Canadians. In terms of the extract from *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002*, Aboriginal participants wanted a clearer focus on Aboriginal health issues, where they would not have to sift through the main Canada-wide report to identify information of this type. They suggested removing the First Nations' statistics from the main report and including this as a separate section of the report or as part of the appendix.
- Additional suggestions vis-à-vis the Aboriginal information in the report, offered to increase the usefulness of the content of the report, included:
  - Add comparisons with Aboriginal populations in other countries.
  - Clarify that the statistics are only for Aboriginal Canadians living on reserves.
  - Ensure that the content is balanced. There was a sense among a few Aboriginal participants that the statistics included in the report were overly positive.
  - Take efforts to ensure the quality of the data for Aboriginal peoples living on reserves (some doubted the accuracy of some statistics).
  - Include statistics for off-reserve Aboriginal Canadians.
  - Include separate data for the Inuit population.

Conclusions

The research suggests that the federal report, *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002*, presents information about the health indicators in a way that makes them readily accessible to most readers. Feedback on the report was largely positive, with many design and content features singled out for positive comment. Overall, the report was seen to be easy to read, easy to follow, and containing interesting information. Moreover, the health indicators that were included were judged to be appropriate by most people. That said, the two main deficiencies, as perceived by participants, were the virtual lack of financial information (to help ensure accountability), and the lack of interpretation or analysis. The latter was seen to be a significant short-coming since it negatively impacts on readers' ability to understand the meaning or relevance of many of the indicators.

Other observations for Health Canada's consideration:

- While this type of information was judged to be important by most people, it was not seen to personally useful by many. It would appear that most participants would be interested in reviewing a summary report, with few inclined to wade through the full report. A lack of personal relevance and practical information that could be acted on were cited to explain why.
- The report does not meet some of the objectives identified for this type of reporting by First Ministers in September 2000. The information in the report was <u>not</u> seen to help Canadians make informed health decisions or enable them to better understand the delivery of health care in Canada. Moreover, perceptions were somewhat mixed regarding the two other objectives – enabling Canadians to better understand health outcomes and helping governments in terms of continuous service improvement. The information required in these areas, as identified by participants prior to their review of the report, is noticeably different from that contained in the report.
- Some participants had difficulty distinguishing or differentiating between the different types of indicators (i.e. health status, health outcomes, quality of service). For these people, these areas tended to blend into one another. Not surprisingly, therefore, there was overlap in terms of the feedback received when discussing this type of information.
- There was considerable consistency in the feedback received from participants across the different types of focus groups and locations, both in terms of their reaction to the report and in their information needs. That said, participants with post-secondary education appeared to have an easier time following and responding to the questions, and tended to provide more robust feedback.
- There were a significant number of suggestions in terms of future reports. Principal among these were the perceived need for a summary/highlights report (in addition to the full report), the use of the Internet for distribution, and the need for advertising to increase awareness when the report is available. Recall that virtually no one was aware of the release or existence of the 2002 federal and provincial reports.

Introduction

Health Canada commissioned COMPAS to conduct a set of focus groups with Canadians on issues related to the report entitled *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002.*

Background and Objectives

In September 2002, the Government of Canada made public a report entitled, *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002.* The report was produced in response to a commitment made in September 2000, where First Ministers directed Health Ministers to collaborate on the development of a comprehensive framework using jointly agreed comparable indicators. These comparable indicators address:

- Health status (e.g. life expectancy, infant mortality, low birth weight, people reporting their health as excellent);
- Health outcomes (e.g. change in life expectancy, improved quality of life, reduced burden of disease and illness); and
- Quality of service (e.g. waiting times for key diagnostic and treatment services, patient satisfaction, hospital re-admissions, access to 24/7 first-contact health services, home and community care services, adequacy of public health surveillance, health protection and promotion activities).

On September 30th 2002, all 14 jurisdictions released their respective reports.

Health Canada wanted to explore with Canadians the extent to which the current approach to reporting on these health indicators had met their needs. The main objectives of this research were to:

- #1 Ascertain if the federal report had met the objectives of the First Ministers. That is, did it:
    - allow Canadians to see how Canada is doing in attaining our goals and objectives;
    - assist individuals, governments, and health care providers to make more informed choices;
    - promote the identification and sharing of best practices within jurisdictions and across Canada, and thus contributes to continuous service improvement;
    - increase Canadians' understanding of the utilization and outcomes of health services (e.g. increase in life expectancy, improved quality of life, reduced burden of disease and illness); and
    - help Canadians understand how their publicly-funded health services are being delivered.
- #2 Identify what Canadians like and dislike about the report; and
- #3 Identify what Canadians would like to see in subsequent reports (i.e. specific information or the indicators themselves).

Research Design

To address the research objectives, a set of 10 focus groups was conducted with two groups in each of Halifax, Montreal, Toronto, Winnipeg and Vancouver. The following specifications applied to this study:

- Three target audiences were recruited for this research:
  - Canadians with post-secondary education. This included people who had graduated from college or university (not CEGEP in Quebec). We recruited a mix of participants from both colleges and universities, as well as by the type and number of diplomas/degrees. This group did not include people who had some post-secondary education, but who did not obtained a degree or diploma.
  - Canadians with high school education. People with any post-secondary education were not eligible for participation in this group (nor were people with less than a high school diploma).
  - Aboriginal Canadians (mix of education levels). These groups were conducted in Winnipeg.
- The following table presents the distribution of the focus groups:

Vancouver	**Winnipeg**	**Toronto**	**Montreal**	**Halifax**
January 7	January 8	January 9	January 8	January 9
English	English	English	French	English
Post-secondary Education	Aboriginal Canadians	High school Education	High school Education	High school Education
High school Education	Aboriginal Canadians	Post-secondary Education	Post-secondary Education	Post-secondary Education

- Twelve participants were recruited for 8-10 to show. Turnout was very good.
- All participants were paid an incentive of $60.
- All focus groups were conducted during the evening, with the first group starting at 5:30 p.m. and the second group at 8:00 p.m.
- All groups were conducted in professional focus group facilities with client viewing room and one-way mirror. Refreshments for participants and observers were provided.
- Sponsorship of study was revealed (i.e. Health Canada).

Participants' comments are provided in italics or quotations marks, and are either actual verbatim comments or have been paraphrased to reflect the intent of the remark.

This research was qualitative in nature, not quantitative. As such, the results provide an indication of participants' views about the issues explored, but cannot be generalized to the general public or aboriginal Canadians.

The principal investigator for this study was Stephen Kiar, senior partner of COMPAS, who also moderated most of the English focus groups and wrote the final report. Jeannette Bellerose, vice president of COMPAS, moderated the Quebec and Atlantic Canada focus groups and participated in the drafting of the final report.

Appended to the report are the following:

- The screening questionnaire used to recruit participants.
- The moderator's guide used for the focus groups.
- Extracts from the report entitled *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002* that were used with focus group participants.

Awareness & Importance of Performance Indicators

This section explores participants' awareness of, and the importance they attribute to, federal and provincial reports intended to provide clear accountability and reporting on the health of Canadians and the state of health care in Canada. This includes identifying the reasons why people felt that these types of reports are important (and why not), and whether this information is of interest to them personally.

Few Claim Awareness of Joint Reporting, Almost None Aware of 'Right Things'

Relatively few participants, perhaps one in five, claimed to have heard or read anything about the federal and provincial governments developing reports designed to provide clear accountability and reporting to Canadians on the health of Canadians and the state of health care in Canada. Almost all of these people could only vaguely recall hearing something about this. Moreover, virtually no one was aware of anything that was actually related to the reports. That is, participants recalled a variety of health and health care-related issues that have received coverage in the media over the past few months or years, but nothing in relation to the joint federal and provincial reports themselves.

In terms of what was recalled, the two themes identified most often related to health care service cut-backs in various areas, and federal health care transfer payments and efforts to increase accountability for money spent. Comments on service cut-backs focused on waiting lists for hospitals and procedures, physician and specialist availability, nursing shortages, disability benefits, physiotherapy, and homecare.

Also mentioned were privatization and two-tier health care, and the need to better identify where the money is actually being spent so that health-care resources could be used more effectively. A few participants identified the need to improve health-care statistics/data, different drug therapies, such as Hormone Replacement Therapy (HRT), CIHR, rising costs of drugs for seniors, and general efforts to improve health care in Canada.

When participants who claimed to be aware of the reports were asked whether such reports had already been created, or were still being developed, most thought they were still under development.

Strong Consensus That Joint Health Care Reporting is Important

There was a virtual consensus among participants that the development of reports to provide clear accountability and reporting to Canadians is important. Nearly all participants indicated that this type of reporting is important; for many, it is very important. Only a small minority did not consider developing joint federal and provincial reports to be important.

In terms of inter-group differences, Aboriginal Canadians were somewhat more likely to attribute less importance to the development of these reports.

Fiscal Accountability – Top Reason Why Reporting is Seen to be Important

Fiscal accountability issues were cited most often, by a considerable margin, when participants were asked to identify *why* they consider this type of reporting to be important. The development and sharing of information about health care expenditures was seen to be important to help ensure fiscal accountability.

Participants identified a range of issues related to the financial accountability of Canada's health care system. A significant focus was on enabling Canadians to better understand where their money is being spent in the health care system. Many indicated an interest in knowing exactly how and where their tax dollars are being spent. There was a sense among some that if they were made aware of the actual health care budget, then they might be more accepting of proposed cut-backs and facilities closures. A few also expressed the belief that increased awareness of the cost of operating the health care system might deter people from abusing the system.

Participants also identified other dimensions of the fiscal accountability issue:

- Helping governments in Canada examine trends in health care to enable them to forecast health care expenditures.
- Helping governments in Canada establish clear guidelines with which to direct spending on health care.
- Enabling non-Aboriginal people to see how much money is allocated to health care services delivery on reserves.

Two other reasons with respect to why this type of reporting is important were identified with considerable frequency – increased public awareness and the provision to Canadians of health-related information:

☐ <u>Increased Public Awareness</u>: This encompasses a number of dimensions:

  - Increasing public awareness and discourse of Canada's health care system through the media coverage that would follow the release of these types of reports.
  - Informing Canadians about what services/benefits are covered under the health care system, and which ones are not.
  - Informing Canadians about what they can expect from their health care system.
  - Keeping Canadians up-to-date about the health care system, and of any changes that might affect them. There was a sense among some participants that the health care system was continually undergoing change. For this reason, they felt that is important for Canadians to be kept abreast of the changes.
  - Making Canadians more conscious of the costs of health care, perhaps resulting in greater awareness of what constitutes abuse of the system.

- ☐ Provision of Health-Related Information: Some participants felt that reports like these are important because they deal with an issue that affects all Canadians – health. As such, value was attributed to governments providing information about the general health of Canadians, such as statistics and information about diseases, and keeping Canadians up-to-date about new health issues and illnesses or conditions that face the population.

Additional reasons offered by smaller numbers of participants included:

- Making the system more transparent.
- Encouraging better collaboration between the federal and provincial governments in the delivery of health care services to Canadians.
- Enabling Aboriginal Canadians to compare their health to average Canadians and Canadians to compare themselves to people from other industrialized countries.

The few participants who did not think this type of reporting was important were sceptical about government reports in general, and whether this would be used to facilitate change. Some noted that it is expensive and time-consuming to accumulate the data and, on a cost-benefit basis, it was unclear to them how Canadians would gain from these types of reports. As such, it was perceived by some to be a poor way to spend public money that could be better utilized through direct investment in health care services.

Mixed Level of Personal Interest in This Type of Information

There was less of a consensus in terms of personal interest in this type of information. That said, many people said they were interested in this information, with some expressing strong interest. While a variety of reasons were offered to explain their interest, chief among them was personal relevance. The health care system was of enhanced importance to some for reasons related to themselves, their family or their friends – people either had health conditions, knew others affected by diseases or conditions, or were at a stage in life (i.e. seniors, new parents, etc.) where they relied more heavily on the health care system (e.g. *The closer you get to retirement, you hope you have your health. If you don't, you hope there is something available to help you enjoy a few more years; I'm interested because I have ageing parents.*).

Other reasons offered for interest in this type of information included a more global concern that Canadians should know how their tax dollars are being used for health care in order to make governments more accountable for its quality. Closely linked to accountability concerns was the perception that health care services have gradually declined in terms of availability and that this information might help Canadians better understand why. Finally, mentioned by a few was the opportunity this information offered to them to improve their own state of health through self-education.

For some participants, their level of interest was conditional upon the extent to which the information was personally relevant. These people typically would not be interested in this type of information, but they acknowledged that a change in personal circumstances might result in them becoming interested. For instance, if they or someone they knew became affected by a health condition or became a health care worker, these people would likely become more interested in this information (*If cancer was in my family, I would be more interested; If there is something or someone in your life that has health issues, you are more interested*).

A significant number of people said they were not interested in this type of information. By way of explanation, many pointed to a lack of personal relevance. Some simply had no interest in it. Finally, a few noted that they acquire most of what they need in terms of current affairs from the news media. If the highlights were reported by the media, they would have no reason to turn to the report (*It's not that important for me to read the report; I like the highlights in the news; I wouldn't want to wade through the detail. It is important for the system but you can't act on it*).

Potential Content, Presentation & Distribution of Indicators

This section presents participants' suggestions for the potential content, presentation style, and distribution of this type of information. The focus was on what should be included in a report intended to provide clear accountability and reporting to Canadians, how it should be presented to Canadians for their information or use, and how it should be distributed to Canadians.

Most Want Financial Information, Followed by General Health & Health Care Information

Participants were asked to identify what information, or areas to be assessed (performance indicators), should be included in a report designed to provide clear accountability and reporting on the health of Canadians and the state of health care in Canada. People were told to assume that this type of report would be published every two years.

By a wide margin, the greatest level of interest was in financial information, perhaps not surprising considering that most participants pointed to fiscal accountability issues to explain why joint federal/provincial reporting is important (see above). Many participants wanted to have a clear understanding of where and how their tax dollars are spent on health care. Thus, interest was high in information about the federal budget for health care, including a clear description of how this money is allocated (e.g. what percentage is spent on administration, R&D, services, facilities, etc.). It also includes the percentage of the total federal budget allocated to health care, the amount of federal transfers to the provinces for health care, and statistical comparisons of federal and provincial spending on health care. Some wanted government spending information on a per capita basis.

A range of other types of financial information were also identified:

- ☐ Costs associated with specific treatments and services, and whether they are paid for by individuals, health insurance plans, or governments.
- ☐ Information about the outcomes or benefits associated with health care expenditures.
- ☐ Information about research grants, including to whom they have been awarded and for what purposes.
- ☐ Information about how much money is allotted to fighting various diseases (i.e. cancer, heart and stroke).
- ☐ Costs associated with prescription drug use, including the amount of money reimbursed by insurance plans for prescription drugs.
- ☐ Information about who influences financial decisions pertaining to the health care system. This included identification of the discretion provinces have in terms of resource allocations.
- ☐ Hospital budgets.
- ☐ Costs associated with producing these types of reports to provide clear accountability and reporting to Canadians on the health of Canadians and the state of health care in Canada.

Many participants identified general health information. This included healthy living information, guidelines and information to improve the health of Canadians. Often cited were food and nutrition information, but also exercise/fitness levels and average weights. Some wanted to know about the link between food and health, with special attention paid to new foods (e.g. GM foods). Some, parents in particular, wanted information on the health of children and benchmark measures, while others wanted information on the health of seniors.

Also identified were:

- Information about how the environment (e.g. pollution, insecticides, herbicides, etc.) has an impact on the health of Canadians.
- Information about the leading causes of death in Canada.
- Mortality rates in Canada.
- Information on mental, emotional, and spiritual well-being.

Another type of information that was identified with considerable frequency was information about health care practitioners. This included things like the number of health care professionals (e.g. doctors, specialists, nurses), both overall and on a per capita basis, and the distribution of health care professionals across Canada. Some focused on the supply of health care workers, looking for information on the percentage of doctors/specialists graduating from Canadian universities, retiring, and leaving the country to practice elsewhere per year, trends in education (e.g. number of spaces in medical schools), and projections about the future supply of doctors and nurses. A few wanted information about the cost of and government support for training and the re-testing of doctors. Also cited was an explanation as to why doctors are not required to undergo mandatory competency testing.

In addition to focusing on health care providers, participants wanted information about health care facilities and services. This includes things like average wait times for different services/procedures: non-emergency surgeries, emergency care, and family physician/specialist appointments. It also included the quality and number of diagnostic and other equipment in hospitals and clinics (including their distribution and accessibility), the number of hospital beds, and statistics on hospital performance, bed closures and employee salaries. Some expressed a desire for more general information about the overall state of health care facilities, including their cleanliness. Also identified was information on which facilities offer specialized services (e.g. cancer or heart institutes), the location of trauma centres throughout the country, and information about private sector facilities and services available.

Other potential content for joint federal/provincial reporting that was identified with some frequency included information about:

- Diseases and Conditions: This includes more general information about diseases and conditions that affect Canadians, including possible causes and prescribed treatments. It also includes incidence and survival rates for different illnesses/diseases among Canadians (e.g. cancers, diabetes), demographic breakdowns of this information (i.e. age, region, gender, ethnicity, etc.), and changes in patterns over time. Also mentioned were:
  - Statistics for alcohol consumption, cigarette smokers, and drug users.

  - Addiction information (e.g. alcoholism and substance abuse), including cause, effects, and treatments.
  - Mortality rates by type of disease.

- <u>Treatments, Drugs and R&D</u>: Here, the focus was mainly on information about alternative, non-traditional medicine, preventive medicine, specialized services, and drug development and research:
  - Information about alternative medicine. Many spoke of wanting to know more about holistic medicine, herbal remedies and non-traditional treatments. Some would like information on current research findings in this area, including comparisons between results that have been yielded by alternative therapies vs. traditional medicine.
  - Information about preventive medicine. As noted above, many wanted to know how fitness and eating well could improve their health, as well as reduce their risk of becoming afflicted with diseases or conditions.
  - Information about specialized services (i.e. treatment facilities for heart disease and cancer) broken down by province and territory.
  - Information on drug development/research (including funding) and on which ones have become available on the Canadian market.
  - Medications and treatments that are covered by health insurance.

- <u>Comparative Information</u>: Calls for comparative information tended to focus on inter-provincial comparisons, albeit not exclusively. Information perceived to be useful in this area included provincial comparisons on the health of residents and state of health care in each province, descriptions/ comparisons of the medical services offered by each province and of the health care insurance coverage available, and demographic information that compares the health of the population (and subgroups) in the different provinces and territories. Other comparative information included:
  - Information on the health care system now, compared to previous decades, including performance/outcomes in different areas.
  - Information on how the current year's reports relate to previous ones.
  - Information on how the health of Canadians and the state of our health care system compare to other countries.

Additional things mentioned by smaller numbers included:

- Issues specific to Aboriginal Canadians, including the quality of care provided to those residing on reserves or in the North (identified by an Aboriginal Canadian).
- The number of medical translators available (i.e. translation to languages other than English and French).
- Information on the impact of immigration on health care.
- Federal government vision for the future of health care.

Participants See Need for Two Reports – Short Summary & Full Report

In terms of the presentation or layout of this type of information, there was a general consensus that two reports would be required – a summary report that presents an overview of the information and a full report with all of the details. Most participants would personally prefer to read the former, seen to be a short, simple document that presents the highlights. Suggestions specific to the summary report included:

- Present the highlights in an easily accessible format, supported by graphs and charts. Format suggestions included a brochure, pamphlet, small reference book, CD-ROM, and the Internet.
- Keep the document short, clear and concise, without omitting the most important information. A length of 3-5 pages seemed to be about right for most people.
- Provide information that tells people how to obtain the full document for those who want to read it (participants routinely said there should be clear identification of the Internet address where the full report can be obtained).
- In electronic versions of this report, use hyper-links to link the highlights with the detailed information (i.e. let users click on summary information of interest to them, where the link takes them to the corresponding section of the detailed report).

In addition to consistent calls for both summary and full reports, participants offered suggestions on how this type of information could best be presented to Canadians. There was considerable consistency in participants' suggestions on the design and layout of the reports. Suggestions included:

- Make it interesting. Present the information in a way that engages readers.
- Follow the KISS principle. Keep the language simple, using clear, easy-to-understand words and layman's language (i.e. avoid jargon, large words, medical terminology, and statistics that may be foreign to many).
- Use lots of easy-to-understand graphs, tables and charts to present the information. Participants emphasized the need for non-complicated visuals.
- Use clear and legible font styles and sizes.
- Keep the presentation simple, including effective use of bullets, 'white space', and other design elements. Ensure that the information is well categorized and clearly titled for quick review and digestion.
- Provide interpretive analysis. Many participants said they would value an explanation of the significance of the information, and not just the data themselves.
- Have a fulsome, descriptive table of contents.

- ☐ Have good cross-referencing between the summary document and the full report (e.g. corresponding page numbers) to make it easy for summary report readers to find what they want in the full report.
- ☐ Have a series of different reports or volumes (e.g. financial, training, environmental).
- ☐ Provide the reports in a variety of different languages, including Aboriginal languages.
- ☐ Ensure that the reports are accessible in alternative formats for hearing and visually-impaired Canadians.
- ☐ Make use of colour (but "not too many flashy colours").
- ☐ A few participants suggested the use of photographs.

Multiple Methods of Distribution – Internet & Advertising are Key

Participants were asked to reflect on how this type of information should be *distributed* to Canadians. Across all groups, the Internet and advertising were considered to be integral components of distribution.

As mentioned, participants indicated a clear preference for two reports: a short document that contains report highlights and a full length report. Many saw the Internet (e.g. websites) as an excellent channel for distributing the full length report. A report could be placed on a government website for downloading or online consumption.

While the Internet was identified as a primary method of distribution, especially of a full length report, participants described a number of other ways they would like to receive this type of information. These included through the mail, on CD-ROMs, as features or pull-out sections in local newspapers, and via MPs' newsletters to their constituents.

Advertising was seen to be important to raise awareness among Canadians that this type of information is available. Participants suggested advertising through public transit vehicles, newspapers, radio and television ads (e.g. PSAs like *ParticipAction;* brief TV ad with a 1 800 number). One of the themes in this area was that the federal government should tell Canadians that this information is available, but have people themselves take the step to get it if they want it.

It is important to note that a noteworthy minority of participants did not see value in generating any kind of formal report. Instead, they and some others suggested getting the highlight information out to Canadians using the news media. For some, this would be an adequate amount of information to keep them informed and up-to-date. That is, these people would not need or look for additional information (unless something specific caught their attention).

In terms of mailing this information out to Canadians, participants felt that this could be done for a brochure-type summary report, but should not be done with the full report. Direct mail suggestions tended to focus on inclusion with other materials being mailed out by the federal government (e.g. tax forms, benefit payments, bill payment). If mailed out directly, a few felt that it is important to identify the information as "important" or somehow drawing attention to it (so people will take note and not throw it away). One or two felt that any direct mail efforts should ensure that the mailing is personally addressed to the recipient.

In addition to the various channels of distribution, participants identified a host of locations where this type of information could be made accessible to the public. These included physicians' offices, medical clinics, hospital waiting areas, pharmacies, libraries, universities, and government client service offices.

Other distribution suggestions included:

- ☐ Release the information in parts, such as through weekly community newspapers, to make it more digestible for consumers of it.
- ☐ Have a 1 800 number that people can call to gain access to the reports. A related suggestion is providing a 1 800 number where people can go to have questions answered if anything is clear or if they have questions about anything in the report.
- ☐ Include this type of information in the curriculum of high schools so that people come out of school better informed about health care in Canada.
- ☐ Provide information sessions in communities (e.g. speakers at community centres, public forums). Advertise that these are available.

Potential Use of Performance Indicators

This section explores participants' potential use of a report, or set of health performance indicators. This includes what they would want the report for and the type of information they would like to be included as performance indicators.

Personal Education, Improved Health – Top Uses of Information

Participants who had earlier expressed an interest in this type of information were asked to identify what they would do with the information. Feedback was consistent across all the groups and included the following (in approximate order of the frequency of their expression):

- ☐ Personal Education. This reason or purpose was cited most often in terms of the personal value of this type of information. This generally related to participants' desire to broaden their understanding and awareness of the state of health care in Canada. These people want to be kept up-to-date about government activities and initiatives, and this type of information affords them the opportunity. Specific things mentioned included seeing what services are offered to Canadians, comparing provincial performance in various areas, keeping track of health care facilities closures, and being aware of overall trends in health care.

- ☐ Improve Own Health. Numerous participants said they would use this type of information to improve their own health. Increased awareness of health issues (e.g. new diseases, illness trends) could be used to help improve or safeguard personal health and the health of family members. It was felt that this type of information has the potential to enable Canadians to be more pro-active in terms of their own health, and to enable them to take preventive measures.

- ☐ Voter Accountability. A number of participants said they would use this information to help keep governments accountable. Some noted that this type of information would be among what they would reflect on when it came time to exercise their right to vote.

- ☐ Reference of Services Available. Some people felt that this type of report would have directory-like information (i.e. what services available, which facilities deliver which services). Some even expected contact information (i.e. addresses, phone numbers) for different services.

- ☐ Advocacy/lobbying Tool. A few participants said they would use this type of information to lobby or advocate for things, with governments or in the community at large (e.g. use of alternative medicine, stopping closures).

- ☐ Discussion Purposes. A few people said they might use the information as a topic for discussion or for sharing with others. For instance, one or two people pointed to using this information as a reference guide/resource tool to promote discussion. Others said they would share it with friends, family or colleagues, use it to influence Aboriginal communities (identified in the Aboriginal focus groups), or to educate children (identified by parents).

- ☐ Demystification. This refers to a desire for the health care system to be demystified to enable people to better understand where their tax dollars are being spent.

Other potential uses included:

- ☐ Use of the health performance indicators by governments to establish standards or benchmarks for things such as waiting times.
- ☐ For recourse if service received was not up to standard.
- ☐ Public access to information. There was a sense among some participants that Canadians had a right to information of this nature.

The following are offered as representative comments vis-à-vis participants' use of this information:

- *Strictly for personal information. I'd like to know what the government is doing now and in the future.*
- *For personal learning.*
- *To know what's available.*
- *To gain knowledge.*
- *We would not be kept in the dark and would know what is happening.*
- *Self improvement.*
- *Good to know if there are new diseases and, if so, what steps to take to protect oneself.*
- *Keeping up with health trends, where we are headed, what we are subjected to in terms of diseases.*
- *I'd use it as a voting tool. If they did a usual government thing, I'd bring out the report.*
- *I'd like to see if the planned activities actually happened.*
- *Use as reference documents to hold others accountable.*
- *Instead of just finding out that the emergency ward is closed, you could take a more active stand.*
- *Just to see what hospitals are closing and what departments. Keep track of what's happening, what's coming up.*
- *I would make it a big topic of discussion with my friends.*

Content Elements Seen to be Required to Meet Report Objectives

Thinking in terms of a report, or set of health indicators, produced every two years on the health of Canadians and health care in Canada, participants were asked to identify the type of information they would need to:

- ⇒ Help them make more informed choices in terms of their health and/or that of their family.
- ⇒ Help increase their level of understanding of the outcomes of our health care services.
- ⇒ Help them better understand how health care services are delivered.
- ⇒ Help government identify and share best practices, to contribute to continuous service improvement in health care services in Canada.

The information requirements in each of these areas is presented below.

Informed Health Choices

The following information was seen to be useful to help people make more informed health choices. Heading the list, across all groups, was information in support of healthy living, such as nutrition (identified most often), exercise/ fitness, life-style, and sleep-related information.

A range of other types of information in this area were also seen to be useful. The items in the following list were identified with some consistency:

- ☐ Information about common illnesses/ailments, and the range and effectiveness of medications/treatments available for them, including alternative, prescription, and over-the-counter medicines. This includes incidence rates of diseases and health conditions, how they typically are contracted, and survival rates. Explanations and interpretations are looked for, not just statistical and other factual data.
- ☐ Information about the prevention of diseases and other health conditions, including measures that Canadians can take to improve their health and reduce their chance of becoming ill.
- ☐ A list of preventative or diagnostic tests, and their costs, available to detect hereditary diseases or conditions (*Preventive measures related to hereditary diseases)*.
- ☐ Information about viral versus bacterial infections to educate Canadians about the use and over-use of antibiotics.
- ☐ A directory or 'map' of health care services (e.g. physicians, specialists, treatments, etc.) available by province, including how to access each (*The services available and how to access them*). This could include a list of health care products or treatments available in the United States but not Canada.
- ☐ Information about specific physicians, including access to legal and educational records, treatment success rates, and patient feedback about quality of care. Also suggested for inclusion were how-to information for choosing a competent family physician and guidelines that outline how physicians should behave toward patients.

- Information of the health of children in Canada that includes things like average weight per age, fitness level, television watched, etc. This would include a list of vaccines that should be administered to children.
- Statistics on hospitals and other facilities, including medical equipment, waiting lists, beds available, staff levels, and areas of expertise.

Also mentioned by one or two participants were:

- Success stories about Canadians who have defeated cancer and other life threatening diseases.
- Facts and myths about health care in Canada.
- Water system information (i.e. to avoid Walkerton).
- Drug addiction information.
- Breast cancer information, including the age women are most likely to develop the disease.
- Explanation of government expenditures on R&D in health care.
- Information about the strengths and weaknesses of different provinces in terms of health care services delivery.

Health Care Outcomes

The following information was seen to be useful to help people increase their level of understanding of the outcomes of our health care services.

- Current and historical statistics about the incidence and survival rates for diseases (e.g. cancer, diabetes, etc.) and health conditions or illnesses (e.g. obesity, mental health). This encompasses information on success rates for common illnesses and conditions, including treatment prescribed, the length of time before results are manifested, and related costs.
  - *Treatment results.*
  - *Comparisons of treatments in terms of effectiveness.*
  - *How many people got better. How long it took. How much it cost.*
  - *The number of successful surgeries. The number of good diagnoses.*
- Tracking quality-of-life indicators, including changes in life expectancy, mortality rates, obesity levels, mental health, nutrition, fitness levels, etc. This would also include monitoring trends in smoking, such overall number and by age group (and use the information to determine the impact of government campaigns to stop smoking).
  - *Health statistics of all kinds.*
  - *Quality of life measures.*
  - *Activity levels of children.*
- Hospital comparisons in terms of treatment, equipment, quality of care, cost-effectiveness, waiting times, and cleanliness.
  - *The upkeep of equipment.*
  - *Hospital performance vs. others.*

- ❑ Information about the effectiveness of old vs. new antibiotics and brand name vs. generic medications.
- ❑ Costs of the health care system, including per capita spending, the costs associated with physician visits and various treatments or health care services, and to what extent costs are increasing.
- ❑ Assessments of the impact of 'private systems' on health care outcomes, including a cost and effectiveness comparison of public and private health care delivery.
- ❑ Number of surgeries performed in Canadian hospitals.
- ❑ Performance ratings of physicians.
- ❑ Length of stays in hospitals.
- ❑ Information about health cards to remind Canadians what services are covered under the health care system.
- ❑ Explanation of mistakes made in health care delivery and steps being taken to prevent recurrence.

Health Care Services Delivery

The following information was seen to be useful to help people better understand how health care services are being delivered in Canada:

- ❑ Financial information about how and where tax dollars are spent on health care service delivery, including per capita costs and provincial comparisons.
- ❑ A map or directory of the health care services available (similar to what was identified under "informed health choices"), including who is responsible for what, and who pays to deliver them to Canadians. This includes information about which services are covered under basic provincial insurance plans (e.g. OHIP, BCMSP) and which ones patients must pay for in lieu of additional private insurance coverage.
    - – *A map of the services available and who pays for them.*
    - – *Who's responsible for what?*
- ❑ Statistics about the number and distribution of health care professionals (e.g. physicians, specialists, nurses, technicians).
- ❑ Physician-related information, including the number that:
    - are scheduled for each hospital shift.
    - work at local medical clinics.
    - are available for house calls.
    - are accepting new patients.
    - specialize in the different fields.

  Also mentioned was the number of Canadians without a family physician, the use of family doctors vs. medical clinics, and the brain drain.
- ❑ Hospital information by region or province, including performance ratings, facility physical conditions, number of beds, and bed closures.
    - – *Rating hospitals, conditions.*

- Emergency and non-emergency waiting times for health care services (i.e. wait times in many areas – see a doctor, have a physical, have different surgeries, see a specialist, etc.).
- Information about the use of alternative health services, including herbal drugs, non-traditional treatments, etc.
- Information about emergency services and whether they are adequate to meet the demands placed on them.
- Information about paramedic (including cost effectiveness) and ambulance services available to Canadians.
- Number of overtime hours worked by health care workers (individual and overall numbers).
- Information about health care professionals' salaries and scope of work.
- Information on health care issues as they relate to Aboriginal Canadians.
- Information about whether our present services will be available for the ageing population.

Identify & Share Best Practices

The following information was seen to be useful to help governments identify and share best practices, to contribute to continuous service improvement in health care services in Canada:

- Consultations with hospitals, such as regular round table meetings, to facilitate the sharing of best-practice-type information.
- Surveys (e.g. online, comment cards) to obtain feedback from patients and health care professionals.
- Set industry standards and uniform reporting formats.
- Track Canadian successes to replicate through the establishment of a set of standards. Conversely, review failures to avoid recurrences.
- Track statistical trends (e.g. employment, brain-drain).
- Comparisons with health care systems in other countries to identify best practices to employ in Canada.
- Mortality and recovery rates for diseases.
- Information/research on the link between poverty and nutrition.
- Capital investment in equipment (e.g. MRIs), including a review of its distribution across Canada.
- Conduct legal and ethical analyses of health care practices.
- Comparisons of health care information/data by province and rural-urban location.

It is important to note that participants often tended to express requirements mostly at a regional, and even community, level. For instance, when expressing needs for directories of physicians or health care services, hospital comparisons, physician-related information, etc., they often wanted this information at a geographic level that would be useful to them personally.

Performance Indicators

The federal and provincial governments have identified three main areas where different performance indicators should be provided (i.e. areas in which performance could be assessed and monitored). The areas are health status, health outcomes, and quality of service.

This section presents participants' suggestions regarding the specific measures or performance indicators that should be included in each of the three areas. Not surprisingly, the feedback received from participants in one area tended to overlap with items identified with respect to other areas.

Health Status

Participants were asked to identify what specific measures or performance indicators should be included in the area of health status. Health status refers to the actual status of the health of Canadians, including different subgroups of the population. A large number of performance indicators were identified:

- Number/type of doctor visits.
  - Both overall and per Canadian.
  - Levels of satisfaction with doctor visits.
  - Number/types of physician referrals.
- Number/type of hospital and clinic visits.
  - Availability of hospital beds.
  - Length of hospital stays.
- Number/type of treatments/procedures:
  - Major surgeries.
  - Medical procedures (e.g. organ transplants).
  - Waiting time for surgeries.
  - Use of natural/alternative medicines versus traditional.
- Incidence rates for illnesses/diseases, including mental health (e.g. depression levels, stress) and disabilities (by type of disability).
  - Obesity, eating disorder, anorexia rates.
  - STDs.
  - Major diseases (e.g. West Nile virus).
  - Heart attack rates.
  - Suicide rates.
  - Illnesses affecting children.
  - Mortality rates for diseases/infants.
  - Diabetes among Aboriginal Canadians.
  - Accident rates.
  - Rate of allergies.
  - Rates of addictions (e.g. alcoholism, smoking).
- Level of prescription drug use.
- Average life expectancy.

  - Birth rates.
- Demographic profiles of Canadians using the health care system and affected by different diseases/illnesses.
  - Urban-rural differences.
  - Gender differences.
  - Inter-provincial comparisons.
  - International comparisons.
- Lifestyle, fitness levels, nutritional habits.
- Poverty levels; standards of living.
- Literacy levels.
- The impact of environmental factors on health (e.g. air quality, water quality, power lines).
- Age groups susceptible to specific illnesses/diseases.
- Blood bank donations.
- Level of use of 'safe sex'.
- Self-reporting of Canadians' personal state of health.
- Impact of food additives/preservatives.

Health Outcomes

Participants were asked to identify the specific measures or performance indicators that should be included in the area of outcomes of the health care system in Canada. Suggestions included:

- Effectiveness of generic versus brand name medications.
- Flu shots versus incidence of the flu (e.g. were people who received flu shots less likely to come down with the flu?).
- Treatments for diseases/conditions.
  - Success rates for new diagnoses/treatments.
  - Use of homeopathic remedies.
  - Number/type of transplants.
  - Number/type of prostheses used.
  - Tracking the outcome of preventive measures.
- Incidence rates for illnesses/diseases.
  - Rates of obesity.
  - Work-related stress levels. Health issues resulting from stress.
  - Hereditary diseases.
  - Smoking trends.
  - Industrial accidents.
- Use of prescription drugs.
- EMS response times.
  - Impact of paramedics on outcomes.
- Number/type of doctor and hospital errors.
- Number of sick days used by employees.
- Number of repeat doctor visits.

- Number/type of medical claims (e.g. insurance, EI claims).
- Patient satisfaction.
- Mortality rates.
- Incidence of family breakdown due to illness.
- Volume/type of medical research being conducted.
- Comparisons with the past, other provinces, and other countries.

Quality of Service

Finally, participants were asked to identify specific measures or performance indicators that should be included in the area of quality of service. Suggestions for specific performance indicators included:

- Average waiting times for doctor/specialist appointments, different surgeries and other medical procedures.
    - Availability of hospital beds/rooms.
- Supply of health care providers.
    - Distribution of family physicians/specialists.
    - Ratio of health care providers to patients.
    - Ratio of doctors to specialists.
    - Number of Canadians with/without family physicians.
    - Number of referrals to specialists.
    - Number of nurses/doctors by ward.
    - Number of hours worked by health care workers.
- Patient and health care workers' satisfaction.
    - Level of attrition for health care workers.
    - Level of compassionate care (e.g. bedside manner).
    - Overall quality of doctors (i.e. training, cultural sensitivity).
    - Number/type of malpractice claims.
    - Average time spent per patient per visit.
- Number/type/quality of hospitals and clinics.
    - Distribution and location of facilities.
    - Number of return visits to hospitals.
    - Quality control measures in place.
    - Quality/availability of pre-natal care.
    - Hospital reputation.
    - Length of hospital stay following surgery.
    - Recovery times from operations.
- Number/type of medical equipment.
    - Degree to which equipment is modern/up-to-date.
    - Distribution of equipment/accessibility.
- Use and cost of homecare versus hospitalization.
    - Cost/availability/quality of home care vs. hospitalization.
    - Use of preventative care.

- Length of illnesses.
- Comparative information – international, provincial, municipal, and by different demographic groups (e.g. Aboriginal Canadians, seniors).

In both the Montreal and Halifax focus groups, participants with high school education found it much more difficult than those with higher levels of education to identify performance indicators that should be included in such a report.

Review of Federal Report on Health Indicators

This section explores participant reaction to an extract from *Healthy Canadians: A Federal Report on Comparable Health Indicators 2002*. This report was publicly released on September 30th by Health Canada on behalf of the federal government.

Participants were told that this is the first report of its kind, that it provides a series of health indicators in the areas of health status, health outcomes, and quality of service, and that it will be published every two years. The report extract was handed out to participants (appended), who read the document on their own.

Large Majority Reacted Positively to Report Extract

Most participants had a positive overall impression of the report extract. That said, perceptions tended to be moderately, not strongly positive. Reasons offered by participants for their favourable reaction were relatively consistent across the groups, and related to the presentation, tone and content of the report. These people tended to view the document as interesting, easy to understand, easy to review, and containing useful information. In describing the report, participants routinely offered descriptors like “excellent”, “clear”, “simple”, and “informative”.

The relatively small number of participants who did not react positively to the report extract, fewer than one in four, pointed to their perceptions that the report contained too much information (information overload), that the information tended to be too general in nature or lacked personal relevance, and that there were important things missing from the report.

In terms of sub-group differences, participants with a high school education in the Montreal and Halifax groups expressed greater interest in the document than their counterparts with a post-secondary education. Their attitude toward the report was more positive and they admitted that, while they would not have read the report outside the focus group, they enjoyed reading it and learning about the state of health care. Elsewhere, subgroup or regional differences were minimal.

The following are offered as representative comments of participants’ overall reaction to the report extract:

- *Interesting. Easy to understand. Clear.*
- *Good layout. Report is clear and to the point.*
- *As much as we’re not trying to do worldwide comparison, we are. It’s a yardstick. I think it’s appropriate.*
- *My overall impression is that it’s alright. Comparing us to the rest of the world is good.*
- *It was very informative.*
- *I didn’t really like it. I thought there was too much information here. I would never read it.*
- *People just don’t want statistics. It has to be more comprehensive.*

- *Aboriginal people would rather have specific information relating to their health care in a province than across Canada.*

Best Liked Aspects of Report – Clarity, Ease of Use, Graphs, Content

In terms of what participants liked most about the information, including how it was presented, people routinely pointed to a number of design and content elements, most of which were mentioned with consistency across the groups.

The report was seen to be easy to read and understand. The language used was generally described as being clear and straightforward. Participants routinely identified the graphs as being useful, clear and easy to understand (although this was not the case for all graphs – see below). The layout of the report was said to make it easy to scan the document for information of interest or relevance. The use of three categories to organize the health performance indicators makes the information easier to follow and digest, while the use of bullets, white space and columns contribute to the clarity and accessibility of the information.

In short, the layout and design of the report, as well as the writing style and graphs used to present the information, were very well received by most people.

Also singled out for positive comment was:

- The statistical comparisons with other industrialized countries. These were valued because they offer context for the interpretation of the data.
- The statistical breakdowns by gender provided for performance indicators.
- The identification of trends, evident through tracking data.
- The conciseness or brevity of the information presented (*Quick information in many areas. It's not belaboured).*
- The highlights section (pages 2-3), seen to provide a useful summary or "snap-shot" of the information for those not inclined to read the full report.
- The clear identification of the sources of the information and statistics presented in the report.
- The definitions provided for terminology (without the explanations, some may not have read any further).
- The colour scheme, aesthetically appealing to many people.
- The opportunity for learning new things.
- The inclusion of a significant volume of important information, which was widely (if not unanimously) seen to be accurate and comprehensive.
- Interpretative and explanatory language, wherever this appears.

Least Liked Aspects of Report – Lack of Explanations & Interpretation

In terms of what they liked least about the information and its presentation, participants identified a number of shortcomings. That said, one concern stood out vis-à-vis all others, and was articulated with consistency across the groups – the need for more explanation and interpretation of the information. Many people felt that there were too many statistics without adequate explanation/discussion of their implications (i.e. no interpretation). As a result, the statistics tended to blend together without meaning or definition for readers. This prompted calls for the addition of interpretative language in subsequent versions of the report to provide greater meaning and context to the information. Participants appeared to be most interested in the interpretation of trends, explanations of causes and effects, and information that they could personally act on (e.g. identification of alternative treatments). Representative comments in this area included:

- *I don't feel like this is finished. All the information is here, but there is no analysis or interpretation.*
- *There are too many statistics.*
- *They don't give you explanations, just data.*
- *The text all starts to meld together.*
- *They don't tell you what we are doing right or wrong.*

Some participants felt that the information presented in the report is not new, that they had heard it before. As such, the report offered less value to them. As well, since no provincial data is available through the report, some felt that it was too general in nature – they were interested in data that is regionally relevant. Some people also felt that the report is "too positive", and therefore propaganda-like. The overall picture that emerges from the data is very positive, and, for some, this contributes to a sense of suspicion and doubt vis-à-vis the data.

Other aspects of the report that were singled out for negative feedback included:

- A few participants found the first paragraph (page 1) to be difficult to read. This section sets out background information and the purpose of the report.
- Many disliked the fact that the report does not contain financial information or breakdowns of expenditures in relation to health care (recall that fiscal accountability was the most important reason why this type of reporting was seen to be valuable).
- Line graphs lack clarity. While many liked the use of graphs to display the statistics, some did not like the line graphs because they found them to be hard to understand (this feedback was offered in many of the groups).
- Some questioned the choice of health performance indicators, and wanted to know why these were chosen for inclusion in the report (and why others were not).
- Some felt that information about the health of Aboriginal Canadians was over-emphasized in the report. This was seen to get in the way of a review of the other information in the report.
- The use of blue throughout the report. While some cited this as something they liked about the report, others did not like the colour scheme.
- A few people questioned the reliability or accuracy of some of the statistics presented in the report (some linked this to the high sampling variability).
- The overall presentation of the information was described as "drab" and "repetitive" by a few participants.
- The small font size, viewed as a negative aspect by a few participants.

- The lack of direct reference to or emphasis on accountability (*No accountability, just statistics).*

One Third View Content as Useful to Them

When asked to focus specifically on the content of the document, and how useful it is to them, slightly over one-third of the participants viewed it as useful. While this type of report and its content were judged to be important by most people (as noted), clearly this does not automatically translate into the content being useful to them. In short, most participants attributed importance to this type of information, but did not perceive it to be personally useful to them.

In terms of why the content was useful to some people, these participants tended to point to its educational function, viewing the report as offering valuable health-related information. People valued the opportunity it provided them for new learning and self-education. A few also said they might use this information with others (e.g. within their Aboriginal communities, when working with parolees, or in discussions with friends).

Participants who did not find the content of the document to be useful cited its lack of personal relevance and lack of analysis, including information that could be acted on. While the report offers myriad statistics, it does not explain the implications or relevance of them. In this way, these people did not see the report as having a direct impact on the state of health among Canadians. The statistical content may have been of interest to them, but it offered no practical suggestions to help them make informed choices about their own health or health care needs. A few people, in fact, found themselves unclear about the purpose of the report after reading the extract.

The following suggestions were offered by participants to increase the value or usefulness of the content (presented in approximate order of the frequency of their expression):

- Provide explanations and interpretations of the statistics, including why indicators are increasing/decreasing. Along with the explanations, include guidance on how Canadians can use the information to improve their own health (i.e. "what does this mean for me"?). A few people felt that each group of health indicators should end with an interpretation/conclusions section (*More information on causes, effects and remedies).*
- Include "practical information" that people can act on, such as information about the causes of diseases/illnesses/conditions, treatment alternatives, preventative measures that can be taken, and information on how to use the statistics in the report (e.g. lessons learned). For some, this meant including information to help people access the health care system in different regions of the country (e.g. directory-type information informing people about what services are available from whom, etc.).

- Add financial information, including current and future spending on health care and detailed breakdowns of costs and other related financial information.
- Remove the First Nations' statistics from the main report and include this information in a separate appendix. While it was explained to participants that Aboriginal Canadians are highlighted in the report because the federal government has a special responsibility in terms of health care delivery on reserves, many people did not feel that the state of health of this group should be singled out in this national report. Most felt more comfortable including the statistics on Aboriginal Canadians as a separate section of the report or as part of its appendix. It is noteworthy that this suggestion was offered by participants in both the Aboriginal and non-Aboriginal focus groups, albeit for different reasons. The former wanted a clearer focus on Aboriginal health issues, instead of having to sift through the main Canada-wide report to identify information of relevance, while the latter did not want to have to have to keep encountering Aboriginal statistics when trying to get an overview of Canada's health care system as a whole. Similar feedback was received (although less of it) with respect to content related to other groups that are the direct responsibility of the federal government (e.g. the military, RCMP). Additional suggestions related to the Aboriginal information included:
    - Add comparisons with aboriginal populations in other countries.
    - Clarify that the statistics are only for Aboriginal Canadians living on reserves.
    - Ensure that the content is balanced. There was a sense among a few Aboriginal participants that the statistics included in the report were biased toward the positive.
    - Take efforts to ensure the quality of the data for Aboriginal peoples living on reserves (some doubted the accuracy of some of the statistics).
    - Include statistics for off-reserve Aboriginal Canadians.
    - Include separate data for the Inuit population.
- Add an introduction at the beginning of the report that clearly explains the three areas where performance indicators are provided, the types of indicators included, and the overall purpose of the report. A related suggestion is including an explanation about why each health indicator was selected for inclusion in the report.
- Add more demographic breakdowns (e.g. age, sex, region) for the health indicators. A related suggestion is providing separate sections on issues specific to children, adolescents, and seniors.
- Include other health performance indicators (see suggestions in this area below). This includes expanding the content in the *Quality of Service* section, seen by a few participants to be quite "thin". The same was said

of the *Improved Quality of Life* health performance indicator (#6), which now focuses only on knee replacements.

- Provide more international comparisons and explanations about their implications. A few participants felt that the selection of developed countries that were included in the report was arbitrary. Some wanted information about what other countries are doing right (so we could learn from them).
- Have one over-arching report. Some people would have liked to be able to compare provinces, and so would prefer to see one report encompassing all jurisdictions in Canada.
- Direct readers on where they could go to obtain further information in these areas.

Also identified by one or two participants were the following:

- Highlight successes and best practices in each report.
- Provide more detailed references for the statistics (i.e. source information) in order to increase confidence in their validity.
- Include comparisons with past reports, especially the tracking of areas that need improvement. A related suggestion is to provide an action plan to initiate improvements where needed (e.g. "Next Steps"). A few felt that the areas for improvement could become the framework for the next report.
- More extrapolations or projections based on the data.

Information is Clear & Easy to Understand, Few Areas of Confusion

The vast majority of participants found the information contained in the report to be clear and easy to understand. It was routinely described as being concise, straightforward, and easy to follow.

Notwithstanding the positive feedback in this area, participants did identify a few areas of potential confusion with the document. These included:

- The introductory paragraph on page 1. Some people found this hard to understand, and had to reread it a few times to try to get it clear in their minds.
- "Unintentional injuries"(page 22). This concept, and its purpose or value eluded a few people, as did the concept of "potential years of life lost" (page 22 also).
- Some of the graphs, particularly the line graphs. Some people were confused about the break in the line graph on page 13 related to First Nations infant mortality rates.

- ☐ Some of the medical terminology, such as "incipient disease" and "age-standardized mortality rates" (page 17, 19). A related suggestion was to move the definition of the latter to the start of the discussion on this issue.
- ☐ The "KKD" concept (page 35). This was seen to be confusing, as well as providing an incomplete and potentially inaccurate portrait of physical activity levels.
- ☐ "Non-emergency surgeries" (page 25). Examples were seen to be needed to provide a clearer sense of what this refers to.

Indicators Seen to be Appropriate, More Suggested for Inclusion

There was a strong consensus among participants that the set of health indicators in each of the three areas were appropriate for inclusion in this kind of report. A few people noted that the indicators contained in the report incorporated many of the measures that they, as a group, had previously identified when asked to reflect on what performance indicators should be included in each of the three areas.

In addition to the set of current indicators, participants identified a number of other performance indicators that should be considered for inclusion in this type of report. Organized by performance area, these included:

- ☐ Health Status.
  - Mental health issues (e.g. depression, schizophrenia, suicide).
  - Alcoholism issues.
  - Sexual abuse.
  - Disabilities.
  - Use of homeopathic medicine.
  - Cultural and/or racial breakdowns for diseases, including why some groups are more prone to certain diseases/conditions, and what can be done about it.
  - Socio-economic factors, and the impact of these on health.
  - Number of physician visits per year.
  - Use of prescription drugs (i.e. increase versus decrease).
  - Incidence of Canadians reporting having family physicians.
- ☐ Health Outcomes.
  - Government spending on health care over time.
  - Differences between old and new medications in terms of cost and effectiveness.
  - Health impacts and costs (e.g. health care cost differences between smokers versus non-smokers).
  - In the "improved quality of life" section, adding heart by-passes, use of heart pacers, wheelchairs, disability aids, and artificial limbs (and anything else that "helps people get back on their feet"), mental health and palliative care.

- ☐ Quality of Service.
    - Emergency services wait times (e.g. ER ward, ambulances, paramedics, other).
    - Availability of family physicians.
    - Number of health practitioners per region.
    - Hospital transfers due to lack of facilities, equipment, etc.
    - Caregiver perspective or practitioner satisfaction (i.e. nurses, doctors, etc.).

Presentation Effective for Conveying Health Care Information

Participants were asked to reflect on the presentation of the information, including the layout, graphics and other design elements used in the report. As has been noted, most participants reacted positively to the overall style of the report, the quality and choice of graphs, and the layout of information. The report design worked well for most people, with its presentation elements often describe as "good" or "excellent"

Despite the widespread positive reaction to the layout and design of the report, participants offered a range of suggestions to improve its presentation:

- ☐ Use more colour throughout the report. There were frequent calls for the use of more colour to make the report more visually interesting and to more clearly set off some of the information. Related ideas included:
    - ○ Colour coding the three sets of performance indicators (to better set them apart from one another).
    - ○ Introducing another colour for the graphs to improve clarity (the different shades of blue – light blue background, dark blue lines and bars – do not highlight the data very well).
- ☐ Use more prominent titles (e.g. larger font size, capital letters) to better delineate the three sections of the report (i.e. types of indicators). Full title pages for each section were also suggested for this purpose, as was the provision of tabs to enable flipping through information/sections quickly.
- ☐ Provide an index page and/or a table of contents.
- ☐ Improve the introductory paragraph on page 1. As noted, some found this hard to understand. One suggestion was to ensure that readers understand that this report is provided by the Government of Canada, and that separate reports have been provided by the provinces. It was also felt that the introduction needs more context setting, such as explaining who the report is for, how to use it, etc.
- ☐ Change *Executive Summary* to *Overview*. English-speaking participants felt that the current title was not user-friendly and that it would deter people from reading the report. It was described as "too business-like", "old-fashioned", and "hierarchical". No such comments were made in French about the title "*Sommaire*". That said, it should be noted that, in

both languages, the *Highlights* ("*Points saillants*") were very much liked by participants. Some even said that this was all that they would like to see in terms of a report to Canadians, in a brochure or in the written media.

- ☐ Replace line graphs with bar graphs wherever possible because the latter were seen to be easier for people to understand. Also, consider adding pie graphs for more variety.
- ☐ Include graphics or pictures of people engaged in fitness activities to make the report more personal and engaging (however, if this increases the cost of producing this report, some participants rejected the suggestion).
- ☐ Increase the font size. Numerous people commented on the need for the font size to be bigger, particularly in light of our aging population.
- ☐ Highlight important facts (e.g. underline, bold, etc.). While this is now done to a limited extent, there was a desire for more highlighting.
- ☐ Increase the size of some of the smaller graphs.
- ☐ Provide more cross-referencing or indexing.
- ☐ Centre-justify the text.
- ☐ Print on recycled paper.
- ☐ Invite suggestions for improvements to future reports in each version of the report (e.g. an address or email address on the last page inviting feedback/suggestions).
- ☐ Include a website link for Canadians who want more information. Right now, no links are available for accessing more information about the report. This was seen to be important for those who want more detailed information about specific aspects of the report.

Generally Positive Reaction to Report Cover

The full version of the report was handed out to participants who were then asked what they thought about the front cover and whether it encouraged them to pick up the report and read it. Overall, participants' reaction to the cover was mostly positive across the various focus groups. A few described it as "eye catching", and some said they would be motivated to pick up the report and read it after seeing the cover. That said, some people were less favourable in their assessments, viewing the cover as uninteresting, potentially misleading (see below), and designed "for older people" (volunteered by a younger participant). Others were simply indifferent to the report cover, feeling that it is not important, and that the information inside is what counts.

While the cover of the report appears to work for most participants, a number of suggestions for improvement were offered. Mentioned most often was the title of the report. Concern over the title was two-fold. When the picture of two people cycling and part of the title *Healthy Canadians* are considered together, many people were lead to believe that the report was about fitness. Others felt that using a statement of finding as the title (i.e. "healthy Canadians") undermined the ability of Canadians to come to their own conclusions about the state of health care in Canada and the health of Canadians. It was suggested that the title be changed to *A Health Report on Canadians* or something similar.

In terms of presentation, a few people said they would prefer a more traditional red and white colour scheme, while others would like to see different graphics used on the report cover. The white maple leaf was singled out by some participants as an element they did not like, and the image of cyclists mislead others about the content of the report. Some would have liked more pictures added to the cover.

Participants in the Aboriginal focus groups felt that the report cover should incorporate graphics that reflect the multiculturalism of Canada. They suggested including symbols of Aboriginal Canadians, Métis, Inuit, and other ethnic groups.

Interest & Usage of Report

This section explores participants' interest in and potential use of the report, including whether they would have read the report (on their own) and the extent to which the information/contents addresses some of the report's objectives.

Most Would Scan Report, No One Would Read in Full

Virtually none of the participants would have read the report in its entirety if they had seen it when it came out. However, a strong majority think they would have read it in part, scanning the sections for information of personal relevance or interest. It appears that people would have been equally likely to review the report whether it came to them in the mail or they saw it in a waiting room (i.e. family doctor, hospital, etc.).

Reasons offered for why they would read the report, whether in whole or in part, included satisfying curiosity, obtaining useful information, and gathering a sense of the health status of Canadians and the services available to them.

Mixed View on Usefulness of Report in Meeting Objectives

Participants were asked to consider whether the information contained in the report would do a number of things (in relation to the report's objectives). This includes whether the information would…

1. …help them make more <u>informed choices</u> in terms of their own health and and/or that of their family.
2. …increase their level of understanding of the <u>outcomes</u> of our health care services?
3. …help them better understand how health care services are being <u>delivered</u>?
4. … help the governments in Canada to identify and share best practices to contribute to <u>continuous service improvement</u> in health care services in Canada?

Feedback in this area was largely consistent across the focus groups. For two of these items – make more informed choices on own health and better understand the delivery of health care services – the large majority of participants felt that the information in the report would <u>not</u> help them. There were relatively few exceptions to this.

Assessments of the usefulness of the information in the two other areas – better understanding outcomes and helping governments in continuous service improvement – were more positive, although somewhat mixed. For the former – understanding outcomes – many participants felt that the information was likely to be moderately useful ("slightly", "a bit", "in a general way", "to some extent"). In terms of helping governments contribute to service improvement, many people also felt the information might be useful "depending on who reads it and acts on it", at least when all the reports are pulled together (provincial, territorial and federal) and when looked at over time.

Appendices

Recruitment Screener

Profile Characteristics

- 10 focus groups: 2 in each of Halifax, Montreal (French), Toronto, Winnipeg and Vancouver.
- Participants to be recruited from 3 groups:
  - Canadians with high school education. People with more than a high school diploma (e.g. any post-secondary education) or less than a high school diploma are not eligible for participation in this group.
  - Canadians with post-secondary education. This includes people who have graduated from college or university (not CEGEP in Quebec). Recruit a mix of participants from college and university, as well as by the type and number of diplomas/degrees. This group does not include people who have some post-secondary education, but who have not obtained a degree or diploma.
  - Aboriginal Canadians (mix of education levels). These groups will be conducted in Winnipeg.
- Recruit 12 participants for 8-10 to show per group.
- Participants will be paid incentives of $60.
- Sponsorship of study will be revealed (i.e. Health Canada).

Distribution of Groups:

City	**Vancouver**	**Winnipeg**	**Toronto**	**Montreal**	**Halifax**
Date	January 7	January 8	January 9	January 8	January 9
Language	English	English	English	French	English
Target Audience					
5:30 p.m.	Post-secondary Education	Aboriginal Canadians	High school Education	Post-secondary Education	High school Education
8:00 p.m.	High school Education	Aboriginal Canadians	Post-secondary Education	High school Education	Post-secondary Education

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NOTES TO RECRUITERS:

IF AT ANY TIME DURING THE INTERVIEW YOU REALIZE THAT THE PERSON IS DIFFICULT TO UNDERSTAND OR DOES NOT UNDERSTAND THE QUESTIONS ASKED, PLEASE DO NOT INVITE. THANK AND TERMINATE. WE WANT PARTICIPANTS WHO ARE FULLY ABLE TO TAKE PART IN THE DISCUSSION.

IF A PERSON REFUSES TO ANSWER ANY OF THE DEMOGRAPHIC QUESTIONS, EXPLAIN THAT IT IS ONE OF THE STUDY'S REQUIREMENTS THAT THE GROUPS REPRESENT A GOOD MIX OF PEOPLE. EXPLAIN ALSO THAT THEIR NAMES WILL NOT BE GIVEN WITH THIS INFORMATION WHEN PROVIDED TO THE CLIENT. IF THEY STILL REFUSE, REASSURE THEM THAT IT IS THEIR RIGHT TO REFUSE, THANK THEM FOR THEIR TIME AND TERMINATE THE INTERVIEW.

DISCONTINUATION GUIDELINES:

DO NOT END THE INTERVIEW TOO ABRUPTLY WHEN YOU REALIZE THAT A PERSON DOES NOT QUALIFY, AS WE HAVE FOUND IN THE PAST THAT SOME PEOPLE THINK THAT THEY ARE BEING DISCRIMINATED AGAINST. MAKE SURE THAT YOU HAVE ASKED AT LEAST SOME OF THE DEMOGRAPHIC QUESTIONS, THEN SAY SOMETHING LIKE THIS:

"At this point in our recruiting task, we already have enough participants who have a profile similar to yours. Therefore it does not look like we will be able to invite you this time around. However, do you mind if I keep your name on our reserve list in case someone cancels and we need to replace them?"

IF RESPONDENT QUESTIONS THE VALIDITY OF THE RESEARCH:

- ☐ OFFER TO SEND BACKGROUND LETTER (HEALTH CANADA LETTERHEAD) THAT EXPLAINS THE PURPOSE/NATURE OF THE STUDY, EITHER BY FAX OR EMAIL.
- ☐ INVITE THEM TO CALL LISE DESSAINT OF HEALTH CANADA AT 613-954-5353 OR ASK LISE TO GIVE THEM A CALL.

Recruitment Screener

Hello, my name is _______. I'm calling on behalf of COMPAS, a public opinion research firm. We've been commissioned by Health Canada, a department of the Government of Canada, to conduct a series of discussion groups with Canadians on issues related to health care in Canada.

The discussion group will last two hours. Light refreshments will be served. Participation is voluntary, and people's comments will be treated in confidence. May I ask you a few questions to see whether you qualify for the discussion group?

☐ Yes (CONTINUE)
☐ Yes, but later (RESCHEDULE) ______________________________
☐ No (THANK/DISCONTINUE)

[IF ASKED, CONFIRM THAT THERE WILL BE A CASH INCENTIVE, THE VALUE OF WHICH WILL BE REVEALED IF THE INDIVIDUAL QUALIFIES.]

1) Do you, or does any member of your household or immediate family, work in any of the following fields? (READ LIST)

☐ Public relations
☐ Advertising or Marketing
☐ Marketing Research
☐ The media (Radio, Television, Newspapers, Magazines, etc.)
☐ Federal or Provincial Ministry of Health
☐ Health care (e.g. doctor, nurse)
☐ Health care associations/advocacy groups

[If any category is checked, ask a few more questions then thank and discontinue.]

2) What is the highest level of education you have completed? (READ LIST IF NECESSARY; WATCH QUOTAS)

☐ Some high school	(THANK/DISCONTINUE)
☐ Graduated high school	(GO TO Q5 OR 6)
☐ Some college/CEGEP/technical	(THANK/DISCONTINUE)
☐ Graduated CEGEP/technical	(THANK/DISCONTINUE)
☐ Graduated college	(GO TO Q4)
☐ Some university	(THANK/DISCONTINUE)
☐ Graduated university	(GO TO Q3)

3) What type of degree did you obtain? (READ LIST IF NECESSARY; WANT MIX)

- ☐ University certificate/diploma below bachelor level
- ☐ Bachelor's degree (BA/BSc)
- ☐ Master's degree (MA/MSc)
- ☐ Doctorate (Ph.D.)
- ☐ Professional degree (e.g. dentistry, veterinary medicine, etc.)

4) What was your field of study? (WANT GOOD MIX)

____

IN WINNIPEG ASK:

5) Are you an Aboriginal Canadian?

- ☐ Yes
- ☐ No (THANK/DISCONTINUE)

6) Please tell me which of the following age groups you fall into... (READ LIST; WANT GOOD MIX)

- ☐ Under 18 (THANK/DISCONTINUE)
- ☐ 18 to 29
- ☐ 30 to 39
- ☐ 40 to 49
- ☐ 50 to 59
- ☐ 60 to 69
- ☐ 70 and over (THANK/DISCONTINUE)

7) Have you ever attended a discussion group or in-depth interview which was arranged in advance and for which you received payment?

- ☐ Yes
- ☐ No (GO TO END)

8) Have you attended a discussion group or in-depth interview on a heath-related topic in the last two years?

- ☐ Yes (THANK/DISCONTINUE)
- ☐ No

9) When did you last attend a discussion group or in-depth interview for which you received payment?

☐ Within last 6 months (THANK/DISCONTINUE)
☐ More than 6 months ago, but less than 5 years
☐ More than 5 years ago

10) Have you attended more than five discussion groups or paid interviews in your life- time?

☐ Yes (IF LAST ONE WAS LESS THAN 5 YEARS AGO AT PREVIOUS QUESTION, THANK/DISCONTINUE)
☐ No

RECORD GENDER BY OBSERVATION

☐ Female
☐ Male

Invitation:

The discussion group will take place on __________(DAY OF WEEK), January (DATE), at ____________(TIME), at _____________ (LOCATION). It will last two hours. People who attend will receive a cash payment of $60 for their time, and refreshments will be served. Would you be willing to attend?

☐ Yes
☐ No (THANK/DISCONTINUE)

There will be about 8 to 10 people taking part in this discussion group. We ask you to arrive 10-15 minutes before the start time. People who arrive late will not be able to participate and will be asked to leave. We can only pay people who participate for the whole two hours. If you use glasses to read, please remember to bring them with you, as there is often material to read or look at. When you arrive, please tell people that you are there for a focus group.

There will be an audio recording of the session. We need people who feel comfortable expressing their opinion in a group setting. Do you feel comfortable with this, and is this something to which you feel you can fully contribute?

☐ Yes
☐ No (THANK/DISCONTINUE)

[IF ASKED, EXPLAIN THAT THE AUDIO TAPES ARE TO HELP WRITE THE REPORT. THE AUDIO TAPES MIGHT ALSO BE MADE AVAILABLE TO THE CLIENT. HOWEVER, WE WILL ONLY USE FIRST NAMES DURING THE DISCUSSION, AND THE CLIENT WILL NOT BE GIVEN ANY FAMILY NAMES OR PHONE NUMBERS.]

Thank you very much. If you have a pen handy, I will give you the address where the discussion group will be held. [Give the address and directions.] I would like to remind you that the group is at (TIME) on January (DATE).

As we are only inviting a small number of people to attend, your participation is very important to us. If for some reason you are unable to attend, please call so that we can get someone to replace you. Please do not send someone else in your place. They will not be accepted. You can reach us at _______ at our office. Please ask for _______. Someone will call you the day before to remind you about the session.

CONFIRM USUAL INFORMATION AND THANK PARTICIPANT

Moderator's Guide

Welcome and Introduction (5 mins)

Intro + warm-up

- Introduce moderator/COMPAS

- Thank for attending, value your being here today

- Explain purpose of focus group discussions:
  - gauge *opinions* about issues/products/services
  - okay to disagree; no right or wrong answers
  - interested in attitudes not knowledge

- Research is being conducted for Health Canada, a department of the Government of Canada, to explore issues related to the health of Canadians and health care in Canada.

- Looking for candour and honesty; comments treated in confidence; reporting in aggregate form only where no individuals are identified; taping for record keeping purposes; observers behind one-way glass; no one in department will know who you are; no services or benefits you may receive from the department will be affected in any way.

- Any questions?

Roundtable Introduction:

Please introduce yourself by telling us your first name and one of your favourite interests or hobbies.

Awareness & Importance of Performance Indicators (10 mins)

(4) 1a→d (1a) Have any of you heard or read anything about the Government of Canada and the provinces developing reports to provide clear accountability and reporting to Canadians on the health of Canadians and the state of health care in Canada? (HAND COUNT)

ASK THOSE WHO CLAIM AWARENESS:

1b For those of you who have heard or read something about this, what do you recall hearing or reading about? Anything else? 1c

So far as you can tell, has this type of report already been created, or is one still being developed? 1d

(6) 2a→f How important do you think it is for the federal and provincial governments to develop reports to provide clear accountability and reporting to Canadians on the health of Canadians and the state of health care in Canada? 2a Why do you say that? 2b What makes it important/not important? 2c

Probe: - degree of importance — 2e
- reasons why important/not important – 2f

(2) 3ab How interested are you personally in this type of information? 3a Why/why not? 3b.

Potential Content, Presentation & Distribution of Indicators (20 mins)

transition I'd like to turn briefly to the potential content and presentation style of this type of information.

(3) 4a→c In your opinion, what are the types of things that should be included in a report for Canadians that is intended to provide clear accountability and reporting on the health of Canadians and the state of health care in Canada? Please assume that this type of report would be published every two years. (USE FLIP CHART) —4a

Probe: - areas to be assessed (i.e. performance indicators) —4b
- focus on topics/areas, not on ratings in each area —4c

(5) 5a→e How about in terms of the presentation or layout of this type of information? 5a In your view, how should this type of information be presented to Canadians for their information or use? —5b What should it look like? 5c Why? 5d

Probe: - presentation style, design principles/elements –5e

20

6a
How do you think this type of information should be distributed to Canadians?
6ab (2) How would you like to receive this information? 6b

Potential Use of Performance Indicators (20 mins)

7a→d (4) If a report, or set of health performance indicators, along the lines that we have discussed were made available to the public, would you be interested in it? — 7a
Why/why not? What would you want it for? That is, what would you do with this information?
7b 7c 7d

preamble to Q8→11 Again, thinking in terms of a report, or set of health indicators, that would be produced every two years on the health of Canadians and health care in Canada... (ROTATE)

8 What type of information would help <u>you</u> make more <u>informed choices</u> in terms of the health of you and/or your family?

9 What type of information would help increase your level of understanding of the <u>outcomes</u> of our health care services?

10 What type of information would help you better understand how health care services are being <u>delivered</u>?

11 What type of information do you think governments should use to help them identify and share best practices, to contribute to <u>continuous service improvement</u> in health care services in Canada?

Desired Content in Three Performance Areas (20 mins)

Information 12a The federal and provincial governments have identified three main areas where different performance indicators should be provided. By performance indicators, I mean specific areas in which performance could be assessed and monitored. The three areas are – health status, health outcomes and quality of service. I'd like to briefly discuss each one.

ROTATE ORDER. USE FLIP CHART TO RECORD.

Let's start with...

12a
12 ab (2) What specific measures or performance indicators do you think should be included in the area of <u>health status</u>? This refers to the actual status of the health of Canadians, including different subgroups of Canadians. 12b

13a
13ab (2) What specific measures or performance indicators do you think should be included in the area of <u>health outcomes</u>? This refers to the outcomes of the health care system in Canada. 13b

14abcde (5) What specific measures or 14a performance indicators do you think should be included in the area of quality of service? This refers to the quality of 14b service of the health care system in Canada.

IF NECESSARY, GIVE TWO EXAMPLES FOR EACH CATEGORY. DO SO ONLY AFTER PARTICIPANTS HAVE TRIED TO IDENTIFY PERFORMANCE INDICATORS:

- 14c ☐ HEALTH STATUS – LIFE EXPECTANCY, INFANT MORTALITY.
- 14d ☐ HEALTH OUTCOMES – CHANGE IN LIFE EXPECTANCY, QUALITY OF LIFE
- 14e ☐ QUALITY OF SERVICE – WAITING TIMES FOR KEY SERVICES, LEVELS OF PATIENT SATISFACTION.

Review of Federal Report on Health Indicators (50 mins)

Instructions

I'd now like you to take a few minutes to review information that has been drawn from a document entitled, *A Federal Report on Comparable Health Indicators 2002*. This document was publicly released on September 30th by Health Canada on behalf of the Government of Canada. It is the first report of its kind and will be published every two years. It provides a series of health indicators in the three areas that we've just been discussing – health status, health outcomes, and quality of service.

In addition to setting and administering national principles or standards for the health care system, as set out in the Canada Health Act, the Government of Canada provides health care services to such groups as veterans, military personnel, inmates of federal penitentiaries, the RCMP, Aboriginal Canadians living on reserves, and residents of communities in the territories.

Please read the document on your own, in silence. We've set aside 20 minutes for you to read it, which should be enough time. When you've finished reading it, please turn it face down so that I will know that you are finished. Once everyone has finished, or the 20 minutes is up, we'll talk about it as a group.

HAND OUT REPORT EXTRACT. ALLOW 20 MINUTES FOR READING. WHEN PARTICIPANTS HAVE FINISHED, CONTINUE:

Let's talk about what you've just read. Please turn it back over in case you'd like to refer to any part of the document.

15ab (2) What's your overall impression of what you've just 15a read? Why do you 15b say that?

16 What do you like most about the information, including how it's presented?

17 And what do you like least about it?

18abc (3) Focusing specifically on the content of the document, how useful is 18a the content to you? Why/why 18b not? How would you see yourself 18c using this information?

19a→d Was the information clear and easy 19a to understand? If not, why not? 19b Were any 19c parts of it unclear or confusing? If so, which part(s)? 19d

20 ab (4) (2) What about the health indicators themselves... in your view, are they appropriate 20a for inclusion in this kind of report? Why/why not? — 20b

stem for 21 abc

21a I'd like to quickly go through the indicators in each of the three areas. How about the health indicators in the area of... (ROTATE) health status, health outcomes, quality of service?
21a 21b 21c

12 FOR EACH ASK: (3 × 4 Q.)

- ☐ Is this an appropriate set of indicators in this area? 21a¹ 21b¹ 21c¹
- ☐ Are all of them meaningful or useful? If not, which one(s) aren't? 21a² 21b² 21c²
- ☐ Should any other indicators be added? If so, what? 21a³ 21b³ 21c³, 21a⁴, 21b⁴
- ☐ Should any be presented in some other way? 21a⁵, 21b⁵, 21c⁵

I'd now like to turn to the presentation of the information – the overall layout, graphics and other design elements used in presenting this information in the report. What do you think of each of the following...?
stem

22a→c (3) Probe: 22a- overall style
22b- quality and choice of graphics
22c- layout or format

23ab (4) Is the design effective for conveying information about health care? 23a Why/why not? 23b

24 How could the presentation of the information be improved?

25ab (2) Thinking about both the content and presentation of the information, what 25a could be done to make it more useful or valuable to you? Anything else? 25b

26 As I mentioned, this report will come out every two years. Besides what we've already talked about, is there anything else you would like to see changed or added to future reports?

27 Is there a better way, besides in a report like this, for this information to be shared with Canadians?

HAND OUT FULL VERSION OF REPORT FOR PARTICIPANTS TO KEEP IF THEY WOULD LIKE TO. SHOW THE FRONT COVER OF THE REPORT.

28 a→c (3) What do you think about the cover of the report? 28a Does it encourage you to pick 28b up the report and read it? Why/Why not? 28c

Interest & Usage of Report (10 mins)

29ab (2) If you had seen this report when it came out, 29a how likely would you have been to read it, either in whole or in part? Why/why not? 29b

Does this information… (ROTATE)
stem for 30-34.

30 …help you make more informed choices in terms of the health of you and/or your family?

31 …increase your level of understanding of the outcomes of our health care services?

32 …help you better understand how health care services are being delivered?

33 …in your view, help the governments in Canada to identify and share best practices to contribute to continuous service improvement in health care services in Canada?

34 What is the best way to convey or distribute this type of information to Canadians like you?

Conclusion

35 Do you have any final comments or suggestions to help Health Canada develop an effective set of performance indicators on the health of Canadians and the state of health care in Canada?

Thank you for your participation.

MODERATOR COLLECTS ALL MATERIALS.

8

EXECUTIVE SUMMARY

In September 2000, Canada's First Ministers reiterated their commitments to accountability and reporting to Canadians. They directed Health Ministers to provide comprehensive and regular public reporting on health programs and services and on health system performance. They also directed Health Ministers to develop a framework of jointly agreed comparable indicators of health status, health outcomes and quality of service such that each jurisdiction would begin reporting by September 2002. First Ministers identified 14 areas for reporting, and jurisdictions, through the Conference of Deputy Ministers of Health, have agreed to 67 specific indicators.

Healthy Canadians — A Federal Report on Comparable Health Indicators addresses 58 of the 67 indicators for Canadians as a whole. Although there are national numbers for most of the health status and health outcomes measures, national numbers for indicators of quality of service are only available in cases where national surveys were conducted or where all jurisdictions reported data in a manner that made a national total possible. In addition, this report provides information on such populations as First Nations on reserve, veterans, military personnel and inmates of federal penitentiaries, for whom the federal government has particular responsibilities in the area of health care services delivery. (See Annex 1: Comparable Health Indicators: List of 67 Indicators)

Highlights

Good results have been achieved, including:

- Canadians are living longer than ever. Life expectancy for Canadians reached 79.0 years in 1999, compared with 74.9 years in 1979.
- Compared with other developed countries, Canada has one of the lowest rates of low birth weight.
- In 2001, an estimated 87.7% of Canadians reported having a regular family physician.
- In 2000–01, 84.4% of Canadians rated the quality of overall health services they received as either excellent or very good.
- Compared with other developed countries, Canada has one of the lowest mortality rates attributable to colorectal cancer.
- Positive HIV test reports declined in Canada between 1995 and 2000, from 10.2 to 6.9, but increased in 2001 to 7.1 per 100,000 population.
- Between 1979 and 2000, the life expectancy of First Nations populations on and off reserve increased from 59.2 to 68.9 years for men, and from 65.9 to 76.6 years for women.
- Infant mortality rates for First Nations populations have been declining steadily; between 1979 and 1999, the rate dropped from 27.6 to 8.0 deaths per 1,000 live births.

There are areas for improvement, including:

- The lung cancer mortality rate for women in Canada is rising. In 1999 it was 34.8 per 100,000 population compared with 26.9 in 1988.
- The incidence of chlamydia, a sexually transmitted disease, appears to be on the rise in Canada. It increased to 161.0 in 2001 from 126.8 cases per 100,000 population in 1995.
- In 2001, the prevalence of smoking among teenagers continued to be high, with approximately one in five youths aged 12–19 reporting that they smoke.
- Although there have been improvements in the health status of First Nations populations, there are still significant disparities between First Nations and the Canadian population as a whole:
  - — The prevalence of diabetes in the Canadian population seems to be increasing and the self-reported rate for First Nations populations is two to three times as high as for Canadians as a whole.
  - — In 2002, only 38% of First Nations survey respondents reported very good to excellent health, compared with 61.4% of all Canadians in 2000–01.
  - — In 1999, First Nations populations lost almost five times as many potential years of life (per 100,000 population) to unintentional injury and three times as many years to suicide as did Canadians overall.
  - — There has been limited success in reducing the incidence of tuberculosis among First Nations populations, particularly in western Canada and the territories, where clustered outbreaks continue. Tuberculosis rates in First Nations populations are 8 to 10 times as high as they are in the Canadian population overall.

MEASURING PERFORMANCE—HIGHLIGHTS

Health Status

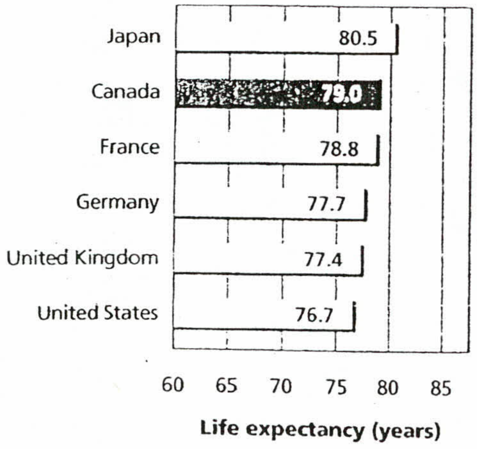
Health status indicators tell us about the health of the overall population. They are influenced by many factors, including education, economic status and living conditions. In general, Canadians are healthy compared with people in other developed countries. There are, however, significant disparities in the Canadian population. Members of First Nations, living on and off reserve, do not on average enjoy the same good health as the rest of the population.

1. Life expectancy

Description: **Male and female life expectancy at birth**

Life Expectancy at Birth

Selected Countries, 1999

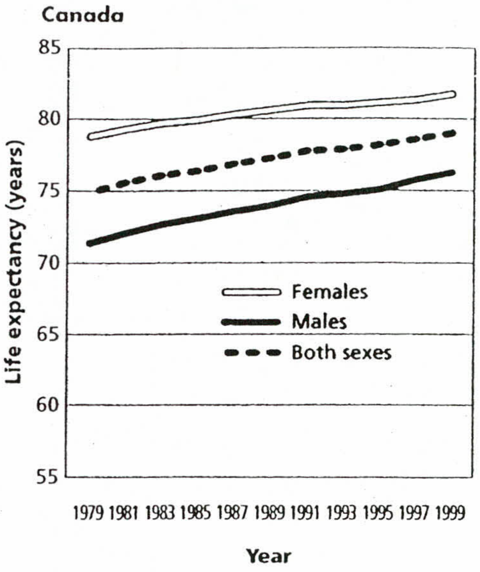


Source: Organisation for Economic Cooperation and Development Health Data, 2002

Results: Canadians have one of the highest life expectancies in the world. In 1999, Canada had the second-highest life expectancy among selected developed countries.

Life Expectancy at Birth

By Sex, Canada, 1979 to 1999

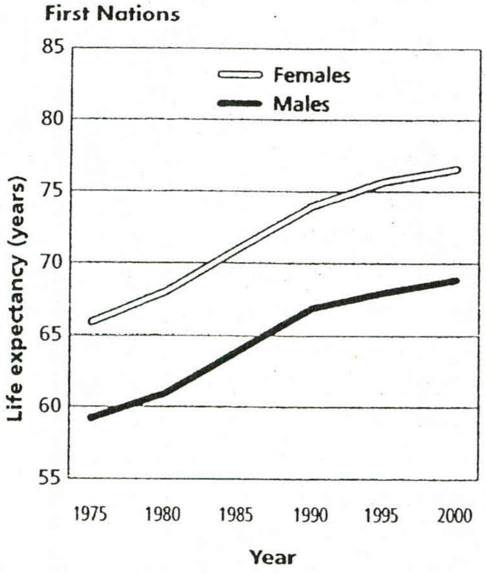


Source: Statistics Canada, Canadian Vital Statistics, Birth and Death Databases, Demography Division (population estimates)

In Canada, life expectancy has been increasing continuously over the last 25 years. In 1999, life expectancy for Canadian males was 76.3 years; for females, it was 81.7 years.

Life Expectancy at Birth

By Sex, First Nations (on and off reserve), 1975 to 2000



Source: Indian and Northern Affairs Canada, Basic Departmental Data, 2001

Between 1975 and 2000, the life expectancy for First Nations populations on and off reserve increased significantly, rising from 59.2 to 68.9 years for men and from 65.9 to 76.6 years for women.

Comments: The life expectancy for a given population indicates the number of years that a person born in a specific year could be expected to live. It is influenced by numerous factors, including educational, social and economic status, as well as the performance of the health system.

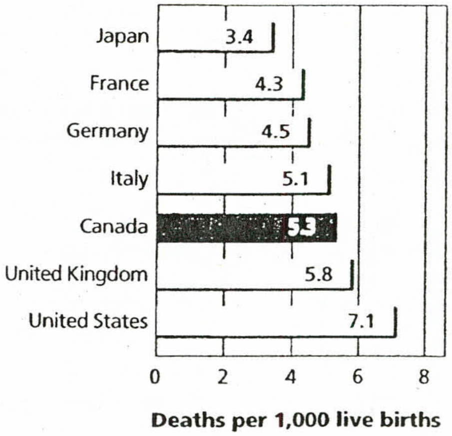
Although the gap between life expectancy of First Nations populations on reserve compared with that of the Canadian population has been closing steadily for 25 years, it remains a concern.

2. Infant mortality

Description: **Infant mortality**

Infant Mortality Rates (including weights < 500 grams)

Selected Countries, 1999



Source: Organisation for Economic Cooperation and Development Health Data, 2002

Results: Canada has a rate of infant mortality that is comparable to selected developed countries.

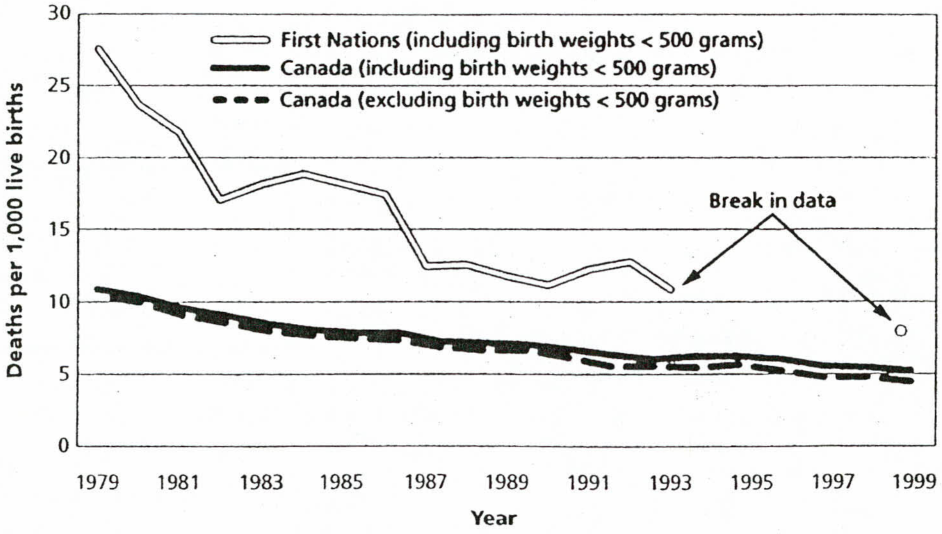
The infant mortality rate in Canada has improved over the past two decades. From 1979 to 1999, the rate declined from 10.5 to 4.4 deaths per 1,000 live births.

Although the infant mortality rate for First Nations populations has historically been much higher than the rate for Canada as a whole, it too has declined steadily since the mid-1980s.

Comments: Infant mortality is a useful measure of both child and societal well-being, offering insight into the health status of the population and shedding light on the effectiveness of preventive health care in that population and the attention paid to the health of mothers and children. It is also linked to the educational and socio-economic status of mothers and the prevalence of smoking.

Infant Mortality Rates

Canada and First Nations (on reserve), 1979 to 1999*



Sources: Statistics Canada, Canadian Vital Statistics, Birth and Death Databases; Health Canada, First Nations and Inuit Branch, in-house statistics

* Contains data from British Columbia and Alberta that are both on and off reserve.

4. Self-reported health

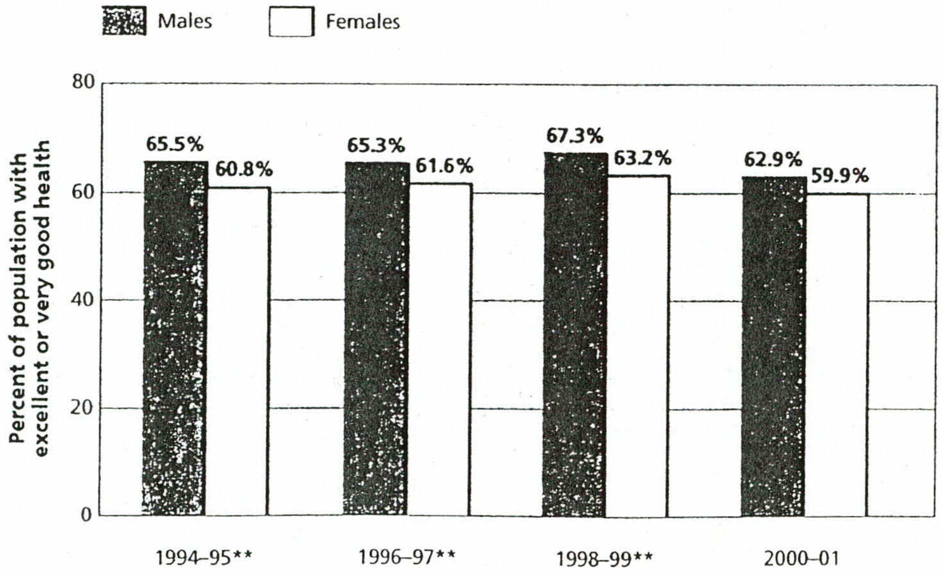
Description: **Self-reported health**

Results: Compared with selected developed countries, Canada ranks second after the United States in the percent of the population reporting their health status as either good or better.[2]

In 2000–01, 62.9% of Canadian males and 59.9% of females aged 12 and over reported being in excellent or very good health, a decline from 67.3% and 63.2%, respectively in 1998–99.

Self-Reported Health Status

By Sex, Canada, 1994–95** to 2000–01*



Source: Statistics Canada, *National Population Health Survey*, 1994–95, 1996–97 and 1998–99, cross-sectional sample, health file; *Canadian Community Health Survey*, 2000–01
* Includes household population 12 years of age and over.
** Data for *National Population Health Survey* excludes the territories.

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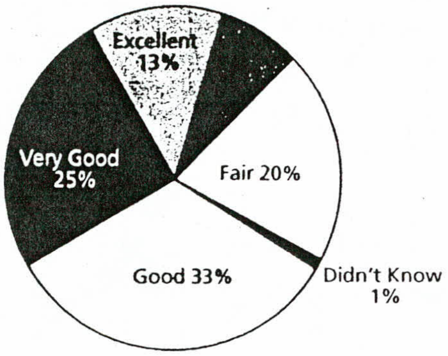
[1] Health Canada, First Nations and Inuit Health Branch, in-house statistics.

[2] Organisation for Economic Cooperation and Development Health Data (2002).

Self-Reported Health

Percent of Survey Respondents Aged 18 and Over, First Nations (on reserve), 2002



Source: National Aboriginal Health Organization. Preliminary results of the *NAHO Public Opinion Poll on Health Care,* July 2002.

In 2002, 38% of First Nations on reserve respondents to the *National Aboriginal Health Organization Public Opinion Poll on Health Care* reported very good to excellent health, while 28% reported poor to fair health.

Comments: Self-reported health is a general indicator of the overall health status of individuals. It can capture what other indicators may miss, such as incipient disease, disease severity, and social and mental function.

In the *Canadian Forces Health and Lifestyle Information Survey* (2000), 62% or 17,230 of 27,482 Regular Force member respondents reported their health as excellent or very good. (www.forces.gc.ca/health/engraph/home_e.asp)

Health Outcomes

Measures of health outcomes attempt to track the effects of policy, program or clinical interventions on quality of life. Ideally, these interventions lead to better health outcomes. Without a baseline and a systematic way of reporting on results, it is difficult to measure the benefits of these interventions or to make informed choices in opting for procedures, setting priorities and allocating resources. There remains considerable work to be done in identifying and refining measures in this area to quantify and compare the effects of specific interventions.

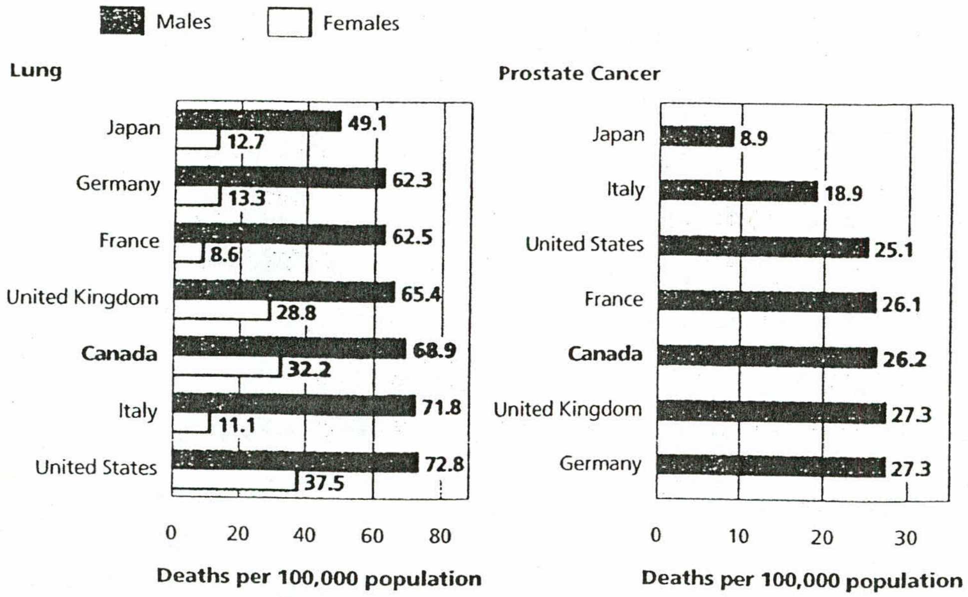
5. Change in life expectancy

Description: **Age-standardized mortality rates for lung, prostate, breast and colorectal cancer**

Results: Canada has one of the lowest mortality rates among selected developed countries for colorectal cancer, and has comparable mortality rates for lung, breast and prostate cancer.

Mortality Rate for Cancer

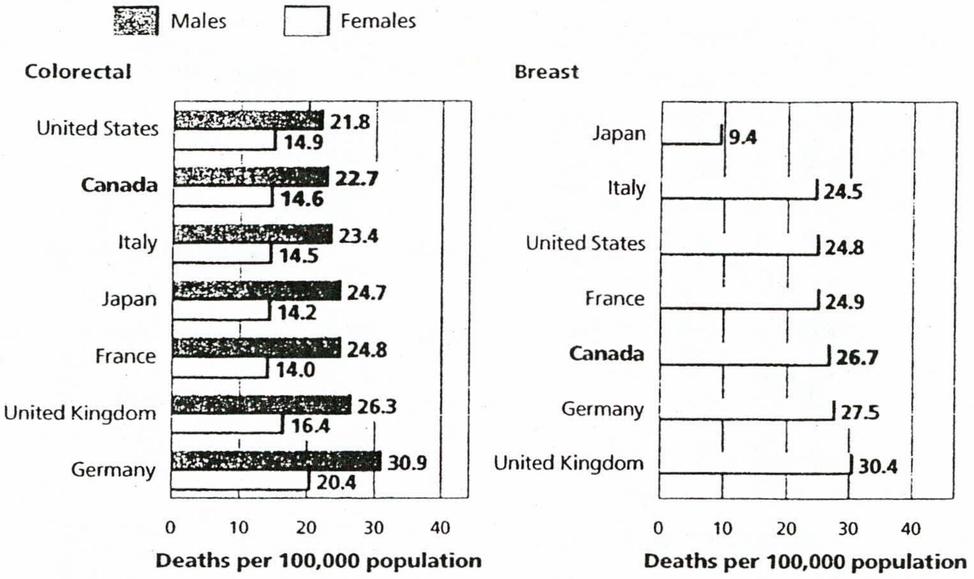
By Sex (Age Standardized), Selected Countries, 1997



Source: Organisation for Economic Cooperation and Development Health Data, 2002
Note: Age standardized to the 1980 OECD population.

Mortality Rate for Cancer

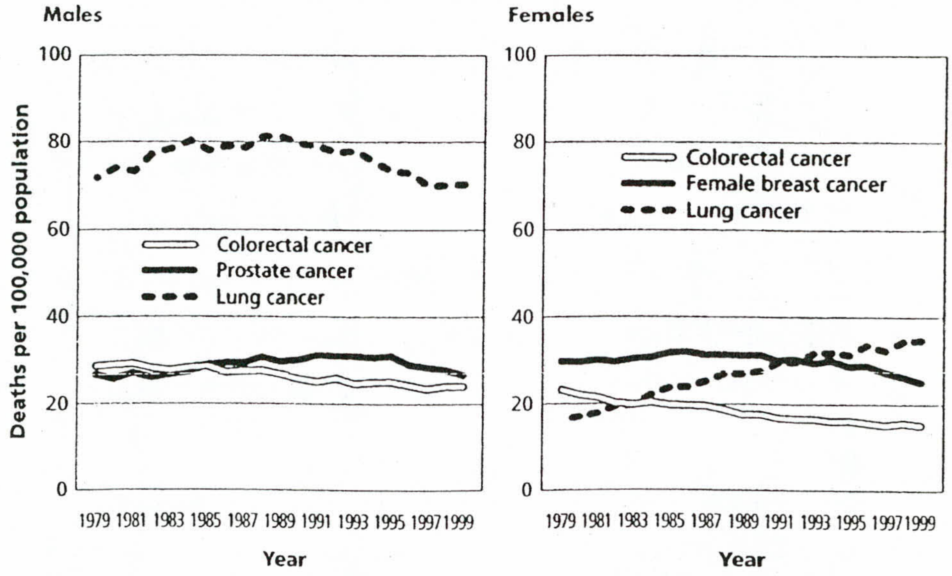
By Sex (Age Standardized), Selected Countries, 1997



Source: Organisation for Economic Cooperation and Development Health Data, 2002
Note: Age standardized to the 1980 OECD population.

Mortality Rate for Cancer

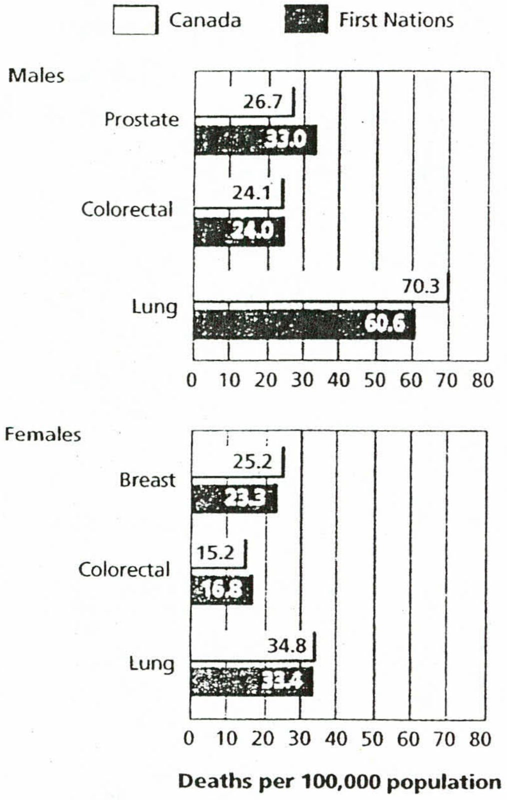
By Sex (Age Standardized), Canada, 1979 to 1999



Source: Statistics Canada, Canadian Vital Statistics, Death Database, Demography Division (population estimates), 1991 Census of Population
Note: Age standardized to the 1991 Canadian population.

Mortality Rates for Cancer

By Sex (Age Standardized), Canada and First Nations (on reserve), 1999*



Sources: Statistics Canada; Health Canada, First Nations and Inuit Health Branch Health, in-house statistics
Note: Age standardized to the 1991 Canadian population.
*Contains data from British Columbia and Alberta that are both on and off reserve.

The lung cancer mortality rate for women in Canada is rising; in 1999, it was 34.8 compared with 26.9 per 100,000 population in 1988. Nevertheless, it has been consistently well below the rate for men. The lung cancer mortality rate for men in Canada is now falling. In 1999, it was 70.3, down from 81.3 per 100,000 population in 1988.

Cancer mortality rates are generally lower in the First Nations populations than in the Canadian population, with the exception of prostate cancer in males and colorectal cancer in females.

Comments: Age-standardized cancer mortality rate trends may indicate long-term success in reducing deaths from these diseases. Lower mortality rates may indicate success in disease detection and treatment.

Age Standardization —
A procedure for adjusting rates (e.g., death rates) designed to minimize the effects of differences in age composition when comparing rates for different populations.

6. Improved quality of life

Results of hip and knee replacements have demonstrated that health-related quality of life improved substantially for the great majority of those receiving these procedures. Due to limitations in data, intervention rates for joint replacements are being used as surrogate indicators of health-related quality of life.

Description: **Total knee replacement rate**

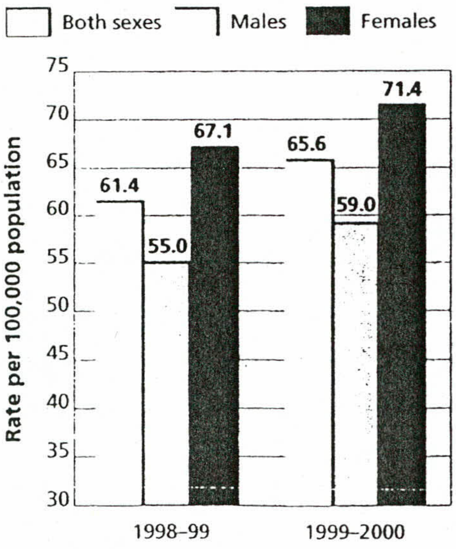
Results: In 1999–2000, the knee replacement rate in Canada increased to 65.6 from a rate of 61.4 per 100,000 population in 1998–99, and the rate was greater for women than for men.

In 1999, First Nations populations had a higher rate of knee replacement than did the Canadian population overall.

Comments: Recent study results show that health-related quality of life substantially improves for the majority of individuals who receive knee replacements. Similarly, in one study more than 94% of individuals who had received hip replacements reported significant lessening of pain and stiffness and improvement in overall functioning.[3]

Knee Replacement Rate

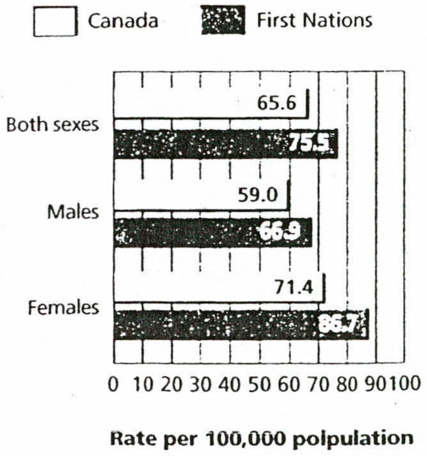
By Sex (Age Standardized), Canada, 1998–99 and 1999–2000



Sources: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, 1991 Census of Population
Note: Age standardized to the 1991 Canadian population.

Knee Replacement Rate

By Sex (Age Standardized), Canada and First Nations (on reserve), 1999*



Sources: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, 1991 Census of Population
Note: Age standardized to the 1991 Canadian population.
* Canadian data are for fiscal year 1999–2000.

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[3] Charles J. Wright and Yoel Robens-Paradise. *Evaluation of Indications and Outcomes in Elective Surgery* (May 2001).

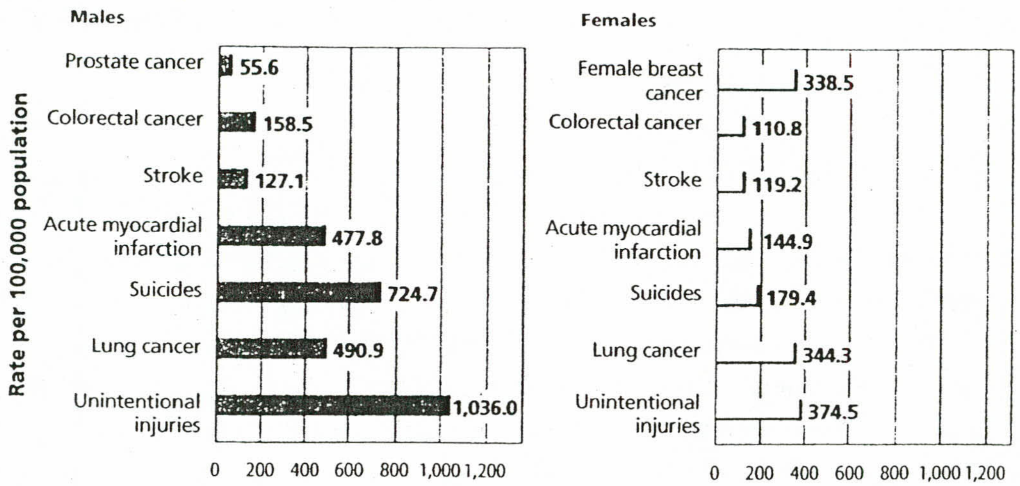
7. Reduced burden of disease, illness and injury

Description: **Potential years of life lost**

Results: In the total Canadian population in 1999, and for the selected causes shown, unintentional injuries accounted for the greatest number of potential years of life lost per 100,000 population for males (1,036 years), followed by suicides (725 years), lung cancer (491 years) and acute myocardial infarction (478 years). For females, unintentional injuries also accounted for the greatest number of potential years of life lost per 100,000 population (375 years), followed by lung cancer (344 years), breast cancer (339 years) and suicides (179 years). The potential years of life lost per 100,000 population is greater for men than for women for all the causes shown. The difference is particularly large for acute myocardial infarction, injury and suicide.

Potential Years of Life Lost

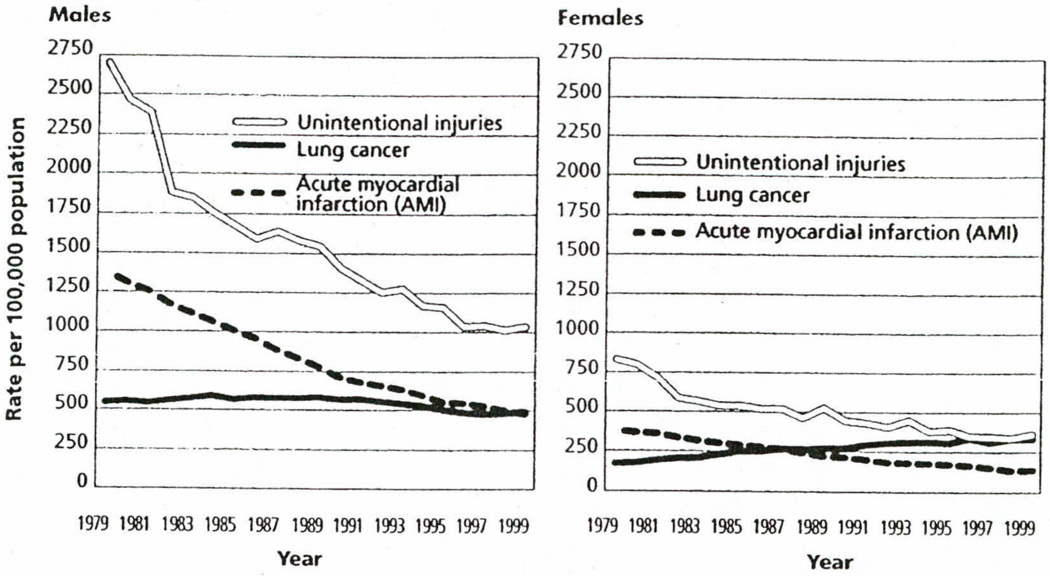
By Sex, Selected Causes of Death, Canada, 1999



Source: Statistics Canada, Canadian Vital Statistics, Death Database, Demography Division (population estimates)
Note: Rates are calculated using the population aged 0 to 74.

Potential Years of Life Lost

By Sex, Selected Causes, Canada, 1979 to 1999



Source: Statistics Canada, Canadian Vital Statistics, Death Database, Demography Division (population estimates)
Note: Rates are calculated using the population aged 0 to 74.

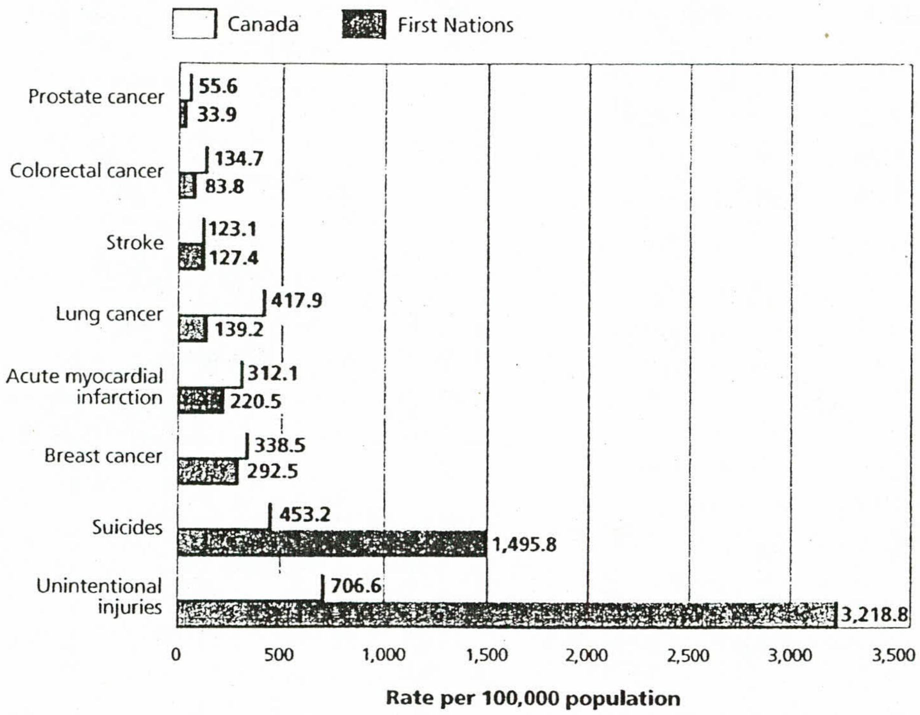
In Canada from 1979 to 1999, the potential years of life lost declined significantly from causes such as unintentional injuries and acute myocardial infarction. The declines have been more dramatic for men than for women. The potential years of life lost per 100,000 population due to lung cancer has been slowly decreasing among men and increasing among women.

First Nations populations lose approximately five times as many potential years of life per 100,000 population due to unintentional injury and three times as many due to suicide as does the Canadian population overall. For most of the remaining causes, which generally occur in older populations, potential years of life lost is lower for First Nations.

Comments: Potential years of life lost is the aggregate number of years of potential life not lived because members of the population die "prematurely" (in this instance, before age 75). A downward trend reflects success in preventing premature loss of life in the population.

Potential Years of Life Lost

By Selected Causes, Canada and First Nations (on reserve), 1999*



Sources: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates); Health Canada, First Nations and Inuit Health Branch, in-house statistics
Note: Rates are calculated using the population aged 0 to 74.
*Contains data from British Columbia and Alberta that is both on and off reserve.

8. Waiting times for key diagnostic and treatment services

Description: **Reported waiting times for visits to specialists, diagnostic tests and surgery**

Results: The self-reported median wait to consult a specialist or receive non-emergency surgery in Canada was 4.3 weeks. The self-reported median waiting time for selected diagnostic tests was 3 weeks.

Fewer than 20% of the individuals who waited for specialized services reported that waiting for care affected their lives.[6]

Service	**Median* Wait *(Weeks)***
Selected diagnostic tests	3.0**
Specialist visits	4.3
Non-emergency surgeries	4.3

Source: Statistics Canada, *Access to Health Care Services in Canada*, 2001

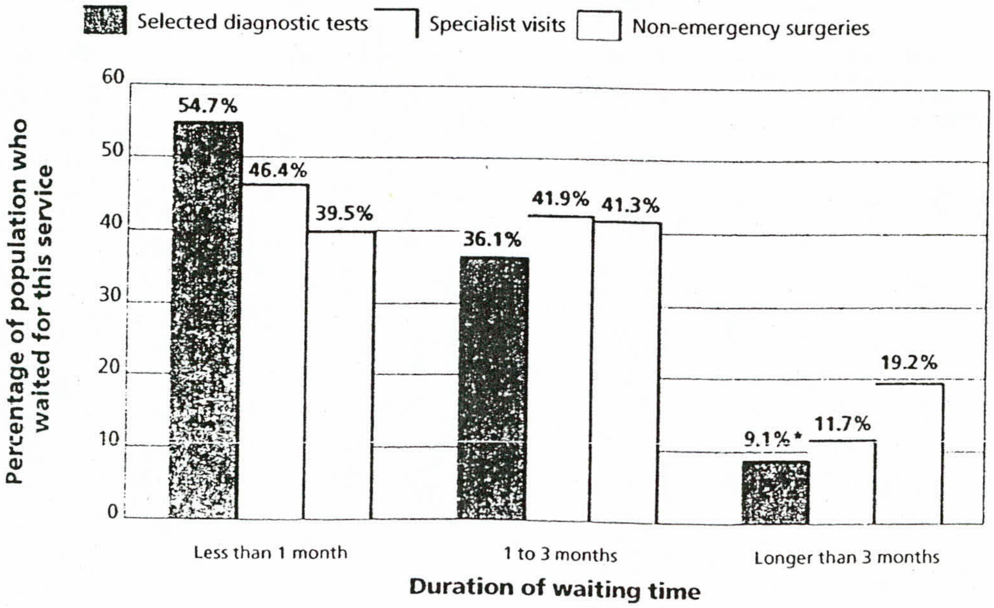
* Median wait: Half the respondents waited longer, half less.

**Use with caution (high sampling variability).

Comments: Using administrative records to systematically collect and report waiting time data is relatively new in Canada. Jurisdictions are working toward comparable and consistent methodologies, in particular, approaches that measure waiting times by severity of illness.

Distribution of Waiting Times

By Duration of Waiting Time, Canada, 2001



Source: Statistics Canada, *Access to Health Care Services in Canada*, 2001
*Use with caution (high sampling variability).

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[6] Statistics Canada, *Access to Health Care Services in Canada* (2001).

To get information on access and waiting times at a national level, Statistics Canada conducted a special household survey in 2001 (*Access to Health Care Services in Canada*).

For First Nations populations, primary care is provided on reserve and procedures requiring hospitalizations are provided in provincial hospitals. Because the hospitalization information is captured in the provincial administrative databases, it is difficult to assess waiting lists. However, according to preliminary data from the *National Aboriginal Health Organization Public Opinion Poll on Health Care* (2002), 78% of First Nations on reserve respondents had access to a nurse and 59% had easy access to a family physician.

9. Patient satisfaction

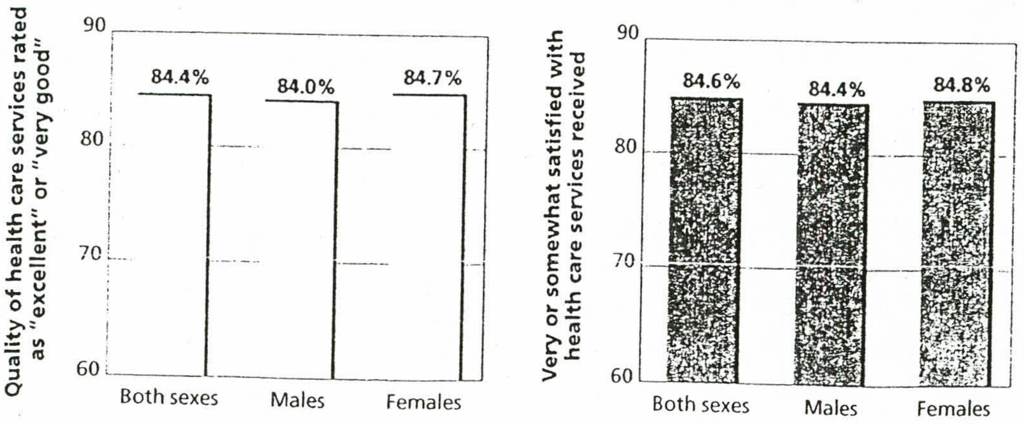
***Description*: Patient satisfaction**

***Results*:** In 2000–01, 84.4% of Canadians rated the quality of the overall health services they received as being either excellent or very good and 84.6% reported that they were very or somewhat satisfied with those services.

Preliminary data from the *National Aboriginal Health Organization Public Opinion Poll on Health Care* (2002) indicate that 66% of First Nations on reserve respondents felt that the health care they had received in the last year was good to excellent, and only 9% rated it as poor.

Patient Satisfaction — Overall Health Services

By Sex, Canada, 2000–01



Source: Statistics Canada, *Canadian Community Health Survey*, 2000–01
Note: Expressed as percent of household population aged 15 and over who reported receiving health care services in the past 12 months.

Comments: The indicators for the Canadian population as a whole apply to adults (15 years or older living in private households) who received health care services over a 12-month period. The individuals assessed the overall health care services received, services received in a hospital, services received from a family doctor or other physician, and community-based services.

10. Hospital re-admission for selected conditions

Description: **Re-admission for acute myocardial infarction (AMI)**

Results: The three-year 1997–1999 average re-admission rate for acute myocardial infarction (AMI) in Canada was 7.3% of AMI cases.[8]

Description: **Re-admission for pneumonia**

Results: The three-year 1997–1999 average re-admission rate for pneumonia in Canada was 3.3% of pneumonia cases.[9]

11. Access to 24/7 first contact health services

Description: **Percent of population having a regular family physician**

Results: In Canada, 87.7% of respondents reported having a regular family physician in 2001.[10]

Preliminary data from the *National Aboriginal Health Organization Public Opinion Poll on Health Care* (2002) indicate that 77% of members of First Nations on reserve have a regular family physician.

Description: **Estimated population that had difficulty obtaining: routine or ongoing health care, health information or advice, immediate care for a minor health problem**

Results: Survey results for 2001 show that 93.7% of the Canadian population sought at least one type of first contact service over the preceding 12-month period for themselves or for a family member.

An estimated 4.3 million Canadians indicated that they had difficulties accessing first contact services: 2.5 million Canadians for routine care, 1.5 million for health information or advice and 1.6 million for immediate care for a minor health problem. Some respondents noted difficulties accessing more than one service.

The table below shows the percentage of the population who needed these services and reported difficulty obtaining them during regular hours, evenings and weekends and the middle of the night.

According to preliminary data from the *National Aboriginal Health Organization Public Opinion Poll on Health Care* (2002), 17% of survey respondents felt that in the past 12 months, there had been times when they

Type of Service	Regular Hours	Evenings and Weekends	Middle of the Night
Routine care	8.6%	8.1%	n/a
Health information or advice	10.1%	10.6%	5.5%*
Immediate care for a minor health problem	11.4%	16.4%	12.4%*

Source: Statistics Canada, *Access to Health Care Services in Canada*, 2001
*Use with caution (high sampling variability).

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[8] Canadian Institute for Health Information, Hospital Morbidity database.

[9] Ibid.

[10] Statistics Canada, *Access to Health Care Services in Canada* (2001).

needed health care, but did not receive it. The primary reasons reported for not receiving care were that waiting times were too long, the services sought were not available in the area, and the services sought were not available at the time required.

Comments: Twenty-four hours a day, 7 days a week (24/7) health services include information and advice and direct treatment services, which may be obtained through first contact with the health system, to meet immediate or routine health care needs.

For First Nations populations, there is usually timely access to care for non-urgent conditions through the local nursing station. More serious conditions often require transport to a provincial hospital or other treatment facility.

12. Home and community care services

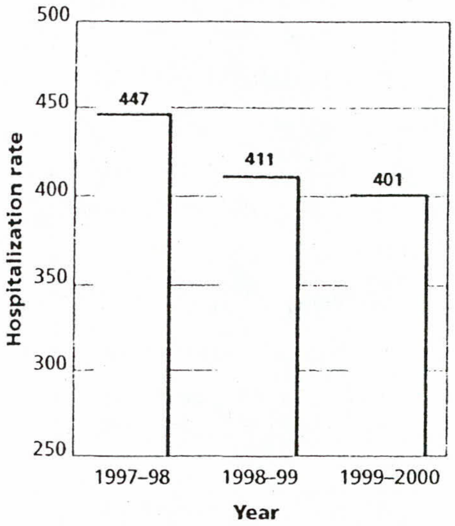
Description: **Ambulatory care sensitive conditions**

Results: Canada's hospitalization rates for ambulatory care sensitive conditions have been declining in recent years, from 447 admissions per 100,000 population in 1997–98 to 401 in 1999–2000.

Comments: Ambulatory care sensitive conditions, such as asthma and diabetes, are long-term health conditions that can often be managed with timely and effective treatment in the community, without hospitalization.

Ambulatory Care Sensitive Conditions

Age Standardized, Canada, 1997–98 to 1999–2000



Sources: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, Canadian Vital Statistics, 1991 Census of Population
Notes: Expressed as rate per 100,000 population. Age standardized to the 1991 Canadian population.

Rates of hospitalization for ambulatory care sensitive conditions are one indicator of appropriate access to community-based care.

Based on provincial data from British Columbia, Manitoba and Saskatchewan, Health Canada's First Nations and Inuit Health Branch estimates that the rate of hospitalization for ambulatory care sensitive conditions in First Nations populations on and off reserve is four times as great (1,807 per 100,000 population in 1997–98) as for the Canadian population as a whole.

14. Health promotion and disease prevention

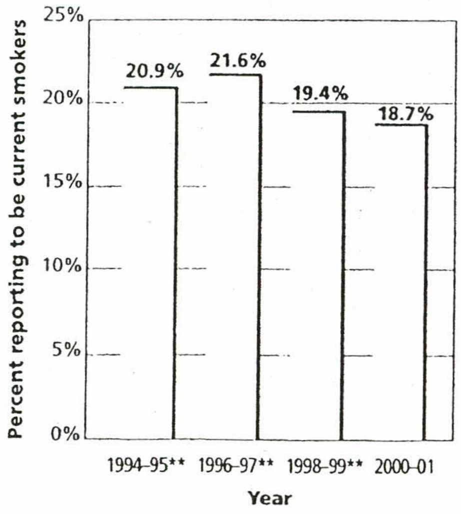
Description: **Percent of current teenaged smokers**

Results: The prevalence of smoking among teenagers continues to be high, with approximately one in five youths (aged 12–19) reporting that they smoke.

In 2000–01, 19.8% of young women reported that they were smokers compared with 17.6% of young men.

Current Teenaged Smokers

Canada, 1994–95 to 2000–01*



Source: Statistics Canada, *National Population Health Survey*, 1994–95, 1996–97 and 1998–99, cross-sectional sample, health file; *Canadian Community Health Survey*, 2000–01
*Includes population aged 12 to 19.
**Data for *National Population Health Survey* excludes the territories.

Comments: According to the *Canadian Community Health Survey* in 2001, 39.3% of the non-smoking population aged 12–19 years reported being exposed to second-hand smoke.

Tobacco use is a leading cause of preventable illness and death in Canada. According to recent results from the *Canadian Tobacco Use Monitoring Survey* (conducted by Statistics Canada on behalf of Health Canada), smoking rates in the overall Canadian population continue to drop. The survey results revealed that in 2001, 5.4 million people (or 22% of the population aged 15 and over) were smokers, compared with 24% in 2000 and 25% in 1999. The majority of new smokers are adolescents, and it is important to understand the process leading to regular smoking and to monitor the prevalence among Canadian youth.

In 2002, 48.3% of First Nations on reserve respondents (aged 18 and over) participating in a Health Canada–commissioned survey[15] reported that they smoke.

Description: **Physical activity**

Results: For each year shown, more Canadian men than women reported that they engaged in regular physical activity. In 2000–01, 44.8% of Canadian men reported that they were either active or moderately active, compared with 40.6% of Canadian women.

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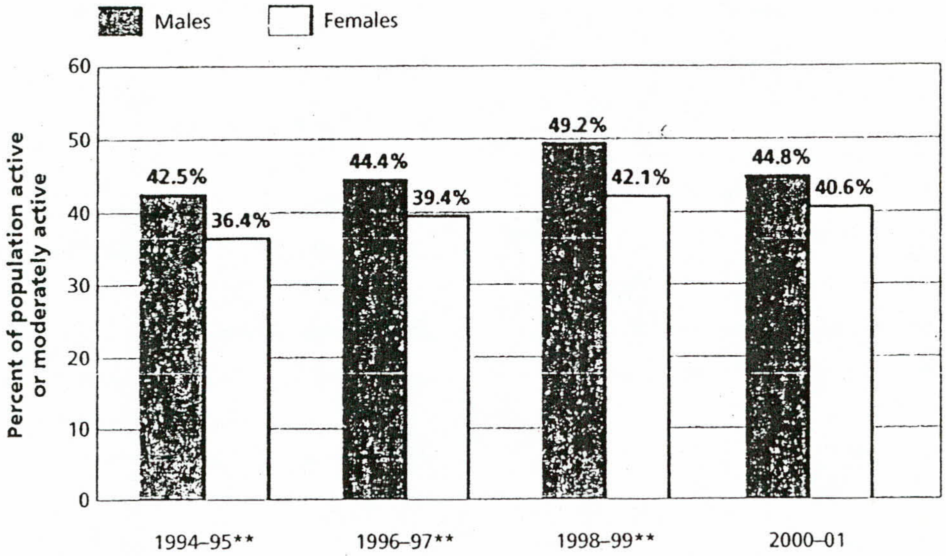
[15] Health Canada, First Nations and Inuit Health Branch, secondary analysis of Ipsos-Reid, *Awareness and Knowledge Levels of Type 2 Diabetes Among Aboriginal Peoples in Canada* (2002).

Physical Activity

By Sex, Canada, 1994–95 to 2000–01*



Source: Statistics Canada, *National Population Health Survey*, 1994–95, 1996–97 and 1998–99, cross-sectional sample, health file; *Canadian Community Health Survey*, 2000–01
* Includes household population 12 years of age and over.
** Data for *National Population Health Survey* excludes the territories.

In a 2002 Health Canada–commissioned survey,[16] the majority (76.4%) of First Nations on reserve respondents rated themselves as either very fit or somewhat fit, while only 5.4% rated themselves as being not fit at all.

According to the *Canadian Forces Health and Lifestyle Information Survey* (2000), 36% of the Regular Force members were physically active and 27% were moderately active.

Comments: Maintaining physical activity is associated with a range of health benefits, including heart health benefits and reduced likelihood of depression.

The 2000–01 data reported for the Canadian population come from the *Canadian Community Health Survey* and, for the first time, include data from the territories and the provinces.

Physical activity levels are defined according to units of kilocalorie/kilogram/day (KKD) where 1 KKD is approximately the energy expended in walking or running one kilometre. The proportion of the population deemed to engage in regular physical activity included those classified as ***active*** (expending 3.0 or more KKD) or ***moderately active*** (expending 1.5–2.9 KKD).

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[16] Health Canada, First Nations and Inuit Health Branch, secondary analysis of Ipsos-Reid, *Awareness and Knowledge Levels of Type 2 Diabetes Among Aboriginal Peoples in Canada* (2002).

SOMMAIRE

En septembre 2000, les premiers ministres du Canada ont réitéré leur engagement à rendre des comptes aux Canadiens. Ils ont demandé aux ministres de la Santé de rendre compte de façon régulière et détaillée des programmes et services de santé qu'ils offrent ainsi que du rendement du système de santé. Ils leur ont également demandé d'élaborer un cadre faisant état d'indicateurs comparables convenus conjointement pour rendre compte de l'état de santé, des résultats en matière de santé et de la qualité des services afin que chaque administration commence à présenter un rapport dès septembre 2002. Les premiers ministres ont relevé 14 domaines visés par le rapport, et les administrations, par le truchement de la Conférence des sous-ministres de la Santé, ont convenu de 67 indicateurs.

Le rapport *Les Canadiens en santé – Rapport fédéral sur les indicateurs comparables de la santé* porte sur 58 des 67 indicateurs pour les Canadiens dans leur ensemble. Même si la plupart des mesures de l'état de santé et des résultats en matière de santé sont fournis à l'échelle nationale, on ne dispose de chiffres nationaux sur les indicateurs de la qualité du service que lorsque des enquêtes nationales ont été menées ou lorsque toutes les administrations ont fait état des données d'une manière permettant de présenter des totaux à l'échelle nationale. Par ailleurs, le présent rapport renferme de l'information sur des populations comme les Premières nations vivant dans les réserves, les anciens combattants, le personnel militaire et les détenus des pénitenciers fédéraux, à l'égard desquels le gouvernement fédéral assume des responsabilités particulières au chapitre de la prestation de soins de santé. (Voir l'annexe 1 – Indicateurs comparables de la santé : Liste des 67 indicateurs.)

Points saillants

On a obtenu de bons résultats, entre autres :

- Les Canadiens vivent plus longtemps qu'autrefois. Leur espérance de vie était de 79,0 ans en 1999 par rapport à 74,9 en 1979.
- Par rapport à d'autres pays industrialisés, le Canada affiche l'un des taux les plus bas pour le faible poids à la naissance.
- En 2001, environ 87,7 % des Canadiens disaient avoir un médecin de famille régulier.
- En 2000-2001, 84,4 % des Canadiens qualifiaient d'excellente ou de très bonne la qualité des services généraux de santé qu'ils avaient reçus.
- Par rapport à d'autres pays industrialisés, le Canada affiche l'un des plus faibles taux de mortalité attribuable au cancer colorectal.
- Entre 1995 et 2000, les rapports de tests VIH positifs ont diminué au Canada, passant de 10,2 à 6,9, mais ils ont augmenté en 2001, s'établissant à 7,1 pour 100 000 habitants.
- Entre 1979 et 2000, l'espérance de vie de la population des Premières nations vivant dans les réserves et à l'extérieur de celles-ci a augmenté, passant de 59,2 à 68,9 ans pour les hommes et de 65,9 à 76,6 ans pour les femmes.
- Le taux de mortalité infantile pour la population des Premières nations a diminué de façon constante; entre 1979 et 1999, le taux a chuté de 27,6 à 8,0 décès par millier de naissances vivantes.

Les domaines à améliorer sont entre autres les suivants :

- Le taux de mortalité attribuable au cancer du poumon chez les femmes augmente au Canada. Il est passé de 26,9 pour 100 000 habitants en 1988 à 34,8 en 1999.
- L'incidence de la chlamydiose, maladie transmissible sexuellement, semble à la hausse au Canada. Elle est passée de 126,8 cas pour 100 000 habitants en 1995 à 161,0 en 2001.
- En 2001, l'usage du tabac chez les adolescents demeurait élevé, puisqu'environ un jeune sur cinq de 12 à 19 ans a déclaré fumer.
- Même si l'état de santé des populations des Premières nations s'est amélioré, on observe encore des disparités entre celle-ci et la population canadienne dans son ensemble :
  - — La prévalence du diabète au sein de la population canadienne semble augmenter, et le taux déclaré pour les populations des Premières nations dépasse de deux à trois fois celui pour la population canadienne dans son ensemble.
  - — En 2002, à peine 38 % des membres des Premières nations ayant répondu au sondage déclaraient être en très bonne ou en excellente santé, par rapport à 61,4 % de l'ensemble des Canadiens en 2000-2001.
  - — Comparativement à l'ensemble de la population canadienne, en 1999, les populations des Premières nations ont perdues près de cinq fois plus d'années potentielles de vie (pour 100 000 habitants) en raison de blessures accidentelles et trois fois plus en raison du suicide.
  - — On n'a réussi qu'en partie à réduire l'incidence de la tuberculose dans les populations des Premières nations, en particulier dans l'Ouest canadien et dans les territoires, où l'on continue à observer des foyers restreints. Les taux de tuberculose observés dans les populations des Premières nations sont de 8 à 10 fois plus élevés que dans la population canadienne dans son ensemble.

MESURE DU RENDEMENT – POINTS SAILLANTS

État de santé

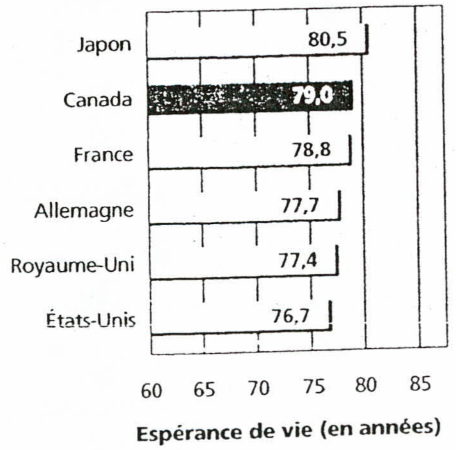
Les indicateurs de l'état de santé nous renseignent sur la santé de la population en général. De nombreux facteurs les influencent, entre autres le niveau d'instruction, la situation économique et les conditions de vie. En général, les Canadiens sont en bonne santé comparativement aux populations d'autres pays industrialisés, mais on observe de grandes disparités au sein de la population canadienne. De façon générale, les membres des Premières nations, qu'ils vivent dans les réserves ou à l'extérieur, ne se portent pas aussi bien que le reste de la population.

1. Espérance de vie

Description : **Espérance de vie des hommes et des femmes à la naissance**

Espérance de vie à la naissance

Pays sélectionnés, 1999

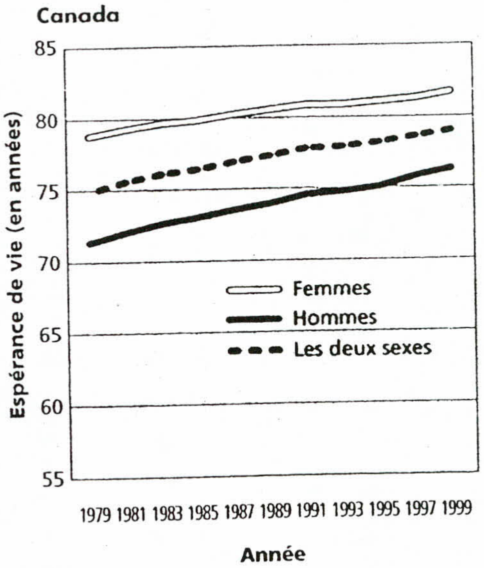


Source : Organisation de coopération et de développement économiques, données sur la santé de 2002.

Résultats : Les Canadiens ont l'une des plus longues espérances de vie au monde. En 1999, le Canada se classait au second rang pour ce qui est de l'espérance de vie par rapport aux pays industrialisés retenus.

Espérance de vie à la naissance

Selon le sexe, Canada, de 1979 à 1999

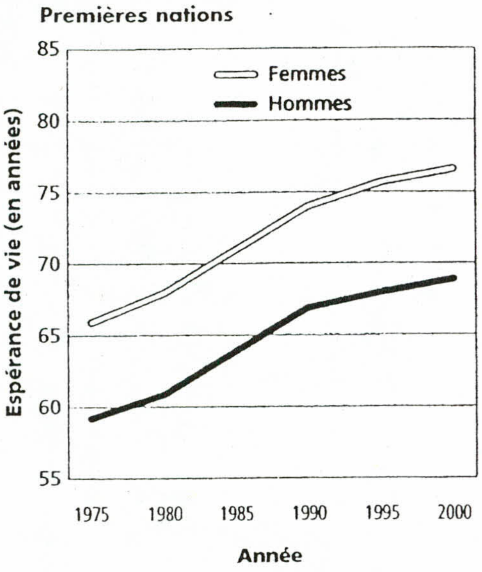


Source : Statistique Canada, Statistique de l'état civil du Canada, bases de données sur les naissances et les décès, Division de la démographie (estimations de la population).

L'espérance de vie des Canadiens n'a cessé d'augmenter au cours des 25 dernières années. En 1999, elle était de 76,3 ans pour les hommes et de 81,7 ans pour les femmes.

Espérance de vie à la naissance

Selon le sexe, Premières nations (dans les réserves et à l'extérieur), de 1975 à 2000



Source : Affaires indiennes et du Nord Canada, Données ministérielles de base – 2001.

Entre 1975 et 2000, l'espérance de vie des membres des Premières nations vivant dans les réserves et à l'extérieur s'est fortement accrue, passant de 59,2 à 68,9 ans pour les hommes et de 65,9 à 76,6 ans pour les femmes.

Commentaires : Par espérance de vie d'une population, on entend le nombre d'années qu'une personne née une année donnée peut s'attendre à vivre. Plusieurs facteurs exercent une influence sur l'espérance de vie, entre autres le niveau d'instruction, la situation socio-économique ainsi que la performance du système de santé.

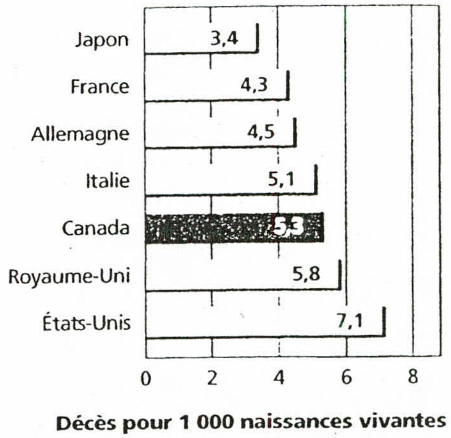
Même si l'écart entre l'espérance de vie des populations des Premières nations vivant dans les réserves et celle de la population canadienne se resserre sans cesse depuis 25 ans, il demeure préoccupant.

2. Mortalité infantile

Description : Mortalité infantile

Taux de mortalité infantile (y compris les nouveau-nés de moins de 500 grammes)

Pays sélectionnés, 1999



Source : Organisation de coopération et de développement économiques, données sur la santé de 2002.

Résultats : Le Canada affiche un taux de mortalité infantile comparable à celui d'autres pays industrialisés.

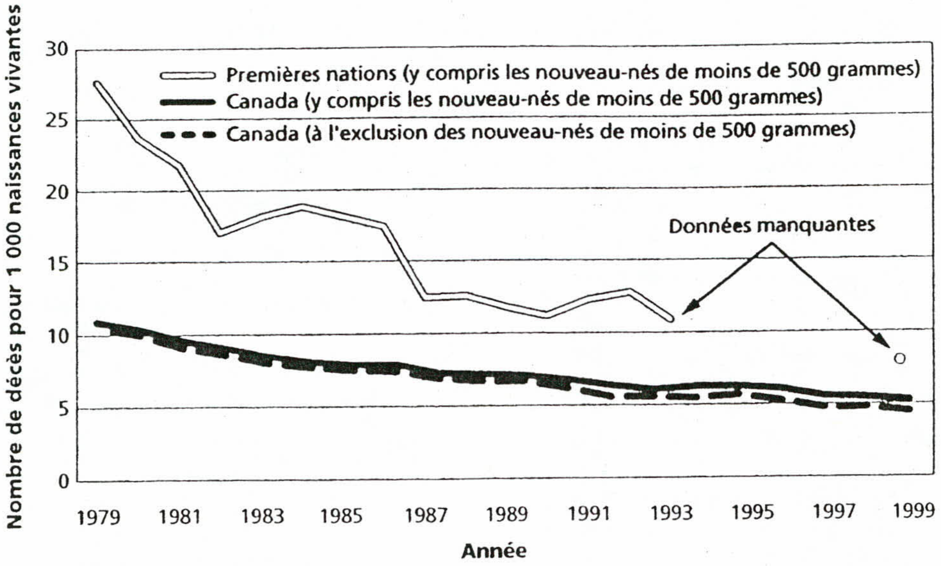
Le taux de mortalité infantile s'est amélioré au Canada au cours des vingt dernières années. Entre 1979 et 1999, il est passé de 10,5 à 4,4 décès par millier de naissances vivantes.

Alors que par le passé, le taux de mortalité infantile était nettement plus élevé chez les Premières nations que dans le Canada dans son ensemble, il a également régressé progressivement depuis le milieu des années 1980.

Commentaires : Le taux de mortalité infantile est une mesure utile non seulement de la santé infantile, mais aussi du bien-être d'une société. Il permet de comprendre l'état de santé de la population et donne une idée de l'efficacité des soins préventifs et de l'attention que suscite la santé de la mère et de l'enfant. Il est également lié au niveau de scolarité et à la situation socio-économique des mères ainsi qu'à l'usage du tabac.

Taux de mortalité infantile

Canada et Premières nations (dans les réserves), de 1979 à 1999*



Sources : Statistique Canada, Statistique de l'état civil du Canada, bases de données sur les naissances et les décès; Santé Canada, Direction générale de la santé des Premières nations et des Inuits, statistiques internes.

* Renferme les données pour la population vivant dans les réserves et à l'extérieur des réserves en Colombie-Britannique et en Alberta.

4. Auto-évaluation de la santé

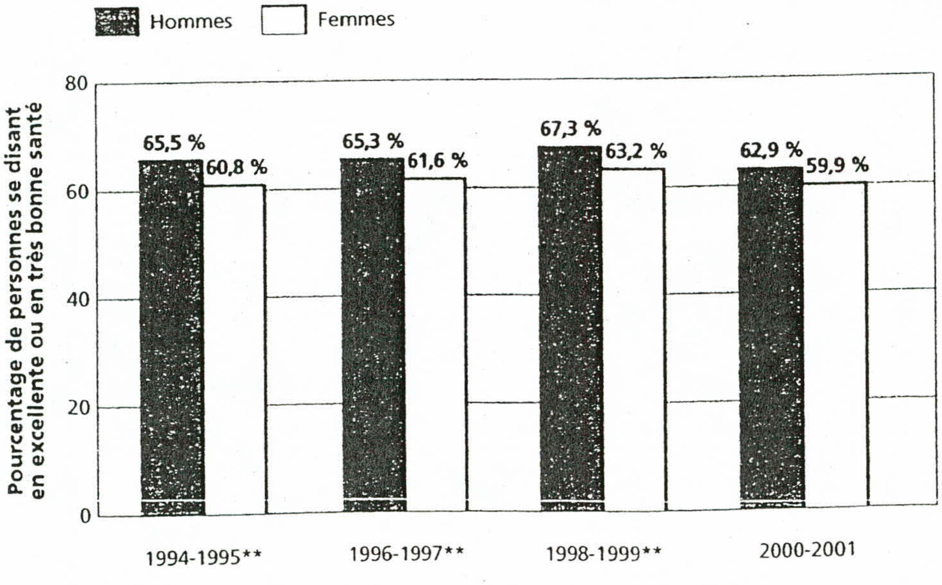
Description : **Auto-évaluation de la santé**

Résultats : Par rapport aux autres pays industrialisés sélectionnés, le Canada se classe deuxième après les États-Unis pour ce qui est de la proportion de population se disant en bonne ou en meilleure santé[2].

En 2000-2001, au Canada, 62,9 % des hommes et 59,9 % des femmes de 12 ans et plus ont déclaré être en excellente ou en très bonne santé, soit une baisse par rapport à 67,3 et 63,2 % respectivement en 1998-1999.

Auto-évaluation de la santé

Selon le sexe, Canada, de 1994-1995** à 2000-2001*



Source : Statistique Canada, Enquête nationale sur la santé de la population, 1994-1995, 1996-1997 et 1998-1999, échantillon transversal, fichier santé; Enquête sur la santé dans les collectivités canadiennes, 2000-2001.
* Comprend les personnes de 12 ans ou plus qui vivent au sein d'un ménage.
** Les données provenant de l'Enquête nationale sur la santé de la population ne comprennent pas les territoires.

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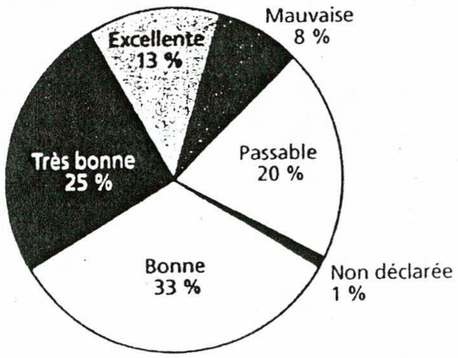
[1] Santé Canada, Direction générale de la santé des Premières nations et des Inuits, statistiques internes.

[2] Organisation de coopération et de développement économiques, données sur la santé de 2002.

Auto-évaluation de la santé

Pourcentage des répondants âgés de 18 ans ou plus, Premières nations (dans les réserves), 2002



Source : Organisation nationale de la santé autochtone, résultats préliminaires du Sondage d'opinion de l'ONSA sur les soins de santé, juillet 2002.

En 2002, 38 % des membres des Premières nations vivant dans les réserves et ayant répondu au Sondage d'opinion de l'Organisation nationale de la santé autochtone sur les soins de santé ont fait état d'une très bonne ou d'une excellente santé, tandis que 28 % qualifiaient leur santé de passable ou mauvaise.

Commentaires : L'auto-évaluation de la santé est un indicateur général de l'état de santé global des personnes. Cet indicateur peut comprendre ce que d'autres indicateurs ne couvrent pas, comme la survenue et la sévérité de la maladie et la fonction sociale et mentale.

Au Sondage d'information sur la santé et les habitudes de vie dans les Forces canadiennes (2000) 17 230 des 27 482 répondants membres des Forces régulières, soit 62 %, se sont déclarés en excellente ou en très bonne santé. (www.forces.gc.ca/health/engraph/home_f.asp)

Résultats en matière de santé

Les mesures des résultats en matière de santé visent à déterminer l'incidence des politiques, des programmes ou des interventions spécialisées sur la qualité de vie. Idéalement, ces interventions donnent lieu à de meilleurs résultats en matière de santé. Sans un niveau de référence et une méthode systématique de communication des résultats, il est difficile de mesurer les bienfaits de ces interventions et de faire des choix informés relativement aux procédures, à l'établissement de priorités et à l'allocation des ressources. Il y a encore beaucoup à faire pour déterminer et peaufiner les mesures dans ce domaine de façon à chiffrer et à comparer les effets d'interventions particulières.

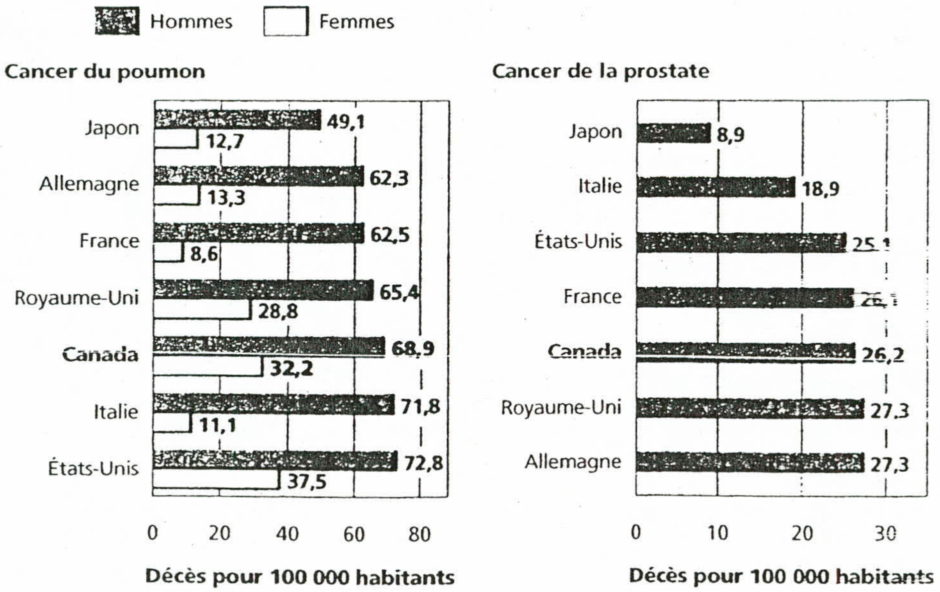
5. Changement dans l'espérance de vie

Description : **Taux de mortalité normalisés selon l'âge pour les cancers du poumon, de la prostate et du sein ainsi que pour le cancer colorectal**

Résultats : Parmi les pays industrialisés sélectionnés, le Canada affiche l'un des plus faibles taux de mortalité pour le cancer colorectal, et des taux de mortalité comparables pour les cancers du poumon, du sein et de la prostate.

Taux de mortalité suivant un cancer

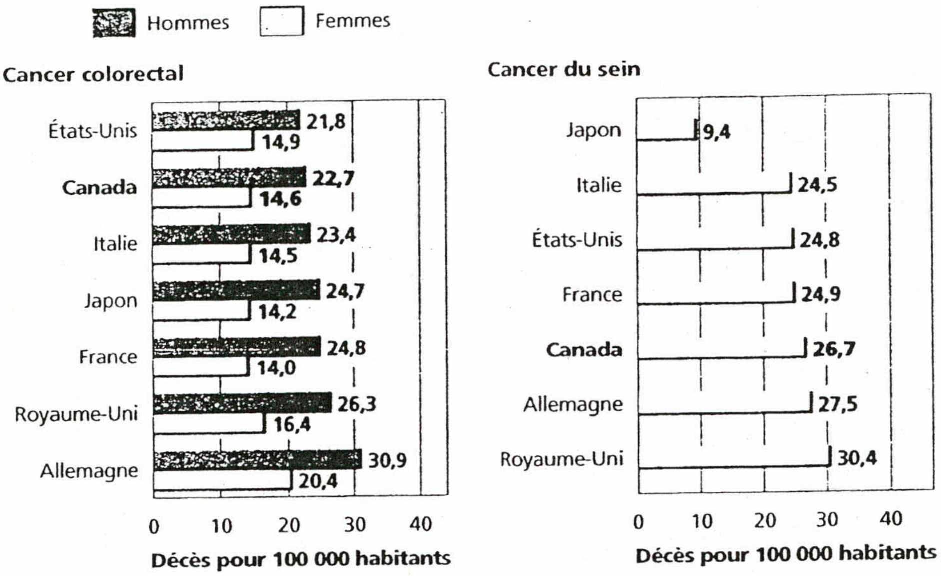
Selon le sexe (taux normalisés selon l'âge), pays sélectionnés, 1997



Source : Organisation de coopération et de développement économiques, données sur la santé de 2002.
Remarque : Taux normalisés selon l'âge au recensement de la population des pays membres de l'OCDE en 1980.

Taux de mortalité suivant un cancer

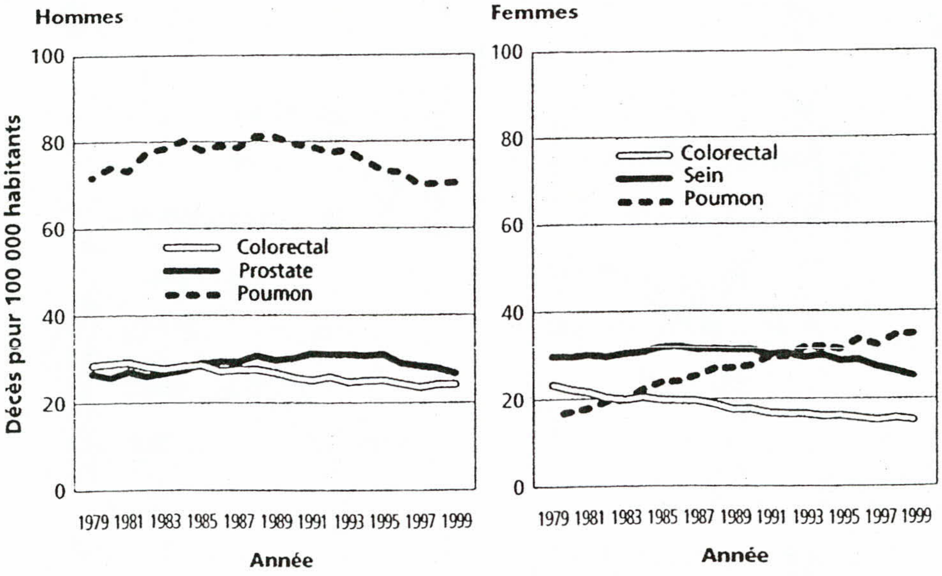
Selon le sexe (taux normalisés selon l'âge), pays sélectionnés, 1997



Source : Organisation de coopération et de développement économiques, données sur la santé de 2002.
Remarque : Taux normalisés selon l'âge au recensement de la population des pays membres de l'OCDE en 1980.

Taux de mortalité suivant un cancer

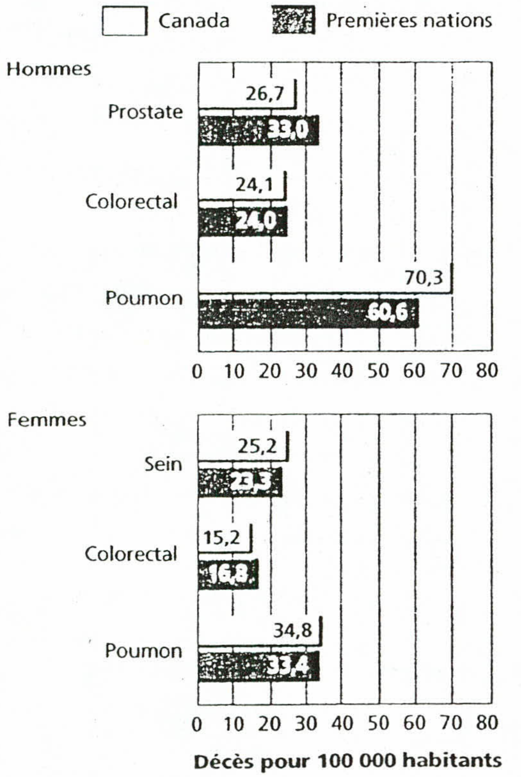
Selon le sexe (taux normalisés selon l'âge), Canada, de 1979 à 1999



Source : Statistique Canada, Statistique de l'état civil du Canada, Base de données sur les décès et Division de la démographie (estimations de la population), Recensement de la population du Canada de 1991.
Remarque : Taux normalisés selon l'âge de la population du Canada en 1991.

Taux de mortalité suivant un cancer

Selon le sexe (taux normalisés selon l'âge), Canada et Premières nations (dans les réserves), 1999*



Sources : Statistique Canada; Santé Canada, Direction générale de la santé des Premières nations et des Inuits, statistiques internes.
Remarque : Taux normalisés selon l'âge de la population du Canada en 1991.
* Renferme les données pour la population vivant dans les réserves et à l'extérieur des réserves en Colombie-Britannique et en Alberta.

Au Canada, le taux de mortalité attribuable au cancer du poumon augmente chez la femme. Il s'élevait en 1999 à 34,8 pour 100 000 habitants, par rapport à 26,9 en 1988. Cependant, il a toujours été bien inférieur au taux enregistré pour les hommes. Le taux de mortalité suivant un cancer du poumon chez l'homme régresse au Canada. En 1999, il s'élevait à 70,3 pour 100 000 habitants, par rapport à 81,3 en 1988.

Les taux de mortalité par le cancer sont généralement moins élevés dans les populations des Premières nations que dans la population canadienne, à l'exception du cancer de la prostate chez l'homme et du cancer colorectal chez la femme.

Commentaires : Les tendances dans les taux de mortalité normalisés selon l'âge peuvent indiquer le succès à long terme des efforts visant à réduire les décès causés par ces maladies. Des taux de mortalité plus bas indiquent l'efficacité du dépistage et du traitement de ces maladies.

Normalisation selon l'âge –
Procédure visant à rajuster les taux (p. ex., taux de décès) en vue d'atténuer le plus possible les effets des différences dans la composition par âge au moment de la comparaison des taux pour différentes populations.

6. Amélioration de la qualité de vie

Si l'on en croit les résultats des arthroplasties de la hanche et du genou, la qualité de vie sur le plan de la santé de la grande majorité des personnes ayant bénéficié de cette intervention s'est grandement améliorée. En raison des limites des données, les taux d'intervention en vue de remplacements articulaires servent d'indicateurs de substitution pour la qualité de vie sur le plan de la santé.

Description : **Taux d'arthroplasties complètes du genou**

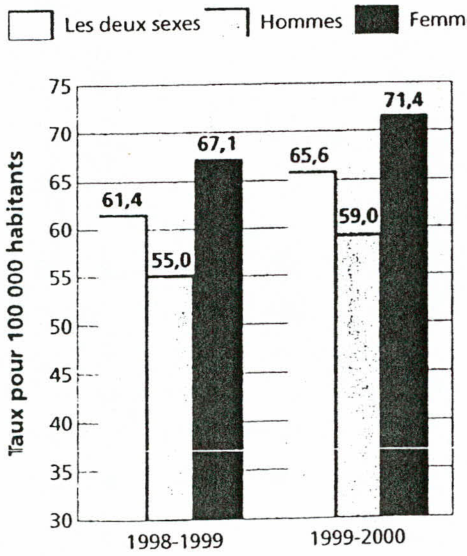
Résultats : Au Canada, le taux d'arthroplasties du genou est passé de 61,4 en 1998-1999 à 65,6 pour 100 000 habitants en 1999-2000, et il est plus élevé pour les femmes que pour les hommes.

En 1999, on observait dans les populations des Premières nations un taux d'arthroplasties du genou plus élevé que dans la population canadienne en général.

Commentaires : Selon les résultats d'études récentes, la qualité de vie sur le plan de la santé s'améliore grandement pour la majorité des personnes ayant bénéficié d'une arthroplastie du genou. De même, selon une étude, plus de 94 % des personnes ayant bénéficié d'une arthroplastie de la hanche ont fait état d'une diminution de la douleur et de la raideur ainsi que d'une amélioration du fonctionnement général[3].

Taux d'arthroplasties du genou

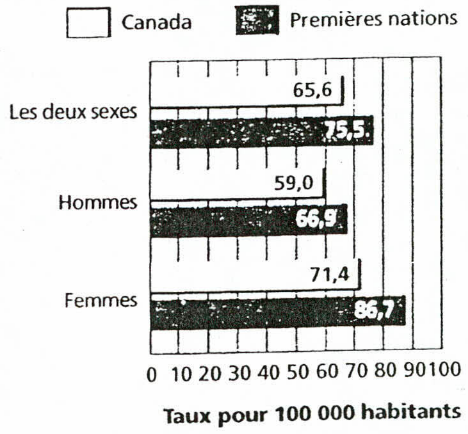
Selon le sexe (taux normalisés selon l'âge), Canada, 1998-1999 et 1999-2000



Sources : Institut canadien d'information sur la santé, Base de données sur la morbidité hospitalière; Statistique Canada, Recensement de la population du Canada de 1991.
Remarque : Taux normalisés selon l'âge de la population du Canada ene 1991.

Taux d'arthroplasties du genou

Selon le sexe (taux normalisés selon l'âge), Canada et Premières nations (dans les réserves), 1999*



Sources : Institut canadien d'information sur la santé; Statistique Canada, Statistique de l'état civil du Canada et Recensement de la population du Canada de 1991; Santé Canada, Direction générale de la santé des Premières nations et des Inuits, statistiques internes.
Remarque : Taux normalisés selon l'âge de la population du Canada en 1991.
* Données canadiennes pour l'exercice 1999-2000.

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[3] Charles J. Wright et Yoel Robens-Paradise, *Evaluation of Indications and Outcomes in Elective Surgery*, mai 2001.

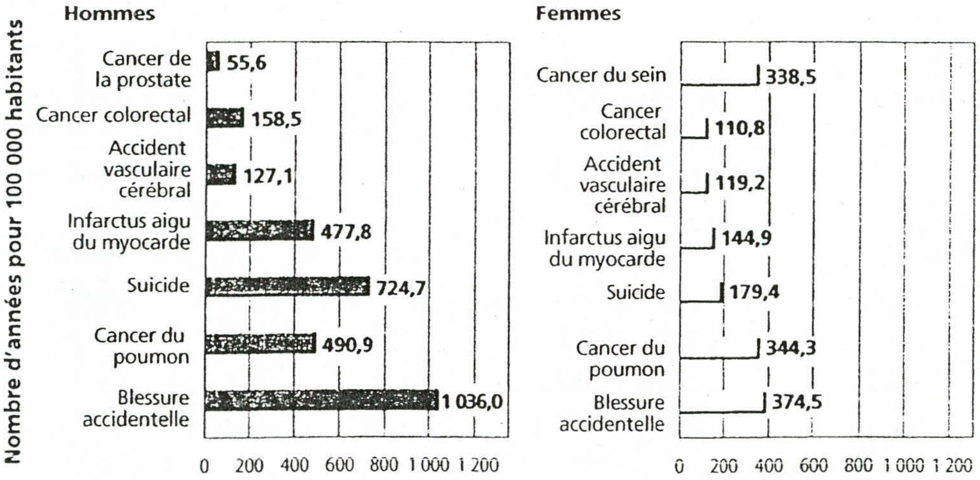
7. Réduction du fardeau associé aux maladies, aux affections et aux blessures

Description : **Années potentielles de vie perdues**

Résultats : Dans l'ensemble de la population canadienne en 1999 et parmi les causes présentées, les blessures accidentelles étaient à l'origine du plus grand nombre d'années potentielles de vie perdues pour 100 000 habitants chez les hommes (1 036 années), suivies par les suicides (725 années), le cancer du poumon (491 années) et l'infarctus aigu du myocarde (478 années). Pour les femmes, les blessures accidentelles étaient également à l'origine du plus grand nombre d'années potentielles de vie perdues pour 100 000 habitants (375 années), suivies par le cancer du poumon (344 années), le cancer du sein (339 années) et les suicides (179 années). Le nombre d'années potentielles de vie perdues pour 100 000 habitants est plus élevé pour les hommes que pour les femmes pour l'ensemble des causes présentées. La différence est particulièrement élevée pour l'infarctus aigu du myocarde, les blessures et le suicide.

Années potentielles de vie perdues

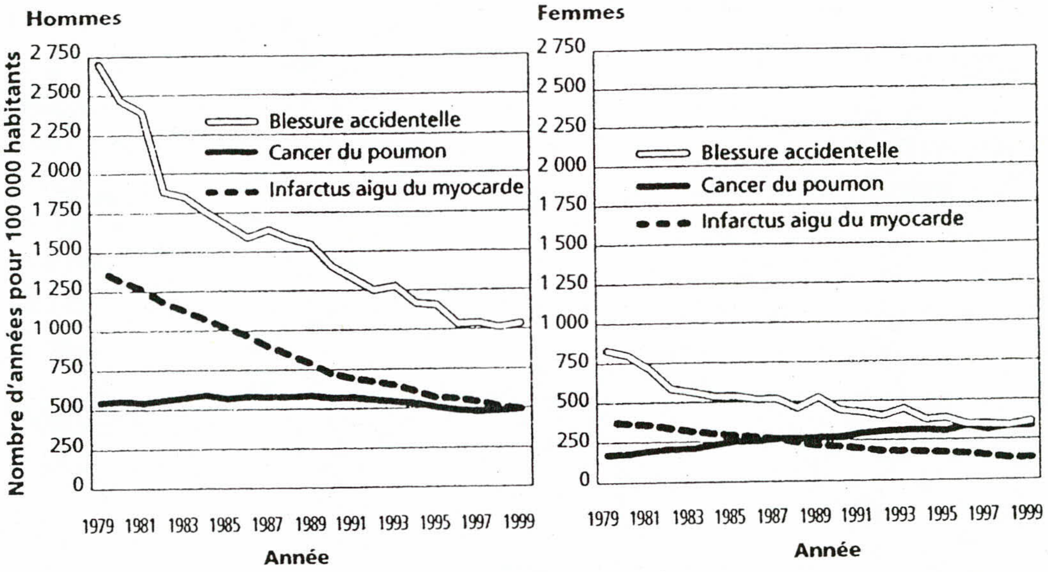
Selon le sexe, causes de décès sélectionnées, Canada, 1999



Source : Statistique Canada, Statistique de l'état civil du Canada, Base de données sur les décès et Division de la démographie (estimations de la population).
Remarque : Les taux sont calculés pour la population âgée de 0 à 74 ans.

Années potentielles de vie perdues

Selon le sexe, causes de décès sélectionnées, Canada, de 1979 à 1999



Source : Statistique Canada, Statistique de l'état civil du Canada, Base de données sur les décès, Division de la démographie (estimations de la population).
Remarque : Les taux sont calculés pour la population âgée de 0 à 74 ans.

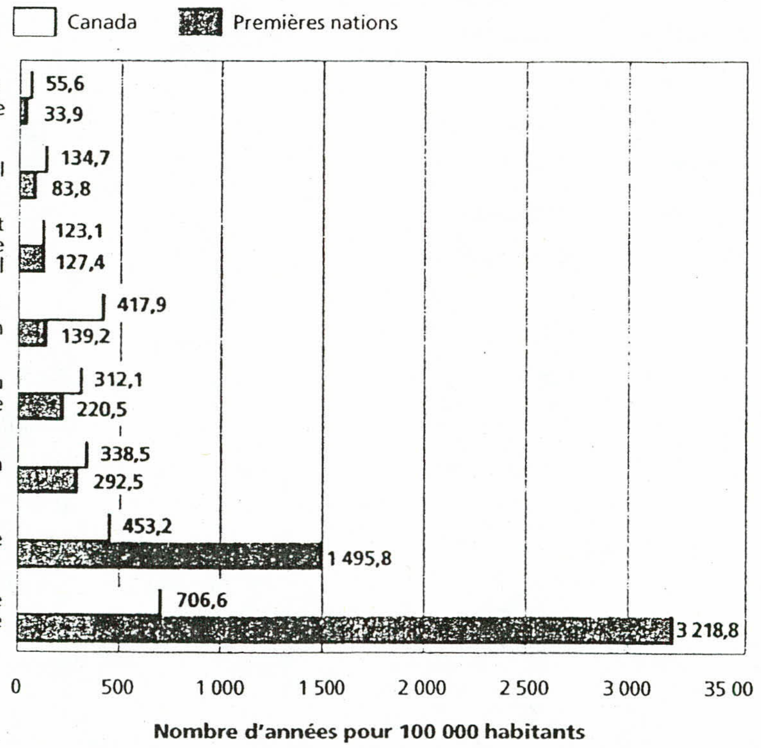
Au Canada, entre 1979 et 1999, le nombre d'années potentielles de vie perdues à cause par exemple de blessures accidentelles et d'un infarctus aigu du myocarde a considérablement diminué. Le recul est plus important pour les hommes que pour les femmes. Le nombre d'années potentielles de vie perdues pour 100 000 habitants en raison du cancer du poumon a lentement diminué chez les hommes et s'est accru chez les femmes.

Par rapport à la population canadienne en général, les populations des Premières nations perdent environ cinq fois plus d'années potentielles de vie pour 100 000 habitants à cause de blessures accidentelles et trois fois plus à cause du suicide. Pour la plupart des autres causes, qui touchent généralement les populations plus âgées, le nombre d'années potentielles de vie perdues est moins élevé pour les Premières nations.

Commentaires : Les années potentielles de vie perdues représentent le nombre total d'années non vécues en raison de la mort « prématurée » d'habitants (dans ce cas, avant 75 ans). Une tendance à la baisse reflète le succès de la prévention des décès prématurés au sein de la population.

Années potentielles de vie perdues

Causes de décès sélectionnées, Canada et Premières nations (dans les réserves), 1999*



Sources : Statistique Canada, Statistique de l'état civil du Canada, Base de données sur les décès et Division de la démographie (estimations de la population); Santé Canada, Direction générale de la santé des Premières nations et des Inuits, statistiques internes.
Remarque : Les taux sont calculés pour la population âgée de 0 à 74 ans.
* Renferme les données pour la population vivant dans les réserves et à l'extérieur des réserves en Colombie-Britannique et en Alberta.

8. Temps d'attente pour les principaux services de diagnostic et de traitement

Description : **Temps d'attente déclaré pour la consultation avec des spécialistes, les services de diagnostic et la chirurgie**

Résultats : Le temps d'attente médian déclaré pour consulter un spécialiste ou bénéficier d'une chirurgie non urgente est de 4,3 semaines au Canada. Le temps d'attente médian signalé pour certains services de diagnostic est de 3 semaines.

Moins de 20 % des personnes qui ont dû attendre pour obtenir des services spécialisés ont indiqué que cette attente avait nui à leur vie[6].

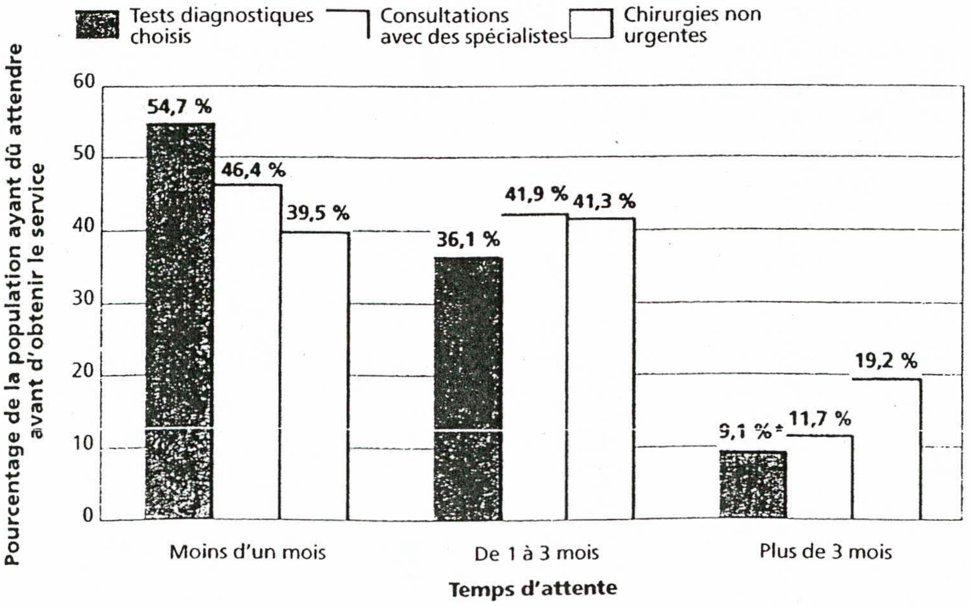
Service	**Temps d'attente médian*** *(en semaines)*
Certains tests diagnostiques	3,0**
Consultations avec des spécialistes	4,3
Chirurgies non urgentes	4,3

Source : Statistique Canada, *Accès aux services de soins de santé au Canada*, 2001.
* Temps d'attente médian : La moitié ont attendu plus longtemps et l'autre moitié, moins longtemps.
** Interpréter avec prudence (coefficient de variation élevé).

Commentaires : Ce n'est que depuis peu qu'on utilise au Canada les dossiers administratifs pour recueillir et rendre compte systématiquement de l'information sur le temps d'attente. Les administrations travaillent à l'élaboration de méthodes comparables et uniformes, en particulier des approches qui mesurent les temps d'attente selon la gravité de la maladie.

Distribution du temps d'attente

Selon la durée du temps d'attente, Canada, 2001



Source : Statistique Canada, *Accès aux services de soins de santé au Canada*, 2001.
* Interpréter avec prudence (coefficient de variation élevé).

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[6] Statistique Canada, *Accès aux services de soins de santé au Canada*, 2001.

Pour obtenir de l'information sur l'accès et le temps d'attente à l'échelle nationale, Statistique Canada a mené une enquête spéciale auprès des ménages en 2001 (*Enquête sur l'accès aux services de soins de santé au Canada*).

Pour les populations des Premières nations, les soins primaires sont assurés dans la réserve et les actes nécessitant une hospitalisation sont posés dans les hôpitaux provinciaux. Comme l'information sur l'hospitalisation est saisie dans les bases de données administratives provinciales, il est difficile d'évaluer les listes d'attente. Cependant, selon les données préliminaires du Sondage d'opinion de l'ONSA sur les soins de santé effectué en 2002, 78 % des répondants des Premières nations vivant dans une réserve avaient accès à une infirmière et 59 % avaient facilement accès à un médecin de famille.

9. Satisfaction des patients

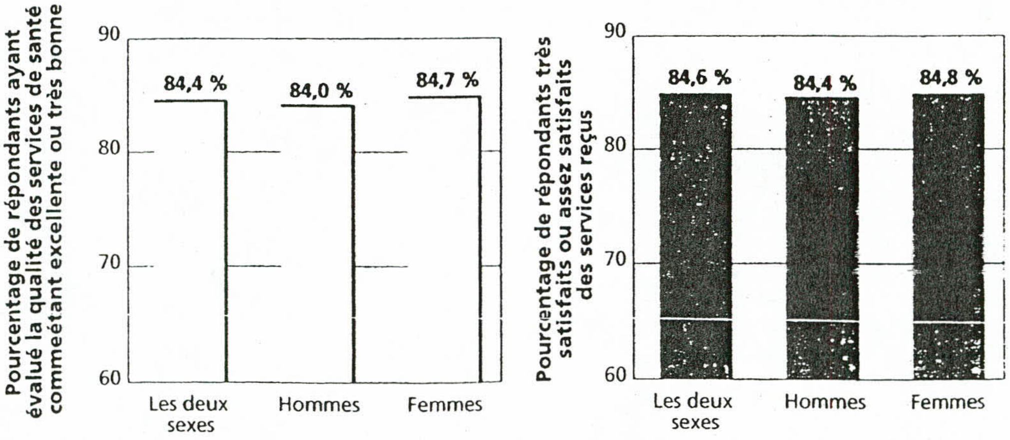
Description : **Satisfaction des patients**

Résultats : En 2000-2001, 84,4 % des Canadiens ont qualifié d'excellente ou de très bonne la qualité générale des services de santé qu'ils avaient reçus, et 84,6 % ont déclaré être très satisfaits ou assez satisfaits de ces services.

Selon les données préliminaires du Sondage d'opinion de l'ONSA sur les soins de santé (2002), 66 % des répondants des Premières nations vivant dans une réserve jugeaient

Satisfaction des patients – Ensemble des services de santé reçus

Selon le sexe, Canada, 2000-2001



Source : Statistique Canada, Enquête sur la santé dans les collectivités canadiennes, 2000-2001.
Remarque : Données exprimées en pourcentage de la population âgée de 15 ans ou plus au sein d'un ménage, qui a indiqué avoir obtenu des services de santé au cours des 12 derniers mois.

que les soins de santé reçus au cours de l'année précédente avaient été bons ou excellents, et seulement 9 % les ont qualifiés de médiocres.

Commentaires : Les indicateurs pour la population canadienne dans son ensemble s'appliquent aux adultes (15 ans ou plus au sein d'un ménage) ayant bénéficié de services de santé au cours d'une période de référence de 12 mois. Ces personnes ont évalué les services de santé généraux qu'ils ont reçus, les services reçus à l'hôpital, les services reçus d'un médecin de famille ou d'autres médecins et les services communautaires.

10. Réadmission à l'hôpital pour une affection donnée

Description : **Réadmission à l'hôpital pour un infarctus aigu du myocarde**

Résultats : Au Canada, le taux triennal moyen de réadmission par suite d'un infarctus aigu du myocarde s'établissait à 7,3 % en 1997-1999[8].

Description: **Réadmission à l'hôpital pour une pneumonie**

Résultats : Au Canada, le taux triennal moyen de réadmission par suite d'une pneumonie s'établissait à 3,3 % en 1997–1999 [9].

11. Accès aux services de santé de première ligne, 24 heures par jour, sept jours par semaine

Description : **Taux de personnes ayant un médecin de famille régulier**

Résultats : Au Canada, 87,7 % des répondants ont indiqué avoir un médecin de famille en 2001 [10].

Selon les données préliminaires provenant du Sondage d'opinion de l'ONSA sur les soins de santé effectué en 2002, 77 % des membres des Premières nations vivant dans une réserve ont un médecin de famille.

Description : **Estimation de la population ayant eu de la difficulté à obtenir des services de santé de routine ou de suivi, des informations ou des conseils en matière de santé et des soins immédiats pour un problème de santé mineur**

Résultats : Selon les résultats du sondage de 2001, 93,7 % des membres de la population canadienne ont cherché à obtenir au moins un type de service de première ligne au cours de la période de 12 mois précédant le sondage pour eux-mêmes ou un membre de leur famille.

Environ 4,3 millions de Canadiens ont indiqué avoir eu de la difficulté à obtenir des services de soins de première ligne : 2,5 millions de personnes aux soins de routine, 1,5 million à des informations ou des conseils en matière de santé et 1,6 million à des soins immédiats pour un problème de santé mineur. Certains ont fait état de difficulté à obtenir plus d'un service.

Le tableau ci-après présente le pourcentage de la population ayant eu besoin de ces services et ayant fait état de difficulté à les obtenir durant les heures normales de travail, en soirée et durant les fins de semaine ainsi qu'en pleine nuit.

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[8] Institut canadien d'information sur la santé, Base de données sur la morbidité hospitalière.

[9] *Ibid.*

[10] Statistique Canada, *Accès aux services de soins de santé au Canada*, 2001.

Type de service	Heures normales de travail	Soirées et fins de semaine	Nuits
Services de santé de routine ou de suivi	8,6 %	8,1 %	s.o.
Informations ou conseils en matière de santé	10,1 %	10,6 %	5,5 %*
Soins immédiats pour un problème de santé mineur	11,4 %	16,4 %	12,4 %*

Source : Statistique Canada, *Accès aux services de soins de santé au Canada*, 2001.
* Interpréter avec prudence (coefficient de variation élevé).

Selon les données préliminaires tirées du Sondage d'opinion de l'ONSA sur les soins de santé effectué en 2002, 17 % des répondants ont indiqué qu'au cours des 12 derniers mois, il leur était arrivé d'avoir besoin de services de santé, mais qu'ils ne les avaient pas reçus. Les principales raisons mentionnées étaient les suivantes : temps d'attente trop long, services non offerts dans la région et services non offerts au moment voulu.

Commentaires : Les services de santé offerts 24 heures par jour, sept jours par semaine comprennent des informations et des conseils et des services de traitement direct, lesquels peuvent être obtenus par le service de première ligne offert par le système de santé, en vue de répondre aux besoins immédiats ou quotidiens en matière de santé.

Les populations des Premières nations peuvent généralement avoir rapidement accès à des soins pour des problèmes non urgents grâce aux postes locaux de soins infirmiers. Les états plus graves requièrent souvent le transport vers un hôpital provincial ou d'autres établissements de traitement.

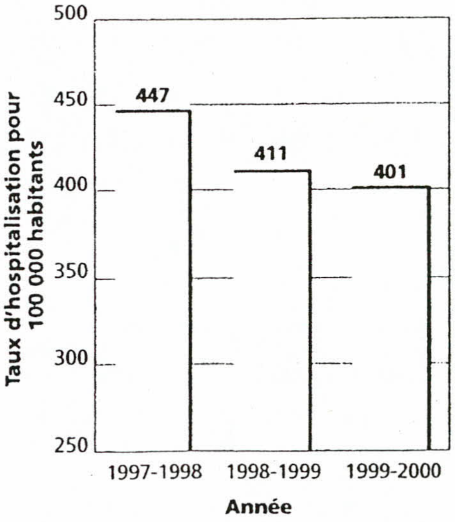
12. Soins à domicile et soins communautaires

Description : **Affections sensibles aux soins ambulatoires**

Résultats : Au Canada, le nombre d'hospitalisations pour des affections sensibles aux soins ambulatoires a diminué au cours des dernières années, passant de 447 pour 100 000 habitants en 1997-1998 à 401 en 1999-2000.

Affections sensibles aux soins ambulatoires

Taux normalisés selon l'âge, Canada, de 1997-1998 à 1999-2000



Sources : Institut canadien d'information sur la santé, Base de données sur la morbidité hospitalière; Statistique Canada, Statistique de l'état civil du Canada, Recensement de la population du Canada de 1991.
Remarques : Taux pour 100 000 habitants.
Taux normalisés selon l'âge de la population du Canada en 1991.

Commentaires : Les affections sensibles aux soins ambulatoires, comme l'asthme et le diabète, sont des troubles chroniques qui peuvent souvent être gérés à l'aide d'un traitement rapide et efficace dans la collectivité, sans qu'il y ait hospitalisation.

14. Promotion de la santé et prévention des maladies

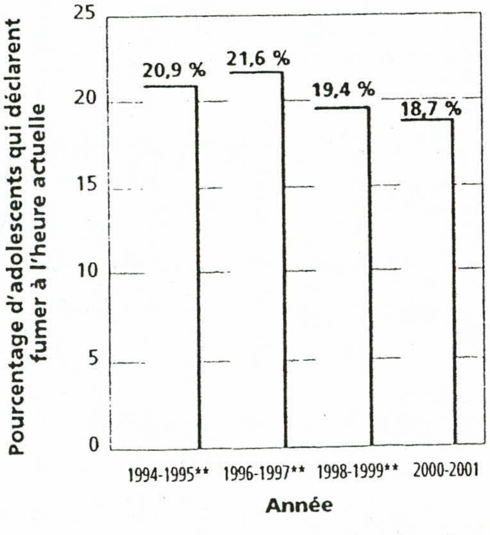
Description : **Pourcentage d'adolescents qui fument à l'heure actuelle**

Résultats : La prévalence du tabagisme chez les adolescents demeure élevée, environ un jeune sur cinq (âgés de 12 à 19 ans) déclarant fumer.

En 2000-2001, 19,8 % des jeunes filles ont déclaré fumer par rapport à 17,6 % des jeunes gens.

Adolescents qui fument à l'heure actuelle

Canada, de 1994-1995 à 2000-2001*



Source : Statistique Canada, Enquête nationale sur la santé de la population, 1994-1995, 1996-1997 et 1998-1999, échantillon transversal, fichier santé; Enquête sur la santé dans les collectivités canadiennes, 2000-2001.
* Comprend les personnes ayant entre 12 et 19 ans.
** Les données provenant de l'Enquête nationale sur la santé de la population ne comprennent pas les territoires.

Commentaires : Selon l'Enquête sur la santé dans les collectivités canadiennes effectuée en 2001, 39,3 % des non-fumeurs âgés de 12 à 19 ans ont déclaré être exposés à la fumée secondaire.

Le tabagisme est l'une des principales causes de maladies et de décès évitables au Canada. Selon les résultats récents de l'Enquête de la surveillance de l'usage du tabac au Canada (effectuée par Statistique Canada pour Santé Canada), le taux de tabagisme au sein de la population canadienne en général continue de baisser. En 2001, 5,4 millions de personnes (ou 22 % de la population âgée de 15 ans ou plus) étaient des fumeurs, comparativement à 24 % en 2000 et à 25 % en 1999. La majorité des nouveaux fumeurs étant des adolescents, il importe de comprendre le processus au tabagisme et de surveiller la qui mène prévalence chez les jeunes Canadiens.

En 2002, 48,3 % des répondants des Premières nations vivant dans les réserves (âgés de 18 ans ou plus) participant à l'enquête commandée par Santé Canada[15] ont signalé fumer.

Description : **Activité physique**

Résultats : Pour chaque année présentée, le nombre de Canadiens ayant signalé faire de l'exercice régulièrement est plus élevé que celui des Canadiennes. En 2000-2001, 44,8 % des Canadiens ont signalé être actifs ou modérément actifs, par rapport à 40,6 % des Canadiennes.

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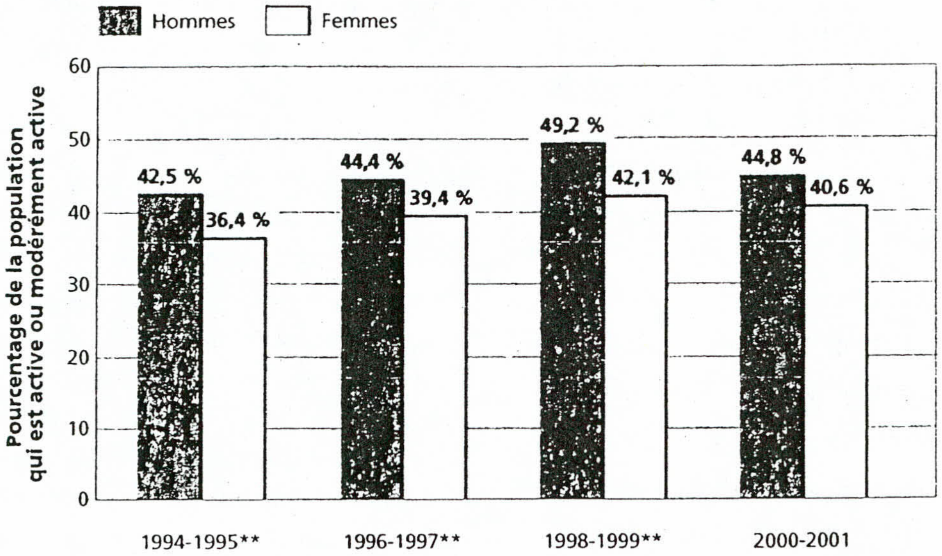
[15] Santé Canada, Direction générale de la santé des Premières nations et des Inuits, analyse secondaire d'Ipsos-Reid, Awareness and Knowledge Levels of Type 2 Diabetes Among Aboriginal Peoples in Canada, 2002.

Activité physique

Selon le sexe, Canada, de 1994-1995 à 2000-2001*



Source : Statistique Canada, Enquête nationale sur la santé de la population, 1994-1995, 1996-1997 et 1998-1999, échantillon transversal, fichier santé; Enquête sur la santé dans les collectivités canadiennes, 2000-2001.
* Comprend les personnes de 12 ans ou plus qui vivent au sein d'un ménage.
** Les données provenant de l'Enquête nationale sur la santé de la population ne comprennent pas les territoires.

Dans une enquête de Santé Canada commandée en 2002[16], la majorité (76,4 %) des répondants des Premières nations vivant dans les réserves se sont déclarés en très bonne forme ou en forme, tandis que seulement 5,4 % se sont déclarés en mauvaise forme.

Selon le Sondage d'information sur la santé et les habitudes de vie dans les Forces canadiennes (2000), 36 % des membres des Forces régulières étaient actifs physiquement et 27 % l'étaient de manière modérée.

Commentaires : L'activité physique est associée à toute une série de bienfaits pour la santé, entre autres pour la santé du cœur, et réduit les risques de dépression.

Les données de 2000-2001 fournies pour la population canadienne proviennent de l'Enquête sur la santé dans les collectivités canadiennes et, pour la première fois, comprennent des données provenant des territoires et des provinces.

Les niveaux d'activité physique sont définis d'après les unités de kilocalories/kilogramme/jour (KKJ), où 1 KKJ correspond à peu près à l'énergie dépensée pour marcher ou courir un kilomètre. La proportion de population considérée comme faisant régulièrement de l'exercice physique incluait les personnes ***actives*** (dépensant au moins 3 KKJ) ou ***modérément actives*** (dépensant entre 1,5 et 2,9 KKJ).

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[16] Santé Canada, Direction générale de la santé des Premières nations et des Inuits, analyse secondaire d'Ipsos-Reid, Awareness and Knowledge Levels of Type 2 Diabetes Among Aboriginal Peoples in Canada, 2002.