

## ACCESS TO HEALTH CARE SERVICES

Access to health care services was examined across a number of categories:

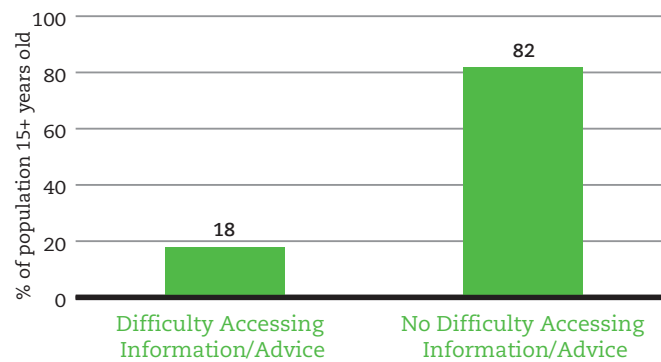
- access to health information or advice;
- access to primary health care, including
  - access to immediate care
  - access to routine care
  - rate of ambulatory sensitive conditions;
- wait times for diagnostic services; and
- drug expenditures.

### ACCESS TO HEALTH INFORMATION OR ADVICE

In the 2003 Health Services Access Survey (HSAS) conducted by Statistics Canada, people were asked if they had experienced any difficulties getting health information or advice for themselves or a family member in the past 12 months. In 2003, 47 per cent of Manitobans (42 per cent of Canadians) reported that they had required health information or advice in the preceding 12 months.

An estimated 82 per cent of those Manitobans reported no difficulty in obtaining the health information they needed (Figure 21).

Figure 21.  
Age-  
standardized  
Per cent of  
Population  
having  
Difficulty  
Accessing  
Information  
or Advice,  
Manitoba,  
2003.

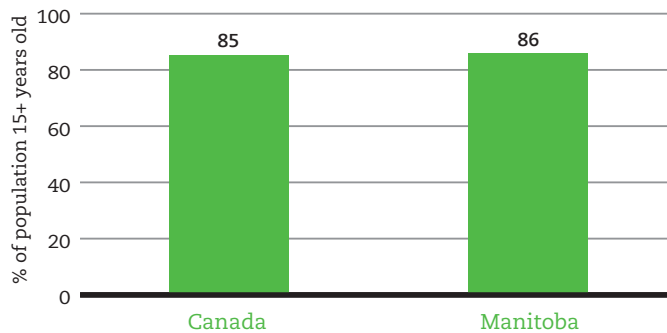


Source: Statistics Canada, Health Services Access Survey, 2003.

## ACCESS TO PRIMARY HEALTH CARE

### Access to a family doctor

In the 2003 Health Services Access Survey (HSAS), 86 per cent of Manitobans and 85 per cent of Canadians reported having a regular family doctor (Figure 22). This difference was not statistically significant.

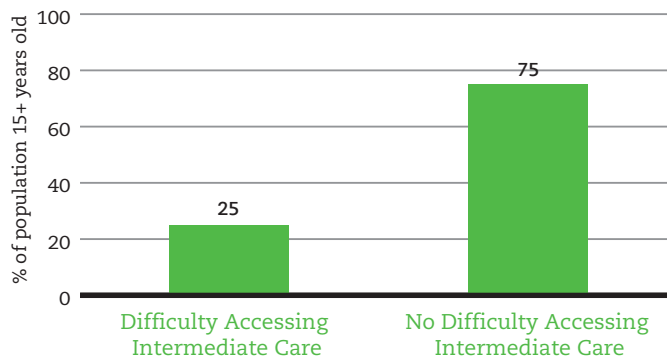


Source: Statistics Canada, Health Services Access Survey, 2003.

Figure 22. Age-standardized Per cent of Population who Reported having a Regular Family Physician, Manitoba and Canada, 2003.

### Access to immediate care

In 2003, an estimated 34 per cent of Manitobans (35 per cent of Canadians) reported that they had required immediate care for themselves or a family member in the preceding 12 months. As Figure 23 shows, about 75 per cent of those who sought immediate care for a minor ailment in the preceding 12 months, such as fever, headache, sprained ankle, vomiting or an unexplained rash, experienced no difficulty obtaining assistance. This was not statistically different from the Canadian average.



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

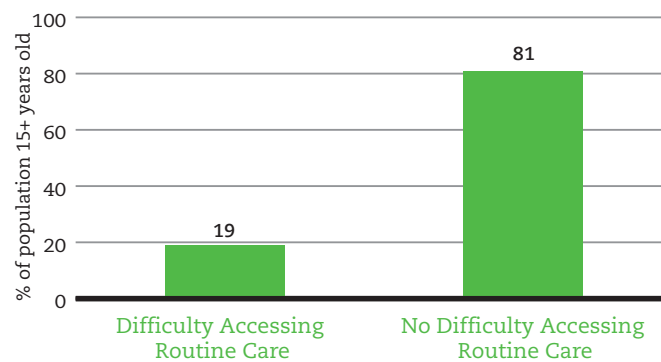
Figure 23. Age-standardized Per cent of Population having Difficulty Accessing Immediate Care, Manitoba 2003.

### Access to routine care

The 2003 Health Services Access Survey also looked at routine medical care (a medical exam or follow-up) in the preceding 12 months. If individuals indicated that they had received routine care, they were asked if they had experienced any difficulties obtaining care.

In 2003, an estimated 54 per cent of Manitobans (57 per cent of Canadians) reported that they had required routine care for themselves or a family member in the preceding 12 months. Eighty-one per cent of those experienced no difficulty obtaining it (Figure 24).

Figure 24.  
Age-  
standardized  
Per cent of  
Population  
having  
Difficulty  
Accessing  
Routine Care,  
Manitoba,  
2003.



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

### Ambulatory care sensitive conditions

Healthy living is about prevention – avoiding illness, or detecting and treating it early to minimize adverse health effects. An important consideration for access to health care is whether people are receiving the care they need in the community to keep them as healthy as possible. For example, are they being hospitalized unnecessarily when this could have been prevented if they had received the care they needed within a community setting? A commonly used indicator that measures this is the rate of ambulatory care sensitive conditions.

Ambulatory care sensitive conditions are those where hospitalization could likely be avoided through appropriate early disease management in a primary care setting, such as a doctor's office or community clinic. These conditions include diabetes, depression, hypertension and asthma. Not all admissions for ambulatory care sensitive conditions are avoidable; however, high hospital admission rates for these types of conditions may indicate that patients are not getting the care they need in their community.

Figure 25 shows the age-standardized rate of hospital admissions for ambulatory care sensitive conditions. Although over time the Manitoba rate has been consistently higher than the Canadian rate, both national and provincial rates are declining. Since 1995-1996, the Manitoba rate has declined by almost one-quarter from 597 admissions per 100,000 population to only 440 admissions per 100,000 population.

Looking at ambulatory care sensitive conditions by gender, in 2001-2002 the Manitoba rate was lower for women than for men: 426/100,000 population for women and 456/100,000 for men. Nationally, the rate was higher also for men: 367/100,000 population compared to 325/100,000 for women.

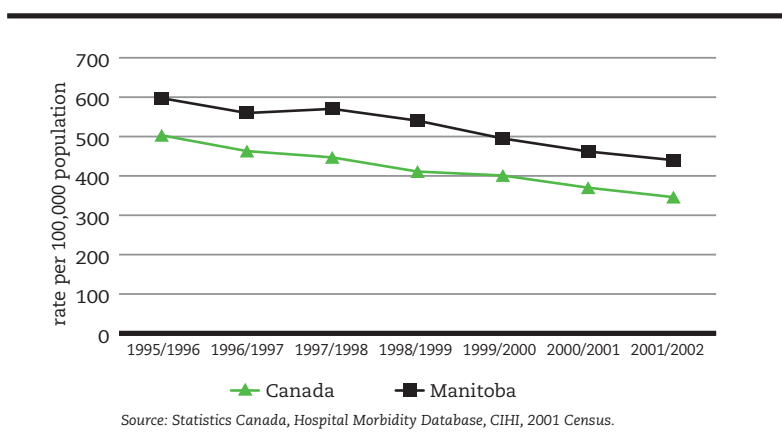


Figure 25. Age-standardized Rate of Ambulatory Care Sensitive Conditions, Manitoba and Canada, 1995/96 - 2001/02.

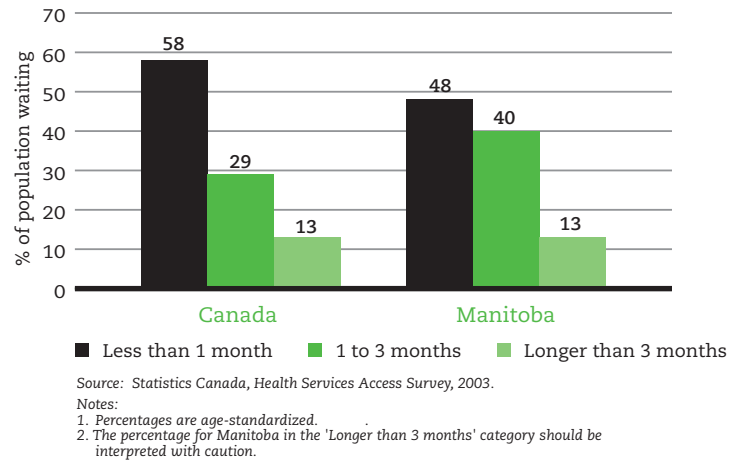
## WAIT TIMES FOR ELECTIVE DIAGNOSTIC SERVICES

Not all illness is preventable, and when a person is sick they may need specialist services or diagnostic testing. Timely access to these is also important.

Figure 26 reflects the proportion of responses of the survey population who recalled waiting for elective (non-urgent) MRI or CT scans or angiography in the 12 months prior to the survey. In Manitoba, about 48 per cent of individuals surveyed who had a diagnostic procedure recalled waiting less than a month for the procedure, compared to 58 per cent nationally.

Both in Manitoba and nationally, approximately 87 per cent of individuals surveyed who required a non-emergent MRI, CT or angiography recalled that they waited less than three months for the procedure. The median wait time for elective diagnostic procedures was two weeks for Canada and four weeks for Manitoba. However, there is no statistically significant difference between these waiting times. These data should be interpreted with caution as they are based on only a small number of responses. Also, the data represent what respondents recollected about how long they waited, and do not include wait times for individuals still waiting for the procedure at the time of the survey.

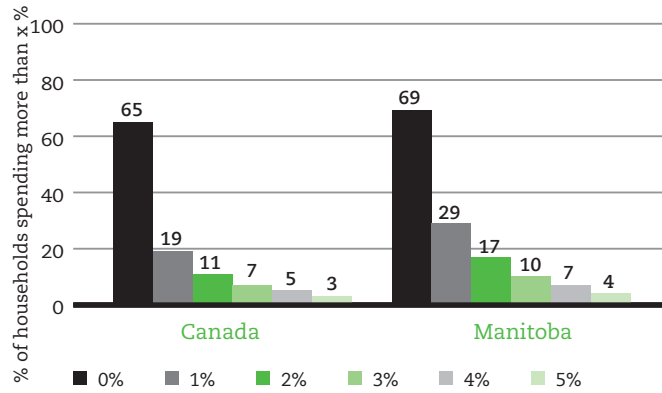
Figure 26.  
Self-Reported  
Wait times  
For Diagnostic  
Services,  
Manitoba  
and Canada,  
2003.



## DRUG EXPENDITURES

A final indicator of access to health care is the proportion of households spending a significant portion of their income on prescription drugs. Many health conditions, particularly chronic diseases, require treatment with pharmaceuticals to cure or prevent the worsening of a condition. As drug expenditures become an increasing financial burden, individuals may be less likely to take their medications as prescribed, or avoid seeking treatment for other conditions that might require more prescriptions and an additional financial burden.

Figure 27 describes the proportion of household after-tax income spent on drugs in 2002. Over-the-counter drugs, and the portion of drugs paid for by governments or insurance companies are not included, nor are drugs obtained in hospital. The trend for Manitoba and Canada was similar; however, a significantly greater number of Manitoba households reported spending some portion of their after-tax income on prescription drugs (69 vs. 65 per cent). The differences between Manitoba and Canada were significant across all the categories reported with the exception of the “more than five per cent” group. The proportion of Canadian and Manitoban households spending more than five per cent of their after-tax income was comparable.



Source: Statistics Canada, Survey of Household Spending, 2002.

Notes:

1. There was a statistically significant difference between the Manitoba and Canadian percentages for the first five categories.
2. The percent of households spending more than 5% did not differ between Manitoba and Canada.

Figure 27.  
 Prescription Drug Spending as a Percentage of After-tax Income, (Crude Percentages) Manitoba and Canada, 2002.