

EXECUTIVE SUMMARY

Building on the September 2000 *First Ministers' Meeting Communiqué on Health*, the February 2003 *First Ministers' Accord on Health Care Renewal* directed Health Ministers to develop additional indicators to supplement the work undertaken in response to the September 2000 Communiqué. With input from a range of stakeholders and experts, consultation with other federal/provincial/territorial (FPT) groups and the general public, all 14 jurisdictions agreed to report on 70 indicators (81 sub-indicators). Eighteen indicators (21 sub-indicators) were required to be featured in the 2004 reports, while the remaining 52 indicators (60 sub-indicators) were to be made available on a common website. Jurisdictions could choose to include these in their reports.

In this report, Manitoba has chosen to report 40 indicators (45 sub-indicators) to highlight key areas of particular interest to Manitobans. These fall into three general categories:

- Healthy Living
 - self-reported health
 - life expectancy
 - infant mortality
 - low birth weight
 - chronic diseases
 - health promotion and disease prevention
- Access to Health Care Services
 - health information or advice
 - primary health care
 - family doctor
 - immediate care
 - routine care
 - ambulatory care sensitive conditions
 - wait times for elective diagnostic services
 - prescription drug expenditures
- Patient Satisfaction and Quality of Care Received
 - telehealth services
 - community-based care
 - physician care
 - hospital care

For most indicators, comparisons to Canada were made. The Auditor General of Manitoba has provided an independent verification of all indicators discussed in this report.

HEALTHY LIVING

Healthy living is about creating conditions and adopting behaviours that promote good health. Manitoba has endorsed and is participating in the development of the national Integrated Pan-Canadian Healthy Living Strategy and its two goals; 1) to improve the overall health of Canadians, and 2) to reduce health disparities among Canadians. In this report, outcomes of healthy living are measured by self-reported health, life expectancy, infant mortality, low birth weight, mortality rates for cardiovascular disease, incidence rates for cancer, prevalence of diabetes, mental health, sexually transmitted infections, unintentional injuries, improving our health, and other indicators related to the goals of healthy living.

In 2003, the Canadian Community Health Survey (CCHS) asked people to rate their own health as excellent, very good, good, fair or poor. **Self-reported health** is considered a good measure as it is known to correlate strongly to actual health. About 62 per cent of Manitobans rated their health as “very good” or “excellent,” compared to 60 per cent for all Canadians. About 10 per cent of Manitobans and Canadians surveyed rated their health “fair” or “poor.”

Life expectancy measures how long people might expect to live. It represents the average age at which a group of people, of the same age and gender, are likely to die. Between 1979 and 2001, life expectancy at birth, for both Manitobans and Canadians, has risen three to four years. Women have a longer life expectancy than men; however, men are beginning to “narrow the gap.” In 2001, the life expectancy at birth of Manitoba females was 81.6 years, compared to 75.7 years for Manitoba males. Nationally, life expectancy for females was 82.1 years; for males, 77.0 years.

Health Adjusted Life Expectancy (HALE) is an estimate of the number of years that an individual can expect to live in “full health.” In 2001, HALE for Manitoba females was 70.4 years, compared to 66.7 years for Manitoba males. HALE was 70.8 years for Canadian females and 68.3 years for Canadian males.

One of the most widely used indicators for international comparisons of a population's health status is the **infant mortality** rate. This indicator identifies the number of infants who die within the first year of life per 1,000 live births. In 2001, Manitoba's infant mortality rate was higher than the Canadian rate, although the overall trend since 1979 has been improving. Also, the infant mortality rate was higher for males than females, for both Manitoba and Canada.

Low birth weight is another key indicator of the general health of newborn babies. Low birth weight is represented as the proportion of live births with a birth weight less than 2,500 grams but no less than 500 grams. In 2001, 5.4 per cent of all live births in Manitoba had low birth weights. This is similar to the Canadian average of 5.5 per cent.

Chronic diseases are a major and growing burden in our population. This report looks at the most common chronic diseases, including cardiovascular disease, diabetes, cancer and mental illness, and compares Manitoba's rates to Canada as a whole. For example, the age-standardized mortality rate for heart attacks is 48 deaths per 100,000 for Manitoba, compared to 52 deaths per 100,000 for Canada in 2001. These numbers have declined dramatically since 1979. Like heart attack deaths, deaths due to stroke have also declined since 1979. In 2001, Manitoba's age-standardized mortality rate for stroke was 37 deaths per 100,000, compared to the Canadian rate of 34 per 100,000.

The type of cancer causing the most deaths in Canada is lung cancer. In 2000, about 60 new cases of lung cancer per 100,000 population were diagnosed in Manitoba, compared to 58 new cases per 100,000 population for Canada as a whole. In 2001, the age-standardized mortality rate for lung cancer in Manitoba was 45 deaths per 100,000, with a higher rate for males than females.

Breast cancer is the most common cancer affecting Canadian women. Since 1979, the mortality rate for breast cancer has declined. Another leading cause of cancer deaths is colorectal cancer. In 2001, the age-standardized mortality rate for colorectal cancer in Manitoba was 18 deaths per 100,000, with the rate for males almost twice as high as that for females.

Another common chronic disease is diabetes. In 1999-2000, the age-standardized percentage of people living with diabetes in Manitoba was 5.5. The comparable Canadian value is 4.8 per cent.

Mental health is fundamental to an individual's overall health and the health of communities. In 2000, the CCHS showed that seven per cent of Manitobans likely suffered from depression, with significantly more women affected than men. The most extreme outcome of depression is suicide. Potential years of life lost (PYLL) is the number of years of life lost when a person dies prematurely before the age of 75. In 2001, The PYLL due to suicide was 375 years in Manitoba. The rate for males was more than double that for females.

The report also looks at the incidence of chlamydia. In 2002, the Manitoba incidence rate for chlamydia was 289 cases per 100,000. This rate was higher than the Canadian rate of 179 per 100,000. Over the last few years, chlamydia incidence rates in Manitoba and Canada have been increasing.

Several main areas of **health promotion and disease prevention** are highlighted in this report. These include obesity, physical activity, smoking, PAP testing, mammography and immunization for those aged 65 years or older. Data for this section is from information gathered in the CCHS.

In 2003, 42 per cent of Manitobans surveyed had an ideal or normal weight, compared to 48 per cent nationally. Eighteen per cent of Manitobans reported being obese, compared to 15 per cent nationally. In 2003, less than 30 per cent of Manitobans surveyed reported being physically active; about 47 per cent reported being inactive. These numbers are similar to the Canadian rates.

In the same survey, 14 per cent of Manitoba teens reported that they smoke, comparable to the national rate of 15 per cent.

Screening and preventative measures, such as vaccinations, also play an important role in keeping people healthy. The CCHS reported that in 2003, 78 per cent of Manitoban women aged 18 to 69 years had a PAP test within the last three years. The comparable Canadian value was 75 per cent. About 72 per cent of Manitoba women 50 to 69 years of age had at least one mammogram in the two years prior to 2003. The survey also reported the percentage of individuals aged 65 years and older who received an influenza immunization (flu shot) within the last year. In 2003, 56 per cent of Manitobans and 62 per cent of Canadians in this age group reported having been immunized.

ACCESS TO HEALTH CARE SERVICES

In this report, access to health care services is examined across a number of categories, including access to health information or advice, access to primary health care, wait times for diagnostic services and drug expenditures.

In the 2003 Health Services Access Survey (HSAS), 82 per cent of Manitobans accessing **health information or advice** reported no difficulty, compared to 84 per cent nationally. The same survey reported that 75 per cent of Manitobans accessing **immediate care** reported no difficulty, compared to 76 per cent nationally. Finally, 81 per cent of Manitobans accessing **routine care** reported no difficulty, compared to 84 per cent for all Canadians.

Conditions that may be cared for in the community, rather than in hospital, are called **ambulatory care sensitive conditions**. High rates of hospital admissions for these types of conditions may indicate that there are problems with patients getting the care they need at a community level. Over time, the Manitoba rate for ambulatory care sensitive conditions appears to be consistently higher than the Canadian rate. In 2001-02, the Manitoba age-standardized hospitalization rate for such conditions was 440 admissions per 100,000, compared to 346 admissions per 100,000 for Canada in total.

The report also looks at **wait times for elective diagnostic services** such as an MRI, CT scan or angiography. In 2003, about 48 per cent of Manitobans surveyed who had a diagnostic procedure waited less than one month for the procedure, compared to 58 per cent nationally. The median wait time for an elective diagnostic procedure was four weeks for Manitoba, compared to two weeks for Canada, but this difference is not statistically significant.

A final indicator of access to health care is the proportion of households who spend a significant portion of their income on **prescription drugs**. A 2002 Statistics Canada survey reported that the proportion of Canadian and Manitoban households that spend more than five per cent of their after-tax income was similar at about three to four per cent.

PATIENT SATISFACTION AND QUALITY OF CARE RECEIVED

The third main category that this report looks at is patient satisfaction and perceived quality of care received. The 2003 CCHS and HSAS both included questions on perceived quality of different types of health care services, both community-based and in hospital, and patients' satisfaction with these different types of care.

In 2003, an estimated 95 per cent of Manitobans surveyed reported receiving some kind of health care service in the preceding 12 months. About 83 per cent of those Manitobans indicated that they were very or somewhat satisfied with the way health care services were provided, compared to 85 per cent nationally. An estimated 85 per cent of Manitobans rated the quality of care they received to be "excellent" or "good."

These surveys also reported on satisfaction and quality for specific kinds of health services. These included **telehealth services, community-based care, physician care and hospital care**. For example, 63 per cent of Manitobans reported that they had received some kind of care from a physician in the preceding 12 months. About 91 per cent of those Manitobans indicated they were very or somewhat satisfied with the way those health care services were provided. An estimated 92 per cent of the same Manitobans rated the quality of care they received as “excellent” or “good.”

CONCLUSION

It is hoped that Manitobans will use the information in this report in a variety of ways to become healthier and reduce health inequalities within our population. In the simplest analysis, these data can be used as indicators of prevention, disease rates and the quality of health care provided to Manitobans. Data, such as those in this report, are a useful reference for this ongoing work by indicating our current status and what more can be achieved. In most cases, the information presented should stimulate further discussion and research. The main goal of this report will be achieved if the indicators presented can be interpreted to show us where action is needed now, and in the future, to improve the overall health of Manitobans while reducing health disparities within our population.

