



Health Services

The vast majority of Canadians who participated in our research were immensely proud of the type of health care system that has been built in Canada. They had an abiding sense of the values of fairness and equality, and do not want to see a system in which the rich are treated differently from the poor.

— National Forum on Health, Values Working Group Report, 1997.

Health services, particularly those designed to maintain and promote health and prevent disease and injury, contribute to population health. Preventive and primary health-care services such as prenatal care, well baby clinics and immunization are important for maternal and child health (Chapter 3). Services that educate children and adults about health risks and healthy choices, and those that encourage them to adopt healthy living practices, make an important contribution (Chapter 5). Services to help seniors maintain their health and independence are important as well (Chapter 7). And community environmental health services help ensure the safety of our food, water and living environments (Chapter 4).

When people are sick, they look to the curative side of health services to help them regain their health. This chapter focuses on some of the key aspects of treatment and secondary prevention that are part of the health services continuum of care. It also takes a brief look at the use of complementary or alternative care in Canada.

The principles of the *Canada Health Act* apply to the provision of medically insured services in all Canadian jurisdictions. These include universality, portability, accessibility, comprehensiveness and public administration. This chapter examines several aspects of health services in Canada, with a particular emphasis on accessibility.

A single chapter on health services cannot do justice to the complexity of this determinant of health. As stated at the outset, this report is not intended to be a “report card” on the health-care system. It does, however, shed light on some of the major challenges to a system that has been undergoing restructuring. It draws primarily on information in the *Statistical Report on the Health of Canadians* related to four dimensions of health services: health expenditures and the provision of services, access to and utilization of health services, unmet health-care needs and alternative care. Information on the quality of services was not readily available; when it does become available, it should be the focus of a complementary, more detailed report on health services as a determinant of health.

In the 1990s, all of the provinces and territories underwent health-care reform to varying degrees. Certain trends emerged over time, including a shift from centralized governing bodies to regional health authorities, a growing shift in emphasis from institutionally focused care to community-based care, decision making based on need and the best available evidence, and funding of health services at sustainable levels.

Over the past several years, governments have been successful in slowing health-care expenditures. However, the effects of these restrictions, including the increased burden on women, families and communities, and longer waiting times for institutional and community services, have yet to be documented at a national level.

Definitions and Measures

- ◆ **Unmet health-care needs:** In the NPHS, “unmet health-care needs” were based on self-report; that is, a person required some health care on at least one occasion but did not receive it. Respondents who had at least one unmet health-care need in the past year were asked to identify the category: physical, emotional/mental, regular check-up or care of an injury.
- ◆ **Home care:** In the NPHS, home care was defined as health-care or homemaker services received at home with all or part of the cost borne by the government.

As noted in a recent report, “the efforts of all levels of government to improve their fiscal health have taken their toll on the health-care system, as well as the public’s confidence in it.” The public’s assessment of the overall quality of the health-care system, although still largely favourable, has deteriorated significantly since the beginning of this decade. In February 1998, 29% of Canadians rated Canada’s health-care system as “excellent” or “very good,” down from 61% in May 1991.¹

This points to the need for increased accountability for the effectiveness and quality of services by both governments and managers within the system. Canadians need to know how well the system performs in relieving pain and suffering, restoring, promoting and protecting health, and providing compassionate care to vulnerable groups.

This form of accountability is an emerging priority for regional health authorities and governments across Canada. Indeed, the lack of data systems to collect this information is a major gap.

At the same time, an examination of current and emerging trends shows that despite financial slowdowns, the core principle of universality has not been noticeably compromised. Access to insured medical services in Canada remains largely unrelated to income. On the other hand, access to needed health services outside of the insured system, including dental services and prescription medications, is seriously restricted for many low-income Canadians. Those who have neither private nor publicly assisted supplementary health benefit plans are most likely to “fall between the cracks.”

Highlights

In the early to mid-1990s, governments were successful in slowing public health-care expenditures. However, for the most part, universality of access has not been jeopardized, and detrimental effects to health appear to have been largely avoided.

- ◆ In spite of population growth, the annual growth rate of Canada’s insured health-care expenditures fell from 11.1% (between 1975 and 1991) to 2.5% between 1991 and 1996. This was largely as a result of reductions in Canadian Health and Social Transfer payments, which increased pressures to control spending and reform the system. However, the 1999 federal budget provided a significant increase in health transfer payments over the next few years.
- ◆ Consistent with a decline in hospital expenditures, there has been a decline in the total days spent in hospitals and in the average length of stay. The shift in the place of care away from the hospital to the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, particularly on women.
- ◆ Despite slowdowns in health-care spending, most major measures of population health in Canada have continued to improve. By most internationally recognized indicators of health status, Canada continues to rank among the healthiest countries in the world (Chapter 1).

Concerns remain about access to non-insured services and the quality of care.

- ◆ At the time of writing, there were few data available on quality of care or the impacts of restructuring upon quality of care. A 1998 survey reflected Canadians’ growing dissatisfaction with the quality of care. Only 24% of Canadians described the overall quality of care they received during the previous year as “excellent” and only 28% described their overall hospital experience as “excellent.” Further research on quality of care is required.

- ◆ Access to dental services, vision correction and required prescription drugs was strongly linked to income and insurance coverage. Canadians with low incomes who did not have publicly assisted insurance or employee health benefits were the most likely to have little or no access to these necessary services.
- ◆ In spite of shorter hospital stays, reduced utilization of emergency services and an increase in the proportion of older Canadians (who are most likely to use home-care services), data from the NPHS showed that publicly sponsored home-care service use did not increase significantly between 1994–95 and 1996–97. However, some provincial utilization data suggest that public expenditures and the use of home care did increase during that time. Further research is required to clarify this discrepancy.
- ◆ It is reasonable to assume that while there were likely some unmet needs in home care, most of the increased need for help at home was picked up by informal caregivers, who are most often women. While most women who cared for others did not claim that this was a burden, some 27% said that their caregiving affected their own health and two-thirds of working women aged 25 to 44 reported job repercussions as a result of their caregiving activities. Further research on these issues is required.
- ◆ Expenditures for medication and the use of prescription drugs have increased dramatically since 1975. Thirty percent of Canadians over age 12 and 46% of Canadians aged 75 and older reported using three or more medications over a two-day period in 1996–97. While 74% of high-income Canadians had prescription drug plans, this benefit was available to only 53% of middle-income Canadians and 38% of low-income Canadians.

Better measures and information gathering systems are needed to increase accountability.

- ◆ This chapter identifies a number of information gaps related to the effectiveness of health services and to the reasons for utilization changes in areas such as home care and emergency services. In addition, more information is needed on long-term care, mental health services and palliative care.

Health Service Expenditures

Countries with the highest health expenditures do not necessarily have the best health outcomes. Recent data from the Organisation for Economic Co-operation and Development (OECD) illustrate this point. Exhibit 6.1 shows Canada's health expenditures per capita, expenditures as a percentage of gross domestic product (GDP), life expectancy at birth and potential years of life lost (PYLL) per 100,000 population, as compared with seven other OECD nations: the United States, Germany, France, Australia, Japan, New Zealand and the United Kingdom.

Although the United States ranked first among the eight OECD nations in expenditures per capita and expenditures as a percentage of GDP, it ranked last in terms of life expectancy and potential years of life lost. Part of the explanation for this may be that much of the U.S. spending on health services is private spending, whose benefits are

not distributed equally across the population. Thus, while those who can pay for health insurance (or pay directly for services) may be healthier, the uninsured or under-insured derive limited benefits from the overall level of health-care spending. In contrast, Japan ranked only sixth in terms of health-care expenditures per capita, and seventh in terms of percent of GDP devoted to health care, but first overall on both life expectancy and potential years of life lost. Canada ranked third overall in health expenditures per capita, and fourth in terms of percentage of GDP devoted to health care, but second in terms

Exhibit 6.1 Health Expenditures, Life Expectancy and Potential Years of Life Lost (PYLL): Selected OECD Countries

Country	Health-care expenditures per capita ^a	Rank	Total health expenditures % of GDP	Rank	Life expectancy (1996) ^b	Rank	PYLL per 100,000 population ^c	Rank
United States	\$4,909	1	14%	1	76.1	8	6496	8
Germany	\$2,339	2	10.4%	2	76.8	7	4921	5
Canada	\$2,095	3	9.3%	4	78.5	2	4368	3
France	\$2,051	4	9.9%	3	78.1	4	4977	6
Australia	\$1,805	5	8.3%	5	78.2	3	4148	2
OECD median	\$1,747	—	7.6%	—	77.2	—	4763	—
Japan	\$1,741	6	7.3%	7	80.3	1	3421	1
New Zealand	\$1,352	7	7.6%	6	77.1	5	6059	7
United Kingdom	\$1,347	8	6.7%	8	76.9	6	4653	4

Notes:

a 1997, US \$, adjusted for cost-of-living differences

b Life expectancy at birth

c 1995

Source: Organisation for Economic Co-operation and Development. *OECD Health Data 1998*. (CD ROM)

of life expectancy, and third in potential years of life lost.

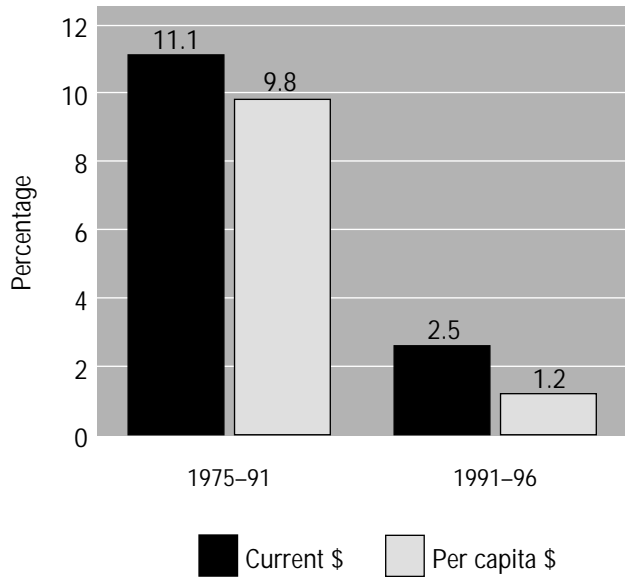
The OECD comparison suggests that enhancing health goes far beyond how much money is spent on health services. It also confirms that despite recent slowdowns in health-care spending, the overall health of Canadians has continued to improve, as documented in Chapter 1.

In recent years, governments have made a concerted effort to control public expenditures on health services. While this has not resulted in a reduction in the absolute amount of money being spent, it has slowed the relentless double-digit, yearly increases of past decades.

In 1996, Canada's total health expenditures (public plus private) were \$75.3 billion, representing 9.2% of the Gross Domestic Product. Between 1975 and 1991, Canada's total health expenditures increased at an average annual rate of 11.1%. Between 1991 and 1996, the average annual rate of growth fell to 2.5% (Exhibit 6.2). The slowdown was most noticeable in expenditures related to hospitals and physicians.

Exhibit 6.2

Average Annual Change in Total Health Expenditures, Current Dollars and Dollars Per Capita, Canada, Selected Periods



Source: Canadian Institute for Health Information. *National Health Expenditure Trends, 1975-1998*.

Historically, increases in total health expenditures tend to be related more to increases in the prices of health-related goods and services than to either population growth or increased utilization.² As such, it is important to consider health expenditure data with the effects of inflation removed (i.e. in constant dollars).

As Exhibit 6.2 shows, health-care expenditures on a per capita basis increased by 9.8% between 1975 and 1991. Between 1991 and 1996 the per capita rate of growth in spending fell dramatically to 1.2%.

Much of this slowdown in expenditures appears to have been attributable to a \$6 billion reduction in Canada Health and Social Transfer payments between 1991 and 1996. However, the federal budget of February 1999 provided significantly increased levels of health-care funding.

In 1996, there was considerable variation in health-care spending across the country (Exhibit 6.3). High per capita costs

in the Northwest Territories (including Nunavut) and the Yukon Territory reflect the cost of providing services in a large geographic area with a small population base.

All provinces and territories experienced a pronounced drop in rates of expenditure growth after 1991. These rates were based on the total health-care spending by both public and private sectors. Some regions — Saskatchewan, Alberta, Nova Scotia, Quebec and the Yukon Territory — had decreases in expenditure growth in the mid-1990s, while the others grew after 1991 at rates that were low compared to those of the previous 20 years.

In 1996, hospitals accounted for the largest share (\$25.9 billion, or 34.3%) of all health expenditures, followed by expenditures for physicians (\$10.7 billion; 14.3%) and drugs (\$10.2 billion; 13.6%). From 1991 to 1996, hospital expenditures declined by 0.1% annually, spending on physicians increased at a rate of 1.0% annually, while expenditures on drugs increased at an annual rate of 5.9%.³ This constitutes an important reorientation of spending priorities in Canada — with relatively more money being spent on the provision of drugs and relatively less on hospitals and physicians.

Exhibit 6.3

Health Expenditures (Total, per Capita, and Proportion of Gross Domestic Product), by Province and Territory, Canada, 1996

	\$ (millions)	\$ per capita	% of GDP
◆ Canada	75,304.1	2,513	9.2
◆ Newfoundland	1,295.9	2,267	12.1
◆ Prince Edward Island	337.2	2,467	11.8
◆ Nova Scotia	2,144.6	2,274	10.9
◆ New Brunswick	1,807.1	2,371	10.8
◆ Quebec	17,059.0	2,309	9.5
◆ Ontario	29,545.1	2,624	8.9
◆ Manitoba	2,941.4	2,579	10.4
◆ Saskatchewan	2,525.7	2,477	9.0
◆ Alberta	6,648.9	2,380	7.1
◆ British Columbia	10,524.8	2,728	9.9
◆ Yukon Territory	102.6	3,267	8.7
◆ Northwest Territories	371.9	5,564	12.9

Source: Canadian Institute for Health Information. *National Health Expenditure Trends, 1975–1998*.

Service Delivery

Reporting on service delivery across Canada is fraught with difficulties due to limitations of the available databases. System-based data collected at the provincial and territorial levels and compiled nationally are primarily hospital-based, whereas the system is increasingly community-based. Self-report data do not always match service delivery data. And sometimes data collected in some regions may not be aggregated or comparable at the national level. All of these issues must be addressed if we are to have accurate information on which to base measures of accountability for health services and their governance.

Hospitals

In 1995–96, diseases of the circulatory system accounted for the most hospital days, followed by mental disorders (Exhibit 6.4). These estimates exclude hospitalization in psychiatric institutions, which normally result in stays of longer duration. If the latter are included, mental disorders account for the most hospital days — over 15 million in 1993–94.⁴

In contrast, hospitalization for childbirth accounted for 3.9% of hospital days and the average length of stay was quite short (2.9 days). Two areas that changed ranking order between 1990–91 and 1995–96 were nervous system disorders, which accounted for more hospital days than cancer in 1995–96, and musculoskeletal diseases which accounted for more days than childbirth that year.

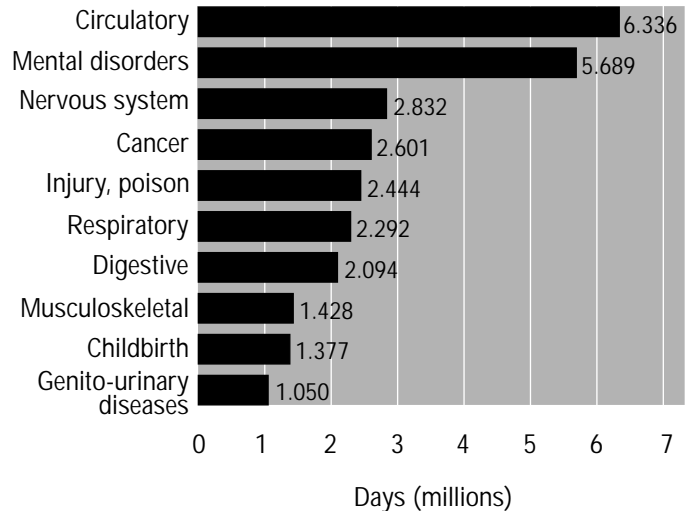
These changed standings were consistent with the increasing prevalence of chronic conditions such as arthritis, rheumatism and back disorders and the major role of nervous system disorders, and back and limb problems as causes of activity limitation during the same period.⁵

Consistent with the decline in hospital expenditures, there has been a substantial reduction in the number of hospitals in Canada as well as fundamental changes to the ways in which they deliver services. From 1986–87 to 1994–95, the number of public hospitals decreased by 14%, and the number of approved beds in public hospitals declined by 11%. As well, a common trend emerged in all categories of public hospitals: the number of outpatient visits increased, while inpatient days decreased.⁶

Changes in hospital stay practices are particularly relevant to women in at least two ways. First, due to childbearing and the tendency for women to live longer than men, women account for more days in hospital and more hospital separations. As such, changes in hospital policies regarding length of stay are relevant to women as clients. Second, early release policies have the potential to increase the burden of caregivers at home — who tend most often to be women.

In 1995–96, Canadians spent 35.5 million patient days in general and allied specialty hospitals (excluding psychiatric institutions) — a decline from 41.4 million days spent in hospital during 1990–91. These declines occurred despite an increase in the population of 1.8 million during that time period. The average length of hospital stays also declined from 11.5 days in 1990–91 to 11.0 in 1995–96 (Exhibit 6.5).

Exhibit 6.4 Total Hospital Days,* by Major Causes, Canada, 1995–96



* Excluding psychiatric institutions.

Source: Canadian Institute for Health Information. *Hospital Morbidity Database, 1994–95 and 1995–96.*

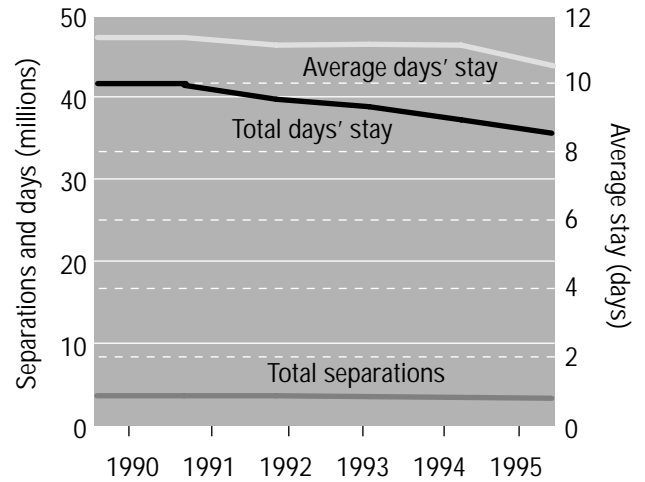
The average length of stay in hospital increases significantly with age, and time in hospital remains highly skewed toward older Canadians. Thus, with an aging population, the decline in hospital days is all the more remarkable. This may reflect the continuing improvements in the health of older Canadians observed in Chapter 1 and, as such, should help to allay concerns about the medical costs associated with an aging population. On the other hand, it may be that greater efficiencies were achieved with young and middle-aged patients, possibly due to the increasing use of ambulatory care, technological changes and improvements in drug therapies. It may also be that the burden of early release from hospital was shifted to family members and community services. Further research is needed to evaluate these factors.

Contrary to the overall trend to reduce the length of hospital stay, there has been an upward trend in the average length of stay for treatment of mental disorders (that is, an increase in the number of patient-days in both acute-care and psychiatric hospitals, combined with a decline in the total number of hospital admissions for mental disorders). This suggests that less serious cases are increasingly being treated without hospitalization, while more severe and persistent cases continue to require inpatient treatment.⁷ Whether trends in psychiatric hospitalization reflect changes in the mental health of the population as well as changes in the service system is a matter for research. Since most mental health care is now delivered in the community, the absence of a national database for community mental health services makes it difficult to examine mental health service delivery and its implications for population health.

Emergency Services

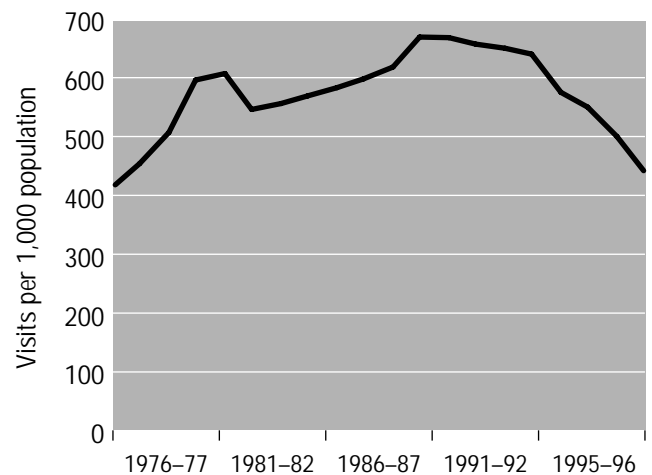
In 1996–97, 25% of Canadians aged 12 and over reported at least one visit to an emergency department. As Exhibit 6.6 shows, there has been a substantial decline in visits to emergency departments in Canada (31% from 1991–92 to 1995–96).

Exhibit 6.5 Hospital Days, Average Stay and Separations, Canada, 1990 to 1995



Source: Canadian Institute for Health Information. *Hospital Morbidity Database, 1994–95 and 1995–96.*

Exhibit 6.6 Emergency Clinic Visits, Canada, 1976–77 to 1995–96



Source: Statistics Canada. *Health Indicators, 1999.* (Statistics Canada Catalogue No. 82-221-XCB).

This may be partly attributable to the closing of hospital emergency departments, as well as to an increase in the number of walk-in clinics and other types of urgent care treatment services. Further database development and research are required to clarify the factors associated with this change.

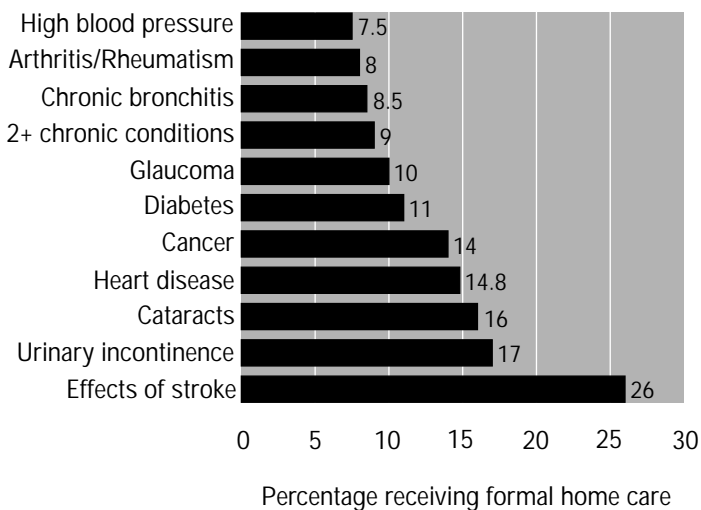
Home Care

As the population ages and health-care services are reorganized, home-care services become increasingly important as a potential means to maintain health and independence, and to contain costs. There is some uncertainty, however, regarding the use of publicly funded home-care services in Canada. According to the 1996–97 NPHS, 2% of Canadians aged 18 and over (450,000) reported use of publicly funded home-care services — a rate largely unchanged from 1994–95. At the same time, many provinces reported increasing provision of home-care services and related expenditures over the same period. For example, data provided by the Ministry of Health in British Columbia showed an increase in home-care visits from 627,000 (176 per 1,000 population) in 1994–95 to 856,000 (223 per 1,000 population) in 1996–97.⁸ This discrepancy may reflect an increase in the number of visits per person, rather than an increase in the number of persons receiving home-care services. Further research is required to help clear up this apparent contradiction.

The rates of reported home-care utilization reported in the 1996–97 NPHS were highest among seniors, particularly older women and people who lived alone. Half of home-care recipients reported their health as “poor” or “fair”; 56% had two or more chronic conditions and 28% had spent eight or more nights in hospital in the previous year. The home-care services most commonly accessed were nursing (46%) and housework (42%).

As shown in Exhibit 6.7, the odds of receiving publicly funded home care for people suffering from the effects of stroke, urinary incontinence, cancer and other conditions were higher than for those with arthritis, even though a home-care worker’s case load would likely include more people with arthritis. This reflects the fact that while arthritis is more common than stroke in the non-institutionalized population, treatment for stroke is more intense.⁹

Exhibit 6.7
Percentage Who Received Formal Home Care in Past Year, by Presence of Chronic Conditions,* Household Population Aged 18+, Canada (Excluding Territories), 1994–95



* As diagnosed by a health professional.

Source: Statistics Canada. *National Population Health Survey, 1994–95*.

There was a clear inverse relationship between household income and receiving publicly funded home care. This may reflect the poorer health status of people with low incomes, the fact that many older people who are prime users of health care have low incomes, and the reality that people with higher incomes are better able to afford private home-care services.

Well over half of those needing help to carry out daily activities including personal care, housework and shopping did not report receiving publicly funded home care. These findings are consistent with a recent study in Saskatchewan of hospital patients discharged to their homes. Sixty percent of those who were assessed in hospital as requiring home care did not go on to receive formal services.¹⁰

Based on the information reported in Chapter 2 on informal support, it is reasonable to assume that many Canadians who did not access home care received informal assistance from family members and neighbours. As well, it is quite probable that some needs were not met.

Long-Term Care

As the population ages, discussion increasingly focuses on how to keep people in the community and out of health-care institutions. But when health fails, sometimes the only option is long-term residential care.

According to the NPHS, in 1995–96, just under one-quarter of a million Canadians were living in long-term care institutions. The vast majority (81%) of these institutional residents were aged 65 and over, and among this age group, 73% were women. Over one-half (58%) of older residents did not belong to groups or participate in group activities in the institution. An even larger proportion had no close friends outside the facility. Nevertheless, many older residents received support from a family member: 61% saw a relative once a week or more.¹¹

Quality of Care

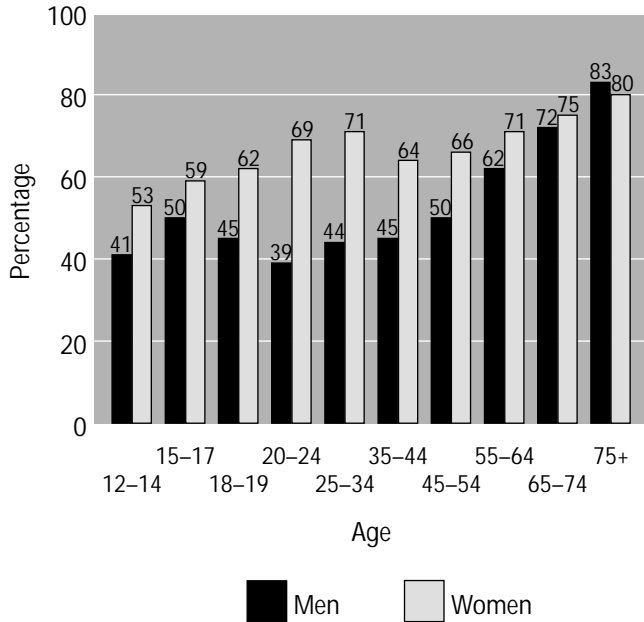
At the time of writing, virtually no data were available to describe the quality of health care in Canada, or to evaluate the impacts of health system restructuring on the quality of care received, including such important dimensions as the impacts of shifting care to communities and homes, the closure of hospital beds, and the waiting time to see a health specialist and/or to access health services. However, a recent poll revealed that only 24% of Canadians felt that the overall quality of care they received in the past 12 months was “excellent” and only 28% described their overall hospital experience as “excellent.” There is a clear need for further research on quality of care issues.¹²

Access to and Utilization of Health Services

The most common focal point for the delivery of health services in Canada continues to be the general practitioner. Consistent with the principles of the *Canada Health Act*, the provision of these services does not seem to be related to the income of the patient. Nevertheless, there appear to be persistent language and cultural barriers to the provision and/or the utilization of services in certain circumstances.

Exhibit 6.8

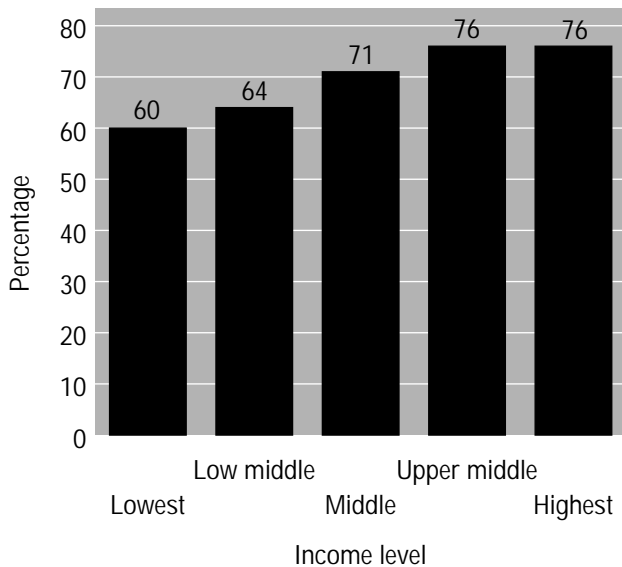
Percentage of Canadians Reporting Two or More Visits to a Doctor, by Sex and Age Group, 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Exhibit 6.9

Percentage of Women Aged 18+ Reporting a Pap Smear Test in the Past Three Years, by Income Level, 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Visits to a General Practitioner or Family Physician

According to the NPHS, during 1996–97, 87% of women and 73% of men reported at least one visit to a physician. Women aged 18 to 54 were two to three times as likely as men in this age group to have seen a physician during the previous year. The highest rates of multiple physician visits were among Canadians aged 65 and over. In this age grouping, the rates of visits reported by men and women were most similar. In fact, among those aged 75 and over, men (83%) were slightly more likely than women (80%) to report two or more visits to a physician (Exhibit 6.8).

Information was not available on the reasons for these visits, although it is well documented that patterns of utilization are markedly different for women than for men. Further investigation into these differences is needed.

Lower-income Canadians reported somewhat more frequent visits to a physician, which is consistent with the higher rates of health problems among economically disadvantaged Canadians.¹³ An analysis of the number of contacts with a medical doctor showed almost no variation between both short- and long-term immigrants and the Canadian-born population.¹⁴ However, there may be differences in patterns of utilization of specific services based on country of birth, as illustrated by the finding related to women receiving Pap tests.

Pap Smear Tests

Cervical cytology screening with a Pap smear can significantly reduce the incidence of and mortality from cervical cancer. Currently, Pap smears are recommended every three years until age 69 for women aged 18 and over. In 1996–97, 72% of Canadian women aged 18+ reported having a Pap smear within the preceding three years; 13% reported never

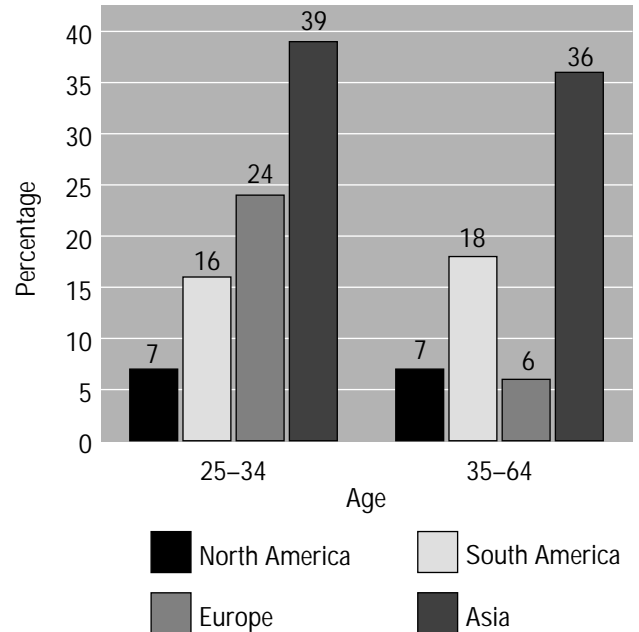
having had a Pap smear. This was a slight but important improvement over 1994–95 when 70% of women aged 18 and over reported having a recent Pap smear, and 15% reported never having had one.

Rates of Pap smear testing were related to education and income: 76% of women in the highest income bracket reported having been tested within the previous three years, compared with only 60% of women in the lowest income group (Exhibit 6.9).

Rates of Pap smear testing were even more strongly related to country of birth, according to a recent analysis based on the 1994–95 National Population Health Survey.¹⁵ Among women aged 25 to 34 who were born in North America, only 7% reported never having had a Pap smear test. This increased to 16% among women of the same age who cited South America as their place of birth; to 24% of women born in Europe; and to 39% of women born in Asia. Similar results held for older women as well. Among women aged 35 to 64, the proportion who had never had a Pap smear increased from 7% among those born in North America to 18% among women born in South America and to 36% among those born in Asia (Exhibit 6.10).

Exhibit 6.10

Percentage of Women Who Have Never Had a Pap Smear Test, by Age Group and Place of Birth, 1994–95



Source: Statistics Canada. *National Population Health Survey, 1994–95*.

Mammograms

Early detection of breast cancer by mammograms has been shown to reduce mortality among women aged 50 to 69. Currently, mammography screening is recommended every two years for women in this age group. Most provincial and territorial governments have established organized programs to provide mammographic screening to women in this age group, and some also accept women above and below these ages. As well, considerable mammography screening is conducted in diagnostic clinics. Exhibit 6.11 shows the proportion of women aged 50 to 69 in 1996–97 who reported that they had had a mammogram within the last two years.

Exhibit 6.11

Proportion of Women Aged 50 to 69 Reporting Having Had a Screening Mammogram within the Last Two Years, 1996–97

Province	%
◆ Newfoundland	29
◆ Prince Edward Island	56
◆ Nova Scotia	40
◆ New Brunswick	60
◆ Quebec	49
◆ Ontario	59
◆ Manitoba	50
◆ Saskatchewan	50
◆ Alberta	56
◆ British Columbia	54

Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Access to Health Professionals Other Than a Physician

Unlike access to universally insured medical services, access to health-related goods and services that are not universally insured (such as dental procedures, eyeglasses and mental health services by a non-physician) is strongly linked to income. Most income assistance programs offer some degree of vision care and dental coverage (although the terms of the coverage may be more restrictive than the terms for private and employer-sponsored coverage). Thus, inequities in access to these services and to (prescription) drugs are most likely greatest among Canadians who work for low wages and/or in jobs that do not offer supplementary health-care benefits. As we have seen in Chapters 2 and 3, women, young people and young families are most likely to be in this category. This has important implications for access to preventive dentistry for children and to needed eye care for all family members.

Dental Visits

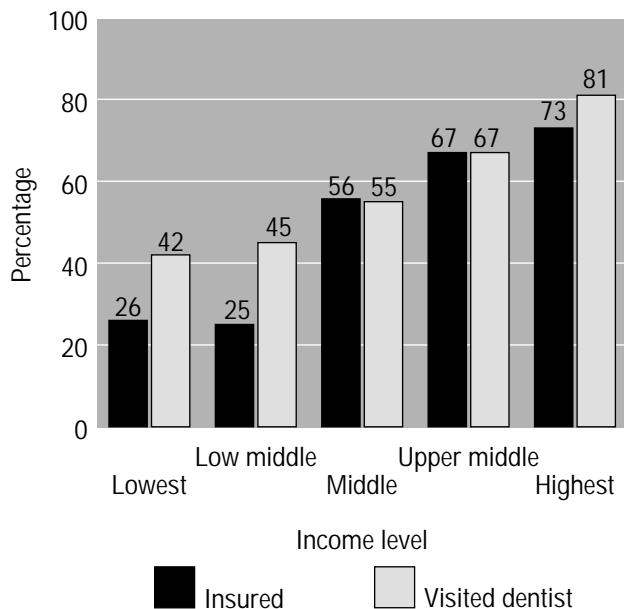
The next most common type of visit to a health professional other than a physician was to a dentist. Sixty-four percent of women and 60% of men aged 12 and older reported a dental visit during 1996–97. The highest rate of dental visits was reported by youth aged 12 to 14 (67%), 15 to 17 (71%), and 18 to 19 (61%), but the frequency dropped sharply to 48% among young people aged 20 to 24.

Income level and dental insurance were powerful determinants of accessibility to dental care: lower-income Canadians were the least likely to have dental insurance or to have visited a dentist during the past year. Among Canadians in the low middle income group, only 25% had dental insurance and only 45% visited a dentist during 1996–97. By contrast, 73% of high-income Canadians had dental insurance, and 81% reported visiting a dentist during the previous year (Exhibit 6.12).

Interprovincial differences in dental insurance coverage were marked, ranging from lows of 40% in Quebec and 43% in Newfoundland to highs of 62% in Alberta and 63% in Ontario.

Exhibit 6.12

Percentage of Canadians with Dental Insurance, and Percentage Who Reported Having Visited a Dentist, within the Past Year, by Income Level (Age-Standardized), 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

In 1997, Aboriginal people reported lower rates of dental visits than the national rate, despite First Nations and Inuit people having dental care coverage as a non-insured health benefit. According to the First Nations and Inuit Regional Health Survey, 51% of the Aboriginal population on reserve reported visiting a dentist during the previous year.¹⁶

In 1994–95, relatively few recent non-European immigrants (40%) contacted a dentist, but the figure for those who had arrived more than a decade earlier was 58%.¹⁷

Eye Examinations and Corrective Lenses

Regular eye examinations to assess vision, prescribe corrective lenses and check for eye diseases such as glaucoma are important to well-being and one's ability to carry out daily activities. Provincial plans vary in their coverage of eye examinations. Most cover an annual checkup by an ophthalmologist or optometrist, but supplementary insurance generally is needed to pay for any corrective lenses that may be prescribed.

The 1996–97 NPHS shows that, during 1996–97, 42% of Canadians (44% of women and 39% of men) reported having had an eye examination. As with visits to a dentist, visits to an eye specialist were strongly related to income. As income increased, so too did the likelihood of having insurance for corrective lenses and of having a recent eye examination. Only 21% of Canadians in the lowest income bracket reported having eyeglass or contact lens insurance, and only 37% reported a recent eye examination. Sixty-four percent of Canadians in the highest income category reported having insurance and 47% reported a recent eye examination (Exhibit 6.13).

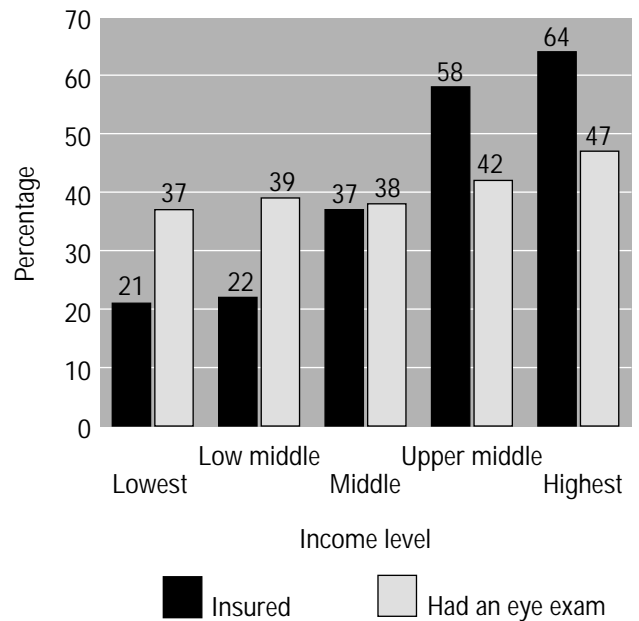
Again, there were wide variations between provinces. The proportion of citizens with insurance for visual correction varied from a low of 26% in Saskatchewan, to 34% in Quebec, 56% in New Brunswick and a high of 57% in Ontario.

Visits to a Chiropractor

According to the 1996–97 NPHS, in 1996–97, 10% of men and 11% of women reported at least one visit to a chiropractor. Visits to a chiropractor were also strongly related to income. Twelve percent of high-income Canadians reported a recent visit to a chiropractor, compared with only 6% of Canadians with low incomes.

Exhibit 6.13

Percentage of Canadians with Eye Glass/Contact Lens Insurance; Percentage Who Reported Having Had an Eye Examination within the Past Year, by Income Level (Age-Standardized), 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97.*

Mental Health Services

Services in psychiatric hospitals are excluded from funding under the national health insurance program, but are funded by the provinces and territories. Psychiatric services in general hospitals, by a general practitioner or, upon referral, by a specialist (e.g. a psychiatrist) are also provided for by the provinces and territories under their respective health insurance plans. When delivered as part of a general hospital inpatient or outpatient service, nursing, psychology, occupational therapy, social work and other clinical services are normally covered by public health insurance plans. The provinces and territories may choose to extend this basic coverage by funding certain community-based mental health services delivered by non-physician practitioners.¹⁸ Although social assistance programs and private health insurance plans may provide limited coverage for non-physician mental health services delivered outside of a hospital setting, it is reasonable to assume that low income remains a significant obstacle to accessing such services.

The 1996–97 NPHS results indicate that 3% of Canadians consulted a social worker and 2% consulted a psychologist during the preceding year. In addition, although the NPHS does not shed much light on this issue, many visits to family physicians are for a mental or emotional health problem.

Medication Expenditures and Use

Between 1975 and 1994, Canadian expenditures on drugs increased from \$1.1 billion to \$9.2 billion. Expenditures per person, adjusted for inflation, more than doubled, rising from \$108 to \$232. Drug expenditures increased faster than any other major category of health care: their share of total health spending between 1975 and 1994 rose from 8.7% to 12.7%. Prescription drugs made up about 70% of this total — \$6.5 billion in 1994. The remainder was spent on over-the-counter drugs and personal health supplies.

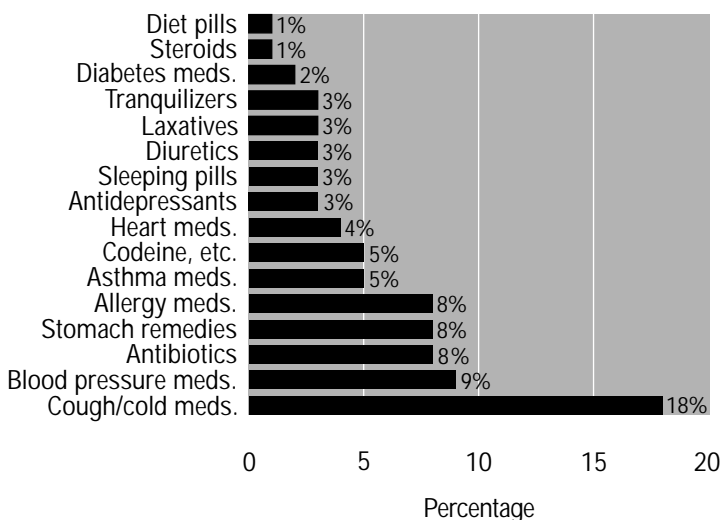
While private funding accounts for much of the total spent on all drugs, the public share of prescription drug expenditures has substantially increased since 1975.¹⁹

In recent years, increased spending on drugs has slowed down, but not as much as for hospitals and physicians. In 1996, spending on drugs accounted for \$10.2 billion or 13.6% of all health expenditures.²⁰

In 1996–97 almost two-thirds of Canadians (60% of men and 67% of women) reported that they took some form of medication (prescription or over-the-counter) in the last two days, and half of these persons (30% overall) reported that they took three or more medications at the same time.

Exhibit 6.14

Percentage of Canadians Aged 12+ Who Used Medication in the Past Month, by Type of Medication, Canada, 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Exhibit 6.14 shows the most common types of medications used. In addition to these, 16% of women aged 12 to 49 reported using birth control pills and approximately 11% of women aged 30 and over were taking hormones.

Generally, medication use increased with age, although the use of allergy medications was highest among youth under the age of 25. Forty-nine percent of Canadians aged 12 to 14 reported the use of at least one medication within the previous two days. This increased steadily across age groups to 89% among seniors aged 75 and over. Twenty-nine percent of young Canadians aged 12 to 14 used three or more medications. This rose to 44% of men and 47% among women aged 75 and older. These proportions are substantially higher than the 20% of seniors who reported using the same number of medications a generation earlier.²¹

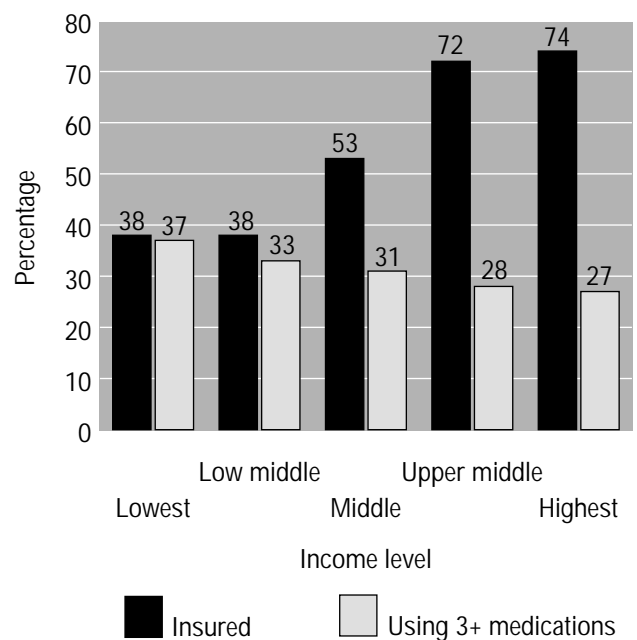
Across all age groups, women were more likely than men to be taking one or two medications, but less likely to be taking three at the same time. Women (5%) were more likely than men (2%) to be using antidepressants.

The prescription drug costs of almost two-thirds of Canadians aged 12 and over are covered to some extent by government plans and employee insurance. Similarly, prescription drugs are considered a non-insured health benefit for First Nations and Inuit peoples. Nevertheless, it appears that lower-income Canadians who are not eligible for social assistance benefits are at greatest disadvantage (Exhibit 6.15). While 74% of high-income Canadians had prescription drug plan subsidies, this benefit was available to only 53% of middle-income Canadians and 38% of low-income Canadians.

Drug insurance coverage from government plans or employee insurance varied among the provinces. Residents of Alberta (67%), Nova Scotia (67%) and Ontario (66%) were most likely to have drug insurance and residents of Saskatchewan (40%) and Manitoba (47%) were least likely to report having drug insurance.²² However, since the NPHS results exclude children under the age of 12, provincial coverage might not be fully reflected, particularly in cases in which these plans focus on children.

Exhibit 6.15

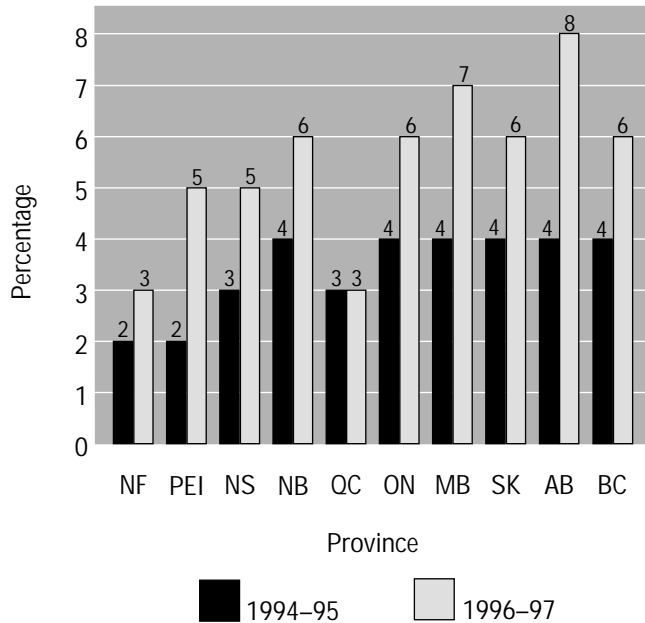
Percentage of Canadians with Insurance for Prescription Medications; and Percentage Taking Three or More Medications in the Past Two Days, by Income Level (Age Standardized), 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Exhibit 6.16

Percentage of Canadians Reporting Unmet Health-Care Needs, by Province, 1994–95 and 1996–97



Source: Statistics Canada. *National Population Health Survey, 1994–95 and 1996–97*.

Unmet Health-Care Needs

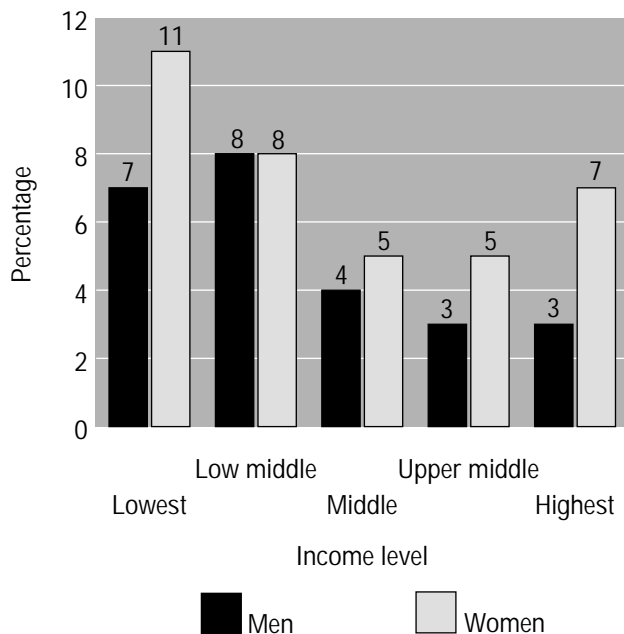
In 1996–97, 5% of Canadians aged 12 and over (1.2 million) said that they had at least one unmet health-care need during the previous year (i.e. they required some health care on at least one occasion but did not receive it). This is a slight increase from 1994–95 when 4% of the population reported unmet health-care needs. Overall, 6% of women and 4% of men reported unmet health-care needs. More than 75% of those who reported an unmet need identified a physical health problem; 9%, an injury; and another 9%, an emotional health problem.

Although the overall level of unmet needs remained low, there were increases in every province except Quebec. In 1996–97, there was almost a threefold interprovincial variation in unmet health-care needs, ranging from a low of 3% in both Newfoundland and Quebec to a high of 8% in Alberta (Exhibit 6.16). These apparent increases in unmet health-care needs should be interpreted with caution, however, due to small sample sizes.

The highest rate of unmet health-care needs was reported by Canadians in the lowest income bracket. This relationship applied to both immigrant and Canadian-born citizens. Eleven percent of women and 7% of men with low incomes reported at least one unmet health-care need (Exhibit 6.17). Among women in the lowest income group who reported unmet health-care needs, 17% identified an emotional health issue as the source of their need. This may reflect the high levels of stress reported by women with low incomes (Chapter 1) and the fact that access to psychological and counselling services (except by a psychiatrist or other physician, or in a hospital setting) is not covered by public insurance schemes.

Exhibit 6.17

Percentage of Men and Women Reporting Unmet Health-Care Needs in the Past Year, by Income Level, 1996–97



Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Alternative Health Services

The number of Canadians aged 12 and over who reported using the services of an alternative health-care practitioner such as an acupuncturist, homeopath or massage therapist within the previous 12 months increased from 5% in 1994–95 to 7% in 1996–97. Exhibit 6.18 shows the most common types of alternative health-care services used.

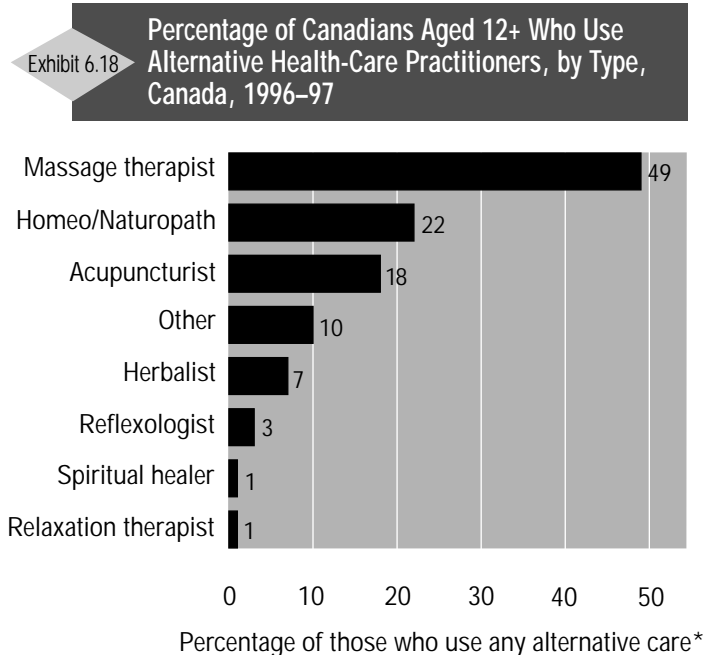
Women were one and one-half times more likely than men to have used alternative care providers in the previous year. The highest rates of use of these services were among women aged 25 to 44 (11%) and women aged 45 to 64 (10%).

Use of alternative health-care providers was higher among Canadians with a university education and among those with higher incomes. Nine percent of Canadians with a university degree reported the use of alternative health-care providers, compared with 3% of Canadians with less than a high school education. This profile suggests that well-educated Canadians may be more aware of different approaches and more likely to be able to afford them. It may also reflect a dissatisfaction with the current medical model of care and a perceived need for a more holistic approach to medical care.

The use of alternative health-care service providers was highest in British Columbia (11%), which may reflect the diverse ethnocultural characteristics of residents of that province. Unfortunately, the NPHS did not include residents of the Yukon Territory and Northwest Territories (including Nunavut) where the use of alternative health-care practices is more widespread. For example, in the 1993 Yukon Health Promotion Survey, 6% of Yukon residents reported the use of a massage therapist; 5% visited a traditional healer; and 2% visited an acupuncturist.²³

A recent Angus Reid Report shows that when the category of alternative care is expanded to include complementary and alternative treatments such as herbal remedies as well as practitioners, the proportion of adult Canadians who reported having used such products or services increased to 42%.²⁴

As more and more Canadians visit complementary therapists and make use of herbal and other alternative medicines, there is a growing concern about the need to evaluate the effectiveness of alternative therapies and the interactions between therapies. At the same time, the public is increasingly asking governments to protect consumers by setting standards and controls on the manufacturing and sale of alternative medicines.



* Total exceeds 100% due to multiple responses.

Source: Statistics Canada. *National Population Health Survey, 1996–97*.

Discussion

Quality and Accountability

As this chapter shows, significant slowdowns in health services costs were achieved with little increase in unmet needs and without compromising overall measures of population health or the right of all Canadians to universally insured medical services. At the same time, public surveys showed an increasing discontent with the quality of services they received. There was growing anxiety about the financial, physical and emotional stress placed on families, especially women, due to gaps in care, waiting times for institutional and community services, and the early release of sicker patients from hospital.

In order to make Canada's health-care system more responsible and accountable to the public, it is necessary to move toward an integrated, high-quality system that provides the care Canadians need in an effective and affordable manner. To do this, the system needs better measures of accountability using a range of indicators to track the outcomes and cost-effectiveness of medical interventions. Combining these measures with a set of indicators that report on the overall health of the population in a certain region, province or territory could be a powerful incentive for agencies inside and outside the formal health-care system to collaborate on common goals that will enhance both individual and population health.

Access to Services

Canadians can be proud of the fact that income is not generally a barrier to universal medical services. The dramatic increase in mammography use is a positive example of how public education combined with efficient screening services can make a dramatic difference in the use of proven preventive measures. Yet large disparities in access to uninsured health services remain. More information on the age and sex of groups most affected by these inequities is needed.

Most Canadians would agree that dental care, vision care and counselling services are not "frills." For many, access to these services is essential to basic health and to leading a productive life in modern society. Yet many Canadians fall between the cracks: without private or publicly assisted insurance, they have restricted or no access to these services. Reducing this inequity needs to be a priority for policy-makers across the country. Whether this is achieved through the creation of universal access programs or the provision of specific support to Canadians without insurance for these services is a subject for discussion and debate.

Home Care and Community Services

Advances in drug therapies that have made it possible for people to leave hospital earlier and changes in the nature of ailments for which people are admitted to hospital over the last 20 years suggest that the need for effective community health- and home-care services will continue to escalate in the next 20 years. Chronic conditions such as arthritis, nervous system disorders and the outcomes of stroke are best treated outside of an acute-care hospital, as long as community nursing and home-care support services are available.

The dramatic change in the length of hospital stay for childbirth also requires community backup services. A 24- to 48-hour stay in hospital is appropriate for healthy mothers who have support at home. Without this help, however, new mothers may face problems such as breastfeeding difficulties, exhaustion and depression. In addition to the mother's suffering, these problems affect maternal-child bonding and can have long-term consequences for a child's emotional and mental development.

The National Forum on Health and other groups have recommended that home care and certain other community services be made insured services. This would ensure that all Canadians have access to an integrated continuum of care that includes services in health promotion and prevention, primary care, acute care, post-acute care, chronic care and palliative care. Within this scenario, incentives should be geared to ensuring that people have access to services in the most appropriate, cost-effective settings, and due regard should be given to the burden on caregivers, many of whom are women.

The information presented in this report supports this notion. However, the literature on population health also suggests that services alone are not the answer to improving health. High-quality services must be supported by policies and programs in communities and workplaces that allow people time and opportunity to care for each other, without compromising their own health or financial security.

Medications

The use of medications has increased dramatically over the last 20 years. The number of Canadians of all ages using more than three medications has risen significantly, including almost half of Canadians over age 75. In some respects, this is not surprising, considering the influx of new drugs that improve quality of life for older people with disabilities and the fact that many more Canadians are living past age 75, when the incidence of health problems requiring medication tends to increase.

There are, however, major concerns associated with multiple drug use, including increased risks for falls and hospitalization due to harmful side effects. In recent years, groups of older adults, pharmacists and organizations of health-care professionals have carried out major campaigns to educate both physicians and older Canadians about the dangers of multiple drug use. These efforts will need to continue. At the same time, more detailed data and analysis of this complex issue are required, including information on the use of more than three drugs and specific outcomes of this use.

Policy-makers need to pay close attention to the costs of prescription drugs. Two areas deserve particular attention. First, policy-makers who regulate payments and physicians who prescribe drugs will need to adopt a rational, evidence-based approach to the complex challenge of containing drug expenditures that is fully informed by and acceptable to consumers. To do this, more information on the links between increased spending on drugs and resulting cost savings in hospitals is needed. Secondly, as drug therapies become increasingly important in the treatment of illness, policy-makers must address the fact that some 25% of Canadians — mostly lower-income Canadians — may have restricted or no access to drug insurance.

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