



Primary Health Care in Canada

A Chartbook of Selected
Indicator Results, 2016

April 2016



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Executive summary

Overview

- For most people, primary health care (PHC) clinicians such as family doctors and nurses are the first point of contact with the health care system. They provide and coordinate the care that people need to manage their health problems in the community and to prevent them from getting sick in the first place.
- Understanding the portrait of PHC and measuring indicators for the PHC sector are essential enablers of high-quality care delivery.
- This chartbook focuses on the results of 16 of 51 PHC indicators outlined in CIHI's 2012 *Pan-Canadian Primary Health Care Indicator Update Report*.² These 16 indicators were selected from the 2012 set based on
 - Data availability and quality;
 - Data that allowed for trends over time and breakdowns by geography, age and gender; and
 - The ability to adhere to the 2012 CIHI PHC indicator technical specifications without major modifications.
- Information on the 2012 indicators that are excluded from this chartbook is presented in Appendix 1.
- The 16 selected indicators have been organized according to relevant domains of CIHI's Health System Performance Measurement Framework.³ Please refer to Figure 1 and the methodology notes for additional information on the selection and organization of these indicators.

Social Determinants of Health indicators

The Social Determinants of Health indicators highlight some of the key risk factors associated with chronic disease. PHC providers play a vital role in counselling patients on lifestyle health risks and promoting healthy behaviours.

- The percentage of Canadians who are current smokers has been declining over time, from 20.8% in 2010 to 18.1% in 2014. Of note is the higher percentage of male smokers compared with female smokers (2014: 21.4% versus 14.8%). Indicator results vary across age groups and jurisdictions.

- Rates of overweight and obesity in Canadian youth and adults have been on the rise, increasing between 2010 and 2014 as follows: from 20.0% to 23.1% (for youth) and from 52.3% to 54.0% (for adults).
 - The most recent data (from 2014) shows variation across Canada, among both adult and youth overweight and obesity, with the lowest rates reported in British Columbia and the highest in Newfoundland and Labrador.
 - For 2014, much higher rates were observed for males than females in each cohort: adults (61.8% versus 46.2%) and youth (28.5% versus 16.9%).
- Fruit and vegetable consumption has been decreasing over time, with 43.3% of Canadians indicating that they ate fruit or vegetables 5 or more times daily in 2010 versus 39.5% in 2014.
- More than half of Canadians (53.7%) were moderately active to active during their leisure time in 2014, with a slight but statistically significant increase from 52.1% in 2010. The most recent data (from 2014) indicates that younger persons (younger than 35 years) had higher rates of being moderately active to active compared with older Canadians.

Health System Inputs and Characteristics indicators (Health system resources)

It is important to monitor PHC resources for planning and sustainability purposes. While indicators related to doctors, registered nurses (RNs) and nurse practitioners (NPs) are provided below, PHC contributions by licensed practical nurses, pharmacists, allied health professionals and others are also important but fall outside the scope of this chartbook.

- The number of RNs/NPs employed in a PHC setting and providing direct care has remained consistent over time, with 67 RNs/ NPs per 100,000 Canadians in 2014. These rates vary widely across Canada and are notably higher in the territories.
- There were more family medicine physicians in 2014 (114 physicians for every 100,000 Canadians) than in 2010 (103 physicians per 100,000 Canadians).
- The uptake of information and communication technology (ICT) by family medicine physicians has increased. Rates rose from 14.9% of physicians using ICT in 2007 to 70.2% in 2014. This mirrors the increasing adoption of electronic medical records (EMRs) in Canada, profiled in CIHI's January 2016 report on The Commonwealth Fund's survey.⁹

Health System Outputs indicators (Access to Comprehensive, High-Quality Health Services)

Access to PHC is a hallmark of better health and lower health care costs.²

- In 2014, most Canadians (85.1%) had access to a regular medical doctor, and rates have remained consistent over time. This includes people who are not actively looking for a doctor.
- Yet, in 2013, 53.6% of Canadians found it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital emergency department.

Health System Outputs indicators (Appropriate, effective and safe)

Use of evidence-based health interventions promotes appropriate, effective and safe PHC.³ Aligning with clinical best practices and monitoring related results supports quality of care.

7 indicators are profiled in this section. However, time trend analysis for some of these indicators was not possible due to limited data availability.

- Among the 4 provinces for which comparable survey data was available (B.C., Alberta, Manitoba and Prince Edward Island), approximately one-third of current smokers had received smoking cessation advice from a regular medical doctor.
- Among the provinces for which comparable survey data was available (B.C., Ontario, New Brunswick, Nova Scotia, P.E.I. and Newfoundland and Labrador), more than half of adults with diabetes had had an eye exam.
- More than half of Canadian seniors received the influenza immunization in 2014, with relatively similar rates observed over the past 4 years.
- In 2012, the national rate for colorectal cancer screening was 43.0% in the population age 50 to 74.
- For cervical cancer screening, in 2012, all jurisdictions had screening rates greater than 70% for the target population (women age 20 to 69).

- The hospitalization rate for ambulatory care sensitive conditions (ACSCs) has declined slightly over time (from 349 hospitalizations per 100,000 population in 2010–2011 to 331 hospitalizations per 100,000 population in 2014–2015). This may reflect that many chronic conditions are being adequately managed in ambulatory settings, including PHC.
- Between 2009 and 2015, there was an increase in the percentage of primary care physicians who generated medication lists using computerized systems, especially younger doctors. The ability to generate medication lists may result in fewer medication errors and is an important contribution to patient safety in PHC.

Considerations for the future: PHC data gaps

- In 2006, CIHI reported on considerations for enhancing the PHC data collection infrastructure in Canada in order to enable the long-term implementation of pan-Canadian PHC indicators.⁴
- Since that time, there has been some limited progress in improving data availability. This includes making patient-level physician billing data available for cross-jurisdictional comparisons, enhancing Canadian jurisdictional coverage in international survey data such as The Commonwealth Fund International Health Policy Surveys, as well as examining other sources of comparable PHC survey data, and improving quality and access to EMR data.
- However, significant PHC data gaps still exist. Only a limited number of indicators from the 2012 PHC indicator set can be calculated today, owing in part to limited pan-Canadian data availability and data quality issues.
- As such, a renewed and coordinated effort is required to improve pan-Canadian data in priority PHC areas.

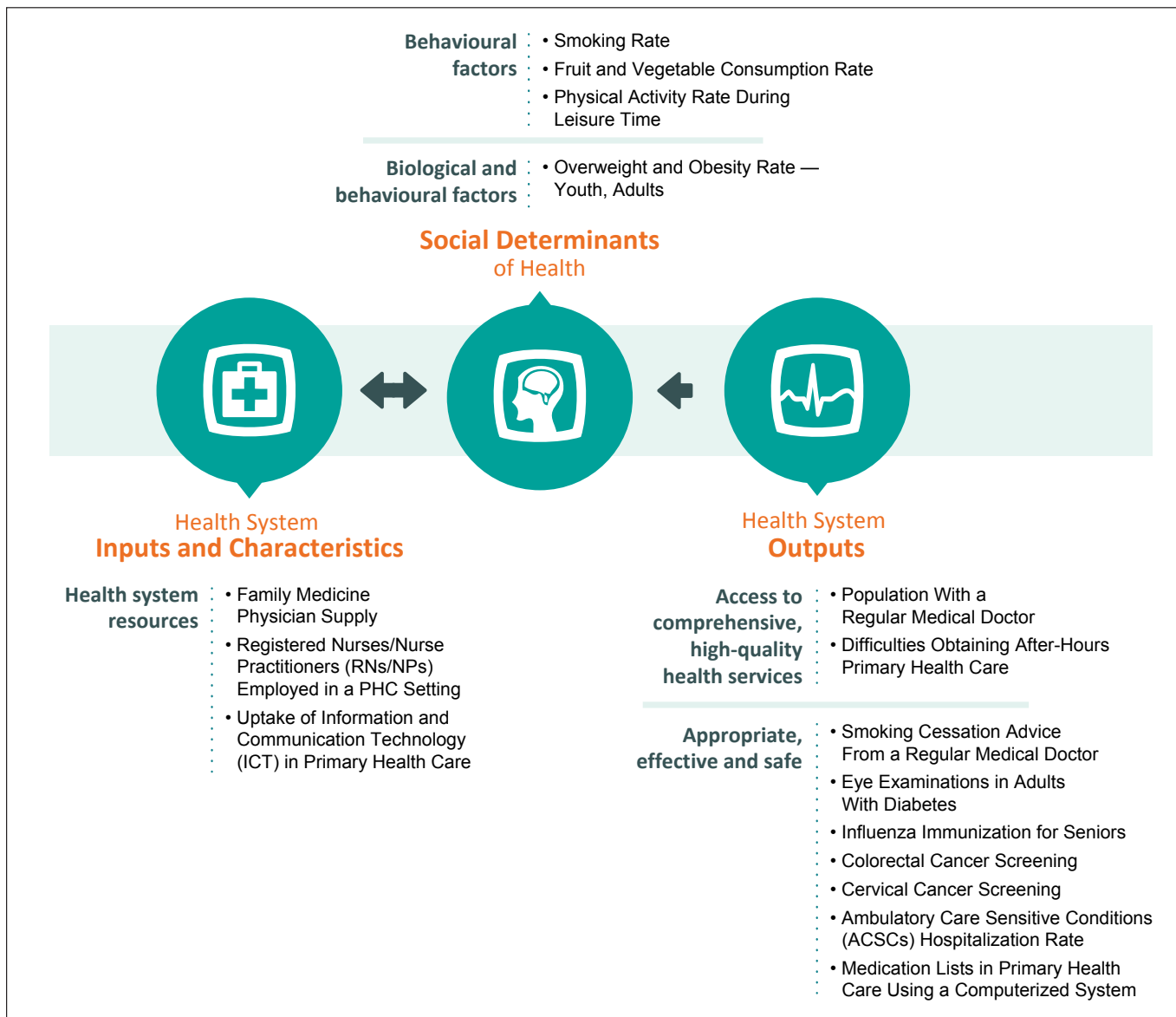
Considerations for the future: PHC measurement in Canada

- Since CIHI released the *Pan-Canadian Primary Health Care Indicator Update Report*² in 2012, the PHC performance measurement landscape in Canada has continued to evolve, with an increased provincial/territorial focus on indicators that reflect their emerging and priority policy themes.
- CIHI is committed to better data and information, and to better decisions and healthier Canadians. Accordingly, better PHC information would result from efforts to update the 2012 pan-Canadian PHC indicator set by identifying and/or refining a limited number of indicators that reflect emerging jurisdictional and pan-Canadian priorities.

About this chartbook

- In 2006, the Canadian Institute for Health Information developed 105 pan-Canadian primary health care (PHC) indicators.¹ They were identified through a consensus process as being necessary to measure and compare PHC performance at multiple levels within and across jurisdictions in Canada.
- In 2012, CIHI released the *Pan-Canadian Primary Health Care Indicator Update Report*,² which included a streamlined set of 51 PHC indicators that were categorized for use by policy-makers or by PHC providers.
- The current chartbook profiles a selected group of 16 pan-Canadian PHC indicators from the 2012 set of 51 PHC indicators (Figure 1), organized according to [CIHI's Health System Performance Measurement Framework](#).³ The indicators were selected for analysis based on data availability — with sufficient detail for comparisons over time, and by geography, age and gender — as well as on data quality and the ability to adhere to the 2012 report's indicator technical specifications without major modifications.
- The remaining 36 PHC indicators in the 2012 set of pan-Canadian indicators, which were excluded from this chartbook, are presented in Appendix 1.
- [Supplementary products](#) include companion data tables that contain expanded indicator data (i.e., regional analysis when possible) as well as methodology notes. Both products are available for downloading online.
- Other CIHI products may provide additional perspectives on some of the indicators featured in this chartbook:
 - [Your Health System interactive tool](#)
 - [OECD interactive tool: International comparisons](#)
 - [Trends in Income-Related Health Inequalities in Canada](#) (2015)
 - [Physicians in Canada, 2014](#) (2015)
 - [How Canada Compares: Results From The Commonwealth Fund 2014 International Health Policy Survey of Older Adults](#) (2015)
 - [How Canada Compares: Results From The Commonwealth Fund 2015 International Health Policy Survey of Primary Care Physicians](#) (2016)
- Please note that all hyperlinked resources are available on [CIHI's website](#).

Figure 1 Selected PHC indicators organized according to 3 quadrants of CIHI's 2013 Health System Performance Measurement Framework






Methodology notes

- The project team used CIHI's 2012 *Pan-Canadian Primary Health Care Indicator Update Report* as a basis for confirming the data sources for each indicator. Unless otherwise stated, the indicator description and rationale are sourced from that report. The 16 indicators featured in this chartbook are in fact 14 indicators plus 2 variations of the PHC Provider Supply indicator outlined in the 2012 report.
- Data sources for these 16 indicators include the following:
 - Canadian Community Health Survey (CCHS), Statistics Canada
 - Discharge Abstract Database (DAD), CIHI, and Maintenance et exploitation des données pour l'étude de la clientèle hospitalière (MED-ÉCHO), ministère de la Santé et des Services sociaux (MSSS) du Québec
 - The Commonwealth Fund International Health Policy Survey of the General Public
 - The Commonwealth Fund International Health Policy Survey of Primary Care Physicians
 - National Physician Survey, College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada
 - Scott's Medical Database, CIHI
 - Health Workforce Database, CIHI
- For the purposes of this chartbook, 5 years of data are presented when available.
- CIHI's standard data suppression rules were applied such that any cell size less than 5 was suppressed.
- As mentioned, detailed methodology notes can be found on [CIHI's PHC web page](#).

- Tests of significance were performed when possible to examine whether provincial and territorial results were significantly different from the Canadian average. For indicators derived from CCHS data, information on significant differences was obtained from Statistics Canada.
 - It must be cautioned, however, that sample sizes in some provinces or age cohorts are much smaller than in others and have wider margins of error. For this reason, 2 groups may have the same numeric results but vary in whether they have been identified as being statistically different from the Canadian average. For example, province A’s result might be coloured blue, or “same as average” as described in the legend below, while province B’s result might be coloured orange, or “below average,” despite having an identical rate. This arises from a difference in margins of error. The wider the margin of error, the less likely it is for a result to show up as significantly different from the Canadian average.
- In certain instances where formal significance testing could not be performed, significant differences are based on whether the 95% confidence intervals (CIs) do not overlap. In situations where the confidence intervals are overlapping, results are displayed within the category “same as average.” When interpreting results, the following colour codes are used throughout the chartbook to denote when results are deemed to be statistically different from the Canadian average.

Results compared with the Canadian average

 Above average  Same as average  Below average

Interpretation note: *Above average* results are more desirable relative to the Canadian average; *below average* results often indicate areas in need of improvement.

Indicator results

Social Determinants of Health

Smoking Rate

This indicator captures the prevalence of Canadians age 12 and older who currently smoke cigarettes daily or occasionally. The health and economic impacts of smoking are numerous and well documented. Tobacco is a leading preventable cause of many diseases, including cancer, heart disease and stroke. The role of PHC in promoting smoking cessation is critical to reducing the morbidity and mortality associated with this risky health behaviour.

Overweight and Obesity Rate — Youth, Adults

This indicator measures the prevalence of overweight and obesity among Canadian youth, age 12 to 17, and among adults, age 18 and older. It includes Canadians who reported a height and weight corresponding to a body mass index (BMI) in the overweight range (adults: BMI 25.00–29.99) or obese range (adults: BMI 30.00+). Being overweight or obese is a risk factor for many chronic diseases and is also associated with certain psychosocial problems, functional limitations and disabilities. The role of PHC providers in counselling patients about the associated health risks is increasingly important as rates of overweight and obesity continue to climb.

Fruit and Vegetable Consumption Rate

This indicator measures the proportion of Canadians age 12 and older who report eating fruit or vegetables 5 or more times daily. Research indicates that consuming a diet rich in fruits and vegetables may help prevent cardiovascular disease and certain types of cancer and is associated with healthy weights and a decreased risk of obesity. PHC providers are well positioned to support their patients in developing healthy eating and other lifestyle habits that promote optimal health and prevent disease.

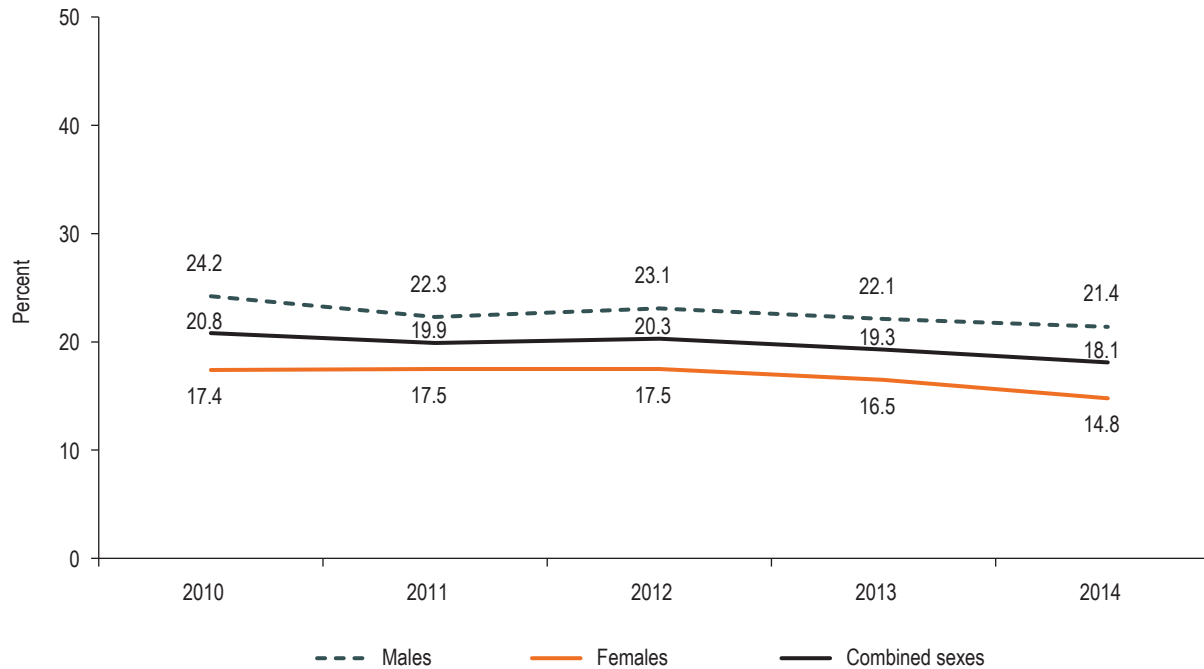
i. Youth BMI is categorized using the Cole classification system, which classifies children age 12 to 17 as “obese,” “overweight” or “neither obese nor overweight” according to age- and sex-specific BMI cut-off points.⁵

Physical Activity Rate During Leisure Time

This indicator measures the proportion of Canadians age 12 and older who report a physical activity rate that corresponds to being moderately active or active. Research indicates that regular physical activity promotes good health and is an important preventive health measure against the development of many chronic diseases. It is associated with a reduced risk of cardiovascular disease, osteoporosis, diabetes, obesity, hypertension, certain types of cancer and certain mental health conditions. PHC providers can play a key role in supporting patients to become physically active.

Smoking rates in Canada declining

Figure 2 Percentage of the population age 12 and older who reported smoking cigarettes daily/occasionally, Canada, 2010 to 2014



Males were more likely than females to be current smokers (2014)

Males
21.4%

Females
14.8%

Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

Since 2010, the rates of smoking in Canada have significantly decreased. In 2014, 18.1% of Canadians age 12 and older reported daily or occasional smoking, with significantly higher rates reported for men than for women (21.4% versus 14.8%).

18% of Canadians current smokers

Figure 3 Percentage of the population age 12 and older who reported smoking cigarettes daily/occasionally, Canada and provinces/territories, 2014

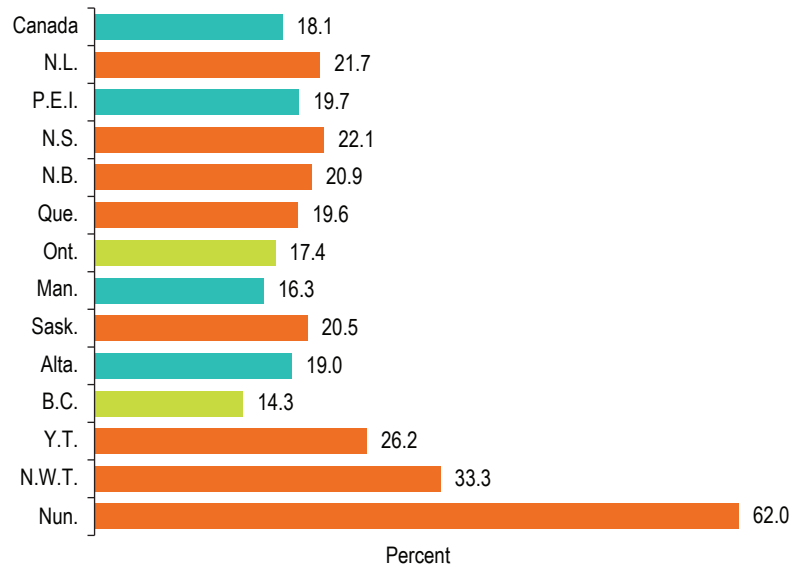
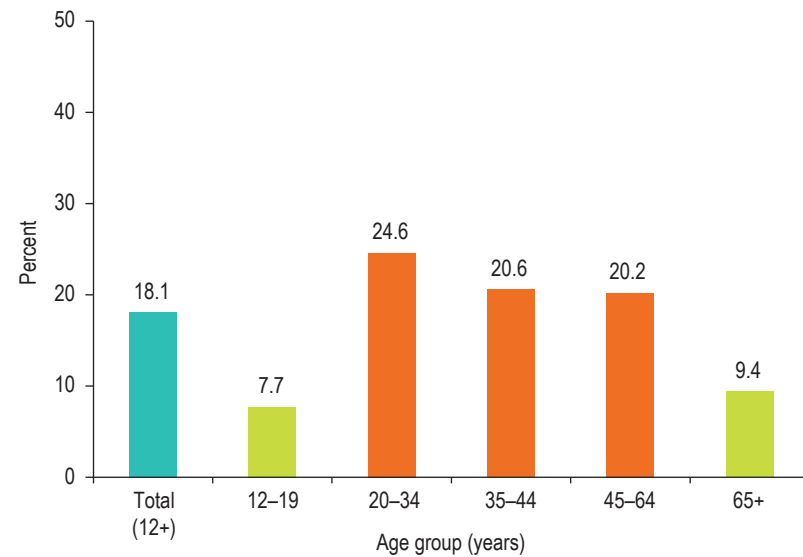


Figure 4 Percentage of the population age 12 and older who reported smoking cigarettes daily/occasionally, Canada, by age group, 2014



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Note

Above average represents the desirable direction for this indicator. In this case, the lower percentage actually represents *above average* results when compared with the Canadian average.

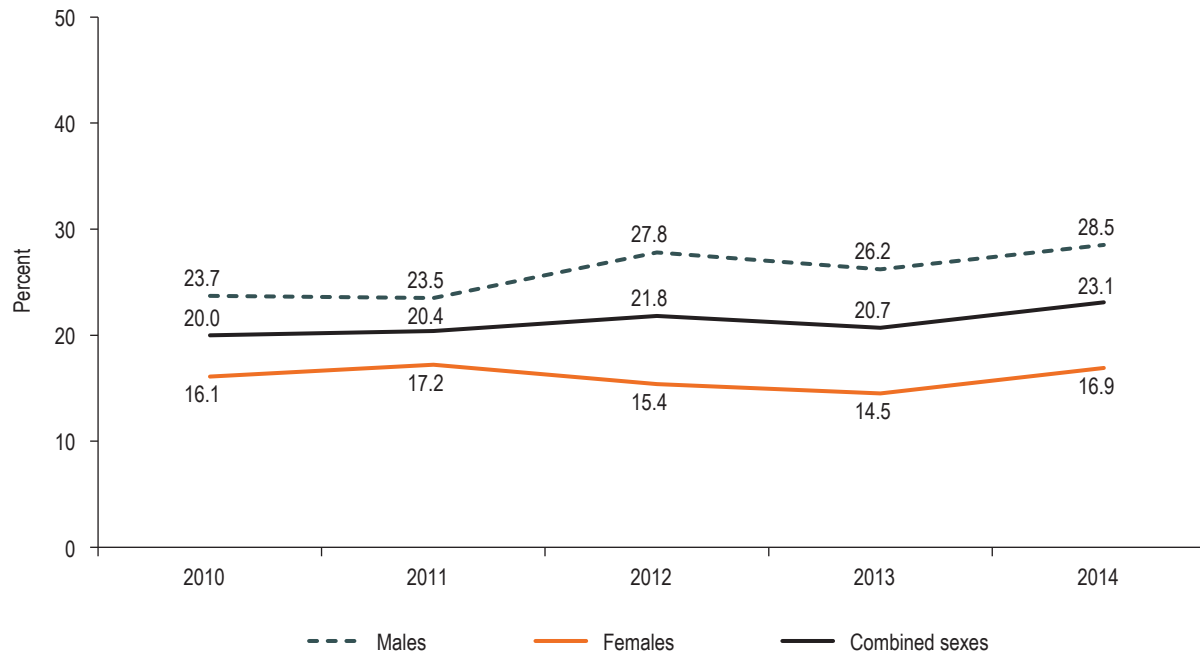
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

In 2014, smoking rates varied across the country, with the highest rate observed in Nunavut (62.0%) and the lowest rate observed in B.C. (14.3%). Smoking rates also varied across the different age groups, with significantly lower smoking rates observed among youth age 12 to 19 and seniors age 65 and older.

Overweight and obesity in Canadian youth rising

Figure 5 Percentage of the population age 12 to 17 classified as overweight and obese, Canada, 2010 to 2014



Among youth, males were more likely than females to be overweight and obese (2014)

Males
28.5%

Females
16.9%

Source

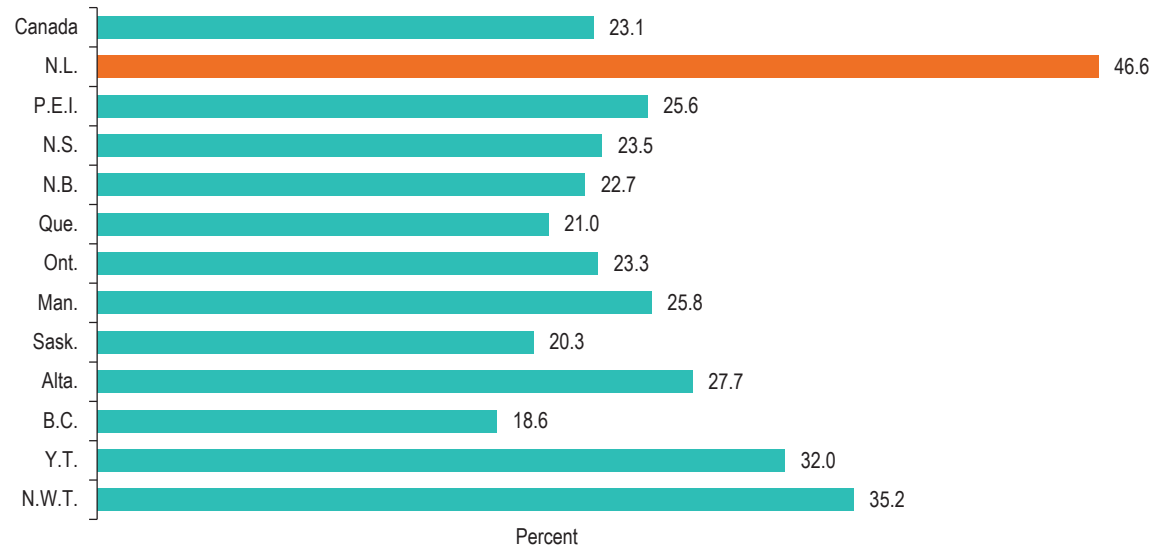
CCHS data from CANSIM Table 105-0501. Statistics Canada.

Since 2010, there has been an increasing trendⁱⁱ in the rate of overweight and obesity in Canadian youth. In 2014, 23.1% of Canadian youth age 12 to 17 reported a height and weight that classified them as overweight and obese, with significantly higher rates observed in males than in females (28.5% versus 16.9%).

ii. The statistical significance of the change from 2010 to 2014 could not be determined due to overlapping confidence intervals.

23% of Canadian youth overweight and obese

Figure 6 Percentage of the population age 12 to 17 classified as overweight and obese, Canada and provinces/territories, 2014



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *below average* results when compared with the Canadian average.

Data for Nunavut has been suppressed.

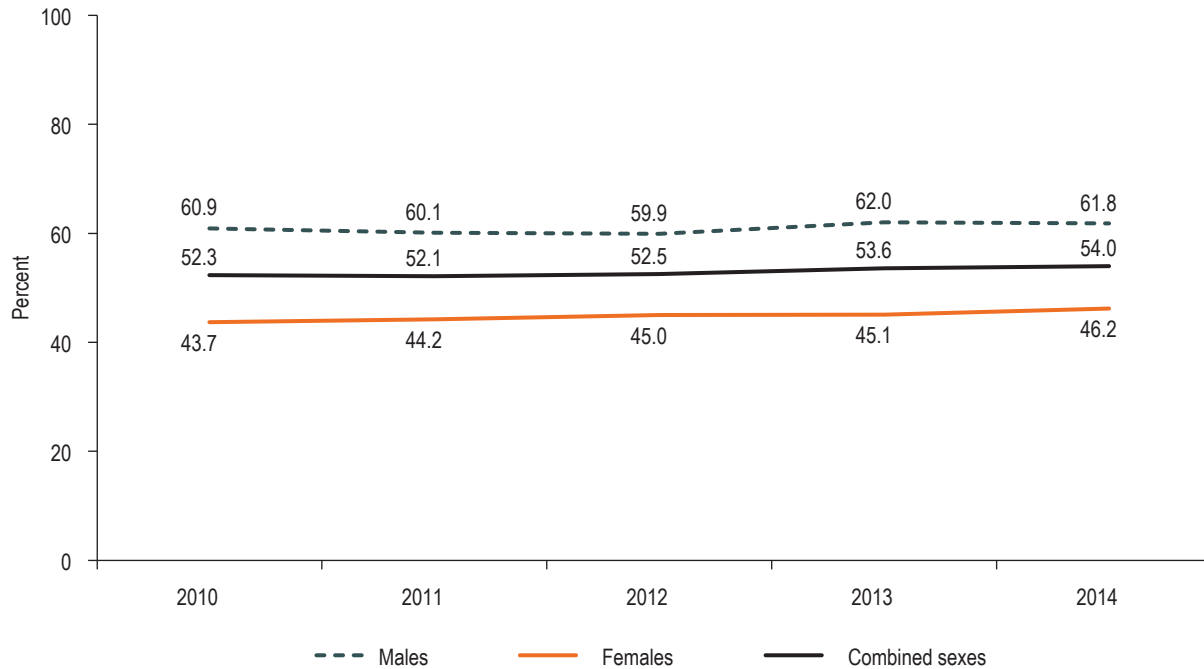
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

About one-quarter of Canadian youth age 12 to 17 are classified as overweight and obese. In 2014, the percentage of youth who were categorized as overweight and obese ranged from a low of 18.6% in B.C. to a high of 46.6% in Newfoundland and Labrador. However, only the latter had a rate that was significantly higher than the Canadian average.

Overweight and obesity in Canadian adults rising

Figure 7 Percentage of the population age 18 and older classified as overweight and obese, Canada, 2010 to 2014



Among adults, males were more likely than females to be overweight and obese (2014)

Males **61.8%**

Females **46.2%**

Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

Rates of overweight and obesity in Canadian adults have been on the rise, with significantly higher rates in 2014 than in 2010. In 2014, 54.0% of adult Canadians reported a height and weight that classified them as overweight and obese. As with the youth rates, significantly higher rates were observed among males than among females in 2014 (61.8% versus 46.2%).

54% of Canadian adults overweight and obese

Figure 8 Percentage of the population age 18 and older classified as overweight and obese, Canada and provinces/territories, 2014

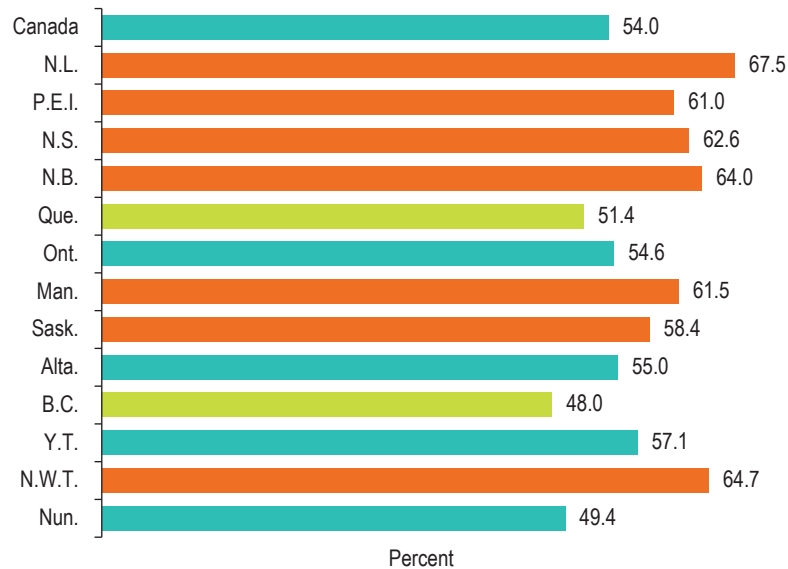
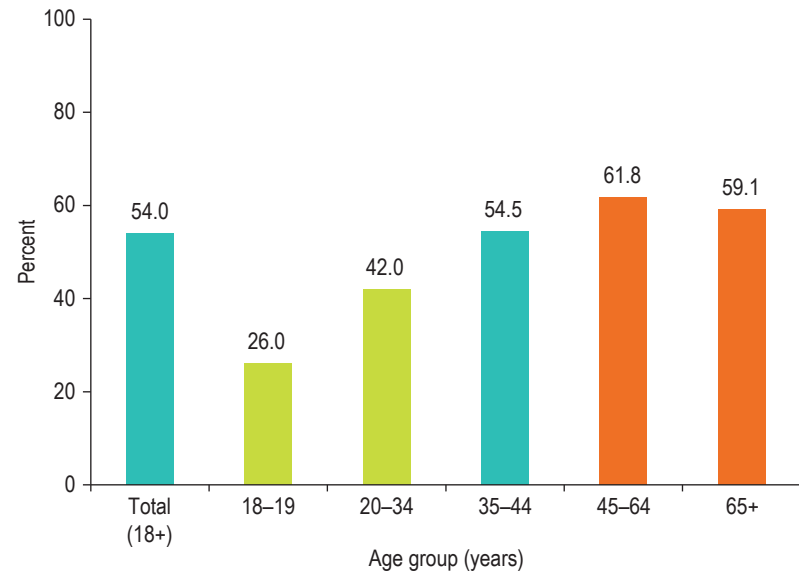


Figure 9 Percentage of the population age 18 and older classified as overweight and obese, Canada, by age group, 2014



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Note

Above average represents the desirable direction for this indicator. In this case, the lower percentage actually represents *above average* results when compared with the Canadian average.

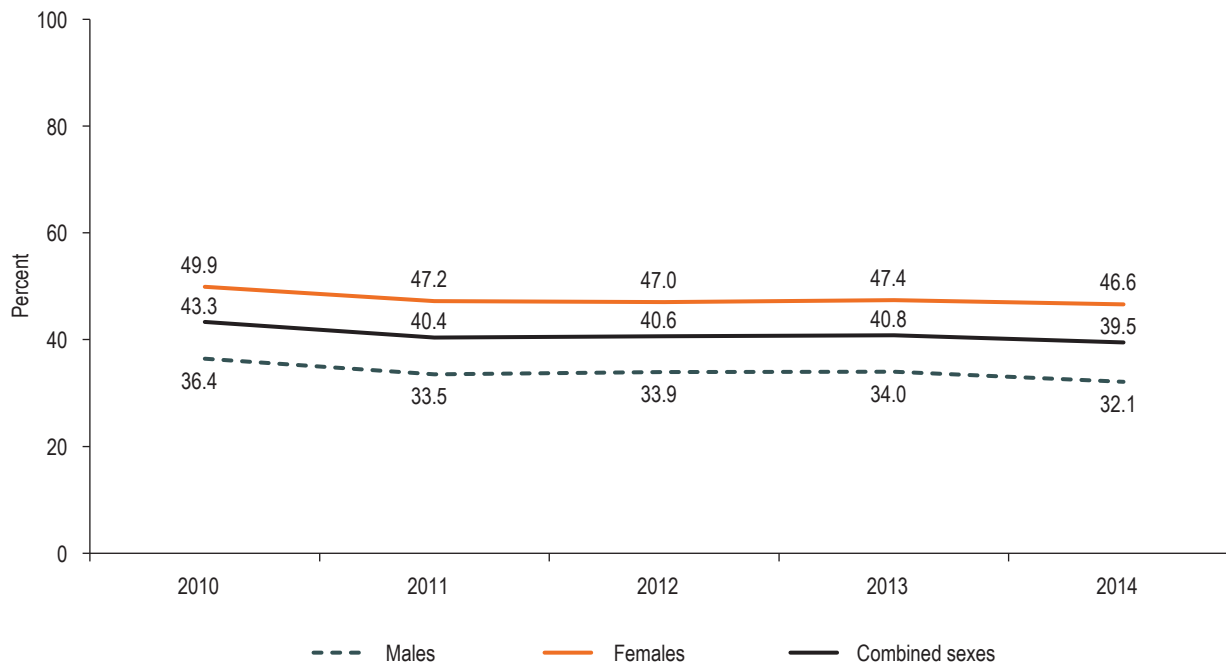
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

More than half of adult Canadians are overweight and obese. In 2014, rates of adult overweight and obesity varied across Canada’s provinces and territories, ranging from a low of 48.0% in B.C. to a high of 67.5% in Newfoundland and Labrador. In 2014, rates of overweight and obesity also varied across the different adult age groups, with lower rates observed among younger adults (those age 18–19 and 20–34).

Canadians' fruit and vegetable consumption declining

Figure 10 Percentage of the population age 12 and older who reported eating fruit or vegetables 5 or more times daily, Canada, 2010 to 2014



Females were more likely than males to report eating fruits or vegetables 5 or more times daily (2014)

Females
46.6%

Males
32.1%

Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

Since 2010, there has been a significant decrease in fruit and vegetable consumption among Canadians, with 39.5% of Canadians reporting fruit and vegetable consumption 5 or more times daily in 2014. Sex differences were also observed, with females having significantly higher rates of consumption than males in 2014 (46.6% versus 32.1%).

40% of Canadians consuming adequate fruit and vegetables

Figure 11 Percentage of the population age 12 and older who reported eating fruit or vegetables 5 or more times daily, Canada and provinces/territories, 2014

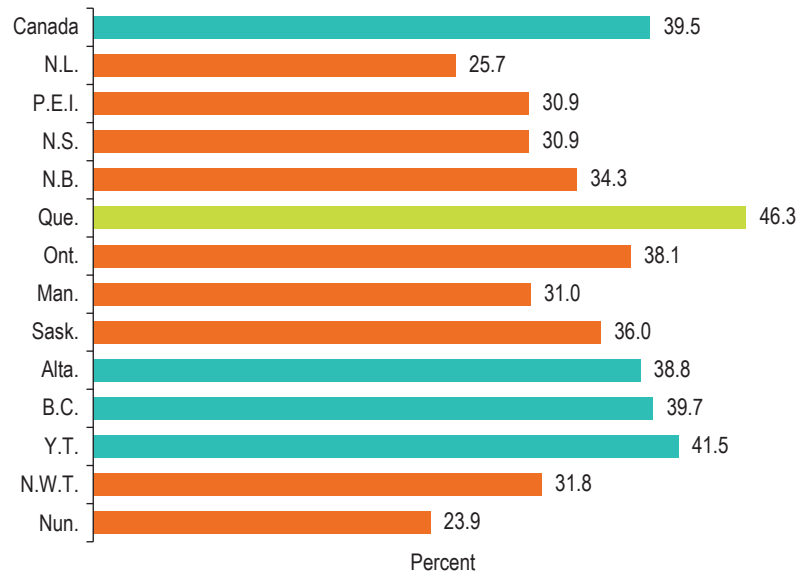
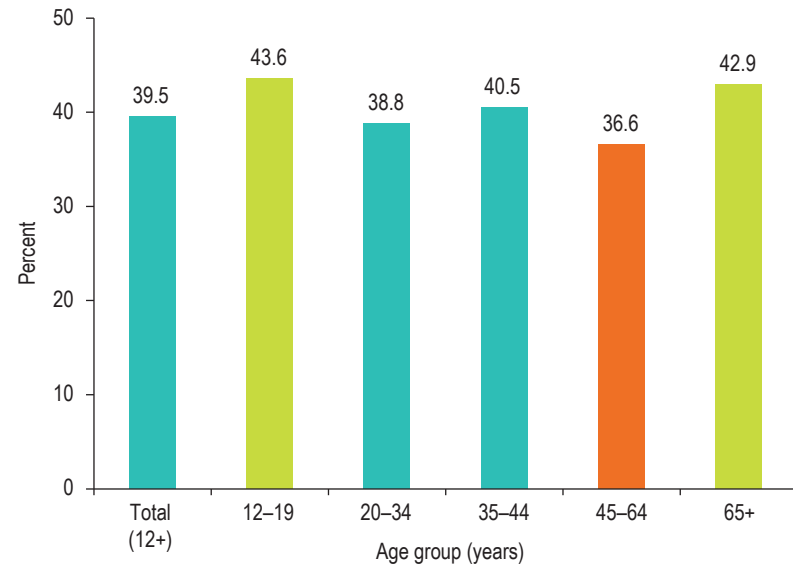


Figure 12 Percentage of the population age 12 and older who reported eating fruit or vegetables 5 or more times daily, Canada, by age group, 2014



Results compared with the Canadian average

● Above average ● Same as average ● Below average

Note

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average.

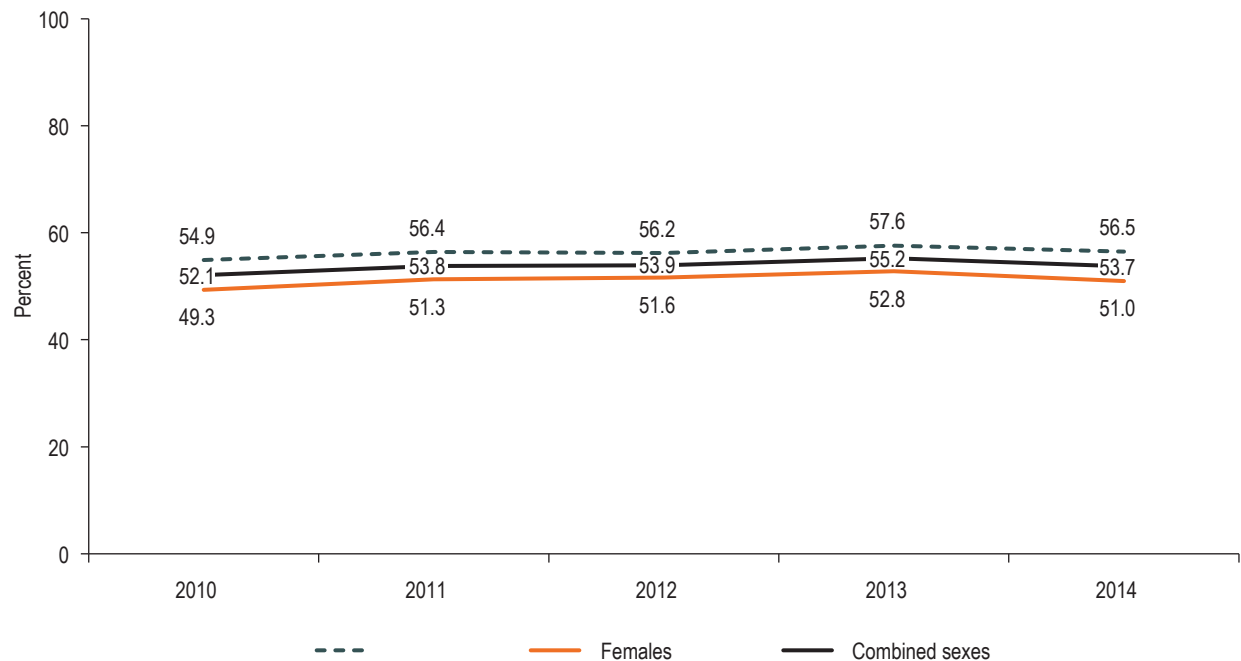
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

In 2014, rates of fruit and vegetable consumption varied across Canada’s provinces and territories, ranging from a low of 23.9% in Nunavut to a high of 46.3 % in Quebec. Fruit and vegetable consumption also varied across age groups when compared with the national average. In 2014, significantly higher rates of consumption were observed in respondents age 12 to 19 and age 65 and older, with significantly lower rates of consumption among those age 45 to 64.

Physical activity rates of Canadians rising

Figure 13 Percentage of the population age 12 and older who reported being moderately active to active during leisure time, Canada, 2010 to 2014



Males were more likely than females to be moderately active to active (2014)

Males
56.5%

Females
51.0%

Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

Between 2010 and 2014, more than half of the Canadian population was moderately active to active during leisure time, with significantly higher rates observed in 2014 than in 2010. In 2014, males were significantly more likely than females to report being moderately active to active (56.5% versus 51.0%).

54% of Canadians moderately active to active

Figure 14 Percentage of the population age 12 and older who reported being moderately active to active during leisure time, Canada and provinces/territories, 2014

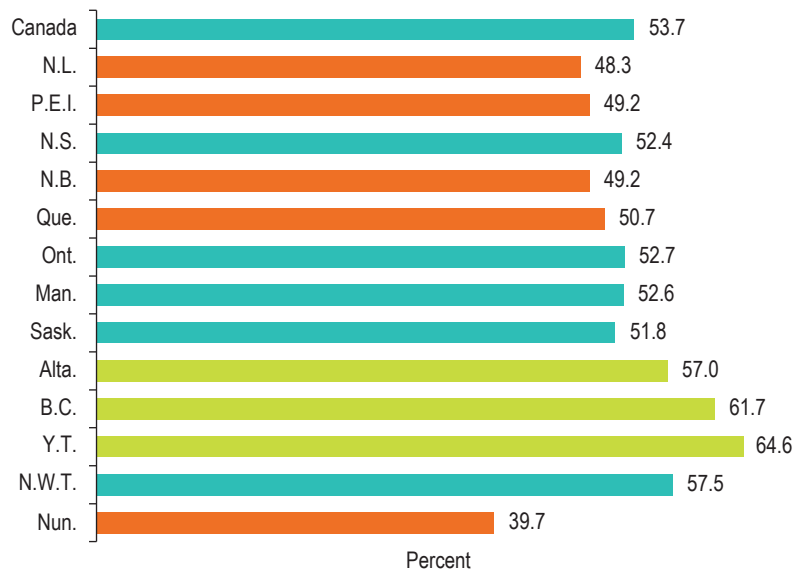
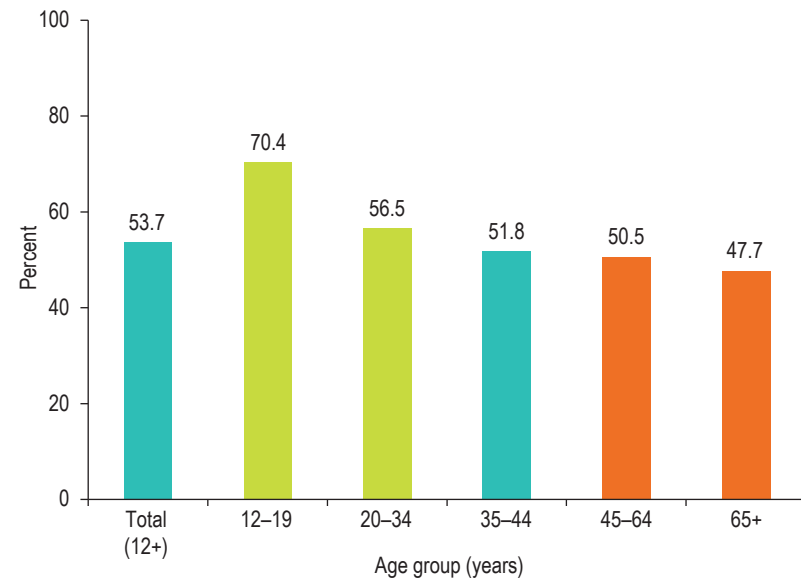


Figure 15 Percentage of the population age 12 and older who reported being moderately active to active during leisure time, Canada, by age group, 2014



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Note

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average.

Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

In 2014, rates of physical activity during leisure time varied across Canada’s provinces and territories, ranging from a low of 39.7% in Nunavut to a high of 64.6 % in Yukon. Younger persons age 12 to 19 and 20 to 34 were significantly more likely to report being moderately active to active, while older age groups (45 to 64 and 65+) had significantly lower rates than the Canadian average.

Health System Resources — Health System Inputs and Characteristics

PHC Provider Supplyⁱⁱⁱ

Having access (or being attached) to a PHC provider has been associated with better overall health and lower health care utilization.⁶ PHC delivery is led by family medicine physicians or nurse practitioners (registered nurses, extended class). Other PHC providers can include registered nurses, licensed practical nurses, dietitians, pharmacists, social workers and other allied health professionals.

This chartbook presents 2 variations of the PHC Provider Supply indicator described in the 2012 report; one focuses on the supply of family medicine physicians, and the other on the number of registered nurses, including nurse practitioners.

Family Medicine Physician Supply

This indicator captures the number of family medicine physicians per 100,000 Canadians.

Registered Nurses/Nurse Practitioners (RNs/NPs) Employed in a PHC Setting

This indicator captures the number of RNs/NPs employed in a PHC setting per 100,000 Canadians.

It is important to note that whether or not an increasing physician or nursing supply in PHC is deemed beneficial depends on the jurisdictional context, prevailing models of care and provider mix.

iii. PHC Provider Supply includes the number of PHC providers, not full-time equivalents.

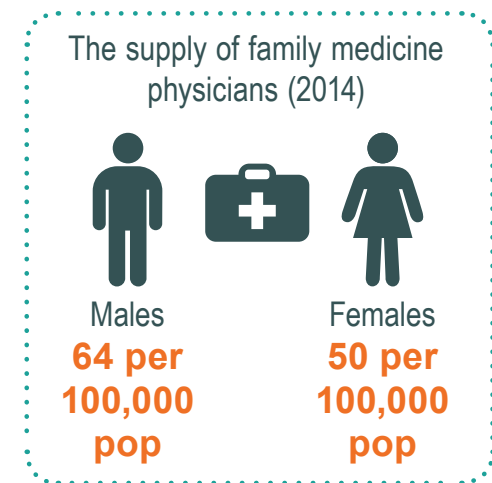
Uptake of Information and Communication Technology (ICT) in Primary Health Care

This indicator measures the percentage of family medicine physicians who use electronic systems to complete their professional tasks. The uptake of ICT by family medicine physicians can lead to benefits in patient care and system efficiencies. Uptake of ICT refers to the use of electronic systems to enter and retrieve clinical patient notes and at least 2 of the following additional functionalities: reminders for patient care, warning for drug interaction, interface to pharmacy, interface to lab/diagnostic test results and interface to other external systems.

In this chartbook, information on the use of electronic medical records by primary care physicians is displayed to facilitate comparisons with the uptake of information and communication technology in primary health care.

Supply of family medicine physicians in Canada rising

Figure 16 Number of family medicine physicians per 100,000 population, Canada, 2010 to 2014



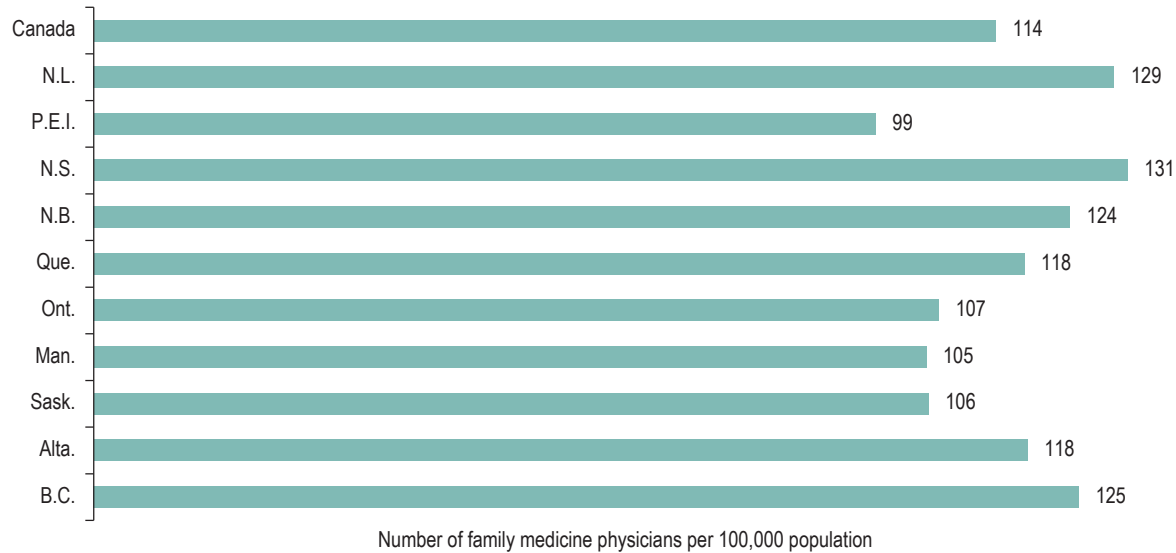
Source

Scott's Medical Database, CIHI; Population projections, Demography Division of Statistics Canada.

In 2014, there were 114 family medicine physicians for every 100,000 Canadians, which translates to 40,781 family medicine physicians in Canada. Of particular note, the supply of female family medicine physicians is increasing at a faster rate than the supply of male family medicine physicians.⁷ In 2014, there were 50 female family medicine physicians for every 100,000 Canadians, compared with 43 in 2010. However, past research found that male and female physicians practise differently and that female physicians were more likely to restrict their practice hours during childbearing years.⁸

114 family medicine physicians per 100,000 Canadians

Figure 17 Number of family medicine physicians per 100,000 population, Canada and provinces, 2014



Note

This indicator does not offer a comprehensive picture for physician supply in remote areas of Canada, such as the territories, where the use of temporary relocation arrangements is common. As such, data from the territories has been suppressed. Significance testing is deemed inappropriate for this indicator.

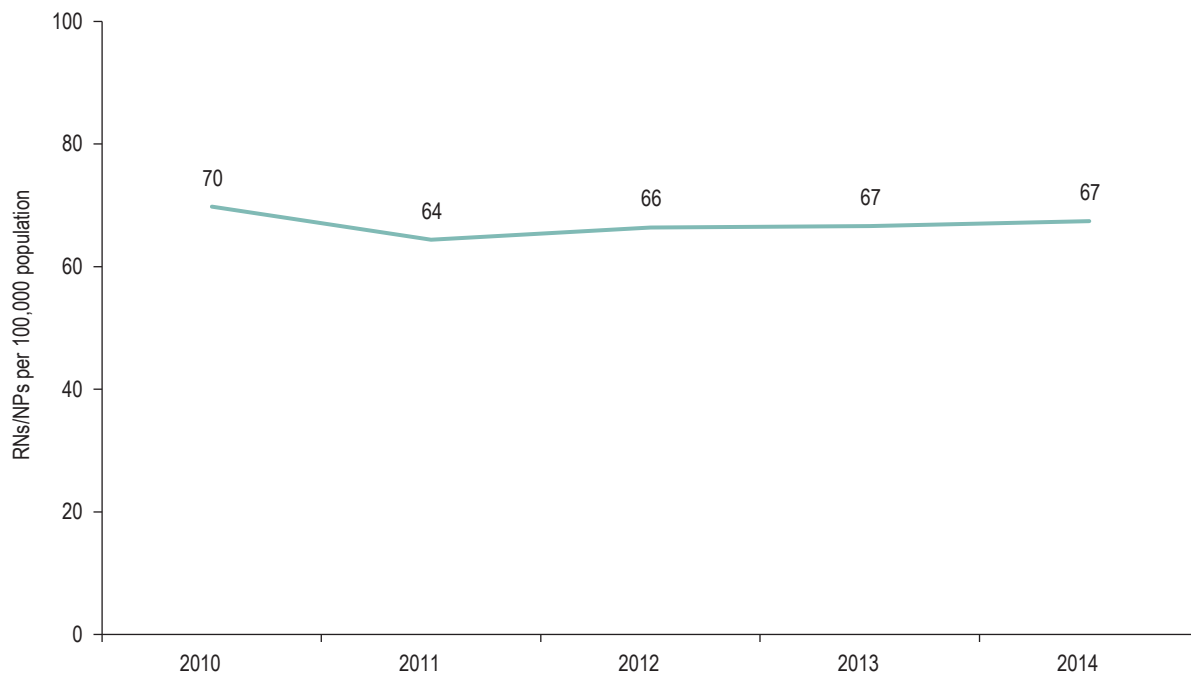
Sources

Scott's Medical Database, CIHI, and Population projections, Demography Division of Statistics Canada.

In 2014, the number of family medicine physicians per 100,000 population varied across Canada, from a high of 131 in Nova Scotia to a low of 99 in P.E.I.

Registered nurses/nurse practitioners employed in PHC consistent over time

Figure 18 Number of RNs/NPs employed in a PHC setting per 100,000 population, Canada, 2010 to 2014



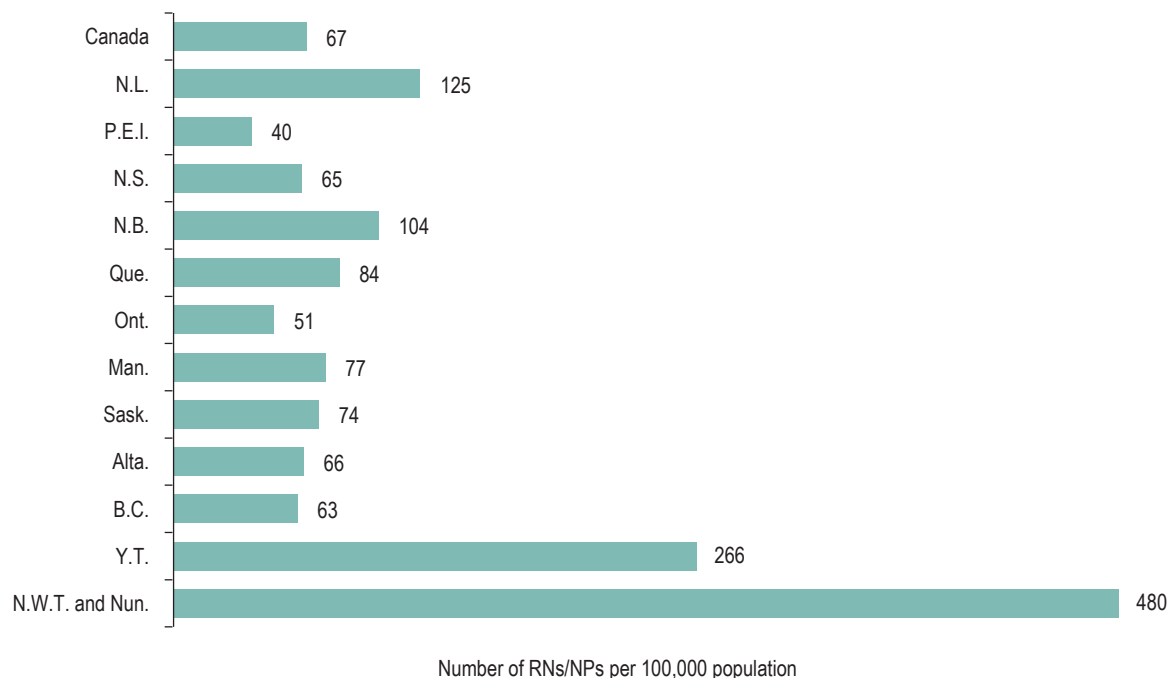
Sources

Health Workforce Database, CIHI; Population projections, Demography Division of Statistics Canada.

In 2014, there were 67 RNs/NPs who provided direct care in PHC for every 100,000 Canadians, compared with 70 in 2010. This number has changed very little over time.

67 registered nurses/nurse practitioners employed in PHC per 100,000 Canadians

Figure 19 Number of RNs/NPs per 100,000 population, Canada and provinces/territories, 2014



Note

Data for the Northwest Territories and Nunavut was submitted to CIHI by the Registered Nurses Association of the Northwest Territories and Nunavut as a single combined set of statistics. It is not possible to assign a nurse to each of these individual jurisdictions. Significance testing is deemed inappropriate for this indicator.

Sources

Health Workforce Database, CIHI; Population projections, Demography Division of Statistics Canada

In 2014, the number of RNs/NPs per 100,000 population varied across Canada's provinces and territories, from a high of 480 in the Northwest Territories/Nunavut to a low of 40 in P.E.I. The high number of RNs/NPs employed in a PHC setting and providing direct care in Yukon, the Northwest Territories and Nunavut may be attributed to the nature of practice in remote Canada, including the model of service delivery and the impact of short-term and relief nurses on workforce size.

Use of technology by family medicine physicians increasing

Figure 20 Percentage of family medicine physicians who used information and communication technology (ICT) in primary health care, Canada, 2007, 2010 and 2014

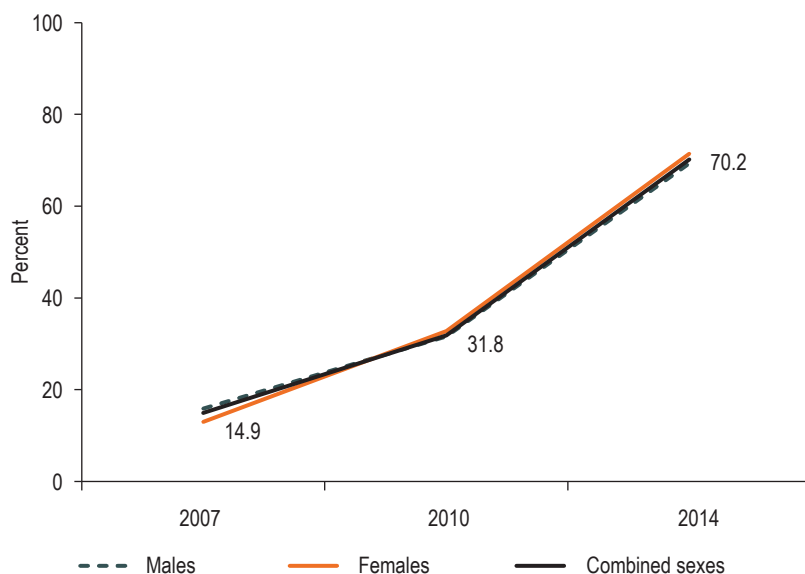
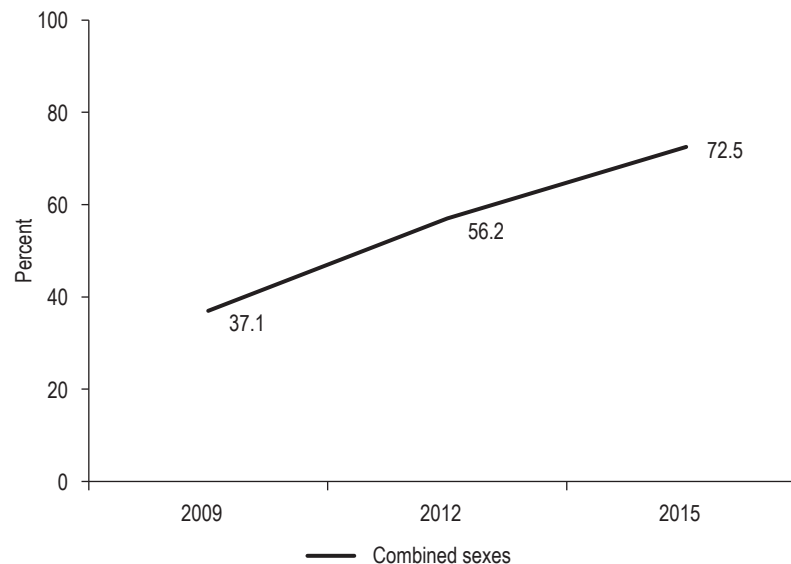


Figure 21 Percentage of primary care physicians who used electronic medical records (EMRs) in their practice, Canada, 2009, 2012 and 2015



Notes

The rates shown in the figure pertain to the Combined sexes category.

The Combined sexes category in Figure 20 includes sex non-response. Please interpret the results in Figure 20 with caution, given the relatively low response rates in the National Physician Survey.

Sources

Figure 20: National Physician Survey, College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada.

Figure 21: The Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Since 2007, the uptake of ICT has significantly increased in Canada, with an uptake rate of 70.2% in 2014. The findings in Figure 20, which were derived from National Physician Survey data, are consistent with findings from The Commonwealth Fund International Health Policy Survey of Primary Care Physicians. In the latter, 72.5% of primary care physicians reported using electronic medical records, a component of ICT, in their practice in 2015. The use of electronic medical records (EMRs) is still significantly lower in Canada compared with other high-income countries.⁹

More than 70% of family medicine physicians using technology

Figure 22 Percentage of family medicine physicians who used information and communication technology (ICT) in primary health care, Canada and provinces, 2014

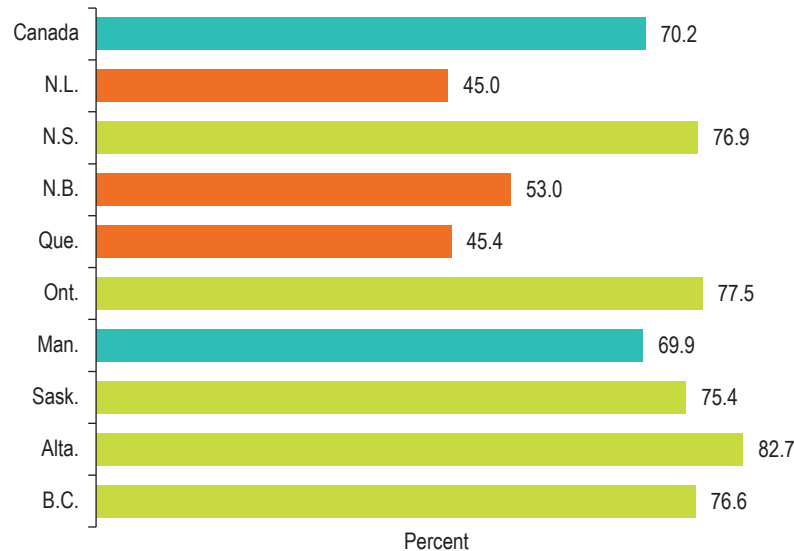
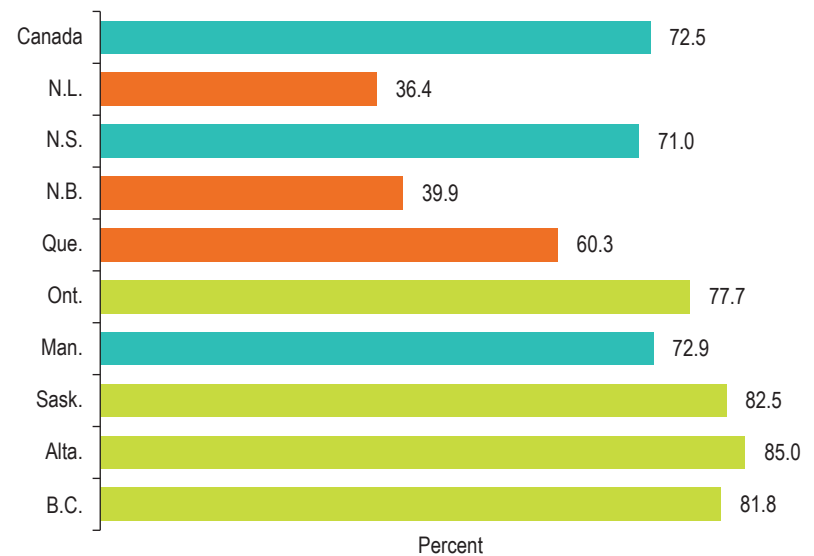


Figure 23 Percentage of primary care physicians who used electronic medical records (EMRs) in their practice, Canada and provinces, 2015



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average. In figures 22 and 23, data for P.E.I. and the territories has been suppressed due to small sample size. Please interpret the results in Figure 22 with caution, given the relatively low response rates in the National Physician Survey.

Sources

Figure 22: National Physician Survey, College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada.

Figure 23: The Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

In 2014, uptake rates of ICT among family medicine physicians varied across Canada's provinces, ranging from a low of 45.0% in Newfoundland and Labrador and 45.4% in Quebec to a high of 82.7% in Alberta. These findings, which were derived from the National Physician Survey, are consistent with findings from The Commonwealth Fund 2015 International Health Policy Survey of Primary Care Physicians.

Access to Comprehensive, High-Quality Health Services — Health System Outputs

Population With a Regular Medical Doctor

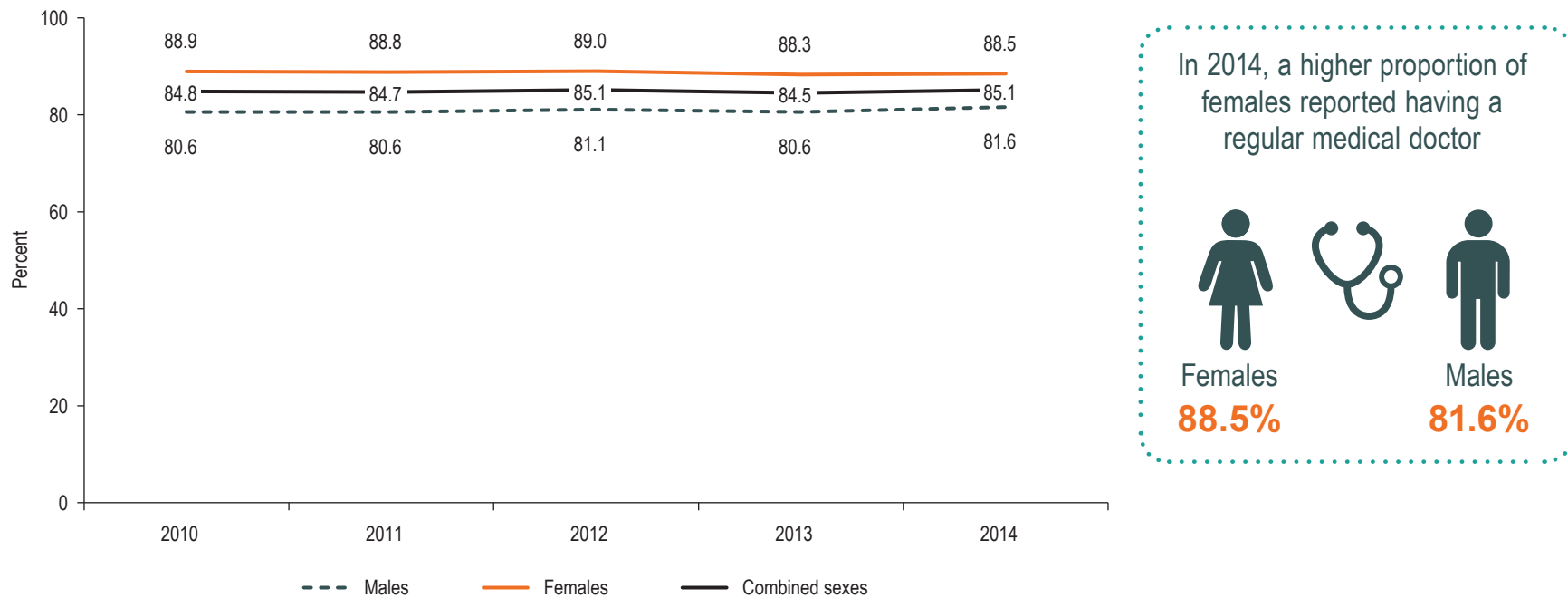
This indicator captures the proportion of Canadians age 12 and older who report having a regular medical doctor. Research illustrates that increased access to a regular medical doctor, which was used as a proxy for a PHC provider in this report, is a hallmark of better health, lower total health care system costs and increased continuity of care.¹⁰ Continuity of care in PHC has been associated with positive health outcomes, including increased rates of preventive care, decreased hospitalization and fewer emergency department (ED) visits.

Difficulties Obtaining After-Hours Primary Health Care

This indicator measures the proportion of Canadians age 18 and older who report finding it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital ED. PHC access, when needed, prevents unnecessary health emergencies and the inappropriate use of services (such as the use of hospital EDs for non-urgent PHC needs). It is an important indicator of how easy it is for the population to interact with the health care system.

Access of Canadians to a regular medical doctor consistent over time

Figure 24 Percentage of the population age 12 and older who reported having a regular medical doctor, Canada, 2010 to 2014



Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

Between 2010 and 2014, the percentage of Canadians reporting that they had a regular medical doctor remained consistent. During that period, females were significantly more likely than males to report having a regular medical doctor (2014: 88.5% versus 81.6%).

85% of Canadians have access to a regular medical doctor

Figure 25 Percentage of the population age 12 and older who reported having a regular medical doctor, Canada and provinces/territories, 2014

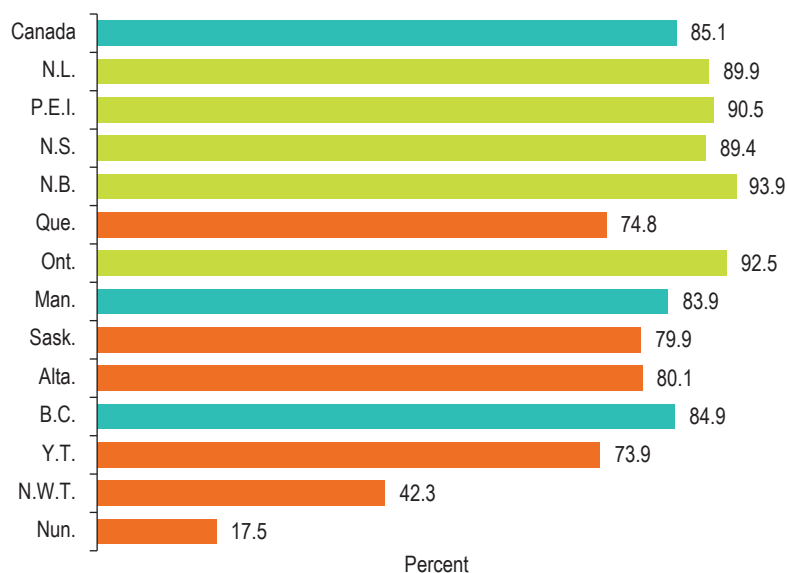
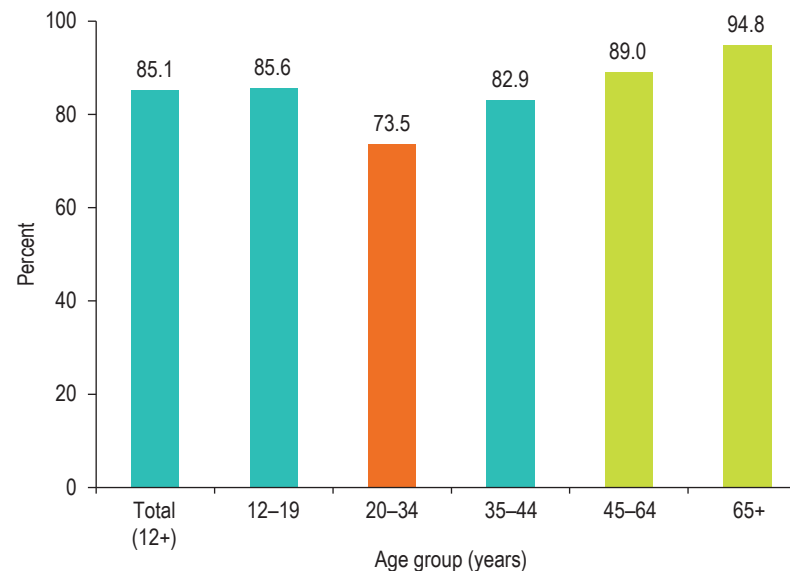


Figure 26 Percentage of the population age 12 and older who reported having a regular medical doctor, Canada, by age group, 2014



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average. In the territories, a nurse practitioner is often used as the first point of medical contact rather than a medical doctor.

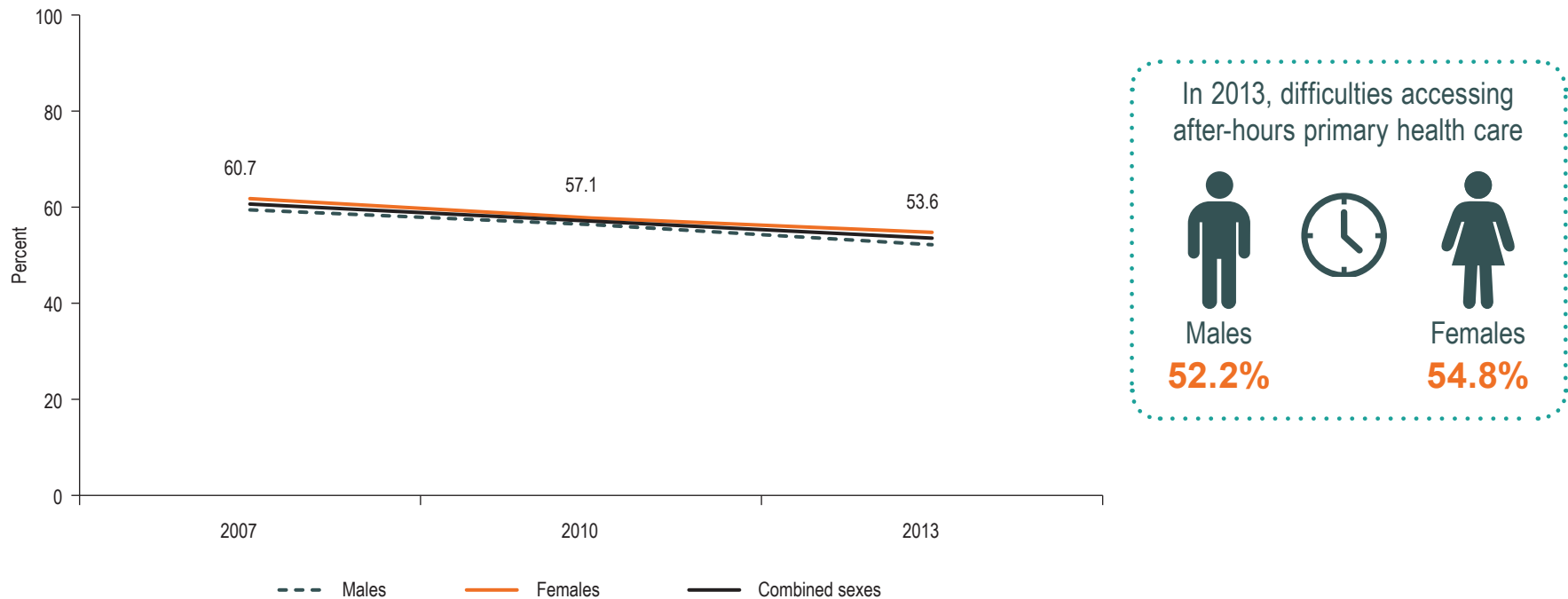
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

In 2014, the percentage of the population age 12 and older who reported having a regular medical doctor varied by jurisdiction, ranging from a high of 93.9% in New Brunswick to a low of 17.5% in Nunavut. In 2014, Canadians age 20 to 34 had a significantly lower rate of having a regular medical doctor, whereas older adults (age 45 to 64) and seniors age 65 and older had significantly higher rates of having a regular medical doctor.

Fewer Canadians reporting difficulty accessing after-hours care

Figure 27 Percentage of the population age 18 and older who reported finding it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital emergency department, Canada, 2007, 2010 and 2013



Notes

The rates shown in the figure pertain to the Combined sexes category.
 Territorial data was suppressed.
 Information on statistical significance over time and between sexes is unavailable.

Source

The Commonwealth Fund International Health Policy Survey of the General Public.

Since 2007, the percentage of Canadians reporting difficulty accessing medical care in the evenings, on weekends or on holidays without going to the hospital ED has declined. However, more than half of Canadians still reported access difficulties in 2013.

54% of Canadians report difficulty accessing after-hours care

Figure 28 Percentage of the population age 18 and older who reported finding it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital emergency department, Canada and provinces, 2013

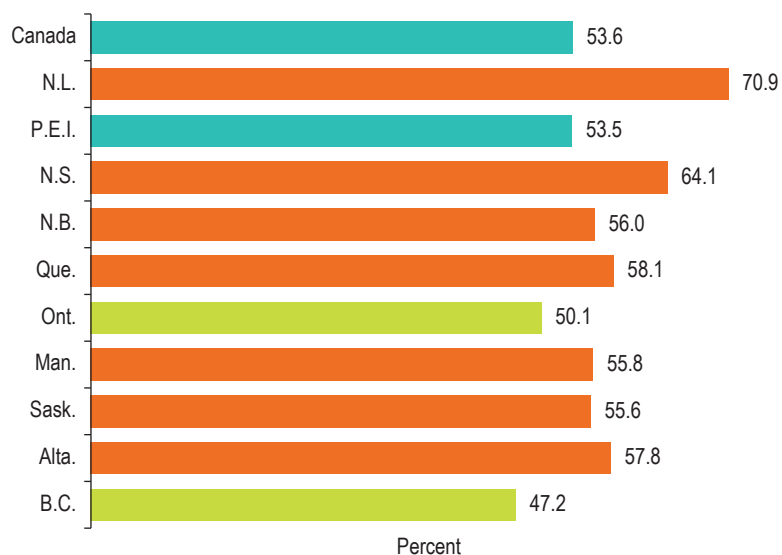
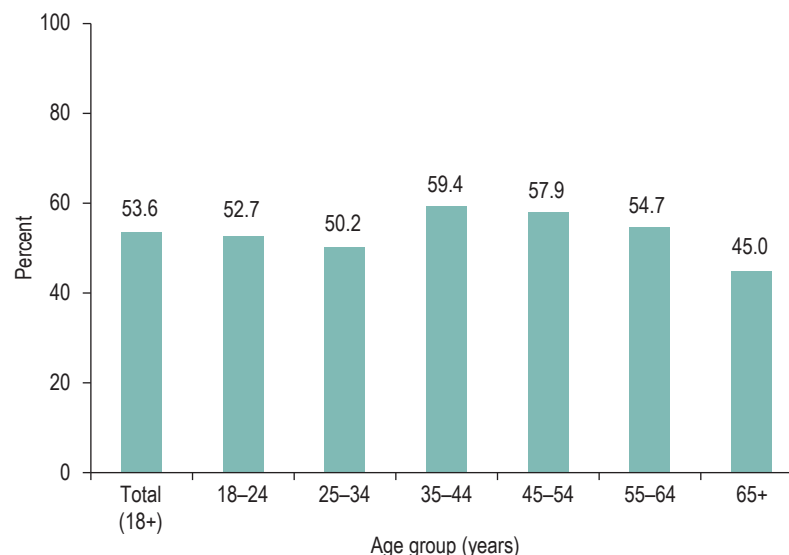


Figure 29 Percentage of the population age 18 and older who reported finding it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital emergency department, Canada, by age group, 2013



Results compared with the Canadian average

● Above average ● Same as average ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the lower percentage actually represents *above average* results when compared with the Canadian average.

Territorial data was suppressed in Figure 28.

Information on significance testing by age category is unavailable in Figure 29.

Source

The Commonwealth Fund International Health Policy Survey of the General Public.

In 2013, 53.6% of Canadians found it somewhat difficult or very difficult to access medical care in the evenings, on weekends or on holidays without going to the hospital ED. Access rates varied across the country, from a high of 70.9% reporting difficulty accessing after-hours care in Newfoundland and Labrador to a low of 47.2% in B.C. Difficulty accessing after-hours care also varied by age, with seniors age 65 and older reporting the lowest rates of difficulty (45.0%).

Appropriate, Effective and Safe — Health System Outputs

Smoking Cessation Advice From a Regular Medical Doctor

This indicator measures the percentage of current smokers age 12 and older who were offered smoking cessation advice from a regular medical doctor in the past 12 months. The health and economic impacts of smoking are numerous and well documented. Tobacco is a leading preventable cause of many diseases, including cancer, heart disease and stroke. The contribution of PHC in promoting smoking cessation is important to reducing the morbidity and mortality associated with this risky health behaviour.

Eye Examinations in Adults With Diabetes

This indicator captures the percentage of adults with diabetes age 20 and older who had an eye exam in the past 2 years. Damage to the retina — diabetic retinopathy — is the most common cause of new cases of legal blindness in adults. Research indicates that effective screening and monitoring of the eyes can significantly reduce the number of new cases of diabetic retinopathy. Clinical practice guidelines recommend regular eye examinations for adults with diabetes. PHC providers can play a key role in encouraging diabetic patients to obtain regular eye examinations for the early detection of treatable diabetic retinopathy.

Influenza Immunization for Seniors

This indicator calculates the percentage of Canadians age 65 and older who were immunized against influenza during the last 12 months. Influenza has the potential to cause significant morbidity and mortality among high-risk groups, such as seniors. The National Advisory Committee on Immunization recommends that at least 80% of eligible Canadian seniors receive the annual influenza vaccine.¹¹ PHC providers are well positioned to support their senior patients in obtaining the annual influenza immunization, in an effort to prevent influenza-related complications.

Colorectal Cancer Screening

This indicator assesses the proportion of the population age 50 to 74 who self-report having undergone colorectal cancer screening. Screening tests can reduce deaths from colorectal cancer. This indicator reflects 2 types of screening modalities: a fecal occult blood test (FOBT) within the past 24 months and/or a screening colonoscopy/sigmoidoscopy within the past 5 years. Experts have recommended that the target population for colorectal cancer screening be average risk Canadians age 50 to 74 years.¹² PHC providers play a key role in ordering screening FOBTs and in referring patients to specialists for screening colonoscopy/sigmoidoscopy.

Cervical Cancer Screening

This indicator captures the proportion of women age 20 to 69 who self-report having undergone cervical cancer screening tests in the past 3 years. Such screening reduces the risk of cervical cancer by identifying the need for treatment before invasive cervical cancer develops. Although different provinces and territories have different target age ranges for screening programs, many Canadian experts have recommended that the target population for cervical cancer screening be women age 20 to 69.¹³ Through screening and follow-up, PHC providers can play an important role in reducing the incidence of cervical cancer and its associated mortality.

Ambulatory Care Sensitive Conditions (ACSCs) Hospitalization Rate

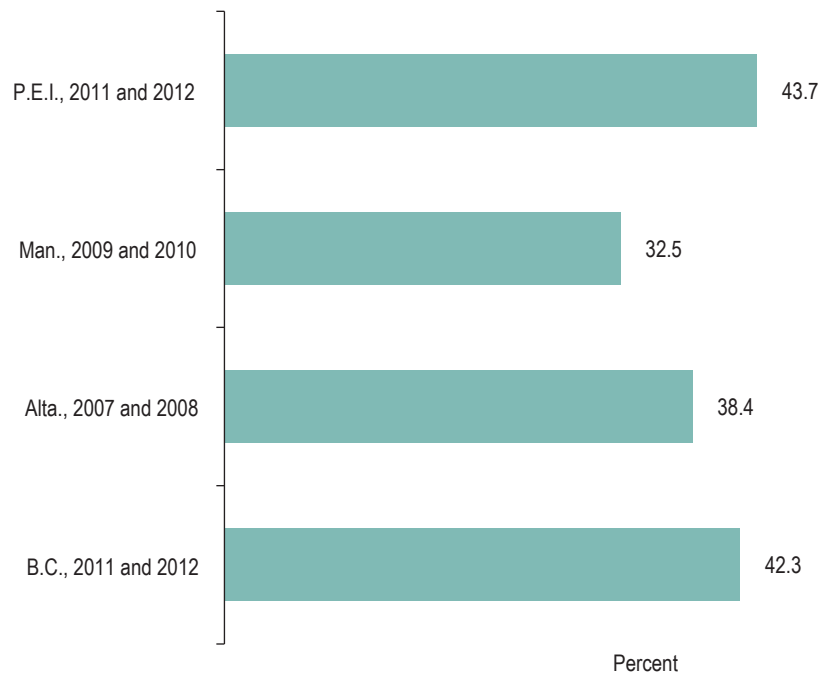
This indicator measures the hospitalization rate for ACSCs in the population younger than 75 years. ACSCs are conditions for which hospitalizations are considered to be largely preventable when they are managed adequately on an outpatient basis, including via PHC. ACSCs include chronic diseases such as asthma, diabetes and chronic obstructive pulmonary disease. This indicator is considered an indirect measure of access to community-based PHC and the ability of the health care system to manage chronic conditions outside of acute care.¹⁴

Medication Lists in Primary Health Care Using a Computerized System

This indicator captures the percentage of primary care physicians who are able to generate a medication list for their patients using a computerized system (such as an electronic medical record system). Medication lists are important in that they provide a complete and quickly accessible listing of the patient's current medications in 1 place, which can enhance patient care. Further, the ability to generate medication lists may result in fewer medication errors and is an important contribution to patient safety in PHC.¹⁵

Less than 45% of smokers were offered smoking cessation advice by their doctor

Figure 30 Percentage of current smokers age 12 and older who were offered smoking cessation advice from a regular medical doctor, Canada, by province and combined calendar years



Notes

The sampling years vary by province.

Data is not available for Newfoundland and Labrador, Nova Scotia, New Brunswick, Quebec, Ontario, Saskatchewan and the territories.

Information on significance testing is unavailable.

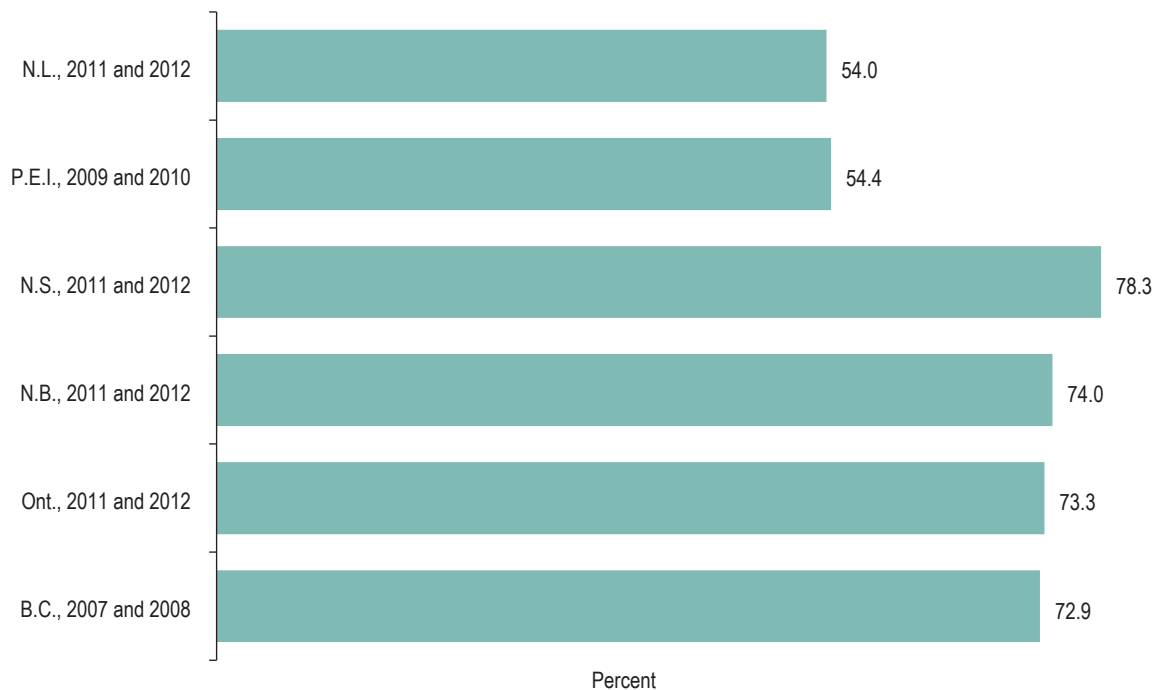
Source

CCHS public use microdata files. Statistics Canada.

Among the 4 provinces for which survey data is available, less than half of current smokers reported that they had received smoking cessation advice from a regular medical doctor. However, pan-Canadian survey data for this indicator is incomplete.

54% to 78% of diabetics had an eye exam

Figure 31 Percentage of adults with diabetes age 20 and older who had an eye exam in the past 2 years, Canada, by province and combined calendar years



Notes

Only the most recent year of data is displayed for provinces with multiple data years.
Data is not available for Quebec, Manitoba, Saskatchewan, Alberta and the territories.
Information on significance testing is unavailable.

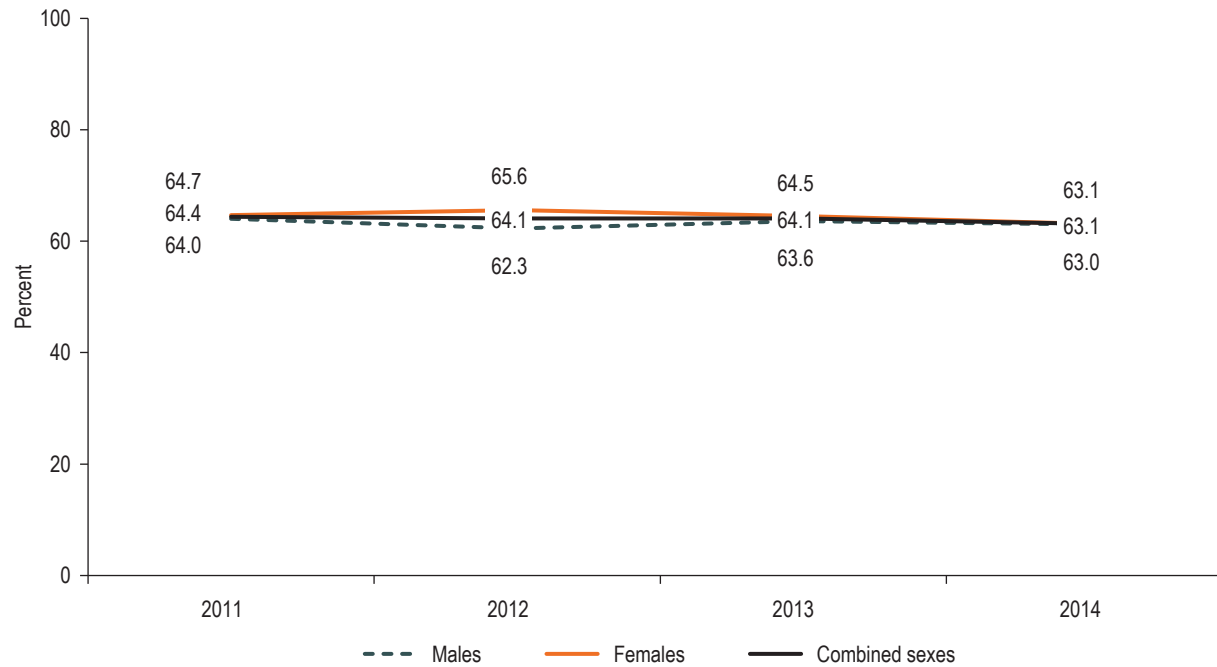
Source

CCHS public use microdata files. Statistics Canada.

Among the 6 provinces for which survey data is available, between one-half and three-quarters of adults with diabetes had an eye examination in the last 2 years. However, pan-Canadian survey data for this indicator is incomplete.

Influenza immunization rates in Canadian seniors consistent over time

Figure 32 Percentage of the population age 65 and older who reported receiving the influenza immunization in the last 12 months, Canada, 2011 to 2014



Influenza immunization rates similar between sexes (2014)

Males
63.0%

Females
63.1%

Notes

Data from 2010 was excluded from temporal analysis because H1N1 immunization was offered separately from seasonal influenza vaccine that year.

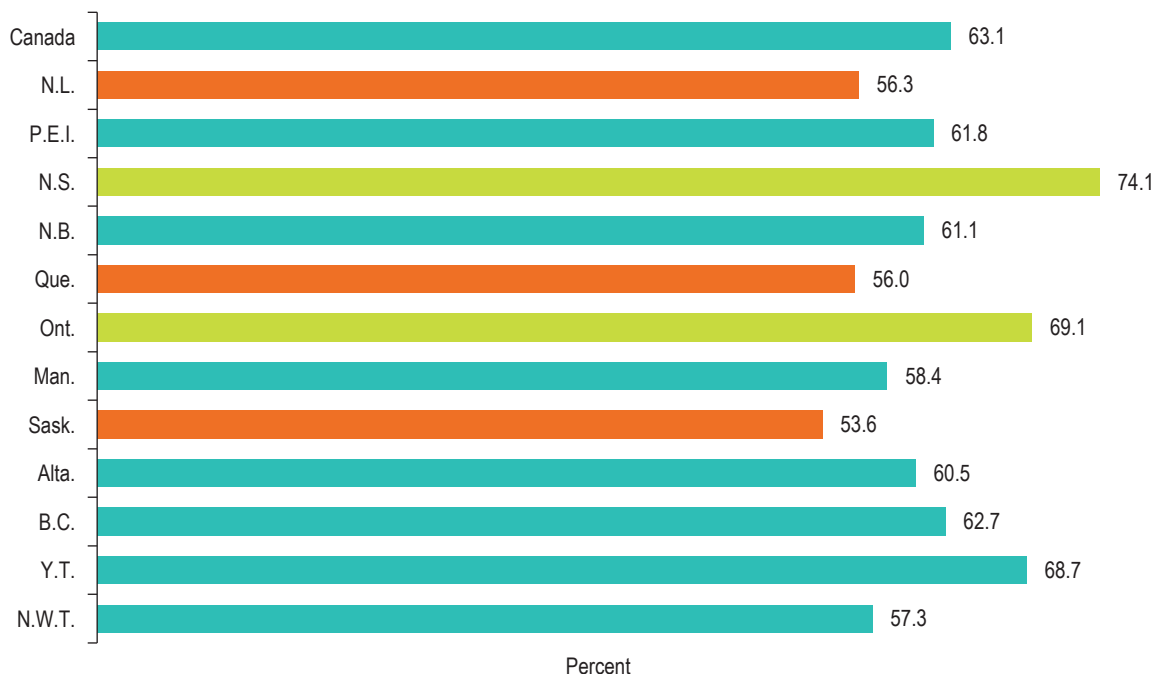
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

From 2011 to 2014, there was no significant change in the percentage of Canadian seniors who reported receiving the influenza immunization. In 2014, 63.1% of Canadian seniors received the influenza immunization, with similar rates observed for males and females.

63% of Canadian seniors immunized against influenza

Figure 33 Percentage of the population age 65 and older who reported receiving the influenza immunization in the last 12 months, Canada and provinces/territories, 2014



In 2014, 3 out of 5 seniors age 65+ reported receiving the influenza vaccination in the last 12 months

Results compared with the Canadian average

- Above average
- Same as average
- Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average. Data from Nunavut was suppressed. CCHS data excludes persons living in residential settings, such as long-term care homes.

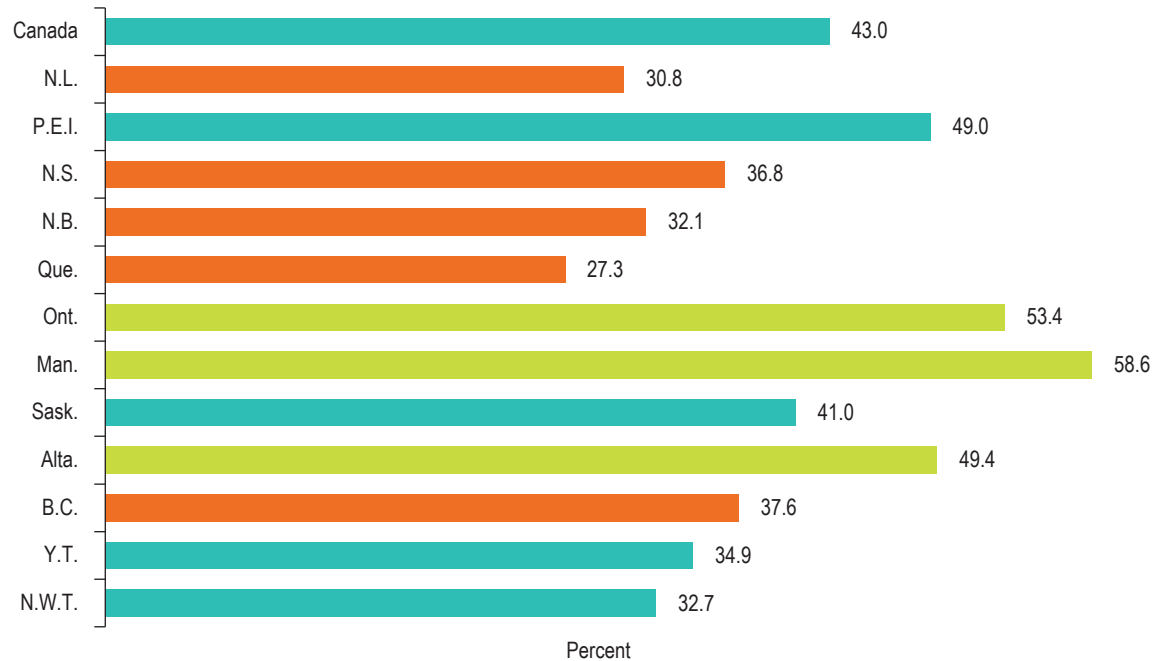
Source

CCHS data from CANSIM table 105-0501. Statistics Canada.

In 2014, the proportion of seniors receiving the influenza immunization varied across Canada's provinces and territories, with the highest immunization rate observed in Nova Scotia (74.1%) and the lowest rate observed in Saskatchewan (53.6%).

43% of Canadians age 50 to 74 screened for colorectal cancer

Figure 34 Colorectal cancer screening rates in adults age 50 to 74, Canada and provinces/territories, 2012



Colorectal cancer screening rates were similar between sexes (2012)

Males: 43.2%
Females: 42.8%

Results compared with the Canadian average

- Above average
- Same as average
- Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average. Data from Nunavut was suppressed. 2013 data is available for some provinces/territories. Procedures were considered to be for screening purposes and not diagnostic purposes if the reason for the procedure was one of the following: family history of colorectal cancer, regular check-up/routine screening, age or race.

Source

Canadian Community Health Survey, Statistics Canada, as provided by the Canadian Partnership Against Cancer.

In 2012, the national rate for colorectal cancer screening was 43.0% (for 2 screening modalities: fecal occult blood test within the past 2 years and/or sigmoidoscopy/colonoscopy within the past 5 years). Self-reported screening rates for colorectal cancer varied across Canada’s provinces and territories in 2012. The highest rate was observed in Manitoba (58.6%) and the lowest rate was observed in Quebec (27.3%).

78% of Canadian women age 20 to 69 screened for cervical cancer



Figure 35 Cervical cancer screening rates in women age 20 to 69, Canada and provinces/territories, 2012

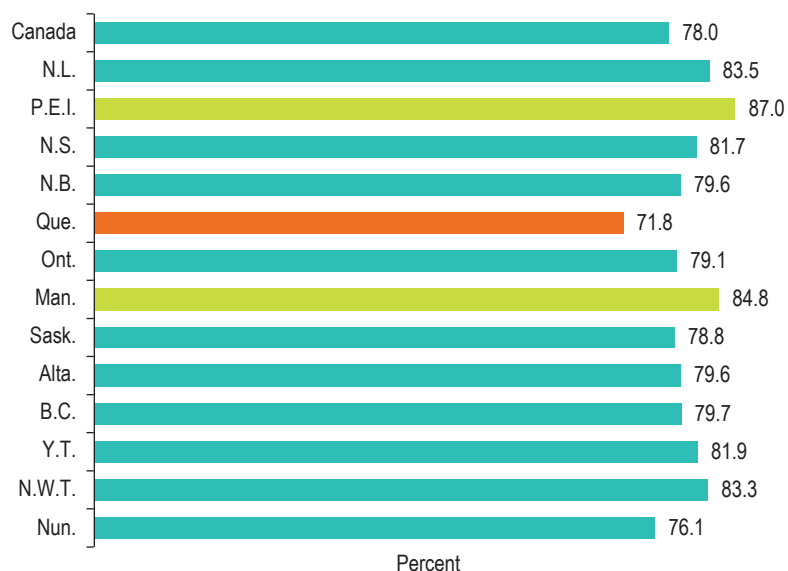
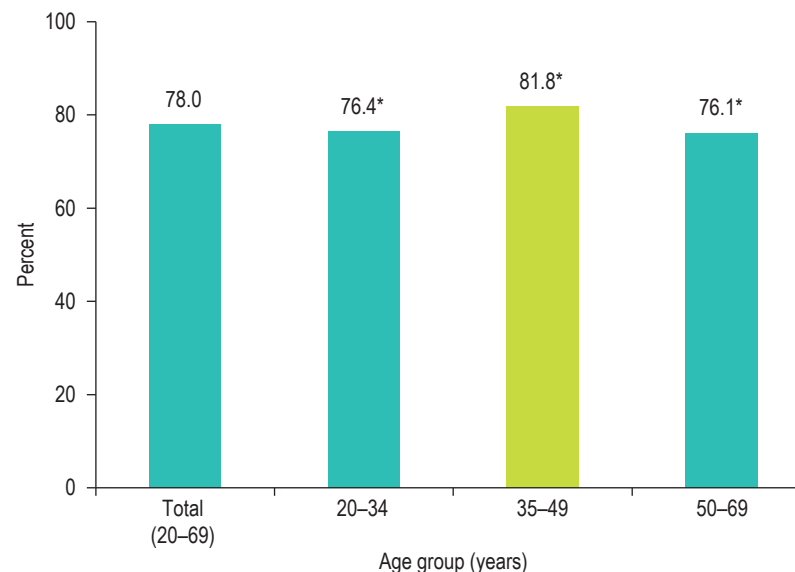


Figure 36 Cervical cancer screening rates in women age 20 to 69, Canada, by age group, 2012



Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average.

* Indicates crude rate.

Age-standardized rates were calculated using the 2011 standard Canadian population, unless otherwise stated.

2013 data is available for some provinces/territories in the companion data tables.

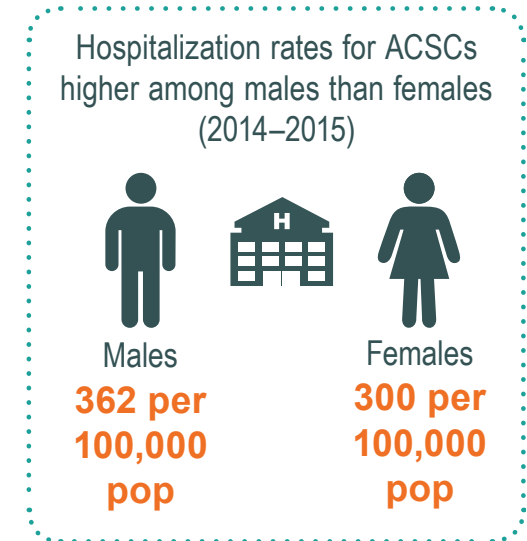
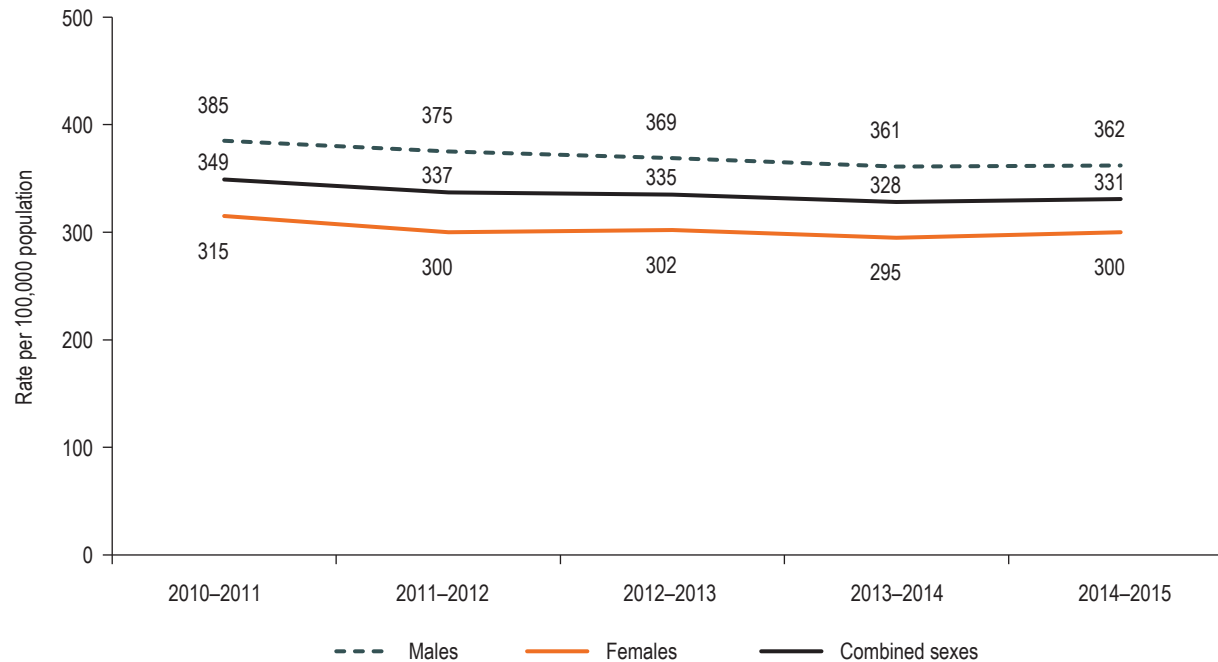
Source

Canadian Community Health Survey, Statistics Canada, as provided by the Canadian Partnership Against Cancer.

In 2012, the national self-reported rate for cervical cancer screening within the past 3 years was 78.0% for women age 20 to 69. All jurisdictions had a cervical cancer screening rate higher than 70%, with the highest rate observed in P.E.I. (87.0%) and the lowest rate observed in Quebec (71.8%).

Hospitalization rate for ambulatory care sensitive conditions (ACSCs) declining slightly

Figure 37 Number of hospitalizations for ACSCs per 100,000 population in the population younger than 75, Canada, 2010–2011 to 2014–2015



Notes

ACSCs do not include seniors age 75 or older and thus do not include hospitalizations for chronic conditions in this age group. Age-standardized rates were calculated using the 2011 standard Canadian population.

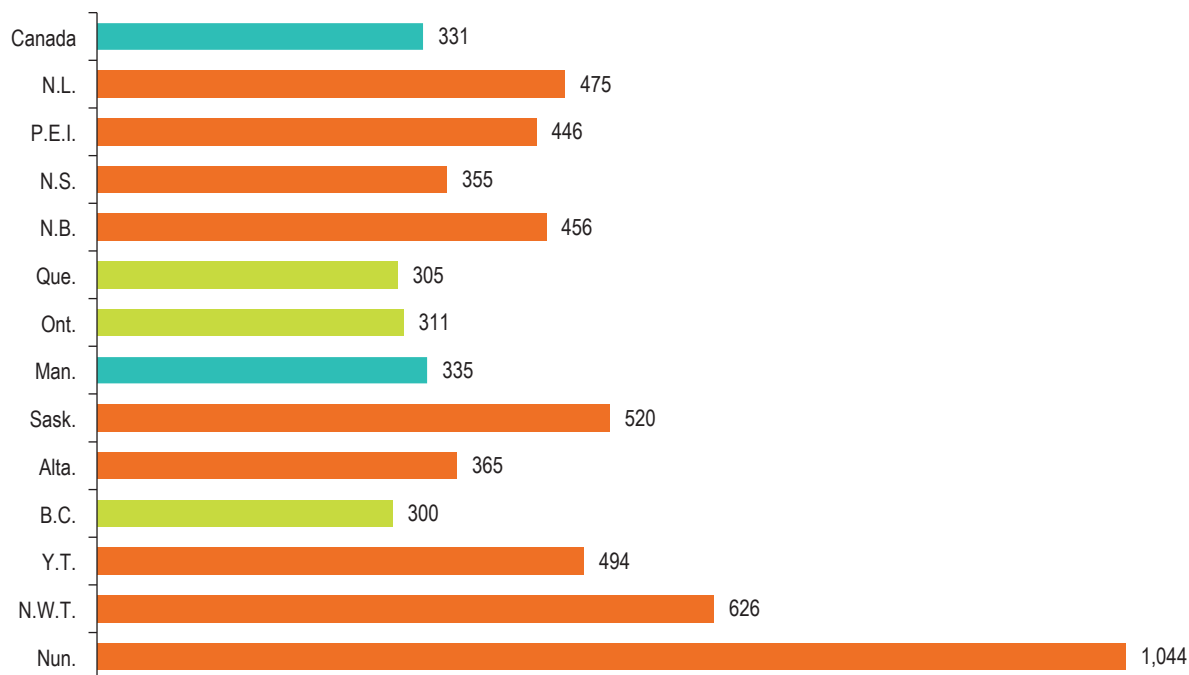
Sources

Discharge Abstract Database, CIHI; MED-ÉCHO, ministère de la Santé et des Services sociaux du Québec; Population projections, Demography Division of Statistics Canada.

Between 2010–2011 and 2014–2015, the hospitalization rate for ACSCs declined from 349 hospitalizations per 100,000 population to 331 hospitalizations per 100,000 population.

331 hospitalizations for ACSCs per 100,000 Canadians

Figure 38 Number of hospitalizations for ACSCs per 100,000 population in the population younger than 75, Canada and provinces/territories, 2014–2015



Results compared with the Canadian average

● Above average ● Same as average ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the lower rate represents *above average* results when compared with the Canadian average. ACSCs do not include seniors age 75 or older and thus do not include hospitalizations for chronic conditions in this older age group. Age-standardized rates were calculated using the 2011 standard Canadian population.

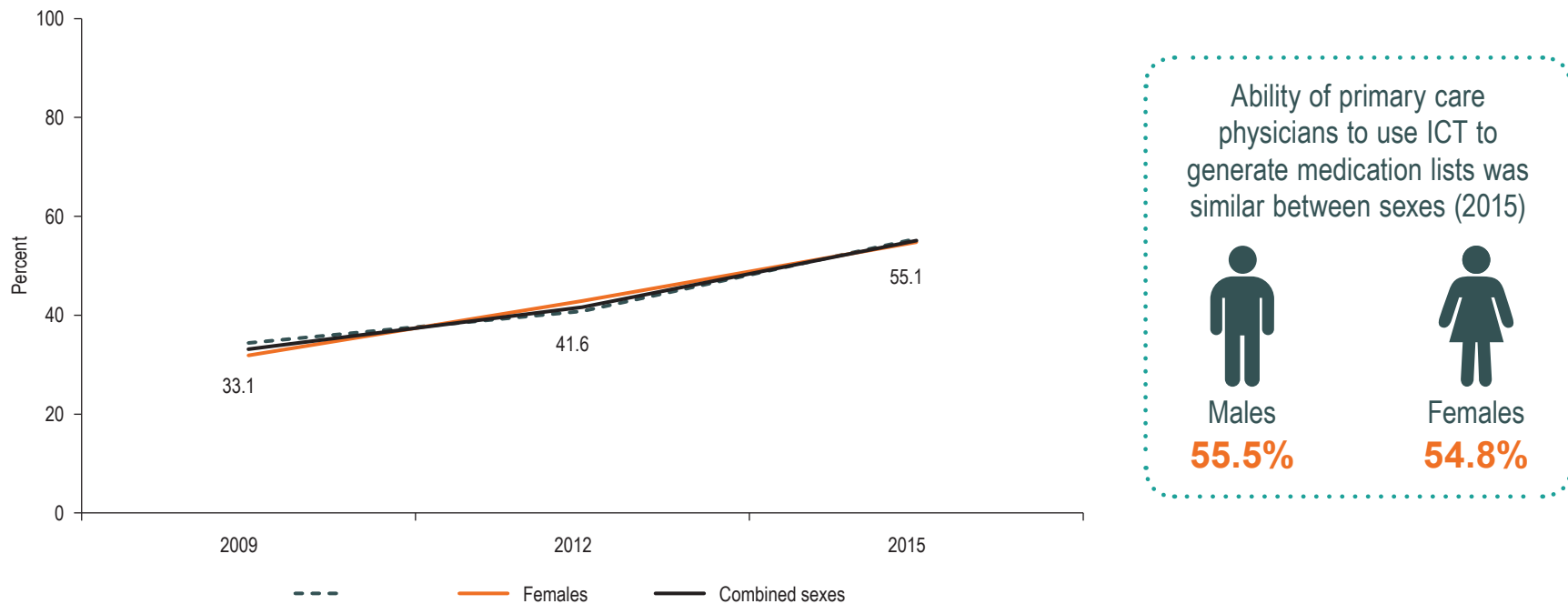
Sources

Discharge Abstract Database, CIHI; MED-ÉCHO, ministère de la Santé et des Services sociaux du Québec; Population Projections, Demography Division of Statistics Canada.

In 2014–2015, the hospitalization rate for ACSCs varied across Canada’s provinces and territories, with the highest rate observed in Nunavut (1,044 hospitalizations per 100,000 population) and the lowest rate observed in B.C. (300 hospitalizations per 100,000 population).

More primary care physicians can generate medication lists using technology

Figure 39 Percentage of primary care physicians who are able to generate a medication list for their patients using a computerized system, Canada, 2009, 2012 and 2015



Notes

The rates shown in the figure pertain to the Combined sexes category.

The 2012 indicator definition was adapted to include an ICT component related to generating a medication list using a computerized system.

Information on significance testing over time and between sexes is unavailable.

Source

The Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Since 2009, there has been an increase over time in the percentage of primary care physicians who were able to generate medication lists using a computerized system. Computerized systems can be viewed as an equivalent to ICT. In 2015, 55.1% of primary care physicians reported being able to use a computerized system to generate medication lists for their patients. However, Canada’s results are lower than those for other high-income countries.⁹

55% of primary care physicians can generate medication lists using technology

Figure 40 Percentage of primary care physicians who are able to generate a medication list for their patients using a computerized system, Canada and provinces, 2015

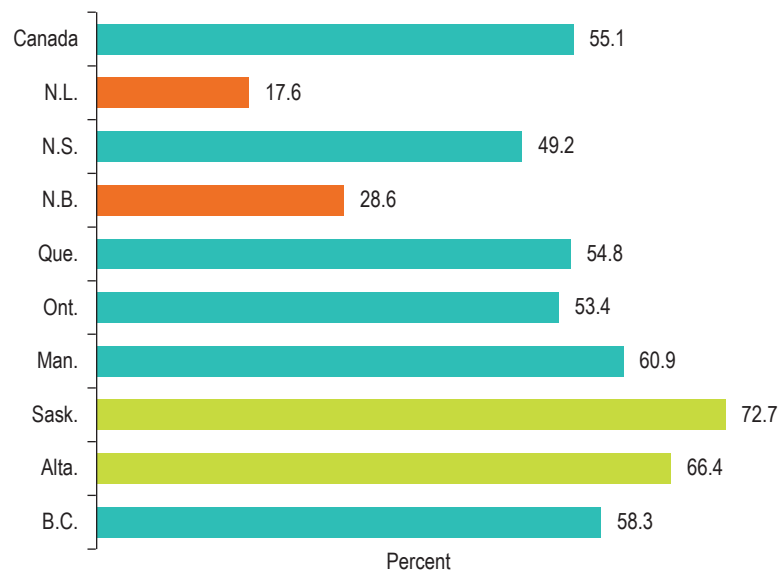
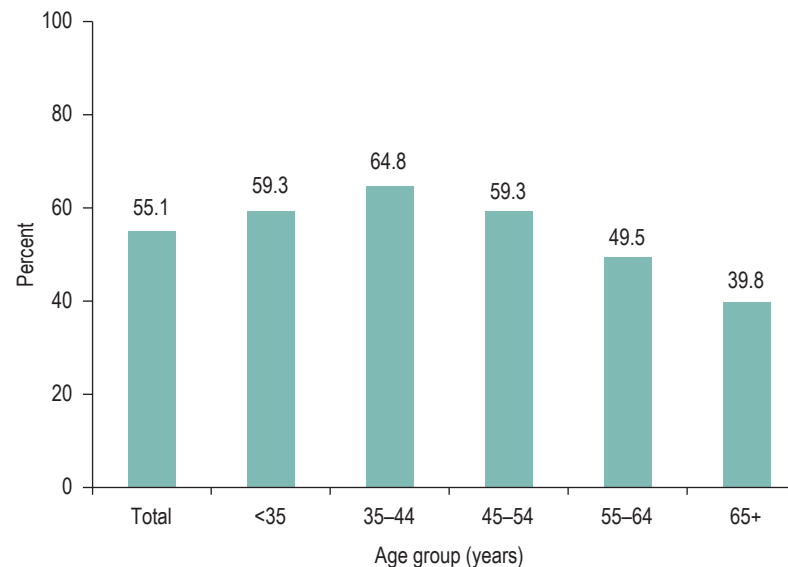


Figure 41 Percentage of primary care physicians who are able to generate a medication list for their patients using a computerized system, Canada, by age group, 2015



Results compared with the Canadian average

● Above average ● Same as average ● Below average

Notes

Above average represents the desirable direction for this indicator. In this case, the higher percentage represents *above average* results when compared with the Canadian average.

In Figure 40, data for P.E.I. and the territories has been suppressed due to small sample size.

The 2012 indicator definition was adapted to include an ICT component related to generating a medication list using a computerized system.

Information on significance testing by age category is unavailable for Figure 41.

Source

The Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

In 2015, the percentage of primary care physicians who are able to generate a medication list for their patients using a computerized system varied across Canada's provinces, ranging from a low of 17.6% in Newfoundland and Labrador to a high of 72.7% in Saskatchewan. Compared with older physicians, younger physicians (younger than 45) were characterized by higher rates of being able to generate a medication list for their patients.

Future considerations

PHC data gaps in Canada

- In 2006, CIHI reported on considerations for enhancing the PHC data collection infrastructure in Canada, to enable the long-term implementation of pan-Canadian PHC indicators.⁴
- Since that time, efforts to improve pan-Canadian data include
 - Making patient-level physician billing data available for cross-jurisdictional comparison. In 2015, 2 provinces submitted patient-level physician billing data to CIHI.¹⁶
 - Augmenting survey sample sizes to obtain more comprehensive provincial data from The Commonwealth Fund International Health Policy Surveys.
 - Activities to improve quality and access to EMR data, such as the development of PHC EMR content standards¹⁷ to improve data structure and quality; and research-based efforts to mine EMR data for data surveillance and other research purposes.¹⁸
 - Examining other sources of comparable PHC survey data. In 2013, the Canadian QUALICO-PC (Quality and Costs of Primary Care) research initiative included the one-time collection of standardized PHC practice-level information to allow for comparisons across Canadian and international jurisdictions.¹⁹
 - Canada's Strategy for Patient-Oriented Research (SPOR), which includes research that engages patients and partners, focuses on patient identified priorities and improves patient outcomes. The initiative includes a pan-Canadian data infrastructure to support research across health care sectors, including PHC.²⁰
- However, pan-Canadian PHC data gaps still exist, as evidenced by the fact that calculations were possible for a relatively small subset of the 51 indicators from the 2012 *Pan-Canadian Primary Health Care Indicator Update Report*. As well, complete pan-Canadian survey data was unavailable for some of the indicators in this chartbook, such as the indicator Eye Examinations in Adults With Diabetes.
- In conclusion, a renewed effort is required to improve the availability and quality of pan-Canadian PHC data in priority areas.

PHC measurement in Canada

- Since CIHI released the *Pan-Canadian Primary Health Care Indicator Update Report* in 2012, the PHC performance measurement landscape in Canada has continued to evolve in terms of PHC measurement activity, policy themes and research.
- A number of groups in Canada have developed performance frameworks and/or indicators and begun reporting activities in an effort to better understand what's important and relevant to them.
- For example, some initiatives use a mix of pan-Canadian and jurisdictional/local indicators:
 - A number of jurisdictions, including Ontario,²¹ have developed PHC performance measurement or evaluation frameworks that include both pan-Canadian and jurisdiction-level indicators.
 - 12 community-based PHC research teams across Canada, funded by the Canadian Institutes of Health Research, have established a set of common PHC indicators to use in their collective research over 5 years. It includes some CIHI PHC indicators.²²
- In other cases, similar indicators are being used by several jurisdictions but are not part of the current pan-Canadian PHC indicator set:
 - B.C., Alberta and P.E.I. advocate the use of Third Next Available Appointment to measure timely access to PHC. This indicator is not included in CIHI's 2012 PHC indicator set.^{23–25}
 - Canada's territories have suggested the use of Days of Physician Service as an indicator of family medicine physician supply. In these jurisdictions, supply is often based on temporary relocation arrangements rather than on the actual count of physicians who permanently reside in the jurisdiction; the latter may understate the access to care in the territories.²⁶
- From a pan-Canadian perspective, stakeholders have highlighted the need for an increased focus on indicators related to the quality of PHC.²⁷
- Data from the 2015 Canadian Community Health Survey, which will be released in the summer of 2016, will allow some indicator results to be updated.

- Of particular note, the 2015 CCHS survey cycle included an additional module on patient experience, which will allow the calculation of meaningful pan-Canadian information on patient experience in PHC. Understanding a patient's experience when he or she receives PHC is integral to improving patient-centred care.
- Capturing and reporting patient experience measures is an important part of CIHI's overall health system performance measurement efforts. CIHI is working closely with jurisdictions across Canada to understand the need to measure patient experience across all health care sectors.²⁸
- Patient-reported outcome measures (PROMs) are also essential to understanding whether PHC services make a difference to patients' health status and quality of life. PROMs are an important part of CIHI's overall health system performance measurement efforts and are increasingly recognized as valuable and essential information for achieving PHC goals.²⁹
- In conclusion, it may be timely to update the pan-Canadian PHC indicator set with a view to confirming indicators that reflect current pan-Canadian priorities.

Appendix 1 — Summary of 2012 indicators excluded from this chartbook

In 2012, CIHI released the *Pan-Canadian Primary Health Care Indicator Update Report*, which included 51 PHC indicators that were intended for policy-makers and PHC providers. Of these 51 indicators, 36 were excluded from this chartbook. The list of excluded indicators, and the rationale for exclusion, appears below.

2012 Primary Health Care indicators excluded	Intended audience, 2012	Proposed data source in 2012	Rationale for exclusion from this chartbook
Scope of PHC Services	Policy-makers	Canadian Practice-Based Primary Health Care Survey Tools: Organization component	Pan-Canadian practice-based survey data not available
Uptake of Information and Communication Technology (ICT) in PHC Organizations*	Providers		
Collaborative Care With Other Health Care Organizations	Policy-makers		
PHC Needs-Based Planning	Policy-makers		
PHC Provider Full-Time Equivalents	Providers	Canadian Practice-Based Primary Health Care Survey Tools: Provider component	
Point-of-Care Access to PHC Client/Patient Health Information	Policy-makers		
PHC Team Effectiveness Score	Providers		
Unnecessary Duplication of Medical Tests Reported by PHC Providers	Providers		
PHC Services Meeting Client's/Patient's Needs	Providers	Canadian Practice-Based Primary Health Care Survey Tools: Patient component	
PHC Support for Self-Management of Chronic Conditions	Providers		
Wait Time for Immediate Care for a Minor Health Problem	Providers		
Screening in Adults With Diabetes	Policy-makers	Survey on Living With Chronic Diseases in Canada	
Blood Pressure Control for Hypertension	Policy-makers		

2012 Primary Health Care indicators excluded	Intended audience, 2012	Proposed data source in 2012	Rationale for exclusion from this chartbook
Difficulties Accessing Routine or Ongoing PHC	Policy-makers	CCHS	Substantial deviations from the 2012 indicator methodology would be required
Complications of Diabetes	Policy-makers	Discharge Abstract Database, MED-ÉCHO, CCHS	
Time With PHC Provider for Patients With Chronic Conditions	Policy-makers	The Commonwealth Fund International Health Policy Survey of Adults	
Wait Time for Immediate Care for a Minor Health Problem	Policy-makers		
Emergency Department (ED) Visits for Asthma	Policy-makers	National Ambulatory Care Reporting System (NACRS) and CCHS	Limited coverage of NACRS (only 2 provinces have full coverage for ED data)
Breast Cancer Screening	Policy-makers	CCHS	CIHI/Choosing Wisely Canada measurement collaborative initiative and CPAC are examining mammography in greater detail
PHC Physician Remuneration Method	Policy-makers	National Physician Survey (NPS)	Data quality concerns around the survey's low response rate and inability to validate findings with a secondary data source

2012 Primary Health Care indicators excluded	Intended audience, 2012	Proposed data source in 2012	Rationale for exclusion from this chartbook
Screening in Adults With Diabetes	Providers	Electronic medical record (EMR)	Lack of available, comprehensive, pan-Canadian EMR data
Blood Pressure Control for Hypertension	Providers		
Child Immunization	Providers		
Child Immunization	Policy-makers		
Antidepressant Medication Monitoring	Policy-makers		
Well-Baby Screening	Providers		
Blood Pressure Testing	Providers		
Screening for Modifiable Risk Factors in Adults With Coronary Artery Disease	Providers		
Screening for Modifiable Risk Factors in Adults With Hypertension	Providers		
Treatment of Dyslipidemia	Providers		
Treatment of Acute Myocardial Infarction	Providers		
Treatment of Anxiety	Providers		
Breast Cancer Screening	Providers		
Cervical Cancer Screening [†]	Providers		
Colon Cancer Screening [†]	Providers		
Overweight and Obesity Rate [†]	Providers		

Notes

* This ICT indicator is intended for providers. The methodology differs from the ICT indicator included in this chartbook, which is intended for policy-makers. Please refer to the 2012 report for additional information.

† This indicator is intended for providers. The methodology differs from similar indicators included in this chartbook, which are intended for policy-makers. Please refer to the 2012 report for additional information.

Appendix 2 — Summary of jurisdictional indicator results

Statistical testing indicates whether results are significantly different from the Canadian average.

Social Determinants of Health indicators

Indicator name	Can.	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Smoking Rate (2014)	18.1%	21.7%	19.7%	22.1%	20.9%	19.6%	17.4%	16.3%	20.5%	19.0%	14.3%	26.2%	33.3%	62.0%
Overweight and Obesity Rate for Youth (2014)	23.1%	46.6%	25.6%*	23.5%*	22.7%	21.0%	23.3%	25.8%	20.3%*	27.7%	18.6%*	32.0%*	35.2%*	†
Overweight and Obesity Rate for Adults (2014)	54.0%	67.5%	61.0%	62.6%	64.0%	51.4%	54.6%	61.5%	58.4%	55.0%	48.0%	57.1%	64.7%	49.4%
Fruit and Vegetable Consumption Rate (2014)	39.5%	25.7%	30.9%	30.9%	34.3%	46.3%	38.1%	31.0%	36.0%	38.8%	39.7%	41.5%	31.8%	23.9%
Physical Activity Rate During Leisure Time (2014)	53.7%	48.3%	49.2%	52.4%	49.2%	50.7%	52.7%	52.6%	51.8%	57.0%	61.7%	64.6%	57.5%	39.7%

Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Interpretation note: *Above average* results are more desirable relative to the Canadian average; *below average* results often indicate areas in need of improvement. Please refer to the companion data tables for additional information.

* Use with caution.

† Suppressed due to small cell count.

Health System Inputs and Characteristics indicators: Health System Resources

Indicator name	Can.	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Family Medicine Physician Supply (2014)	114.2 per 100,000	129.2 per 100,000	99.0 per 100,000	130.9 per 100,000	123.6 per 100,000	117.8 per 100,000	107.0 per 100,000	105.4 per 100,000	105.7 per 100,000	118.2 per 100,000	124.7 per 100,000	‡	‡	‡
Registered Nurses/ Nurse Practitioners (RNs/NPs) Employed in a PHC Setting (2014)	67.4 per 100,000	125.2 per 100,000	39.6 per 100,000	65.0 per 100,000	104.0 per 100,000	84.1 per 100,000	51.0 per 100,000	77.1 per 100,000	73.7 per 100,000	66.1 per 100,000	62.8 per 100,000	265.7 per 100,000	480.0 per 100,000	
Uptake of Information and Communication Technology (ICT) in Primary Health Care (2014)	70.2%	45.0%	†	76.9%	53.0%	45.4%	77.5%	69.9%	75.4%	82.7%	76.6%	†	†	†

Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Interpretation note: *Above average* results are more desirable relative to the Canadian average; *below average* results often indicate areas in need of improvement.

Information on significance testing was not appropriate for Primary Health Care Provider Supply — Family Medicine Physicians and Registered Nurses/Nurse Practitioners (RNs/NPs) Employed in a PHC Setting; these indicators are not based on survey samples.

Please refer to the companion data tables for additional information.

† Suppressed due to small cell count.

‡ Data is not available or does not exist.

Health System Outputs indicators: Access to Comprehensive, High-Quality Health Services

Indicator name	Can.	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Population With a Regular Medical Doctor (2014)	85.1%	89.9%	90.5%	89.4%	93.9%	74.8%	92.5%	83.9%	79.9%	80.1%	84.9%	73.9%	42.3%	17.5%
Difficulties Obtaining After-Hours Primary Health Care (2013)	53.6%	70.9%	53.5%	64.1%	56.0%	58.1%	50.1%	55.8%	55.6%	57.8%	47.2%	†	†	†

Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Interpretation note: *Above average* results are more desirable relative to the Canadian average; *below average* results often indicate areas in need of improvement.

Please refer to the companion data tables for additional information.

† Suppressed due to small cell count.

Health System Outputs indicators: Appropriate, Effective and Safe

Indicator name	Can.	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Smoking Cessation Advice From a Regular Medical Doctor	‡	‡	43.7% (2011 and 2012)	‡	‡	‡	‡	32.5% (2009 and 2010)	‡	38.4% (2007 and 2008)	42.3% (2011 and 2012)	‡	‡	‡
Eye Examinations in Adults With Diabetes	‡	54.0% (2011 and 2012)	54.4% (2009 and 2010)	78.3% (2011 and 2012)	74.0% (2011 and 2012)	‡	73.3% (2011 and 2012)	‡	‡	‡	72.9% (2007 and 2008)	‡	‡	‡
Influenza Immunization for Seniors (2014)	63.1%	56.3%	61.8%	74.1%	61.1%	56.0%	69.1%	58.4%	53.6%	60.5%	62.7%	68.7%	57.3%	†
Colorectal Cancer Screening (2012)	43.0%	30.8%	49.0%	36.8%	32.1%	27.3%	53.4%	58.6%	41.0%	49.4%	37.6%	34.9%	32.7%*	†
Cervical Cancer Screening (2012)	78.0%	83.5%	87.0%	81.7%	79.6%	71.8%	79.1%	84.8%	78.8%	79.6%	79.7%	81.9%	83.3%	76.1%
Ambulatory Care Sensitive Conditions (ACSCs) Hospitalization Rate (2014–2015)	331 per 100,000	475 per 100,000	446 per 100,000	355 per 100,000	456 per 100,000	305 per 100,000	311 per 100,000	335 per 100,000	520 per 100,000	365 per 100,000	300 per 100,000	494 per 100,000	626 per 100,000	1,044 per 100,000
Medication Lists in Primary Health Care Using a Computerized System (2015)	55.1%	17.6%	†	49.2%	28.6%	54.8%	53.4%	60.9%	72.7%	66.4%	58.3%	‡	‡	‡

Results compared with the Canadian average

● Above average
 ● Same as average
 ● Below average

Notes

Interpretation note: *Above average* results are more desirable relative to the Canadian average; *below average* results often indicate areas in need of improvement.

Information on significance testing is not available for Smoking Cessation Advice From a Regular Medical Doctor and Eye Examinations in Adults With Diabetes.

Please refer to the companion data tables for additional information.

* Use with caution.

† Suppressed due to small cell count.

‡ Data is not available or does not exist.

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