QUANTITATIVE RESEARCH

The Canadian Index of Wellbeing: Key Findings From the Healthy Populations Domain

Nazeem Muhajarine, PhD,[1,2] Ronald Labonte, PhD, FCAHS,[3] Brandace D. Winquist, MSc[1]

ABSTRACT

Objectives: The Canadian Index of Wellbeing (CIW) is an ambitious undertaking that aims to measure and track Canadians' overall "wellbeing". The Healthy Populations, one of eight CIW domains, brings together both population health outcomes and important influences on health.

Methods: Indicators from eight subdomains (personal wellbeing, life expectancy/mortality, physical health conditions, functional health, mental health, lifestyle and behaviour, health care, and public health) make up the Healthy Populations domain. Following a review of worldwide literature on health and wellbeing indicators, application of a prespecified set of selection criteria, and expert external validation, ten core indicators and six secondary indicators were selected. The data sources include several national population data systems (CCHS, NPHS) and databases kept at the Canadian Institute for Health Information. Indicators were examined for trends over time, and were stratified by age, sex, income and education. A single summary measure, health domain index, was calculated and reported annually from 1994 to 2008.

Results: Analysis of data over a 15-year time period found that Canadians are living longer, but with fewer years in optimal health. Diabetes rates have risen, along with obesity rates, while smoking rates are on the decline and regular physical activity is becoming more common. There were notable income and education gradients for virtually all indicators measured, and gender disparities evident for life expectancy, health-adjusted life expectancy, diabetes, and depression. A worrisome downward trend in health outcomes for Canada's youth (12-19 years) was observed. The overall health index score showed a modest rise of 6.6% from 1994 to 2008.

Conclusion: The Healthy Populations domain, and its ongoing use and refinement, can be an important resource for understanding and monitoring the health of Canadians. Knowledge about the status of Canadians' wellbeing will benefit from the contextualization of these findings through evidence generated from the other CIW domains.

Key words: Health status indicators; health status index; health status disparities; population health; health equity

The Gross Domestic Product (GDP) of a country is a high-profile and often tracked measure that has emerged by default as a surrogate for wellbeing.[1] However, as the recent Commission on the Measurement of Economic Performance and Social Progress noted, "it has long been clear that GDP is an inadequate metric to gauge well-being over time particularly in its economic, environmental, and social dimensions."[2, p.8] Reliance upon the GDP points to the need for a robust set of indicators able to measure other important dimensions of Canadians' social, economic and cultural lives. While measurement activity and indicator reporting are now commonplace across all sectors, Canada lacks a single, highly visible national instrument that monitors and publicly reports on improvements or setbacks to our collective wellbeing and its important influences. A well-designed, easily understandable, and technically sound tool that captures all of the factors contributing to our wellbeing would offer important information for all Canadians, and be useful as a guide to public policy discourse and decision-making.

The Canadian Index of Wellbeing (CIW), the result of almost eight years of preparatory work, has emerged as a tool for this purpose. Bringing together a diversity of indicators across eight principal domains – Arts, Culture and Recreation; Civic Engagement; Community Vitality; Education; Environment; Healthy Populations; Living Standards; and Time Use – a primary aim of the CIW is to monitor trends within each domain and to emphasize interconnections between them. *Healthy Populations* is the CIW domain that measures health outcomes and other risk (or protective) factors. This article describes the Healthy Populations framework, indicator selection process, and data sources, and a few of the key findings from the domain report.

METHODS

Healthy Populations Framework

Composed of ten "core" and six "secondary" health indicators, the CIW Healthy Populations framework covers eight subdomains (see Figure 1). Subdomains identify core aspects of health status (physical, functional, emotional, and psychological) and proximal health deter-
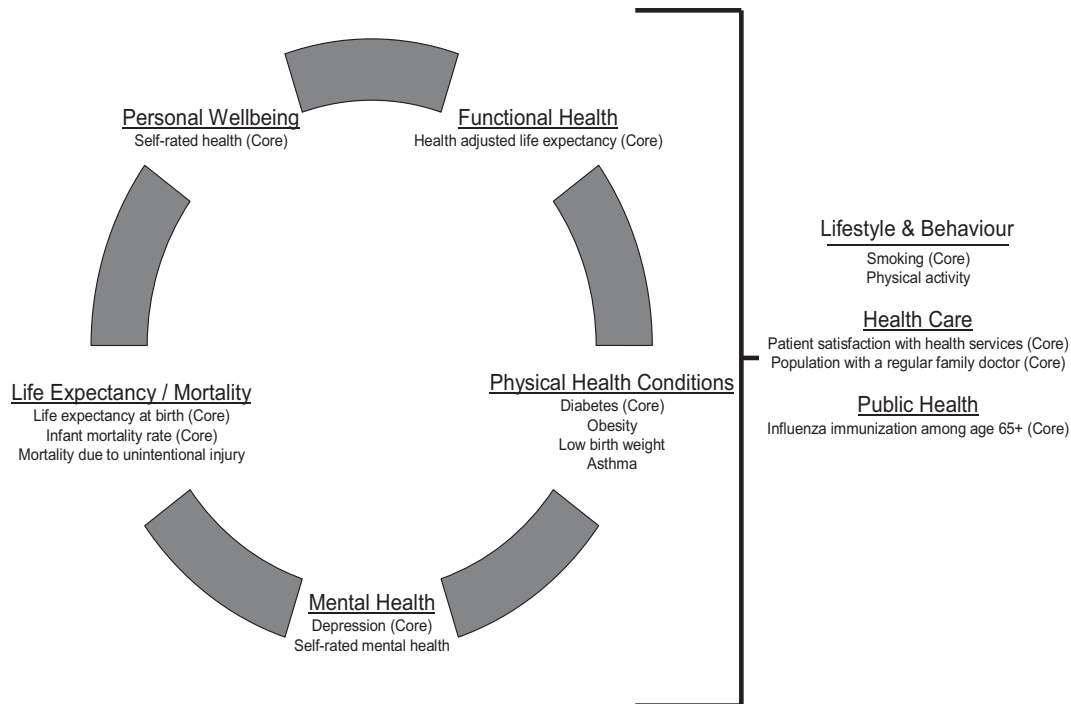
Author Affiliations

1. Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan, Saskatoon, SK
2. Saskatchewan Population Health and Evaluation Research Unit, University of Saskatchewan, Saskatoon, SK
3. Department of Epidemiology and Community Medicine, Faculty of Medicine, and Institute of Population Health, University of Ottawa, Ottawa, ON

Correspondence: Dr. Nazeem Muhajarine, Health Sciences Building, University of Saskatchewan, 107 Wiggins Road, Saskatoon, SK S7N 5E5, Tel: 306-966-7940, E-mail: Nazeem.Muhajarine@usask.ca

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Figure 1. Eight subdomains of the CIW Healthy Populations and within each domain associated core and secondary indicators

Personal Wellbeing
Self-rated health (Core)

Functional Health
Health adjusted life expectancy (Core)

Lifestyle & Behaviour
Smoking (Core)
Physical activity

Health Care
Patient satisfaction with health services (Core)
Population with a regular family doctor (Core)

Public Health
Influenza immunization among age 65+ (Core)

Life Expectancy / Mortality
Life expectancy at birth (Core)
Infant mortality rate (Core)
Mortality due to unintentional injury

Physical Health Conditions
Diabetes (Core)
Obesity
Low birth weight
Asthma

Mental Health
Depression (Core)
Self-rated mental health

minants such as lifestyle and behaviour, and health care. Since our framework is part of the larger CIW set, it does not incorporate important social determinants of health which are the foci of other CIW domains. Some key determinants of health that relate to equity (e.g., income, education, place and ethnocultural status) and the essential biological factors (notably age and sex) are considered in the Healthy Populations indicator analysis. Each subdomain is measured by at least one core indicator, and several are measured by additional secondary indicators. Age and sex differences as well as national and provincial/territorial trends are reviewed for each indicator in the full report. All core indicators were stratified by income and education to describe differences in health indicators and to identify instances of health inequity. In this paper we report the selected findings, or the "core story", of the CIW Healthy Populations domain.

Indicator selection

Indicators were selected based on the following criteria developed in this project. These criteria were set following extensive discussions at the CIW National Working Group and are consistent with the literature.[3,4]

- Quality of data: indicators are clearly defined, measurable, transparent and verifiable.
- Adequacy of data: indicators support benchmarking and monitoring over time; that is, longitudinal or repeated data are available for at least three points in time, allowing trend analyses.
- Relevance of data: indicators are commonly used, understandable, credible, meaningful, and policy relevant (that is, can change as a result of policy interventions).
- Variety of data: indicators capture both subjective and objective aspects of health outcomes, and represent both positive (desired) and negative (undesired) outcomes.
- Spatial sensitivity of data: indicators are available at national, provincial and municipal or lower levels of aggregation, allowing comparisons by geographic scale.

- Socio-demographic sensitivity of data: indicators allow for analyses by socio-economic and demographic differences; that is, data can be stratified by important socio-economic and demographic variables (sex, age group, income, cultural identity, geographic place).

Based on these criteria and a review of the international literature for comparable national indicator projects, the authors first compiled a comprehensive list of candidate indicators. A number of external experts, within Canada and internationally, were then consulted in a validation process, which involved experts indicating their recommendations and reasons for retaining or dropping a variable. The selection of the final "core" and "secondary" indicators for each subdomain rested with the authors of the domain with input from the National Working Group.

As a form of additional face validation, our final indicator selection was "mapped" against the Health Indicators Framework (HIF) used by Statistics Canada and the Canadian Institute for Health Information.[5] Our indicators overlap fully with the "health status" category and partially with other categories of the HIF, which include categories relevant to other CIW domains and so are not part of the Healthy Populations Domain. The HIF is one of the standard frameworks used by health ministries in determining their indicator use for a variety of purposes; and the independent coherence and comparability of the Healthy Populations Domain with existing health categories of public policy and data-gathering frameworks such as HIF suggests the relevance of the Domain's indicators within the larger CIW project.

Data sources

For the selected indicators, data were primarily obtained from Statistics Canada's data products, and included the Canadian Community Health Survey (CCHS) (cycles 1.1, 2.1, 3.1, 4.1) and the National Population Health Survey (1994, 1996, and 1998), the CCHS Mental Health and Wellbeing (cycle 1.2), CCHS Health Services Access Survey, Canadian Vital Statistics Database, and the

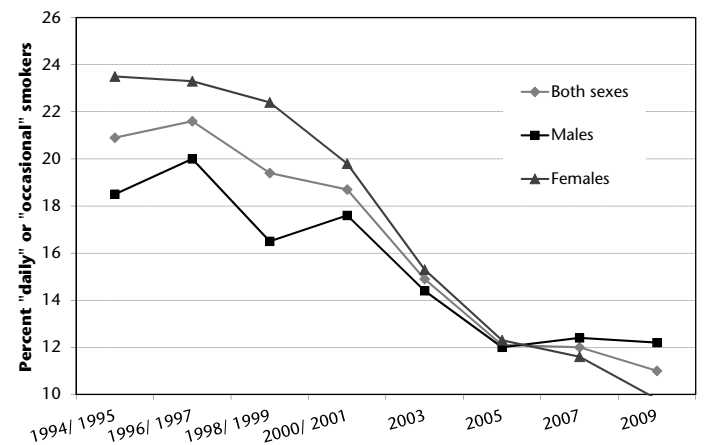**Figure 2.**   Self-rated health status by sex, Canada, 1994/95-2009
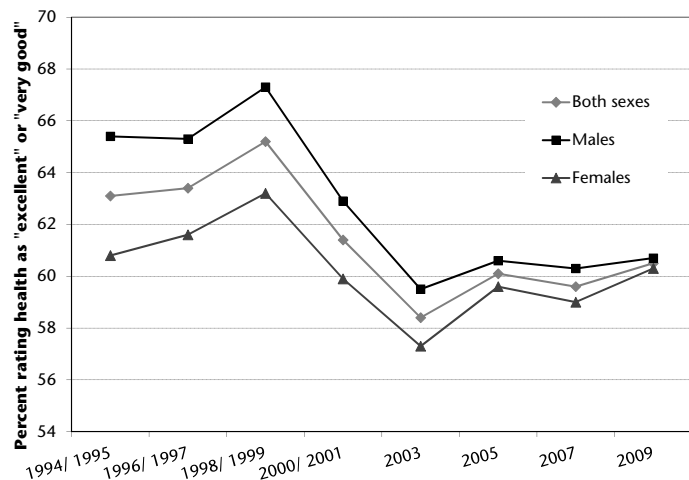
Sources: Statistics Canada CANSIM Tables 105-4022 and 105-0501.

Figure 3.   Teen smoking rates by sex, Canada, 1994/1995-2009

Sources: Statistics Canada CANSIM Tables 104-0027, 105-0027 and 105-0501.

Canadian Institute for Health Information, Hospital Morbidity Database.

Deriving a summary measure: Healthy Population Index

From the outset, following extensive discussions at the CIW National Working Group, it was decided that each CIW domain will have a summary measure and that this will be derived from a smaller subset of indicators within each domain. Each indicator was reviewed by members of the CIW National Working Group and voted on using a five-point rating (5=very important to 1=not at all important to the composite CIW). Voting was done individually, then again following group discussion. From this process, eight indicators ("headliners") were included in the calculation of the Healthy Population Index: percent rating their own health as excellent or very good, percent with diabetes, life expectancy at birth, percent daily or occasional smokers among adolescents (aged 12-19), percent with probable depression, percent rating health services overall as excellent or good, percent who had received immunization for influenza (age 65+) and average Health-Adjusted Life Expectancy (HALE) for those ≥15 years (percent of remaining years expected to be lived in good health).

All indicators were deemed equally important, therefore treated equally (not weighted) in the index (see Michalos et al. for in-depth discussion[4]). The headliner indicators included four negative indicators (i.e., increases in numerical values indicate decreases in some aspect of wellbeing) and four positive indicators (i.e., increases in numerical values indicate increases in some aspect of wellbeing). The calculation of index scores are described in detail elsewhere (see reference 4). Briefly, the principle for calculating an index score involved taking the first value for each indicator (1994 in our case, or baseline) and fixing it as a base of 100, and taking each value for subsequent years as a percentage change of this base value, and then taking the mean across all eight headliner indicators. The positive indicators were converted into a value of percent change by dividing every data value within an indicator by its first value and multiplying the result by 100. In order to standardize the index values so that increases and decreases in figures uniformly represent improvement or deterioration, respectively, the values of negative indicators were transformed into their reciprocals and the latter were turned into percentage change, similar to the manoeuvre for the positive indicators.
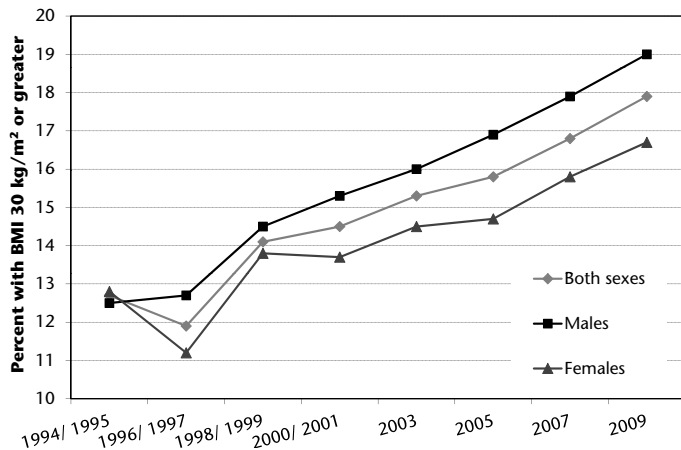
FINDINGS

A summary of the key findings is presented below; for a more detailed discussion, please refer to the full report.[6]

Canadians live longer, but not necessarily healthier, lives

The relatively high standard of living enjoyed by Canadians is matched by life expectancy rates that are among the best in the world. A closer look at health indicators, however, reveals a more mixed picture. Although Canadians are living longer, these additional gains in years of life are not necessarily lived in the fullest health possible. When taking into account functional limitations brought on by disease and disability, the number of years lived in full health for Canadian women is not substantially different in 2005 compared to in 1991 (data not shown); Canadian men, however, made slightly more gains during this period. As has been the case historically, women are still outliving men, but the gap is shrinking. A rich–poor gap in Canadian life expectancy was observed and can largely be explained by higher rates of death in childhood through to middle age, not in old age. Such preventable deaths early in life also negatively impact Aboriginal life expectancy, which continues to lag behind that of non-Aboriginal Canadians (data not shown).

For more than a decade, a majority of Canadians have declared that their overall health is very good or excellent (Figure 2). However, the proportion of Canadians who considered themselves as having optimal health peaked in 1998/99 at 65.2% and decreased dramatically in 2003 to 58.4%. Self-rated health began to rebound in 2005, but is still considerably lower than it was 10 years previously.

The decline in those who report their health in superlative terms needs some further explanation. Given the consistency of findings between this subjective measure and the objective and derived HALE measure, it could safely be said that the decline in self-reported health is likely not an artefact. Self-rated health is one of the most intensely researched measures of overall subjective health, and over the years studies have found a wide array of correlates of self-rated health. The overall Canadian population's age structure is likely

Figure 4. Obesity prevalence by sex, Canada, 1994/1995-2009

Sources: Statistics Canada CANSIM Tables 105-4009 and 205-0502.

Figure 5. Diabetes, treated and untreated (Type I and II), prevalence by sex, Canada, 1994/1995-2009

Sources: Statistics Canada CANSIM Tables 104-0011, 105-0011 and 105-0501.

not a solid explanation as our period of study is relatively short (15 years) and we observe downward trends every two years of data availability. The likely explanation would tend to be a complex mix of factors, including but not exclusively, changing prevalence of chronic diseases, mental health, and other psychosocial and social factors.

The decline in the share of the population who consider themselves in excellent or very good health has been most marked among Canadian teenagers, with a drop of 12.5 percentage points from its 1998/99 peak. This is matched by a steadily increasing share of teenagers who report problems with everyday functions (an increase of 8.8 percentage points from 1994/95 to 2005), and increasing obesity rates – a trend that augurs poorly for the health of this generation as they advance in age.

After peaking at the start of the new millennium, depression rates gradually declined. However, the 2007/08 estimate represented a slight increase. Throughout this period, the prevalence of depression has been consistently higher in women than in men. At their peak in 2000/2001, depression rates in women were nearly double those of men (9.4% and 5%, respectively). While this difference has diminished slightly in recent years, more women report depression than men. A notable income gradient in depression was also observed for both sexes, with males being most impacted by lower income levels.

Healthy living trends (some) catching on

Two encouraging findings were that the number of Canadians who smoke dropped markedly from 1996/97 to 2009, particularly among youth (Figure 3), and that there is a greater proportion of Canadians now compared to a decade ago reporting that they are at least "moderately active". A steep household income gradient was observed for both findings. In 2007/08, smoking rates in the lowest income households were more than double those of the highest.

Obesity continues to rise, despite more physical activity

Despite the overall and sustained rise in physical activity, the number of Canadians who are obese continues to increase (from 11.9% in 1997 to 17.9% in 2009). At the same time, more Canadians are now living with chronic diseases such as diabetes (which includes treated and untreated diabetes), the prevalence of which has doubled over
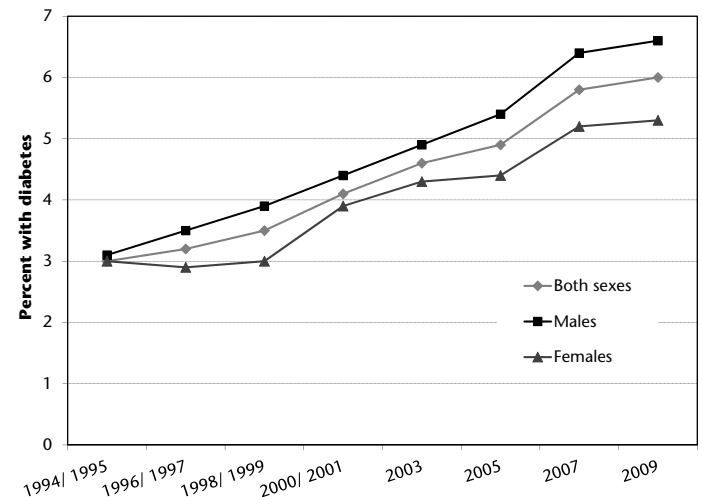
15 years (3% in 1994/95 to 6% in 2009). Diabetes rates are highest in the oldest age group, with nearly one in five people aged 65 and over affected in 2009. Income and education, even at relatively low levels, have a marked protective effect for diabetes. While this is true for both sexes, the effect is greater for women (data not shown).

Higher income adds both quantity and quality to life

Higher incomes and higher levels of education are associated with longer life expectancy and better self-reported health. Interestingly, the positive impact of income and education on self-rated health is most marked among women. At higher levels of income, women are more likely than men to consider themselves in very good or excellent health. Income and education effects were observed, with varying patterns, for most of the indicators analyzed. Income increases in the lower income brackets have the greatest impact in reducing the prevalence of diabetes, depression, and teen smoking.

Place matters

On a number of indicators, there were interesting differences between physical and mental health at the provincial and territorial levels. For instance, Newfoundlanders have lower life expectancies and generally higher rates of diabetes and other adverse health conditions than people in other Canadian provinces and territories; however, they have among the lowest levels of depression and are most likely to consider themselves as having excellent or very good health. On the other hand, British Columbians and Albertans enjoy among the longest life expectancies and lowest levels of obesity and diabetes; but they are also more likely than Newfoundlanders to report high levels of depression and less likely to say they are satisfied with the quality of their health services. These intriguing geographic differences may point towards cultural differences in self-evaluations, and should be the subject of further inquiry.

Pervasive health gaps remain for Aboriginal populations

Considerable progress has been made in terms of Aboriginal health and wellbeing in Canada, but challenges remain.[7] In recent years,

Appendix A. Indicators included in the Healthy Population Index, Canada

Year	Self-rated Health (% excellent or very good)	Diabetes Prevalence (% yes)	Life Expectancy at Birth (years)	Teen Smoking Rate (aged 12-19, % daily or occasional smokers)	Depression (% with probable depression)	Patient Satisfaction With Overall Health Services (% rating services as excellent or good)	Influenza Immunization Rate (age 65+) (% yes)	Average HALE for 15+ (% of remaining years expected to be lived in good health)	Average of Healthy Population Indicators
1994	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1995	100.2	96.8	100.3	98.4	112.8	100.0	100.0	101.1	101.2
1996	100.5	93.8	100.5	96.8	129.3	100.0	100.0	102.2	102.9
1997	101.9	89.6	100.8	102.0	123.3	100.0	106.3	99.3	102.9
1998	103.3	85.7	101.0	107.7	117.8	100.0	112.6	96.5	103.1
1999	101.3	81.1	101.3	109.0	98.1	100.0	118.9	96.3	100.8
2000	99.3	76.9	101.5	110.4	84.1	100.0	125.2	96.0	99.2
2001	97.3	73.2	101.8	111.8	73.6	100.0	131.5	95.8	98.1
2002	94.9	69.0	102.0	124.4	80.9	101.4	130.9	97.1	100.1
2003	92.6	65.2	102.2	140.3	89.8	102.8	130.3	98.4	102.7
2004	93.9	63.2	102.5	154.8	95.5	101.9	134.6	97.2	105.4
2005	95.2	61.2	102.8	172.7	101.9	100.9	138.8	96.1	108.7
2006	94.8	56.1	103.3	173.4	94.6	101.9	136.5	96.1	107.1
2007	94.5	51.7	103.3	174.2	88.3	102.8	134.2	96.1	105.7
2008	93.3	50.8	103.3	183.3	88.3	102.8	134.2	96.1	106.6

Figure 6. Healthy Populations Domain index for Canada, 1994-2008
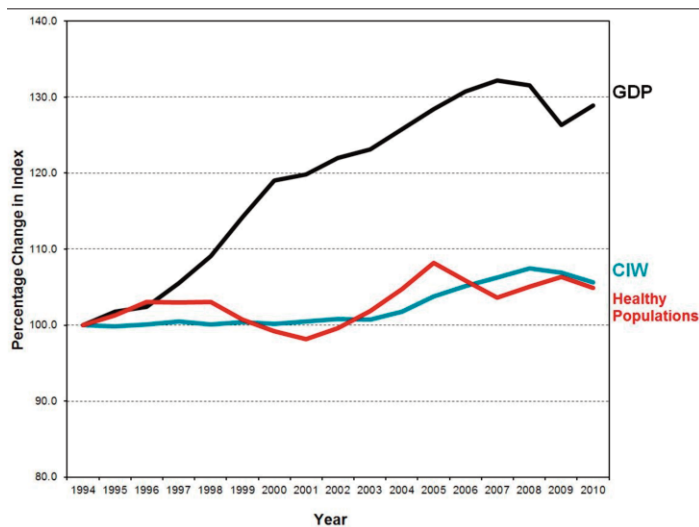
Aboriginal people have experienced longer life expectancies and reduced mortality rates, although the gap in these rates between Aboriginal and non-Aboriginal Canadians remains unacceptably high. Life expectancy at birth in 2000 for the Aboriginal population was 68.9 years for males and 76.6 for females – a full 7.4 and 5.2 years lower than for Canadian men and women, respectively. The infant mortality rate for Aboriginal populations has fallen dramatically, from 27.6 deaths per 1,000 live births in 1979 to 6.4 in 2000. Still, it was 16% higher than the comparable Canadian rate for that same year. First Nations living on-reserve also rate their health in poorer terms. In 2002-03, 79.7% said their health was "excellent" or "very good" compared to 88% of the general Canadian population.[8] One potential explanation for this discrepancy could be the much higher rate of diabetes on-reserve (19.7% vs. 5.2%), a condition with which one in five adults had been diagnosed. The differences between diabetes rates on- and off-reserve were highest for young and middle-aged adults, with implications for future generations of seniors. Unintentional injury and suicide remain key challenges for Aboriginal people, as does infectious disease. Potential years of life lost from injury were almost 3.5 times higher than the national rate, with motor vehicle accidents being a primary cause of death for all

age groups. The Healthy Populations report highlights a small portion of the long-known health disparities between Aboriginal and non-Aboriginal Canadians, a health gap that in recent years has narrowed somewhat but still remains unacceptably large.

Equity: The driving value
Equity is the core value that drives the CIW project. Health equity similarly informs the work undertaken in the *Healthy Populations Domain*. Health equity refers to the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically.[9] Various analyses of health indicators and comparisons to other nations suggest the potential for our collective capacity to improve the health of all Canadians. Income and other socioeconomic conditions that influence health are shaped by both private economic practices ("the market") and public policies (regulation, taxes, transfers and social protection spending). Income-related negative health effects are caused by both material conditions (inadequate access to resources for health) and psychosocial dynamics.[10,11] These conditions can be mitigated by government regulation, programs and services.

Despite the availability of universal health care services, with which a large majority of Canadians are satisfied when they encounter it as patients, the persistence of significant health gaps suggests both the need for health interventions tailored to socially excluded groups and the potential health benefits of initiatives outside the health field. This latter point was emphasized most strongly in the August 2008 Report of the World Health Organization Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health*, to which many Canadian public health researchers and policy analysts made substantial contributions.[12]

Pulling it together: The Healthy Populations Index
A key deliverable for the CIW project is the calculation of a single, overall measure, or index, of Canadians' wellbeing. Such indices were also calculated for each individual CIW domain.* Figure 6 presents the Healthy Populations Domain index along with the overall Canadian Index of Wellbeing and the GDP from 1994 to

2010. As shown, there is an overall increase or positive trend in the health of populations that began in 2001 (corresponding to a 6.6% increase in the index), and while this increase tracks closely with the overall CIW index, it is far below the rapidly climbing increase in GDP. The gains in GDP do not necessarily translate directly to gains in overall wellbeing or health of populations. Decreasing teen smoking rates and increasing influenza immunization rates in seniors were two of the key drivers behind the recent improvement in the Healthy Population index, while increasing prevalence of diabetes, depression, and stagnant self-rated health in recent years suppressed further gains in the overall score.

CONCLUSION

The Canadian Index of Wellbeing is a multifaceted measurement and monitoring tool developed to engage Canadians in conversations about their health and wellbeing that go beyond health care or the economy, and about acting on changes that matter in their lives. The Healthy Population domain of the CIW stands as one important component in measuring wellbeing; however, a greater value of the domain is to understand the contributions it makes to and receives from other domains of the CIW that, collectively, contribute to overall wellbeing. Understanding the interactions between the indicators comprising CIW domains, currently and over the years past, is the next challenge facing CIW researchers.

The gains made in health trends in recent years, however, are surprisingly modest and hide vast discrepancies in the health of Canadians. Without proper policy intervention, Canada will continue to see a health divide along income lines. Inaction will lead to increased pressures on the health care system in the long run. With the current rates of growth in obesity and diabetes, we might experience diminishing life expectancy, particularly among the younger generation of Canadians. The relationship between income and health calls for a multipronged approach that does not simply address health policies, but also social policies in order to advance our collective wellbeing. By implementing greater intergovernmental efforts in benchmarking, streamlining, and coordinating health programming and targets, we will enhance equity and effectiveness across regions and populations.

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RÉSUMÉ

Objectifs : L'Indice canadien du mieux-être (ICMÊ) est un ambitieux projet qui vise à mesurer et à suivre le « mieux-être » général de la population canadienne. Le domaine des Populations en santé, l'un des huit domaines de l'ICMÊ, établit des liens entre les résultats de santé de la population et les grands facteurs qui influencent la santé.

Méthode : Le domaine des Populations en santé comprend des indicateurs pour huit sous-domaines (mieux-être personnel, espérance de vie/mortalité, troubles physiques, santé fonctionnelle, santé mentale, mode de vie et comportement, soins de santé, santé publique). Après un examen de la documentation mondiale sur les indicateurs de la santé et du mieux-être, nous avons appliqué un ensemble prédéterminé de critères de sélection, que nous avons fait valider par des spécialistes indépendants, et sélectionné 10 indicateurs de base et 6 indicateurs secondaires. Nos données provenaient de plusieurs bases et systèmes nationaux de données démographiques (ESCC, ENSP) hébergés à l'Institut canadien d'information sur la santé. Nous avons cherché à déceler les tendances des indicateurs au fil du temps, et nous avons stratifiés les indicateurs selon l'âge, le sexe, le revenu et l'instruction. Une mesure sommaire unique, l'indice du domaine de la santé, a été calculée et publiée annuellement entre 1994 et 2008.

Résultats : L'analyse des données sur 15 ans a permis de constater que les Canadiens vivent plus longtemps, mais moins d'années dans un état de santé optimal. Les taux de diabète ont augmenté, tout comme les taux d'obésité, tandis que les taux de tabagisme ont baissé et que l'activité physique régulière a gagné du terrain. Presque tous les indicateurs mesurés font état de gradients notables pour le revenu et l'instruction, et de disparités manifestes entre les sexes sur le plan de l'espérance de vie, de l'espérance de vie corrigée en fonction de la santé, du diabète et de la dépression. Une tendance baissière inquiétante observée au Canada est celle des résultats sanitaires des jeunes (12-19 ans). L'indice de santé global a présenté une légère hausse (6,6 %) entre 1994 et 2008.

Conclusion : Le domaine des Populations en santé (et son utilisation et son perfectionnement continus) peut être une importante ressource pour comprendre et surveiller la santé des Canadiens. Les connaissances sur le mieux-être de la population canadienne profiteront de la mise en contexte de nos constatations à la faveur des données probantes produites dans les autres domaines de l'ICMÊ.

Mots clés : indicateurs d'état sanitaire; indice d'état sanitaire; disparités d'état sanitaire; santé des populations; équité en santé

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* Refer to the Composite Index Report[4] for a full discussion on the methodology and individual results for each Healthy Populations domain indicator and the other CIW domains.