

Toronto Health Status at a Glance



 **TORONTO** Public Health

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1. Toronto is getting older

Our population increased by 205,740 or 9% from 1991 to 2001. By 2011, the population is projected to increase by a further 299,445 or 12%. The overall population is ageing with the median age at 36.9 years in 2001, up from 35.5 years five years ago. Seniors 65 years and older increased by 16% since 1991 and are projected to increase by 21% by 2011. People who are eligible to retire have also increased relative to the rest of the population. This is projected to increase dramatically in the next 10 years.

Our ageing population has major implications for the labour force, our economy, social services and health care systems. The federal government is therefore considering increasing immigration levels. Toronto is the most popular destination for immigrants to Canada so we can expect continuing increases in new immigrants to the city. Public health program planning must continue to consider these demographic changes in order to ensure that our programs are effective and efficient in the future.

2. Just over half of Toronto's adults have acceptable weights

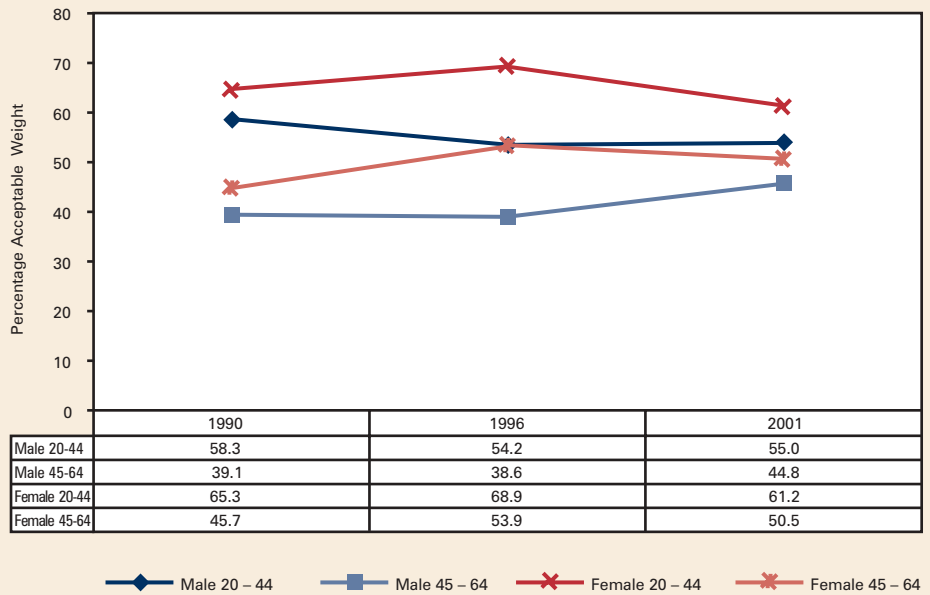
The Body Mass Index (BMI), is a method of determining if an individual's weight is in a healthy range based on their height. It is commonly used as a measure of health status. Rates for illness and premature death are generally higher among underweight, overweight, and obese people. Excess weight is associated with many health problems including heart disease, type II diabetes, high blood pressure, stroke and cancer.

Results from the 2001 Canadian Community Health Survey indicate that the proportion of Toronto residents with an acceptable weight was 52% among males and 57% among females. For both sexes, the proportion of older adults (age 45 – 64) with an acceptable weight was higher in 2001 than 1990. Among younger adults (age 20 – 44), the proportion with acceptable weight was lower in 2001 than 1990. The Ministry of Health and Long-Term Care has set a **target of slowing the decrease in the proportion of adults (20 – 64) with healthy weight status (BMI 20 – 27) by the year 2010**. The International Standard for BMI is: under 18.5 (underweight), 18.5 – 24.9 (acceptable weight), 25.0 – 29.9 (overweight) and 30 or higher (obese).

Figure 1 – Total Population Change (%), Toronto, 1991 – 2011

Age	1991 - 2001	2001 - 2011	1991 - 2011
0 – 4	4.23	-6.64	-2.69
5 – 9	22.29	5.20	28.65
10 – 14	20.16	25.33	50.60
15 – 19	8.50	30.61	41.71
20 – 24	-11.68	2.09	-9.83
25 – 29	-19.19	-24.51	-38.99
30 – 34	-1.25	-29.67	-30.54
35 – 39	22.42	-10.36	9.74
40 – 44	21.60	25.10	52.12
45 – 49	36.55	39.80	90.90
50 – 54	37.13	32.83	82.15
55 – 59	3.04	47.70	52.20
60 – 64	-8.53	50.04	37.24
65 – 74	6.60	11.67	19.04
75+	30.05	32.87	72.81
65+	16.06	21.25	40.73
Total Change	9.04	12.07	22.20

Figure 2 – Body Mass Index* – Acceptable Weight, Toronto, 1990, 1996, 2001



*International Standard

Sources: Ontario Health Survey 1990, Ontario Ministry of Health and Long-Term Care (MOHLTC) ; Ontario Health Survey 1996/97, Statistics Canada, Share File, Health Planning Branch, Ontario MOHLTC; Canadian Community Health Survey 2001, Statistics Canada, Share File, Health Planning Branch, Ontario MOHLTC.

3. Fertility rates dropping

The General Fertility Rate (GFR) is an indicator of overall reproductive behaviour and outcomes.

While the number of women of child bearing years (aged 15 – 49) has been shrinking, the corresponding decrease in births has been even greater. This may be due in part to:

- couples delaying having children
- economic difficulties experienced by young households
- increases in divorce or separation

As a result of these and other factors, Toronto's GFR declined by about 9% from 1990 to 1999.

4. Toronto babies more likely to have low birthweight

Although Toronto's low birthweight (LBW) rates have been improving since 1993, they were consistently higher than Ontario during the 1990's. In 1999, 1,602 or 5.3% of singleton newborns to Toronto residents were LBW births.

LBW is used as an indicator of a newborn's chances for survival. It is related to maternal health and socio-economic factors. It is a predictor of child growth and development, some conditions in adult life, increased health and social services cost and stress on families². Studies that link births and infant mortality have consistently shown extreme differences in survival rates by birthweight. The Ministry of Health and Long Term Care (MOHLTC) has set a **target of reducing the LBW rate to 4% by 2010**. In 1999, the province-wide LBW rate was 4.5%.

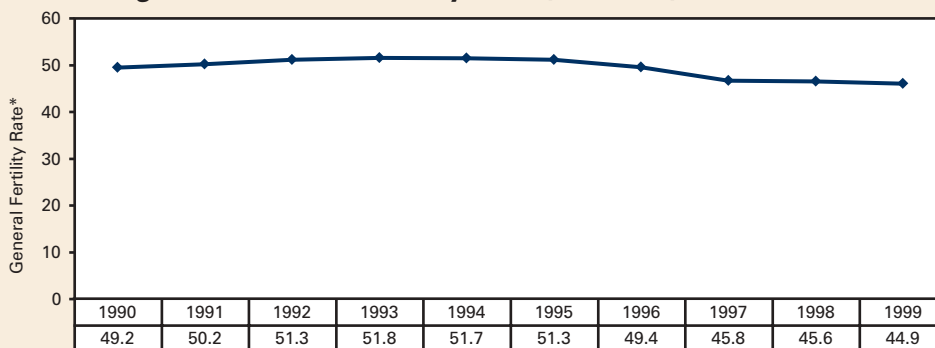
5. Cigarette use down for students

About 16% of students reported cigarette use in 2001. This figure was the lowest over 20 years from 1981 – 2001. The Ministry of Health and Long-Term Care has set a **target of reducing daily smoking among 12 to 19 year olds to 10% by 2005**.

The factors that influence smoking include personal issues such as low self-esteem and peer pressure and also include smoking patterns in the family and the accessibility of cigarettes³. Decreases in population-wide smoking are associated with decreases in the incidence of youth smoking.

Despite this positive trend, tobacco remains the leading cause of preventable ill health and premature death in Ontario. In Toronto, approximately 2,184 people died from smoking-related diseases between 1995 and 1997⁴. Second-hand smoke is the third leading cause of preventable death.

Figure 3 – General Fertility Rate*, Toronto, 1990 – 1999

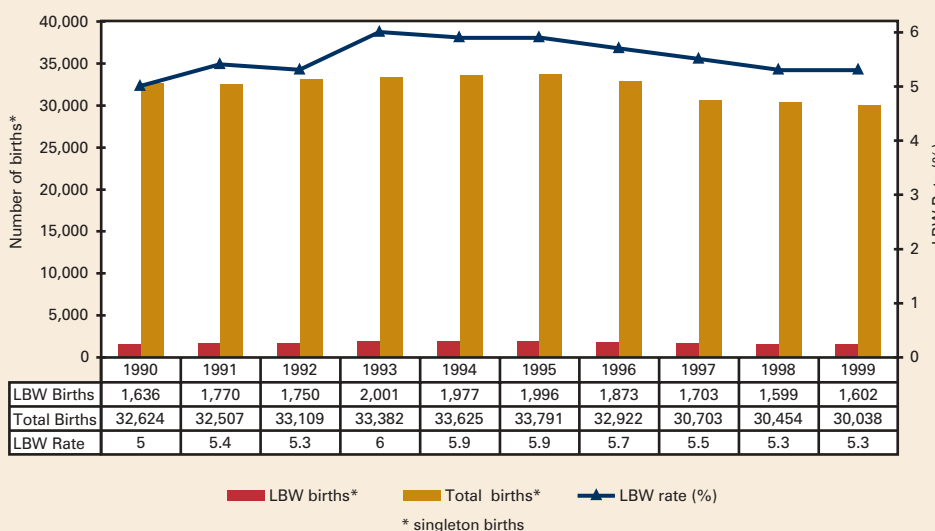


* GFR per 1,000 women aged 15-49

—◆— GFR

Source: Live Birth Database, Health Planning System (HELPS), Ontario Ministry of Health and Long-Term Care and Statistics Canada and Central East Health Information Partnership Population Data Cubes, July 2002.

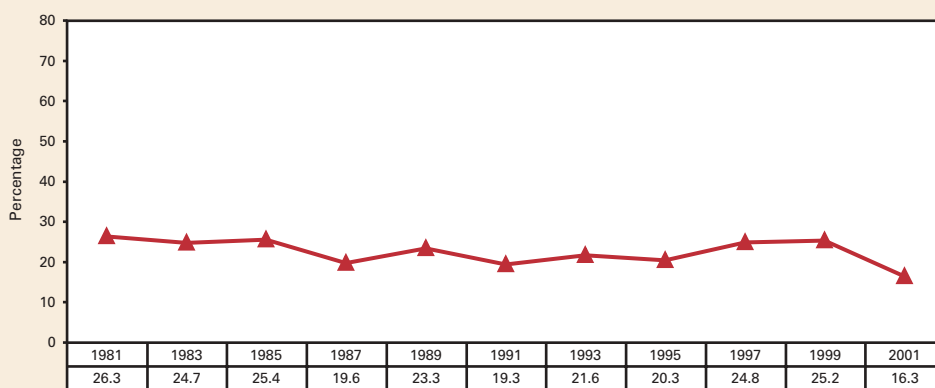
Figure 4 – Low Birthweight Rate*, Toronto, 1990 – 1999



■ LBW births* ■ Total births* —◆— LBW rate (%)
* singleton births

Source: Live Birth Database, Health Planning System (HELPS), Ontario Ministry of Health and Long-Term Care

Figure 5 – Student* Cigarette Use During the Past 12 Months, Toronto, 1981 – 2001



—◆— % Cigarette Use
* Grade 7, 9, 11 & 13

Source: "Drug Use Among Ontario Students – Findings from the OSDUS 1977 – 2001", E.M. Adlaf and A. Paglia, Addiction Research Foundation, Centre for Addiction and Mental Health, 2001.

6. Circulatory system diseases the leading cause of hospitalization

Torontonians were hospitalized about 201,000 times in 2001. Approximately 6 out of 10 of these were to females. If hospitalizations related to pregnancy are excluded, the odds of being hospitalized are the same for both sexes. Diseases of the circulatory system are the leading cause of hospitalization for men and women when child birth is excluded.

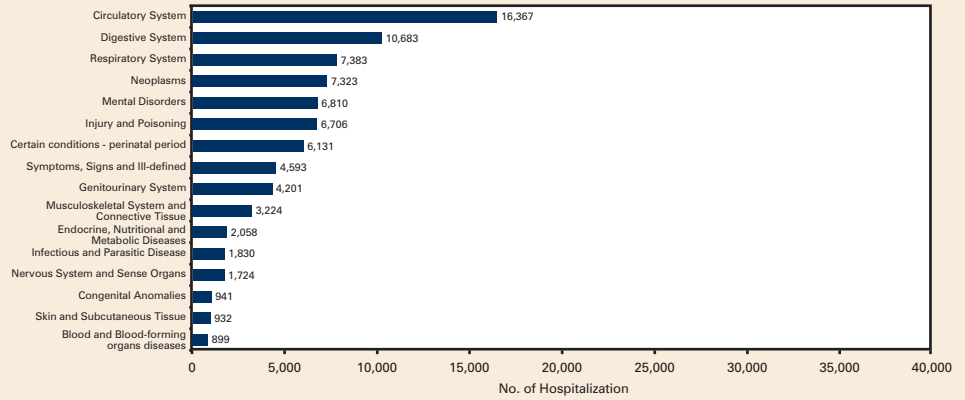
Risk factors such as smoking, physical inactivity, high blood pressure, dyslipidemias, obesity, and diabetes contribute to heart disease and stroke⁵. Health promotion and disease prevention programs need to consider specific at-risk groups such as youth and sedentary overweight middle-aged individuals in order to decrease the risk of cardiovascular diseases.

7. Toronto reportable disease rates higher than Ontario

Toronto Public Health investigates approximately 35,000 reports of confirmed and/or potential cases of reportable diseases per year. There were 16,709 confirmed cases in 2001. Over the last decade, the incidence rate of reportable diseases in Toronto has consistently exceeded that for all of Ontario. Toronto averaged 685 cases per 100,000 population since reaching a high of 832 cases per 100,000 in 1994.

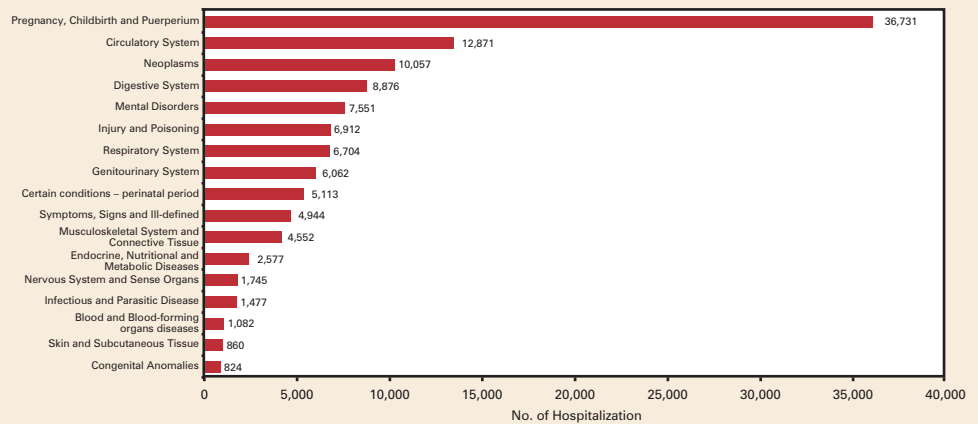
Reportable Diseases, Toronto, 2001	
Category	%
Sexually transmitted, blood-borne	63
Enteric, food-borne, water-borne	27
Direct contact, respiratory routes (including tuberculosis)	7
Vector-borne, zoonotic	1
Vaccine preventable (routine use)	1
Other	1

Figure 6a – Hospitalization – Male, Toronto, 2001



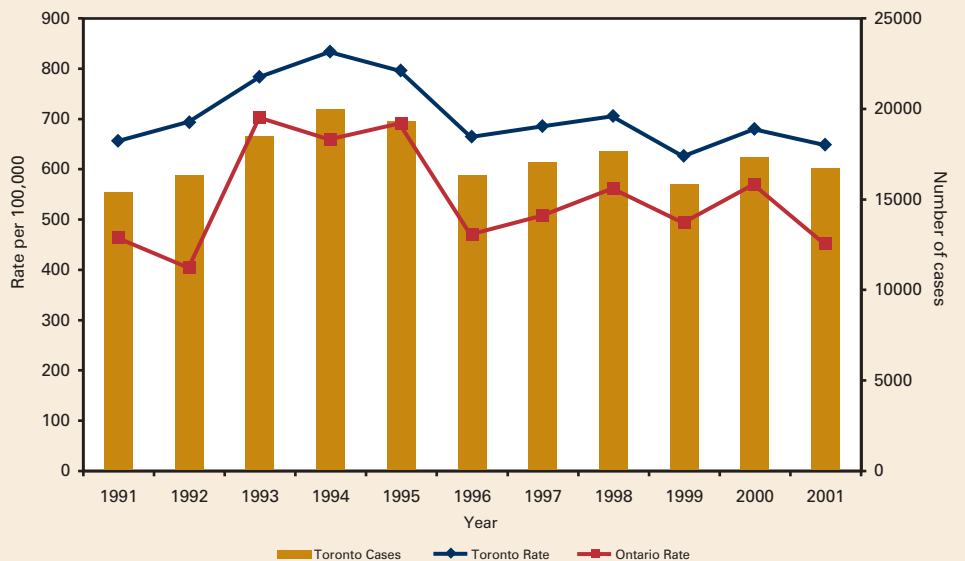
Source: Provincial Health Planning Database (PHPDB), Version 13.14, Ontario Ministry of Health and Long-Term Care.

Figure 6b – Hospitalization – Female, Toronto, 2001



Source: Provincial Health Planning Database (PHPDB), Version 13.14, Ontario Ministry of Health and Long-Term Care.

Figure 7 – Cases of Reportable Diseases, Toronto and Ontario, 1999 – 2001

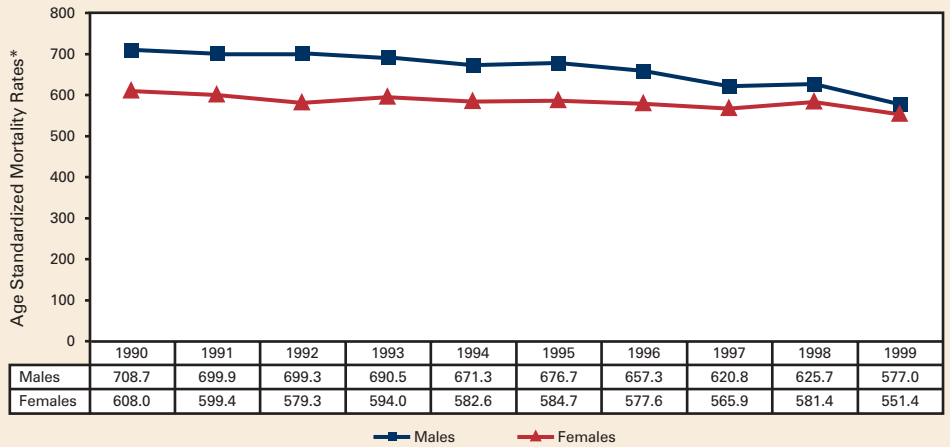


Sources: Reportable Disease Information System (RDIS), Toronto Public Health, Communicable Disease Surveillance Unit. Statistics Canada, Population Estimates and Population Projections used to calculate rates.

8. Mortality rates continue to drop

Men die at a higher rate than women after accounting for differences in age. Mortality rates for both sexes however, appear to be steadily declining. During the last decade, mortality rates decreased by 19% for men and by 9% for women, thereby narrowing the gap between male and female mortality.

Figure 8 – Age Standardized Mortality Rates*, Toronto, 1990 – 1999



* Rates per 100,000 population, standardized to the 1991 Canadian population.

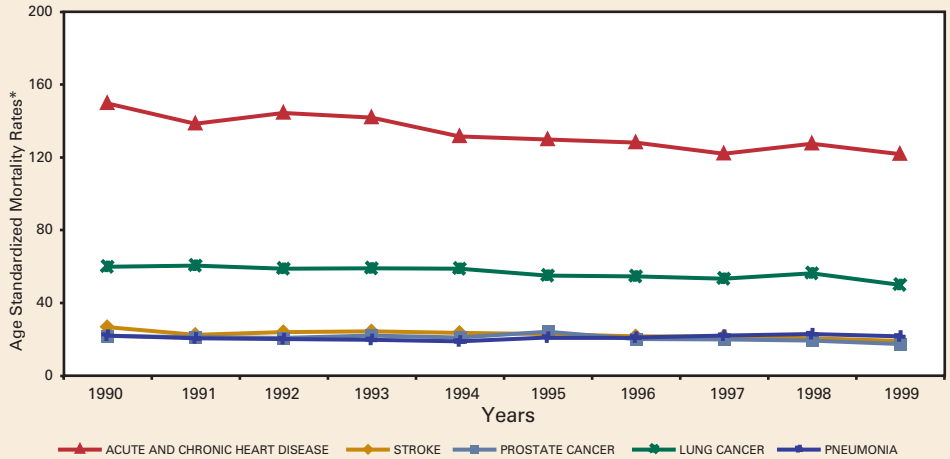
Source: Health Planning System (HELPS), Ontario Ministry of Health and Long-Term Care .

9. Heart disease is still the leading cause of death

Between 1990 and 1999, acute and chronic heart disease remained the leading cause of death for both males and females. The other leading causes of death were stroke, lung cancer, breast cancer (females only), prostate cancer (males only), and pneumonia.

While the mortality rate due to acute and chronic heart disease experienced a substantial decrease, mortality rates for the other leading causes have changed very little in the past 10 years. Men have higher mortality rates for acute and chronic heart disease and lung cancer than women, while women have a higher mortality rate from stroke.

Figure 9a – Age Standardized Mortality Rates*, Males, Toronto, 1990 – 1999

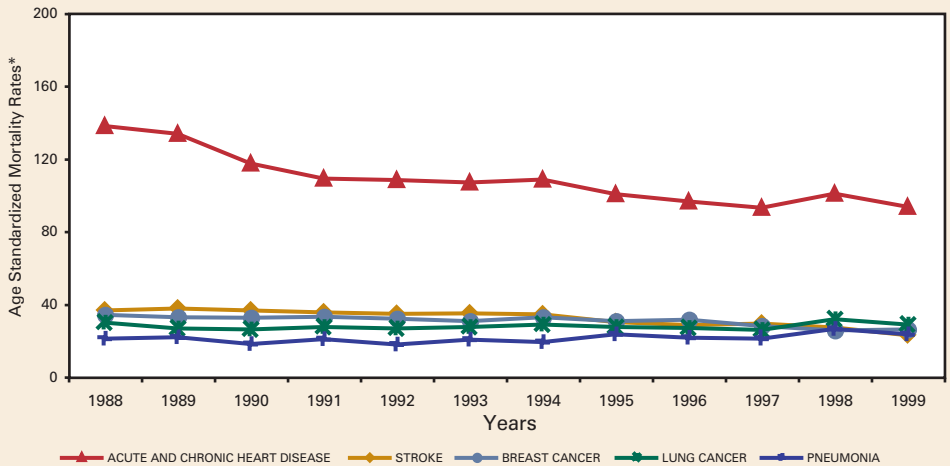


* Rates per 100,000 population, standardized to the 1991 Canadian population.

Source: Health Planning System (HELPS), Ontario Ministry of Health and Long-Term Care.

The Ministry of Health and Long-Term Care has set the following related **targets**:
1) to reduce the mortality from ischemic heart diseases by 25% by the year 2010.
2) to reduce the mortality from stroke by 10% by the year 2010.

Figure 9b – Age Standardized Mortality Rates*, Females, Toronto, 1988 – 1999



* Rates per 100,000 population, standardized to the 1991 Canadian population.

Source: Health Planning System (HELPS), Ontario Ministry of Health and Long-Term Care.

Heart disease has a significant impact on a person's quality of life including chronic pain or discomfort, activity limitation, disability and unemployment⁶. Behaviours that increase the risk of cardiovascular diseases and the underlying pathophysiologic changes begin early in life, so prevention should begin in early childhood. Efforts must be directed at preventing smoking, obesity and physical inactivity among children and youth.

Data Comments:**Census population by age and sex**

- The Census undercounts some groups such as the homeless, young adults and aboriginal people on reserves.
- Some people are not counted while others are counted more than once. These errors result in a net under-count.
- Comparisons between censuses are affected by changes in question wording and in the definition of the population concerned.

Body Mass Index – International Standard

- Body Mass Index (BMI) = (body weight in kg's) ÷ (height in metres²). The index is calculated for those aged 20 – 64 excluding pregnant women and persons less than 3 ft. (0.914 m) or greater than 6 ft. 11 in. (2.108 m) in height.
- BMI in surveys is based on height and weight as reported by the respondents. Since people tend to underestimate their weight and overestimate their height, the values of the index are probably low and overestimate the proportion of the population with acceptable weight.

Fertility

- General Fertility Rate (GFR) = (total number of live births to women aged 15 to 49 x 1000) ÷ (total number of women aged 15 to 49).
- Some consider the reproductive age range to be 15 to 45 years so GFR comparisons are not always appropriate. Live births occurring to women under age 15 are excluded from the GFR.

Births

- Ontario vital statistics data are collected by the Office of the Registrar General using the birth registration form. This form is completed by the parents. As such, data may be subject to some recall bias.
- A number of live births are not reported in the Ontario vital statistics each year. The last estimate in 1997 showed that 3.2% of Toronto live births were not reported, an increase from the previous year. The percentage of unregistered births is higher among births to mothers less than 20 years of age and low birth weight births. Therefore, teen births and low birth weight births are likely to be underestimated.

Tobacco use

- The data source is the Ontario Student Drug Use Survey (OSDUS) which is a province-wide survey of elementary (grades 7 and 8) and secondary (grades 9 – OAC) school students conducted every 2 years since 1977.
- Cigarette smoking is defined as smoking less than an entire cigarette to any number of cigarettes on a daily basis in the past 12 months. This excludes trying a cigarette.

Hospitalization

- Hospitalization is defined by the number of separations (i.e. the number of stays in hospital until discharge, transfer or death).
- The main diagnostic code gives the primary reason or "most responsible" diagnosis for the hospital stay. Secondary diagnosis codes are not as reliable.
- Co-morbidity contributes some uncertainty to classifying the most responsible diagnosis.
- Since a person may not be hospitalized or hospitalized several times for the same disease or injury, or discharged from more than one hospital (after transfer) for the same event, hospitalization data provide only a crude measure of disease and injury prevalence.
- Data are influenced by factors that are unrelated to health status such as availability and accessibility of hospital care, administrative policies and procedures. This may influence comparisons between areas and over time.
- Data are collected based on location of hospital but are generally analyzed by the residence of the patient.

Communicable disease

- Reportable Diseases are defined in Ontario Regulations 559/91 and amendments under the Health Protection and Promotion Act.
- "Toronto" refers to the amalgamated City of Toronto. Toronto data for the years between 1990 and 1998 were obtained by combining data from the former cities of Etobicoke, East York, Toronto, North York, Scarborough and York.
- Cases for Ontario were obtained from the Ontario Ministry of Health and Long Term Care. Data for 2000 and 2001 are preliminary and are subject to change.
- Vaccine Preventable Diseases (Routine Use) include Haemophilus Influenzae B, Measles, Mumps, Pertussis, Rubella, Rubella Congenital Syndrome, Polio, Tetanus, and Diphtheria. The National Advisory Committee on Immunization has recommended the routine use of vaccination to prevent the development of these diseases.

Mortality

Age standardized mortality rate is defined as the number of deaths per population that would occur if the population had the same age distribution as the 1991 Canadian population.

- The Office of the Registrar General obtains information about mortality from death certificates that are completed by physicians.
- Causes are those that initiated the sequence of morbid events leading to death.
- Co-morbidity contributes some uncertainty to classifying the underlying cause(s) of death.
- Determining true cause of death may be influenced by the social or legal conditions surrounding the death and by the level of medical investigation.
- Data analysis is based on the deceased's geographic place of residence and not where he/she died.
- Ontario residents who died outside of the province were included in the HELPS database from 1981 to 1992 but have been excluded since 1993. Out-of-province residents who died in Ontario are excluded from HELPS.
- Variation in data collection procedures over time and/or geography may reduce the accuracy of time and/or place-specific comparisons.

References

- ¹ Association of Public Health Epidemiologists in Ontario (APHEO), Core Indicators for Public Health in Ontario, September 2002, www.cehip.org/apheo/indicators/index.html
- ² Statistics Canada. *Infant mortality and low birthweight, 1975 to 1995*. Health Reports, Winter 1997, Vol.9, No. 3.
- ³ Centre for Addiction and Mental Health. Highlights from the 2001 *Ontario Student Drug Use Survey Drug Report. CAMH Population Studies e Bulletin, Nov/Dec 2001, No. 11*. Toronto, Ontario: CAMH.
- ⁴ Institute for Clinical Evaluative Sciences. Unpublished data.
- ⁵ Heart and Stroke Foundation of Canada. *The Changing Face of Heart Disease and Stroke in Canada 2000*. Ottawa, Canada, 1999.