APPENDIX E: DEFINITION OF TERMS AND METHODOLOGY

International Classification of Diseases (ICD)-9

The International Classification of Diseases (ICD) is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. The Ninth Revision of the ICD was approved by the 29th World Health Assembly in May 1976 to come into effect January 1, 1979. ICD-9 was adopted in Canada in 1979. ICD-9 contained 17 chapters plus two supplementary classifications: the Supplementary Classification of External Causes of Injury and Poisoning (the E code) and the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (the V code).

Methodological Details for Map 2

Map 2 shows Toronto's 41 local health planning areas. All city singleton low birth weight (LBW) rates are derived from postal codes beginning with the letter M only. Each area's singleton LBW rate is compared to the city's rate of 5.2%.

Neighbourhood Income Quintiles

In the 'Births in Toronto' and 'Birth Weight' sections, differences in the distribution of births and low birth weight (LBW) rates were examined according to neighbourhood income quintiles. Neighbourhood income quintiles are commonly used in population health research as an indicator of socio-economic disparities in health. Population quintiles are defined according to methods developed at Statistics Canada, based on postal code of place of residence and the Statistics Canada Census income information for the geographic areas (such as census tracts) that the postal codes are assigned to. The rate for the 20% of the population living in the highest income neighbourhoods (i.e., census tracts) is compared to the rate for the 20% of the population in the lowest income neighbourhoods (census tracts). The difference in rates according to income level is often called the social gradient in health where populations at each step up the income scale have better health than groups on the step below.

The rate achieved by the population living in the highest income areas may be considered to be potentially achievable for the population as a whole if the rate in each of the other income quintiles can be brought to the same level as that achieved in the wealthiest neighbourhoods. The number of events that would have occurred if all population groups had the same rate as the 20% of the population in the highest income quintile are called "income-related excess events" (e.g. births, deaths, hospitalizations, etc.).[98] When places set targets for reducing health disparities, income quintiles examined over time are often

used to gage progress on bringing lower income groups closer to the rates of higher income groups; and to ensure that progress achieved on the overall population or city rate is accompanied by a reduction in health disparities.

In LBW analysis, multiple births which are more likely to be LBW are usually excluded in order to make the quintiles more comparable on a population basis.

Population Projections

Population estimates, as shown in Figure 11, were calculated using the following assumptions for fertility, mortality, and migration:[99]

Fertility

The total fertility rate for the province is assumed to increase slightly from 1.53 to 1.55 children per woman by the end of the projection period. This is an almost constant fertility assumption, and mean age at childbirth is assumed to increase to 31 years.

Mortality

Life expectancy for Ontario is assumed to increase from its recent level to reach 81.0 years for males and 84.5 years for females by 2028. Male life expectancy is expected to progress at a faster pace than female life expectancy.

Migration

The immigration level for Ontario is set at 115,000 at the beginning and is increased to 120,000 in 2004-2005. This level is held constant thereafter.