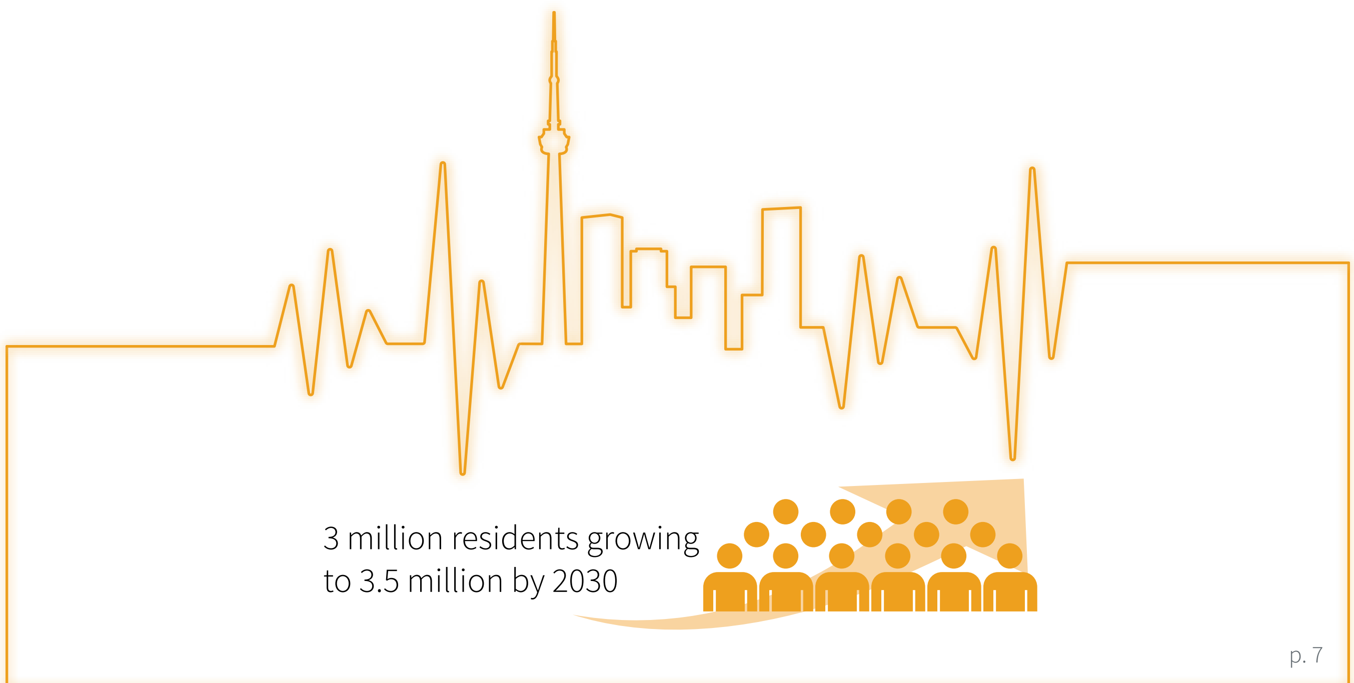
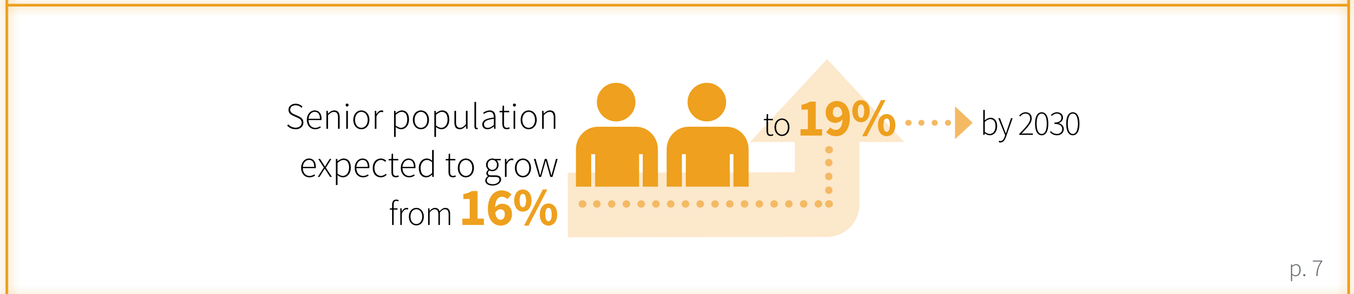
Introduction

Toronto is Canada's largest city, with one of the most diverse populations in the world. The structure of Toronto's population has changed over time, influencing population health status and other social outcomes, and shaping the city in a dynamic fashion. Demographic information reflecting the city's changing size and composition, helps public health and other service providers prepare to respond to issues and demands arising from population growth, aging, migration, and other changes.

Some of the demographic characteristics described in this chapter such as age and sex, influence health status directly through biology. Others including Indigenous identity, immigration, ethnicity, sexual orientation and others, are linked to social processes that influence health status. For example, people of some ethnic backgrounds may experience discrimination or racism which is harmful to their health. The demographic information in this chapter sets a foundation for the health inequities and differences between groups that are highlighted throughout this report.


3 million residents growing
to 3.5 million by 2030
p. 7


Senior population
expected to grow
from 16%
to 19%
by 2030
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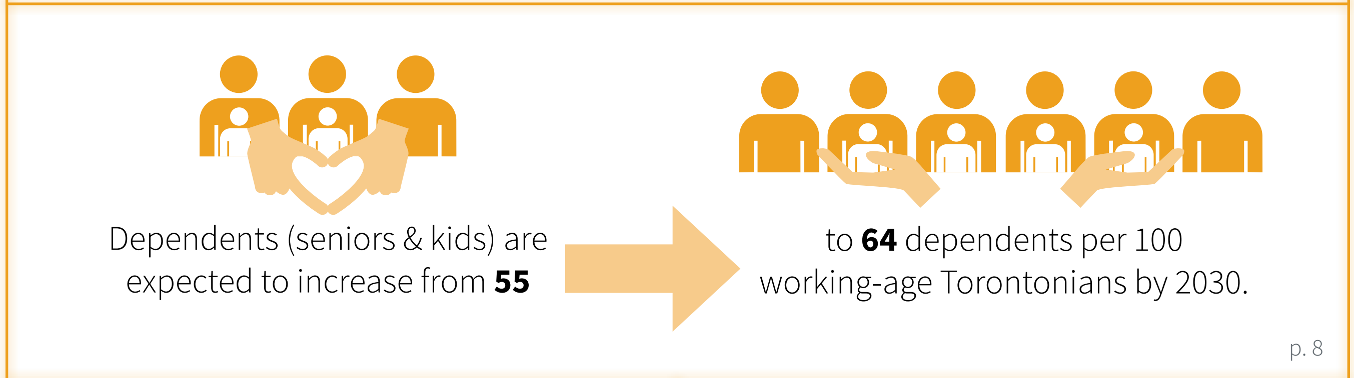
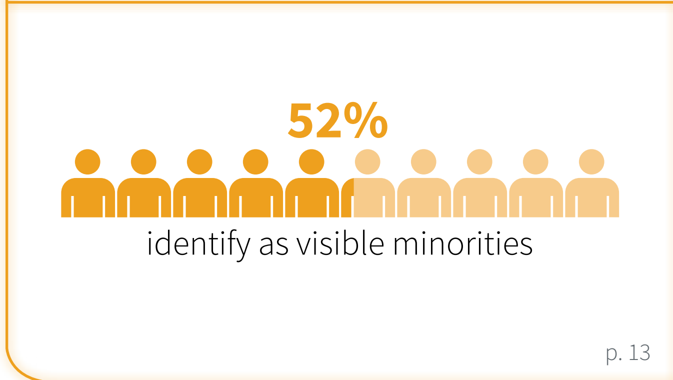
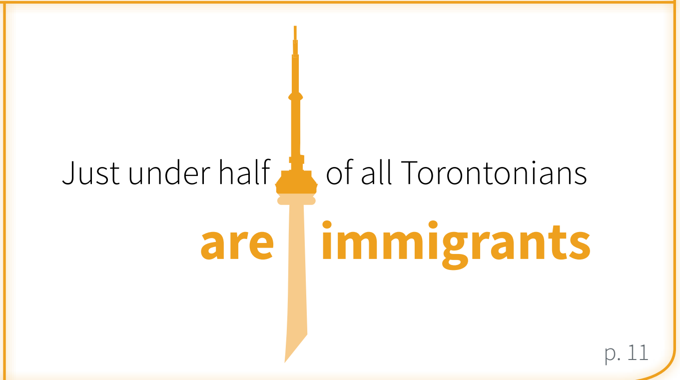

Dependents (seniors & kids) are
expected to increase from 55
to 64 dependents per 100
working-age Torontonians by 2030.
p. 8


52%
identify as visible minorities
p. 13


Just under half of all Torontonians
are immigrants
p. 11

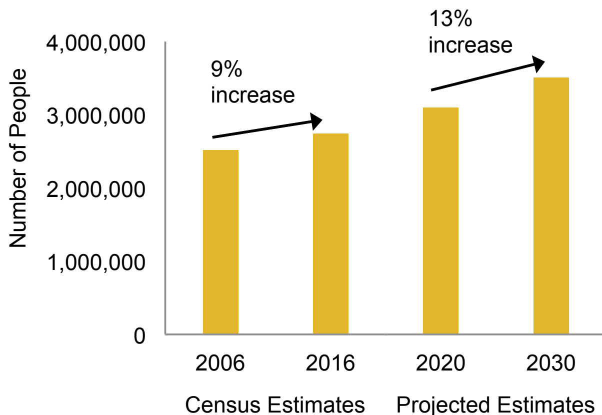
Population Size and Growth

Population growth is a function of birth and death rates, as well as immigration and emigration. Given the relationship between each factor and the social and physical environments, population growth can be viewed as both a health outcome and determinant of health.

Toronto's population:

- Was approximately 2,731,570 according to the 2016 Census of Population.
- Increased by 9% between 2006 and 2016. This translates to on average, 63 more people each day, or 22,830 each year during this ten year period.
- Was more recently estimated for 2019 at over 3,060,000 people. This is predicted to increase to 3,109,676 in the following year (2020).
- Is estimated to grow to almost 3,500,000 by 2030 which is an increase of 13% from 2020 (Figure 1.1).

Figure 1.1: Population Growth, Toronto, 2006 to 2016 and 2020 to 2030



Data Sources: Statistics Canada, Census of Population, 2006.
Population Projections 2019 & 2030, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 8, 2018 .

Sex, Age and Age-Related Dependency

The sex and age composition of the population also affects population growth and health status. Forecasted changes in population structure are vital for understanding future population health needs and ensuring that today's planning is effective in meeting the population health needs of tomorrow's city.

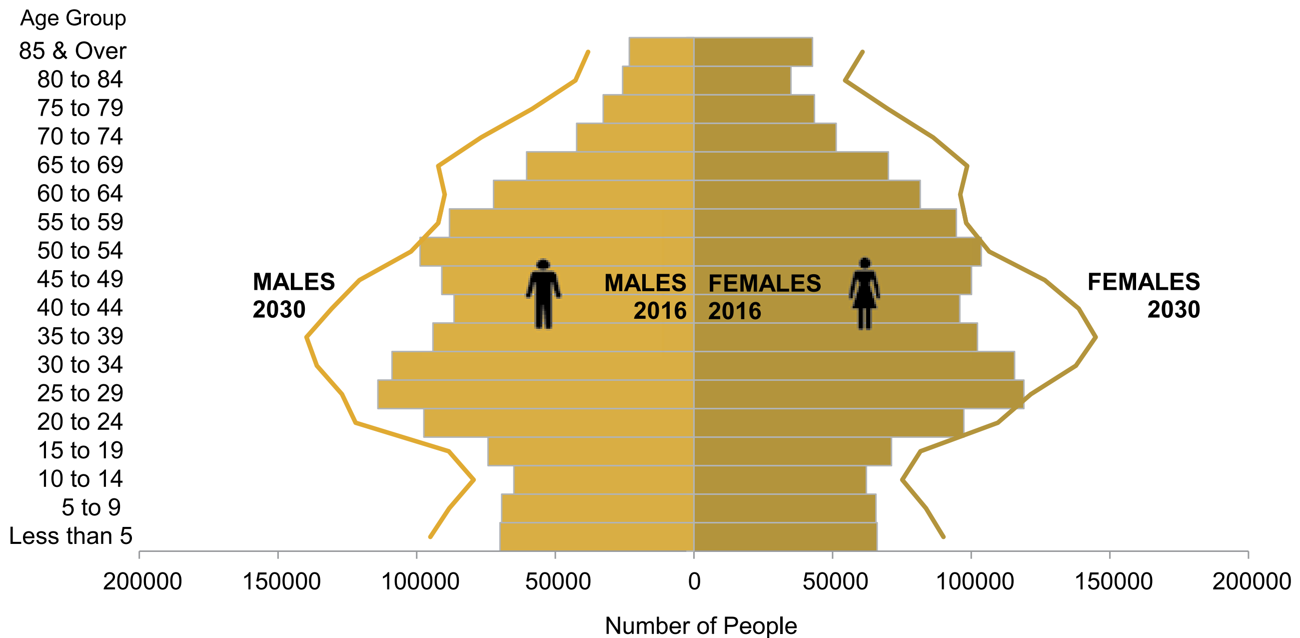
Age and Sex

In Toronto:

- There were slightly more females (52%) than males (48%) in 2016. This is the equivalent of 93 males for every 100 females.
- 2016 marked the first time that there were more people aged 65 years and over, than 14 and under.
- The share of seniors aged 65 years and over increased over the ten years from 2006 (14%) to 2016 (16%). By 2030, this figure is projected to increase and represent about 19% of the population, or more than 678,000 individuals.
- Life expectancy is 86.6 years for females and 82.0 years for males, figures that are higher than those for Ontario (Ontario females: 84.2 years, Ontario males: 80.3 years).
- The aging population is a result of decreasing fertility rates (described in Chapter 4) and increases in life expectancy. This affects the incidence of certain chronic health conditions or events (eg. cancer, dementia, falls, obesity, and diabetes) and by extension, the amount and type of health resources and other urban design features required to respond to these emerging issues.

Toronto's changing age and sex distribution is depicted in Figure 1.2.

Figure 1.2: Population by Age and Sex, Toronto, 2016 and 2030



Data Sources: Statistics Canada, Census of Population, 2016. Population Projections 2030, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 8, 2018.

Dependency on the Working-Age Population

The proportion of non-working age people compared to those who are working (known as the dependency ratio) is one way to assess the age structure of the population. A low dependency ratio is desirable because there are proportionally more working-age adults who can support the young and the elderly. The growth of Toronto's senior population has led to an increasing dependency ratio. This is a signal for greater social and economic burdens on the working-age population and additional demands on government support programs and the health care system [1] [2]. These can have negative impacts on the growth of the economy and financing the pensions of retirees [1] [2].

In 2016:

- There were 24 senior dependents per 100 working-age Torontonians.
- There were 55 total dependents (including both seniors and children/youth) per 100 working-age Torontonians.

In 2030:

- There will be 32 senior dependants per 100 working-age Torontonians.
- There will be 64 total dependents (including both seniors and children/youth) per 100 working-age Torontonians.

Living Arrangements, Marital Status, and Family Type

Living arrangements, marital status, and household composition can impact the amount of social, physical, and economic support an individual receives, and can also affect stress levels, feelings of loneliness, and isolation [3] [4]. Each of these is considered an important social determinant of health. Living alone has been associated with increased hospitalization, poorer health, and increased mortality, particularly in men and older adults [5] [6]. People with spouses, friends, and family members who provide psychological, social, and material resources are in better health than those with fewer social contacts [3] [7]. The absence of a second parent can leave single-parent families more vulnerable to socio-economic strain and higher levels of stress, possibly leading to various health disadvantages than two-parent families [8].

Living Arrangements

In Toronto in 2016:

- 16% of people aged 15 years and over were living alone, an increase from 14% in 2006. This was slightly higher than Ontario (12%).
- Females were slightly more likely to be living alone (17%) compared to males (15%).
- 27% of seniors (aged 65 years and over) were living alone, unchanged from 2006. Seniors were twice as likely to be living alone as people aged 15 to 64 (13%). Female seniors were almost twice as likely to live alone (33%) compared to male seniors (18%), largely due to having a longer life expectancy [9].

Marital Status[2]

For Torontonians aged 20 years and over, in 2016:

- 54% were married or living common-law[3].
- 30% were single (never married).
- 16% were divorced, separated or widowed. Females were twice as likely (21%) to be in this category compared to males (10%). This is due in part to longer life expectancies for females who often outlive their male partners.

Family Type

In Toronto in 2016:

- 33% of families with children were lone-parent families, an increase from 30% in 2006. Most lone-parents were female (84%).
- 22% of children[4] (14 years and under) were living in a lone-parent family.

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[2] The 2006 and 2011 Census reported on 'legal marital status' for people aged 20 years and older whereas the 2016 Census reported on 'marital status' (see Appendix 3 for clarification on these terms). As such, no temporal comparisons are made for this section.

[3] "Includes same-sex common-law and married couples.

[4] This indicator is calculated using the number of children from birth to age 14 years that were living in a lone-parent census family relative to the total number of children from birth to age 14 years living in all census families. Children living in a census family may be living with one or two biological parents, adoptive parents, step-parents, and/or grandparents. One or more grandparents may also be present in the household for children living with one or both parents.

Indigenous People[5]

Many Indigenous people[6] living in Toronto face multiple health challenges and have been largely under-represented in national surveys and other health data sources available at the local and provincial level. Recently however, a local survey of Toronto's Indigenous population, Our Health Counts (OHC) Toronto, produced a comprehensive health status and health care utilization dataset. Due to concerns about the reliability of the 2016 Census estimates and potential under-counting (see first bullet point below), the OHC results are used for demographic indicators related to Indigenous people in this and the following chapter, and for other health-related findings in the rest of this report[7].

- According to the 2016 Census, there were 23,065 people living in Toronto who identified as Aboriginal[8], representing less than 1% of the total 2016 Toronto population. The OHC Toronto study provided a much larger estimate of between 54,000 and 87,000 for the same year.
- The majority of Indigenous adults living in Toronto in 2016 identified as First Nations (86%), followed by Métis (14%).
- The Indigenous population tended to be younger than the general population in Toronto. Of those aged 15 years and over, 62% of the Indigenous population was between 15 and 45 years of age compared to 50% of the overall Toronto population. Three percent were 65 years and over compared to 16% for Toronto overall.
- In 2016, approximately 65% of Indigenous people (aged 15 years and older) in Toronto were single, almost twice as high as the percent observed for Toronto overall (35%).

More information on sexual orientation and gender identity for Indigenous people is included in the corresponding sections of this chapter. Information on education, employment and low income is included in Chapter 2.

A history of colonialism resulting in economic, social, and cultural marginalization has had a strong negative impact on the health of Indigenous people in Canada [10]. Through colonization, systematic racism and discrimination, Indigenous people have been denied the resources necessary to maximize their socio-economic status, leading to both social and economic inequities such as reduced opportunities for education, unemployment, food insecurities, lack of appropriate housing, and lack of access to quality health care [11]. As a result of these conditions, Indigenous people face health inequities related to behavioural risk factors, nutrition, mental health, and morbidity and mortality [10] [12] [13]. Toronto-specific examples are provided in the following chapters of this report.

5 Toronto comparisons in this section use the 2016 Census of Population data. Caveats related to comparing results from different surveys are provided in Appendix 3.

6 "Indigenous" means 'native to the area. It is the preferred collective name for the original people of Canada and their descendants. This includes First Nations (status and nonstatus), Métis and Inuit. It is important to remember that each Indigenous nation in the larger category of "Indigenous" has its own unique name for its community (e.g., Cree, Ojibwa, Inuit).

7 More information about the Toronto Our Health Counts study and its findings can be found at: http://www.welllivinghouse.com/what-we-do/projects/our-health-counts-toronto/.

8 The 2018 Relationship with Indigenous Community Guidelines under the Ontario Public Health Standards state that the term 'Indigenous' is increasingly preferred in Canada over the term 'Aboriginal'. Ontario's current practice is to use the term Indigenous when referring to First Nations, Métis, and Inuit as a group, and to refer to specific communities whenever possible. The term 'Aboriginal' is used in certain instances in this report to be consistent with the 2016 Census of Population. The term 'Indigenous' is used otherwise for consistency with the Our Health Counts study and the Ontario Public Health Standards.

Immigration, Residency, Ethnicity and Language

Toronto has become one of the most ethnically diverse cities in the world due largely to immigration. Newcomers to Toronto bring many strengths and assets that make Toronto vibrant and prosperous. These include good health, education, professional experience and skills, new perspectives, and cultural, ethnic and linguistic diversity. Toronto's global community also poses ever changing health needs that must be met through culturally competent programs, translated materials, language interpretation, partnerships with community agencies and continuous community engagement.

Immigrant Status

Immigration compensates for an aging population, lower fertility rates, and a shrinking working-age population. It also has a positive effect on overall population health status in Toronto as recent immigrants tend to be healthier than their Canadian-born counterparts, a phenomenon known as the "Healthy Immigrant Effect" [14] [15] [16] [17]. Over time however, their health begins to deteriorate, resembling the rest of the population [16] [17]. Racialization[9] is one of the factors impacting the health of many newcomers, as they establish themselves in Toronto and embark on their journey towards successful integration into Canadian society (see section on Ethnicity).

In Toronto in 2016:

- Immigrants comprised a slightly smaller proportion of the population (47%) compared to Canadian-born people (49%). Non-permanent residents (e.g. temporary residents, refugee claimants, etc.) made up approximately 3% of the population. These figures have changed slightly from 2006 when immigrants comprised 50% of the population, Canadian-born people 48%, and non-permanent residents 2%.
- Most immigrants were longer-term immigrants (85%) who first obtained landed immigrant or permanent resident status before 2011. Recent immigrants, who first obtained landed immigrant or permanent resident status between 2011 and 2016, represented the remainder (15%).
- 83% of recent immigrants in Toronto belonged to a racialized group, higher than the percent observed for Canadian-born individuals (31%) and longer-term immigrants (69%). This demonstrates how immigration has shaped racial and ethnic diversity in Toronto [39].
- The top three countries of birth for recent immigrants were the Philippines, China, and India. The top three for all immigrants were China, the Philippines, and India (Table 1.1).

[9] Racialization refers to the social processes that construct racial categories as "real, different and unequal in ways that matter to economic, political and social life". Racialization is often based on perceived differences in anatomical, cultural, ethnic, genetic, geographical, historical, linguistic, religious, and/or social characteristics and affiliations [35]. The use of the term in this section of the report acknowledges that health inequities often exist for people as a result of racialization, based in part, on their ethno-racial identity.

Table 1.1: Top Ten Countries of Birth for Immigrants, Toronto, 2016

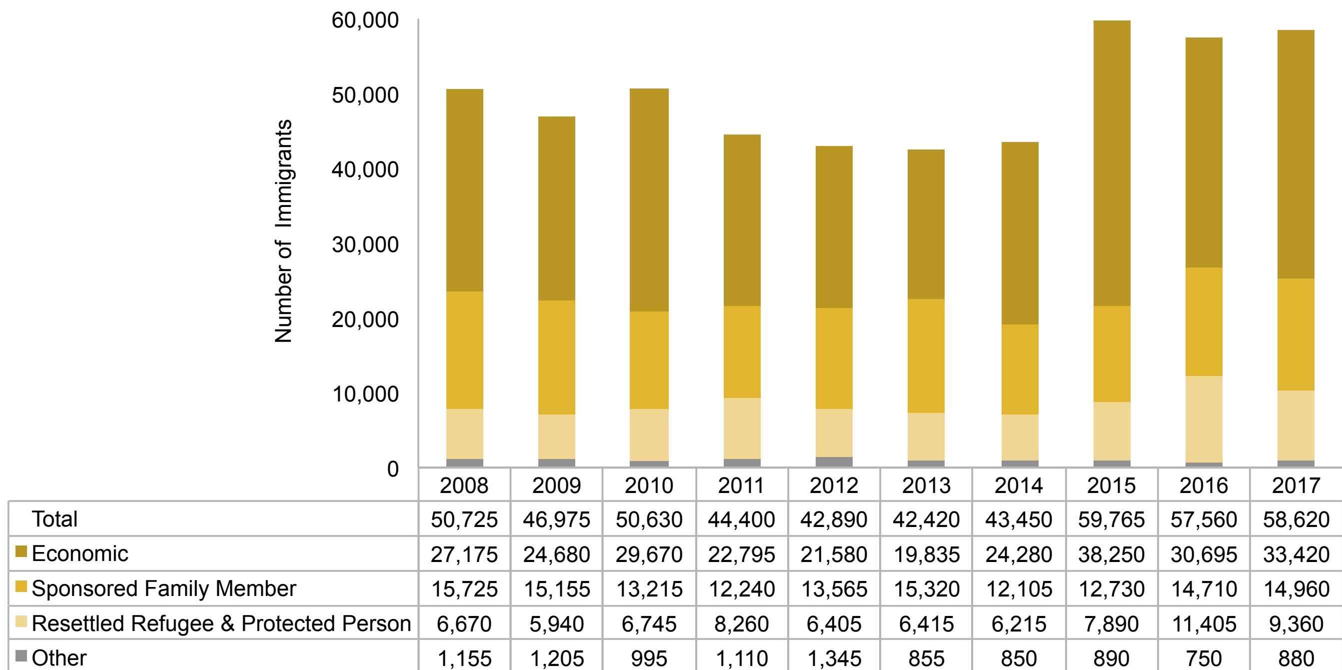
	All Immigrants		Recent Immigrants*	
Rank	Country of Birth	Percent of Total Immigrant Population**	Country of Birth	Percent of Total Immigrant Population**
1	China	10%	Philippines	17%
2	Philippines	9%	China	12%
3	India	6%	India	11%
4	Sri Lanka	4%	Iran	6%
5	Italy	4%	Pakistan	4%
6	Jamaica	4%	Bangladesh	3%
7	United Kingdom	3%	Sri Lanka	2%
8	Hong Kong	3%	United States	2%
9	Portugal	3%	Iraq	2%
10	Guyana	3%	Jamaica	2%

Data Source: Statistics Canada, Census of Population, 2016

*Recent immigrants first obtained landed immigrant or permanent resident status between 2011 and 2016.

**Percentages do not total 100% as only the top tean countries are shown.

Figure 1.3: Number of Immigrants by Admission Category, Toronto as Intended Destination, 2008 to 2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total	50,725	46,975	50,630	44,400	42,890	42,420	43,450	59,765	57,560	58,620
Economic	27,175	24,680	29,670	22,795	21,580	19,835	24,280	38,250	30,695	33,420
Sponsored Family Member	15,725	15,155	13,215	12,240	13,565	15,320	12,105	12,730	14,710	14,960
Resettled Refugee & Protected Person	6,670	5,940	6,745	8,260	6,405	6,415	6,215	7,890	11,405	9,360
Other	1,155	1,205	995	1,110	1,345	855	850	890	750	880

Data Source: Immigration, Refugees and Citizenship Canada (IRCC), Permanent Residents.

During the ten-year period from 2008 to 2017 in Toronto:

- There was a 16% increase in immigrants arriving in the city (50,725 to 58,620) (Figure 1.3).
- 55% of all immigrants[10] arriving in the city during this period were economic immigrants, 28% were sponsored family members, 15% were resettled refugees or protected persons, and the remaining 2% were other types of immigrants.
- Approximately 7,500 resettled refugees or protected persons arrived annually. The number of resettled refugees and protected persons peaked in 2016 to 11,405.
- The number of non-permanent residents (or temporary residents) arriving in the city almost doubled (58,215 to 103,465).

Data on refugee claimants, temporary residents who request refugee protection upon or after arrival in Canada, are currently only available at the provincial level.

Moreover, there are no current estimates on the number of undocumented (or non-status) immigrants in Toronto. The only information available is from outdated reports published between 2003 and 2006, indicating that there were approximately 20,000 to 500,000 undocumented people living in Canada [18], with nearly half residing in Toronto [19].

Health disparities among immigrant sub-groups exist due to the circumstances of their immigration. For example, stressors experienced due to war and violence may be worsened after immigration for refugees and asylum-seekers [15] [20] [21]. Medically uninsured immigrants such as temporary residents, refugees, asylum-seekers, and undocumented people may also suffer poorer health outcomes due to limited options to access healthcare [21] [22].

Ethnicity

While ethnic and cultural diversity is celebrated in Toronto, it can also lead to prejudice, racism and discrimination, racial tension, and reduced social cohesion. Discrimination, which is experienced by two-thirds of racialized[11] group members in Toronto, contributes to poorer health outcomes among members of racialized groups compared to non-racialized groups (see Health Inequities later in this section). Racialized status does not however, always translate into poor health outcomes. For example, Canadian data show that racialized people had lower age-standardized mortality rates than non-racialized people from 2006 to 2011 [23].

In Toronto in 2016:

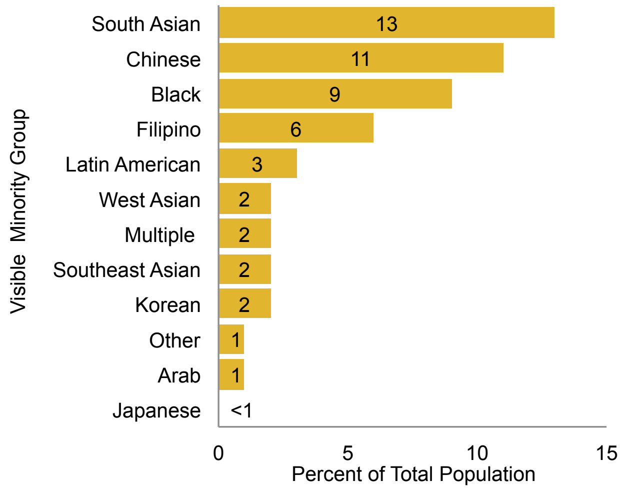
- 52% of the population belonged to a visible minority[12] group, an increase from 47% in 2006.
- The leading visible minority categories were South Asian (13%), Chinese (11%) and Black (9%) (Figure 1.4).

[10] The Immigration, Refugees and Citizenship (IRCC) (data provider for the immigrant admission category data) uses the term 'permanent resident' to describe landed immigrants/ immigrants. The term 'immigrant' is used in this section instead of 'permanent resident' to be consistent with the language employed by the 2016 Census of Population and the rest of the report. These terms are synonymous in the context of this report.

[11] "Racialized group" can be understood as non-dominant ethno-racial communities who, through the process of racialization, experience race as a key factor in their identity and experience of inequality" [24].

[12] The term "visible minority", no longer appropriately reflects the composition of Toronto's population. It is used here however, to be consistent with the term used in the 2016 Census of Population which defines visible minority as whether a person belongs to a visible minority group as defined by the Employment Equity Act. The Employment Equity Act defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour'. The visible minority population consists mainly of the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese.

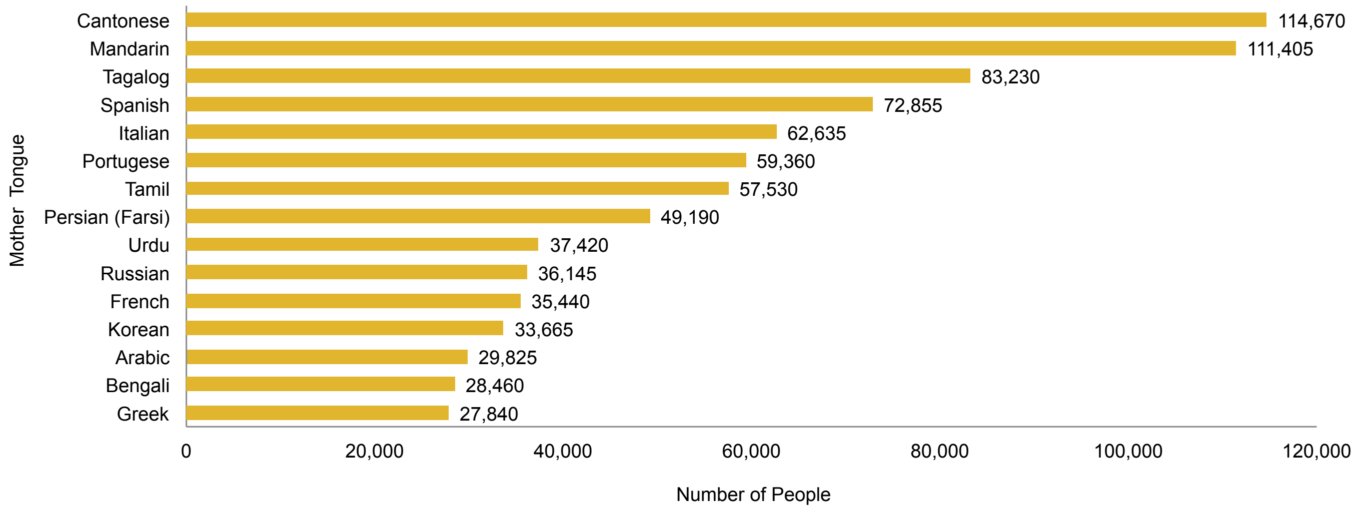
Figure 1.4: Percent of Total Population by Visible Minority Group, Toronto, 2016



Data Source: Statistics Canada, Census of Population, 2016

Health inequities exist between Toronto's racialized and non-racialized populations. In 2013, TPH's Racialization and Health Inequities report [24] found that Black people were more likely to be overweight or obese than non-racialized people, whereas East/Southeast Asian people were less likely. Black people were also more likely to report pain or discomfort. Black and Latin American/Multiple/Other respondents were more likely to have high blood pressure. Other studies show that South Asian people have some of the highest rates of cardiovascular disease in Canada and in the world [25].

Figure 1.5: Number of People by Top 15 Mother Tongues Other Than English, Toronto, 2016



Data Source: Statistics Canada, Census of Population, 2016

Language[13]

Toronto's diversity is reflected by the more than 200 different languages spoken by its residents [26]. Language barriers can impair access to services including interaction with healthcare providers] [27] [28].They can also lead to economic difficulties (e.g. unemployment), reduce social participation, and increase social exclusion. Aligning health communications with the language spoken by the local population helps to facilitate access to services, promotes health and creates equal opportunities for all residents.

Toronto continues to be linguistically diverse. In Toronto, in 2016:

- 44% had a mother tongue other than English or French. This represents a slight decrease from 2011 (45%). The top five mother tongues included: Cantonese, Mandarin, Tagalog, Spanish and Italian (Figure 1.5).
- 26% regularly spoke a language[14] other than English or French at home, a decrease from 2011 (28%).
- 5% had no knowledge of either official language.
- Seniors (65 years of age and over) were almost five times more likely (15%) to not have knowledge of either official language compared to people under 65 years (3%).
- 11% of recent immigrants did not have knowledge of either official language compared to one percent of Canadian-born people.
- Racialized people were more than twice as likely (7%) to not have knowledge of either official language compared non-racialized people (3%).

Sexual Orientation

Sexual orientation is defined as one's romantic, emotional, or sexual interest or attraction. In this report, the acronym 2SLGBTQ (two-spirit, lesbian, gay, bisexual, trans, queer/questioning) is used to represent the group of people whose sexual orientation or gender identity is included in the term. Other variations (e.g. LGB) are used when the term corresponds to a specific reference cited in this report.

- In 2015/16, 3%[15] of Toronto adults (18 years and over) self-identified as homosexual[16] and 2%[17] identified as bisexual, compared to 2%[18] and 1%[19], respectively, in 2007/8.
- In 2014, 6% of Toronto students in grades 9 to 12 in the public school system (excluding students attending Catholic schools; see data notes and caveats, Appendix 3) identified as gay, lesbian, bisexual, pansexual or other. 4% were unsure.
- In 2016, among Indigenous people in Toronto aged 15 years and over, 4% identified as bisexual, 4% as gay, 1% as lesbian, and 4% as other.

Gender Identity

Gender is a system that operates in a social context and classifies people frequently based on their assigned sex [29]. A person's gender identity is their sense of being a woman, a man, both, neither, or anywhere on the gender spectrum. It can match one's sex assigned at birth (cisgender identity) or differ from it (trans[20] identity) and is separate from sexual orientation [30].

[13] Comparison to the 2006 Census of Population is not recommended for the indicators in this section due to methodology changes. As such, temporal comparisons to the 2011 Census of Population are made. See data notes for more details.

[14] Includes people that spoke only a non-official language at home most often (single responses).

[15] High degree of variability. Interpret with caution.

[16] These terms were used by the survey tool that collected these data and do not reflect the terminology used by Toronto Public Health.

[17] High degree of variability. Interpret with caution.

[18] High degree of variability. Interpret with caution.

[19] High degree of variability. Interpret with caution.

[20] Includes but is not limited to people who identify as transgender, transsexual, cross-dressers or gender non-non-binary.

Research on the social determinants of health among trans people in Ontario shows that lower income levels and underemployment are two key factors affecting trans people. Trans individuals are frequently the target of stigma, discrimination, and violence [31]. In addition, over-half of trans individuals have reported experiencing symptoms consistent with clinical depression [32] while 43% have attempted suicide in their lifetime [33].

More information on Toronto's demographics is available on the City of Toronto website at: toronto.ca/city-government/data-research-maps

Youth and Indigenous People

- In 2014, 2.6% of Toronto students in grades 9 to 12 in the public school system (excluding students attending Catholic schools; see data notes and caveats, Appendix 3) self-identified with a gender other than cisgender, including 1.5% gender non-conforming, 0.4% trans or other gender, and 0.7% unsure in 2014.
- In 2016, one percent of Indigenous people (15 years and over) in Toronto identified as trans or other, 23% identified as two-spirit[21].

Estimates suggest that one in 200 adults may identify with a trans gender identity. There is however, an absence of related population health data. Information on dimensions of sex and gender in the trans population will help to better understand the social determinants of health and health outcomes for trans people. This in turn can provide population-specific evidence that can inform approaches to healthcare, service delivery and social inclusion.

[21] The term "Two-spirit" is used by people who identify as having both a feminine and masculine spirit. Some Indigenous people use it to describe their sexual, gender, and/or spiritual identity [34].

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