Health Profile, February 2011

Definitions, sources and symbols

Well-being

1. Perceived health, very good or excellent

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported perceiving their own health status as being either excellent or very good or fair or poor, depending on the indicator. Perceived health refers to the perception of a person's health in general, either by the person himself or herself, or, in the case of proxy response, by the person responding. Health means not only the absence of disease or injury but also physical, mental and social well being.

2. Perceived health, fair or poor

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported perceiving their own health status as being either excellent or very good or fair or poor, depending on the indicator. Perceived health refers to the perception of a person's health in general, either by the person himself or herself, or, in the case of proxy response, by the person responding. Health means not only the absence of disease or injury but also physical, mental and social well being.

Note: This indicator is only available in the comprehensive download.

3. Perceived mental health, very good or excellent

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported perceiving their own mental health status as being excellent or very good or fair or poor, depending on the indicator. Perceived mental

health refers to the perception of a person's mental health in general. Perceived mental health provides a general indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in perceived health.

4. Perceived mental health, fair or poor

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported perceiving their own mental health status as being excellent or very good or fair or poor, depending on the indicator. Perceived mental health refers to the perception of a person's mental health in general. Perceived mental health provides a general indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in perceived health.

Note: This indicator is only available in the comprehensive download.

5. Perceived life stress

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 15 and over who reported perceiving that most days in their life were quite a bit or extremely stressful. Perceived life stress refers to the amount of stress in the person's life, on most days, as perceived by the person or, in the case of proxy response, by the person responding.

Health Conditions

6. Overweight or obese

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Body mass index (BMI) is a method of classifying body weight according to health risk. According to the World Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each of the following BMI categories:

- normal weight = least health risk;
- underweight and overweight = increased health risk;
- obese, class I = high health risk;

- obese, class II = very high health risk;
- obese, class III = extremely high health risk.

Body mass index (BMI) is calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared.

A definition change was implemented in 2004 to conform with the World Health Organization (WHO) and Health Canada guidelines for body weight classification. The index is calculated for the population aged 18 and over, excluding pregnant females and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).

According to the World Health Organization (WHO) and Health Canada guidelines, the index for body weight classification is:

- less than 18.50 (underweight);
- 18.50 to 24.99 (normal weight);
- 25.00 to 29.99 (overweight);
- 30.00 to 34.99 (obese, class I);
- 35.00 to 39.99 (obese, class II);
- 40.00 or greater (obese, class III).

7. Overweight

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Body mass index (BMI) is a method of classifying body weight according to health risk. According to the World Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each of the following BMI categories:

- normal weight = least health risk;
- underweight and overweight = increased health risk;
- obese, class I = high health risk;
- obese, class II = very high health risk;
- obese, class III = extremely high health risk.

Body mass index (BMI) is calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared.

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According to the World Health Organization (WHO) and Health Canada guidelines, the index for body weight classification is:

- less than 18.50 (underweight);
- 18.50 to 24.99 (normal weight);
- 25.00 to 29.99 (overweight);
- 30.00 to 34.99 (obese, class I);
- 35.00 to 39.99 (obese, class II);
- 40.00 or greater (obese, class III).

8. Obese

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Body mass index (BMI) is a method of classifying body weight according to health risk. According to the World Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each of the following BMI categories:

- normal weight = least health risk;
- underweight and overweight = increased health risk;
- obese, class I = high health risk;
- obese, class II = very high health risk;
- obese, class III = extremely high health risk.

Body mass index (BMI) is calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared.

A definition change was implemented in 2004 to conform with the World Health Organization (WHO) and Health Canada guidelines for body weight classification. The index is calculated for the population aged 18 and over, excluding pregnant females and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).

According to the World Health Organization (WHO) and Health Canada guidelines, the index for body weight classification is:

- less than 18.50 (underweight);
- 18.50 to 24.99 (normal weight);
- 25.00 to 29.99 (overweight);
- 30.00 to 34.99 (obese, class I);
- 35.00 to 39.99 (obese, class II);
- 40.00 or greater (obese, class III).

9. Overweight or obese, youth

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Body mass index (BMI) is a method of classifying body weight according to health risk. According to the World Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each of the following BMI categories: normal weight = least health risk; underweight and overweight = increased health risk; obese, class I = high health risk; obese, class II = very high health risk; obese, class III = extremely high health risk.

Body mass index (BMI) is calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared.

Body mass index (BMI) for youths is different from that of adults as they are still maturing. This indicator classifies children aged 12 to 17 (except female respondents aged 15 to 17 who were pregnant or did not answer the pregnancy question) as 'obese' or 'overweight' according to the age- and sex-specific BMI cut-off points as defined by Cole and others. The Cole cut-off points are based on pooled international data (Brazil, Great Britain, Hong Kong, Netherlands, Singapore and United States) for BMI and linked to the internationally accepted adult BMI cut-off points of 25 (overweight) and 30 (obese).

Note: This indicator is only available in the comprehensive download.

10. Arthritis

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have been diagnosed by a health professional as having arthritis.

Arthritis includes rheumatoid arthritis and osteoarthritis, but excludes fibromyalgia.

11. Diabetes

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have been diagnosed by a health professional as having diabetes.

Diabetes includes females 15 and over who reported that they have been diagnosed with gestational diabetes.

12. Asthma

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have been diagnosed by a health professional as having asthma.

13. High blood pressure

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have been diagnosed by a health professional as having high blood pressure.

14. Mood disorder

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have been diagnosed by a health professional as having a mood disorder, such as depression, bipolar disorder, mania or dysthymia.

15. Pain or discomfort, moderate or severe

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they usually have pain or discomfort.

16. Pain or discomfort that prevents activities

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported having pain or discomfort that prevents activities.

17. Low birth weight

Source : Vital Statistics, Birth Database, 2005/2007.
CANSIM table no.: 102-4303

Live births less than 2,500 grams, expressed as a percentage of all live births (birth weight known).

Counts and rates (percentages) in this table are based on three consecutive years of data which were summed and divided by three. Counts have been rounded and do not always add to the exact totals.

The reference period associated with these data reflects the mid-point of the three-year period.

18. Chronic obstructive pulmonary disease (COPD)

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 35 and over who reported being diagnosed by a health professional with chronic bronchitis, emphysema or chronic obstructive pulmonary disease (COPD).

19. Injuries within the past 12 months causing limitation of normal activities

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who sustained injuries in the past 12 months. Repetitive strain injuries are not included. Refers to injuries which are serious enough to limit normal activities. For those with more than one injury in the past 12 months, refers to "the most serious injury", as identified by the respondent.

20. Injuries in the past 12 months, sought medical attention

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who sustained injuries in the past 12 months. Repetitive strain injuries are not included. Refers to injuries which are serious enough to limit normal activities. For those with more than one injury in the past 12 months, refers to "the most serious injury", as identified by the respondent.

21. Hospitalized stroke event rate

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), April 1, 2008 to March 31, 2009.
Related data: Hospitalized stroke event rate

Age-standardized rate of new stroke events admitted to an acute care hospital per 100,000 population age 20 and older. New event is defined as a first-ever hospitalization for stroke or a recurrent hospitalized stroke occurring more than 28 days after the admission for the previous event in the reference period.

Stroke is one of the leading causes of long-term disability and death. Measuring its occurrence in the population is important for planning and evaluating of preventive strategies, allocating health resources and estimating costs. From a disease surveillance

perspective, there are three groups of strokes: fatal events occurring out of the hospital, non-fatal stokes managed outside acute care hospitals and those admitted to an acute care facility. Although strokes admitted to a hospital do not reflect all stroke events in the community, this information provides a useful and timely estimate of the disease occurrence in the population.

Refer to the technical notes for more details.

22. Hospitalized acute myocardial infarction (AMI) event rate

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Hospitalized acute myocardial infarction (AMI) event rate

Age-standardized rate of new AMI events admitted to an acute care hospital per 100,000 population age 20 and older. New event is defined as a first-ever hospitalization for an AMI or a recurrent hospitalized AMI occurring more than 28 days after the admission for the previous event in the reference period.

AMI is one of the leading causes of morbidity and death. Measuring its occurrence in the population is important for planning and evaluating preventive strategies, allocating health resources and estimating costs. From a disease surveillance perspective, there are three groups of AMI events: non-diagnosed events, fatal events occurring outside the hospital and those admitted to acute care hospitals. Although AMIs admitted to a hospital do not reflect all acute myocardial infarctions in the community, this information provides a useful and timely estimate of the disease occurrence in the population.

Refer to the technical notes for more details.

23. Injury hospitalization rate

Source : Canadian Institute for Health Information (CIHI), National Trauma Registry (NTR), Fichier des hospitalisations MED-ÉCHO, Ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Injury hospitalization rate

Age-standardized rate of acute care hospitalization due to injury resulting from the transfer of energy (excluding poisoning and other non-traumatic injuries), per 100,000 population.

This indicator contributes to an understanding of the adequacy and effectiveness of injury prevention efforts, including public education, product development and use, community and road design, and prevention and treatment resources.

Refer to the technical notes for more details.

Health Behaviours

24. Current smoker, daily or occasional

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported being a current smoker.

Daily smokers refers to those who reported smoking cigarettes every day.

Does not take into account the number of cigarettes smoked.

Occasional smokers refers to those who reported smoking cigarettes occasionally. This includes former daily smokers who now smoke occasionally.

25. Current smoker, daily

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported being a current smoker.

Daily smokers refers to those who reported smoking cigarettes every day.

Does not take into account the number of cigarettes smoked.

Although the Canadian Tobacco Use Monitoring Survey (CTUMS) and the Canadian Community Health Survey (CCHS) produce estimates of national and provincial smoking rates, users should be aware of a number of differences between the two surveys. Firstly, the surveys use different sampling frames. Secondly, the annual sample for CTUMS is 20,000 compared to 65,000 for CCHS. Thirdly, in CCHS, smoking questions are asked in the context of a wide range of health-related behaviours whereas in CTUMS all questions are related to smoking. These differences could influence the accuracy of information provided by the respondent. Although these factors can influence the estimates produced at a single point in time, the trends produced by the two surveys have been noted to be very consistent over time. Rather than comparing smoking rates produced from the two surveys, Statistics Canada advises users to choose a single source, based on their objectives, and to use that source consistently.

26. Frequency of drinking

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported having 5 or more drinks on one occasion, at least once a month in the past year.

Starting in 2009, the denominator includes all the population aged 12 and over. This change applies to rates from all years in this table. In data released before 2009, the denominator included only the population who reported having had at least one drink in the past 12 months. Increasing the population in the denominator reduces the estimate rates. This change was implemented to produce more comparable rates over time and is more consistent with methods used in calculating other indicators.

27. Leisure-time physical activity, moderately active or active

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported a level of physical activity, based on their responses to questions about the nature, frequency and duration of their participation in leisure-time physical activity.

Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over the past 3 months. For each leisure time physical activity engaged in by the respondent, an average daily energy expenditure is calculated by multiplying the number of times the activity was performed by the average duration of the activity by the energy cost (kilocalories per kilogram of body weight per hour) of the activity. The index is calculated as the sum of the average daily energy expenditures of all activities. Respondents are classified as follows: 3.0 kcal/kg/day or more = physically active; 1.5 to 2.9 kcal/kg/day = moderately active; less than 1.5 kcal/kg/day = inactive.

28. Leisure-time physical activity, inactive

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported a level of physical activity, based on their responses to questions about the nature, frequency and duration of their participation in leisure-time physical activity.

Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over the past 3 months. For each leisure time physical activity engaged in by the respondent, an average daily energy expenditure is calculated by multiplying the number of times the activity was performed by the average duration of the activity by the energy cost (kilocalories per kilogram of body weight per hour) of the activity. The index is calculated as the sum of the average daily energy expenditures of

all activities. Respondents are classified as follows: 3.0 kcal/kg/day or more = physically active; 1.5 to 2.9 kcal/kg/day = moderately active; less than 1.5 kcal/kg/day = inactive.

29. Fruit and vegetable consumption, 5 times or more per day

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Indicates the usual number of times (frequency) per day a person reported eating fruits and vegetables. Measure does not take into account the amount consumed.

30. Bike helmet use

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they always wore a helmet when riding a bicycle in the last 12 months.

Human Function

31. Participation and activity limitation, sometimes or often

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported being limited in selected activities (home, school, work and other activities) because of a physical condition, mental condition or health problem which has lasted or is expected to last 6 months or longer.

32. Functional health, good to full

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over reporting measures of overall functional health, based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain).

A score of 0.8 to 1.0 is considered to be good to full functional health; scores below 0.8 are considered to indicate moderate to poor functional health problems.

Otherwise known as the Health Utility Index (HUI), this index, developed at McMaster University's Centre for Health Economics and Policy Analysis, is based on the Comprehensive Health Status Measurement System (CHSMS).

Accessibility

33. Influenza immunization, less than one year ago

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported when they had their last influenza immunization (flu shot).

The 2009 data on flu shots may include H1N1 vaccines received in the Fall of 2009. In 2010, questions were revised in order to collect the two types of vaccines seperately.

34. Received mammogram within the last 2 years, females aged 50 to 69 years

Source : Statistics Canada, Canadian Community Health Survey, 2008.
CANSIM table no.: 105-0543

Women aged 50 to 69 who reported when they had their last mammogram for routine screening or other reasons.

Screening mammography is an important strategy for early detection of breast cancer.

35. Pap smear within the last 3 years, by age group, females aged 18 to 69 years

Source : Statistics Canada, Canadian Community Health Survey, 2005.
CANSIM table no.: 105-0442

Women aged 18 to 69 who reported when they had their last Pap smear test.

Pap tests detect pre-malignant lesions before cancer of the cervix develops.

36. Regular medical doctor

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that they have a regular medical doctor.

37. Wait time for hip fracture surgery (surgery same or next day)

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), April 1, 2008 to March 31, 2009.
Related data: Wait time for hip fracture surgery (surgery same or next day)

Proportion with surgery same or next day: risk-adjusted proportion of hip fracture patients aged 65 and older who underwent hip fracture surgery on the day of admission or the next day.

Wait time for surgery following hip fracture provides a measure of the access to care. While some hip fracture patients need medical treatment to stabilize their condition before surgery, research suggests patients typically benefit from timely surgery in terms of reduced morbidity, mortality, pain, length of stay in hospital, as well as improved rehabilitation.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

38. Wait time for hip fracture surgery (surgery same, next day or day after)

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), April 1, 2008 to March 31, 2009.
Related data: Wait time for hip surgery (surgery same, next day or day after)

Proportion with surgery same, next day or day after: risk-adjusted proportion of hip fracture patients aged 65 and older who underwent hip fracture surgery on the day of admission, the next day or the day after that.

Wait time for surgery following hip fracture provides a measure of the access to care. While some hip fracture patients need medical treatment to stabilize their condition before surgery, research suggests patients typically benefit from timely surgery in terms of reduced morbidity, mortality, pain, length of stay in hospital, as well as improved rehabilitation.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

Appropriateness

39. Caesarean section

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Caesarean section

Proportion of women delivering babies in acute care hospitals by caesarean section.

Caesarean section rates provide information on the frequency of surgical birth delivery relative to all modes of birth delivery. Since Caesarean section delivery increases maternal morbidity/mortality and is associated with higher costs, Caesarean section rates are often used to monitor clinical practices with an implicit assumption that lower rates indicate more appropriate, as well as more efficient care.

Refer to the technical notes for more details.

Effectiveness

40. Ambulatory care sensitive conditions

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Ambulatory care sensitive conditions

Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population under age 75 years.

Ambulatory care sensitive conditions have been considered to be a measure of access to appropriate primary health care. While not all admissions for ambulatory care sensitive conditions are avoidable, it is assumed that appropriate prior ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to primary care.

Refer to the technical notes for more details.

41. 30-day acute myocardial infarction (AMI) in-hospital mortality

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Rates are based on the 3 years of pooled data: April 1, 2006 - March 31, 2009.
Related data: 30-day acute myocardial infarction (AMI) in-hospital mortality rate

The risk-adjusted rate of all-cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of acute myocardial infarction (AMI).

To enable comparison across regions, a statistical model was used to adjust for differences in age, sex and co-morbidities. Adjusted mortality rates following AMI may reflect, for example, the underlying effectiveness of treatment and quality of care. Inter-regional variation in 30 day in hospital mortality rates may be due to jurisdictional and institutional differences in standards of care, as well as other factors that were not included in the adjustment.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

42. 30-day stroke in-hospital mortality

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Rates are based on the 3 years of pooled data: April 1, 2006 - March 31, 2009.
Related data: 30-day stroke in-hospital mortality rate

The risk-adjusted rate of all–cause in–hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of stroke.

To enable comparison across regions, a statistical model was used to adjust for differences in age, sex and co-morbidities. Adjusted mortality rates following stroke may reflect, for example, the underlying effectiveness of treatment and quality of care. Inter-regional variations in rates may be due to jurisdictional and institutional differences in standards of care, as well as other factors that are not included in the adjustment.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

Safety

43. Hospitalized hip fracture event rate

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services

sociaux, April 1, 2008 to March 31, 2009.
Related data: Hospitalized hip fracture event rate

Age-standardized rate of new hip fractures admitted to an acute care hospital per 100,000 population age 65 years and over. New event is defined as a first-ever hospitalization for hip fracture or a subsequent hip fracture occurring more than 28 days after the admission for the previous event in the reference period. A person may have more than one hip fracture event in the reference period.

Hip fractures represent a significant health burden for seniors and for the health system. As well as causing disability or death, hip fracture may have a major effect on independence and quality of life. Measuring occurrence of hip fractures in the population is important for planning and evaluating preventive strategies, allocating health resources and estimating costs.

Refer to the technical notes for more details.

Environmental Factors

44. Exposure to second-hand smoke at home

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Non-smoking population aged 12 and over who reported that at least one person smoked inside their home every day or almost every day.

Smoking includes cigarettes, cigars and pipes.

45. Exposure to second-hand smoke in the past month, in vehicles and/or public places

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Non-smoking population aged 12 and over who reported being exposed to second-hand smoke in private vehicles and/or public places on every day or almost every day in the past month.

Smoking includes cigarettes, cigars and pipes.

46. Second-hand smoke, exposure in vehicles

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Non-smoking population aged 12 and over who reported being exposed to second-hand smoke in private vehicles and/or public places on every day or almost every day in the past month.

Note: This indicator is only available in the comprehensive download.

47. Second-hand smoke, exposure in public places

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Non-smoking population aged 12 and over who reported being exposed to second-hand smoke in private vehicles and/or public places on every day or almost every day in the past month.

Note: This indicator is only available in the comprehensive download.

48. Smokers asked to refrain from smoking in the house

Source : Statistics Canada, Canadian Community Health Survey, 2008.
CANSIM table no.: 105-0501

Population aged 12 and over who reported that smokers were asked to refrain from smoking in the house.

Note: This indicator is only available in the comprehensive download.

Deaths

49. Infant mortality

Source : Statistics Canada, Vital Statistics, Birth and Death Databases, 2005/2007.
CANSIM table no.: 102-4305

Infant mortality corresponds to the death of a child under one year of age. Expressed as a rate per 1,000 live births.

A long-established measure, not only of child health, but also of the well-being of a society. This indicator reflects the level of mortality, health status, and health care of a

population, and the effectiveness of preventive care and the attention paid to maternal and child health.

50. Life expectancy at birth

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4307

Life expectancy is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), on the basis of the mortality statistics for a given observation period.

A widely used indicator of the health of a population. Life expectancy measures quantity rather than quality of life.

51. Life expectancy at age 65

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4307

Life expectancy is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), on the basis of the mortality statistics for a given observation period.

A widely used indicator of the health of a population. Life expectancy measures quantity rather than quality of life.

52. Total, all causes of death

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death from all causes per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). All causes of death [A00-Y89].

53. All cancers

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). All malignant neoplasms (cancers) [C00-C97].

54. Colorectal cancer

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Colorectal cancer [C18-C21].

55. Lung cancer

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Lung cancer [C33-C34].

56. Breast cancer

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Breast cancer [C50].

Rates for breast cancer (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) code C50) were calculated for females only.

57. Prostate cancer

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Prostate cancer [C61].

Rates for prostate cancer (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) code C61) were calculated for males only.

58. Circulatory diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Circulatory diseases [I00-I99].

59. Ischaemic heart diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Ischaemic heart diseases [I20-I25].

60. Cerebrovascular diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Cerebrovascular diseases [I60-I69].

61. All other circulatory diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). All other circulatory diseases [I00-I02, I05-I09, I10-I15, I26-I28, I30-I52, I70-I79, I80-I89, I95-I99].

62. Respiratory diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Respiratory diseases (excluding infectious and parasitic diseases) [J00-J99].

63. Pneumonia and influenza

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Pneumonia and influenza [J10-J18].

64. Bronchitis, emphysema and asthma

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Bronchitis, emphysema and asthma [J40-J43, J45-J46].

65. All other respiratory diseases

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). All other respiratory diseases [J00-J06, J20-J22, J30-J39, J44, J47, J60-J70, J80-J84, J85-J86, J90-J94, J95-J99].

66. Unintentional injuries

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Unintentional injuries [V01-X59, Y85-Y86].

External causes of unintentional injuries include transport accidents, falls, poisoning, drowning and fires, but not complications of medical and surgical care (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) codes V01 to X59, Y85 to Y86).

67. Suicides and self-inflicted injuries

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Suicides and self-inflicted injuries [X60-X84, Y87.0].

68. Human immunodeficiency virus [HIV] disease

Source : Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007.
CANSIM table no.: 102-4309

Age-standardized rate of death per 100,000 population.

World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Human immunodeficiency virus [HIV] disease [B20-B24].

Personal Resources

69. Sense of community belonging

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported their sense of belonging to their local community as being very strong or somewhat strong. Research shows a high correlation of sense of community-belonging with physical and mental health.

70. Life satisfaction, satisfied or very satisfied

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported being satisfied or very satisfied with their life in general. Starting in 2009, this indicator is based on a grouped variable. In 2009, the question was changed from 5-point answer category to an 11-point scale. The concordance between the two scales was found to be good.

Living and Working Conditions

71. High school graduates aged 25 to 29

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Questions pertaining to education on the census questionnaire changed substantially between 2001 and 2006, principally to reflect developments in Canada's education system. The education portion of the questionnaire had not changed in many years, even

though the education system had evolved considerably. For additional information, please refer to 'Educational Portrait of Canada, 2006 Census: Substantial changes to census questions on education' at http://www12.statcan.ca/english/census06/analysis/education/changes.cfm.

Population aged 25 to 29 who have a secondary (high) school graduation certificate or equivalent.

'High school certificate or equivalent' refers to the possession of a secondary (high) school graduation certificate or its equivalent, regardless of whether other educational qualifications are held or not. High school graduates exclude institutional residents.

72. Post-secondary graduates aged 25 to 54

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Questions pertaining to education on the census questionnaire changed substantially between 2001 and 2006, principally to reflect developments in Canada's education system. The education portion of the questionnaire had not changed in many years, even though the education system had evolved considerably. For additional information, please refer to 'Educational Portrait of Canada, 2006 Census: Substantial changes to census questions on education' at http://www12.statcan.ca/english/census06/analysis/education/changes.cfm.

Population aged 25 to 54 who have obtained a post-secondary certificate, diploma, or degree.

'Highest certificate, diploma or degree' refers to the highest certificate, diploma or degree completed based on a hierarchy which is generally related to the amount of time spent 'in-class'. For postsecondary completers, a university education is considered to be a higher level of schooling than a college education, while a college education is considered to be a higher level of education than in the trades. Although some trades requirements may take as long or longer to complete than a given college or university program, the majority of time is spent in on-the-job paid training and less time is spent in the classroom. Post-secondary graduates exclude institutional residents.

73. Adult unemployment, 15 years and over

Source : Statistics Canada, Labour Force Survey (special tabulations), 2009.
CANSIM table no.: 109-5304

Proportion of the Labour force aged 15 and over who did not have a job during the reference period.

The labour force consists of people who are currently employed and people who are unemployed but were available to work in the reference period and had looked for work in the past 4 four weeks. The reference period refers to a one-week period (from Sunday to Saturday) that usually includes the 15th day of the month.

The unemployment rate is a traditional measure of the economy. Unemployed people tend to experience more health problems.

74. Youth unemployed

Source : Statistics Canada, Labour Force Survey (special tabulations), 2008.
CANSIM table no.: 109-5304

Proportion of the Labour force for youths, aged 15 to 24 years, who did not have a job during the reference period.

The labour force consists of people who are currently employed and people who are unemployed but were available to work in the reference period and had looked for work in the past 4 four weeks. The reference period refers to a one-week period (from Sunday to Saturday) that usually includes the 15th day of the month.

The unemployment rate is a traditional measure of the economy. Unemployed people tend to experience more health problems.

75. Long-term unemployed

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

The long term unemployed includes unemployed individuals who last worked in or before 2005.

Long-term unemployment excludes institutional residents.

76. Low income rate

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

An economic family refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law or adoption. By contrast, the census family concept requires that family members be either a male or female spouse, a male or female common-law partner, a male or female lone parent, or a child with a parent present. The concept of economic family may therefore refer to a larger group of persons than does the census family concept. All census family persons are economic family persons. For 2006, foster children are considered economic family

members. Note that as of 2001, same-sex partners are considered to be common-law partners. Thus they are considered related and members of the same economic family.

As of 1971, published family statistics included families living in private households (including those enumerated outside Canada) and all collective households.

For 2006, married spouses may be of opposite or same sex.

The persons not in economic families refers to household members who do not belong to an economic family. Persons living alone are included in this category.

Age refers to the age at last birthday (as of the census reference date, May 16, 2006). This variable is derived from date of birth.

Low-income cut-offs (LICOs) represent levels of income where people spend disproportionate amounts of money for food, shelter and clothing. They are based on family and community size and are updated to account for changes in the consumer price index. LICO data exclude institutional residents and were not derived for economic families or unattached individuals in the territories or on Indian reserves. Prevalence of low income rates are calculated from rounded counts of low income persons or families and the total number of persons or families. These counts have been rounded independently of the rounded counts shown in the table; thus, there may be a small difference between the rate shown and the one derived from the counts shown. Users are advised to interpret prevalence of low income rates based upon small counts with caution. For additional information and a table of low income cut-offs, please refer to the 2006 Census Dictionary, catalogue number 92-566-XWE.

77. Children aged 17 and under living in low income families

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

An economic family refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law or adoption. By contrast, the census family concept requires that family members be either a male or female spouse, a male or female common-law partner, a male or female lone parent, or a child with a parent present. The concept of economic family may therefore refer to a larger group of persons than does the census family concept. All census family persons are economic family persons. For 2006, foster children are considered economic family members. Note that as of 2001, same-sex partners are considered to be common-law partners. Thus they are considered related and members of the same economic family.

As of 1971, published family statistics included families living in private households (including those enumerated outside Canada) and all collective households.

For 2006, married spouses may be of opposite or same sex.

The persons not in economic families refers to household members who do not belong to an economic family. Persons living alone are included in this category.

Age refers to the age at last birthday (as of the census reference date, May 16, 2006). This variable is derived from date of birth.

Low-income cut-offs (LICOs) represent levels of income where people spend disproportionate amounts of money for food, shelter and clothing. They are based on family and community size and are updated to account for changes in the consumer price index. LICO data exclude institutional residents and were not derived for economic families or unattached individuals in the territories or on Indian reserves. Prevalence of low income rates are calculated from rounded counts of low income persons or families and the total number of persons or families. These counts have been rounded independently of the rounded counts shown in the table; thus, there may be a small difference between the rate shown and the one derived from the counts shown. Users are advised to interpret prevalence of low income rates based upon small counts with caution. For additional information and a table of low income cut-offs, please refer to the 2006 Census Dictionary, catalogue number 92-566-XWE.

Community

78. Total population

Source : Statistics Canada, 2006 Census.
Related data: Not applicable

The number of people living in a geographic area by sex.

A population's size and age/sex composition impact the health status of a region and its need for health services. Population data also provide the 'denominators' used to calculate rates for most health and social indicators.

2006 population based on 100% data.

Statistics Canada asks the same basic questions to every household and individual in Canada. Information drawn from these basic questions is referred to as 100% data, as they are collected for every individual and household in Canada.

For more recent estimates of health region population, see CANSIM table no. 109-5325

Please note that the most appropriate 2006 population figures for Canada, provinces and territories are the current postcensal population estimates.

79. Population density per square kilometre

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Population density is the number of persons per square kilometre. The calculation for population density is total population divided by land area. Land area is the area in square kilometres of the land-based portions of standard geographic areas.

80. Dependency ratio

Source : Statistics Canada, Demography Division. Data are derived from the Census and administrative sources on births, deaths, and migration, 2009.
CANSIM table no.: 109-5326

The ratio of the combined population aged between 0 to 19 years old and the population aged of 65 years and over to the population aged between 20 to 64 years old.

This ratio is usually presented as the number of dependents for every 100 people in the working age population.

81. Aboriginal population

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Included in the Aboriginal identity population are those persons who reported identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or those who reported being a Treaty Indian or a Registered Indian, as defined by the *Indian Act of Canada*, and/or those who reported they were members of an Indian band or First Nation.

Aboriginal population excludes institutional residents.

Aboriginal people living in a geographic area as a proportion of the total population.

82. Immigrant population

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

For the 1991 to 2006 censuses, the term 'immigrants' refers to persons who are, or have ever been, landed immigrants in Canada. A landed immigrant is a person who has been granted the right to live in Canada permanently by immigration authorities. Some immigrants have resided in Canada for a number of years, while others are recent arrivals. Most immigrants are born outside Canada, but a small number were born in Canada. Data on the landed immigrant population have been collected in a direct census question since the 1991 Census. In the 1981 and 1986 censuses, the immigrant population

was defined as persons who were not Canadian citizens by birth and prior to the 1981 Census, the immigrant population referred to all persons born outside Canada. Changes to the definition of the immigrant population since 1981 should not have a major impact on the comparability of census data on immigrants over time. The immigrant population excludes institutional residents.

83. 1 year internal migrants

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Number or proportion of people that lived in a different Canadian municipality one year before the current census (1-year internal migrants) or at the time of the previous census (5-year internal migrants). Refers to the relationship between a person's usual place of residence on Census Day and his or her usual place of residence five years earlier. A person is classified as a non-mover if no difference exists. Otherwise, a person is classified as a mover and this categorization is called mobility status (5 years ago). Within the movers category, a further distinction is made between non-migrants and migrants; this difference is called migration status. Non-movers are persons who, on Census Day, were living at the same address as the one at which they resided five years earlier. Movers are persons who, on Census Day, were living at a different address from the one at which they resided five years earlier. Non-migrants are movers who, on Census Day, were living at a different address, but in the same census subdivision (CSD) as the one they lived in five years earlier. Migrants are movers who, on Census Day, were residing in a different CSD five years earlier (internal migrants) or who were living outside Canada five years earlier (external migrants). Intraprovincial migrants are movers who, on Census Day, were living in a different census subdivision from the one in which they resided five years earlier, in the same province. Interprovincial migrants are movers who, on Census Day, were living in a different census subdivision from the one in which they resided five years earlier, in a different province.

Mobility excludes external migrants who were living outside Canada.

Mobility excludes Canadians in households outside Canada (military and government personnel) and institutional residents in Canada.

84. 5 year internal migrants

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Number or proportion of people that lived in a different Canadian municipality one year before the current census (1-year internal migrants) or at the time of the previous census (5-year internal migrants). Refers to the relationship between a person's usual place of residence on Census Day and his or her usual place of residence five years earlier. A person is classified as a non-mover if no difference exists. Otherwise, a person is

classified as a mover and this categorization is called mobility status (5 years ago). Within the movers category, a further distinction is made between non-migrants and migrants; this difference is called migration status. Non-movers are persons who, on Census Day, were living at the same address as the one at which they resided five years earlier. Movers are persons who, on Census Day, were living at a different address from the one at which they resided five years earlier. Non-migrants are movers who, on Census Day, were living at a different address, but in the same census subdivision (CSD) as the one they lived in five years earlier. Migrants are movers who, on Census Day, were residing in a different CSD five years earlier (internal migrants) or who were living outside Canada five years earlier (external migrants). Intraprovincial migrants are movers who, on Census Day, were living in a different census subdivision from the one in which they resided five years earlier, in the same province. Interprovincial migrants are movers who, on Census Day, were living in a different census subdivision from the one in which they resided five years earlier, in a different province.

Mobility excludes external migrants who were living outside Canada.

Mobility excludes Canadians in households outside Canada (military and government personnel) and institutional residents in Canada.

85. Population living within a Census Metropolitan Area, a Census Agglomeration or a strong Census Metropolitan Area and Census Agglomeration Influenced Zone.

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Strong Census Metropolitan Area and Census Agglomeration Influenced Zones (MIZ) is the population or the proportion of the population living in Census Metropolitan Areas (CMA), Census Agglomerations (CA) and communities that fall outside CMAs and/or CAs that have at least 30% of the employed labour force commuting to CMAs and/or CAs. The Statistical Area Classification (SAC) groups census subdivisions according to whether they are a component of a census metropolitan area, a census agglomeration, a census metropolitan area and census agglomeration influenced zone (strong MIZ, moderate MIZ, weak MIZ or no MIZ), or the territories (Yukon, Northwest Territories and Nunavut). The SAC is used for data dissemination purposes. Care should be exercised when applying the MIZ concept in the three territories. As many CSDs in the territories are very large and sparsely populated, the place of work-population relationship upon which the MIZ is constructed is unstable.

The Census Metropolitan Areas (CMAs) and Census Agglomerations (CAs) are large urban areas with adjacent urban and rural areas that have a high degree of economic and social integration.

These Census Metropolitan Areas (CMAs) and Census Agglomerations (CAs) are defined around urban areas that have attained certain population thresholds: 100,000 for CMAs and 10,000 for CAs.

Commuting flows are based on the 2006 Census place of work file.

86. Lone-parent families

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

Census family refers to a married or common-law couple or lone parent with at least one never-married son or daughter living in the same household.

87. Visible minority population

Source : Statistics Canada, 2006 Census.
CANSIM table no.: 109-0300

The Employment Equity Act defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour'. Visible minority excludes institutional residents and Aboriginal persons.

Health System

88. Contact with a medical doctor in the past 12 months

Source : Statistics Canada, Canadian Community Health Survey, 2009.
CANSIM table no.: 105-0501

Population aged 12 and over who reported having consulted with a medical doctor in the past 12 months.

Medical doctor includes family or general practitioners as well as specialists such as surgeons, allergists, orthopaedists, gynaecologists or psychiatrists. For population aged 12 to 17, includes pediatricians.

89. Coronary artery bypass graft

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Coronary artery bypass graft surgery rate

Age-standardized rate of coronary artery bypass graft (CABG) surgery performed on inpatients in acute care hospitals per 100,000 population age 20 and over.

As with other types of surgical procedures, variations in CABG surgery rates can be attributed to numerous factors, including differences in population demographics, physician practice patterns, and availability of services. In cases amenable to treatment with less invasive procedures percutaneous coronary intervention (PCI), an alternative intervention to improve blood flow to the heart muscle, may be used. Variations in the extent to which PCI is utilized may result in variations the rate of in bypass surgery.

Refer to the technical notes for more details.

90. Percutaneous coronary intervention

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); Alberta Health and Wellness, Alberta Ambulatory Care Database, April 1, 2008 to March 31, 2009.
Related data: Percutaneous coronary intervention rate

Age-standardized rate of percutaneous coronary interventions (PCI) performed on patients in acute care hospitals, same day surgery facilities or catheterization laboratories, per 100,000 population age 20 years and over.

In many cases, PCI serves as a non-surgical alternative to coronary artery bypass graft (CABG) surgery and is undertaken for the purpose of opening obstructed coronary arteries. While PCI encompasses several techniques, angioplasty is the procedure most frequently provided. The choice of revascularization mode (that is, PCI or CABG) depends on numerous factors including severity of coronary artery disease, physician preferences, availability of services, referral patterns, as well as differences in population health and socio-economic status.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

91. Cardiac revascularization

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); Alberta Health and Wellness, Alberta Ambulatory Care Database, April 1, 2008 to March 31, 2009.
Related data: Cardiac revascularization rate

Age-standardized rate of coronary artery bypass graft (CABG) surgery performed on inpatients in acute care hospitals or percutaneous coronary interventions (PCI) performed on patients in acute care hospitals, same day surgery facilities or catheterization laboratories, per 100,000 population age 20 years and over.

The choice of revascularization mode (i.e. PCI or CABG) depends on numerous factors including severity of coronary artery disease, physician preferences, availability of services, referral patterns, as well as differences in population health and socio-economic status. The combined cardiac revascularization rate represents total activity of cardiac revascularization in a jurisdiction.

Rates for Quebec are not available due to differences in data collection.

Refer to the technical notes for more details.

92. Hip replacement

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Hip replacement rate

Age-standardized rate of unilateral or bilateral hip replacement surgery performed on inpatients in acute care hospitals per 100,000 population age 20 years and over.

Hip replacement surgery has the potential to result in considerable improvement in functional status, pain relief, as well as other gains in health-related quality of life. Over the past two decades, rates of surgery have increased substantially. Wide inter-regional variation in the hip replacement rate may be attributable to numerous factors including the availability of services, provider practice patterns, and patient preferences.

Beginning with 2005/2006, this indicator is calculated for the population age 20 years and over and therefore is not comparable with rates reported for previous years. Rates for the previous years, calculated using the new definition, are presented to enable comparisons over time.

Refer to the technical notes for more details.

93. Knee replacement

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); Alberta Health and Wellness, Alberta Ambulatory Care Database; Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Knee replacement rate

Age-standardized rate of unilateral or bilateral knee replacement surgery performed on patients in acute care hospitals or same-day surgery facilities, per 100,000 population age 20 years and over.

Knee replacement surgery has the potential to result in considerable improvement in functional status, pain relief, as well as other gains in health-related quality of life. Over the past two decades, rates of surgery have increased substantially. Wide inter-regional variation in the knee replacement rate may be attributable to numerous factors including the availability of services, provider practice patterns, and patient preferences.

Beginning with 2005/2006, this indicator is calculated for the population aged 20 years and older and includes same day surgery procedures, and therefore is not comparable with rates reported for previous years. Rates for the previous years, calculated using the new definition, are presented to enable comparisons over time.

Refer to the technical notes for more details.

94. Hysterectomy

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); Alberta Health and Wellness, Alberta Ambulatory Care Database; Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Hysterectomy rate

Age-standardized rate for hysterectomy provided to inpatients in acute care hospitals, per 100,000 women age 20 and over.

Utilization rates may reflect the level of uncertainty about the appropriate use of this surgical procedure. The "right" level of utilization is not known.

Beginning with 2006/2007 data, hysterectomy rates include both total and sub-total hysterectomies, similar to the reporting prior to 2001/2002 data. Sub-total hysterectomy was not uniquely identified in the Canadian Classification of Health Interventions (CCI) versions 2001 and 2003, therefore hysterectomy rates reported for 2001/2002 to 2005/2006 fiscal years included only total hysterectomies. Identification of sub-total hysterectomies became possible again with version 2006 of CCI. For jurisdictions with higher volumes of sub-total hysterectomies comparability with the previous years might be affected.

Beginning with 2005/2006 data, this indicator includes same day surgery procedures. However, due to small counts of same day surgery procedures, comparability with the previous years is not affected.

Refer to the technical notes for more details.

95. Inflow/outflow ratio

Source : Canadian Institute for Health Information (CIHI), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); Alberta Health and

Wellness, Alberta Ambulatory Care Database; Fichier des hospitalisations MED-ÉCHO, ministère de la Santé et des Services sociaux, April 1, 2008 to March 31, 2009.
Related data: Inflow/Outflow ratio (Overall)

A ratio of the number of discharges from relevant facilities (acute care/same day surgery) within a given region divided by the number of discharges generated by residents of that region. An overall ratio is calculated for discharges associated with any diagnosis or procedure for acute care discharges only, and separately for hip replacement, knee replacement, hysterectomy, percutaneous coronary intervention and coronary artery bypass surgery procedures from all relevant facilities.

This indicator reflects the balance between the quantity of hospital stays provided to both residents and non-residents by all acute care hospitals in a given region and the extent of acute care utilization by residents of that region, whether they receive care within or out of the region. A ratio less than one indicates that hospital stays utilized by residents of a region exceeded hospital care provided within that region, suggesting an outflow effect. A ratio greater than one indicates hospital stays provided by a region exceeded the quantity of stays utilized by its residents, suggesting an inflow effect. A ratio of one indicates that the volume of hospital discharges in the region is equivalent to that generated by its residents, suggesting that inflow and outflow activity, if it exists at all, is balanced.

Refer to the technical notes for more details.

Resources

96. Doctors rate - General/family physicians

Source : Canadian Institute for Health Information (CIHI), Scott's Medical Database, December 31, 2008.
Related data: Doctors

Physician counts include all active physicians as of December 31 of the reference year. Physicians in clinical and non-clinical practice are included. Residents and unlicensed physicians who have requested that their information not be published are excluded. Generally, specialist physicians include certificants of the Royal College of Physicians and Surgeons of Canada (RCPSC) and/or the Collège des médecins du Québec (CMQ) with the exception of Saskatchewan, Newfoundland and Labrador, Nova Scotia, New Brunswick and Yukon, where specialists also include physicians who are licensed as specialists but who are not certified by the RCPSC or the CMQ (that is, non-certified specialists). For all other jurisdictions non-certified specialists are counted as general practitioners with the exception of the criteria just noted, all other physicians are counted as family practitioners, including certificants of the College of Family Physicians of Canada. For further information on physician count methodologies please see CIHI's

reports on the “Supply, Distribution and Migration of Canadian Physicians” and “Certified and Non-Certified Specialists: Understanding the Numbers”.

Physician-to-population rates are useful indicators and are published by a variety of agencies to support health human resource planning. However, due to differences in data collection, processing and reporting methodology, CIHI results may differ from provincial and territorial data. Readers are cautioned to avoid inferences regarding the adequacy of provider resources based on supply ratios alone.

Note: Scott's Medical Database (SMDB) information may undercount physicians due to Provincial/Territorial licensing authority data supply interruptions. SMDB data does not reflect licensing authority updates for the following jurisdictions and years: British Columbia 2004; Québec 2003; Ontario 2002; Alberta and the Yukon 2000.

Refer to the technical notes for more details.

97. Doctors rate - Specialist physicians

Source : Canadian Institute for Health Information (CIHI), Scott's Medical Database, December 31, 2008.
Related data: Doctors

Physician counts include all active physicians as of December 31 of the reference year. Physicians in clinical and non-clinical practice are included. Residents and unlicensed physicians who have requested that their information not be published are excluded. Generally, specialist physicians include certificants of the Royal College of Physicians and Surgeons of Canada (RCPSC) and/or the Collège des médecins du Québec (CMQ) with the exception of Saskatchewan, Newfoundland and Labrador, Nova Scotia, New Brunswick and Yukon, where specialists also include physicians who are licensed as specialists but who are not certified by the RCPSC or the CMQ (that is, non-certified specialists). For all other jurisdictions non-certified specialists are counted as general practitioners with the exception of the criteria just noted, all other physicians are counted as family practitioners, including certificants of the College of Family Physicians of Canada. For further information on physician count methodologies please see CIHI's reports on the “Supply, Distribution and Migration of Canadian Physicians” and “Certified and Non-Certified Specialists: Understanding the Numbers”.

Physician-to-population rates are useful indicators and are published by a variety of agencies to support health human resource planning. However, due to differences in data collection, processing and reporting methodology, CIHI results may differ from provincial and territorial data. Readers are cautioned to avoid inferences regarding the adequacy of provider resources based on supply ratios alone.

Note: Scott's Medical Database (SMDB) information may undercount physicians due to Provincial/Territorial licensing authority data supply interruptions. SMDB data does not

reflect licensing authority updates for the following jurisdictions and years: British Columbia 2004; Québec 2003; Ontario 2002; Alberta and the Yukon 2000.

Refer to the technical notes for more details.

Symbols

Symbol legend

Symbol	Description
·	Not available for any reference period
..	Not available for a specific reference period
...	Not applicable
E	Use with caution
F	Too unreliable to be published
x	Suppressed to meet the confidentiality requirements of the Statistics Act
^	Statistically different from the average (Canada) rate ($p \leq 0.05$)

Source: Statistics Canada. 2011. Health Profile.
Statistics Canada Catalogue No. 82-228-XWE. Ottawa. Released February 28, 2011.
http://coddigger.statcan.ca/health-sante/82-228/index.cfm?Lang=E