

2000



Health Profile: Windsor-Essex County

Summary Report

A publication of the
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Summary Highlights

Our Community

- In 1996, the population of Windsor-Essex County was 350,335.
- The population grew 7% between 1991 and 1996 in Windsor-Essex County.
- The age group that made up the largest percentage of the population in Windsor-Essex County was 30 to 39 years. In the city of Windsor however, the largest proportion of the population was split between 20 to 29 years and 30 to 39 years.
- In 1996, about 20% of the Windsor-Essex population were immigrants. Recent immigrants (people immigrating between 1991 and 1996) totalled 3.4% of the population. Recent immigrants came to Windsor-Essex County primarily from Lebanon, the United States, and Mexico.
- Italian, Arabic and Chinese were the most commonly reported (non-official) mother tongues in Windsor. Whereas, German, Italian and Portuguese were most commonly reported in the County.
- In 1996, the unemployment rate in Windsor-Essex County was 7.7%, lower than the 9.1% rate reported for Ontario.
- In 1996, Windsor Essex-County had a lower percentage of individuals in the “low income” category (14.5%) as compared to Ontario as a whole (17.7%).

Our Environment

- 1998 air quality data indicated a higher number of hours that ozone was above acceptable levels at the two Windsor testing sites than the average number of hours reported for sites across the province.
- During 1998, 15,484 water samples were tested in Windsor-Essex County. Test results on drinking water revealed that no health related standards were exceeded.

Assessing Our Health

- The percentage of low birth weight infants in Windsor-Essex County has remained relatively constant from 1981 to 1996. In 1996, the percentage of low birth weight infants was 4.7% in Windsor-Essex County.
- In 1996, the leading causes of death in males were ischemic heart disease, lung cancer and stroke. The male mortality rates for ischemic heart disease and lung cancer were 28% and 24% higher in Windsor-Essex County than for all of Ontario.
- For females, the leading causes of death were ischemic heart disease, stroke, and diseases of the arteries, arterioles and capillaries. The mortality rates for ischemic heart disease were 29% higher for females living in Windsor-Essex County than Ontario.

- In 1998, the leading causes of hospitalization among females were related to complications of pregnancy (23%), followed by respiratory diseases (20%), circulatory diseases (12%), and diseases of the digestive system (11%).
- The leading causes of hospitalization among males included respiratory diseases (31%), circulatory diseases (19%), diseases of the digestive system (14%), and mental disorders (9%). As well, males were hospitalized in Windsor-Essex County at a rate that was 54% higher than Ontario for suicide attempts.
- In Windsor-Essex County, the male mortality rate due to suicide in 1996 was 66% higher than Ontario as a whole.

Our Behaviours: Impact on Health

- In 1996, about 72% of the Windsor-Essex County population had either never smoked or were former smokers. Twenty-five percent reported being daily smokers.
- In Windsor-Essex County, 13% of the population were binge drinkers in 1996. Binge drinking is defined as drinking 5 or more drinks in one session, at least once a month. The highest proportion of binge drinking occurred in males in the age group 19 to 29.
- In 1996, the percentage of male drivers in Windsor-Essex County who reported drinking and driving in the past year (10.5%) was similar to the percentage in Ontario (9.5%).
- In 1996, most men (52.6%) and women (60.5%) in Windsor-Essex County were physically inactive.
- Teens were more likely to be active than the rest of the population, but 38.5% were considered physically inactive.



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Introduction

Health: A Community Investment

Health has been described as a *resource for everyday life*. It is far more complex than the absence of disease. A variety of factors determine the health of individuals, families and communities. There is no simple way to measure health. At the community level, there are a number of indicators that help to identify how healthy we are. Death rates, disease incidence, and hospitalizations are some of the key indicators used to measure the health status of a community.

Optimal health depends on much more than good health care services. Today, health care dollars are spent primarily to treat people with disease and illness. However, if we want to improve the health of our community, we also need to focus on what makes people healthy. These factors are often referred to as determinants of health. As well as access to health care, the health of our community will continue to be influenced by our investment in:

- ▶ the social, economic and physical environments
- ▶ personal health behaviours
- ▶ early childhood development
- ▶ supporting the capacity and coping skills of individuals

Why a Community Health Profile?

A community health profile is a collection of current facts and figures on population demographics, health indicators and determinants of health for the community. Building this profile is like creating a series of snap shots. The pieces of information fit together to create a community composite. We examine the pictures and develop a profile to better understand how healthy we are in Windsor-Essex County. One challenge of completing this profile is that our community is constantly changing. Our snap shots primarily capture information for Windsor-Essex County collected in 1996. In addition, comprehensive data sources for key health areas like environment, for example, are not available. Throughout this report we have tried to use the most current information available. More information about our data sources is on pages 2 and 3.

The purpose of the community health profile is to provide information for assessing local needs, and for planning and evaluating public health programs. We hope that this report will also encourage discussion locally about the determinants of health in order to influence action that will improve the health and well being of our community.

Features and Layout of this Report

This report includes facts and figures for key information as displayed in the sections outlined below. Most information is provided for Windsor-Essex County, Southwest Region and for all of Ontario. This allows us to compare our community with our region and with the province as a whole. Figures and tables are used throughout the report to illustrate key information. We have also included the “Did You Know” sections to identify some of the provincial objectives we are working towards in our community. These objectives are outlined in the 1997 Mandatory Health Programs and Services Guidelines. The guidelines represent minimum standards for programs and services provided by Boards of Health across Ontario and guide minimum requirements for public health programs targeting prevention of

disease, health promotion and health protection.

Geographical Definitions

Windsor - City of Windsor.

Windsor-Essex County (WEC) - As defined in 1996, includes Pelee, Mersea, Leamington, Gosfield South, Gosfield North, Kingsville, Colchester North, Colchester South, Harrow, Malden Amherstburg, Anderdon, LaSalle, Tecumseh, Sandwich South, Maidstone, St. Clair Beach, Essex, Rochester, Belle River, Tilbury West, Tilbury North and Windsor.

Essex County – Includes all municipalities excluding Windsor.

Southwest Region – Includes Bruce-Grey-Owen Sound, Huron Perth, Oxford, Middlesex-London, Lambton, Elgin-St. Thomas, Kent-Chatham, Windsor-Essex.

Key Sections

a) Our Community

- Population
- Age distribution
- Cultural Diversity
- Mother tongue
- Employment
- Household income
- Access to Physicians
- Air quality
- Water quality

b) Assessing Our Health

- Live births
- Teen pregnancy rates
- Teen live births
- Low birth weight
- Leading causes of death
- Leading causes of hospitalization
- Suicide and mental health
- Unintentional injuries

c) Our Behaviour: Impact on Health

- Smoking
- Alcohol consumption
- Physical activity
- Sexual health
- General preventive practices

Data Sources

Collecting, analyzing and summarizing demographic and health population data is a detailed and expensive process. Nationally and provincially, there is significant lag time between the time of data collection and the release of information. Most of the information in this report is from 1996. To build this health profile, we have compiled the most recent data available



from a number of sources:

1996 Census - The data are available through Statistics Canada. The census is conducted once every 5 years to gather information about the social and economic situation of Canada. Because a census includes the total population in Canada, coverage errors may exist which affect the accuracy of the census counts. Undercoverage occurs when a person is not enumerated. Overcoverage occurs when persons are counted more than once or those not in the census population are counted (i.e., foreign visitors).

1996/97 Ontario Health Survey - The OHS was conducted in conjunction with the National Population Health Survey (NPHS). Certain groups such as the homeless, aboriginal people living on reserves, and those living in institutions were excluded. The OHS covers the general population, and focuses on broad aspects of health, including lifestyle behaviours, health problems, and health care utilization that are not available elsewhere.

Ontario Mortality Database - The data are received through the Ministry of Health, and its Provincial Health Planning Database (PHPD or Data Warehouse), and the HEaLth Planning System (HELPS) initiative. Due to legal reporting requirements under the Vital Statistics Act, registration of deaths is considered to be virtually complete. Some records received after the "cut-off date" as well as deaths of Canadians occurring in other countries are missing however.

Ontario Live Birth Database - Live birth data are collected under the Vital Statistics Act. The data are received through the Ministry of Health, and its Provincial Health Planning Database (PHPD or Data Warehouse), and the HEaLth Planning System (HELPS) initiative. Since registration of live births is required by law, data are considered to be complete. Records of birth notifications received after the "cut-off date" are not included. Stillbirths are included in a separate database in HELPS, but are combined with live births in the PHPD.

Hospital Morbidity Data - The data is compiled from discharge abstracts submitted to the Canadian Institute for Health Information by public general hospitals and allied special hospitals. The data shows the number of hospital separations recorded in the year by medical diagnosis. Separations are due to death, discharge, or transfer to another hospital or facility. As a result, this data includes individuals who enter and leave hospital more than once in a given year for the same health problem.

1998 Air Quality - The Ministry of the Environment monitors air quality hourly, analyses data yearly, and prepares a summary report. The process creates a 1-2 year lag in reporting results. Ozone and suspended particles were two contaminants monitored during 1998 that were above acceptable levels.

1998 Drinking Water Surveillance - The Ministry of the Environment tests raw and treated water for the presence of a variety of substances including viruses, bacteria, salts, metals, pesticides, herbicides, and radioactive materials. The data is analysed yearly and a summary report prepared. The process creates a 1-2 year lag in receiving results.

Our Community

This section provides a “snap shot” of who we are as well as the important factors that determine the health of our community. These include basic demographics, socio-economic and environmental factors.

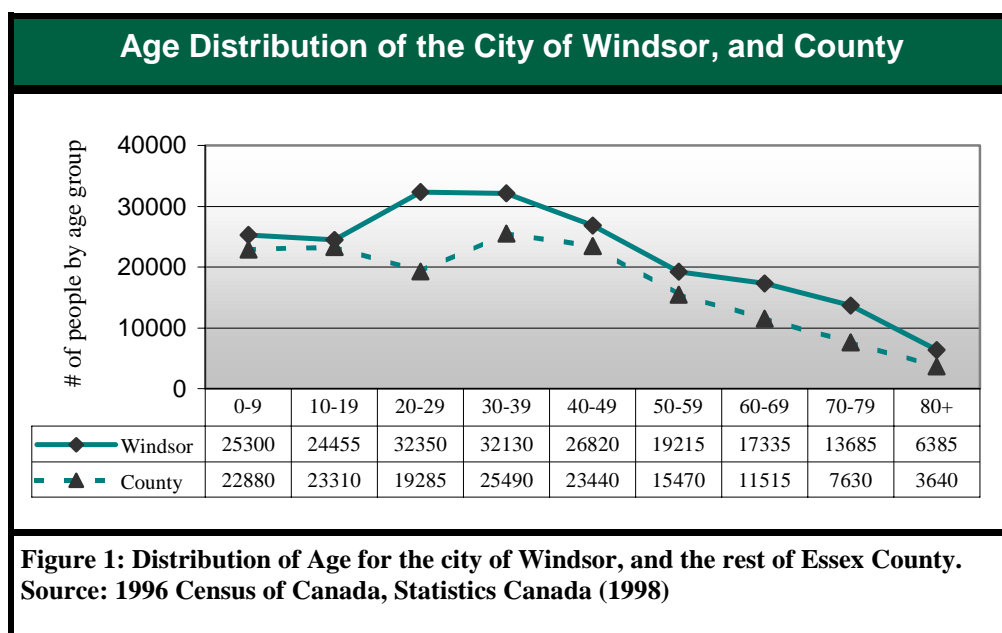
The Population

In 1996, there were 350,335 people living in Windsor-Essex County. 56% of people lived in the city of Windsor. From 1991 to 1996, there was 7.0% growth in the population of Windsor-Essex County, very similar to the 6.6% growth reported for Ontario as a whole. During this same period, the population growth in Essex County was more than double the percentage increase reported for the rest of the Southwest Region (3.1%).

Age Distribution

Figure 1 shows the age distribution of our population in 1996. The largest percentage of the population for Essex County (16.4%) was 30 to 39 years. In the city of Windsor the largest percentage of the population included people age 20 to 29 years (16.4%) and 30 to 39 years (16.3%). The larger percentage of people age 20 to 29 in the city of Windsor may reflect the influence that industry, college and university have on attracting young adults from the county to the city of Windsor.

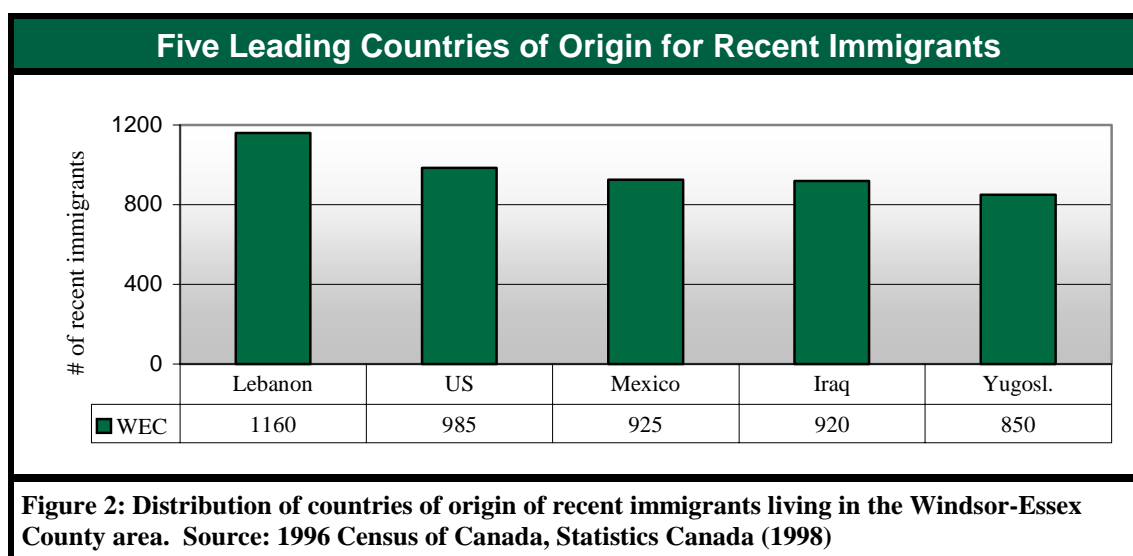
The population of Ontario is aging as the baby boom generation is now mainly between 30 and 49 years old. Based on population projections calculated by the Ministry of Finance, there are presently 48,650 people over the age of 65 in Essex County, representing 12.8% of the total population. By the year 2010, this number is projected to rise to 56,490, representing 13.5% of the population. By the year 2020, there will be an estimated 74,770 people over the age of 65, representing 16.5% of the population. An aging population will continue to have a significant impact on existing health services.



Cultural Diversity

In 1996, about 20% of Windsor-Essex County residents were immigrants, compared with 25.3% for all of Ontario. Recent immigrants, individuals who immigrated between 1991 and 1996, represented 3.4% of the population in the County. The percentage of recent immigrants to Ontario was 5.2%.

Figure 2 displays the distribution of countries of origin of recent immigrants to Windsor-Essex County for 1996. As of 1996, 12,035 recent immigrants were residing in the Windsor-Essex County area. The top countries of origin with the largest group of recent immigrants included Lebanon (9.7%), the United States (8.2%), and Mexico (7.7%).



Mother Tongue

According to the 1996 Census, 88% of residents of Windsor-Essex County were English speaking only, 10.2% were bilingual (both English and French), 0.2% were French speaking only, and 1.6% were allophones (spoke neither English or French). Mother tongue is described as the first language learned and still understood by an individual. **Figures 3 and 4** show the most commonly reported mother tongues, other than English and French, in both the city of Windsor and the County. Italian was the most commonly reported non-official mother tongue in Windsor, followed by Arabic and Chinese. In the County, German, Italian, and Portuguese were the most commonly reported non-official mother tongues.



Mother Tongues within the City of Windsor

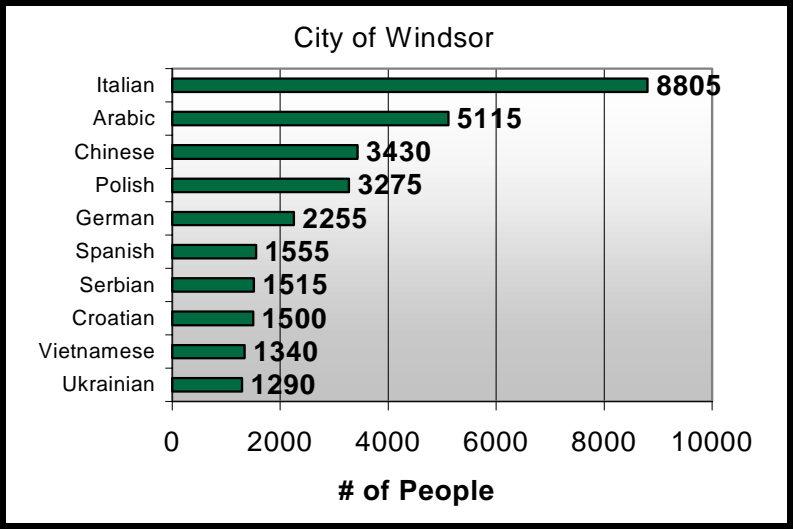


Figure 3: Distribution of Mother Tongue (single response/non-official languages) within the City of Windsor. Source: 1996 Census of Canada, Statistics Canada (1998).

Mother Tongues within the County of Essex (excluding Windsor)

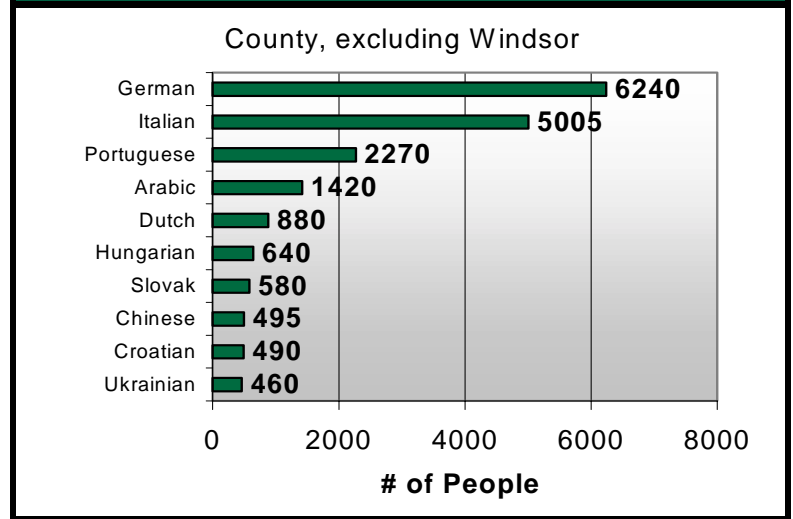


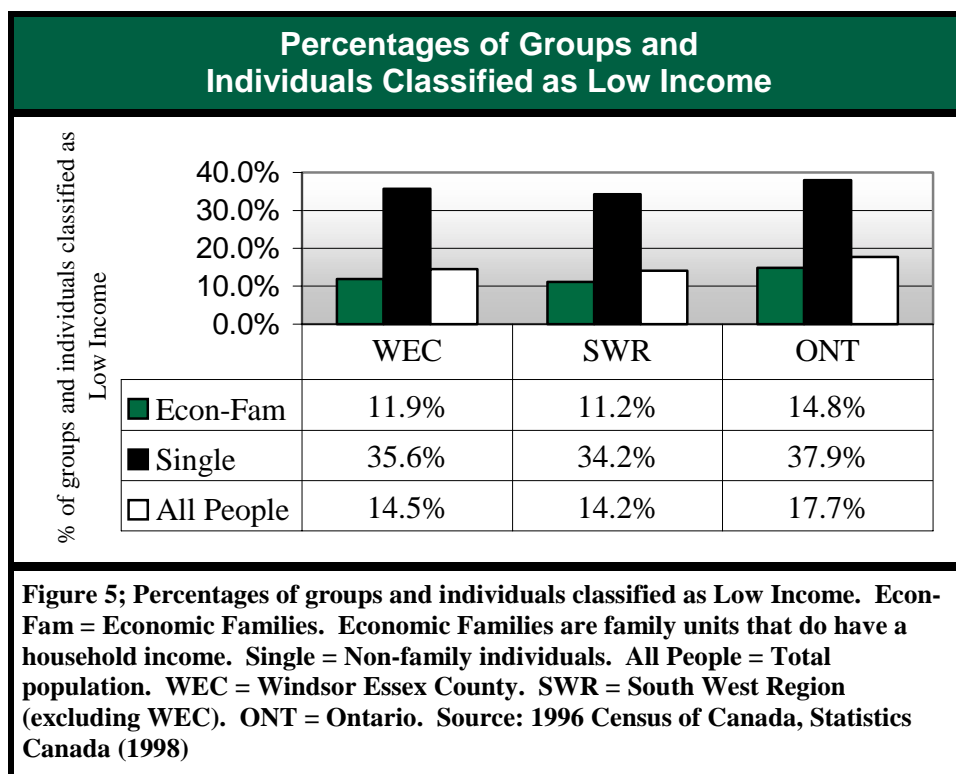
Figure 4: Distribution of Mother Tongue (single response/non-official languages) within the county of Essex (excluding Windsor). Source: 1996 Census of Canada, Statistics Canada (1998).

Employment

Employment is linked positively to good health. People who are unemployed are more likely to suffer more health problems and die earlier than people with jobs. As well, sick people are less likely to be employed. In 1996, the unemployment rate in Windsor-Essex County was lower than the provincial rate. Approximately 7.7% of people in Windsor-Essex County age 15 and over were unemployed as compared to 9.1% of people in all of Ontario.

Household Income

In Canada, individuals with low incomes are more likely to suffer more illness and die sooner than people with higher incomes. **Figure 5** shows the percentage of individuals with “low income”. “Low-income cut off” is defined by Statistics Canada in terms of levels for families based on the total family income, place of residence and number of members in the household. In Windsor-Essex County, 14.5% of the total population was classified as “low income” for 1996. This percentage was slightly lower than the 17.7% reported for Ontario. Across Ontario a much higher percentage of single individuals were classified as “low income” than were family units with income.



Access to Physicians

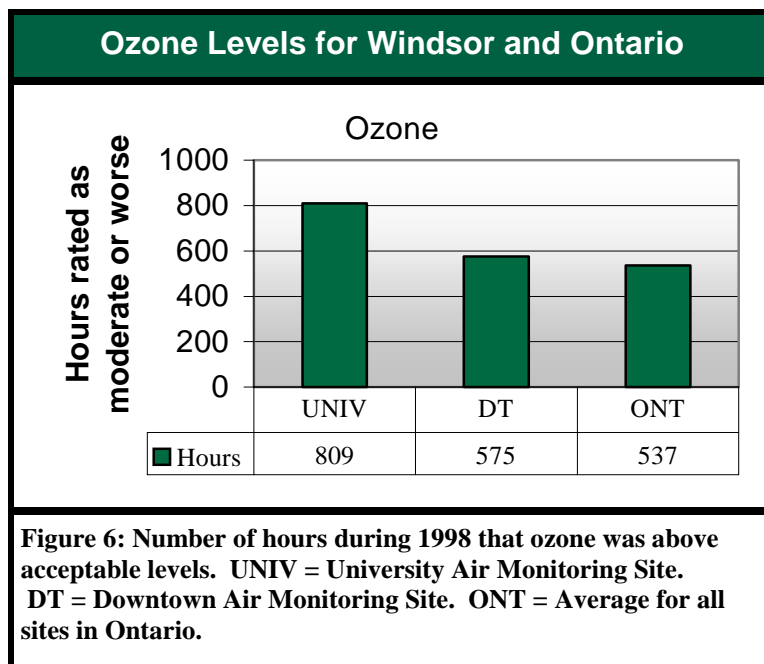
According to a recent report on physicians in Ontario, the number of general practitioners and family physicians (GP/FP) in this province has been steadily declining from approximately 100 GP/FP per 100,000 people in 1993 to approximately 85 GP/FP per 100,000 in 1998. The Essex-Kent-Lambton District was identified as one of the three most

under-serviced areas in the province along with the Niagara Region and Waterloo-Wellington-Dufferin Region. The number of general practitioners and family physicians in these districts ranges from 70 to 74.9 per 100,000.

Air Quality

The Ministry of the Environment monitors air quality hourly at two different locations in Windsor. Air quality is rated as either ‘Very Good’, ‘Good’, ‘Moderate’, ‘Poor’, or ‘Very Poor’. Ratings of ‘moderate’ or worse are deemed unacceptable by the Ministry. Among other contaminants, the Ministry measures levels of Ozone and Suspended particles. Ozone is a colourless gas and is a major component of smog. Ozone irritates the respiratory tract and eyes. Exposure to high levels results in chest tightness, coughing and wheezing. **Figure 6** shows the number of hours during 1998 that ozone levels were rated as ‘Moderate’ or worse. At the University air monitoring site there were 809 hours that ozone was above acceptable levels (‘Moderate’ or worse) and 575 at the downtown monitoring site. The average number of hours that ozone was above acceptable levels for the remaining 25 sites in the province was 537.

Suspended particles are tiny pieces of solid or liquid matter that are so small that they do not settle out of air or settle out in periods of hours or days. They include dust, aerosols, smoke, fumes and pollen. The smaller the particle, the greater the effect on health, because the particle is able to penetrate further into the lungs. Suspended particles can aggravate lung disease, asthma, bronchitis and other respiratory diseases. **Figure 7** shows the number of hours that suspended particles were rated as “Moderate” or worst. During 1998, this pollutant was above acceptable levels 11 hours at the downtown monitoring site and 0 hours at the University air monitoring site. The provincial average of suspended particles above acceptable levels was 3.8 hours at the remaining sites.



Levels of Suspended Particles in Windsor and Ontario

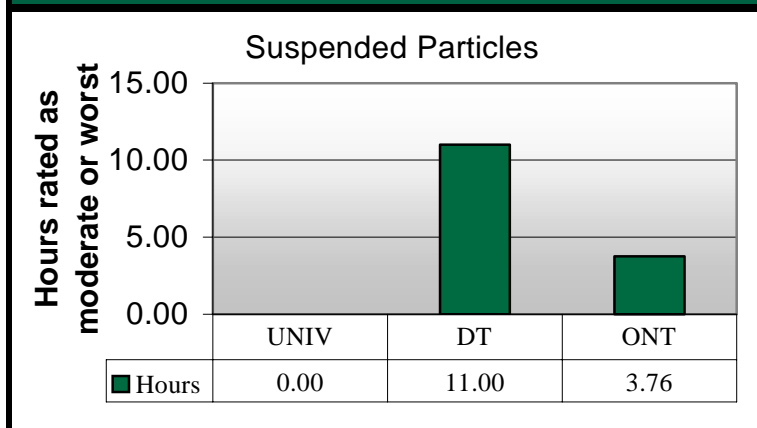


Figure 7: Number of hours during 1998 that suspended particles were above acceptable levels. UNIV = University Air Monitoring Site. DT = Downtown Air Monitoring Site. ONT = Average for all sites in Ontario.

Water Quality

The Drinking Water Surveillance Program of the Ministry of the Environment monitors eight municipal water works facilities in Windsor and Essex County. The Ministry reported that 15,484 samples were tested in Windsor and Essex County during 1998. Test results revealed that no health related standards were exceeded and that all eight facilities produced good quality water that was maintained in their distribution system. In comparison, there were 309,000 tests performed in Ontario on drinking water systems during 1998. Ninety-one test results showed substance levels above maximum health related standards in municipalities outside of Windsor and Essex County.

In August of 2000, a more comprehensive program for testing water sources was introduced in Ontario. This will enhance our efforts to provide more local information in the future.

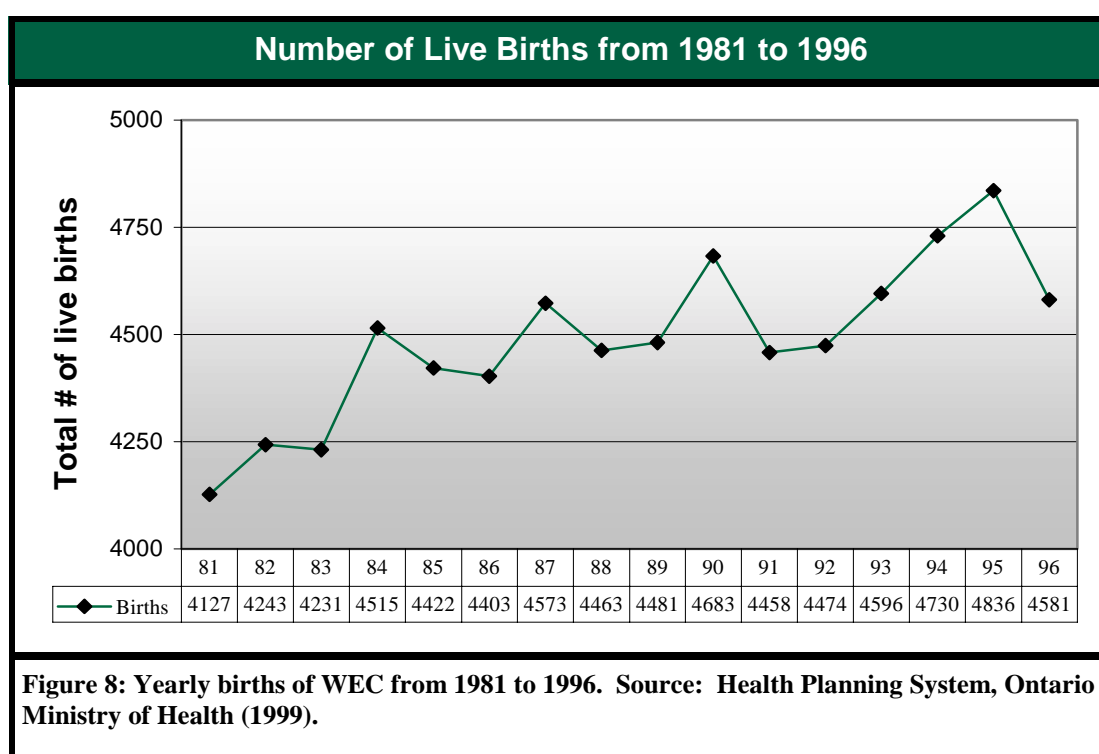
Assessing Our Health

Reproductive Health

Reproductive health is the ability of a population to produce healthy offspring who have the best chance of surviving and thriving in the future. This section focuses on some traditional indicators of reproductive health including birth rates, teen pregnancy rates and low birth weights.

Live Births

Figure 8 displays the total number of live births for Windsor-Essex County from 1981 to 1996. Since 1981, the number of live births has been steadily rising in the Windsor-Essex County. However, the birth rate in Windsor-Essex County has remained stable. The 1996 birth rate for WEC was 47.4/1000 women. The live birth rate across the province for women aged 15-49 has remained fairly stable throughout the 1990s.

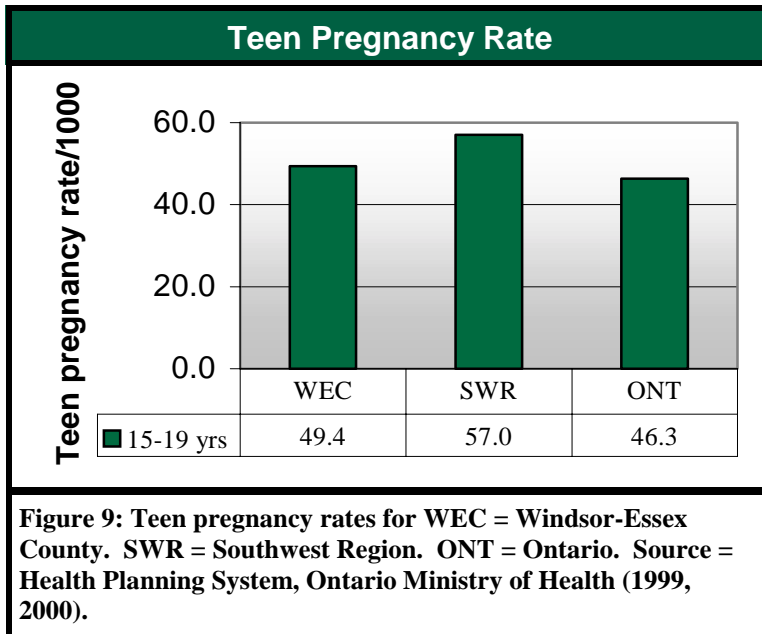


Teen Pregnancy Rates

Teen pregnancy is calculated using the total number of live and still births, and recorded abortions for all females 15 to 19 years of age. **Figure 9** displays the teen pregnancy rate. The 1996 teen pregnancy rate in Windsor-Essex County was 49.4 per 1000 females, age 15 to 19, not significantly different from Ontario as a whole (46.3 per 1000 females).

Did you know?

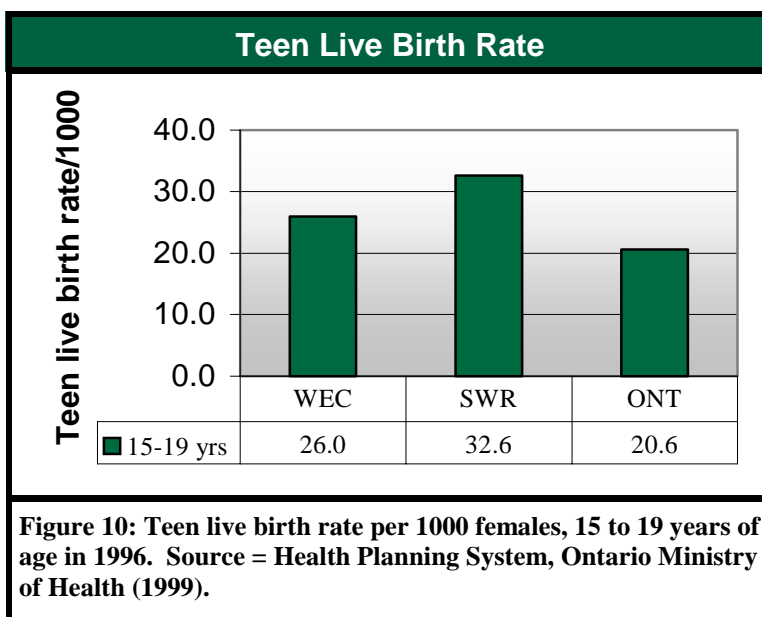
In an effort to reduce unwanted pregnancies and the risks associated with early parenthood, the Ontario government has set a goal of reducing the pregnancy rate of women age 15 to 19 to 40 per 1,000 by the year 2005.



According to the Report on the Health Status of the Residents of Ontario, the teenage pregnancy rate for all of Ontario has been increasing from 38.4 pregnancies/1,000 females in 1991 to 47.1 pregnancies per 1,000 females in 1995.

Teen Live Births

Teen live births refer to the number of births to mothers aged 15 to 19 years of age. In 1996, 303 infants were born to teenage mothers (15 to 19 year olds) in Windsor-Essex County. The live birth rate for teens in 1996 was 26.0 per 1000 females, age 15-19. This rate is 26% higher than Ontario's rate of 20.6 per 1000. (See figure 10).

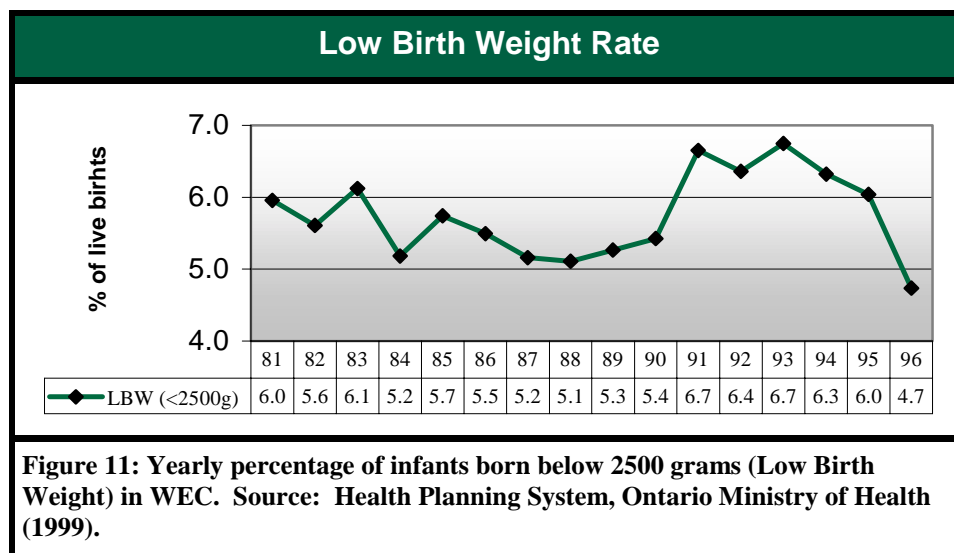


Low Birth Weight Rate

Low birth weight babies refer to babies born weighing less than 2500 grams (5 lbs). Low birth weight babies are at increased risk of death and complications and are more likely to develop health problems throughout their lives. Major risk factors for low birth weight include prematurity, maternal age, maternal smoking, poor prenatal care, socio-economic factors and poor maternal nutrition. **Figure 11** shows the percentage of low birth weight babies in Windsor-Essex County from 1981 to 1996. The percentage of low birth weight infants in Windsor-Essex County has remained relatively constant at 5.6% of all babies born each year. However, from 1993 to 1996, the percentage of low birth weight infants decreased. In 1996, 4.7% of babies born in Windsor-Essex County were low birth weight babies as compared to 6% of low birth babies across Ontario. Across Ontario, women aged 15-19 and those over age 35 had the highest rates of low birth weight.

Did you know?

The goal of the Ontario government is to reduce the low birth weight rate to 4% by the year 2010.



Leading Causes of Death

The leading causes of death discussed in this section are diseases that have commonly been termed “lifestyle” diseases because they are linked in part to our behaviours. While these diseases are influenced by many factors, the leading causes of death in communities across North America are associated with behaviours such as smoking, diet, physical activity, body weight and environmental exposures.

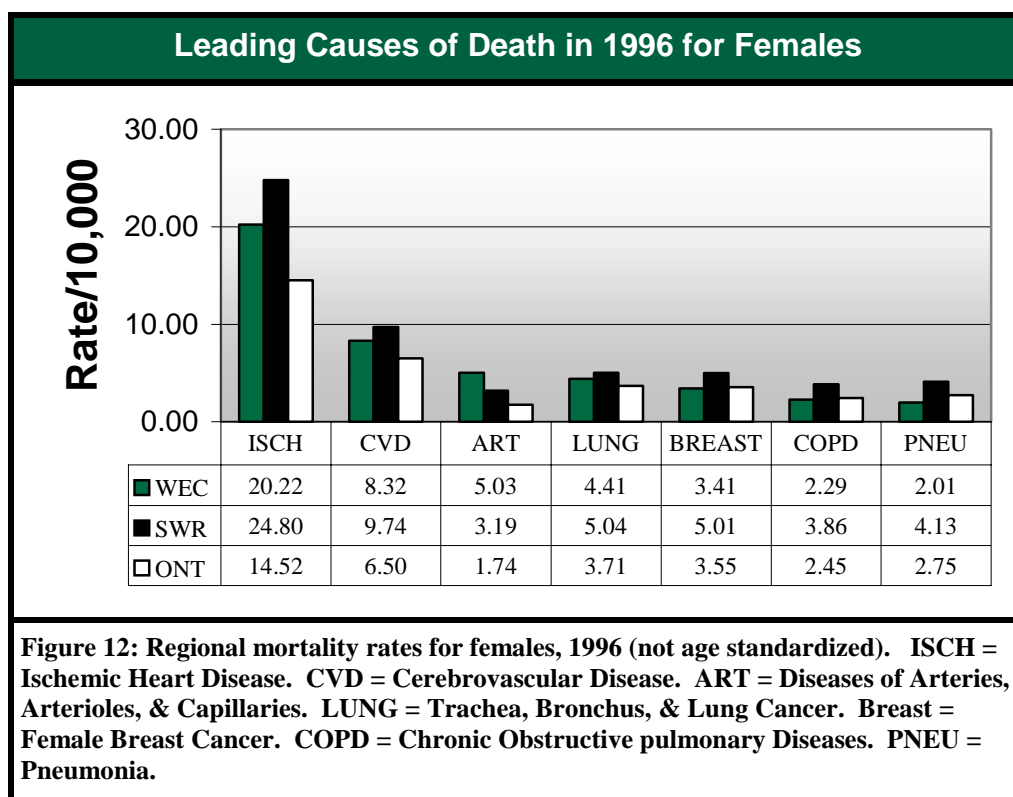
Females

Figures 12 & 13 show the leading causes of death for females and males in Windsor and Essex County, Southwest Region and Ontario. In 1996, the 3 leading causes of death in females were ischemic heart disease, cerebrovascular disease and diseases of the arteries,

arterioles and capillaries. In ischemic heart disease, the blood vessels to the heart become blocked and cannot carry enough blood to sustain the heart muscle. The resulting damage causes the heart muscle to die, commonly known as a heart attack. Cerebrovascular disease, commonly known as a stroke results when the blood vessels of the brain are either blocked or get weakened and rupture. Lack of blood flow to the brain results in death of brain cells.

In 1996, the mortality rate of ischemic heart disease was significantly higher for females living in Windsor-Essex County than Ontario as a whole. Windsor-Essex County's mortality rate due to ischemic heart disease for women was 29% higher than Ontario's rate.

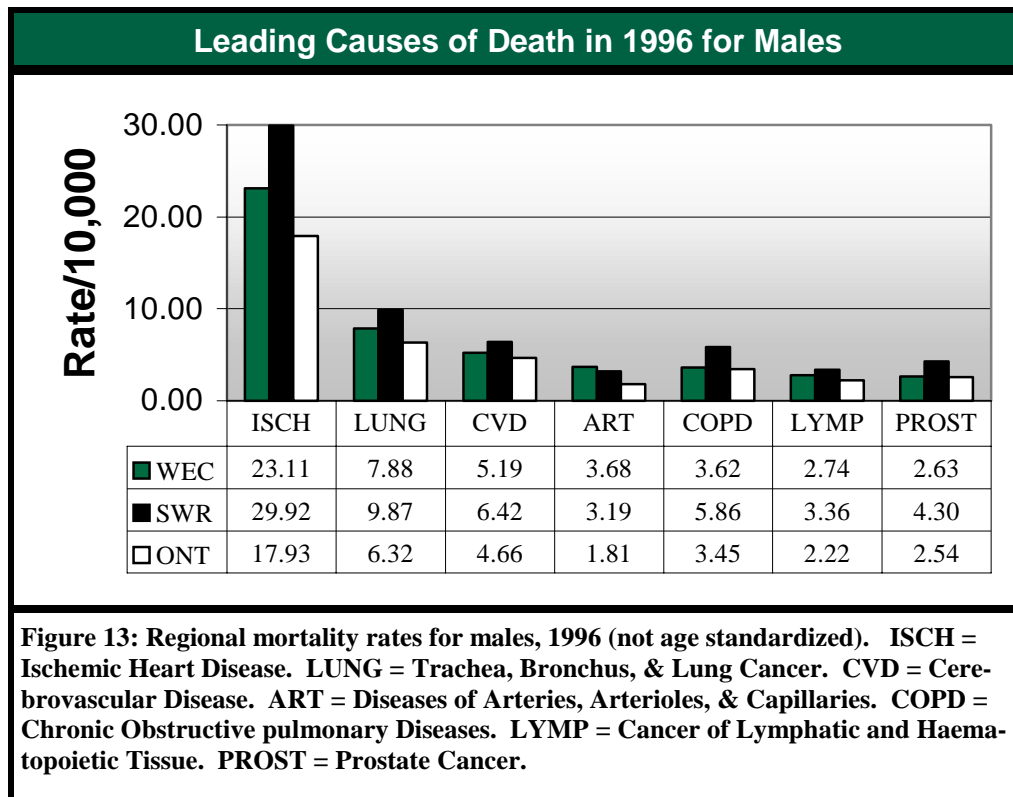
The percentage reported above is based on a standardized mortality ratio (SMR). The SMR is a ratio of the observed number of deaths divided by the expected number of deaths. Expected number of deaths is calculated by applying the age-specific mortality rates of all of Ontario to the WEC population. This method of comparing mortality rates between regions takes into account any differences in age distributions.



Males

For males, the 3 leading causes of death were ischemic heart disease, lung cancer and cerebrovascular disease (stroke). Lung cancer refers to cancer of the airways and tissues of the lung, bronchus and trachea. The male mortality rates for ischemic heart disease were

28% higher in Windsor Essex County than for all of Ontario. Similarly, the male mortality rates for lung cancer were 24% higher than for all of Ontario. These percentages were based on standardized mortality ratios comparing Windsor-Essex County to all of Ontario.



Did you know?

The goal of the Ontario government is to reduce deaths from ischemic heart disease by 25% and to reduce deaths from stroke by 10% by the year 2010.

Hospitalization

Figures 14 and 15 provide information about the leading causes of hospitalization for females and males in Windsor-Essex County, 1998. A hospital separation is defined as discharge from hospital due to death, return to home, transfer to another facility, or patients signing themselves out. Females in Windsor-Essex County were hospitalized most often for complications of pregnancy (23%), followed by respiratory diseases (20%). Males in Windsor-Essex County were hospitalized most often for respiratory diseases (31%) and circulatory diseases (19%).

Hospital Separations for Women, 1998

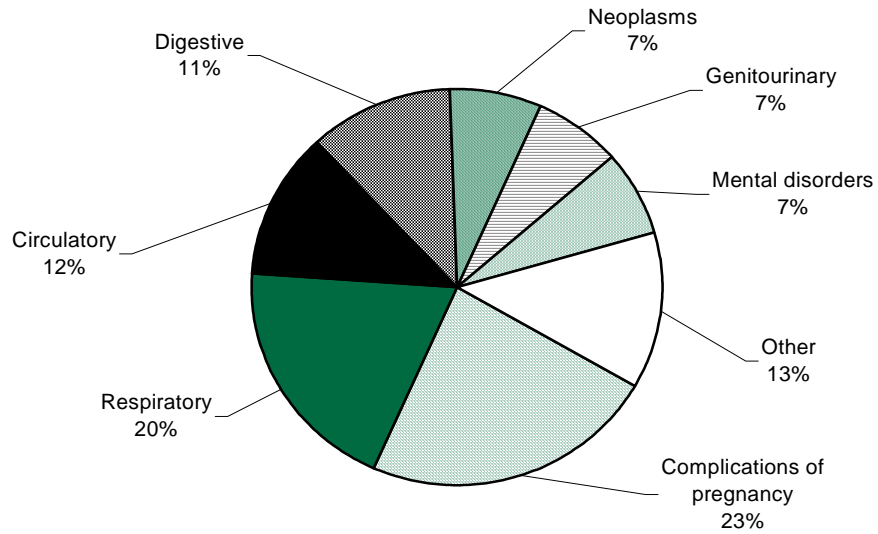


Figure 14: Distribution of types of hospital separations for women, 1998.

Hospital Separations for Men, 1998

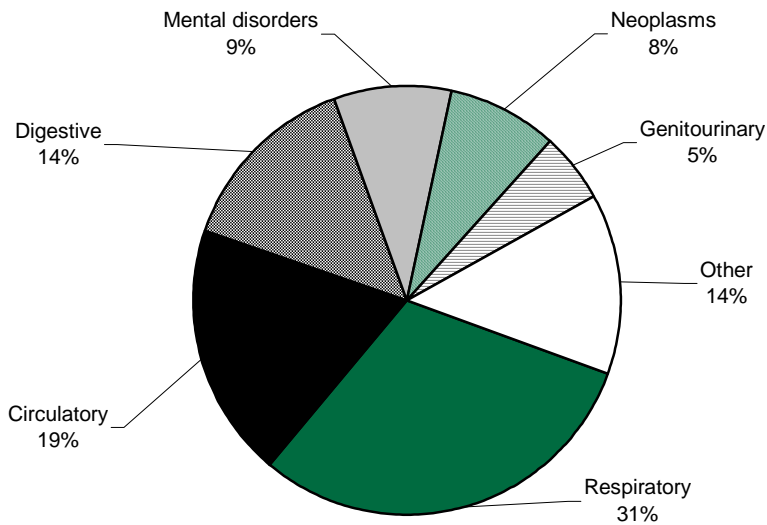


Figure 15: Distribution of types of hospital separations for men, 1998.



Suicide and Mental Health

Suicide has been defined as the act of deliberate, self-inflicted injury of oneself with the intention ending one's life. It is extremely difficult to determine the incidence of suicide in a population as the suicide mortality rate provides only an estimate of completed suicides. Suicides are under-reported due to social, cultural, religious and financial influences. It is also difficult to determine the intent of the deceased in a suicide.

In 1996, the leading cause of injury and poisoning deaths in Windsor Essex County was due to suicide (16/100,000 individuals). Males living in Windsor Essex County experienced a mortality rate due to suicide that was 66% higher than all of Ontario. Suicide was the second leading cause of premature deaths in males in Ontario. In 1998, males were hospitalized in Windsor Essex County for suicide attempts at a rate 54% higher than Ontario as a whole. Females were hospitalized at a rate 20% higher than Ontario for suicide attempts.

Suicide rates provide a standardized measurement of population mental health. Mental illnesses are chronic diseases that frequently cause disability, yet few, other than suicide, cause death. Measuring the true scope of mental health is a challenge. It is important to differentiate between mental health and mental illness as health is more than simply the absence of disease. Both mental health and illness are linked to other components of health including substance use and violence. In fact, mental illness can influence the development of these health problems. The causal relationship is difficult to untangle. In relation to the determinants of health, mental health has been linked to poverty and poor living conditions.

Unintentional Injuries

Although injuries are often classified as "accidents" many injuries are preventable. Unintentional injuries in this section refer to incidents such as motor vehicle crashes, falls and drownings. In 1996, the two leading types of unintentional injuries resulting in death in Windsor-Essex County were motor vehicle traffic accidents (10/100,000 population), and accidental falls (8.3 /100,000 population). In Windsor-Essex County, motor vehicle accidents were the third leading cause of premature death in females in 1996.

In 1998, accidental falls were the leading cause of hospitalizations due to unintentional injury in Windsor-Essex County. However, the rates of hospitalizations due to falls for both males and females were lower than Ontario as a whole. Females in Windsor-Essex County were hospitalized at a rate 25% higher than Ontario for motor vehicle traffic accidents.

Across the province, mortality and hospital separation rates from injury have been falling in most regions for nearly all conditions (intentional and unintentional) perhaps due in part to prevention efforts such as promotion of seatbelt use or reduction of drunk driving across the province.

Did you know?

The goal of the Ontario government is to reduce injury rates due to motor vehicle crashes by 20% and to reduce the rate of all fall related injuries in the elderly by 20% by the year 2010.

Our Behaviour: Impact on Health

In this section we have highlighted the findings of some behaviours that impact on our health – smoking, drinking, physical activity, sexual activity, in addition to some general preventative practices. The relationships between behaviours and health are complex and influenced in large part by our social environment. Successfully modifying these behaviours requires a focus on promoting healthy individual choices, advocating policies that will make such choices easy and creating environments that support them.

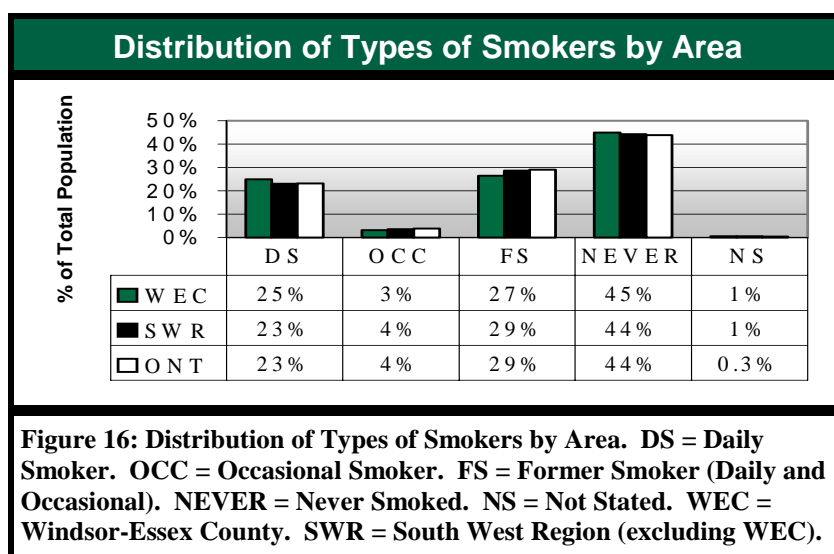
Smoking

Smoking is the leading cause of preventable death in Canada. It is implicated in deaths for lung cancer, ischemic heart disease, chronic lung disease and other cancers. Recent studies also indicate that smoking is a major preventable factor associated with disability.

Smoking behaviour appears to be similar across Ontario. In 1996, about one-quarter of the population in Windsor Essex County, Southwest Region, and Ontario were daily smokers (see figure 16). A slightly higher percentage of the population (27% – 29%), were former smokers. Forty-five percent had never smoked. These findings were also very similar between males and females. According to the Report on the Health Status of the residents of Ontario, persons with lower income and lower education were more likely to report smoking on a regular basis.

Did you know?

The goal of the Ontario government is to reduce the percentage of adult daily smokers to 15% by the year 2005.



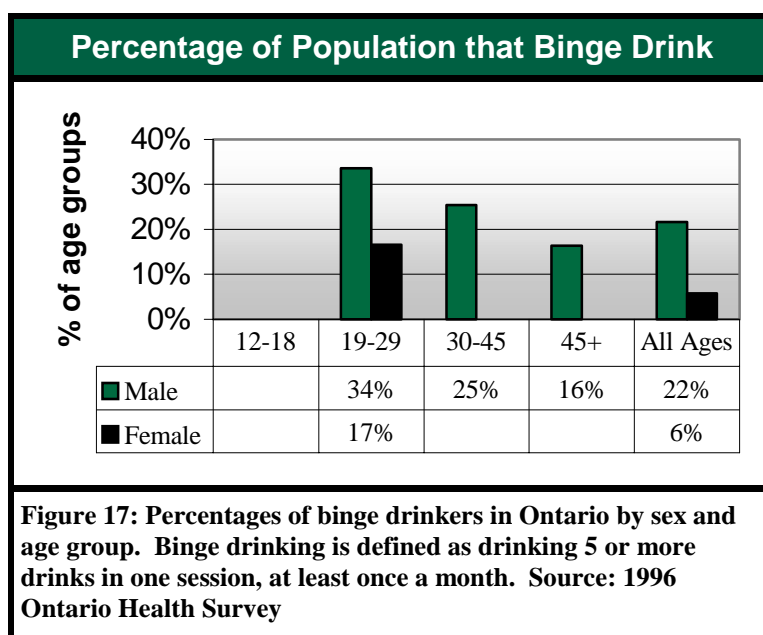
Alcohol Consumption

Alcohol is a commonly used drug that can have either an immediate impact on health through “binge” drinking and injuries from drinking and driving, or long-term effects through chronic conditions such as liver disease.

In 1996, 52.1% of the population in Windsor Essex County were regular drinkers (drinks at least once a month). About 11%-13% of the population in Windsor-Essex County, the Southwest Region, and Ontario were binge drinkers (see figure 17). Binge drinking is defined as drinking 5 or more drinks in one session, at least once a month. Binge drinking is the pattern of drinking most associated with injury. In Ontario, 22% of the male population were binge drinkers. While the highest proportion of male binge drinking occurred in the age group 19 to 29 (34%), this behaviour also continued into later years.

Did you Know?

The goal of the Ontario Government is to reduce the percentage of adults who drink more than two drinks per day by 20% by the year 2010.



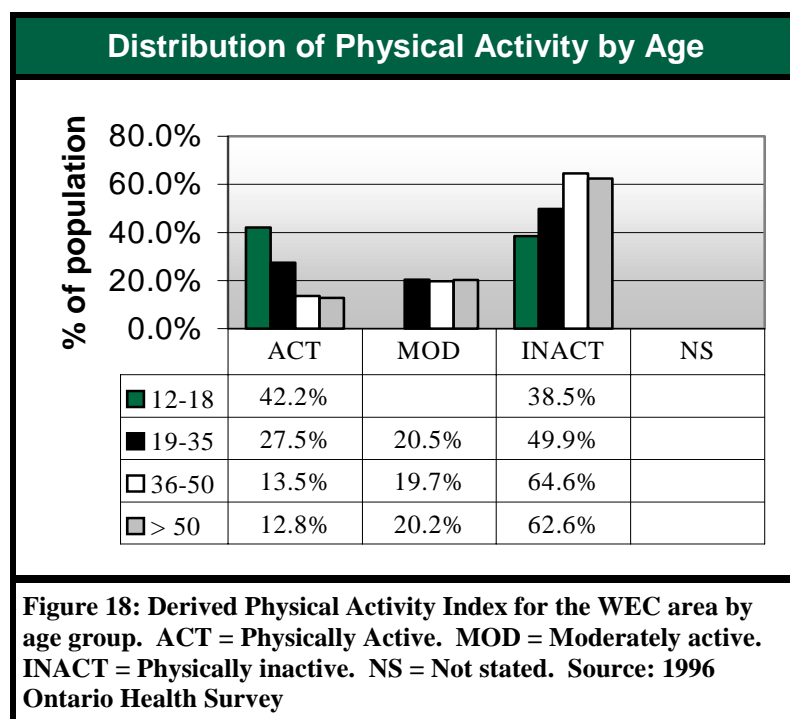
In 1996, the percentage of male drivers that admitted to drinking and driving in the past year was 10.5% in Windsor-Essex County as compared to 11.3% in the Southwest Region, and 9.5% in Ontario. Across the province, the rates of drinking and driving were associated with increased levels of income and education.

Physical Activity

Physical activity contributes to the improvement of physical and emotional health. Regular, moderate physical activity has been linked to the prevention of several diseases including ischemic heart disease and osteoporosis in women. There is a growing body of evidence that increasing the regular physical activity of a population could reduce rates of heart disease to the same extent as smoking prevention.

Intensity of physical activity is measured by a physical activity index that is based on the type and duration of exercise, which is reported as energy expenditure. In 1996, most men (52.6%) and women (60.5%) in Windsor-Essex County were in the inactive category. Inactive was defined as expending below 1.5 kcal/kg/day.

Figure 18 displays levels of physical activity by age group for Windsor-Essex County, 1996. Teens (12- 18 years) were more likely than the rest of the population to be active (expending 3.0kcal/kg/day) but 38.5% were considered inactive. Among all other age groups, inactive adults comprised the majority of the population. Adults, age 36 to 50, had the highest rate of inactivity (64.6%). This may be a reflection of the busy home and work responsibilities demonstrated by this age group. However this level of inactivity was also carried into the later years (62.6% of adults over 50).

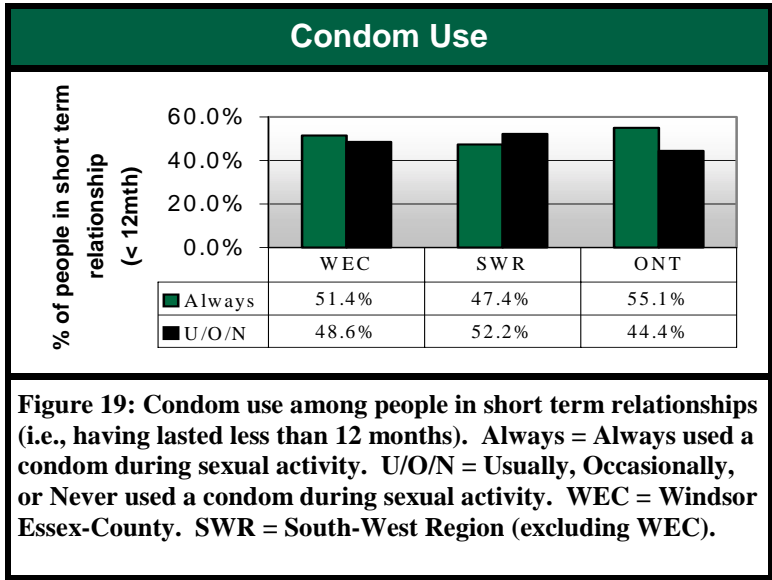


Did you know?

The goal of the Ontario government is to increase the percentage of adults who do moderate physical activity for at least 30 minutes a day to 40%, and to increase the percentage of youths to 60% by the year 2010.

Sexual Health

Early sexual activity, multiple partners and unprotected sex are behaviours associated with negative outcomes such as sexually transmitted diseases, unwanted pregnancies and in some cases the risk of developing cancer. The 1996/97 Ontario Health Survey asked questions about sexual activity, and on the use of condoms to prevent the transmission of sexually transmitted diseases. **Figure 19** displays condom use among people in short-term relationships. Among those who were considered to be in a relationship lasting less than 12 months, 51.4% in Windsor-Essex County reported they always used a condom. This percentage was slightly lower for the Southwest Region (47.4%) and higher for Ontario overall (55.1%). This means a high percentage of the population in short-term relationships are placing themselves and others at risk for sexually transmitted diseases.



General Preventative Practices

Table 1 displays a list of general preventative practices of males and females in Windsor-Essex County, 1996. Visiting a dentist was the most common preventative practice among males and females. Although most people had visited a dentist, less people had visited a dentist within the last year. Significantly more females than males reported having physical examinations on an annual basis.

For females, about 83% reported having had a PAP smear. However only 45.7% of women reported having a PAP smear within the last year. About 72% of females, age 35 years and older, had mammograms.

Table 1: General Preventative Practices

	Males	Females
Mammograms (35 years+)		72.1%
Professional Breast Exams (18 years+)		69.9%
Ever had a PAP smear		82.9%
Had a physical check-up (without a specific health problem)	67.2%	68.9%
Gets physicals at least annually	40.8%	57.3%
Ever visited a dentist	95.0%	97.2%
Visited dentist within last year	64.4%	69.3%

Did you know?

The goal of the Ontario government is to increase the percentage of women 50-69 years receiving mammograms to 70%, and to increase the percentage of women getting regular PAP smears to 85%, and at least one PAP smear to 95% by the year 2010.



Building a Healthy Community

The information contained in this report provides a snap shot of how healthy we are in Windsor-Essex County. We release this report as a catalyst for new ideas and partnerships. We encourage the whole community, including community groups, health and social service agencies, politicians, planners and residents to use this report as a tool for future planning and action.

The report challenges us to broaden our understanding of what makes and keeps people healthy. There is growing evidence that factors outside the health sector significantly affect health. Taking action on many of the health issues highlighted in this report will require a community effort to address the complex factors that determine health.

A Population Health Approach

Population health is an approach to health that aims to improve the health status of the population by addressing the determinants of health. The focus of this approach is reducing health inequities among population groups. Taking action will mean paying close attention to how factors such as income, education, employment, social and physical environments personal health practices, healthy child development and health services influence our health. The success of this approach will depend on the extent to which we:

- 1. Invest Upstream:** We must continue to invest our efforts in actions that have the greatest potential to influence the health of our community. The earlier in the causal stream that action is taken, the greater the potential for population health gains.
- 2. Make decisions based on evidence:** Quantitative and qualitative evidence on the determinants of health should be used to identify priorities and strategies to improve health.
- 3. Use multiple strategies:** A variety of strategies and settings should be used to act on the determinants of health in partnership with sectors outside the traditional health sector.
- 4. Collaborate across levels and sectors:** Population health calls for a shared responsibility and accountability for health outcomes.
- 5. Are able to engage citizens:** The success of a population health approach will depend on the degree to which members of our community have meaningful input into the development of health priorities, strategies and the review of outcomes.
- 6. Increase accountability for health outcomes:** As a community we will need to increase the focus on health outcomes and on determining the degree of change that can be linked to an intervention.

For More Information

In addition to this community health profile summary report, we have produced a larger, technical report that includes a more comprehensive collection of community health indicators. The technical report also displays more detail for each indicator. If you have any questions about the information included in this community health profile summary report or would like a copy of the full technical report, please contact the Health Unit.

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