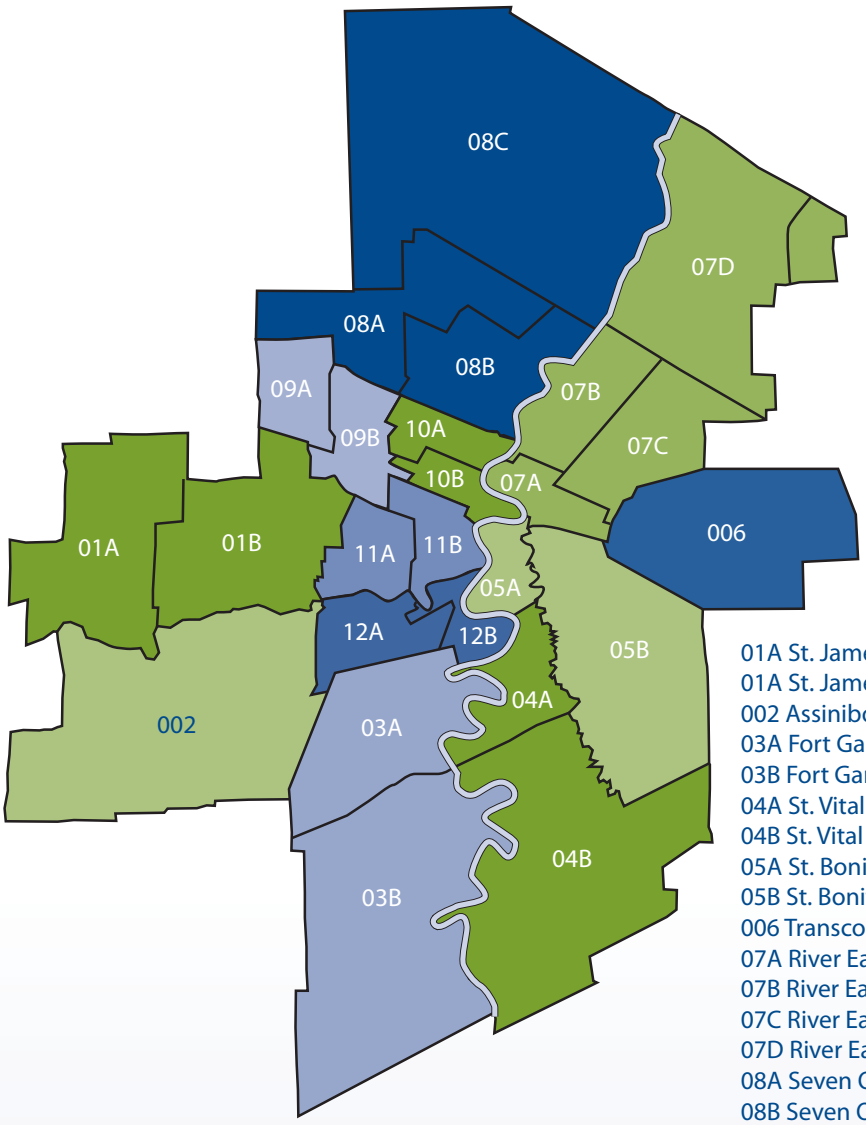
Winnipeg Regional Health Authority

COMMUNITY HEALTH ASSESSMENT 2009 2010

Winnipeg Regional Health Authority
Caring for Health
Office régional de la santé de Winnipeg
À l'écoute de notre santé

Winnipeg Geography & Population

Neighbourhood Clusters



01A St. James-Assiniboia West
01A St. James-Assiniboia East
002 Assiniboine South
03A Fort Garry North
03B Fort Garry South
04A St. Vital North
04B St. Vital South
05A St. Boniface West
05B St. Boniface East
006 Transcona
07A River East South
07B River East West
07C River East East
07D River East North
08A Seven Oaks West
08B Seven Oaks East
08C Seven Oaks North
09A Inkster West
09B Inkster East
10A Point Douglas North
10B Point Douglas South
11A Downtown West
11B Downtown East
12A River Heights West
12B River Heights East

Winnipeg Health Region (WHR)

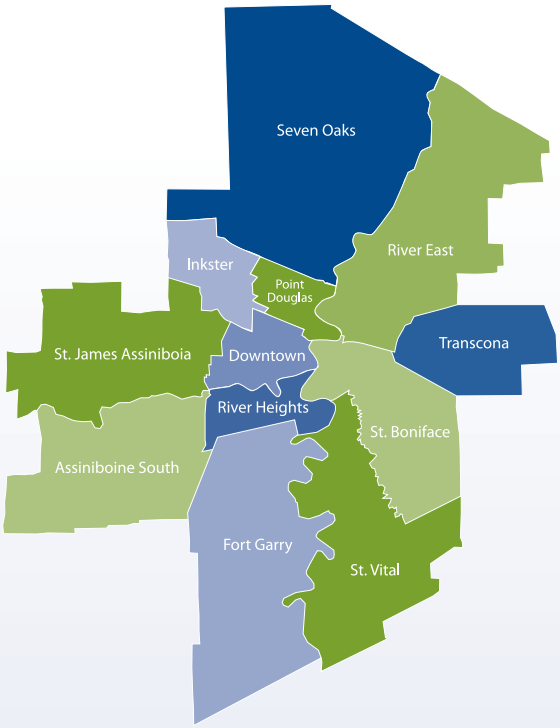
Population by Community Areas

	Population (Census)		
	1996	2001	2006
Fort Garry	59866	62388	66399
Assiniboine South	36149	36869	36740
St. Boniface	45345	47359	51802
St. Vital	60769	60526	61997
Transcona	33574	33097	33233
River Heights	57513	56384	55688
River East	90557	92391	93041
Seven Oaks	57088	57804	60593
St. James - Assiniboia	60833	59543	58478
Inkster	31372	31275	31953
Downtown	74406	75645	75217
Point Douglas	41230	40447	41897
Winnipeg HR	648702	653728	667038

MAP OF WHR'S COMMUNITY AREAS AND NEIGHBORHOOD CLUSTERS

The Community Health Assessment 2009/2010 reports on 107 indicators of the region's health status, determinants of health and well-being, health system performance and demographics. Most of the indicators are reported by Community Area (12 in total) and charted by Neighborhood Cluster (25 in total).

Winnipeg Health Region: Community Areas



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Message from Arlene Wilgosh

President & Chief Executive Officer
Winnipeg Regional Health Authority

The Community Health Assessment serves as an important information resource for the many organizations and programs associated with health, wellness and community development. It plays a key role in helping us engage with the public in a shared effort to improve the health for everyone in the Winnipeg Health Region.

The Winnipeg Regional Health Authority has taken much care in preparing this report. It provides a snapshot in time of where we need to go. Our community facilitators, as well as numerous community stakeholders, use this information as part of their ongoing public engagement and community development activities. By sharing and using this information, they are better able to determine strategies and priorities aimed at building stronger communities.

As we move forward, we will be actively soliciting community input from community stakeholders who share our commitment to ensuring that our priorities are based on sound analysis, constructive feedback and open dialogue.

The conversation starts here.

Assessing the Health of our Community

A message from the Medical Officers of Health

Assessing the health of a community is a fundamental part of improving health. It is the way we gather "diagnostic" information about our population to be able to make an informed "treatment plan" to improve population health - in a similar way a physician would for an individual. This Community Health Assessment report is part of an ongoing process of population health assessment. It contributes to our understanding of our strengths and challenges assisting to inform solutions and directions. However, it is not an answer book. By itself, it cannot tell us how to set priorities or where to focus our attention. Rather, it is a starting point, like a pencil sketch outline, from which we can invite community conversations and identify issues that need further exploration to fill in more of the picture.

Overall, people in Winnipeg enjoy good health.

So what are some of the things this report does tell us? Overall, people in Winnipeg enjoy good health. Life expectancy continues to increase, heart disease mortality is declining, and the incidence of cancer is trending downward. We have more types of vaccines to prevent serious infections and the majority of people living in the Winnipeg Health Region (WHR) describe their health as good, very good or excellent.

However there are some concerning findings as well. Our premature mortality rate (an indicator of early death) is not decreasing, and our life expectancy is below the national average. The number of people being treated for diabetes is increasing at a rapid pace and having diabetes increases the risk of other chronic diseases. Many people are experiencing mental health problems, and injury deaths, including suicide, are not decreasing even though many are preventable. Rates of sexually transmitted infections (STIs) among our youth and young adults are high. Most people in the WHR do not get the optimum amount of physical activity, more adults have a Body Mass Index (BMI) in the overweight or obese range than the normal range, a very low proportion of people eat the recommended amount of fruits and vegetables, our smoking rates are above the national average, and a concerning number of pregnant mothers smoke. Childhood immunization rates are stable or decreasing despite the increase in protective vaccines available.

Most concerning of all are the differences in health and risk factors across our community. Significant gaps between the health of those living in more affluent areas of our city and those living in lower income areas are evident in most indicators. Poverty underlies these unacceptable disparities in health and threatens the health and wellbeing of many, particularly our children. In some areas of Winnipeg parents face challenges that put their children's health at risk at rates up to five times that of parents in other areas.

Significant gaps between the health of those living in more affluent areas of our city and those living in lower income areas are evident in most indicators.

These findings resonate with what we already know about health in the WHR. Compared to other Canadian cities, Winnipeg has been found to have much wider gaps in health status between affluent and less affluent areas. Related to the impact of poverty, housing problems and a variety of social and behavioral risk factors, tuberculosis (TB) is a continuing health threat in Winnipeg, and STIs, including HIV, continue to spread. Many of our citizens who face the highest risks to their health also face the most barriers in accessing preventive and health care services. Those who experience barriers due to language, culture or low income, persons experiencing homelessness, people living with mental health issues (including addictions), and newcomers (settling in increasing numbers) are among those facing higher risks of injury, infections, mental health problems and chronic diseases.

All children should have the chance to grow to their full potential in health and achievement, and this is not presently the case for all children in Winnipeg. The early years of childhood are becoming increasingly recognized as having profound influence on the long-term health and development of individuals. That many Winnipeg children lack optimum conditions to flourish - such as safe environments, adequate housing, protection from hazards, and food security - is not acceptable.

How we design and use our buildings, roads, transit system, cycling routes, housing and public places affects our level of physical activity, body weights, stress, mental health and community cohesion.

There are newer threats to keep our eyes on as well. Environmental issues are fundamental to health. The relationship between our natural physical environment and health has been well recognized, but recently, the impact of our man-made "built" environment is receiving more attention. How we design and use our buildings, roads, transit system, cycling routes, housing and public places affects our level of physical activity, body weights, stress, mental health and community cohesion. Due to climate change and other factors, public health emergencies and disasters, including severe weather events, are increasingly common. With world travel being very accessible, diseases can spread around the world faster than ever before. Outbreaks, such as influenza pandemics, will continue to occur.

So where do we go from here? We need to continue to assess the health of our population. That includes listening to stakeholders and community members, so that lived experience can add to the picture. It also means identifying key areas that require further in-depth reports and research. These are all next steps in the ongoing health assessment process. But in the meantime, we also need to act now to improve health.

We need to continue to assess the health of our population...and we need to act now to improve health across the WHR.

An increasing focus on addressing poverty in Winnipeg is already underway and more momentum is needed. Additional efforts towards supporting families and children, particularly during the formative early years, are critical to improving the health of the next generation. We need to recognize how our social and environmental norms are herding us towards increasingly sedentary lives even during childhood, with the associated chronic disease risks that follow. Reclaiming cooking healthy food and eating together as a family is also urgently needed. Mental health and well-being need to be prioritized as foundational elements of health. And we all need to share in creating solutions to improve our own health – ranging from individual and family lifestyle decisions, to local community efforts, to corporate and policy action that can create healthier living conditions.

We have identified many challenges to health in the Winnipeg Health Region. But Winnipeg has many strengths with which to address these challenges. We have a sense of community belonging and a tradition of helping each other. We value diversity and inclusiveness, and celebrate our heritage. We care about our children. Winnipeg is a large enough urban centre to have significant expertise from many sectors, but yet is small enough to foster familiarity and collaboration. It is within our grasp, if we collectively put sufficient will, effort and strategy to bear, to considerably improve health in the Winnipeg Health Region overall, and close the health disparity gap.

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Community Health Assessment AT A GLANCE (Selected Indicators) by Community Area, Winnipeg RHA and Manitoba Overall

Selected Indicators	Data Years	Fort Garry	Assiniboine South	St. Boniface	St. Vital	Transcona	River Heights	River East	Seven Oaks	St. James-Assiniboia	Inkster	Downtown	Point Douglas	Winnipeg RHA	Manitoba OVERALL
Health Status (page 27)															
Life Expectancy (Female) in years	2001-2005	84.1	82.3	83.5	83.3	82.4	82.8	82.2	81.5	81.4	81.8	79.6	75.7	81.8	81.5
Life Expectancy (Male) in years	2001-2005	79.8	79.4	78.8	78.7	77.5	77.6	77.7	77.0	77.4	76.4	72.1	71.5	76.9	76.3
Premature Mortality Per 1000 residents	2001-2005	2.38	2.33	2.71	2.66	2.82	3.01	2.94	3.17	3.10	3.35	4.92	5.52	3.19	3.29
Infant Mortality Rate/1000 live births	2001-2005	3.4	4.9	5.5	2.6	4.0	3.9	4.2	4.2	3.0	6.6	7.2	9.5	5.0	5.3
Health Status: rated Excellent (%)	2001/03/05	25.1	29.7	23.6	20.1	25.5	29.2	20.6	22.8	21.6	29.3	22.7	18.2	23.3	21.9
Physical Functioning Less than perfect (%)	39 14/51	35.9	42.0	43.1	43.9	47.9	39.5	46.3	43.1	49.8	44.7	46.0	45.8	44.0	44.4
Mental Health % reporting a low score	39 14/51	26.5	18.8	23.4	24.7	29.1	25.9	27.6	19.4	23.7	30.6	31.0	40.5	26.7	25.4
Early Childhood & Maternal Health (page 48)															
Teen Birth Rate per 1000 aged 15-19	FY2 2001-05	7.55	6.66	12.55	12.26	12.22	15.27	19.54	14.56	16.03	35.64	58.15	79.80	24.03	30.13
Pre-term Births % live births < 37 weeks	FY 2001-05	7.0	8.3	8.2	6.7	9.2	7.4	7.1	7.3	7.2	8.3	10.0	9.4	8.0	7.7
Maternal Alcohol Use % Families 1st Screen	2003-2006	4.0	9.5	16.7	9.9	13.4	3.1	10.4	8.7	5.5	20.8	16.0	22.3	11.8	12.9
Maternal Smoking % Families 1st Screen	2003-2006	7.4	10.7	13.1	13.4	19.1	10.6	22.0	15.8	13.4	29.3	31.4	46.4	20.7	21.0
Financial difficulties % Families 1st Screen	2003-2006	8.3	7.9	9.8	10.5	9.6	8.1	17.5	12.0	9.8	27.0	40.0	49.2	19.5	17.7
Mothers < Gr 12 Ed % Families 1st Screen	2003-2006	4.5	6.8	7.7	7.9	10.0	5.7	17.4	12.4	9.9	28.2	36.8	48.8	18.1	21.6
Chronic Diseases (page 70)															
Diabetes[3, 4] % residents aged 19+	FY 2003-06	7.0	5.9	7.3	7.2	8.6	6.7	7.7	9.3	7.4	10.7	10.3	11.3	8.2	8.7
Hypertension[3] % residents aged 19+	FY 2005	21.9	21.3	22.2	22.3	24.0	21.7	22.9	24.7	22.9	26.1	23.3	24.8	22.9	23.7
Stroke Incidence[3] Per 1000 aged 40+	FY 2001-05	2.95	2.44	2.08	2.28	2.95	2.53	3.16	2.76	3.00	2.57	2.88	2.99	2.79	3.05
Arthritis[3] % residents aged 19+	FY 2004-05	18.0	20.4	18.6	19.5	19.7	19.4	18.8	20.0	19.9	19.6	22.4	24.9	19.9	20.2
Asthma in Children[3] % aged 5-19	FY 2004-05	17.5	15.3	14.6	15.1	14.6	16.6	16.0	18.5	15.8	19.0	15.8	18.0	16.4	13.9

[1] From Canadian Community Health Survey (CCHS); multiple years of data combined. 2 FY=fiscal year (e.g., 2001-02=01 Apr 2001-31 Mar 2002) 3 Definition is based on treatment prevalence, i.e., chronic disease estimates (with the exception of cancer) are based on who gets treatment for the disease not those who have the disease. 4 Proportion (%) is based on total cases found over a 5-year period. 5 Mood disorders includes the constellation of disorders associated with depression and the use of antidepressants/mood stabilizer prescription drugs.

Selected Indicators	Data Years	Fort Garry	Assiniboine South	St. Boniface	St. Vital	Transcona	River Heights	River East	Seven Oaks	St. James-Assiniboia	Inkster	Downtown	Point Douglas	Winnipeg RHA	Manitoba OVERALL
Mental Health (page 97)															
Mood Disorders[3, 4] % residents aged 10+	FY 2001-05	17.0	20.6	19.9	19.4	20.2	22.2	19.9	19.9	20.8	15.8	20.3	22.5	20.3	19.1
Schizophrenia[3, 4] % residents aged 10+	FY 2001-05	0.7	0.7	1.1	0.8	0.7	1.4	1.0	0.9	1.0	0.9	2.7	1.9	1.2	1.1
Teenager Use of SSRI Antidepressants	FY 2005	14.9	22.3	17.3	14.9	14.5	24.3	15.8	13.5	17.5	9.0	13.4	12.2	15.5	14.5
Injuries (page 116)															
Injury Hospitalization 5/10,000 (aged 0-19)	FY 2001-05	20.9	28.1	23.4	27.0	23.1	27.6	28.9	30.7	28.2	35.4	59.8	64.4	33.2	57.8
Suicide Rates per 100,000 (aged 10+)	FY 2001-05	5.0	5.5	12.5	10.1	11.0	13.6	14.6	14.0	13.8	17.2	31.9	27.6	15.0	16.3
Preventive Health Interventions (page 128)															
Adult Influenza Immun-zation (% aged 65+)	FY 2005	69.2	72.3	68.2	70.9	69.4	67.6	68.9	67.8	73.5	59.2	61.3	61.6	67.9	66.4
Childhood Immunization % 2-year olds	2002-04	74.7	77.1	79.6	79.2	75.7	74.7	75.7	77.8	74.8	69.4	64.4	58.5	73.0	69.6
Cervical Cancer Screen % women aged 18-69	FY 2003-05	77.5	77.4	77.3	78.3	77.7	75.7	73.4	71.3	76.2	64.6	61.8	61.3	73.2	69.2
Breast Cancer Screen % women aged 50-69	FY 2004-05	65.7	68.1	64.8	64.2	61.5	63.5	60.9	59.6	65.9	51.2	45.8	43.6	60.7	61.7
Health Risk Factors (page 147)															
Smoking (current) % CCHS respondents	2001/03/051	11.3	14.8	21.9	19.5	27.4	21.2	24.6	19.1	27.1	22.5	26.1	32.6	22.1	22.7
Second-Hand Smoke % Exposed (CCHS)	39 14/51	7.7	9.9	16.2	12.1	17.8	15.3	21.9	12.2	22.1	20.8	20.6	32.8	16.0	17.4
Body Mass Index % Obese (CCHS)	2001/03/051	15.4	11.8	18.2	19.1	17.8	11.2	21.4	18.4	26.3	18.9	16.5	22.0	18.4	20.8
Total Activity Level % Active (CCHS)	2001/03/051	20.0	20.0	23.7	21.1	24.3	22.0	28.0	15.7	28.4	29.8	31.0	36.2	25.3	29.5
Nutrition: Fruit & Vegs % having 5+ times/day	39 14/51	40.2	37.2	30.1	34.1	33.1	37.1	27.8	32.0	33.5	38.2	36.4	35.6	34.4	33.5
Socio-economic Conditions (page 161)															
Education (ages 25-64) % with no certificate	2006 Census	8	8	12	11	18	9	17	17	12	21	21	29	15	20
School Changes % Gr 3 with no changes	FY2002-05	85.2	78.5	84.5	80.1	85.6	76.3	79.2	80.2	84.0	74.3	63.0	63.2	77.8	79.8
High-School Completion (%)	FY 2005	89.7	87.7	84.9	88.4	68.8	81.4	79.5	80.5	79.8	77.4	59.5	52.8	78.7	77.7
LICO % at (Individuals) LICO % at (Household)	2006 Census	46 16	31 10	39 14	39 15	33 13	37 19	38 18	37 16	32 14	46 23	57 40	59 40	42 20	38 17
Median Income ($s): Individuals (Males) Individuals (Females) Households	2006 Census	36,156 22,743 63,059	43,365 27,304 74,992	36,565 24,883 58,840	35,217 23,703 55,363	35,329 23,149 59,199	33,381 24,547 47,646	32,646 21,567 49,616	31,419 22,140 54,460	36,025 23,824 52,153	27,848 19,744 49,799	20,323 17,626 30,307	21,629 21941 33,831	31,615 21,941 50,182	29,919 20,169 47,875

How to Read this Report

Winnipeg Regional Health Authority
Community Health Assessment 2009/2010

It is impossible to fully describe all aspects of the health of a population, particularly a large, diverse, multifaceted urban community. However, a variety of indicators are available that, when taken together, can start to sketch out the picture of a population's health.

This report collates and presents the "core" indicators for the Winnipeg Health Region. **Core indicators** are those identified by Manitoba Health and other members of the Community Health Assessment Network (CHAN) as essential information for describing regional health status. Also, core indicators are based on data available at the regional level to facilitate comparisons.

As such, this report represents **a starting point** in describing the health of residents living in the Winnipeg Health Region. It will not answer all the questions a reader may have; in fact, it will likely stimulate more questions than it provides answers. But it forms a platform of descriptive statistics on which to begin an iterative, engaged, consultative process that will further our understanding of health in the Winnipeg Health Region.

INDICATORS

As stated above, part of the process of a community health assessment is to present statistics on a set of core indicators. Indicators describe or measure particular characteristics, events and factors that are important for health planning, decision making and evaluation. We have grouped our mandatory core indicators (over 100) into four major sections:

A. Health Status
B. Determinants of Health and Well-being
C. Health System Performance
D. Demographics

The first two sections form the majority of this report, with the remaining sections providing useful reference information. Many subsections exist; for example, the section on "Health Status" includes six sub-sections on such diverse subjects as: early childhood and maternal health, chronic diseases and injuries among others. Each sub-section is comprised of several "core" indicators.

SOURCES OF INDICATOR DATA

It is important to note that most of the **indicators are derived from two primary sources:** Manitoba Health's administrative databases and the Canadian Community Health Survey. Further, most of the indicators can be found in two Manitoba Centre for Health Policy (MCHP) Reports which were compiled using Manitoba Health's administrative databases (RHA Atlas, 2009 and Child Health Atlas Update, 2008). These reports are available at: http://umanitoba.ca/faculties/medicine/units/mchp/ (choose "Publications"). In the case of the RHA Atlas (MCHP 2009), some indicators were based on data derived from the Canadian Community Health Survey (CCHS) and analyzed by MCHP. Other secondary sources of indicator data are used and referenced accordingly. Data from the Canadian Institute of Health Information, Manitoba's Bureau of Statistics, Manitoba Health and Healthy Living (as RHA Profiles 2008), Healthy Child Manitoba are examples of other sources.

CCHS Data Source

CCHS is a cross-sectional survey that collects information, using telephone interviews, from a random sample of Canadians every two years on topics related to health status, healthcare utilization and health determinants. It relies upon a large sample of respondents from across the country (about 7500 persons are surveyed in Manitoba every two years) and is designed to provide reliable estimates at the health region level.

Whereas administrative databases are used to report on rates derived from almost the entire population, CCHS relies on sampled data. Indicators derived from the CCHS have several limitations: first, interviewers ask questions of participants and answers can be affected by personal bias and recall error. Second, certain population groups may be under-represented. For instance, Winnipeg residents without regular (land line) telephone service and those living in an institution are not included in the survey. In addition, certain groups may be more inclined than others to participate in the survey. Finally, every two years, approximately 7500 Manitobans are administered the survey and data are combined from several years (e.g., CCHS 1.1: 2001, CCHS 2.1: 2003 and CCHS 3.1: 2005) to increase the sample size and the statistical

precision of the results. In this report, because the waves of the CCHS were combined, change over time cannot be analyzed and instead represent a single (multi-year) time period.

Administrative Data bases

Similarly, data derived from administrative databases have their own limitations. Diagnostic codes that reflect the reason for a billable service and not necessarily a confirmed condition will over count some conditions. Also, some physicians must submit 'shadow bills' for services rendered and this is not always done particularly in areas with limited access to physicians. With less billing information through shadow billing, there is less information available for analysis and fewer conditions identified resulting in an underestimation of treatment prevalence. Further, coding errors and lack of specificity in some diagnostic codes (e.g., some codes cover multiple conditions, meaning that one cannot differentiate among conditions within a code) will further compromise the accuracy and completeness of administrative data used to identify medical conditions and use of the health care system. All of these limitations make it difficult to interpret and compare some indicators.

SUB-SECTION OUTLINE

Each sub-section starts with an ***"AT A GLANCE table"***. This one-pager is a summary of current and past indicator values for the sub-section's indicators. Included in the table is the "Range of Current Estimates" for each indicator which reports high and low values that define the range of the indicator across Community Areas (CAs).

Following the summary table, the reader will find ***commentary*** on the overall sub-section and the descriptive statistics for each indicator comprising it. For brevity, the text highlights the important findings of the Winnipeg Health Region's (WHR) Community Health Assessment (CHA), but no attempt was made to provide detailed explanations of the observed patterns. We also did not focus on comparing the WHR indicators to other Regional Health Authorities (RHAs) because of the significant socio-economic, geographic and other differences between the WHR and the much smaller rural RHAs. Comparisons with other Canadian urban centers and more in-depth analyses are planned for future reports.

After the text-commentary, the ***indicators*** comprising the sub-section are described, where possible, in two ways: using a table of data by CA and a chart by Winnipeg Neighbourhood Cluster (NC). An explicit definition for each indicator is at the beginning of each indicator to assist with interpretation. Where applicable, the source of the data, the time periods of analysis and how the rates have been adjusted are listed as footnotes. In addition, all tables and charts include the overall Winnipeg RHA and Manitoba figures.

Tables

Note that the indicator data table includes numerator data (case, numbers, etc.) by CA and the accompanying population-based rate (where applicable, the 'adjusted' rate or proportion). These are listed for two time-periods which vary depending on the indicator and the data available to measure it. For example, these could be periods of one year as in the "Adult Influenza Immunization" indicator (Fiscal year FY, 2000/01) or five years in the case of the "Ischemic Heart Disease" indicator (FY 1996/97-2000/01). Where multi-year time periods appear, the numbers presented are cumulative numbers for the specified time period. Most core indicators are based on data to 31 March 2006. Please see the following figure for an example of most tables' format.

In addition, there is a "% Change" column, which reflects the percentage change in the numerator (number, cases, etc.) for the CA between the two time periods. We have used this convention as a means of showing the actual numbers of persons affected in a CA and how the numbers have increased or decreased. The statistical significance of the change between the two time periods is reported behind each CA label as a ***'t'*** where appropriate and is based on the adjusted rate.[2] Two other labels of statistical significance are attached: ***'1'*** 'indicates that in the first time period, the area's rate was statistically different from the Manitoba average at that time; ***'2'*** indicates that in the second time period, the area's rate was statistically different from the Manitoba average at that time. Occasionally, an 's' is referred to and it indicates that the results were suppressed to ensure confidentiality.

[2] See explanation of significance testing in the MCHP RHA Atlas, 2009 page 14: http://mchp-appserv.cpe.umanitoba.ca/deliverablesList.html. Occasionally, another designation of significance is used: e.g., "Incr" for increasing and "Dcr" for decreasing when considering Families First screening form data.

Adult Influenza Immunization					
Community Area	FY 2000/01		FY 2005/06		% Change
	Persons Immunized	Adjusted Rate	Persons Immunized	Adjusted Rate	
Fort Garry (1,t)	4217	60.4%	5798	69.2%	16.4%
Assiniboine South (1,2,t)	3269	68.2%	4048	72.3%	6.8%
St. Boniface (t)	3486	53.1%	4706	68.2%	28.4%
St. Vital (1,2,t)	4713	59.0%	5993	70.9%	20.0%
Transcona (t)	1828	54.0%	2497	69.4%	28.8%
River Heights (t)	5442	54.7%	6180	67.6%	23.5%
River East (t)	7620	56.9%	9671	68.9%	20.6%
Seven Oaks (t)	4809	57.2%	5882	67.8%	18.7%
St. James - Assiniboia (1,2,t)	6489	60.9%	8103	73.5%	21.3%
Inkster (1,2,t)	1321	45.8%	1692	59.2%	29.5%
Downtown (1,2,t)	4320	47.7%	4886	61.3%	27.9%
Point Douglas (1,2,t)	2843	49.1%	3085	61.6%	25.7%
Winnipeg (t)	50357	55.5%	62541	67.9%	24.1%
Manitoba (t)	85664	54.5%	107276	66.4%	22.9%

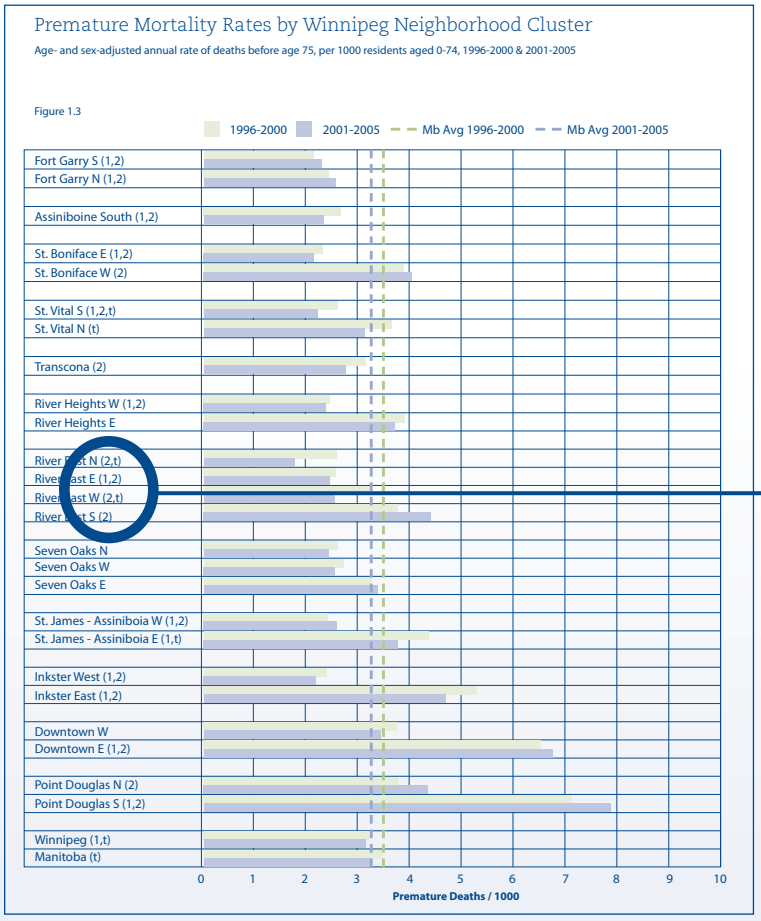
Based on the change in the numerator between time periods.

Based on adjusted rates and statistical modelling. Possible values:

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from Time 1 to Time 2 was significant

Graphs

The table (with CA indicator values) is followed in most cases by a graph of the same indicator by Winnipeg Neighbourhood Cluster (NC). NCs are the next level of geographic breakdown in the WHR; there are 25 NCs that comprise the 12 CAs. Assessments of the statistical significance are again indicated behind the NCs' name. The data underlying these graphs are available, separately from this report. It is important when comparing one NC to another to note that the differences stated are age- and sex-adjusted using the Manitoba population in the first time period as the standard population.



Based on adjusted rates and statistical modelling. Possible values:

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from Time 1 to Time 2 was significant

Order of Community Areas/Neighbourhood Clusters in Tables & Graphs

Graphs and tables throughout this report show the Community Areas (CAs)/Neighborhood Clusters (NC) in the order of their premature mortality rates (PMR). For the purpose of calculating the PMR, a death before the age of 75 years is considered to be premature, so the ***PMR*** indicates the average annual rate of deaths occurring before age 75, per 1000 area residents under 75. PMRs were adjusted to account for differences in the age and sex composition between areas. Because of small populations in some areas, the PMRs used to order the areas were averaged over a 10-year period from 1996-2005.

Understanding the meaning of the indicators

To better understand the meaning of the indicators related to the occurrence of diseases or conditions (e.g., the indicators listed in the chronic disease chapter), it is important to understand the difference between disease prevalence and incidence:

What is the difference between prevalence & incidence?

Prevalence is the proportion of the population that are cases at a point in time (point prevalence) or over a defined period of time (period prevalence). All the prevalence estimates used in this report are estimates of period prevalence.

Incidence is the number of NEW cases diagnosed within a defined period of time divided by the size of the population at the beginning of that period.

Treatment Prevalence

In certain chapters, e.g., the one on chronic diseases, "treatment prevalence" estimates are used instead of disease prevalence or disease incidence rates. Because these estimates were derived using health administrative databases, ***only*** those persons who have received health services or treatment for the disease (by visiting a doctor, being admitted to a hospital or having a prescription dispensed) are counted, but those who may have undetected disease, disease that does not require frequent medical care, and those not receiving the care they may need for their condition are not counted. This must be kept in mind when treatment prevalence rates are interpreted—rates that change may mean that the disease is actually getting more or less common, or it may mean that more or less people are getting diagnosed or receiving care. For example, an increase in the treatment prevalence for hypertension could mean that more people are getting high blood pressure or that more people are having their high blood pressure diagnosed and treated appropriately. Sometimes, changes in physician billing or disease coding practices (e.g., when a new tariff is created) could also cause treatment prevalence to change even if the disease prevalence has not changed. For these reason, sometimes it is not possible to be certain about the meaning of changes in treatment prevalence over time.

More about Rates and Proportions

Most figures shown in the tables section of an indicator use adjusted rates or proportions. Since age and sex are often key determinants of health status and health service use, the results you see are rates or proportions 'adjusted' to account for age and sex differences among CAs.

Reporting adjusted rates (versus crude rates) allows us to make valid comparisons across areas that have different population compositions. The actual number of events (disease or condition) observed in each area is also reported where possible. The percentage change shown in the tables is based on changes in the actual numbers to facilitate planning of health care services.