A health and social profile

FALL 2013

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Contents

Health is where we live, learn, work and play

We are pleased to present this package of Health and Social Profiles for the six community Health Areas (CHAs) in Vancouver. The full package includes Health and Social Profiles for CHA 1 (City Centre), CHA 2 (Mid-East), CHA 3 (North East), CHA 4 (Westside), CHA 5 (Midtown) CHA 6 (South Vancouver), as well as a Citywide Summary.

These profiles were prepared by Vancouver Coastal Health (VCH). They were compiled by Nerissa Tai, a student in the Master of Public Health Program at Simon Fraser University, with guidance from Community Developers in Vancouver; Charito Gailling, Katie Hume, Lisa McCune, Nicole Latham, Lycia Rodrigues and Jazmin Miranda as well as Dr. Jat Sandhu and Eleni Kefalas at the VCH Public Health Surveillance Unit (PHSU).

VCH is the regional health authority responsible for providing public health services to over 1 million people in British Columbia. We serve the residents of Vancouver, Richmond, the North Shore and Coast Garibaldi, Sea-to-Sky, Sunshine Coast, Powell River, Bella Bella and Bella Coola. We operate 13 hospitals and also provide primary care, mental health and addiction services, community-based residential and home health care, and more. To deliver public health services in Vancouver, VCH divides the city into six geographical areas called "Community Health Areas" (CHAs). CHAs vary in population size and are each comprised of three to eight neighbourhoods.

A population health approach aims to improve the health of the entire population.

While hospital care and clinical services are an important part of the health care system, Vancouver Coastal Health also uses a population health approach to address the determinants that influence the health of population. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups.

In these Health and Social profiles we report on some of the factors that influence the health of individuals and populations in Vancouver. These factors are called the "social determinants of health". In each profile we include population-level data about income, housing, education, employment and child development. We also report on health indicators such as life expectancy, birth rates, standardized mortality ratios and we include information about how health services are used and list key community resources.

Addressing the social determinants of health can improve the health of the whole population and reduce health inequities. But Vancouver Coastal Health cannot do it alone. We need to work in partnership across sectors and with communities to address local issues, facilitate access to services and strengthen the environments in which people live, learn, work and play. We hope that these profiles will help VCH staff and our partners in community to identify emerging needs, undertake strategic planning, and implement health-supporting initiatives.

The majority of the information presented in these profiles comes from BC Vital Statistics Agency, BC Statistics, the 2006 Statistics Canada Census and Vancouver Coastal Health databases (see the References at the end of each profile for a complete list of data sources).

Where possible, we have included information obtained through the 2011 Statistics Canada Census. At the time of publication, only limited data from the 2011 Census has been released. For that reason, where data was unavailable for 2011, we have used information from the 2006 Census. Nevertheless, the 2006 Census remains a valuable source of information about populations in Vancouver because it contains details collected through the mandatory long-form Census, which was discontinued prior to the 2011 Census.

We also consulted with community groups, public organizations and VCH staff to better inform the profiles and to share local knowledge about unique neighbourhood characteristics and emerging trends.

We hope that this will be a useful and motivating document in your work. Any comments or feedback is welcome at: phsu@vch.ca.

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Introduction by community partner

JENNIFER GRAY-GRANT, EXECUTIVE DIRECTOR,
COLLINGWOOD NEIGHBOURHOOD HOUSE

As I've been reading the Community Health Area Profile for CHA 3 just now, I've glanced up occasionally to peer through my glass walls into the lobby of Collingwood Neighbourhood House (CNH). It's remarkable to think about how the numbers on these pages translate into the people sitting, laughing, chatting, reading, or, in one case, screeching intensely in his mother's arms, in our lobby.

CHA 3 is a part of Vancouver that is now home to many immigrants. Many of those beyond my office window (both staff and participants) come from other countries: almost 56 percent of residents are immigrants. The most recent immigrants are mainly from China and the Philippines which is reflected in reporting of mother tongues: the highest percentage of residents report Chinese (39.7 percent) as their first language; only 31.9 percent report that English is their first language. We see this in the uptake of our settlement services and English classes too.

But what we also see is the coming together of immigrants and those born in Canada. We have seen over the years the growing excitement around Lunar New Year celebrations and the area's Moon Festival, which take an Asian festival or myth and create an intercultural celebration enjoyed by all. We can actually taste the difference immigrants make in the explosion of great ethnic and fusion restaurants in our commercial areas and intercultural community gardens and cooking classes organized by our service providers.

The baby screeching outside my office windows is also a good illustration of another trend in this area: CHA 3 is home to one of the highest percentages in Vancouver of those aged 0-19.

So this is a family- oriented area, albeit one with some families facing tough challenges. A high percentage of families are on income assistance. As well, the area's family (and individual) incomes are lower than the median and average incomes of families (and individuals) in Vancouver and BC. Further, the number of group childcare and preschool spaces per 100 children is among the lowest in Vancouver. We see daily evidence of that deep need in the long wait lists for our childcare spaces.

Today I also thought about those on the other end of life's spectrum as I watched some seniors hold their monthly celebration of recent birthdays. Many of those seniors are part of our Community Action for Seniors' Independence (CASI) pilot project, which provides non-medical services to support seniors to live in their homes for as long as possible. Funded by the provincial government and administered by the United Way, CASI brings to life the statistics showing that there is a very high number of seniors in CHA 3 and that the numbers are expected to continue to grow through 2036. That means our healthcare and other service providers must continue to put some focus on increasing and improving opportunities for seniors to stay engaged and healthy.

As a service provider in CHA 3, I'm grateful for this report, which certainly confirms the trends I see daily both on the other side of my office window and in my travels throughout the neighbourhood. I'm grateful to VCH for assembling them and thereby assisting us in our work.

Population estimates and projections

Population estimates and projections provide social agencies, government and other service providers with an opportunity to plan for emerging trends.

Population projections can be used to gauge future population and composition rates.

Multiple projection series are produced using different combinations of assumptions about future fertility (births), mortality (deaths), and migration.

Table 1. Population estimates. Community Health Areas, Vancouver, and British Columbia, 2011

	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Count	121,165	71,358	106,364	137,666	95,928	136,209	668,690	4,573,321
Total 0-19 years	8.5%	14.5%	20.0%	20.5%	20.1%	19.9%	17.4%	21.1%
0-4 years	3.6%	3.8%	5.2%	4.3%	5.7%	4.7%	4.5%	4.9%
5-19 years	5.0%	10.6%	14.9%	16.2%	14.4%	15.2%	12.9%	16.2%
Total 20-64 years	81.2%	75.5%	66.8%	67.3%	69.7%	66.3%	70.7%	63.6%
20-34 years	37.6%	25.8%	23.2%	26.2%	23.8%	22.8%	26.7%	20.9%
35-49 years	27.0%	28.3%	24.2%	22.9%	26.9%	22.7%	25.0%	21.5%
50-64 years	16.6%	21.5%	19.5%	18.1%	19.0%	20.8%	19.1%	21.2%
Total 65+years	10.3%	10.0%	13.1%	12.2%	10.2%	13.8%	11.8%	15.3%
65-79 years	7.4%	7.0%	9.1%	8.1%	7.1%	9.3%	8.1%	11.0%
80+ years	2.9%	3.1%	4.1%	4.1%	3.1%	4.5%	3.7%	4.3%

Source: BC Stats (2012, March)

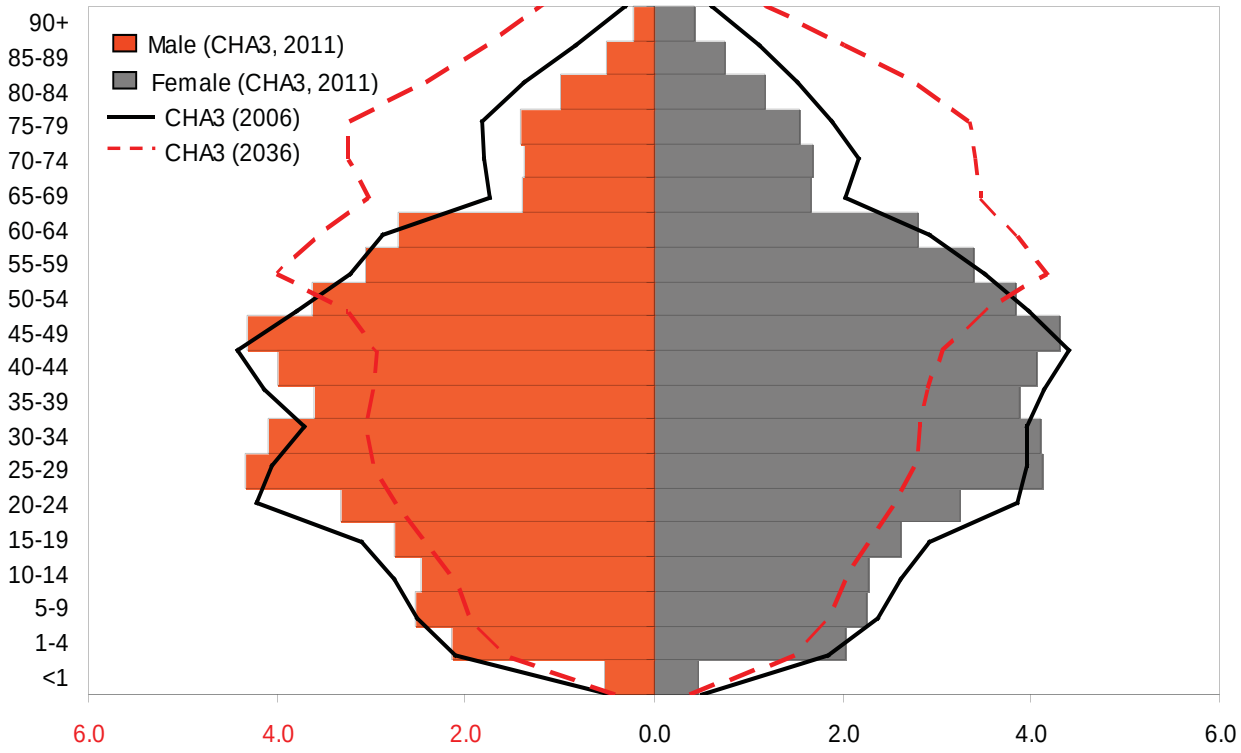
In 2011, the population of CHA 3 was 106,364, the fourth largest out of the six CHAs, comprising 15.9% of Vancouver's total population. CHA 3 is a family-oriented community with 20% of people 19 years and under. In 2011 CHA 3 had the second highest proportion of seniors age 65-79 years (9.1%) and 80+ years (4.1%) of the CHAs.

Table 2. Population projections. Community Health Areas, Vancouver, and British Columbia, 2036

	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Count	160,936	96,444	123,785	166,865	118,775	161,984	828,789	6,155,588
Total 0-19 years	15.6%	14.9%	16.5%	18.5%	14.9%	16.6%	16.3%	19.0%
0-4 years	3.6%	4.2%	3.8%	3.6%	4.4%	3.7%	3.9%	4.4%
5-19 years	12.0%	10.8%	12.6%	14.8%	10.5%	12.9%	12.5%	14.6%
Total 20-64 years	71.0%	64.5%	57.6%	59.9%	64.6%	57.0%	62.4%	57.3%
20-34 years	22.2%	18.4%	16.9%	25.3%	20.5%	16.8%	20.3%	17.0%
35-49 years	30.4%	25.3%	18.7%	18.1%	21.9%	19.1%	22.1%	21.1%
50-64 years	18.4%	20.9%	22.0%	16.6%	22.3%	21.2%	20.0%	19.2%
Total 65+years	13.4%	20.5%	25.9%	21.6%	20.5%	26.4%	21.3%	23.7%
65-79 years	10.5%	15.0%	18.4%	15.2%	15.9%	18.3%	15.5%	16.3%
80+ years	2.9%	5.5%	7.5%	6.4%	4.5%	8.0%	5.8%	7.4%

Source: BC Stats (2012, March)

FIGURE 1. Population distribution (%) by sex and age group. Community Health Area 3, 2006, 2011, and 2036



Source: BC Stats (2012, March)

Figure 1 illustrates the sex distribution in CHA 3 with males on the left and females on the right. Overall, there are 49.4% males and 50.6% females in this CHA; however, this shifts according to the age group.

Figure 1 also shows the number of people in each five-year age group. The figure shows what the population looked like in 2006 (black line) and 2011 (bars), and what the data is expected to look like in 2036 (red dotted line).

By 2036, the total population of CHA 3 is projected to increase by 16.6%. The population of CHA 3 is also expected to age, with more older people and fewer younger people in the community. In 2036, there will be 12.8% more people in the 65+ year age group.

Demographic composition

This section draws attention to the demographic composition of Community Health Area 2 and how it relates to diversity, education and childhood development, employment and income, and housing and household characteristics.

Diversity

Visible Minorities. Both Statistics Canada and the Public Service Commission of Canada use the following definition of visible minority: A person in a visible minority group is someone who is non-white in colour/race, regardless of place of birth.

The immigrant population is defined as persons who are, or who have been, landed immigrants in Canada. This term does not include non-permanent residents, persons in Canada on employment or student authorizations, refugee claimants or persons born outside Canada who are Canadian citizens by birth (Statistics Canada, 2010, July 6).

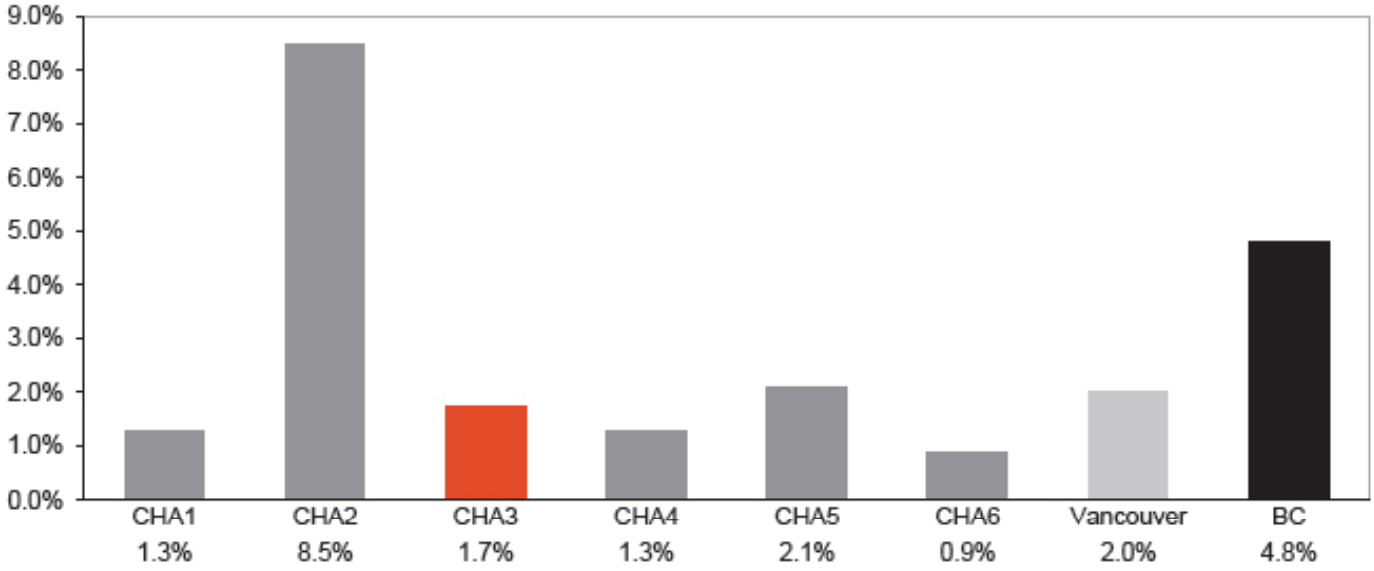
Recent immigrants refer to landed immigrants who came to Canada up to five years prior to a given census year. For the 2006 Census, recent immigrants are landed immigrants who arrived in Canada between January 1, 2001 and May 16, 2006 (Statistics Canada, 2010, July 6).

Data Source: Statistics Canada

Aboriginal population

Over the past few decades the health status of Aboriginal peoples in Vancouver has improved, particularly in the areas of infant mortality, unintentional injuries and suicide. These improvements can be attributed to changes in the social determinants of health, improved access to health care services and greater emphasis on cultural teachings. Participants at the 2011 Forum for Aboriginal Elders identified many positive impacts that result from preserving Aboriginal cultural traditions. A number of community organizations operate in Vancouver to meet the needs of urban Aboriginal people. These include the Vancouver Aboriginal Council, the Vancouver Aboriginal Friendship Centre, the Urban Native Youth Association, and the Aboriginal Mother Centre Society.

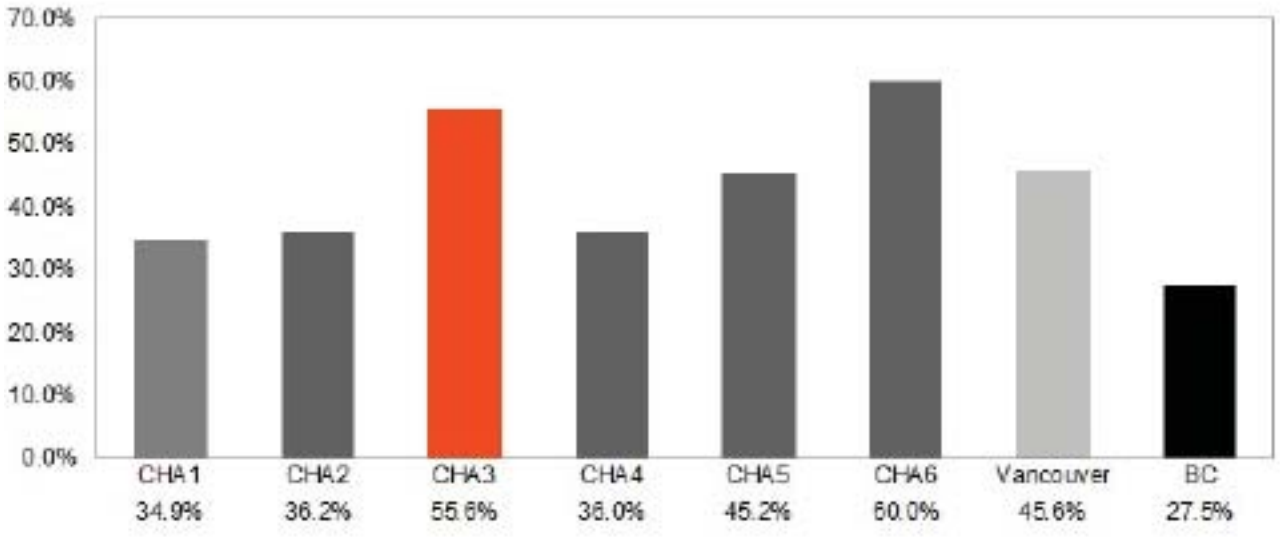
FIGURE 2. Aboriginal population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

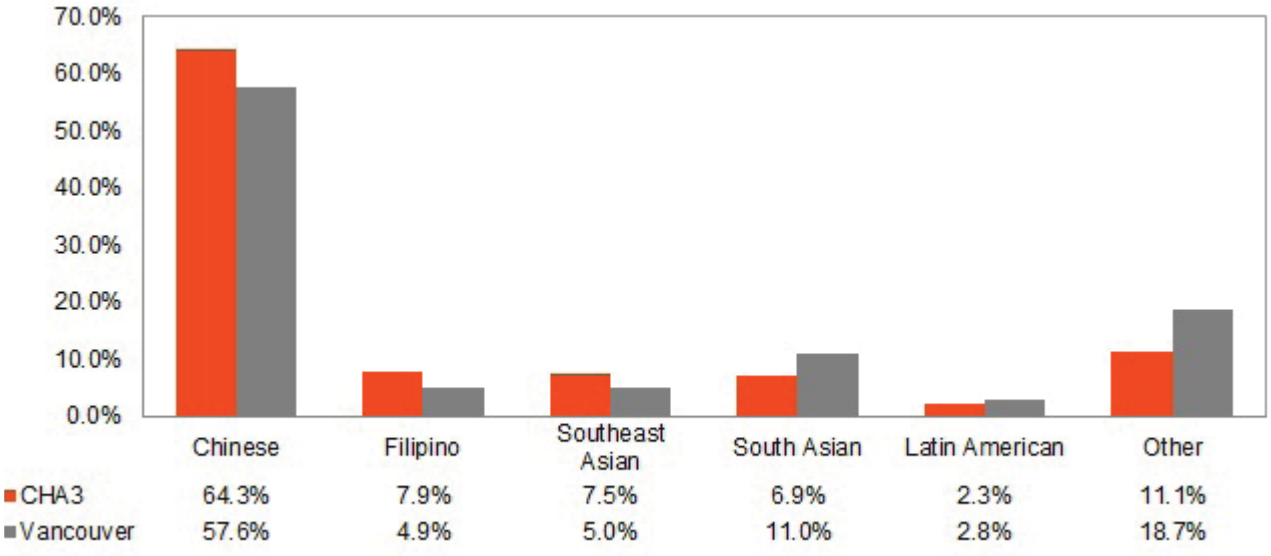
Immigrant population

FIGURE 3. Immigrant population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

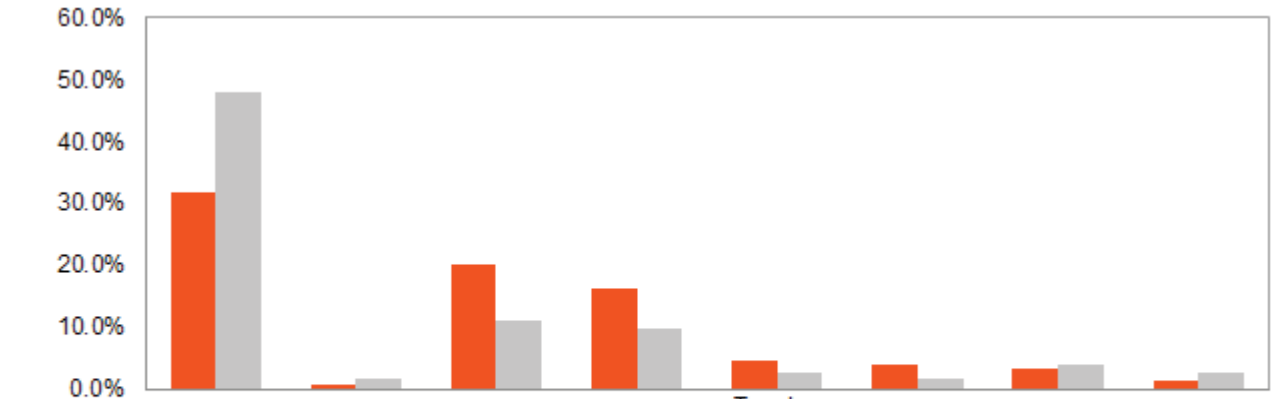
FIGURE 4. Select visible minority groups as a percentage (%) of the total visible minority population. Community Health Area 3 and Vancouver, 2006



Source: Statistics Canada, 2006 Census of Population

Visible minorities comprise 70.8% of the total population of CHA 3. Relative to Vancouver as a whole, a greater proportion identify as either Chinese (64.3%), Filipino (7.9%), or Southeast Asian (7.5%)

FIGURE 5. Total population by select mother tongue. Community Health Area 3 and Vancouver, 2006



	English	French	Cantonese	Chinese n.o.s.	Tagalog (Pilipino, Filipino)	Vietnamese	Mandarin	Panjabi (Punjabi)
CHA3	31.9%	0.7%	20.1%	16.3%	4.5%	4.1%	3.2%	1.5%
Vancouver	48.0%	1.6%	11.0%	9.8%	2.8%	1.8%	4.1%	2.7%

Source: Statistics Canada, 2006 Census of Population

"N.o.s." stands for "not otherwise specified". This refers to people who reported "Chinese" in their response to the question on language spoken most often at home without specifying Mandarin, Cantonese or other Chinese languages.

Education and healthy child development

Child care enables parents of young children to work or study on a full or part-time basis. A vast body of research has demonstrated that quality early learning and child care has significant educational, social, and emotional benefits for children.

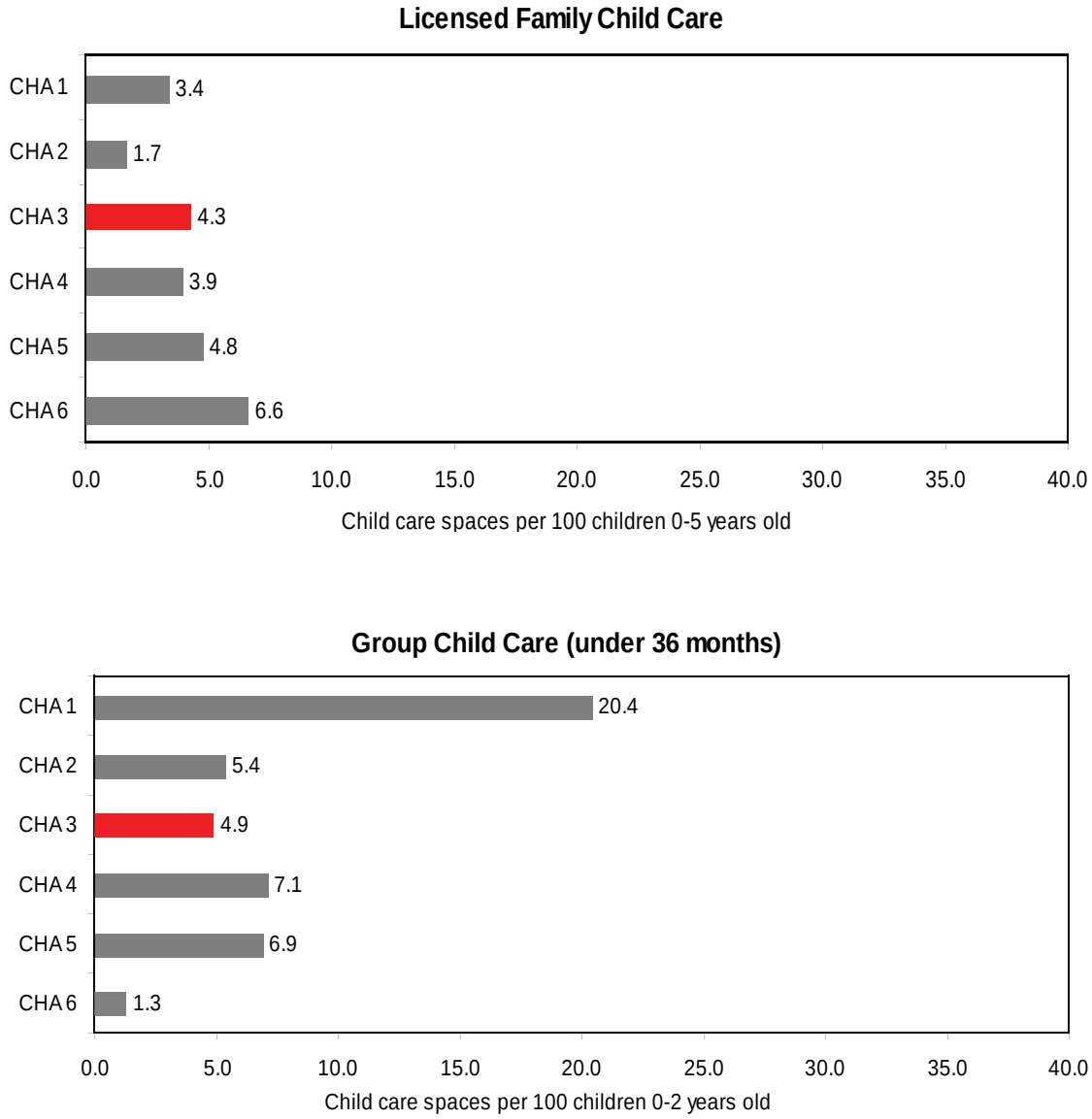
Licensed Family Child Care is offered in a child care provider's own home, and serves a maximum of 7 children from birth to age 12. Group Child Care serves children in two age groupings: from birth to 36 months and from 30 months to school-age. Preschools serve children age 30 months to school entry. Preschools are part-day programs, typically operating on the school-year, September to June (Vancouver Coastal Health, 2009).

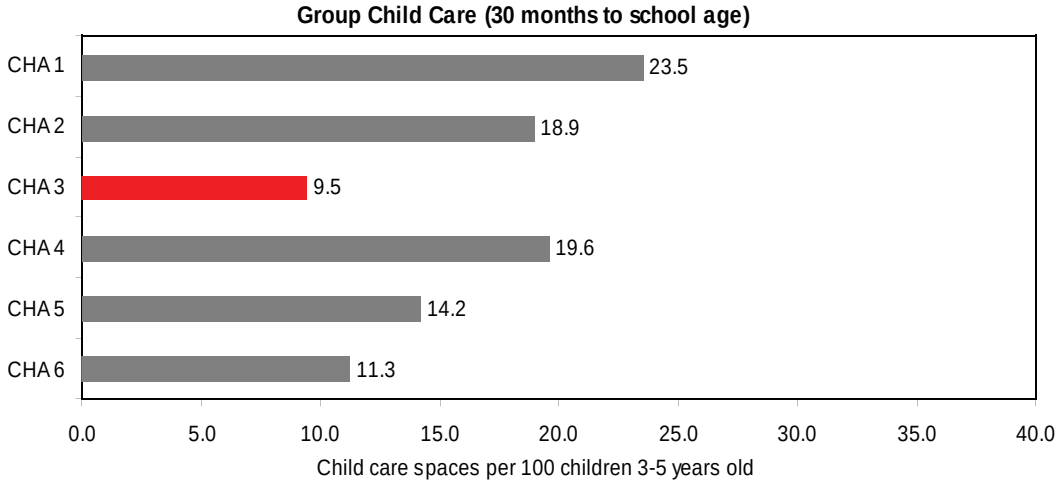
Within Vancouver, the number of child care spaces varies considerably by CHA. While the number of spaces has increased in recent years, the population under age 5 is also increasing and child care availability remains low. Many families rely on informal child care arrangements.

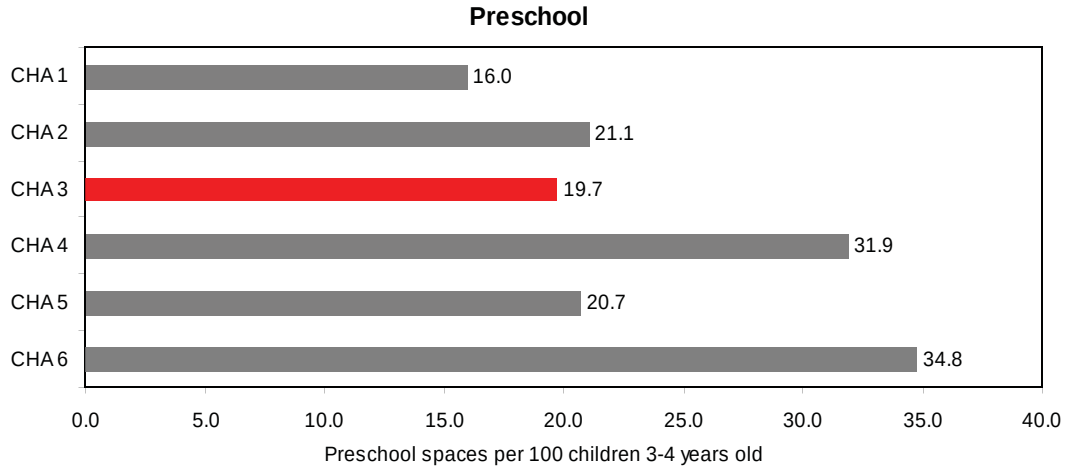
In CHA 3 there are 4.9 licensed group child care spaces for every 100 children under 36 months and 9.5 licensed group child care spaces for every 100 children age 3-5 years. More than 90 of every 100 children age 3-5 years do not have access to licensed group child care.

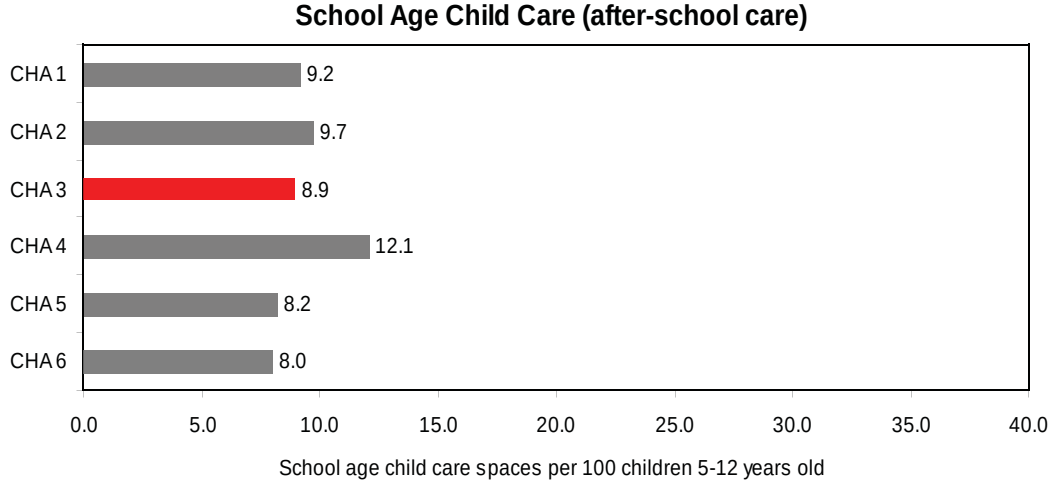
Note: data provided here do not include unlicensed, "licence-not-required" nor informal child care arrangements (e.g. care by relative, nanny).

FIGURE 6. Child Care spaces per 100 children. Community Health Areas, 2012









Source: Westcoast Child Care Resource and Referral and City of Vancouver, personal communication, (2012, August 16).

TABLE 3. Percentage of Kindergarten children vulnerable on five domains of development as measured by the Early Development Instrument (EDI). Community Health Areas, and British Columbia, 2009/11 (compared to 2007/09)

	Percentage vulnerable (%)						
	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	BC
Total Count	252 (270)	210 (254)	643 (772)	627 (715)	557 (623)	988 (950)	47,318 (37,398)
Physical Health and Well Being	19% (14%)	24% (25%)	17% (18%)	8% (7%)	13% (13%)	17% (17%)	14% (12%)
Social Competence	17% (18%)	24% (24%)	18% (18%)	17% (13%)	17% (12%)	20% (19%)	15% (13%)
Emotional Maturity	17% (17%)	22% (25%)	13% (15%)	10% (10%)	14% (13%)	18% (19%)	14% (12%)
Language and Cognitive Development	13% (8%)	16% (20%)	12% (4%)	7% (4%)	12% (8%)	14% (13%)	10% (10%)
Communication Skills and General Knowledge	21% (22%)	25% (23%)	27% (28%)	14% (10%)	25% (20%)	27% (26%)	14% (13%)
One or more domain	39% (39%)	49% (47%)	43% (43%)	29% (25%)	37% (25%)	45% (43%)	31% (29%)

Source: University of British Columbia, Human Early Learning Partnership (2011, September 22).

The quality of a child's early development plays a significant role in lifelong health, social ability and educational achievement. Research has clearly shown that poor early development is associated with a wide range of acute and chronic health issues later in life.

This table shows the percentage of children in each CHA who are considered to be vulnerable in each of the five domains of the EDI. The first row shows the number of children who participated in the EDI in each of 2009/11 and 2007/09 (in parentheses).

In CHA 3, of 643 children who participated in the EDI in 2009/11, 27 percent are considered vulnerable in the domain of "Communication Skills and General Knowledge". 18 percent are considered vulnerable in the domain of "Social Competence".

The Early Development Instrument (EDI) is a research tool that measures children's health and well-being as they enter kindergarten in five core developmental domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills. These are proven and reliable predictors of later educational outcomes, social capability and adult health.

Reporting EDI data allows us to better understand levels of child "vulnerability". Children are considered to be vulnerable when they receive a low score on EDI in one or more of the domains of development. A child who is vulnerable is at increased risk of encountering difficulties in their school years and beyond. This information is viewed at a population level (e.g., community, health area, etc.) and this makes it possible to see the proportion of vulnerable children in a geographic area (UBC Human Early Learning Partnership, personal communication, August 13, 2012.)

Note: CHA 5 includes neighbourhood data for Cedar Cottage (which is typically included in CHA 3).

TABLE 4. Middle Years Development Instrument Well-Being Index, 2011

Community Health Area	Number of students	Low	Medium/High	Very High/ Thriving
CHA 1	143	16.2%	30.9%	52.9%
CHA 2	180	22.3%	39.4%	38.3%
CHA 3	735	31.9%	35.5%	32.6%
CHA 4	600	17.3%	33.2%	49.5%
CHA 5	418	22.3%	35.9%	41.8%
CHA 6	925	31.3%	30.5%	38.3%

Source: University of British Columbia, Human Early Learning Partnership, Personal Communication (2012, August 13)

The Middle-Years Development Instrument (MDI) measures social and emotional health, and also gathers information about children's perceptions of the community assets available to support their health and development.

The MDI is a self-report questionnaire administered to Grade 4 children. It was used to gather data from all Vancouver School District children starting in 2011. Data from the Vancouver MDI project can be used to provide an overall picture of child well-being. The MDI calculates an overall health and well-being score which is composed of 5 dimensions: optimism, happiness, self-esteem, general health, and sadness (reverse-scored) (UBC Human Early Learning Partnership, personal communication, August 13, 2012).

Table 4 shows that 735 grade 4 children from CHA 3 participated in the MDI questionnaire in 2011, and of these almost 68.1% are doing well (i.e. scored "medium/high" or "very high/ thriving"). Children who scored "high" agreed or strongly agreed with statements like "I have more good times than bad times," "I am happy with my life," and "the things in my life are excellent." Children who were considered "medium" on the well-being index responded that these statements were partially or somewhat true for them. Children who responded that they disagreed with these statements were designated as having a "low" level of well-being.

TABLE 5. Middle Years Development Instrument Percentage of Students Reporting Presence of Each Asset, 2011

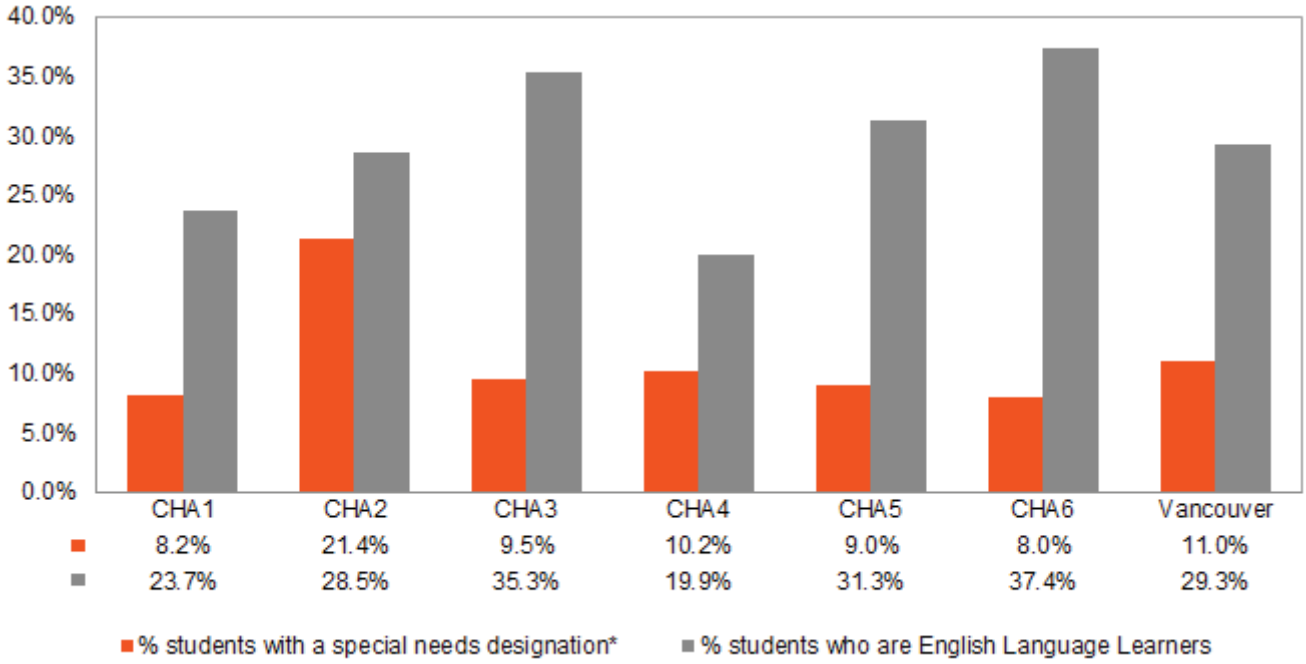
Community Health Area	Percentage of grade 4 students that report the presence of each asset			
	After School Activities	Peer Relationships	Nutrition and Sleep	Adult Relationships
CHA 1	67.4%	85%	72%	83.7%
CHA 2	76.2%	74%	63.3%	79.5%
CHA 3	63.5%	76%	65.2%	70.9%
CHA 4	88.5%	79.8%	76.7%	82.7%
CHA 5	71.4%	78.3%	71.8%	75.5%
CHA 6	72.6%	76.9%	67.2%	73.5%

Source: University of British Columbia, Human Early Learning Partnership, Personal Communication, (2012, August 13).

The MDI also gathers information from children about their perception of the community and school assets they experience. Children were asked about their experiences of connection with adults in their schools, neighbourhoods and at home and with their peers. They were also asked about how often they eat breakfast, how often they get a good night's sleep, and whether they participated in after-school activities.

Table 5 shows that children in CHA 3 report having positive relationships with peers and adults. Only about 64% of children in CHA 3 participate in after-school activities. This is the lowest rate of participation in after-school activities among all of the CHAs. Further, only 65% of children in CHA 3 report that they usually eat breakfast and get a good night's sleep.

FIGURE 7. Percentage of students enrolled in the Vancouver School Board with a special needs designation or who are English Language Learners, Community Health Areas and Vancouver, 2010/11 school year



Source: Vancouver School Board, 2011

*The "special needs designation" includes all children designated with any of the following needs: physically dependent – multiple needs, deaf-blind, moderate to profound intellectual disabilities, physical disability or chronic health impairment, visual impairment, deaf or hard of hearing, autism spectrum disorder (ASD), students requiring intensive behaviour intervention or students with serious mental illness, mild intellectual disabilities, gifted, learning disabilities, students requiring behaviour support or students with mental illness. Detailed definitions for these designations can be found here: http://www.vsb.bc.ca/ministry-designations

In September 2011 there were 55,062 students enrolled in the Vancouver School Board. Of these, about 1 in 10 students had a "special needs" designation and about 1 in 3 students were English Language Learners.

To best understand this information, it's important to consider both the percentages and numbers of children in each category. For example, while CHA 4 has a low percentage of students with a special needs designation (10.2%), it is home to the highest number of children with special needs designations (1,487 children).

TABLE 6. Percentage of families with children enrolled in the Vancouver School Board receiving income assistance (IA) and/or with a child in care of the BC Ministry of Children and Family Development. Community Health Areas and Vancouver, 2010/11 school year

	Total enrolment in Vancouver School Board	% of families on Income Assistance	% of families with a child in care
CHA 1	2,265	4.6%	0.2%
CHA 2	3,319	20.9%	2.2%
CHA 3	13,365	7.3%	0.9%
CHA 4	14,548	0.8%	0.2%
CHA 5	5,919	4.1%	0.6%
CHA 6	15,646	5.2%	0.5%
Vancouver	55,062	7.1%	0.8%

Source: Vancouver School Board, Personal Communication, (2011, September 30)

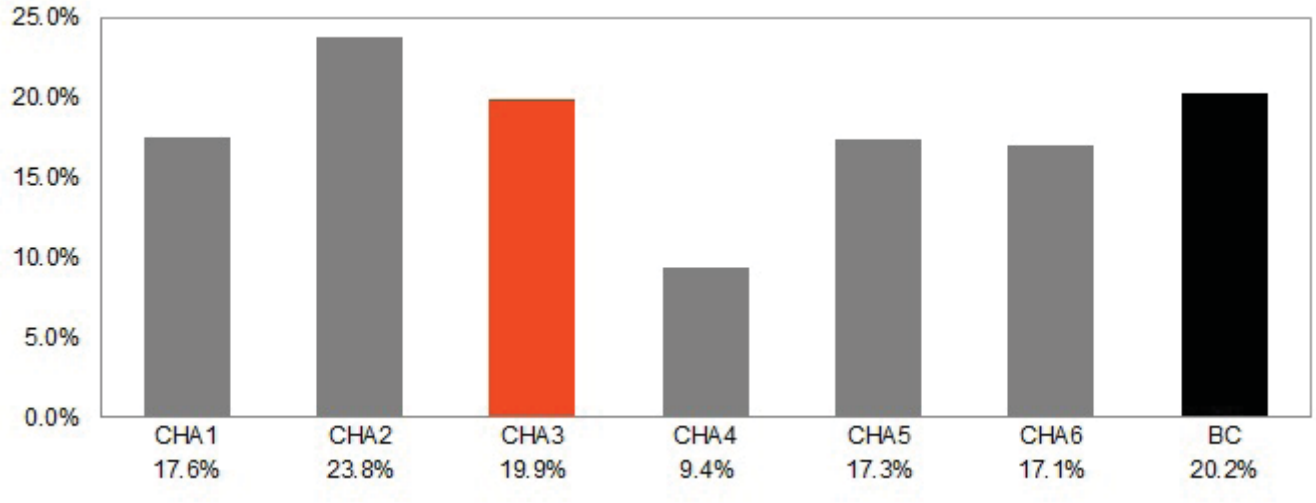
Families in BC who rely on income assistance (IA) may be experiencing temporary unemployment or disability. While income assistance helps these families with the basic costs of living, the support is limited and these families live in poverty.

Children and youth come into foster care with the BC Ministry of Children and Family Development (MCFD) for a variety of reasons including voluntary agreements with parents or guardians who are experiencing difficulties, specialized care for a child who has mental or physical difficulties, or to escape neglect or abuse in their own homes. Whatever the reason for coming into care, for these children, separation from their families is a very difficult experience (BC Ministry of Children and Family Development, 2011).

Children and youth in care are highly vulnerable to poor health and poor educational attainment. Within BC, more than half (51.7%) of the children who come into care are Aboriginal (British Columbia Provincial Health Officer, 2006).

Note: this table reports data based on school of enrolment. Some students attend schools in a community health area that is different from their community health area of residence.

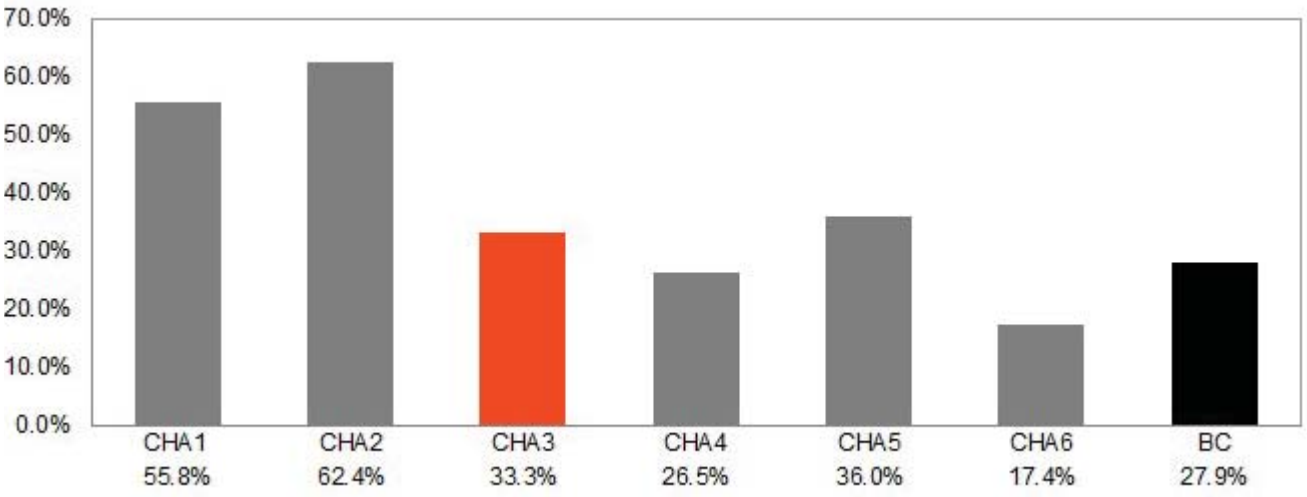
FIGURE 8. Percentage of students below the average on the Foundation Skills Assessment reading tests - average of Grade 4 and 7 students. Community Health Areas and British Columbia, average 2008/09-2010/11



Source: BC Stats (2011)

The Foundation Skills Assessment (FSA) is an annual, province-wide assessment of Grade 4 and 7 students' academic skills, providing a snapshot of how well BC students are performing in reading comprehension, writing, and numeracy (BC Ministry of Education). There has been controversy over the meaningfulness and misuse of the data and many parents have opted their children out of writing these exams. As such, these numbers do not reflect all Grade 4 and 7 students.

FIGURE 9. Percentage of 18 years olds who did not graduate from high school. Community Health Areas and British Columbia, average 2008/09-2010/11

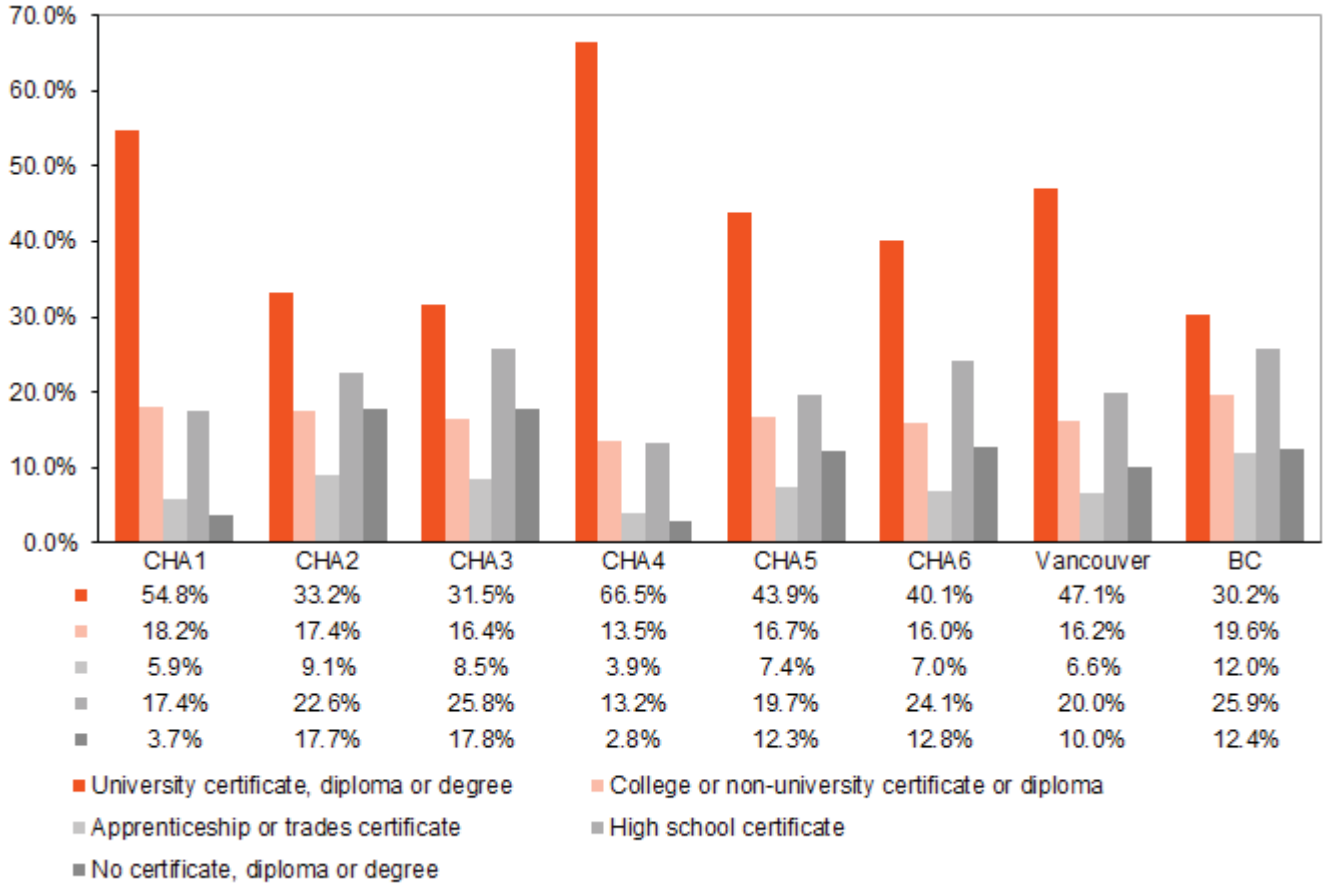


Source: BC Stats (2011)

This figure reports on the percentage of 18 year olds enrolled in the Vancouver School Board who did not graduate at age 18. However, a significant number of youth graduate at age 19 or older. The district-wide average for those who graduated in grade 12 (first time eligible) in 2008/09-2010/11 was 72%. The district average for students graduating within 6 years of starting grade 8 (the "six-year completion rate") for the same time period is higher (81%) (BC Ministry of Education, 2011).

There are various reasons why non-graduation rates for 18 year olds appear high in Vancouver. For example, newcomer students may take extra time to complete required courses. Also, youth with a special needs designation are entitled to an additional year of high school.

FIGURE 10. Percentage of population, 25-64 years, by highest level of education attained. Community Health Areas, Vancouver, and British Columbia, 2006

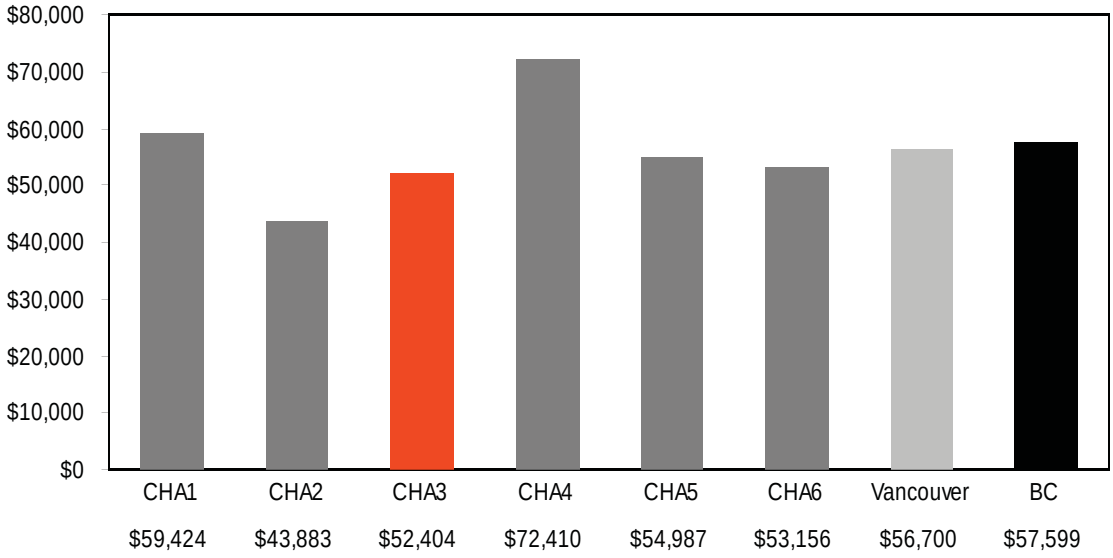


Source: Statistics Canada, 2006 Census of Population

Figure 10 shows the percentage of the population of each CHA that have attained various levels of education. For all CHAs, the percentage of the population that has attained a university certificate, diploma or degree is higher than the percentage in BC overall. CHA 4 is home to the highest percentage of people who have attained a university certificate, diploma or degree, while CHA 3 is home to the highest percentage of people who have not attained any certificate, diploma or degree. 9.1% of residents of CHA 2 have attained an apprenticeship or trades certificate, the highest rate for that certification among all CHAs.

Employment and income

FIGURE 11. Median after-tax incomes of economic families. Community Health Areas, Vancouver, and British Columbia, 2006

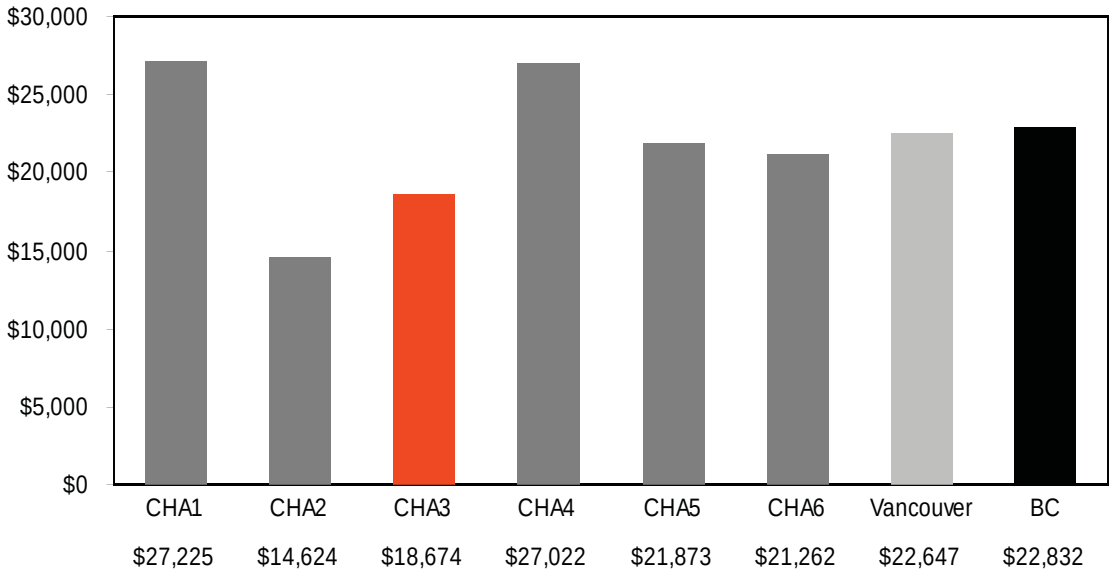


Source: Statistics Canada, 2006 Census of Population

Median income divides income distribution into two groups - half having income above that amount and the other below (Statisics Canada, 2010, July 6). This measure of income is not distorted by the highest and lowest values average income.

Economic families refer 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. A couple may be of opposite or same sex. For 2006, foster children are included (Statisics Canada, 2010, July 6).

FIGURE 12. Median after-tax income of individuals (aged 15+ years) not in economic families. Community Health Areas, Vancouver and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

TABLE 7. Median and average after-tax income of individuals (aged 15+ years), by sex. Community Health Areas, Vancouver, and British Columbia, 2005

	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Median after-tax income ($)								
Total	$27,624	$16,309	$18,916	$27,831	$21,334	$18,952	$21,840	$22,785
Male	$29,950	$16,823	$21,304	$31,885	$23,366	$21,276	$24,200	$28,251
Female	$25,585	$15,996	$17,231	$24,682	$19,812	$17,129	$19,951	$18,930
Difference (%)	17.1%	5.2%	23.6%	29.2%	17.9%	24.2%	21.3%	49.2%
Average after-tax income ($)								
Total	$34,233	$22,230	$22,719	$43,746	$26,229	$24,340	$30,107	$28,908
Male	$39,135	$22,801	$25,011	$56,323	$28,483	$27,347	$34,832	$34,652
Female	$29,222	$21,562	$20,547	$32,639	$24,122	$21,622	$25,595	$23,408
Difference (%)	33.9%	5.7%	21.7%	72.5%	18.1%	26.5%	36.1%	48.0%

Source: Statistics Canada, 2006 Census of Population

When looking at median income, males in CHA 3 make 23.6% more than females.

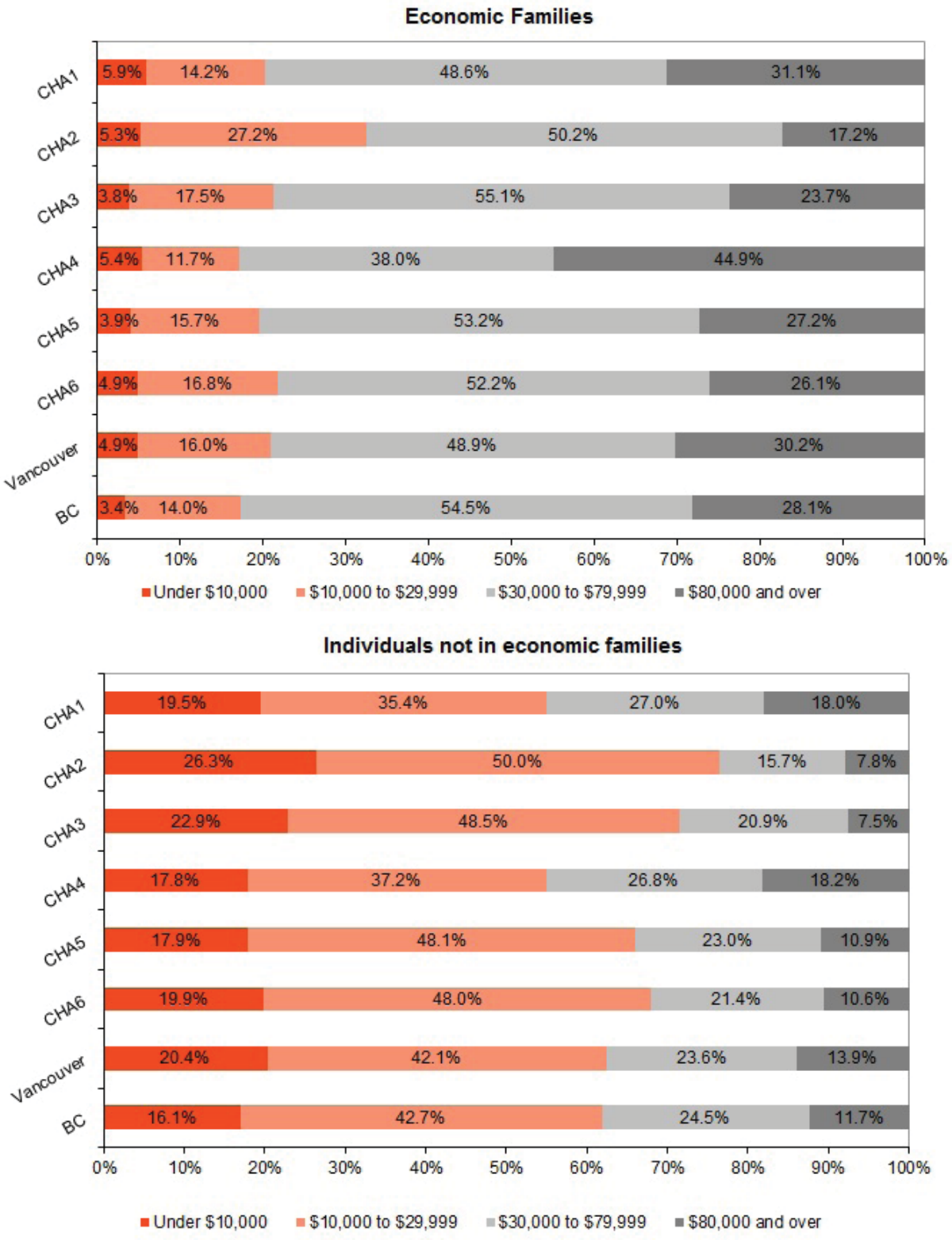
TABLE 8. Employment income and unemployment rates for Canadian-born, all immigrants, and recent immigrants. Community Health Areas and British Columbia, 2006

	Employment Income ($), 2005			Unemployment Rate (%), 2006		
	Canadian-Born	All Immigrants	Recent Immigrants	Canadian-Born	All Immigrants	Recent Immigrants
CHA 1	$41,201	$33,967	$22,973	3.8%	5.7%	8.5%
CHA 2	$28,520	$24,044	$19,202	8.1%	8.0%	9.9%
CHA 3	$34,922	$24,800	$17,940	6.0%	5.8%	7.5%
CHA 4	$41,597	$34,962	$18,164	3.4%	5.6%	10.2%
CHA 5	$35,067	$25,080	$17,992	4.4%	6.1%	11.9%
CHA 6	$37,202	$24,558	$14,643	4.8%	5.1%	8.7%
BC	$36,053	$28,009	$17,994	4.8%	5.5%	9.7%

Source: BC Stats (2011)

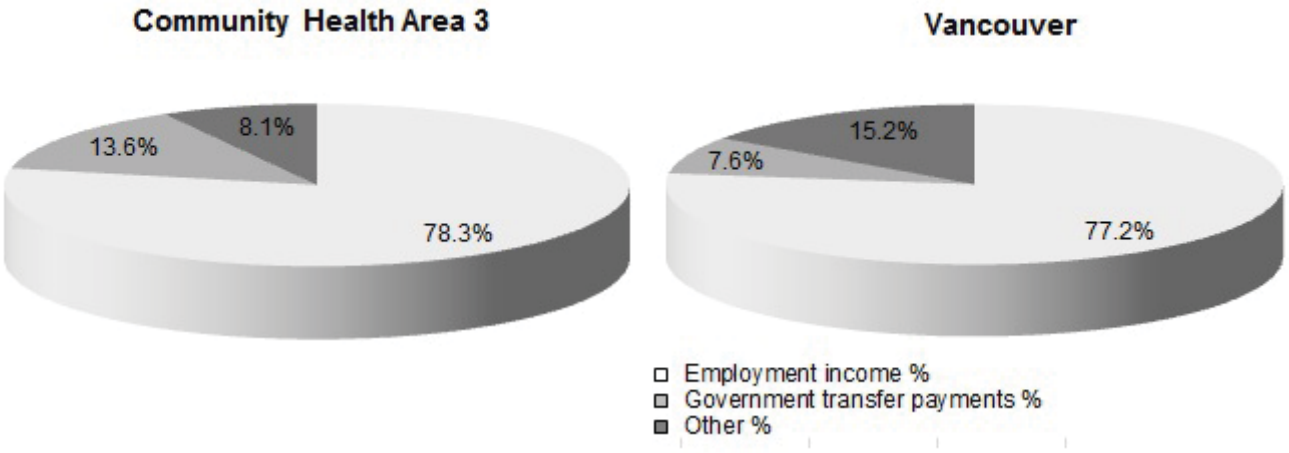
Immigrants and, in particular, recent immigrants may experience a disadvantage in the labour force. Within CHA 3 recent immigrants earn $16,982 less than the average Canadian-born worker while facing higher rates of unemployment (7.5% vs. 6.0%). However, these are moderate differences as compared with the other CHAs.

FIGURE 13. Income distribution (%), after-tax. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

FIGURE 14. Composition of family income of economic families. Community Health Area 3 and Vancouver, 2006



Source: Statistics Canada, 2006 Census of Population

These figures break down income source (employment, government transfer payments and other sources) as a percentage of the total income of economic families in CHA 3 compared to that of Vancouver.

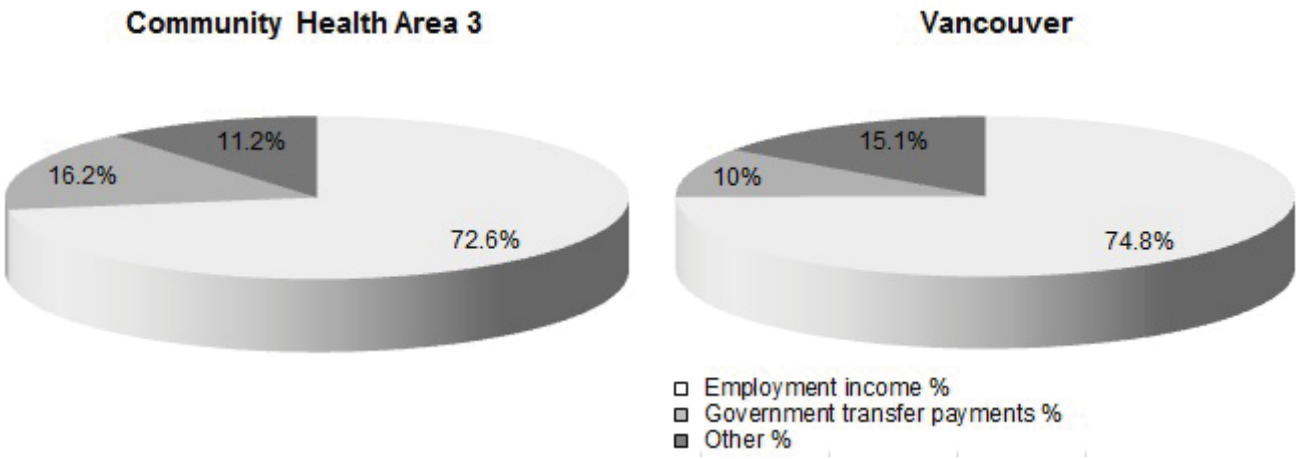
At 13.6%, the relative share of government transfer payments to family income is greatest in CHA 3 and greater when compared to Vancouver overall (7.6%)

Government transfer payments include the Old Age Security pension and Guaranteed Income Supplement, benefits from the Canada Pension Plan, benefits from Employment Insurance, and child benefits.

Other money income includes dividends, interests, other investment income, retirement pensions, superannuation and annuities, and income from abroad (Statistics Canada, 2010, July 6).

Note: see page 30 for definition of economic families.

FIGURE 15. Composition of individual income of persons not in economic families. Community Health Area 3 and Vancouver, 2006

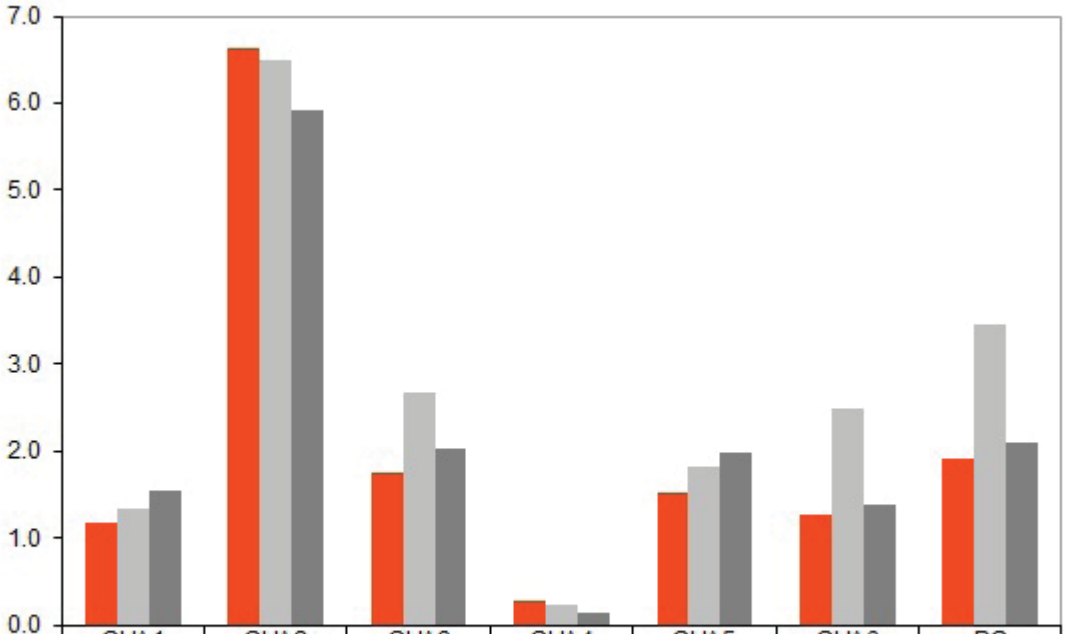


Source: Statistics Canada, 2006 Census of Population

Within CHA 3, government transfer payments make up 16.2% of individual income, the third highest amongst the CHAs and higher as compared to Vancouver overall (10.0%).

In 2013, new regulations under the Employment Insurance system will be in place affecting seasonal workers, most of whom are immigrants. This may impact CHA 3's high immigrant population, as after six weeks of unemployment "frequent claimants" will have to accept any job offered to them at 70% of their "on season" salary, or risk losing benefits.

FIGURE 16. Perentage of population (%) receiving income assistance. Community Health Areas and British Columbia, 2010

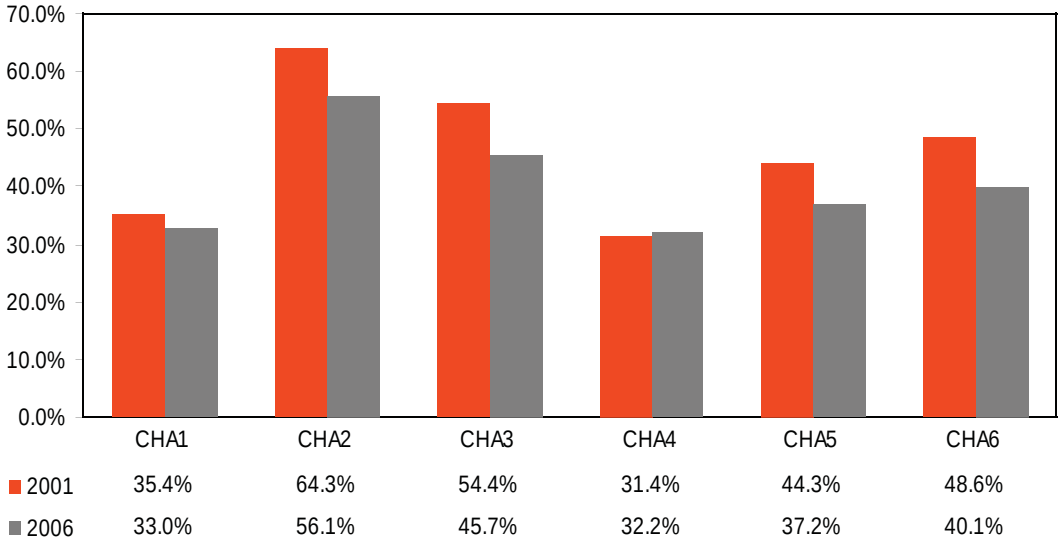


	CHA1	CHA2	CHA3	CHA4	CHA5	CHA6	BC
Total	1.2	6.6	1.8	0.3	1.5	1.3	1.9
Children (0-14 years)	1.3	6.5	2.7	0.2	1.8	2.5	3.5
Youth (15-24 years)	1.5	5.9	2.0	0.1	2.0	1.4	2.1

Source: BC Stats (2011)

The BC Employment and Assistance program is meant to assist British Columbians move from income assistance to sustainable employment. Applicants are expected to take advantage of all other sources of income and assets before qualifying and to actively seek work, and participate in employment programs while receiving assistance (BC Ministry of Social Development, 2010, May 28). Included are those on temporary assistance: expected to work, expected to work - medical condition, temporarily excused and persistent multiple barriers. Excluded are those on continual assistance who have access to other forms of assistance: persons with disabilities, children in the home of a relative, and Old Age Security/seniors (BC Stats, n.d.).

FIGURE 17. Incidence of low-income among individuals over age 15 after-tax. Community Health Areas, 2001 and 2006



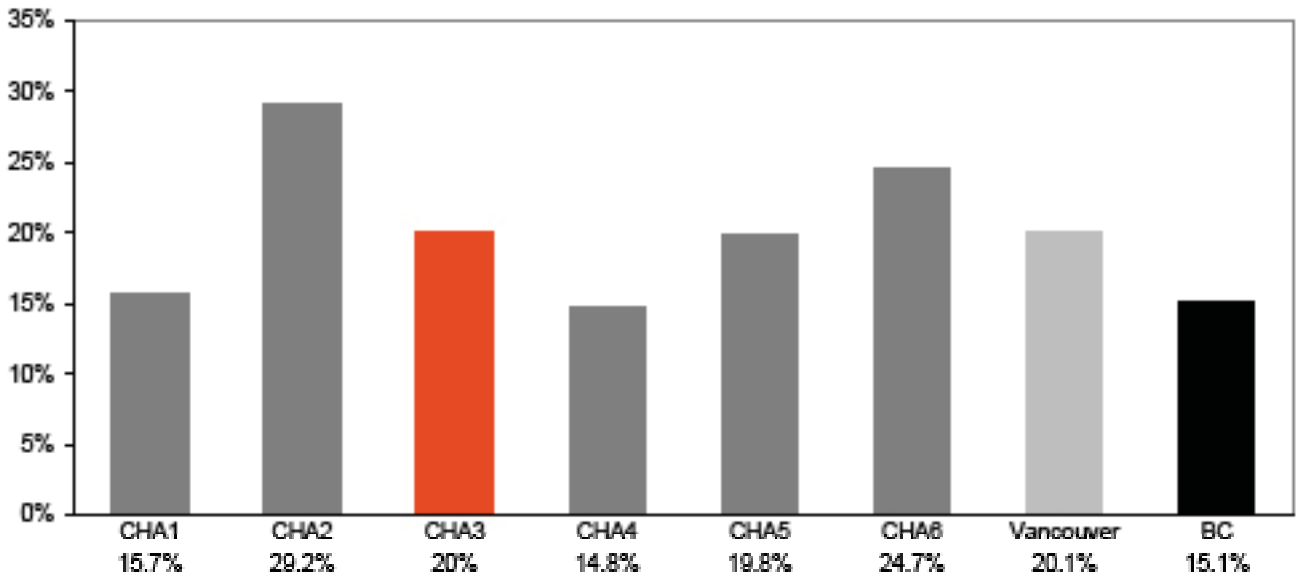
	CHA1	CHA2	CHA3	CHA4	CHA5	CHA6
2001	35.4%	64.3%	54.4%	31.4%	44.3%	48.6%
2006	33.0%	56.1%	45.7%	32.2%	37.2%	40.1%

Source: Statistics Canada, 2001 Census of Population and 2006 Census of Population

The most widely recognized approach to understanding poverty is the "Low Income Cut Off" (LICO) calculated by Statistics Canada: "A LICO is an income threshold below which a family will likely devote a larger share of its income to the necessities of food, shelter and clothing than an average family would". Statistics Canada calculates different LICOs for families of various sizes living in rural and urban communities. For example, in 2006 the LICO, after tax, for a single person living in a city with a population over 500,000 was $17, 568. The LICO, after tax, for a family of four in a similar sized city was $33, 216 (Statistics Canada. 2012, December 20).

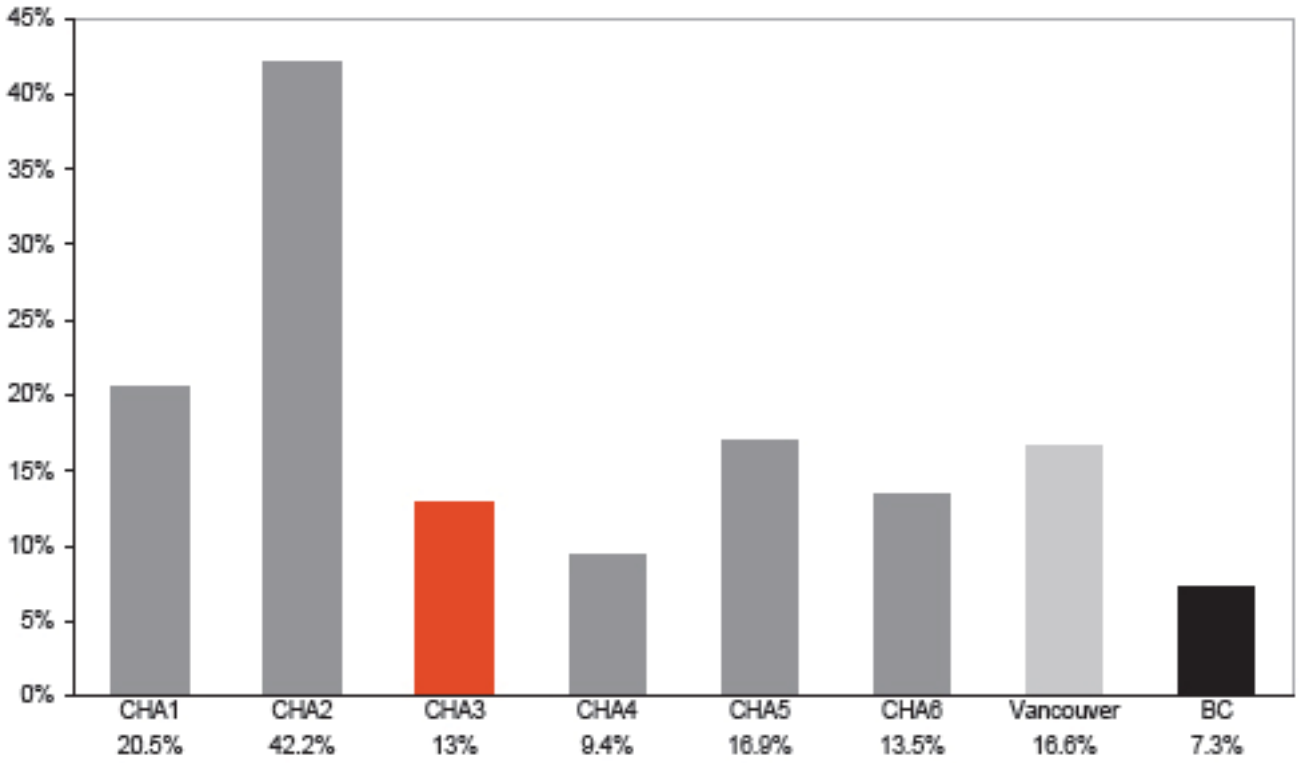
From 2001 to 2006, the incidence of low-income among individuals over the age of 15 decreased in all CHAs with the exception of CHA 4 (Westside), which showed a very small increase.

FIGURE 18. Children, aged less than 6 years, (%) living in low income conditions, after-tax. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

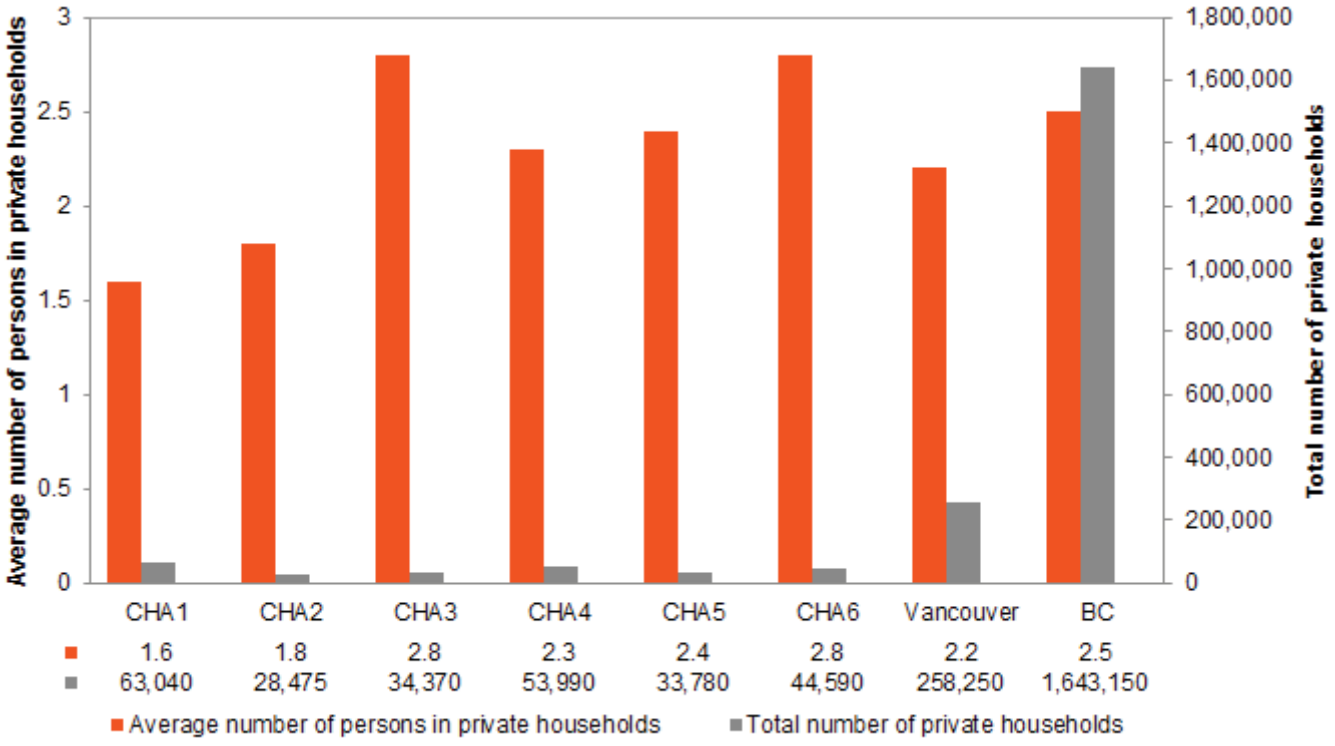
FIGURE 19. Seniors, aged 65 years and over, (%) living in low income conditions, after-tax. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

Housing and household characteristics

FIGURE 20. Average number of persons in households. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

CHA 3 has the second highest percentage of families with two (44.0%) or three (16.9%) children.

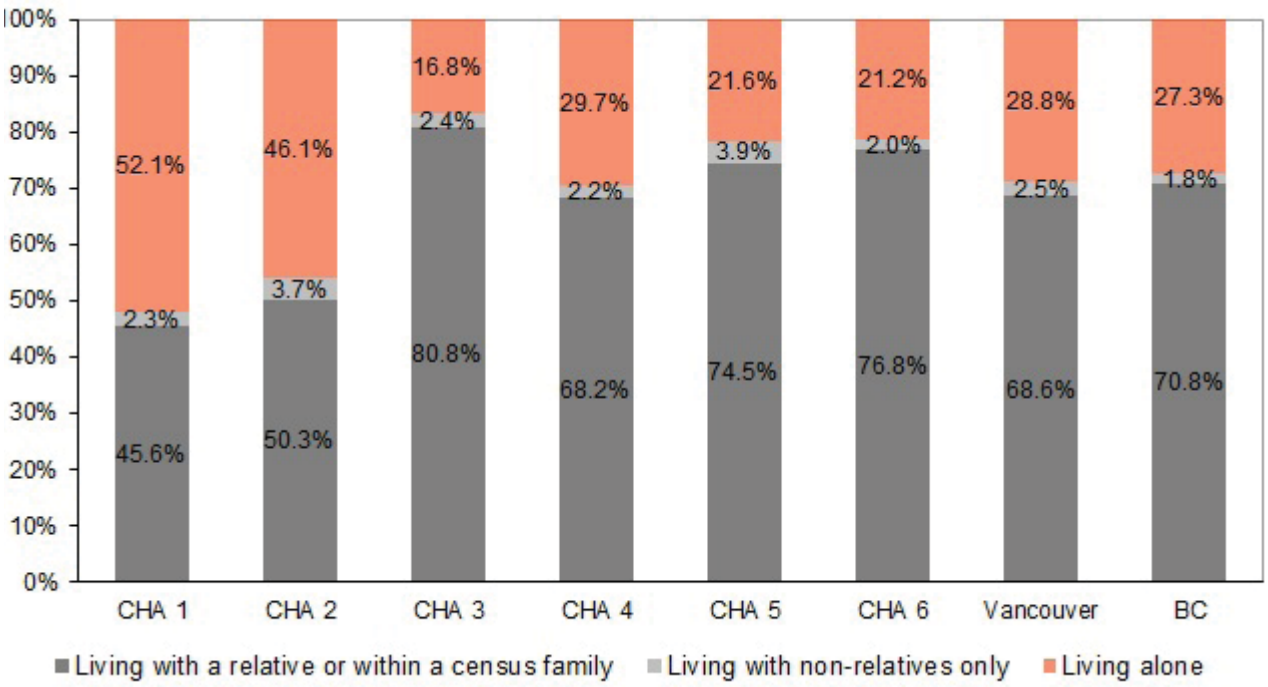
TABLE 9. Total lone parent families as a percentage of all census families by sex of parent. Community Health Areas, Vancouver, and British Columbia, 2006

	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Total lone-parent families	11.3%	22.4%	18.5%	13.1%	17.6%	17.5%	16.2%	15.1%
Female parent	81.4%	81.0%	81.0%	83.0%	78.0%	83.4%	81.6%	79.8%
Male parent	18.6%	19.0%	19.0%	17.0%	22.1%	16.6%	18.4%	20.2%

Source: Statistics Canada, 2006 Census of Population

Lone parent families, over 80% of whom are led by women, are often at a disadvantage economically. With housing costs so high and women's incomes typically lower than men's, children in lone parent families may live in poorer quality housing and have less access to enrichment programs than their counterparts in two-income households.

FIGURE 21. Living arrangements of seniors age 65 years and over. Community Health Areas, Vancouver and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

At 16.8%, CHA 3 has the lowest percentage of seniors living alone and the highest percentage living with a partner or relative (80.8%). CHA 3 has a high immigrant population and these numbers may reflect that immigrant born seniors are more likely than their Canadian counterparts to live in extended families (Citizenship and Immigration Canada, 2005, April 1).

These figures cover seniors living in private homes and do not include those living in facilities or hospitals.

TABLE 10. Percentage of population 15 years and older by hours of unpaid care/assistance to seniors. Community Health Areas, Vancouver, and British Columbia, 2006

	Total population 15 years and older	Hours unpaid care/assist. to seniors	Less than 5 hrs unpaid care/ assist. to seniors	5 – 9 hrs unpaid care/assist. to seniors	10+ hrs unpaid care/assist. to seniors
CHA 1	95,705	88.9%	7.2%	2.2%	1.6%
CHA 2	46,560	88.4%	6.4%	2.6%	2.6%
CHA 3	82,015	81.6%	10.3%	4.2%	3.9%
CHA 4	107,290	83.5%	10.7%	3.3%	2.5%
CHA 5	69,110	83.4%	10.0%	3.4%	3.1%
CHA 6	107,165	80.3%	11.0%	4.5%	4.2%
Vancouver	507,850	84.0%	9.6%	3.4%	3.0%
BC	3,394,910	82.5%	10.3%	3.9%	3.3%

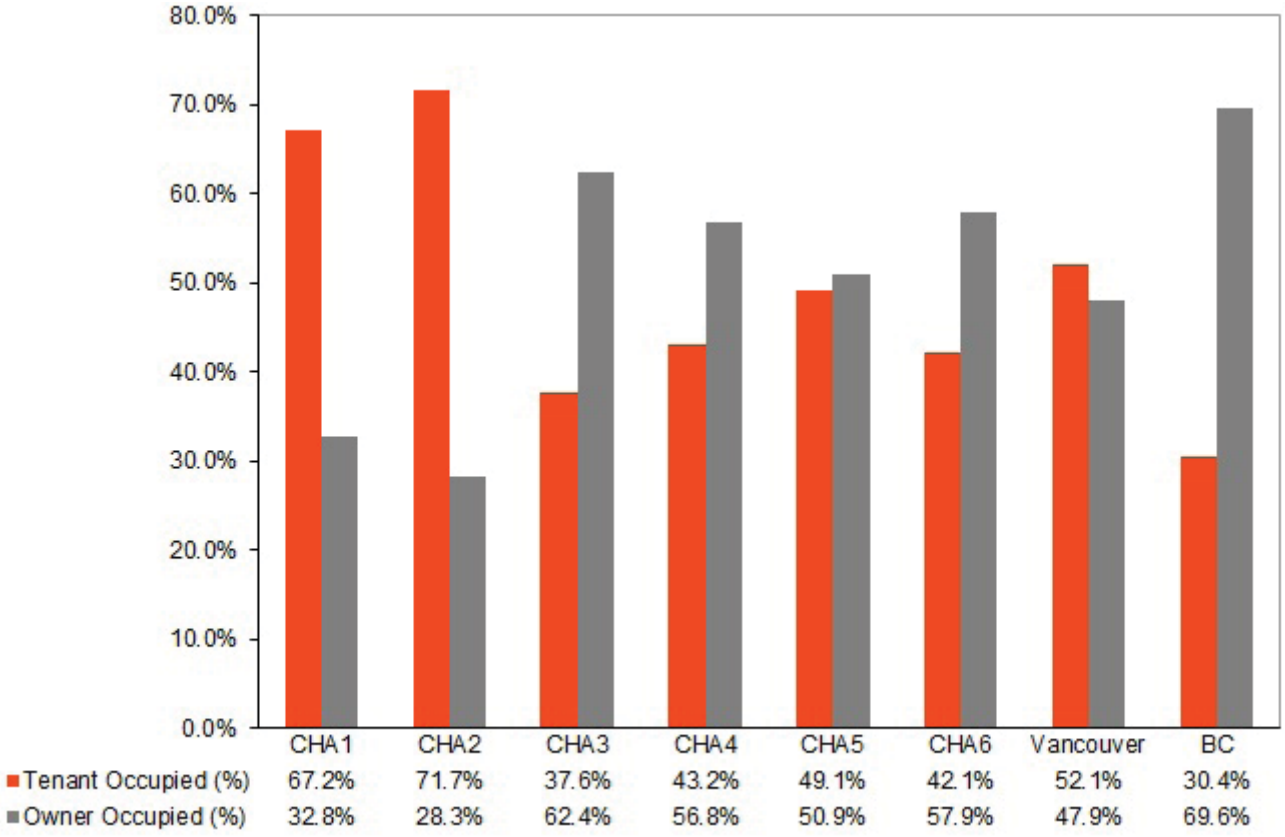
Source: Statistics Canada, 2006 Census of Population

Table 10 shows the percentage of the adult population that is providing unpaid care to seniors. These caregivers are most often relatives or spouses.

It also refers to the number of hours persons spent providing unpaid care or assistance to seniors of one's own household, to other senior family members outside the household, and to friends or neighbours in the week (Sunday to Saturday) prior to Census Day (May 16, 2006).

Unpaid care or assistance to seniors does not include volunteer work for a non-profit organization, religious organization, charity or community group, or work without pay in the operation of a family farm, business or professional practice. (2006 Census Dictionary).

FIGURE 22. Tenant and owner-occupied dwellings (%). Community Health Areas, Vancouver, and British Columbia, 2006

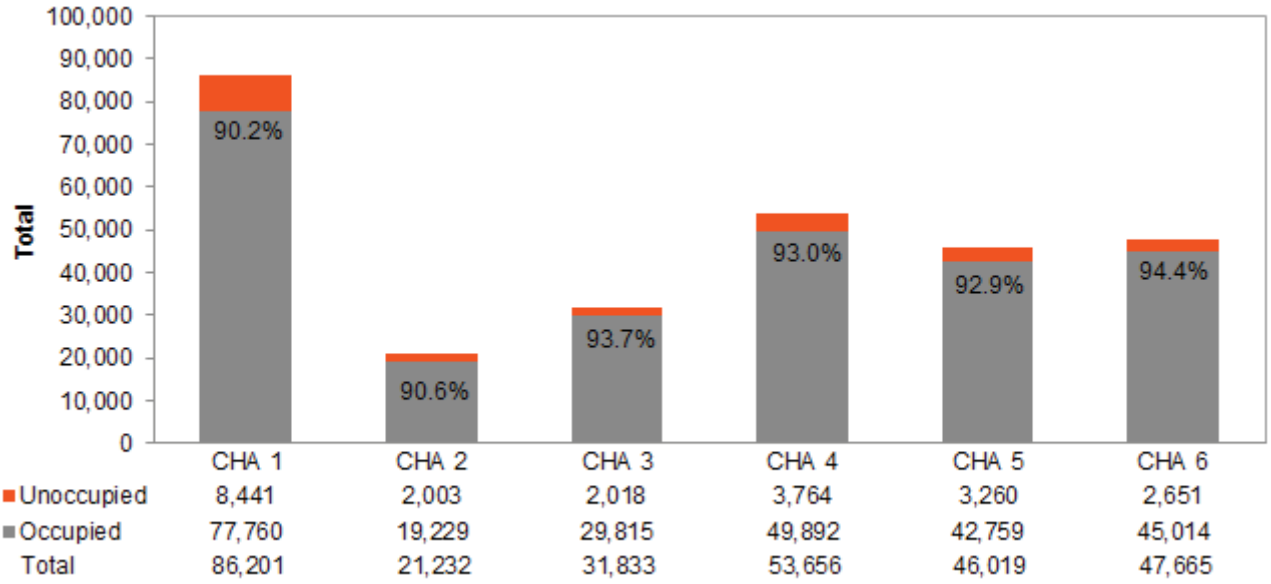


	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Tenant Occupied (%)	67.2%	71.7%	37.6%	43.2%	49.1%	42.1%	52.1%	30.4%
Owner Occupied (%)	32.8%	28.3%	62.4%	56.8%	50.9%	57.9%	47.9%	69.6%

Source: Statistics Canada, 2006 Census of Population

CHA 3 has the highest percentage of owner occupied dwellings (62.4%) amongst the CHAs, standing in contrast to Vancouver as a whole. It is particularly interesting that CHA 3 has such a high proportion of home-owners considering that it has the second lowest median family income and the second highest incidence of low-income individuals among the CHAs.

FIGURE 23. Total number of dwellings and the percentage that are occupied. Community Health Areas, 2011



	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6
Unoccupied	8,441	2,003	2,018	3,764	3,260	2,651
Occupied	77,760	19,229	29,815	49,892	42,759	45,014
Total	86,201	21,232	31,833	53,656	46,019	47,665

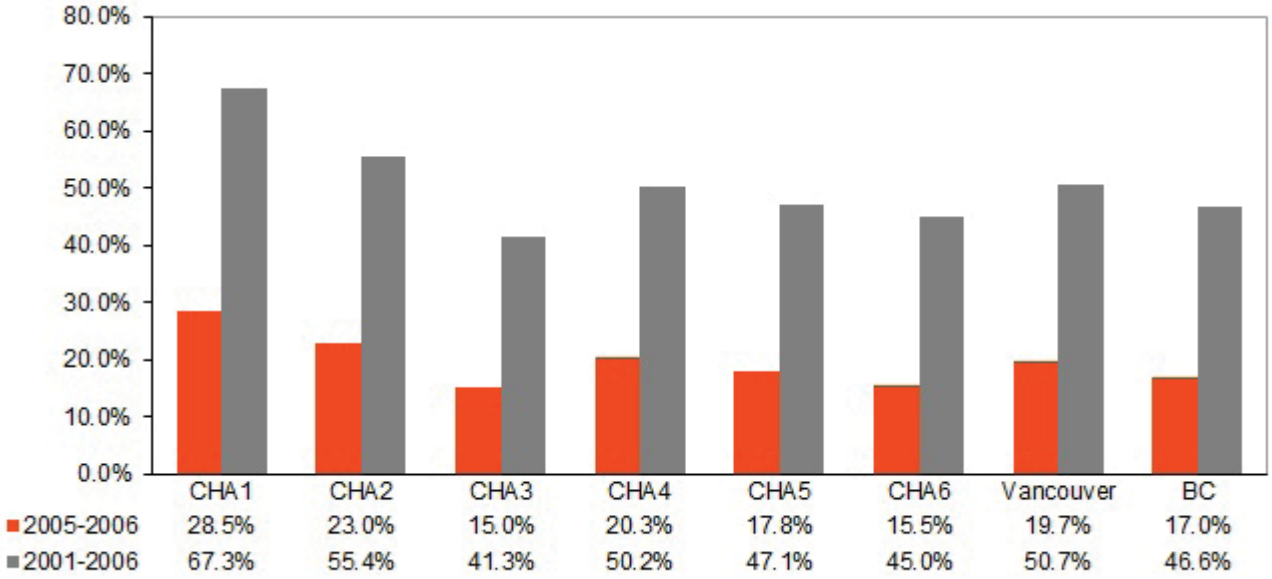
Source: City of Vancouver, Personal Communication, (2012, July 5)

A dwelling may be considered as "unoccupied" if there was someone living there who was not counted in the census (overseas visitors, etc.) or someone living there who the census didn't find, or a part-time resident. It also includes housing that is empty due to being renovated, those vacant and for sale, or those in-between tenants (City of Vancouver, Personal Communication, 2012, July 5).

A high number of unoccupied dwellings in an area may have an impact on feelings of community vibrancy and safety. The above figure shows the total number of dwellings in each CHA and the percentage of dwellings that were occupied at the time of the 2011 Census.

Note: The neighbourhood of Cedar Cottage spans across CHAs 3 and 5. In this figure, data for Cedar Cottage is included in CHA 5 only.

FIGURE 24. Percentage of population who have moved recently (within 2005-2006 or 2001-2006). Community Health Areas, Vancouver, and British Columbia, 2006



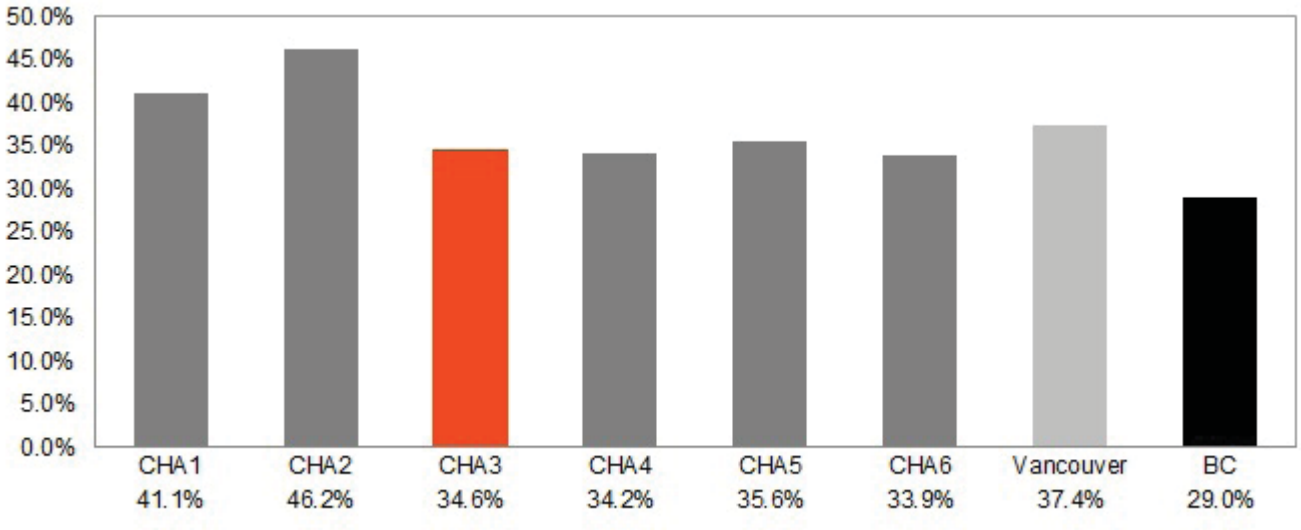
	CHA1	CHA2	CHA3	CHA4	CHA5	CHA6	Vancouver	BC
2005-2006	28.5%	23.0%	15.0%	20.3%	17.8%	15.5%	19.7%	17.0%
2001-2006	67.3%	55.4%	41.3%	50.2%	47.1%	45.0%	50.7%	46.6%

Source: Statistics Canada, 2006 Census of Population

Mobility refers to the number of people who have changed addresses within the last year (2005-2006) or last 5 years (2001-2006) before the Census Day (Statistics Canada, 2010, July 6). It takes into account the level of in-migration, nature of the population (i.e. students), and cost of housing (Statistics Canada, 2010, July 6).

A more stable community with lower mobility may imply a closer social support network with higher social capital and consequent positive health effects. Renters tend to move more often than home owners, so with the highest percentage of owner occupied dwellings, CHA 3 has the most stable population within Vancouver.

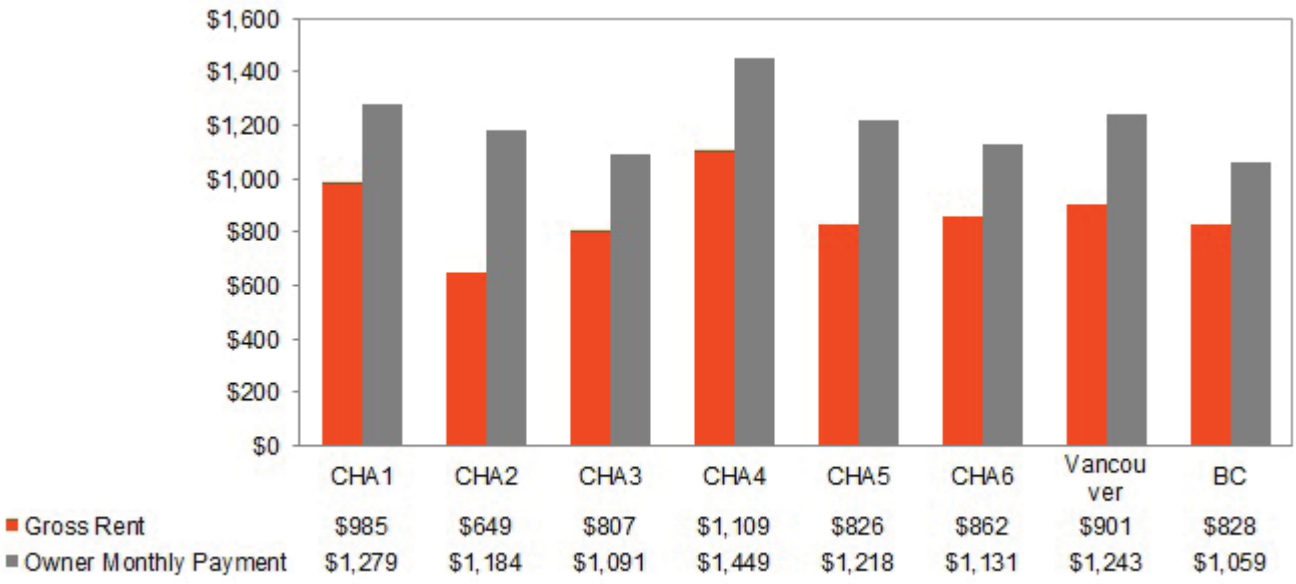
FIGURE 25. Percentage of households paying 30% or more of their income on housing costs. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

A household paying more than 30% of their annual income on housing is considered to be living in unaffordable conditions. This cost burden makes it difficult to pay for other necessities such as food, clothing, education, transportation, and health care.

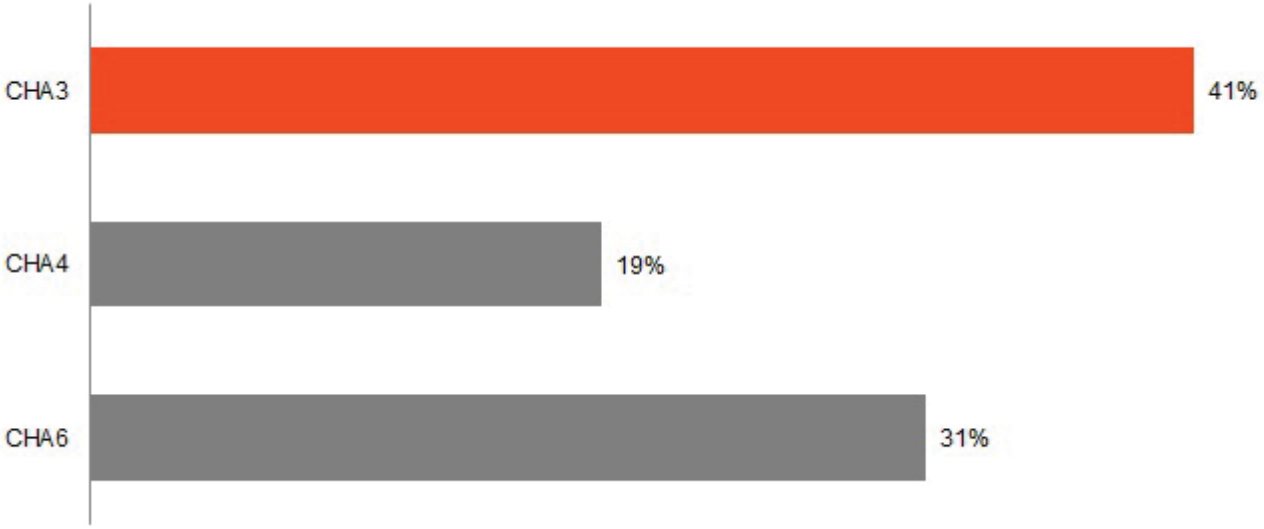
FIGURE 26. Average gross rent and owner monthly payment ($). Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

Within CHA 3, the average gross rent is $807, while the average owner monthly payment is $1,091. This is the lowest average owner monthly payment amongst the CHAs. This may help to explain why CHA 3 has the highest percentage of owner-occupied dwellings, despite its relatively low median income.

FIGURE 27. Percentage of properties with secondary suites. Community Health Areas 3, 4, and 6, 2009



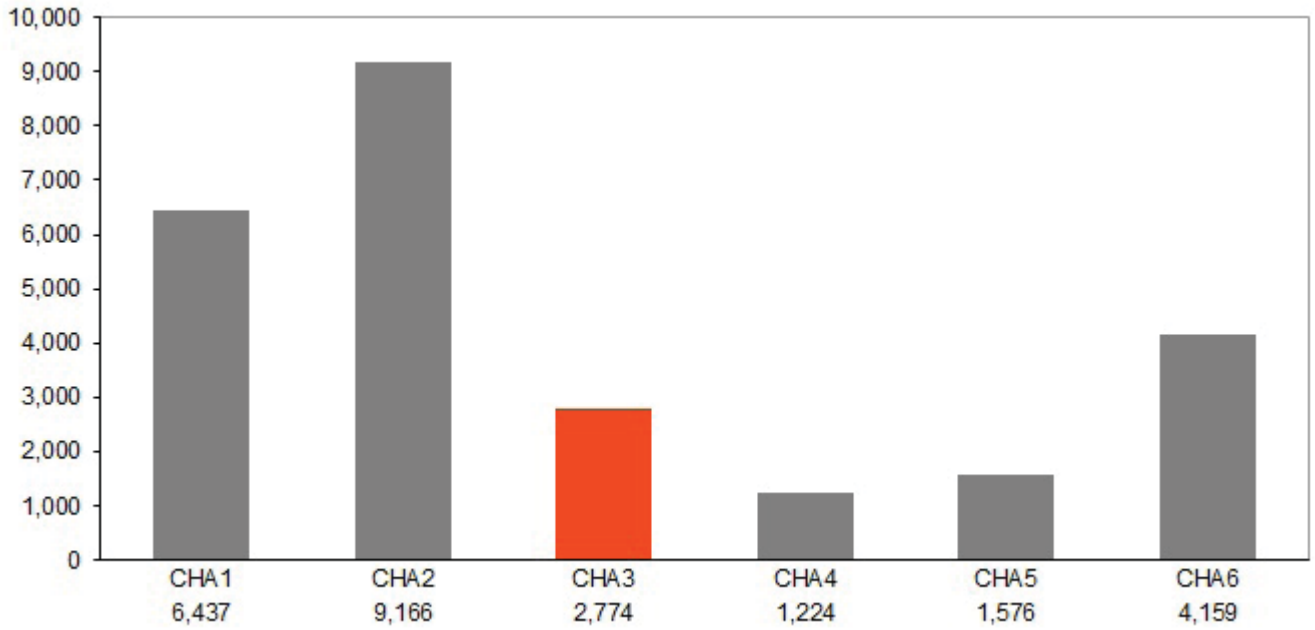
Source: City of Vancouver , 2009

Note: CHA 1, CHA 2, and CHA 5 have been excluded due to their non-residential zones, as distinguishing single-family dwellings with suites from other multi-family properties is impractical.

CHA 3 has the highest percentage of properties with secondary suites within Vancouver at 41%. This includes 57% of Kensington-Cedar Cottage, 44% of Renfrew Collingwood, and 38% of Hastings Sunrise properties, amongst the highest of all Vancouver neighbourhoods.

Secondary suites, involving the use of basements or the ground floors of houses to provide additional accommodation, are thought to provide affordable housing to renters and to facilitate home ownership by providing additional income to qualify and pay for mortgages.

FIGURE 28. Number of non-market housing units. Community Health Areas, 2011



Source: City of Vancouver, 2012

Non-market housing provides housing mainly for those who cannot afford to pay market rents. It is housing owned by government, a non-profit, or co-operative society where rents are determined not by the market but by the residents' ability to pay (City of Vancouver, 2010c). Non-market housing is designed for independent living. In 2010, non-market housing accounted for 8.4% of Vancouver's total housing stock (City of Vancouver, 2010b).

CHA 3 has 62 non-market housing complexes with 2,774 units. 13 are housing co-operatives, 19 are for seniors, 12 are for families, 4 for people with a mental illness, 3 for people with a disability, and 3 for Aboriginal people.

TABLE 11. Number of permanent and temporary shelter spaces. Community Health Areas, 2011/2012

	Permanent Shelter Spaces	Temporary Shelter Spaces	Sheltered Homeless Population	Street Homeless Population
CHA 1	261	80	533	127
CHA 2	298	216	461	134
CHA 3	0	0	no data available	no data available
CHA 4	18	0	19	no data available
CHA 5	103	140	128	6
CHA 6	0	0	no data available	no data available

Source: City of Vancouver, Personal Communication (2012, June 26)

All homeless counts underestimate the number of homeless people at one time and do not take into account the mobility of this population. CHA 3 has no shelter spaces to accommodate this population.

Note: For permanent shelters, three facilities that serve particularly vulnerable populations (e.g. youth safe houses) do not publish their locations and/or number of spaces due to safety concerns and have been excluded from these Profiles.

For temporary shelter spaces, these include all HEAT or Winter Response shelters that were open at any point during 2011/2012. These figures do not include Extreme Weather Alert shelter spaces.

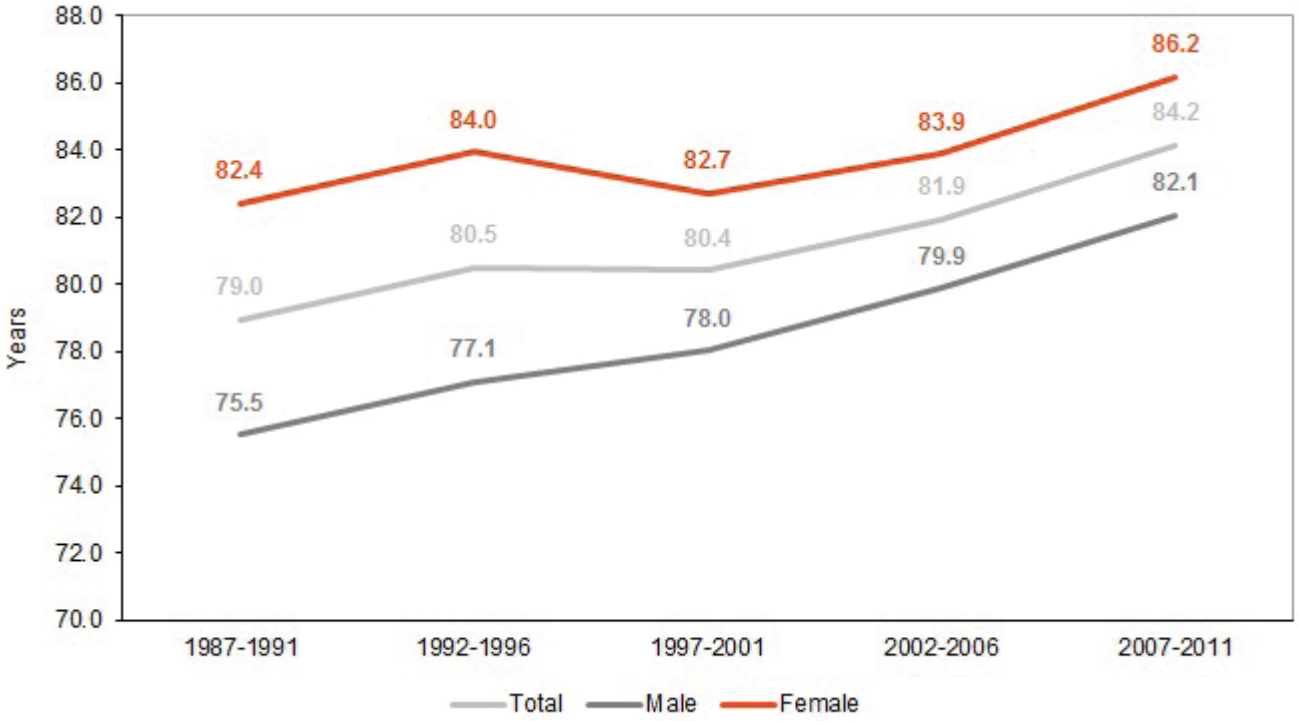
Health status

This section details the type of data used to profile the health of communities and illustrates the interaction between the determinants of health, illness and injury.

Understanding the health status of a population provides an opportunity to evaluate current health programs, and to be proactive in planning future health initiatives and tailoring interventions to meet community needs.

Life expectancy

FIGURE 29. Life expectancy at birth. Community Health Area 3, 1987-2011

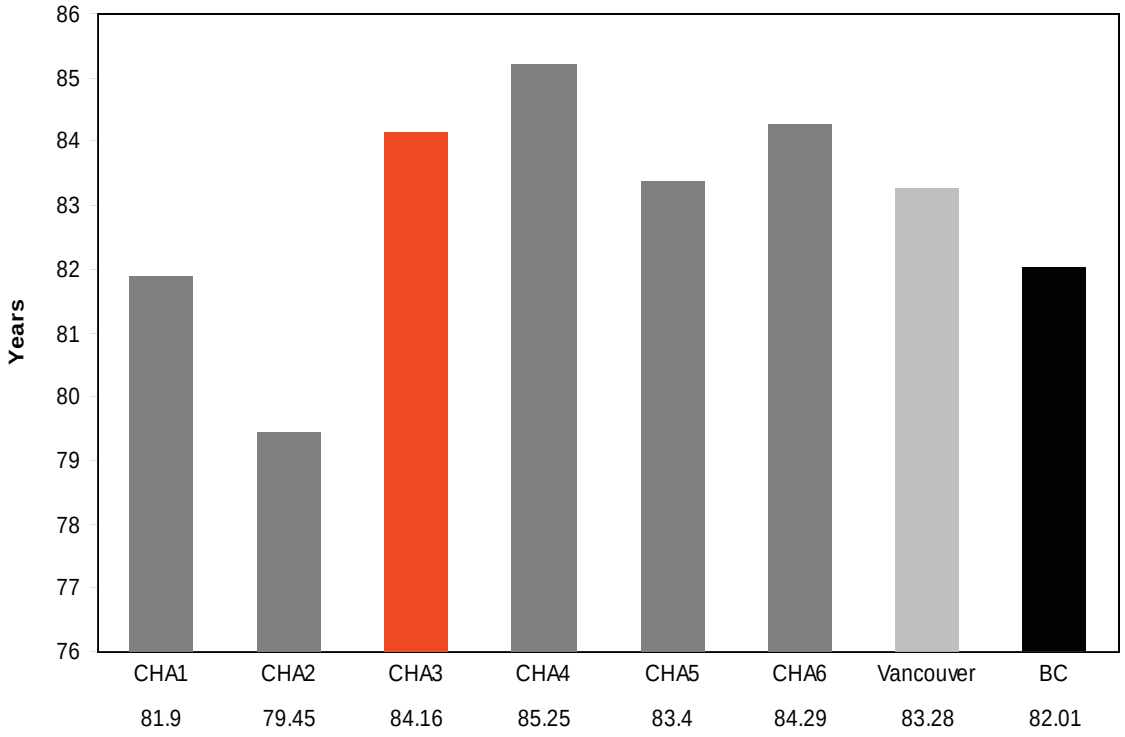


Source: BC Stats, 2012

Life expectancy at birth represents the mean number of years a birth cohort (persons born in the same year) may expect to live given the present mortality experience of a population. Life expectancy is an internationally accepted indicator of the health status of a population. (British Columbia Vital Statistics Agency, "Selected Vital Statistics and Health Status Indicators, Annual Report 2008" www.vs.gov.bc.ca/stats/annual/index.html)

Within CHA 3, life expectancy has been steadily increasing reaching a high of 84.2 years in 2007-2011, with females living 4.1 years longer than males.

FIGURE 30. Life expectancy at birth. Community Health Areas, Vancouver, and British Columbia, 2007-2011



Source: BC Stats, 2012

Figure 31 shows the average life expectancy for the total population (males and females together) within each CHA. Life expectancy in CHAs 3, 4, 5, and 6 is higher than the provincial average. While life expectancy in CHA 2 is the lowest among all CHAs, it is steadily increasing.

Births

FIGURE 31. Crude live birth rate per 1,000 population. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010

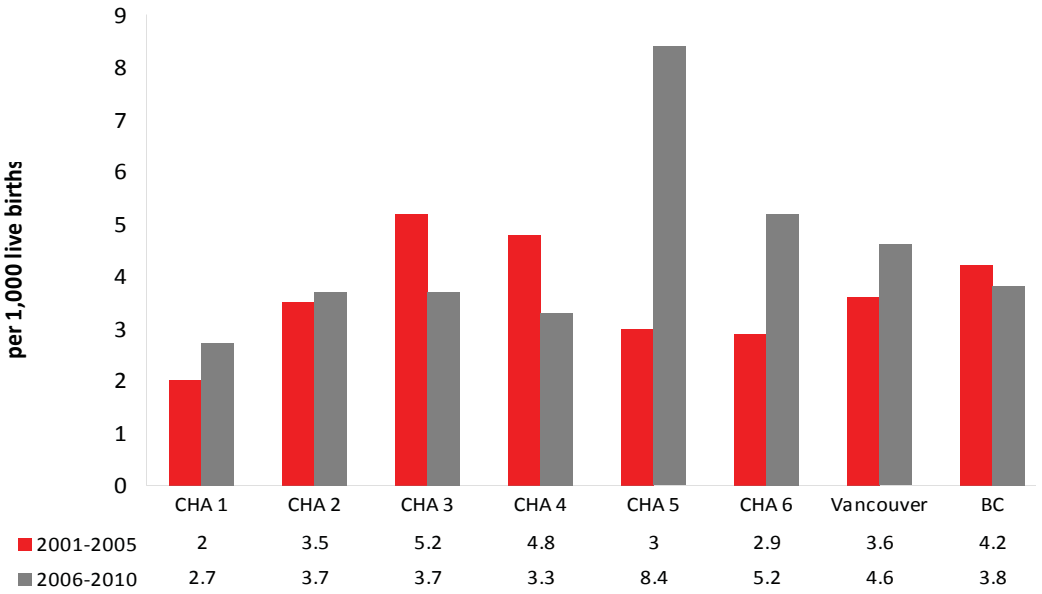
	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
2001-2005	7.9	8.3	11.3	8.6	11.8	9.8	9.6	9.8
2006-2010	8.4	7.9	10.6	8.6	11.8	9.7	9.5	9.9

Source: BC Vital Statistics Agency (VISTA), June 16, 2011

The crude live birth rate is the number of births divided by the mid-year population and converted to a rate per 1,000 population. Crude rates allow for comparisons to be made between different time periods or geographic areas where the populations are not identical (BC Vital Statistics Agency, 2009).

From 2001 through to 2010, CHA 3 has had the second highest live birth rate amongst the CHAs, only behind CHA 5. From 2006 to 2010, this was 10.4% higher and 6.6% higher as compared to Vancouver and BC, respectively.

FIGURE 32. Infant mortality rate per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010



Source: BC Vital Statistics Agency (VISTA), April 14, 2011

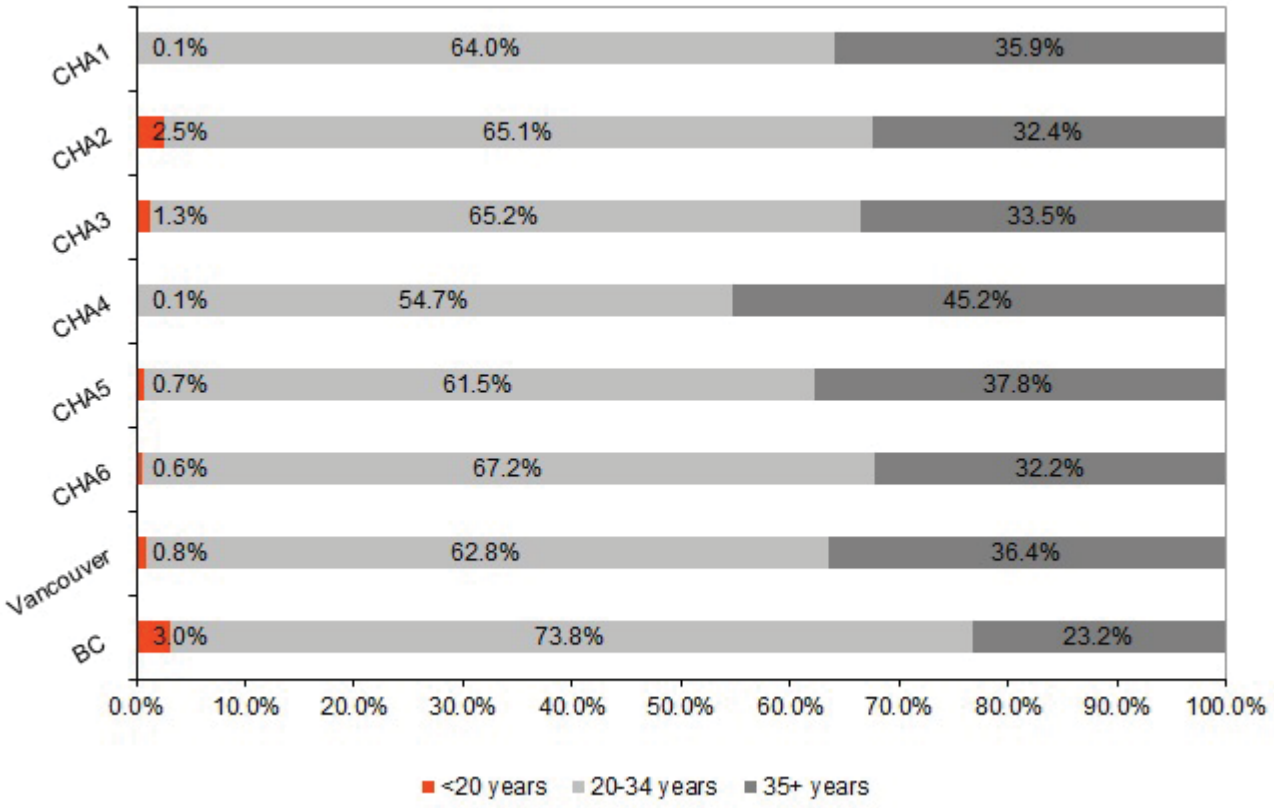
The infant mortality rate is calculated as the number of deaths of children less than one year of age per 1,000 live births in the same year. Infant mortality is an internationally accepted indicators of maternal and child health. "They reflect not only on the state of health care within a jurisdiction, but also on the social environments, the policy supports, and the priority that a society places on childbearing. Our societal goal is to improve infant health and reduce infant mortality to the lowest level possible". (British Columbia Provincial Health Officer, 2003).

Figure 32 shows that infant mortality rates increased in some CHAs between 2001-2005 and 2006-2010, notably CHAs 1, 2, 5 and 6. However, these rates need to be interpreted with caution as the population size is small giving rise to tremendous variability. The infant mortality rate in Vancouver increased slightly between 2001-2005 and 2006-2010. The rate in Vancouver is slightly higher than the provincial average.

In 2003 the BC Provincial Health Officer published a review of infant mortality rates in BC to determine whether increases in the number and rate of deaths in infants are long term trends or random fluctuations. It concluded that there is an overall trend in BC toward declining rate of infant mortality, though random fluctuations may occur in any given year.

Major causes of infant mortality include perinatal conditions (where the fetus or newborn is affected by maternal factors and complications of pregnancy, labour and delivery), respiratory and cardiovascular disorders specific to the perinatal period, congenital anomalies (such as defects of the heart and circulatory system), Sudden Infant Death Syndrome (SIDS) and pneumonia/influenza. Infant mortality can be reduced by ensuring access to maternal and newborn care as well as by attending to the environments in which infants live (e.g. via immunization, injury prevention, and measures to reduce the risk of SIDS). (British Columbia Provincial Health Officer, 2003).

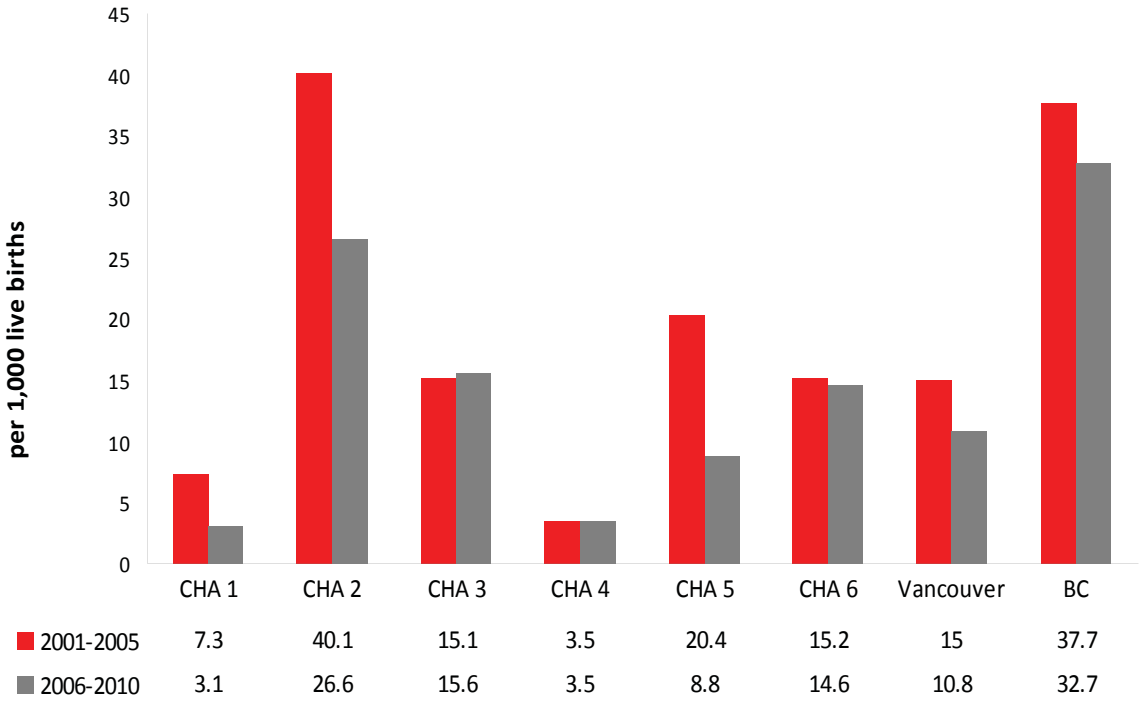
FIGURE 33. Live births by age of mother (%). Community Health Areas, Vancouver, and British Columbia, 2010



Source: BC Statistical Agency (VISTA), June 16, 2011

In 2010, CHA 3 had the second highest percentage of mothers who were less than 20 years of age when they gave birth.

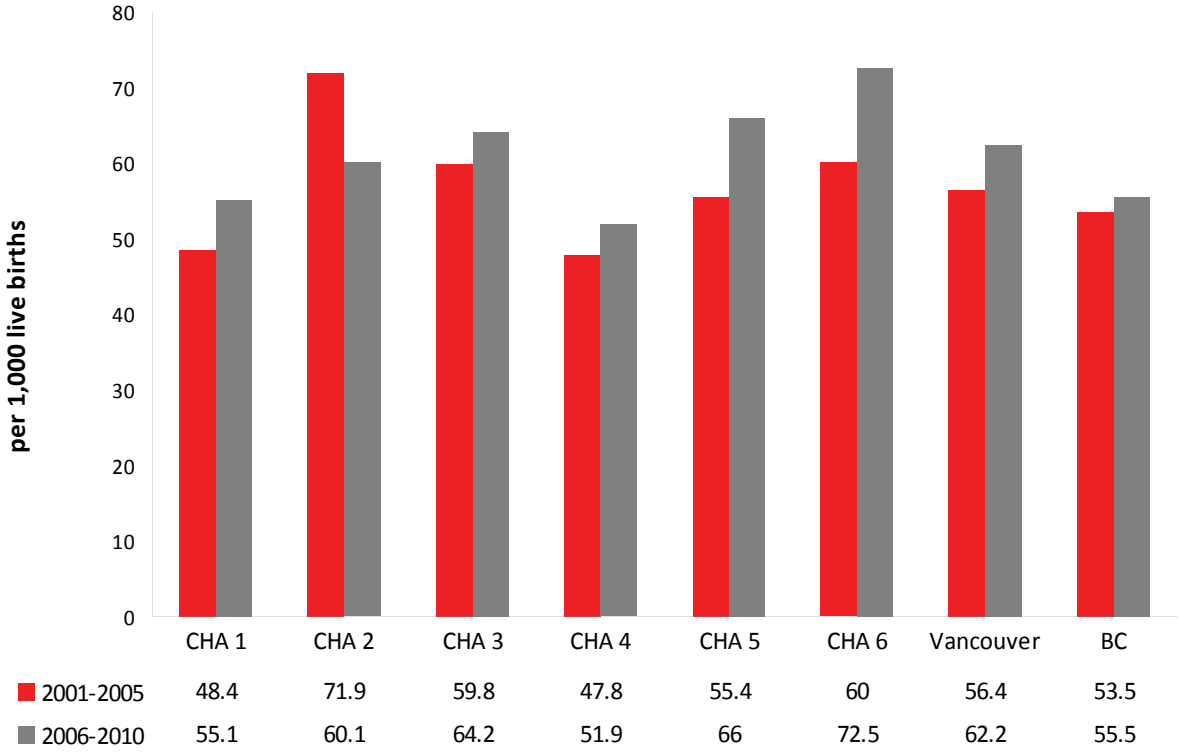
FIGURE 34. Teenage mother (females aged less than 20 years) birth rates per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010



Source: BC Vital Statistics Agency (VISTA), June 16, 2011

Within CHA 3, teenage mother birth rates have remained relatively stable from 2001 t0 2010. However, for the years 2006 through to 2010, CHA 3 had the second highest rate amongst the CHAs.

FIGURE 35. Low birth weight (less than 2,500 grams) rate per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010



Source: BC Vital Statistics Agency (VISTA), June 16, 2011

Figure 35 shows the number of low birth weight births for every 1,000 births in each CHA. For example, in CHA 3 there were 64.0 babies born with low birth rate for every 1,000 babies born between 2006 and 2010. This figure also shows that the rate of low birth weight is increasing in every CHA except in CHA 2. In CHA 2, between 2001-2005 and 2006-2010 the rate of low birth weight babies decreased from 71.7 to 59.3 of every 1,000 babies born.

There are many factors that contribute to low birth weight, and these factors tend to overlap. Risk factors for low birth weight include multiple births, pre-term births (less than 259 days gestation), maternal infections, maternal use of alcohol, tobacco, cocaine or narcotics, maternal experience of violence/abuse and fertility/IVF treatments. Efforts to address low birth weight need to be multidisciplinary and include substance use prevention and prenatal medical care.

Birth weight is an indicator of the general health of newborns, and a key determinant of infant survival, health and development. Low birth weight infants are at a greater risk of dying during the first year of life, and of developing chronic health problems (Human Resources and Skills Development Canada, 2012).

Mortality

Cancer mortality includes deaths from all forms of malignant tumours (neoplasms).

Cardiovascular disease mortality includes deaths from coronary heart disease, heart failure, hypertensive heart disease, and more.

Cerebrovascular disease mortality includes deaths from ischemic or hemorrhagic stroke as a result of blood clots or bleeding inside the head.

Chronic pulmonary disease mortality includes deaths from emphysema or chronic bronchitis.

Infectious disease mortality includes deaths from Human Immunodeficiency Virus (HIV), viral hepatitis, bacterial intestinal infectious, and other viral and bacterial infections. These are largely preventable and mortality is rare in most cases.

Unintentional ("accidental") injuries includes injuries due to causes such as motor vehicle collisions, falls, drowning, burns, and poisoning, but not medical misadventures/complications.

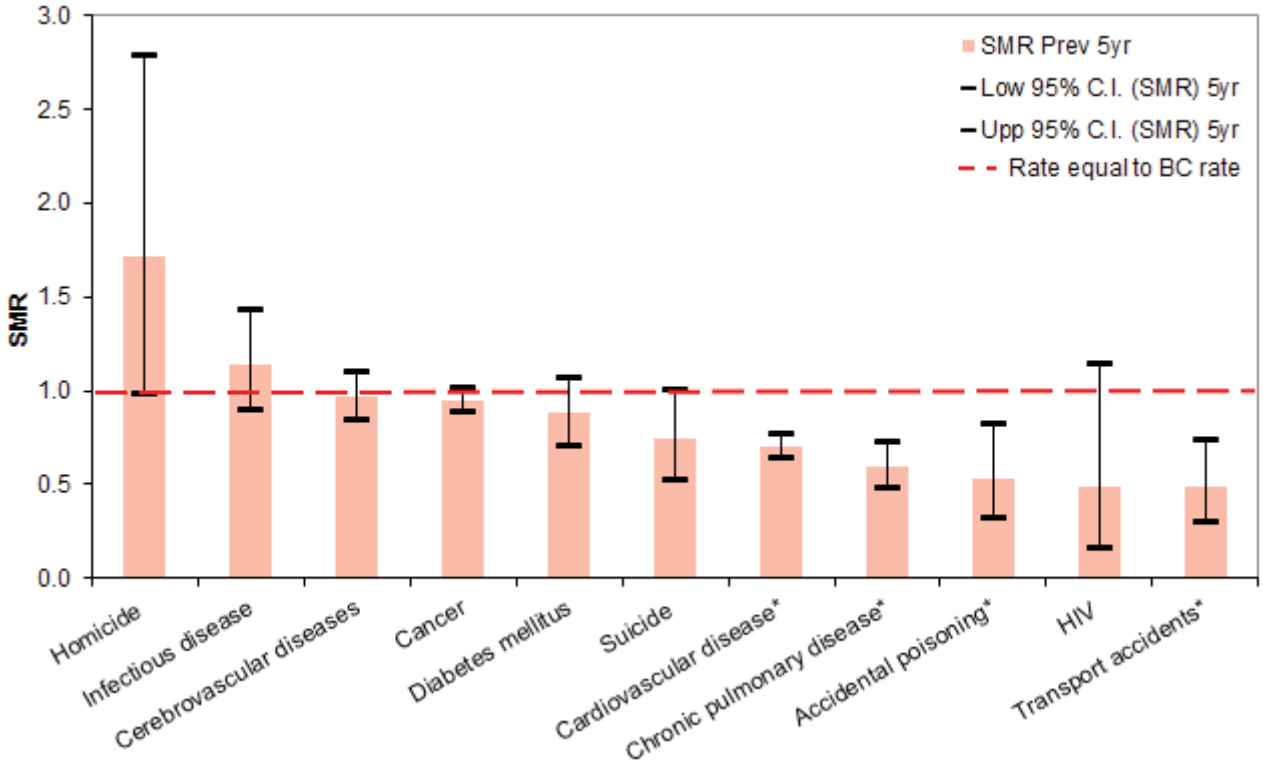
Table 12. Leading causes of death per 10,000 population. Community Health Areas, Vancouver, and British Columbia, 2006-2010

Cause of death	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
Malignant neoplasms	15.8	19.2	18.0	14.5	13.8	16.4	16.1	20.2
Cardiovascular disease	10.1	14.6	9.9	12.1	10.0	13.8	11.7	15.4
Cerebrovascular diseases	3.8	4.6	4.6	4.6	4.8	5.2	4.6	5.3
Unintentional injuries	1.9	7.3	1.8	1.6	2.0	1.8	2.3	3.1

Souce: BC Vital Statistics Agency (VISTA), October 2012.

With the exception of CHA-2, the top three leading causes of death for each region are malignant neoplasms, cardiovascular disease and cerebrovascular diseases. For CHA-2, the top three leading casues of death are malignant neoplasms, cardiovascular disease, unintentional injuries.

FIGURE 36. Standardized mortality ratio (SMR) by specific cause of death. Community Health Area 3, 2007-2011



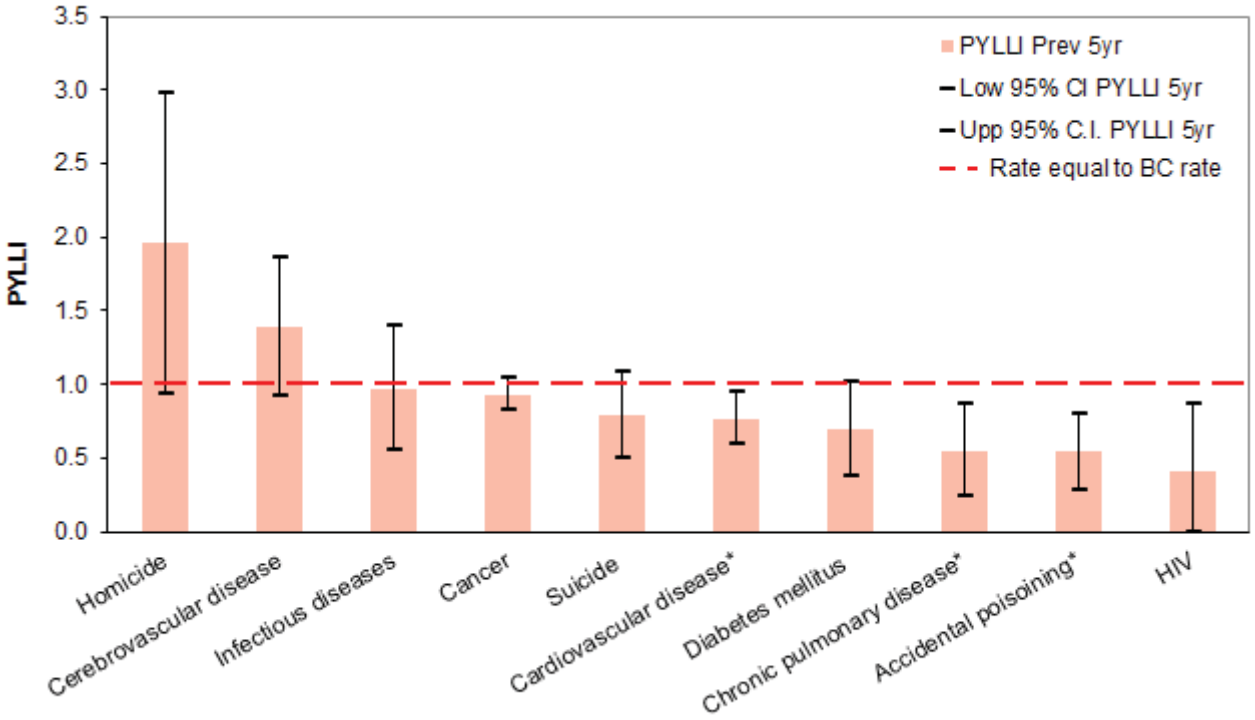
Source: BC Vital Statistics Agency (VISTA), July 28, 2011

The standardized mortality ratio (SMR) is a ratio of the number of deaths occurring to residents of a geographic area to the expected number of deaths in that area based on provincial age-specific mortality rates (BC Vital Statistics Agency, 2009).[1]

Within CHA 3, there are significantly fewer deaths related to cardiovascular disease (0.7), chronic pulmonary disease (0.6), transport accidents (0.4), and accidental poisonings (0.53) than what is based on provincial rates. CHA 3 has highest SMR for homicide and the lowest for cardiovascular disease and chronic pulmonary disease.

[1] SMR=1, the observed deaths in the area are as would be expected based on provincial rates; SMR>1, observed deaths are higher than expected; SMR<1, observed deaths are lower than expected; The black bars show the 95% confidence interval (CI) or range of accuracy

FIGURE 37. Potential years of life lost index (PYLLI) by specific cause of death. Community Health Area 3, 2007-2011



Source: BC Vital Statistics Agency (VISTA), July 28, 2011

The potential years of life lost is the number of years of life lost when a person dies before a specified age (75 years). It is an indicator of premature death and highlights the causes of death that occur at younger ages.

Within CHA 3, there are significantly fewer premature deaths related to cardiovascular disease, chronic pulmonary disease, and unintentional injuries than what is expected based on provincial rates. Similar to the Standardized Mortality Ratio shown in Figure 36, CHA 3 has the highest PYLLI for homicide at 1.96.[2]

[2] The PYLL index (PYLLI) is the ratio of the geographic area's observed PYLL to its expected PYLL. The black bars show the 95% confidence interval (CI) or range of accuracy of the PYLLI.

TABLE 13. Age specific suicide rates per 10,000 people. Community Health Areas, Vancouver, and British Columbia, 2006-2010 (compared to 2001-2005)

	CHA 1	CHA 2	CHA 3	CHA 4	CHA 5	CHA 6	Vancouver	BC
< 24 years	2.3 (2.5)	1.7 (2.6)	2.3 (0.6)	0.7 (0.8)	1.6 (1.1)	1.4 (1.0)	1.5 (1.1)	1.6 (1.9)
25-44 years	1.4 (1.2)	2.7 (3.5)	0.8 (1.4)	0.6 (0.8)	0.7 (1.5)	0.8 (0.7)	1.1 (1.4)	1.2 (1.5)
45-64 years	3.3 (3.1)	3.5 (4.3)	0.7 (1.7)	1.6 (1.3)	1.4 (1.7)	1.0 (0.8)	1.8 (1.9)	1.4 (1.6)
65-84 years	1.4 (1.8)	2.5 (2.2)	1.4 (0.9)	1.0 (1.2)	0.5 (1.5)	1.0 (1.2)	1.2 (1.4)	1.2 (1.2)
85+ years	2.4 (5.3)	0.0 (0.0)	0.0 (7.9)	2.0 (1.5)	1.5 (1.8)	1.3 (0.0)	1.4 (2.4)	1.3 (1.8)

Source: BC Vital Statistics Agency (VISTA), July 28, 2011

Table 13 shows the suicide rates for five age groupings for the periods 2006-2010 compared with 2001-2005. Overall in Vancouver the highest rate is within the age group of 45-64 years.

The BC Crisis Centre reports various statistics about suicide. While suicide deaths include people from all socioeconomic, age, gender, culture and ethnic groups, some groups experience higher rates. Suicide rates tend to be higher among youth, Aboriginal peoples and people who identify as lesbian, gay, bisexual, transgender and two-spirit. It is estimated that in more than 70 percent of suicides, the person was suffering from one or more unmanaged mental health issues.

In CHA 3 the highest suicide rate in 2006-2010 is within the age group of under 24.

TABLE 14. Lifestyle related deaths, Community Health Area 3, 2006-2010

	Standardized Mortality Ratio (SMR)	Potential Years of Life Lost (PYLL)	PYLL Index (PYLLI)
Alcohol-related	0.52*	1560	0.44*
Medically treatable	0.77	335	0.67
Drug induced	0.58*	898	0.6*
Smoking attributable	0.82*	2481	0.85*

*significantly different from expected values based on provincial rates
Source: BC Vital Statistics Agency (VISTA), March 2011

Within CHA 3, there are significantly fewer deaths and premature deaths from alcohol, drugs, and tobacco use than provincial rates.

Alcohol-related deaths include deaths where alcohol was a contributing factor (indirectly related) as well as those due to alcohol (directly related). Alcohol-related and drug overdose deaths are the only cause of death categories that are not based entirely upon underlying causes of death.

Deaths due to drug-induced causes excludes unintentional injuries, homicides, and other causes that could be indirectly related to drug use and are based on those used by the National Center for Health Statistics.

Medically treatable disease deaths are ones for which mortality could potentially have been avoided through appropriate medical intervention. The incidence of deaths from medically treatable diseases can be used by public health professionals as a way of monitoring the effect of health promotion programs.

The absence on death certificates of complete and reliable data on smoking requires the use of estimation techniques to approximate the extent of smoking-attributable deaths. These are derived by multiplying a smoking-attributable mortality percentage by the number of deaths aged 35+ years in smoking-related categories including cancers, circulatory system diseases, and respiratory system diseases (BC Vital Statistics Agency, 2009).

Chronic and communicable disease

Chronic diseases are typified by long duration and slow progression. They are by far the leading cause of death across Canada.

Human Immunodeficiency Virus (HIV) is a virus that attacks the immune system, resulting in a chronic progressive illness that leaves people vulnerable to opportunistic infection. HIV is transmitted from person to person through unprotected sexual intercourse, shared needles or equipment for injection drug use, or perinatally (from mother to her baby) (Public Health Agency of Canada, 2012).

Hepatitis C is a virus that results in chronic liver disease and is transmitted in the same ways as HIV, i.e. sharing of sharp instruments or unsterilized personal hygiene equipment with an infected person, sharing of drug-use equipment, unprotected sexual intercourse, or perinatally.

TABLE 15. Chronic and communicable disease new diagnosis rates per 100,000 people. Community Health Area 3, Vancouver, and British Columbia

	CHA 3	Vancouver	BC
Chronic disease new diagnosis rate per 100,000 population, 2010/11 (compared to 2008/09)			
Arthritis (osteoarthritis and rheumatoid arthritis)	491.7 (467.6)	487.2 (447.6)	690.5 (642.8)
Cardiovascular disease	337.5 (334.3)	358.5 (364.8)	421.7 (469.6)
Chronic obstructive pulmonary disease (COPD)(aged 45+ years)	320.6 (490.7)	298.0 (476.1)	424.7(643.5)
Diabetes	829.2 (682.1)	641.0 (561.3)	644.6 (650.4)
Communicable disease new diagnosis rate per 100,000 population, 2009/11 (compared to 2006/08)			
HIV (males)	15.8 (19.2)	42.0 (51.0)	11.1 (13.7)
HIV (females)	0.6 (5.8)	5.2 (7.9)	2.6 (3.3)
Hepatitis C	31.3 (45.8)	58.4 (75.7)	N/A (64.3)

Sources: BC Primary Health Care Disease Registries, November 2011, BC Centre for Disease Control, Annual Report 2011, VCH, Public Health Surveillance Unit (PARIS), July 16 2012

In 2010/11, CHA 3 had the second highest chronic disease new diagnosis rate for diabetes among the CHAs. The new diagnosis rate for COPD in CHA 3 decreased by 34.7% from 2008/09 to 2010/11. CHA 3 also has some of the lowest new diagnosis rates for both HIV (males) and Hepatitis C within Vancouver, each of which have shown a decrease from 2006-2008 to 2009-2011.

Note: Chronic disease cases are notified to various registries by primary care physicians and therefore these numbers may not truly reflect incidence. Communicable disease data are collected by primary care physicians, laboratories, hospitals and institutions and reported to the local public health unit through a mandatory notification system. Even though the reporting of diseases is mandatory under legislation, the number of cases may be underreported for a number of reasons: 1) not all diseases present signs and symptoms, 2) not all individuals who experience illness seek care, and 3) health care providers do not always conduct laboratory tests.

School-age immunization coverage

Immunization is one of the most effective methods to protect adults and children from communicable disease illness or deaths. Widespread immunization reduces the number of susceptible people making it difficult for disease to spread from person to person (British Columbia Centre for Disease Control, 2011)

The figures below report on two indicators for school immunization coverage. Meningococcal C immunization protects against meningoccal infection that affects the lining around the spinal cord and brain often resulting in death or permanent brain damage to those who survive. The Tdap immunization protects against the potentially lethal diseases of diphtheria, tetanus, and pertussis (British Columbia Centre for Disease Control, 2011).

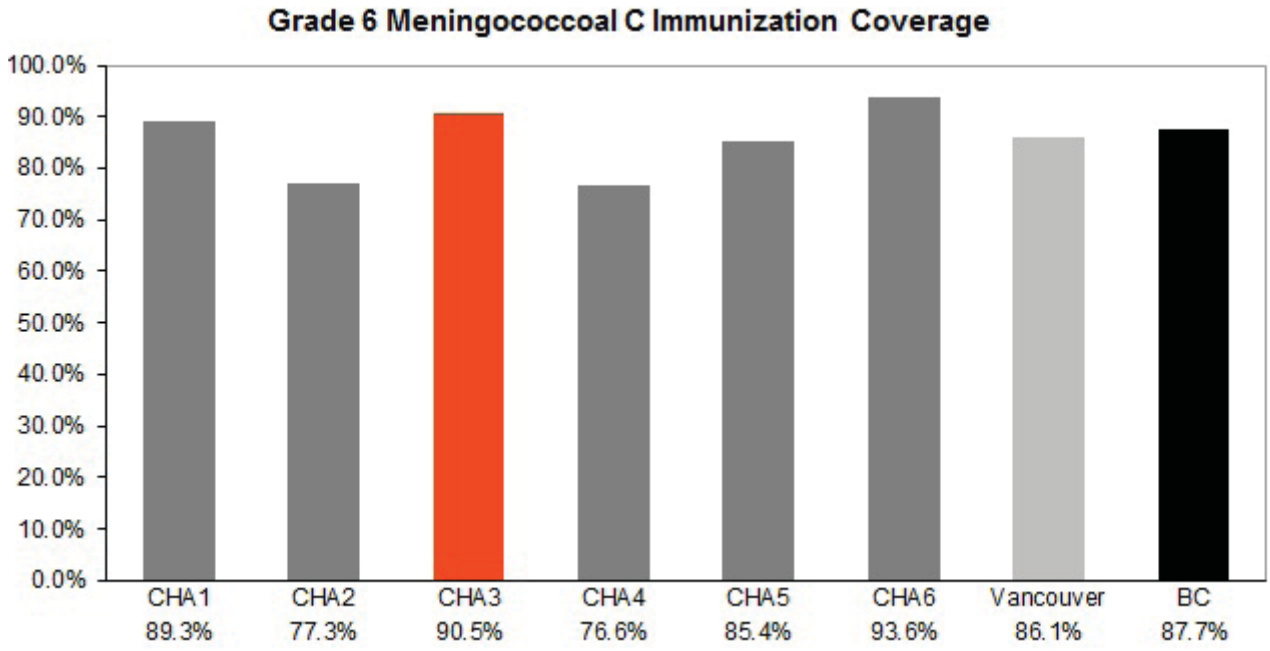
BC's publicly funded immunization program offers many vaccinations free of charge. VCH is the public health authority in Vancouver responsible for providing these vaccinations in the school setting, however, private practice general practitioners may also provide the vaccine (British Columbia Centre for Disease Control, 2011).

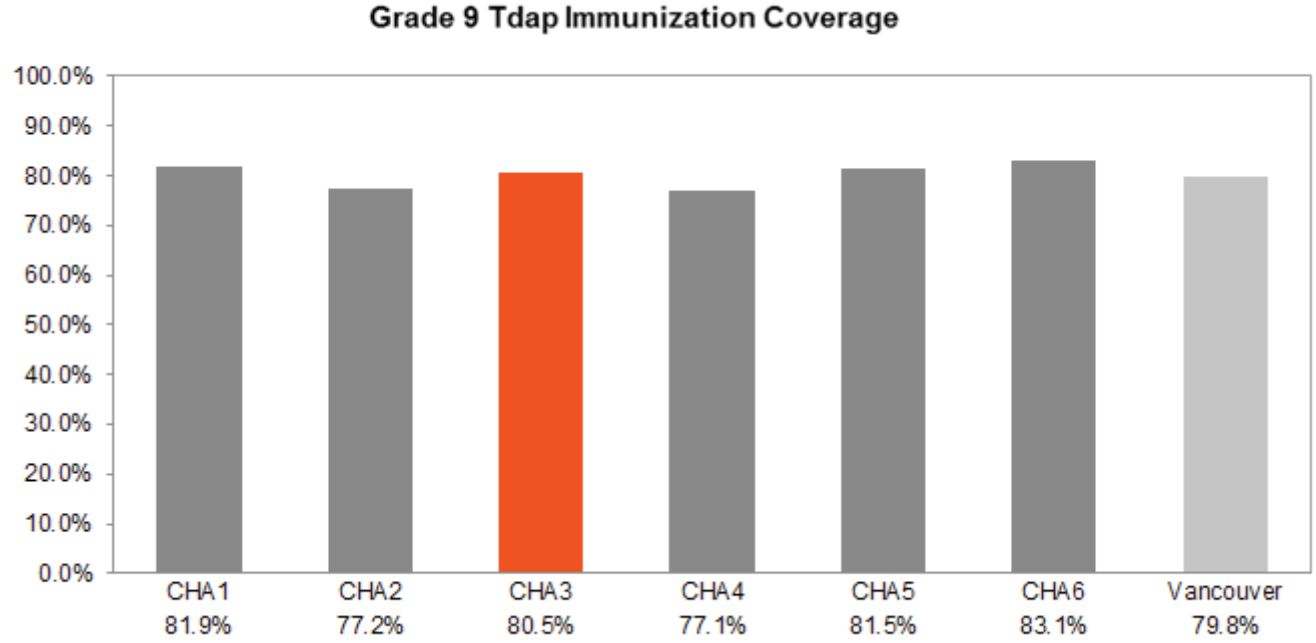
Immunization coverage in CHA3 is comprehensive, with 90% of grade 6 students having been vaccinated against Meningococcal C and around 80% of grade 9 students having been vaccinated against tetanus, diphtheria and pertussis (Tdap).

Immunization coverage may be lower in certain community health areas for several reasons. Although vaccines are demonstrated to be safe, some families do not consent to their children receiving vaccinations. Some children may receive vaccinations via their primary care practitioner and not through VCH public health.

Newcomer students also tend to have lower rates of immunization. They may have been vaccinated in their home countries but have incomplete records or they may be living with sponsors or in home-stay situations with adults who are unable to authorize vaccinations for minors.

FIGURE 38. Grade 6 Meningococcal C and Grade 9 Tdap (tetanus, diphtheria and pertussis) immunization coverage, Community Health Areas, Vancouver, and British Columbia, 2010/11 school year





Source: Vancouver Coastal Health Public Health Surveillance Unit, August 18, 2011

Immunize BC, 2011

Primary Access Regional Information System (PARIS) for Vancouver, August 18, 2011 via Vancouver Coastal Health, Public Health Surveillance Unit

Health service utilization

Health care utilization has evolved as the population's need for care has changed over time. Factors which have influenced the population's need for care include: aging, socio-demographic population shifts and changes in the prevalence and incidence of different diseases.

The prevalence of chronic health conditions has resulted in the emergence of both residential and community-based health services designed to promote functional independence and hence, keep people out of institutional settings.

Health service utilization data provide valuable insight into the health of a population and can be used to help determine the allocation of health prevention efforts and resources.

Acute care services

Acute care services include hospital admissions related to the:

- Circulatory system include heart disease, hypertensive disease, and diseases of the arteries or veins
- Digestive system include diseases of the oral cavity, esophagus, stomach, small intestine, liver, gallbladder, appendicitis, hernia, enteritis and colitis
- Respiratory system include pneumonia, influenza, COPD, and acute respiratory infections
- Mental disease and disorders include organic brain disorders, mental and behavioural disorders due to psychoactive substance use, schizophrenia, mood disorders, and more

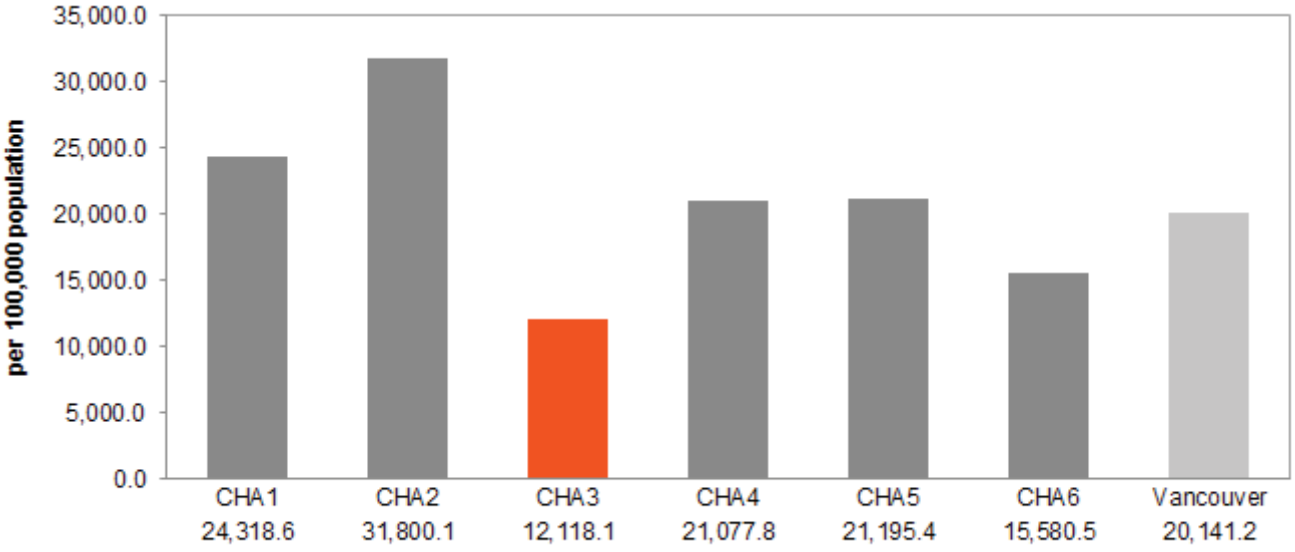
TABLE 16. Acute care hospital admissions (inpatient) by clinical category per 100,000 population. Community Health Areas, Vancouver and British Columbia, 2007/08

	CHA1	CHA 2	CHA3	CH4	CH5	CHA 6	Vancouver	BC
Circulatory system	500.7	717.8	595.4	557.8	582.4	682.6	598.0	1049.5
Mental disease and disorders	666.4	1669.1	504.5	426.8	514.2	477.0	645.8	645.2
Respiratory system	329.7	992.5	488.9	514.2	687.1	508.7	495.6	622.3
Significant trauma, injury, poisoning, and toxic effect of drugs	417.1	688.6	447.8	457.4	470.6	458.1	471.9	705.2
Pregnancy and childbirth	962.5	882.6	1221.2	993.0	1353.1	1175.4	1102.3	1184.9

Source: BC Ministry of Health Services, Management Information Branch (Discharge Abstract Database), December 2008 via Vancouver Coastal Health Authority Knowledge Base

As compared to Vancouver, CHA 3 has similar rates of acute care hospital admissions across all clinical categories.

FIGURE 39. Emergency room visits per 100,000 people. Community Health Areas and Vancouver, 2010



Source: Vancouver Coastal Health, Emergency Department Systems (CareCast, Eclipsys and McKesson

In 2010, the rate for emergency room visits by CHA 3 residents was 12,118.1 visits per 100,000 population. This was the lowest rate amongst the CHAs, and 66.2% lower as compared to Vancouver overall.

Home and community care services

Adult day centres (ADC) are community based services for seniors and people with disabilities that provide health care supports such as medication management, personal care such as bathing, health education, and therapeutic social and recreational programs such as meal programs, fitness, and out trips. The purpose of ADCs is to support people to remain at home and provide respite for their caregivers.

Assisted living provides housing plus supportive health services for seniors or people with physical disabilities who need extra help with meals and personal care (i.e. bathing, grooming, dressing and medication management).

Physical and occupational therapy, also known as community rehabilitation services, provides assessment, consultation, treatment and education to clients and their families in home or community clinics to help clients improve or maintain physical and functional abilities.

People are eligible for home nursing if they have been released from hospital and need short-term care, have an ongoing or chronic health issue requiring more complex care, or have a worsening health issue and need help to continue living at home. Services provided by home care nurses include assessment, education, counselling, medical and post surgical care, and palliative care.

Home support provides care for those just released from hospital or as a means of prevention from going to the hospital by providing services such as personal grooming, special exercises, and support and relief for the primary caregiver to help people remain independent and safe in their own home as long as possible.

Residential care (RC) is for people who have complex care needs and can no longer remain safely in their own home. RC clients require 24 hour nursing care in a supervised and secure environment (Vancouver Coastal Health, 2011.)

TABLE 17. Home and community care utilization rates per 1,000 people. Community Health Area 3 and Vancouver, 2010/11

	CHA 3	Vancouver
Adult Day Service	2.1	1.4
Assisted Living Service	0.9	1.0
Case Management Services	7.0	8.3
Community Rehabilitation Services	10.5	10.2
Home Nursing Services	7.7	8.6
Home Support Services	6.4	7.9
Home Support Services - Short Term	2.5	2.6
Residential Care Services	5.7	8.1

Source: Vancouver Coastal Health, June 28, 2012

People aged 65 years and over make up 13.1% of the CHA 3 population and this age group are projected to increase to 25.9% of the population over the next 25 years. One of the primary challenges currently facing the health care system is to ensure that there is an adequate supply of home and community care services so that people can avoid institutional care. The volume of clients receiving these services is determined both by the demand for the service (reflecting the proportion of the CHA that is elderly and their health status) and the resources available.

TABLE 18. The number of publicly funded assisted living, hospice, and residential care beds. Community Health Areas and Vancouver, 2010/2011

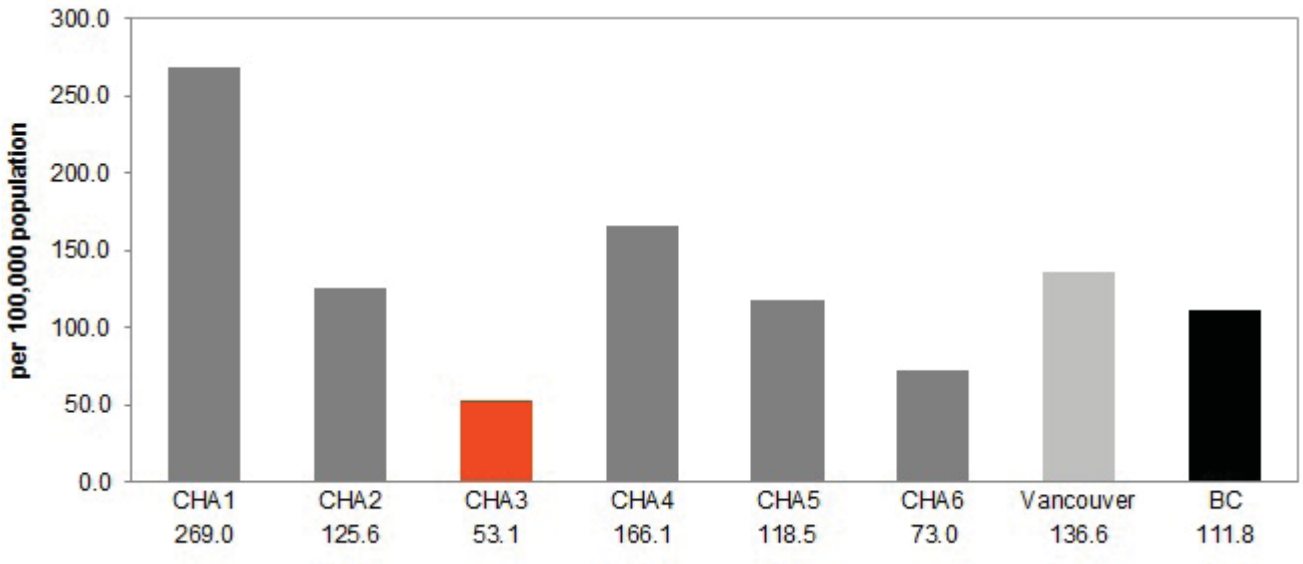
	Assisted Living	Hospice	Residential Care
CHA 1	113	12	917
CHA 2	105	6	185
CHA 3	96	10	474
CHA 4	15	0	888
CHA 5	75	0	387
CHA 6	199	0	1035
Vancouver	603	28	3886

Source: Vancouver Coastal Health, 2010

CHA 3 is home to roughly 16% of Vancouver's assisted living beds and 12% of Vancouver's residential care beds. It is home to approximately one-third of the hospice beds in the city.

Note: Assisted living, hospice, and residential care facilities are open to all residents and do not just serve a surrounding community. Some residents in a community health area might access home and community health services outside their area of residence but often prefer to stay in their neighbourhood whenever possible.

FIGURE 40. General physicians per 100,000 population. Community Health Areas, Vancouver, and British Columbia, 2009



Source: BC Ministry of Health Services Health System Planning Division, Medical Services Plan Information Resource Manual, 2008/2009

CHA 3 has the lowest number of general physicians amongst the CHAs.

Neighbourhoods in CHA 3

Northeast Vancouver CHA 3 is composed of three of the city's oldest neighbourhoods: Hastings Sunrise, Renfrew Collingwood, and Cedar Cottage. Although each has its own unique character, there is a fair degree of consistency in the profile of their residents.

Hastings-Sunrise

Boundaries: stretching from Boundary Road to Nanaimo Street and from East Broadway to the Burrard Inlet

Area (hectares): 812

Population: 33,130

Hastings-Sunrise includes Hastings Park, home of the Pacific National Exhibition and Hastings Racecourse; Vancouver Heights, located on the east side of the Cassiar Connector and Highway #1; and a dense strip of shops and services along East Hastings Street.

Hastings-Sunrise is primarily working class, known for its Italian-Canadian community, with 5.5% reporting Italian as their mother tongue. More recently, there has been an influx of immigrants from China and Southeast Asia, with 39.6% reporting Chinese, 3.9% reporting Vietnamese, and 2.5% reporting Tagalog as their mother tongue. Similar to all other CHA 3 neighbourhoods, it has a high percentage of persons aged 19 years and under (21.5%) and the highest percentage of persons aged 65 years and over (16.2%). Residents have a median household income, after-tax of $49,907. The average gross rent is $823, with rentals making up 35.6% of dwellings (City of Vancouver, 2009).

As part of the City of Vancouver's Community Vision Program, the Hastings-Sunrise (H-S) Community Vision was approved by City Council in 2004 making recommendations to City Council to set priorities for funding, programs, and services, providing a focus on local actions and initiatives.

Renfrew-Collingwood

Boundaries: stretching from Boundary Road to Nanaimo Street and from Broadway and Lougheed Highway on the north to 41st Avenue and Kingsway on the South

Area (hectares): 820

Population: 48,885

Renfrew-Collingwood is the largest and most populated neighbourhood in the CHA 3 area. It encompasses the light industrial and big box shopping areas between Broadway and Grandview Highway, and the 11 acre Collingwood Village with 2,800 housing units- a mix of rental, strata, and co-operative housing- and community amenities.

Within Renfrew-Collingwood, there is a high immigrant population, where 42.7% report Chinese, 6.0% report Tagalog, 4.0% report Vietnamese, 2.5% report Punjabi, and 2.0% report Hindi as their mother tongue. Similar to all other CHA 3 neighbourhoods, it has a high

percentage of persons aged 19 years and under (21.9%) and 65 years and over (13.8%). Residents have a median household income, after-tax of $47,320. The average gross rent is $811, with rentals making up 34.7% of dwellings. Renfrew-Collingwood has the highest number of families (13,430) with an average 2.9 people per household (City of Vancouver, 2009).

As part of the City of Vancouver's Community Vision Program, the Renfrew-Collingwood (R-C) Community Vision was approved by City Council in 2004 and makes recommendations to City Council to set priorities for funding, programs, and services, providing a focus on local actions and initiatives.

Cedar Cottage

Boundaries: stretching from 16th Avenue/Kingsway to 41st Avenue and from Fraser Street to Kingsway/Nanaimo

Population: 47,471

Often referred to as "Kensington-Cedar Cottage" (KCC), this area is composed of two historic neighbourhoods that fall into two different Community Health Areas: Cedar Cottage - just north of Kingsway (Northeast CHA 3) - and Kensington to the south (Midtown CHA 5).

NOTE: neighbourhood socio-demographic statistics uniquely related to Cedar Cottage or Kensington are not available as the city neighbourhood boundaries combines Cedar Cottage with Kensington.

Property use in Kensington is mostly residential with two commercial zones (Knight and Kingsway and Victoria and 41st). KCC has the highest percentage of persons aged 19 years and under (21.9%) and is ethnically diverse with 34.5% reporting English, 33.3% reporting Chinese, 6.4% reporting Tagalog, 5.3% reporting Vietnamese, and 3.1% reporting Punjabi as their mother tongue. The median household income, after-tax is $49,484. KCC is home to mostly single detached houses (25.2%), detached duplexes (44.7%), and low-rise apartments (26.5%). Rentals make up 40.5% of dwellings at an average gross rent of $790 (City of Vancouver, 2009).

CHA 3 community resources

Public elementary schools

23 in total

9 in Hastings Sunrise (Sir Matthew Begbie, Sir John Franklin, Garibaldi Annex, Hastings, Dr A.R. Lord, Chief Maquinna, Maquinna Annex, Tillicum Annex and Thunderbird)

8 in Renfrew-Collingwood (Lord Beaconsfield, Graham D. Bruce, Sir Guy Carleton, Sir Wilfred Grenfell, John Norquay, Nootka, Renfrew and Collingwood Neighbourhood/Bruce Annex)

6 in Cedar Cottage (George T. Cunningham, Charles Dickens, Queen Alexandra, Laura Secord, Lord Selkirk, and Tyee)

Public secondary schools

3 in total

2 in Renfrew-Collingwood (Windermere and Vancouver Technical)

1 in Cedar Cottage (Gladstone)

Family resource programs

7 Strong Start Programs (Collingwood, Queen Alexandra, Grenfell, Selkirk, Thunderbird, Tillicum Annex, Maquinna Annex)

Several family resource programs operate by community centres and neighbourhood houses

Note: Family Places / family resource programs are parent / child interactive programs for families with children 0-6 years. Family resource programs are unique from other early childhood development programs in that parent and child attend together. Family resource programs have five core areas of service which include: family support, play-based learning, early literacy, learning and care, parent education, and information and referrals. They are low cost or free with subsidies readily available. Family Places may be independent stand-alone organizations or embedded in a multi-service agency such as a neighbourhood house.

Non-market housing complexes

62 in total

17 in Hastings-Sunrise: 3 housing co-operatives, 7 for seniors, 3 for families

24 in Renfrew-Collingwood: 7 housing co-operatives, 7 for seniors, 5 for families, 2 for Aboriginal people, 1 for persons with a mental illness

21 in Cedar Cottage: 3 housing co-operatives, 5 are for seniors, 4 are for families, 3 are for people with a mental illness, and 2 are for people with a disability

Publicly funded VCH assisted living facilities

The Cedars at Beulah Gardens

Publicly funded VCH residential care facilities

Adanac Park Lodge

Lakeview Care Centre

Renfrew Care Centre

Three Links Care Centre

Villa Carital

Publicly funded VCH hospice facilities

St. James Cottage Hospice

Adult Day Centres

The Cedars at Beulah Gardens

Cedar Cottage ADC

Renfrew Collingwood Senior's Society

Public parks

36 in total (including Trout Lake Park)

Libraries

Hastings Branch Library

Renfrew Branch Library

Collingwood Branch Library

Kensington Branch Library

Community centres

- Thunderbird Community Centre
- Hastings Community Centre
- Renfrew Park Community Centre
- Trout Lake Community Centre

Neighbourhood houses

- Collingwood Neighbourhood House
- Frog Hollow Neighbourhood House
- Cedar Cottage Neighbourhood House
- Kiwassa Neighbourhood House

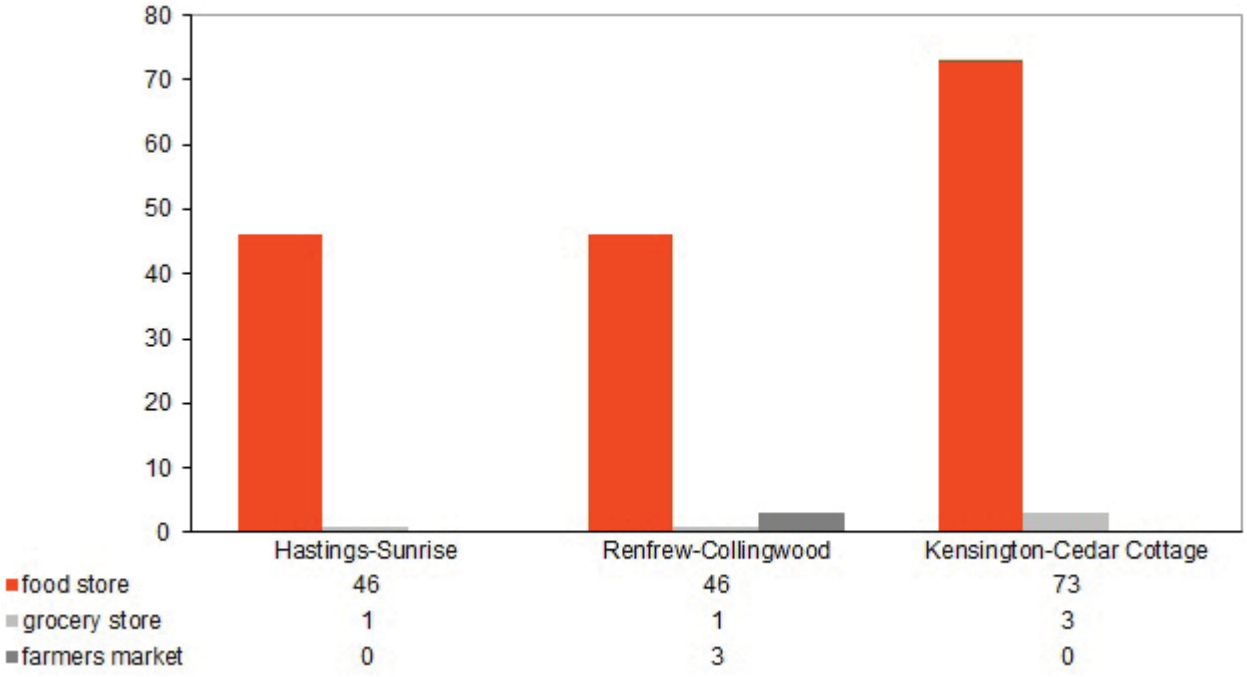
Community policing centres

- Hastings Sunrise Community Policing Centre
- Collingwood Community Policing Centre

Business improvement areas

- 2 (Collingwood and Hastings-North)

FIGURE A. Number of food stores by type. Community Health Area 3, 2009



Food stores include stores identified by subtypes including "convenience store," "vitamins/ health food," "pharmacy", and "other", and includes non-food stores that may have some food.

Vancouver Coastal Health Community Resources

Evergreen Community Health Centre
3425 Crowley Drive
Vancouver, BC V5R 6G3
Tel: 604-872-2511

Northeast Mental Health Team
2750 E Hastings Street
Vancouver, B.C V5K 1Z9
Tel: 604-675-3890

For mental health services, addiction services, youth clinics, and other health related information, please contact your local community health centre.

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