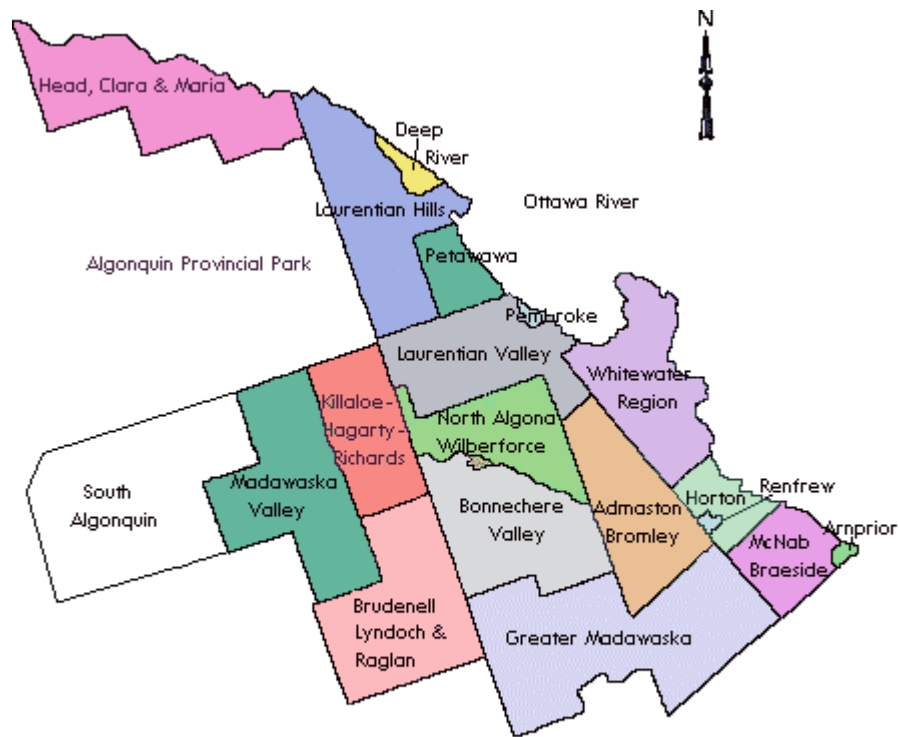


Renfrew County and District
Community Health Status Report
Issue #12, December 2005

Mortality Update



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1. Introduction

The Renfrew County and District Health Unit is mandated under the Ontario Health Protection and Promotion Act to review and report on health status in the community on a regular basis. Health status information is used to assist with planning local health promotion and disease prevention programs and services.

This report presents information on mortality rates and premature death in Renfrew County and District (RC&D) for the 2000 – 2002 period. Comparisons are made between RC&D, Ontario and Peer Group E. (Peer Group E is comprised of 25 mainly rural health regions in Ontario, Quebec and the prairies with similar social and economic characteristics.) This report is the twelfth in a series that present information related to the health status of residents in RC&D.

Renfrew County and District is comprised of the County of Renfrew, the City of Pembroke, the Township of South Algonquin and most of Algonquin Provincial Park in Ontario, Canada. This area covers about 15,000 square kilometers and is mainly rural, with a population estimated at just over 100,000 during the 2000 – 2002 period.

Issue #7 of this series, published in December 2000, focused on mortality for the 1991 – 1995 time period and compared it to the previous reporting period, 1986 -1990. Some significant differences were noted between RC&D and Ontario as a whole. For example, age-standardized death rates from all cardiovascular disease, heart attack and stroke, some types of cancer, all injuries and motor vehicle collisions were higher in RC&D. Premature death rates were also higher than in Ontario as whole for all cardiovascular disease, heart attack, stroke, some types of cancer, all injuries, motor vehicle collisions and suicide. This report provides updated information on most of these indicators.

A good companion document to this report is Mortality in Eastern Ontario 1986 to 1999 by the Health Information Partnership Eastern Ontario Region. It covers mortality rates, life expectancy and potential years of life lost rates for the years 1997 – 1999 for each health unit in the East Region of Ontario, and for the years 1986 – 1999 for the East Region as a whole. *Throughout this report, comments based on references to Mortality in Eastern Ontario 1986 - 1999 are shown in italics.*

Note: An updated system for identifying the underlying cause of death began to be used in Canada in 2000: the International Classification of Diseases and Related Health Problems, Tenth Version (ICD-10). Updates in this system are necessary to maintain its currency. However, updates also disrupt the ability to monitor trends in cause of death statistics over time. Comparisons of data from 2000 and later with previous years should be made with caution.⁴

Note: In Figures 5 through 14, the significance of differences between Renfrew County and District and the comparison populations was assessed by looking at whether or not the confidence intervals overlap. If the confidence intervals of an estimated rate do overlap, the difference is shown to be not significant (no asterisk). If the confidence intervals do not overlap, the difference is shown to be significant (indicated by an asterisk). This method was used because it is simple, and other data for testing the significance of differences was not available. However, this method is not ideal. It is more conservative than statistical tests. I.e. it may erroneously find that differences are not significant.⁵

2. Life Expectancy at Birth

Life Expectancy at Birth – trend in Ontario

Life expectancy at birth is the number of years a person is expected to live, based on mortality statistics for a given observation period. Life expectancy is a widely used indicator of the health of the population. However, it measures quantity rather than quality of life.

Life expectancy in Ontario has been increasing gradually. For example, life expectancy for Ontario females was 79 years in 1979. By 1999, life expectancy had increased by 3 years, to 82 years.

Life expectancy at birth is lower for males than for females. However, the gap has been narrowing. In 1979, life expectancy for males was just under 72. By 1999 it had increased by 5 years, to 77.

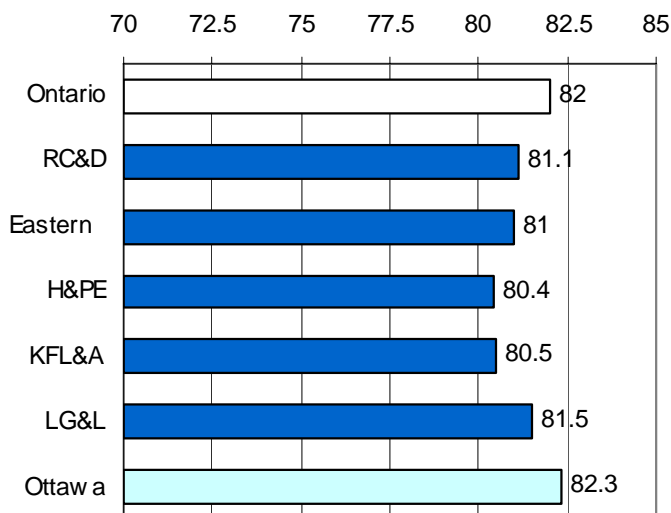
Life Expectancy at Birth - Ontario and east region

Life expectancy at birth for females and males living in eastern Ontario health units is shown in figures 1 and 2.

Life expectancy for both females and males in RC&D increased since 1996², but was significantly lower than in Ontario as whole (.9 years lower for females and 1.8 years lower for males). Other Health Units shown with dark blue bars also had life expectancies significantly lower than the provincial average.

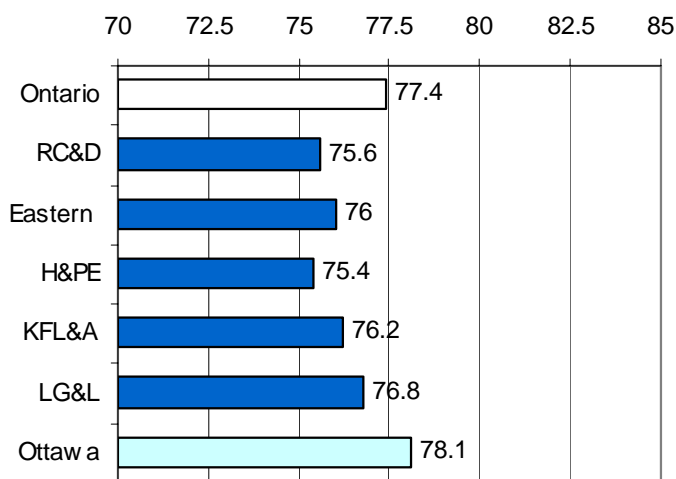
Life expectancy in the City of Ottawa was significantly higher than the Ontario average (light blue bar).

Figure 1: Life expectancy at birth, Ontario and East Region health units, females, 2000 - 2002



■ significantly lower than the Ontario average
 ■ significantly higher than the Ontario average

Figure 2: Life expectancy at birth, Ontario and East Region health units, males, 2000 - 2002



Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0218.

3. Causes of Death

Causes of Death, 2000 – 2001

Figures 3 and 4 show causes of death according to main categories (“chapters”) in the tenth version of a coding system called the International Classification of Diseases (ICD-10).

There was an average of 924 deaths per year in 2000 and 2001 in Renfrew County and District (RC&D).

The top four causes of death were “circulatory diseases” (also called cardiovascular disease), “neoplasms” (mostly cancers), “respiratory diseases,” and “external causes” (formerly called injury and poisoning). This ranking is consistent with the 1991 – 1995² and 1996 – 1999 periods in RC&D and in Ontario as a whole, and also with Eastern Ontario³ (1998 – 1999).

Causes of Death, 2000 – 2001 by sex

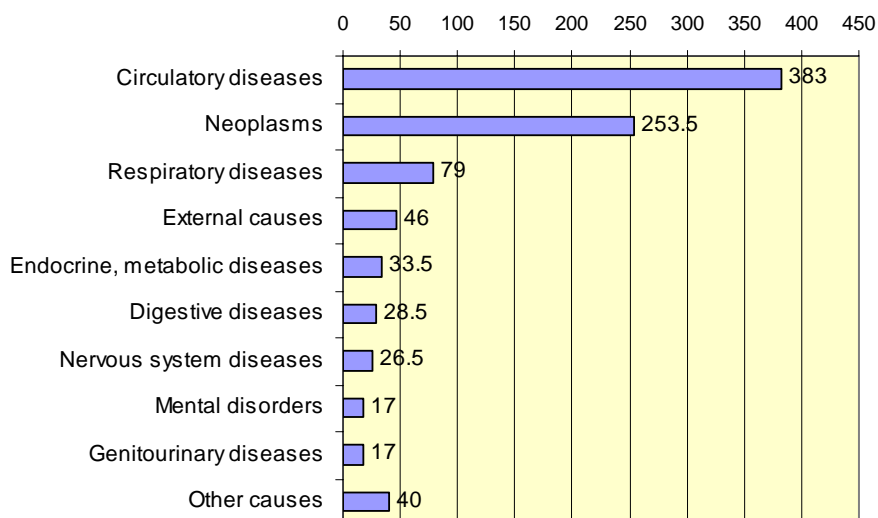
In RC&D, circulatory diseases accounted for a higher proportion of female deaths (40%) than male deaths (36%) in 2000 - 2001.

Neoplasms accounted for a lower proportion of female deaths (24%) than male deaths (31%).

The most striking difference between the sexes is in external causes (injuries and poisonings). During the time period shown, just over 7% of male deaths were due to external causes, compared to only 2.7% of female deaths.

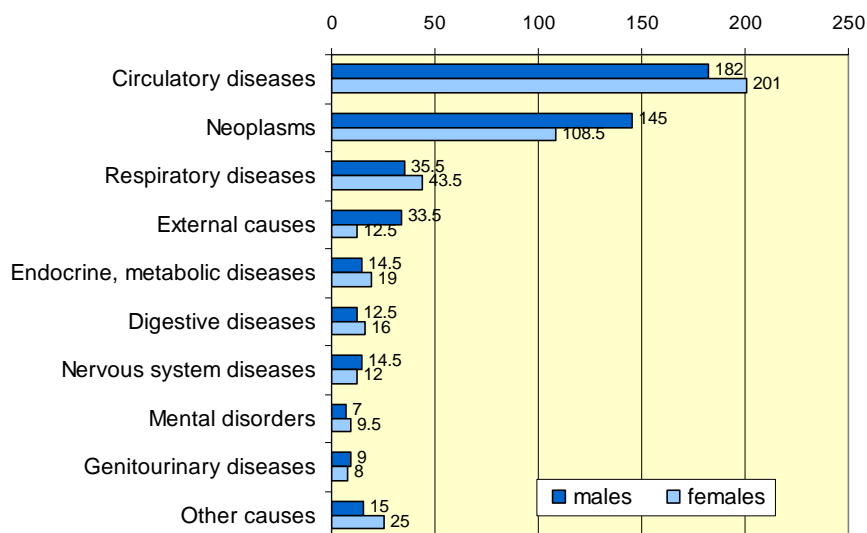
These differences are similar to those found in Eastern Ontario in the 1998 – 1999 period³.

Figure 3: Average number of deaths per year by ICD-10 chapter, Renfrew County & District, 2000 - 2001



See Appendix A for complete chapter headings for ICD-10 chapters.

Figure 4: Average number of deaths by ICD-10 chapter and sex, Renfrew County and District, 2000 - 2001



Source: Ontario Office of the Registrar General. Distributed by Public Health Division, Ontario Ministry of Health and Long-Term Care, Ontario Mortality Database, HELPS (Health Planning System), September 2003 and October 2004 Releases.

4. Potential Years of Life Lost (PYLL) Rates

The majority of deaths occur among older age groups, so mortality statistics are heavily influenced by the diseases and conditions that affect older people. The concept of **premature** mortality draws attention to deaths that occur early in life. Potential years of life lost, or PYLL, is often used as a measure of premature death.

PYLL is calculated by subtracting the age at death from the normal lifespan of 75 years for each death that occurs. (The age limit of 75 is recommended by Statistics Canada since it is reflective of life expectancies in Canada in recent years.) PYLL for a given disease is the sum of all potential years of life lost due to that disease.

Page 54 of Mortality in Eastern Ontario shows that PYLL rates for all East Region health units decreased between 1981 and 1999. For the region as a whole, the decrease was faster for males than for females. However, the greatest decrease in PYLL for females was in RC&D. Ottawa had consistently lower PYLL rates than other health units in the East Region.

See pages 51 – 55 of Mortality in Eastern Ontario 1986 – 1999³ for an overview of trends in PYLL and more detailed information for this earlier time period.

Potential Years of Life Lost (PYLL) Rates, all causes combined

Figure 5 shows that PYLL from all causes combined is higher for males than for females.

The PYLL rate for males in RC&D was higher than in both Ontario as a whole and in Peer Group E for the time period shown.

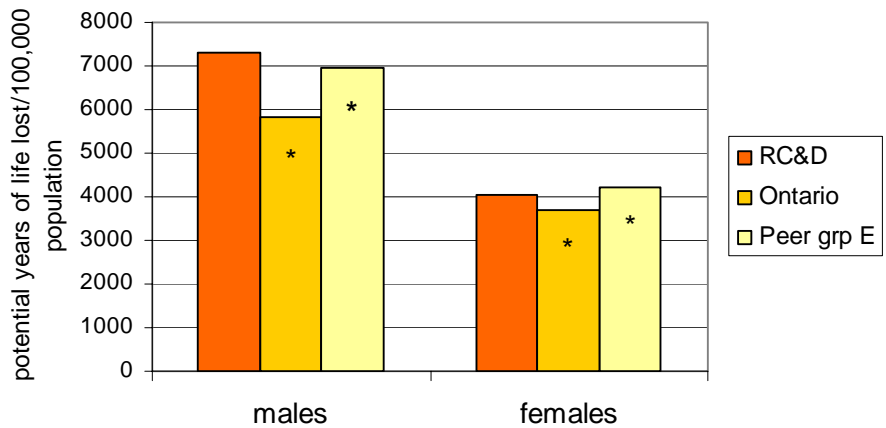
PYLL for females in RC&D was **higher** than in Ontario but **lower** than in Peer Group E. This peer group is comprised of 25 mainly rural health regions in Ontario, Quebec and the prairies with similar social and economic characteristics.

Potential Years of Life Lost (PYLL) Rates, selected causes

Figure 6 shows some of the leading causes of PYLL.

One can see that premature death affects males and females differently. Circulatory diseases, unintentional injuries and suicides are much greater causes of potential years of life lost for males than for females.

Figure 5: PYLL rates/100,000 population for all causes of premature death, males vs. females, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.
 Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

Figure 6: PYLL rates/100,000 population for selected causes of premature death, males vs. females in RC&D, 3-year average, 2000 - 2002



Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

5. Age-standardized mortality rates and potential years of life lost rates

Circulatory Diseases - age standardized mortality rates (ASMR)

Circulatory diseases are the leading cause of death in RC&D (41% of deaths) and in Ontario as a whole. ASMRs declined between 1986 and 1999, more rapidly for males than females. However, death rates for males were still substantially higher.³

Although ASMRs for 2000 – 2002 continued a declining trend², they also continued to be higher in RC&D when compared to Ontario and Peer Group E.

See pages 38-41 of *Mortality in Eastern Ontario* for similar information for 1997-99, for each health unit in the East Region. With the exception of Ottawa, all health units had circulatory disease mortality rates that exceeded both the regional and Ontario rates.

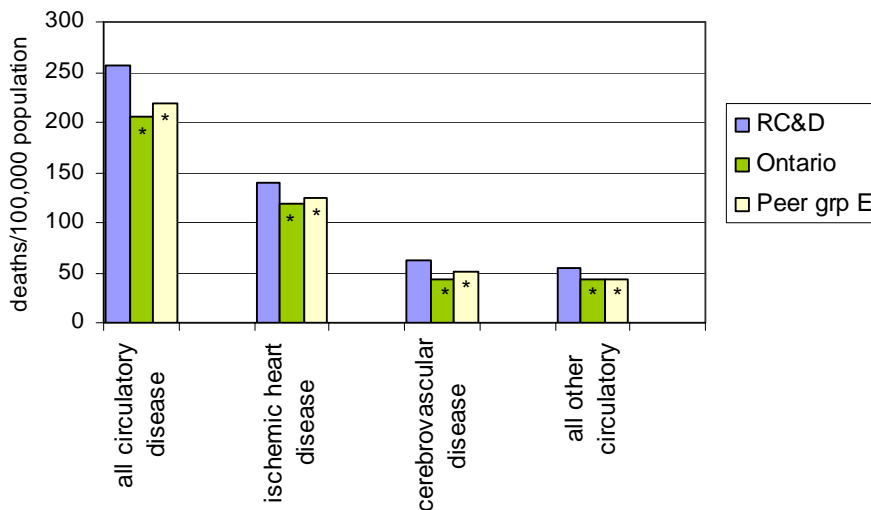
Circulatory Diseases - potential years of life lost (PYLL)

PYLL rates for circulatory diseases have been declining in Ontario and in the East Region. The decline for males has been more rapid than that for females.³

In 2000 - 2002 in RC&D, circulatory diseases accounted for about 1/5 of all PYLL. PYLL rates for the circulatory diseases shown were higher in RC&D than in both Ontario as a whole and Peer Group E.

Page 57 of *Mortality in Eastern Ontario*³ shows that PYLL rates in 1997-99 for all circulatory disease were higher than the provincial average for all health units in Eastern Ontario except for Ottawa, which was lower.

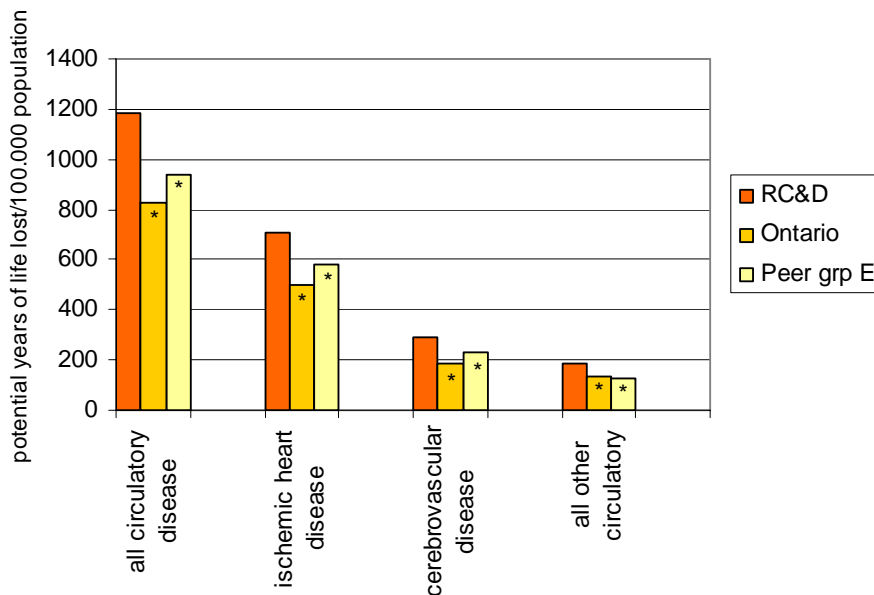
Figure 7: Age-standardized mortality rates/100,000 population, circulatory diseases, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.

Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0303.

Figure 8: PYLL rates/100,000 population, circulatory diseases, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.

Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

Cancers - age standardized mortality rates (ASMR)

Cancers are the second most common cause of death in RC&D (28% of deaths) and in Ontario as a whole.

ASMRs for cancers have been declining or stable in Canada, Ontario and RC&D between 1986 and 1999.^{2,3} Female death rates in Ontario and the East Region have been consistently lower than for males.³ A few types of cancer appear to be increasing, most notably lung cancer in women.

Figure 9 shows that ASMRs in RC&D were similar to Ontario and Peer Group E except for lung cancer.

In RC&D, lung cancer represented 29% of all cancer deaths in the three-year period shown and was significantly higher than in Ontario as a whole. Although not shown, the higher ASMR for lung cancer is due to a higher death rate in women.

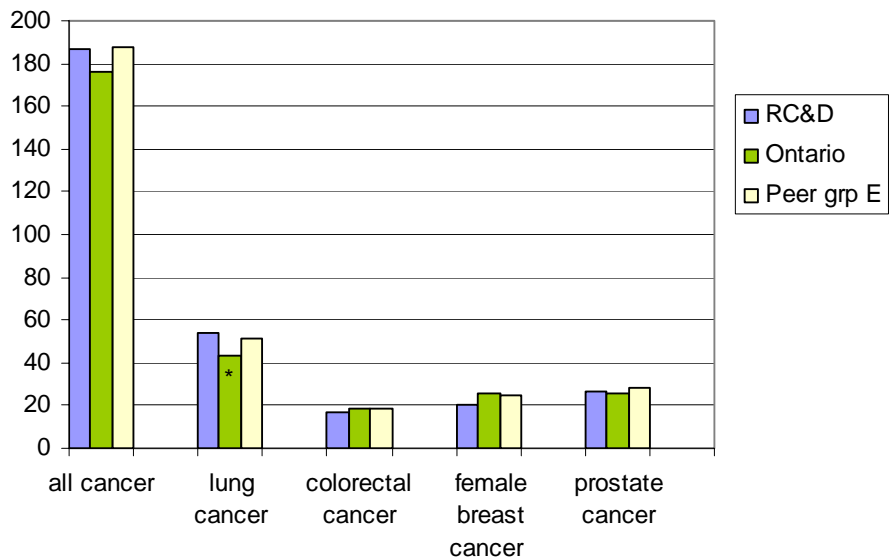
Cancers - potential years of life lost (PYLL)

Cancers are the leading cause of premature death in RC&D (29% of all PYLL) and in Ontario as a whole.

In RC&D, lung cancer accounted for 30% of PYLL from all cancers, breast cancer accounted for 14% and colorectal cancer, 7%.

During the time period shown in Figure 10, there was **more** premature death in RC&D from all cancer and lung cancer than in Ontario. However, we had **less** premature death from colorectal cancer and female breast cancer compared to Ontario, and **less** premature death than our Peer Group for 4 of the 5 cancers shown.

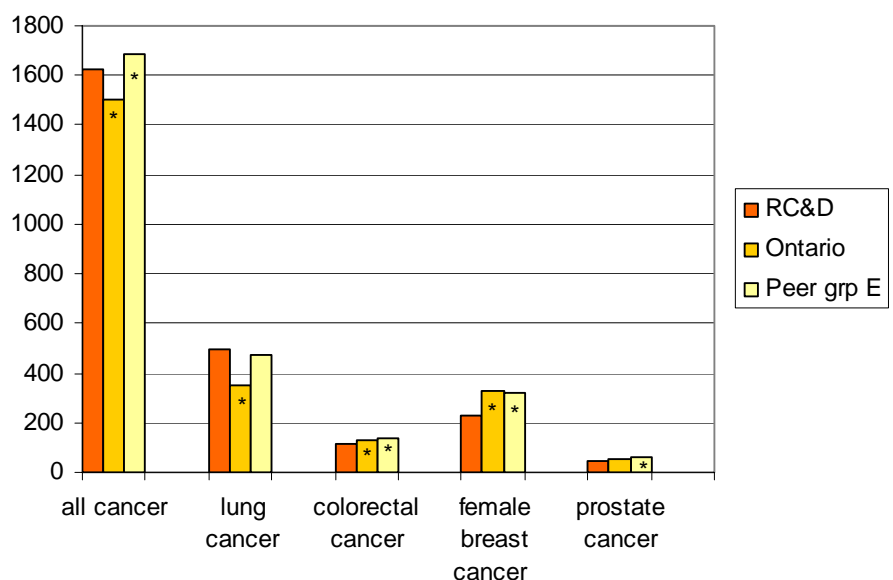
Figure 9: Age-standardized mortality rates/100,000 population, cancers, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.

Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0303.

Figure 10: PYLL rates/100,000 population, cancers, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.

Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

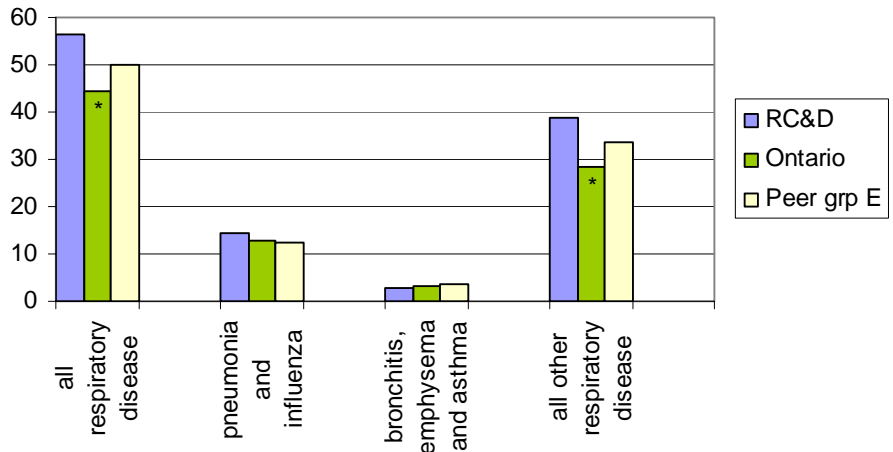
Respiratory Diseases - age standardized mortality rates (ASMR)

Respiratory diseases are the third most common cause of death in RC&D (8.6% of deaths) and in Ontario as a whole.

ASMRs for respiratory diseases have been declining in Ontario males and increasing in Ontario females, although rates for males are still substantially higher than those for females.³

For the time period shown, ASMRs for “all respiratory diseases” and “all other respiratory diseases” were significantly higher in RC&D when compared to Ontario, but not significantly different from Peer Group E.

Figure 11: Age-standardized mortality rates/100,000 population, respiratory diseases, 3-year average, 2000 - 2002



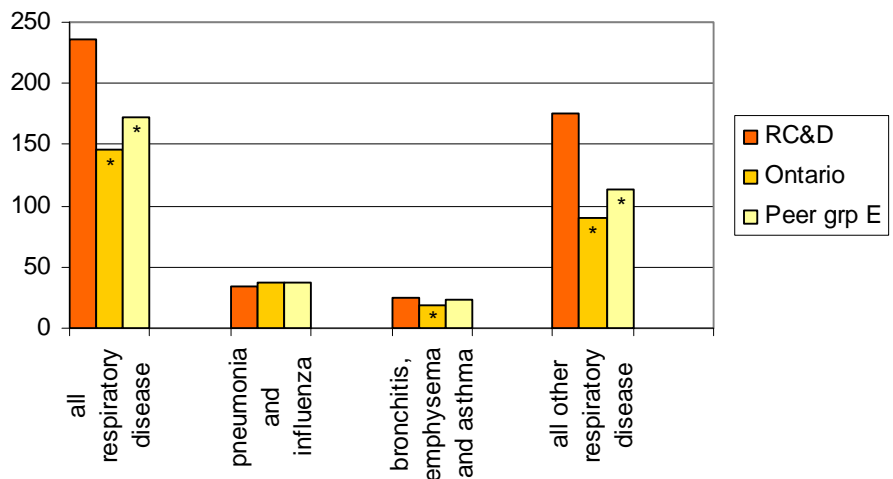
* Significantly different from RC&D at the 95% level.
 Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0303.

Respiratory Diseases - potential years of life lost (PYLL)

A high proportion (over 90%³) of respiratory disease deaths occur in people age 65 and over. Therefore respiratory diseases accounted for a relatively small proportion of all PYLL: about 4% in RC&D, and 3% in Ontario and Peer Group E in 2000 - 2002.

However, RC&D had significantly higher PYLL rates than Ontario and Peer Group E for two of the four disease groupings shown.

Figure 12: PYLL rates/100,000 population, respiratory diseases, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.
 Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

Unintentional Injuries and Suicides - age standardized mortality rates (ASMR)

Unintentional injuries include transport accidents, falls, drownings and other external causes of accidental injury. In 2000 - 2002, the ASMR for RC&D was higher than in Ontario as a whole (33.4 vs. 22.3 deaths per 100,000 people). Over 1/3 (36%) of unintentional injury deaths in RC&D involved motor vehicles.

The ASMR for suicides and self-inflicted injuries in 2000 - 2002 was similar to Ontario and Peer Group E. 90% of suicide deaths in RC&D were among males. *This pattern is similar to eastern Ontario (1997-1999)³ where almost 80% of suicide deaths were among males.*

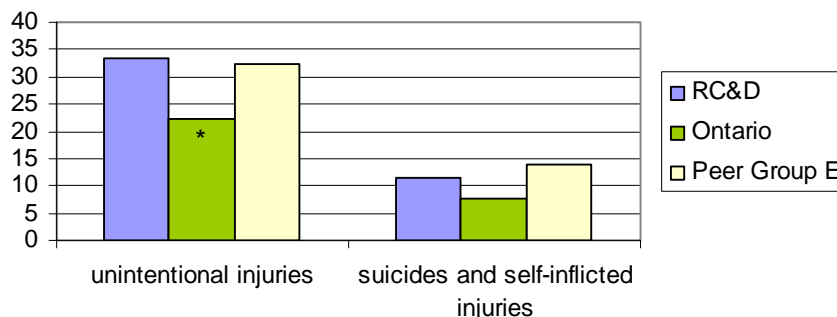
Unintentional Injuries and Suicides - potential years of life lost (PYLL)

In RC&D, unintentional injuries accounted for about 3.5% of all deaths and 14% of PYLL in the 2000 - 2002 period. Suicides accounted for about 1% of deaths and almost 7% of PYLL. Together, these pre-ventable deaths accounted for over 1/5 of all PYLL.

This chart shows that the PYLL rate for unintentional injuries in RC&D was **higher** than in Ontario as whole but **lower** than in Peer Group E in 2000 - 2002.

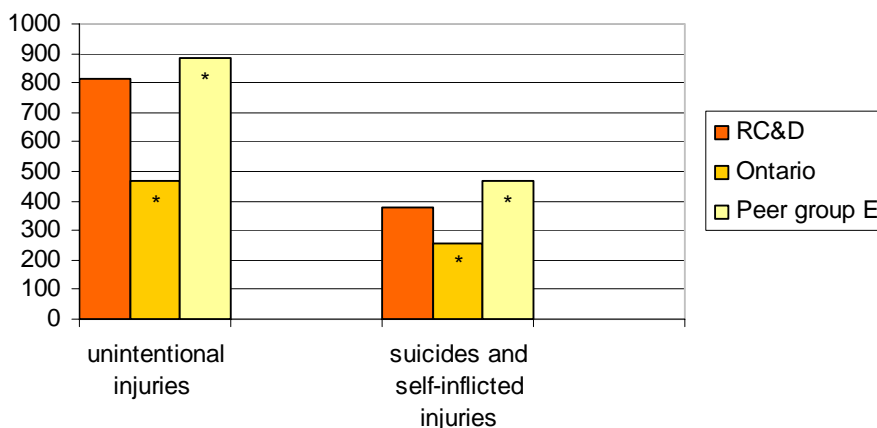
The same pattern exists for suicides. Although the ASMR for suicides did not differ from Ontario or Peer Group E, looking at PYLL shows that suicide deaths occurred at younger ages in RC&D compared to Ontario, but at older ages than Peer Group E.

Figure 13: Age-standardized mortality rates/100,000 population, unintentional injuries and suicides, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.
Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0303.

Figure 14: PYLL rates/100,000 population, unintentional injuries and suicides, 3-year average, 2000 - 2002



* Significantly different from RC&D at the 95% level.
Source: Statistics Canada, Canadian Vital Statistics, Death Database, and Demography Division (population estimates), Table 102-0311.

6. Summary

This report identifies death and potential years of life lost from circulatory diseases (commonly called heart disease) as a pressing health issues for Renfrew County and District (RC&D). For “all circulatory disease” and three components of this (“ischemic heart disease”, “cerebrovascular disease” and “all other circulatory disease”), RC&D had significantly higher age-standardized mortality rates (ASMR) and potential years of life lost (PYLL) rates than both Ontario and Peer Group E. These findings are relatively consistent with previous reports.^{1,2}

Lung cancer in women has emerged as an issue due to a higher ASMR and PYLL rate in 2000 – 2002 than in Ontario as a whole. However, RC&D is similar to Peer Group E.

Life expectancy has increased over previous years in RC&D and in Ontario as a whole and is still longer for females than for males. This is related to gradually decreasing ASMRs for some diseases (e.g. circulatory diseases, some cancers, respiratory diseases in men) between 1986 and 1999 in Ontario and the East Region.³

The year 2000 marks the beginning of a new chapter in our understanding of causes of mortality in Canada, as this was the first year that ICD-10 was used for classifying underlying causes of death. It will be important to monitor future trends in relation to the findings in this report.

It remains urgent to apply our understanding of the prevention of diseases and the promotion of health through the efficient and effective use of resources. In particular, heart disease prevention efforts should be maintained and enhanced.

7. Glossary

Age-standardized mortality rate (ASMR or SRATE): the number of deaths that would occur if the population had the same age distribution as a standard population. In this report the standard is the 1991 Canadian population. ASMR in this report is expressed per 100,000 population.

Formula: $ASMR = \frac{\text{sum of (crude rates by age group} \times \text{1991 Canadian population in each age group)}}{\text{Total Canadian population}} \times 100,000$

Cerebrovascular disease: conditions where blood flow is disrupted, as well as diseases of blood vessels of the brain, including stroke.

Confidence interval: the computed interval with a given probability, e.g. 95%, that the true value of a variable (in this case a rate) is contained within the interval.

Crude mortality (death) rate: the total number of deaths relative to the total population (per 1,000 population in this publication), usually measured on an annual basis.

Formula: Crude mortality rate = total number of deaths / total population x 1,000

Eastern: Eastern Ontario Health Unit

H&PE: Hastings and Prince Edward Counties Health Unit

International Classification of Diseases (ICD): The ICD is the international standard diagnostic classification for all general epidemiological and many health management purposes. These include analysis of the general health of populations and monitoring of the incidence and prevalence of diseases and other health problems in relation to variables such as the characteristics and circumstances of the individuals affected.

The ICD has been updated 10 times since 1900. The updates often cause disruptions in the ability to observe changes in morbidity and mortality over time. However, they are necessary to stay abreast of medical advances in disease nomenclature and etiology.

International Classification of Diseases, Injuries and Causes of Death, Ninth Version (ICD-9): ICD-9 was in use in Canada from 1979 to 1999 for coding causes of death and until 2000 for coding morbidity.

International Statistical Classification of Diseases and Related Health Problems, Tenth Version (ICD-10): ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and came into use in WHO member states beginning in 1994 (2000 in Canada for classifying mortality). ICD-10 is far more detailed than ICD-9. Some additions and modifications were made to the chapters, and some of the coding rules and rules for selecting the underlying cause of death have changed.

Ischemic heart disease: includes angina pectoris, chronic ischemic heart disease, acute myocardial infarction (heart attack) and sudden death.

KFL&A: Kingston, Frontenac and Lennox & Addington Health Unit

LG&L: Leeds, Grenville and Lanark District Health Unit

Peer Group E: Peer groups are nine groupings of health planning regions across Canada based on similar social and economic characteristics. Peer Group E is comprised of mainly rural regions in Quebec, Ontario and the prairies with a high proportion of people recently moved to or within these regions since 1996, an average percent of aboriginal people and moderate population growth.

Potential years of life lost (PYLL): a measure of the loss to society as a result of deaths that occur prematurely. In this report, deaths that occur before the age of 75 are considered to be premature. This age limit is recommended by Statistics Canada because it reflects life expectancies in Canada in recent years. For example, a person who died at age 20 would contribute 55 potential years of life lost, and a person who died at age 70 would contribute 5 years. Deaths occurring in individuals age 75 or older are not included in the calculation. PYLL rates are obtained by adding up the total years of life lost due to deaths from a given cause, and dividing the total by the population less than 75 years of age.

Standardized mortality ratio (SMR): a comparison between a population of interest (e.g. Renfrew County and District residents) and a larger standard or reference population.

8. References

¹ Renfrew County and District Health Unit. Our Health in Renfrew County and District Community Health Status Report Issue #3, December 1994.

² Renfrew County and District Health Unit. Our Health in Renfrew County and District Community Health Status Report Issue #7, December 2000.

³ Health Information Partnership - Eastern Ontario Region. Mortality in Eastern Ontario 1986 – 1999, September 2003.

⁴ Statistics Canada – Catalogue no. 84-548. Comparability of ICD-10 and ICD-9 for Mortality Statistics in Canada, 2005.

⁵ Schenker, N. and J.F. Gentleman. “On judging the significance of differences by examining the overlap between confidence intervals”, in The American Statistician, vol. 55, #3; August 2001.

Appendix A

International Classification of Diseases (ICD-10) Chapter Headings

- Chapter 1: Certain infectious and parasitic diseases
- Chapter 2: Neoplasms
- Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
- Chapter 4: Endocrine, nutritional and metabolic diseases
- Chapter 5: Mental and behavioural disorders
- Chapter 6: Diseases of the nervous system
- Chapter 7: Diseases of the eye and adnexa
- Chapter 8: Diseases of the ear and mastoid process
- Chapter 9: Diseases of the circulatory system
- Chapter 10: Disease of the respiratory system
- Chapter 11: Diseases of the digestive system
- Chapter 12: Diseases of the skin and subcutaneous tissue
- Chapter 13: Diseases of the musculoskeletal system and connective tissue
- Chapter 14: Diseases of the genitourinary system
- Chapter 15: Pregnancy, childbirth and the puerperium
- Chapter 16: Certain conditions originating in the perinatal period
- Chapter 17: Congenital malformations, deformations and chromosomal abnormalities
- Chapter 18: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- Chapter 19: Injury, poisoning and certain other consequences of external causes
- Chapter 20: External causes of morbidity and mortality
- Chapter 21: Factors influencing health status and contact with health services

For more information about the types of diseases classified in each chapter, see <http://www3.who.int/icd/vol1htm2003/fr-icd.htm>

Appendix B

Age-standardized mortality rates/100,000 population, 3-year average, 2000 - 2002

	total mortality	all circulatory disease	ischemic heart disease	cerebrovascular disease	all other circulatory disease	all cancer	lung cancer	colorectal cancer	female breast cancer	prostate cancer
RC&D	677.6	257	139	63	55.1	186.6	53.6	16.5	20.7	26.6
Ontario	597.8	205	118.3	43.6	43	176.2	43.8	18.4	25.3	25.4
Peer grp E	644.4	219.1	124.6	51.4	43.1	187.5	51	18.9	24.7	28.6

	all respiratory disease	pneumonia and influenza	bronchitis, emphysema and asthma	all other respiratory disease	unintentional injuries	suicides and self-inflicted injuries
RC&D	56.4	14.4	3	39	33.5	11.6
Ontario	44.6	12.9	3.1	28.5	22.3	7.7
Peer grp E	50.1	12.6	3.8	33.7	32.3	13.9

Potential years of life lost rates/100,000 population, 3-year average, 2000 - 2002

	total PYLL	all circulatory disease	ischemic heart disease	cerebrovascular disease	all other circulatory disease	all cancer	lung cancer	colorectal cancer	female breast cancer	prostate cancer
RC&D	5684	1187	710.2	287.1	189.6	1621.7	493.8	114.5	225.8	44.3
Ontario	4755	823.4	500.3	189.7	133.5	1505	353.5	130.2	330.3	51.6
Peer grp E	5595	940.8	582.3	229.1	129.9	1683	469.9	140.1	323.6	64.2

	all respiratory disease	pneumonia and influenza	bronchitis, emphysema and asthma	all other respiratory disease	unintentional injuries	suicides and self-inflicted injuries
RC&D	236.2	34.9	25.1	176.2	813.3	380.2
Ontario	145.8	37.3	17.9	90.4	470.6	258.1
Peer grp E	172.9	36.5	23	112.9	885.8	470.6

Confidence intervals are not shown.

	indicates significantly lower than RC&D
	indicates significantly higher than RC&D