It is my pleasure to introduce Nova Scotia’s first population health profile. This profile is the result of many hours of analysis and discussion by staff in the Department of Health and Wellness and our health authorities. I offer them a tremendous thank you for this work.

The profile is intended to provide a snapshot, rather than a complete picture, of the overall health of Nova Scotians and key factors that determine our collective well-being. Its aim is to stimulate discussion about our health in communities, homes and workplaces across the province. It uses creative infographics to convey our population’s health status. The indicators and data are highlights from numerous credible sources of health information.

As we embark on a significant transformation of Nova Scotia’s health system, it is critical that appropriate attention is given to the prevention of disease and injury, along with the provision of high quality health care. Increased understanding of the root causes of poor health and the development of social, economic and physical environments that better support our collective well-being are critical to the long-term sustainability of our province.

Creating healthy communities is a role shared across society. I encourage individuals, families, communities and community organizations, businesses and corporations, public institutions, and all levels of government to read Nova Scotia’s population health profile. Then I encourage everyone to ask, “What role can I play to help improve the health of Nova Scotians?”

Dr. Robert Strang
Chief Public Health Officer
Some things to consider when using the information in the Nova Scotia Health Profile

What is a health profile?

A health profile is a collection of statistics that provide an overview of the health of a population. A health profile typically includes both determinants of health (the things that make us healthy or unhealthy) and health status (how healthy or unhealthy we are) indicators.

What is the purpose of the Nova Scotia Health Profile?

The Nova Scotia Health Profile aims to:

- Describe a broad range of population health characteristics in Nova Scotia
- Stimulate discussions around population health and determinants of health in Nova Scotia
- Contribute to Public Health planning and decision making
- Provide direction for future health profile reporting

How were the indicators selected for the Nova Scotia Health Profile?

In 2011, a network comprised of members from the Department of Health and Wellness and each health authority was created to connect individuals and groups doing work related to health profiles. This network led the development of a set of core indicators for Public Health profile reporting at the health authority or provincial level. First, an extensive list of indicators was drafted by considering the experience of other jurisdictions and the concepts of population health and health equity. These indicators were subsequently ranked by the network (and additional members of the Public Health system) against criteria such as data availability, relevance, validity, and whether indicators were understandable and actionable. The resulting core indicators were recommended by the network as the 'minimum' set of indicators to be included in health profiles across the province.

What indicators are included in the Nova Scotia Health Profile?

The Nova Scotia Health Profile is focused on the core set of indicators. The indicators are organized into three sections: Who We Are, How Healthy Are We, and What Affects Our Health. Each section includes a broad range of topics relevant to Public Health. However, each individual topic (e.g. Healthy Eating) is only represented by a single or small number of indicators (e.g. consumption of fruit and vegetables).
Where does the indicator data come from?

The indicator data in the Nova Scotia Health Profile comes from a number of different sources such as the Canadian Community Health Survey, the Canadian Census, and specific provincial programs. The year and source of the indicator data are identified on each of the profile pages. Priority was given to data sources where reporting the data by factors such as age, sex, geography (health authorities), income, and education was possible.

Why does indicator data from different sources differ from what is presented in the profile?

There are several reasons why the statistics presented in the health profile may differ from similar statistics generated from other data sources. Data that was collected using different methodology will yield different results. This is particularly true for data that has been self-reported versus data that has been objectively measured (e.g. physical activity levels or height and weight). With national surveys (e.g. Canadian Community Health Survey), there can be slight differences in the datasets used for analyses at the national and provincial levels.

Why are the statistics presented in the profile a few years old?

The statistics presented in the health profile were based on the most current data available at the time that the data was analyzed. The data sources used in the health profile are routinely updated, therefore for some indicators, new data may have become available before the release of the profile. However, population health issues change slowly over time and big changes are not usually observed from one release to the next.

How are statistics impacted by a small sample?

Statistics calculated from a small sample are less likely to represent a true finding. Many of the statistics presented in the health profile are generated from the Canadian Community Health Survey data. Because the number of Nova Scotians who are sampled for this survey is small, the data for Nova Scotia is combined over two years. However, there are some indicators where the sample remains too small to reliably report the findings by age, sex, education, income, or health authority.
What does statistical significance mean?

A statistically significant result is one that is not likely due to chance. When results are not statistically significant, the possibility of the result being due to chance cannot be ruled out. In the profile, comparisons are made across age, sex, education, and income groups. Only statistically significant results are shown for these comparisons.

What is an age-standardized rate?

An age-standardized rate is a rate that has been adjusted to remove the effect of age so that groups (e.g. males and females, health authorities) with different age distributions can be compared. When interpreting age-standardized rates, the focus should be on the trend (e.g. Nova Scotia higher than Canada) rather than the value of the rate.

What are income quintiles?

Income quintiles refer to data on income that has been divided into five equally sized groups. In the profile, comparisons for a given indicator are made across these income groups.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Current Estimate</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizenship</td>
<td>Proportion of the population who are Canadian citizens</td>
<td>97.6%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
<tr>
<td>Immigration</td>
<td>Proportion of the population who are immigrants</td>
<td>5.3%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
<tr>
<td>Visible Minorities</td>
<td>Proportion of the population who report being visible minorities</td>
<td>5.2%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
<tr>
<td>Aboriginal Identity</td>
<td>Proportion of the population who report being an Aboriginal person</td>
<td>3.7%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
<tr>
<td>Population Growth</td>
<td>Percent population increase between 2001 and 2011</td>
<td>1.5%</td>
<td>2011</td>
<td>NS Community Counts (modeled from Stats Can)</td>
</tr>
<tr>
<td>Lone-Parent Families</td>
<td>Proportion of families who are lone parent families</td>
<td>17.3%</td>
<td>2011</td>
<td>Stats Can (Census short form)</td>
</tr>
<tr>
<td>Births</td>
<td>Total number of births</td>
<td>8862</td>
<td>2011</td>
<td>Stats Can (CANSIM table 102-4509)</td>
</tr>
<tr>
<td>Birth Rate</td>
<td>Number of live births per 1,000 population</td>
<td>9.3</td>
<td>2011</td>
<td>Stats Can (CANSIM table 102-4505)</td>
</tr>
<tr>
<td>Life Expectancy at Birth</td>
<td>The number of years a person would be expected to live, starting at birth if the age and sex-specific mortality rates for a given observation period were held constant over his/her life span</td>
<td>80.1 years</td>
<td>2007-2009</td>
<td>Stats Can (CANSIM table 102-0512)</td>
</tr>
<tr>
<td>Deaths</td>
<td>Total number of deaths</td>
<td>8532</td>
<td>2011</td>
<td>Stats Can (CANSIM table 102-0552)</td>
</tr>
<tr>
<td>Unemployment Rate</td>
<td>The number of unemployed persons (ages ≥15) as a percentage of the labour force (people who are currently employed and people who are unemployed but were available to work in the reference week and had looked for work in the past 4 weeks)</td>
<td>9.0%</td>
<td>2012</td>
<td>Stats Can (CANSIM table 109-5324)</td>
</tr>
<tr>
<td>Low Income</td>
<td>Proportion of families classified as low income based on ‘after-tax low income cut-offs (1992 base)’</td>
<td>7.0%</td>
<td>2011</td>
<td>Stats Can (CANSIM table 109-5324)</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td>Population (ages 25-64) with no certificate, diploma, or degree</td>
<td>14.6%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Current Estimate</td>
<td>Year</td>
<td>Source</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Population (ages ≥14) who reported that they have been diagnosed by a health professional as having arthritis</td>
<td>22.7%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Self-reported Health Status</td>
<td>Population (ages ≥12) who perceived their own health status as being excellent or very good</td>
<td>57.8%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Self-reported Mental Health Status</td>
<td>Population (ages ≥12) who perceived their own mental health status as being excellent or very good</td>
<td>72.3%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Population (ages ≥12) who reported that they have been diagnosed by a health professional as having heart disease</td>
<td>5.8%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>Population (ages ≥12) who reported being diagnosed by a health professional with asthma, or aged ≥35 who reported being diagnosed by a health professional with chronic bronchitis, emphysema, or chronic obstructive pulmonary disease</td>
<td>13.0%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Life Stress</td>
<td>Population (ages ≥15) who perceived that most days in their life were quite a bit or extremely stressful</td>
<td>18.1%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Deaths from Injury</td>
<td>Proportion of deaths (based on ICD-10 Cause of Death codes) classified as injuries</td>
<td>6.0%</td>
<td>2011</td>
<td>Stats Can (CANSIM table 102-0552)</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Population (ages ≥12) who reported that they have been diagnosed by a health professional as having high blood pressure</td>
<td>22.9%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Health-Adjusted Life Expectancy at Birth</td>
<td>The expected number of years that an individual will live in full health</td>
<td>67 years (M) 69 years (F)</td>
<td>2005-2007</td>
<td>Stats Can</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>Percent of all live births with birth weight less than 2,500 grams</td>
<td>6.0%</td>
<td>2007-2011</td>
<td>Stats Can (CANSIM table 102-4005)</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>The number of deaths of children &lt; one year of age per 1,000 live births in the same year</td>
<td>4.9</td>
<td>2011</td>
<td>Stats Can (CANSIM table 102-0504)</td>
</tr>
<tr>
<td>Overweight or Obese</td>
<td>Population (ages ≥18) classified as overweight or obese based on Body Mass Index</td>
<td>61.2%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Diabetes Prevalence</td>
<td>Population aged ≥20 with diabetes (type 1 and type 2)</td>
<td>9.9%</td>
<td>2008-2009</td>
<td>Diabetes Care Program of NS</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Current Estimate</td>
<td>Year</td>
<td>Source</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>Cancer Incidence</td>
<td>Age-standardized rate per 100,000 of new cases of invasive cancers per year</td>
<td>487.8 (M) 406.2 (F)</td>
<td>2012</td>
<td>Cancer Care NS</td>
</tr>
<tr>
<td>Cancer Mortality</td>
<td>Age-standardized rate per 100,000 of invasive cancer deaths per year</td>
<td>215.5 (M) 160.7 (F)</td>
<td>2011</td>
<td>Cancer Care NS</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Crude rate of hepatitis C cases per 100,000 population</td>
<td>30.4</td>
<td>2013</td>
<td>NS Department of Health &amp; Wellness</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Current Estimate</td>
<td>Year</td>
<td>Source</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Exclusive Breastfeeding</td>
<td>Percent of females (ages 15-55 and had a baby in the last 5 years) who reported exclusive breastfeeding (infant receives only breast milk, without any additional liquid (even water) or solid food) for the first 6 months</td>
<td>22.2%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Fruit and Vegetable Consumption</td>
<td>Population (ages ≥12) who reported consumption of fruits and vegetables ≥ 5 times per day (usual intake). The indicator does not take into account the amount consumed.</td>
<td>34.0%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Heavy Drinking</td>
<td>Population (ages ≥12) who reported having 5 or more drinks on one occasion, at least once a month in the past year</td>
<td>28.1%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Sense of Belonging</td>
<td>Population (ages ≥12) who reported their sense of belonging to their local community as being very strong or somewhat strong</td>
<td>71.0%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Smoking</td>
<td>Population (ages ≥12) who reported smoking cigarettes every day or occasionally. Includes former daily smokers who now smoke occasionally. Does not take into account the number of cigarettes smoked.</td>
<td>22.3%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Self-reported Physical Activity</td>
<td>Based on responses to questions about the nature, frequency and duration of participation in leisure-time physical activity. Average daily energy expenditure is calculated and respondents (ages ≥12) are classified as active or moderately active.</td>
<td>53.7%</td>
<td>2011-2012</td>
<td>CCHS</td>
</tr>
<tr>
<td>Housing Affordability</td>
<td>Proportion of the population that spend 30% or more of total household income on shelter costs. Shelter costs include electricity, heat, water and other municipal services, monthly mortgage payments, property taxes, condominium fees, and rent.</td>
<td>22.0%</td>
<td>2011</td>
<td>Stats Can (National Household Survey)</td>
</tr>
</tbody>
</table>
Nova Scotia is Canada’s second smallest province (land area: 52,939 square kilometres) and is home to approximately 921,725 people.

The capital of Nova Scotia is Halifax. 42.3% of the province’s population reside in Halifax.

Between 2000 and 2014, Nova Scotia’s health system was divided into 9 District Health Authorities (DHAs) and the IWK Health Centre.

In 2015, the DHA Structure was reorganized into two health authorities, one for the province (comprised of four management zones) and one for the IWK.

Given the recent nature of the change in health system boundaries, indicator data presented in the “Across the Province” section throughout the health profile reflect the former DHA structure.

Footnotes:
In 2011 the population of Nova Scotia was approximately 921,725. This is a 1.5% increase since 2001.

Population By:

**By Sex**

- **Males**: 48%
- **Females**: 52%

Population Growth\(^1\)
Across Nova Scotia (2001-2011)

- **High**: +8.3%
- **Low**: -7.7%

Percent of Total Population

Population By:

**Citizenship**

- Canadian citizens: 98%

**Immigration**

- Immigrants: 5%

**Visible Minorities**

- Identify as visible minorities: 5%

**Aboriginal Identity**

- Identify as aboriginal: 4%

17% of families in Nova Scotia are lone-parent families.
Life Expectancy at Birth

The number of years that a person would be expected to live, starting at birth if the age and sex-specific mortality rates for a given observation period (e.g. calendar year) were held constant over his/her life span.

Compared to Canada

- **80 YRS** vs. **81 YRS**
- **Males** 78 YRS vs. **Females** 82 YRS

**Deaths**

- **8,325** deaths per year

**Leading Causes of Deaths**

- Cancer (Malignant Neoplasms)
- Major Cardiovascular Diseases
- Accidents (Unintentional Injuries)
- Chronic Lower Respiratory Diseases
- Diabetes Mellitus

**Cancer and CVD Mortality Over Time**

- Cancer (Malignant Neoplasms)
- Major Cardiovascular Diseases

Footnotes:

**Unemployment Rate (15+yrs)**

In 2012, 9% of Nova Scotians were unemployed.

**Compared to Canada**

9% **vs.** 7%

Across the province the unemployment rate ranged from 6.3% to 14.7% in 2012.

**Low Income**

In 2011, approximately 64,000 People (7%) in Nova Scotia were living in low income.

**Compared to Canada**

7% **vs.** 9%

By Sex

Males 6% **vs.** Females 8%

**Persons in Low Income (%), 1981-2011**

**Educational Attainment**

15% of Nova Scotians, ages 25-64, have less than a highschool diploma.

**Compared to Canada**

15% **vs.** 13%

By Sex

Males 17% **vs.** Females 13%
Perceived health is an indicator of overall health status that encompasses physical, mental and social well-being as well as the absence of disease or injury.¹

In Nova Scotia, 58% report their health status as excellent or very good.

**Self-Reported Health Status By Income:**

- **Highest Income Quintile:** 70%
- **Lowest Income Quintile:** 42%

**Self-Reported Health Status By Education:**

- **Post-Secondary Degree:** 61%
- **Less Than High School Graduation:** 50%

**Self-Reported Health Status By Age:**

- **12-19 years:** 72%
- **65+ years:** 41%

**Self-Reported Health Status By Sex:**

- **Males:** 57%
- **Females:** 59%

**Perceived health is an indicator of overall health status that encompasses physical, mental and social well-being as well as the absence of disease or injury.¹**

**Footnotes:** (1) Statistics Canada, Health Indicators: Definitions and data sources, http://www.statcan.gc.ca/pub/82-221-x/2013001/def/def1-eng.htm
Self-Reported Mental Health Status
(Excellent or Very Good)

**In Nova Scotia**

72% report their mental health status as *excellent* or *very good*.

There were no significant differences between 2007 and 2012.

Measuring self-reported mental health provides an indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in self-reported (physical) health.¹

Presented here is the population who perceive their mental health status as *excellent* or *very good*.

**Self-Reported Mental Health Status By Income:**

- **Highest Income Quintile:** 81%
- **Lowest Income Quintile:** 60%

**Self-Reported Mental Health Status By Education:**

- **Post-Secondary Degree:** 75%
- **Less Than High School Graduation:** 62%

**Self-Reported Mental Health Status By Sex:**

There were no significant differences in self-reported mental health status by sex.

**Self-Reported Mental Health Status By Age:**

There were no significant differences in self-reported mental health status by age groups.

**Indicators:**

- **INDICATOR SOURCE:** Canadian Community Health Survey (Provincial ‘Share’ file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.
- **INDICATOR DESCRIPTION:** Population aged 12 and over who reported perceiving their own mental health status as being "excellent or very good".
- **Footnotes:** (1) Statistics Canada, Health Indicators: Definitions and data sources, http://www.statcan.gc.ca/pub/82-221-x/2013001/def/def-eng.htm#web
Life Stress
( most days quite a bit or extremely stressful )

18% Nova Scotians perceive that most days are quite a bit or extremely stressful.

There were no significant differences between 2007 and 2012

Negative health consequences associated with stress include: heart disease, stroke, high blood pressure, as well as immune and circulatory complications. Stress can also impact behaviours such as smoking, alcohol consumption, and eating habits.

Perceived Life Stress By Income:
There were no significant differences in perceived life stress by income quintiles.

Perceived Life Stress By:

Age
35-44 years: 26%
65+ years: 10%

By Sex
There were no significant differences in perceived life stress by sex.

Education
Post-Secondary Degree: 20%
Less Than High School Graduation: 16%

Statistics not presented due to insufficient sample in greater than four DHAs

INDICATOR SOURCE: Canadian Community Health Survey (Provincial 'Share' file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

INDICATOR DESCRIPTION: Population aged 15 and over who reported perceiving that most days in their life were quite a bit or extremely stressful.

Footnotes: (1) Statistics Canada, Health Indicators: Definitions and data sources, http://www.statcan.gc.ca/pub/82-221-x/2013001/def/def-eng.htm#wb
The proportion of low birth weight babies is the same for Canada and Nova Scotia (6%). Low birth weight impacts infant health, development, and survival. Low birth weight infants are at increased risk for cerebral palsy, visual problems, learning disabilities and respiratory problems.¹

Each year in Nova Scotia approximately 6% of babies (~520 babies) are born with a low birth weight. The proportion of low birth weight babies is the same for Canada and Nova Scotia (6%).

In 2011 there were approximately 43 infant deaths (5 per 1,000 live births) in Nova Scotia. Compared to Canada, 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.
Health-adjusted life expectancy is the expected number of years that an individual will live in full health. It encompasses quality of life by considering current morbidity and mortality conditions.¹
61% of the Nova Scotia population is overweight or obese*.

*Information on height and weight are self-reported.

The World Health Organization and Health Canada use the following BMI categories to classify body weight based on health risk:

- Underweight = increased health risk
- Normal weight = least health risk
- Overweight = increased health risk
- Obese class I = high health risk
- Obese class II = very high health risk
- Obese class III = extremely high health risk

There were no significant differences in overweight or obese by education.

Footnotes: (1) Statistics Canada, Health Indicators: Definitions and data sources, http://www.statcan.gc.ca/pub/82-221-x/2013001/def/dfr1-eng.htm#web
Causes of Injury Deaths:

Between 2007 and 2011 in Nova Scotia the leading causes of injury death were: falls, suicide, motor vehicle collisions, and accidental poisoning.

In 2011, the number one cause of injury deaths among males was suicide and among females was falls.

In 2011, 6% of deaths in Nova Scotia were due to unintentional injuries or suicide.

Deaths from Injury By:

Injury mortality rates are higher among males than females.

Deaths from Injury for Males and Females, 2011

Deaths by Injury

There were no significant differences between 2007 and 2012.
Most common cancer deaths:

- Lung: 63 per 100,000
- Prostate: 23 per 100,000
- Colorectal: 23 per 100,000

Most common cancer cases:

- Prostate: 123 per 100,000
- Lung: 77 per 100,000
- Colorectal: 73 per 100,000

Age-standardized incidence rates for all invasive cancers:

- 2008: 423 cases per 100,000
- 2012: 391 cases per 100,000

Age-standardized mortality for all invasive cancers:

- 2007: 180 deaths per 100,000
- 2011: 154 cases per 100,000

*Between 2008 and 2012
*Between 2007 and 2011

INDICATOR SOURCE: ¹Cancer Care NS, 1998-2012, ²Statistics Canada, Cansim Table:103-0553, ³Statistics Canada, Cansim Table 102-0552

INDICATOR DESCRIPTION: Incidence refers to the number of new cases of invasive cancer diagnosed within a specified time period. Incidence rates are the number of new cases per 100,000 population in a specified time period. Mortality refers to the number of deaths from invasive cancer within a specified time period. Mortality rates are the number of deaths per 100,000 population in a specified time period. Age-standardized rates account for differences in age distribution and are used to compare rates over time or between groups (e.g. sexes).
In Nova Scotia approximately 77,000 adults ages 20+ have diabetes.¹

**Compared to Canada**³

- **6.1%** in Nova Scotia
- **5.6%** in Canada

*Comparison with Canada represents prevalence rate for all ages

**Across Nova Scotia**²

- **High**: 9.4% (77,000 adults)
- **Low**: 7.7% (77,000 adults)

*Age-standardized rates for adult population aged 20+, 2008/09

**Diabetes By:**

- **Age**
  - **40-49** years: 5%
  - **70-79** years: 26%

- **By Sex**
  - **Males**: 9.0%
  - **Females**: 7.3%

When comparing different groups (e.g. males/females, DHAs, years) age standardized rates are used. When interpreting age-standardized rates the focus should be on the trend (e.g. NS higher than Canada) rather than the value of the rate.


¹Derived using the Canadian Chronic Disease Surveillance System, v2010, Diabetes Care Program NS. ²Diabetes in Canada: Facts and figures from a public health perspective. http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/chap1-eng.php#Pre0 ³INDICATOR DESCRIPTION: Diabetes prevalence is the proportion of the population living with the disease at a given point in time. With the exception of the comparison with Canada, the prevalence estimates above are for the population ages 20+. The prevalence estimates for the comparison with Canada are for the population one year and older. Age-standardization is to the 1991 Canadian population.
23% of Nova Scotians report that they have been diagnosed by a health professional with high blood pressure.

Compared to Canada

21% vs. 18%

Across Nova Scotia

High 34% (28%* ***Significantly higher than the provincial estimate of 23%)
Low 18% (28%**) ***Significantly lower than the provincial estimate of 23%

High Blood Pressure By Income:

- Highest Income Quintile: 19%
- Lowest Income Quintile: 28%

High Blood Pressure By Education:

- Post-Secondary Degree: 21%
- Less Than High School Graduation: 25%

High Blood Pressure By Age:

- 35-44 years: 14%
- 65+: 54%

By Sex

- There were no significant differences in high blood pressure by sex.

Footnotes: (1) Statistics Canada, Health Indicators: Definitions and data sources, http://www.statcan.gc.ca/pub/82-221-x/2013001/dif/dif1-eng.htm#web
Joint pain, swelling, and stiffness caused by arthritis can have negative impacts on activities of daily living and quality of life. According to the Canadian Community Health Survey, 23% of Nova Scotians report having arthritis compared to 16% of Canadians. Within Nova Scotia, the percentage of individuals reporting arthritis is higher than the provincial estimate. However, the percentage of individuals reporting arthritis is not significantly different between 2007 and 2012.

**Arthritis By Income:**
- Highest Income Quintile: 16%
- Lowest Income Quintile: 32%

**Arthritis By Sex:**
- Males: 16%
- Females: 28%

**Arthritis By Education:**
- Post-Secondary Degree: 21%
- Less Than High School Graduation: 27%

Nova Scotians report having been diagnosed by a health professional with heart disease.

Heart Disease By Income:

- Income Quintile 3*: 6%
- Lowest Income Quintile: 10%

Heart Disease By Sex:

- Males: 7%
- Females: 4%

Heart Disease By Education:

- Post-Secondary Degree: 5%
- Less Than High School Graduation: 8%

Statistics not presented for higher income quintiles due to insufficient sample with heart disease.

There were no significant differences between 2007 and 2012.

Statistics not presented for younger age groups due to insufficient sample with heart disease.

INDICATOR SOURCE: Canadian Community Health Survey (Provincial ‘Share’ file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

INDICATOR DESCRIPTION: Population aged 12 and over who report that they have been diagnosed by a health professional as having heart disease.
Respiratory Disease (Asthma, Chronic Bronchitis, Emphysema, COPD)

Nova Scotians report having been diagnosed by a health professional with respiratory disease.

13% vs. 10%

Compared to Canada

Statistics not presented due to insufficient sample in greater than four DHAs

Across Nova Scotia

There were no significant differences by age groups.

Respiratory Disease By Income:

<table>
<thead>
<tr>
<th>Income Quintile 4*</th>
<th>Lowest Income Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>19%</td>
</tr>
</tbody>
</table>

*Statistics are not presented for higher income quintiles due to insufficient sample with respiratory diseases.

Respiratory Disease By Sex

Males 11%  Females 14%

Respiratory Disease By Education

Post-Secondary Degree 11%  Less Than High School Graduation 16%

INDICATOR SOURCE: Canadian Community Health Survey (Provincial 'Share' file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

INDICATOR DESCRIPTION: The prevalence of respiratory diseases is derived from the Canadian Community Health Survey by the Department of Health and Wellness. It represents the population: Aged 12 and over who reported being diagnosed by a health professional with asthma or Aged 35 and over who reported being diagnosed by a health professional with chronic bronchitis, emphysema, or chronic obstructive pulmonary disease.
In 2013, 286 cases of hepatitis C were reported in Nova Scotia (Incidence rate of 30.4/100,000 population).

Hepatitis C is a chronic liver disease caused by the hepatitis C virus (HCV). The hepatitis C virus (HCV) is spread through contact with infected blood.

Across Nova Scotia

Compared to Canada*

* data are for 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nova Scotia</td>
<td>29.3</td>
</tr>
<tr>
<td>Canada</td>
<td>26.5</td>
</tr>
</tbody>
</table>

Hepatitis C By:

Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-39</td>
<td>67</td>
</tr>
<tr>
<td>60+</td>
<td>9</td>
</tr>
</tbody>
</table>

By Sex

<table>
<thead>
<tr>
<th>Gender</th>
<th>Per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>40</td>
</tr>
<tr>
<td>Females</td>
<td>21</td>
</tr>
</tbody>
</table>

Risk Factors

53% of hepatitis C cases in Nova Scotia reported using injection drugs.

Incidence rates of Hepatitis C in Nova Scotia:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>24.9</td>
</tr>
<tr>
<td>2005</td>
<td>26.7</td>
</tr>
<tr>
<td>2006</td>
<td>27</td>
</tr>
<tr>
<td>2007</td>
<td>24</td>
</tr>
<tr>
<td>2008</td>
<td>30.1</td>
</tr>
<tr>
<td>2009</td>
<td>28.5</td>
</tr>
<tr>
<td>2010</td>
<td>32.1</td>
</tr>
<tr>
<td>2011</td>
<td>22.4</td>
</tr>
<tr>
<td>2012</td>
<td>26.5</td>
</tr>
<tr>
<td>2013</td>
<td>30.4</td>
</tr>
</tbody>
</table>

How Healthy Are We? Health Profile 2015

*The largest Federal correctional facility in NS is located here. Inmates are tested for hepatitis C upon admission.
Fruit & Vegetable Consumption
(5 or more times per day)

1 out of 3 Nova Scotians (34%) consume fruit and vegetables (5 or more times per day).

There were no significant differences between 2007 and 2012.

Canada’s Food Guide\(^1\) recommends:
More than 5 servings\(^2\) per day for individuals ages 12+.

Consumption of Fruits & Vegetables By:

Age
There were no significant differences in fruit and vegetable consumption by age groups.

By Sex
Males 28% | Females 40%

Fruit & Vegetable Consumption By Income:

Highest Income Quintile | Lowest Income Quintile
38% | 30%

Education
Post-Secondary Degree | Less Than High School Graduation
39% | 27%

Heavy Drinking
(5 or more drinks on at least 1 occasion per month in the past year)

Nova Scotians report heavy drinking.

28% vs. 24%

Compared to Canada

28% vs. 24%

Across Nova Scotia

High

34%

Low

25%

* - not included due to small sample

Canada’s Low-Risk Alcohol Drinking Guidelines:

Females
0 to 2 drinks a day, up to 10 drinks per week

Males
0 to 3 drinks a day, up to 15 drinks per week

Heavily Drinking By Income:

There were no significant differences in heavy drinking by income levels.

Heavily Drinking By Sex:

Males 39%
Females 18%

Heavily Drinking By Age:

43% 11%

20-34 years 65+ years


INDICATOR SOURCE: Canadian Community Health Survey (Provincial ‘Share’ file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

INDICATOR DESCRIPTION: Population aged 12 and over who reported having 5 or more drinks on one occasion, at least once a month in the past year.
Nova Scotians report a sense of belonging to their local community as somewhat or very strong. There were no significant differences between 2007 and 2012.

There were no significant differences in sense of belonging by income levels.

There were no significant differences in sense of belonging by sex.

Nova Scotia report a sense of belonging to their local community as somewhat or very strong.

What Affects Our Health
Health Profile 2015

INDICATOR SOURCE: Canadian Community Health Survey (Provincial 'Share' file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

INDICATOR DESCRIPTION: Population aged 12 and over who reported their sense of belonging to their local community as being very strong or somewhat strong.
Breastfeeding is important for healthy growth and development and protects against certain infections (gastrointestinal, acute otitis media, respiratory tract), sudden infant death syndrome, and obesity. 

The rate of exclusive breastfeeding at six months in Nova Scotia is: **22%**

**Exclusive breastfeeding for the first six months of life is the recommended standard for infants.**

Compared to Canada

| Nova Scotia | Canada | 22% | 26% |

Breastfeeding duration is an important population health indicator.

Understanding how long babies are breastfed is valuable for Public Health programming and is a requirement for achieving Baby Friendly Initiative designation.

Currently, the only information source for exclusive breastfeeding at six months in Nova Scotia is the Canadian Community Health Survey (CCHS).

The sample of Nova Scotians who responded to the breastfeeding questions in this survey is small therefore rates must be interpreted with caution.

Exclusive breastfeeding at 6 months


(2) The Baby Friendly Initiative (BFI) is a worldwide program of the WHO and UNICEF that aims to implement practices that protect, promote and support breastfeeding.

**INDICATOR SOURCE:** Canadian Community Health Survey (Provincial ‘Share’ file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

**INDICATOR DESCRIPTION:** This indicator is based on information provided by females aged 15 to 55 who had a baby in the last 5 years. Exclusive breastfeeding refers to an infant receiving only breast milk, without any additional liquid (even water) or solid food.
22% of Nova Scotians report daily or occasional smoking.

**Indicators:**

**Smoking by Income:**
- Highest Income Quintile: 17%
- Lowest Income Quintile: 29%

**Smoking by Education:**
- There were no significant differences in smoking by education levels.

**Smoking by Age:**
- 27% of 20-34 years old
- 11% of 65+ years old

**Smoking by Sex:**
- There were no significant differences in smoking by sex.

**Smoking Compared to Canada:**
- Nova Scotia: 22%
- Canada: 20%

**Notes:**
- * - not included due to small sample

**Indicator Source:**
Canadian Community Health Survey (Provincial 'Share' file for NS), 2007-2012. Unless otherwise indicated, statistics presented are for 2011 and 2012 combined years.

**Indicator Description:**
Population aged 12 and over who reported smoking cigarettes every day or occasionally. Includes former daily smokers who now smoke occasionally. Does not take into account the number of cigarettes smoked.
54% of Nova Scotians are categorized as active or moderately active based on their self-reported participation in leisure-time physical activity.

Results in 2011/2012 were significantly higher than in 2007/2008.

1. Self-reported and measured methods can produce different results.

2. The estimate presented above does not measure the proportion of the population meeting the Canadian Physical Activity Guidelines. According to data for Canada, 22% of Canadians (ages 18-79) meet the guidelines for moderate-to-vigorous activity. Similar data is not available for Nova Scotia.

Self-Reported Leisure-Time Physical Activity By Income:

- Highest Income Quintile: 68%
- Lowest Income Quintile: 46%

Physical Activity By:

**Age**
- 20-34 years: 62%
- 65+ years: 38%

**By Sex**
- Males: 57%
- Females: 51%

**Education**
- Post-Secondary Degree: 58%
- Less Than High School Graduation: 48%
Housing affordability is an indicator to estimate the proportion of the population experiencing financial strain due to shelter costs. Spending more than 30% of household income (particularly among those who rent their home) increases the risk of having inadequate income for necessities such as food, clothing, and transportation.¹

Among both renters and owners in Nova Scotia, 22% spend > 30% of household income on shelter costs. This is lower than the Canadian rate of 25%.²

A much larger proportion of renters (43%) spend > 30% of household income on shelter costs than owners (15%).²

The proportion of RENTERS who spend > 30% of household income on shelter costs is 43%, compared to 40% for CANADA.

The rate of home ownership in Nova Scotia in 2011 was 71%. This is slightly higher than the Canadian rate of 69%.²

The proportion of HOME OWNERS who spend > 30% of household income on shelter costs is 14%, compared to 19% for CANADA.

**Footnotes:**