Health of Canadians

Release date: March 5, 2025

Statistics Canada   Statistique Canada

Canada

How to obtain more information

For information about this product or the wide range of services and data available from Statistics Canada, visit our website, www.statcan.gc.ca.

You can also contact us by

Email at infostats@statcan.gc.ca

Telephone, from Monday to Friday, 8:30 a.m. to 4:30 p.m., at the following numbers:

- Statistical Information Service   1-800-263-1136
- National telecommunications device for the hearing impaired   1-800-363-7629
- Fax line   1-514-283-9350

Standards of service to the public

Statistics Canada is committed to serving its clients in a prompt, reliable and courteous manner. To this end, Statistics Canada has developed standards of service that its employees observe. To obtain a copy of these service standards, please contact Statistics Canada toll-free at 1-800-263-1136. The service standards are also published on www.statcan.gc.ca under "Contact us" > "Standards of service to the public."

Note of appreciation

Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses, governments and other institutions. Accurate and timely statistical information could not be produced without their continued co-operation and goodwill.

Table of contents

Acknowledgments

This report was prepared by the Health Statistics Branch, Statistics Canada.

Thank you to all Canadians who provide Statistics Canada with data. We appreciate your time and the trust you place in us to protect your information so that we can deliver high-quality statistics that matter to all Canadians.

Chief Statistician's message

Statistics Canada plays a leading role in collecting, analyzing and reporting on health statistics. The Health Statistics Branch within Statistics Canada is the country's primary source of national population health data and insights. It is building on its well-established foundation as a critical source of health information by providing more data and actionable insights for all levels of government, researchers, clinicians and the public to support the health and the economic, social and environmental well-being of Canadians.

The *Health of Canadians* report brings together important health data, both for the population overall and for specific groups, to paint a comprehensive portrait of population health and to shed light on health disparities. This second iteration of the report builds on the first by examining health outcomes across additional subpopulations, including people with disabilities, immigrants and those living in rural areas. In addition, new health outcome domains have been added to the report, including statistics on sexual health, oral health and COVID-19.

As Statistics Canada continues to develop innovative ways to collect health data, this report represents one aspect of the agency's commitment to improving access to these data, including disaggregated data, to achieve better health outcomes for all Canadians.

André Loranger
Chief Statistician of Canada

Introduction

Understanding the population's health and the various factors that influence it is essential for developing effective health policies, enhancing health outcomes, promoting health equity and fostering community engagement. This understanding also provides valuable insights into reducing health care costs, improving the sustainability of the health care system and ensuring a high quality of life for all.

Statistics Canada serves as a leader in collecting comprehensive data on various aspects of Canadian life, including health, demographics, social conditions and the economy. These integrated data provide a holistic understanding of the health and well-being of the population.

The annual *Health of Canadians* report offers a comprehensive overview of the state of population health in Canada, using the latest data on health indicators across various domains, as outlined in the Health Statistics Branch's Population Health Data Framework (Figure 1). This iteration of the report features statistics from 2022 to 2024, including previously reported health outcomes—such as perceived health and mental health, chronic diseases, and mortality—as well as newly added domains like sexual health, oral health and COVID-19.

Health outcomes, health behaviours and access to health care services are significantly shaped by the broader socioeconomic determinants of health. Accordingly, in line with Statistics Canada's Disaggregated Data Action Plan, the *Health of Canadians* report details the variation in health outcomes and behaviours across the Canadian population by sociodemographic characteristics, including racialized group, Indigenous identity, sex, gender and sexual orientation. This second iteration of the report explores health outcomes among additional subpopulations, including people with disabilities, immigrants and those living in rural areas.

Collectively, this compilation of information paints a detailed portrait of population health for policy makers, researchers, health professionals and Canadians. Moreover, it serves as a valuable resource for policies and initiatives, ultimately leading to improved and more equitable health outcomes for all Canadians.

Figure 1
Health Statistics Branch Population Health Data Framework

Population Health Data Framework

Access to health care

Health determinants

Health behaviours

Health outcomes

HEALTH EQUITY

Chronic diseases

Oral health

Substance use health

Health of children and youth

Mortality

Healthy aging

Mental health

Infectious diseases

Sexual and reproductive health
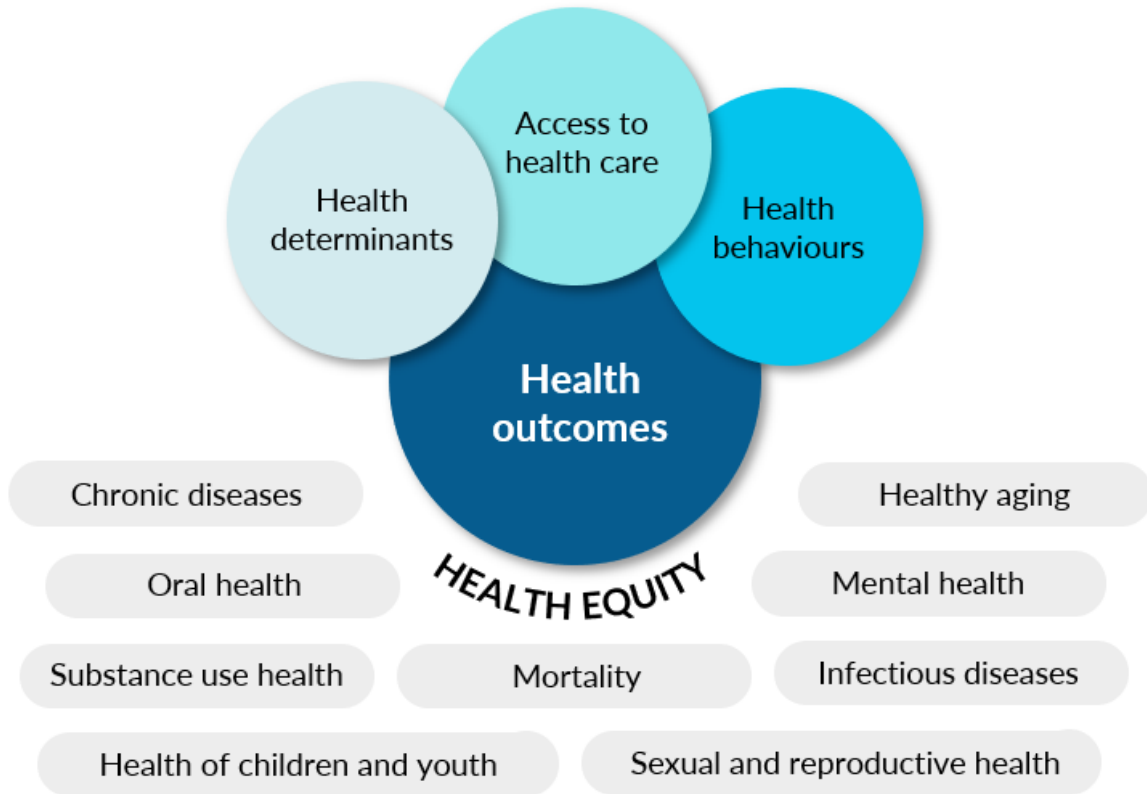
Source: Statistics Canada, Health Statistics Branch, Strategic Plan 2023-2025, Figure 2, Population Health Data Framework, February 2023 (revised April 2024).

Report highlights and future directions

Like the first annual *Health of Canadians* report,[1] this report provides a comprehensive overview of the state of population health in Canada. It uses the latest data (mainly from 2022 and 2023) to highlight trends for key health indicators across several sociodemographic characteristics.

New to the report are statistics on sexual health, oral health and COVID-19, as well as analyses across additional subpopulations, including people with disabilities, immigrants and those living in rural areas.

In 2023, life expectancy rose for the first time in three years. Crude birth rate and the total fertility rate continued to drop, and stillbirths and maternal mortality rates kept increasing. Cancer and heart disease remained the leading causes of death, while deaths from COVID-19 decreased. Projections for 2024 indicate that, although age-standardized incidence and mortality rates for all cancers combined are expected to decrease for both males and females compared with previous years, the rates for males will remain higher than those for females.

This report finds that perceived health declined among Canadian adults from 2021 to 2022 and further dropped in 2023. Perceived mental health also decreased from 2018 to 2022 but remained relatively stable in 2023, except for adults aged 35 to 49, among whom it continued to decline. Lower perceived health and mental health were observed among women; people whose reported sexual orientation is lesbian, gay, bisexual or another orientation that is not heterosexual (LGB+); those with a self-reported disability; non-immigrants; those living in the Atlantic provinces or in population centres; and those with lower household incomes.

While the prevalence of most chronic diseases and risk factors has remained stable, the prevalence of overweight, obesity, arthritis and high blood pressure stayed elevated for certain groups, especially males, older adults, longer-term immigrants, those in low-income households and those with a self-reported disability. The prevalence of mental health conditions like anxiety and mood disorders continued to climb; they were more prevalent among women, younger adults, LGB+ people and individuals with the lowest household incomes. In Canada, 2.1 million people still suffered from long-term COVID-19 symptoms and reported missing days of school or work as a result.

The 2023 Canadian Community Health Survey asked about alcohol use in the past seven days and revealed that half of Canadian adults reported not drinking any alcohol in the past week.[2] Heavy drinking increased from 2021 to 2022 but then decreased in 2023. Consistent with previous findings, proportionally more people in higher-income households were classified as heavy drinkers and reported consuming seven or more drinks in the past week.[3] While the prevalence of vaping increased from 2021 to 2022, it remained stable in 2023. Cannabis use was down in 2023 from the previous year, and overall cigarette smoking kept declining. Daily or occasional cigarette use continued to be prevalent among low-income adults and those with a self-reported disability, while vaping and cannabis use remained prevalent among men and younger adults.

Proportionally fewer Canadian adults reported having a regular health care provider in 2023 than in 2022. The shares were particularly low for young adults, those with the lowest income, LGB+ people, and those living in the territories and Quebec. Close to 3 million Canadians reported unmet needs for health care in 2022, a 1.3 percentage point increase from the previous year. Unmet needs for health care were higher among those living in the Atlantic provinces and among women. Meanwhile, unmet needs for home care were high among those with the lowest income, women and longer-term immigrants. Three-quarters of Canadians visited an oral health professional in 2023 to 2024, and two-thirds had dental insurance.

In the coming years, as the Canadian population grows (because of immigration) and ages (because of the large baby-boomer cohort reaching 85 years of age),[4] there will be implications for population health. Comprehensive strategies will be critical for addressing the varying needs and challenges presented by these demographic shifts. Policy makers will need to consider the unique health needs of aging populations and immigrants in planning and resource allocation. Statistics Canada will keep updating *Health of Canadians,* with the goal of continuing to monitor and report on population health.

The next iteration of the report will incorporate findings from the Survey on Health Care Access and Experiences – Primary and Specialist Care, which will include data on quality of life health indicators, cost-related non-adherence to prescription medications and access to supplementary health insurance. As this year's report focused on adult population health, key findings on child and youth health from the 2023 Canadian Health Survey on Children and Youth will be presented in the next annual publication. Data from Cycle 7 (2022 to 2024) of the Canadian Health Measures Survey, including directly measured health indicators such as overweight and obesity, hypertension, and oral health, in both adults and children, may also be included.

In collaboration with partners, Statistics Canada is also conducting several new health surveys that address data gaps, including on sexual and reproductive health, pharmaceuticals, electronic health information, virtual care, and palliative care.

A methodological note to readers

The health indicators presented in this report were selected based on several criteria, including whether they

1. have been identified as key population health indicators by Statistics Canada subject-matter experts, environmental and media scans, and international and national health indicator frameworks

2. allow for systematic disaggregation of data across key population groups identified in Statistics Canada's Disaggregated Data Action Plan

3. are informative for the Canadian public and Statistics Canada's partners and stakeholders interested in health.

Data included in this report come from the following Statistics Canada sources:

- Canadian Cancer Registry
- Canadian Community Health Survey (CCHS)
- Canadian COVID-19 Antibody and Health Survey
- Canadian Health Measures Survey
- Canadian Health Survey on Children and Youth, longitudinal component
- Canadian Income Survey
- Canadian Oral Health Survey
- Canadian Social Survey
- Canadian Vital Statistics – Birth database (CVSB)
- Canadian Vital Statistics – Death database (CVSD)
- Canadian Vital Statistics – Stillbirth database (CVSS)
- Canadian Wastewater Survey
- Census of Population
- Indigenous Peoples Survey
- Mental Health and Access to Care Survey.

The CVSB, CVSS and CVSD are administrative surveys that collect demographic and medical information on all births, stillbirths (fetal deaths) and deaths in Canada from all provincial and territorial vital statistics registries. The provinces and territories provide these data to Statistics Canada at different times. Consequently, they are subject to annual revisions to incorporate new and updated information received from the provinces and territories. The information presented in this report reflects the versions of the CVSB and CVSS released on September 25, 2024, and the CVSD released on February 19, 2025.

The inaugural 2023 *Health of Canadians* report used data from the 2015 to 2021 cycles of the CCHS, which included individuals aged 12 and older. In this updated report, the focus shifted to data from the 2022 and 2023 CCHS cycles, now covering the population aged 18 and older. Consequently, all data were reanalyzed to examine this age group and allow for a comparison of findings from 2015 to 2023.

Unless otherwise specified, the analysis of indicators in this report is based on data from the 2023 CCHS, which was conducted from January 3 to December 31, 2023. The sample is representative of Canadians aged 18 and older living in the provinces (excluding people living on reserves and other Indigenous settlements, full-time members of the Canadian Forces, the institutionalized population, and people living in some health regions of Quebec). Altogether, these exclusions represent less than 3% of the Canadian population aged 18 and older. The 2023 CCHS did not include a design to represent the entire population of the territories; however, data for these areas will be incorporated when the combined CCHS data for 2023 and 2024 are released in 2025. Therefore, the territorial data presented in this report are drawn from the 2022 CCHS.

The 2023 cycle of the CCHS included a targeted oversample to enhance coverage for racialized groups, Indigenous peoples and people with disabilities, as part of the Disaggregated Data Action Plan. All breakdowns presented in this report, unless otherwise noted, are unadjusted for any factors that might explain the differences between groups. Consequently, any observed differences may be attributable to other factors once adjustments are made. The intention of this report is to highlight statistically significant differences—that is, those that are not thought to have occurred by chance—that can be further investigated. When two estimates are described as different in this report, the difference is statistically significant at a 95% confidence level (p-value less than 5%).

Unless otherwise specified, the annual estimates for provinces are compared with the estimate for Canada (excluding the territories). Territorial estimates are compared with the estimate for all of Canada (for 2022 only). The word "prevalence" is often used, referring to the percentage or proportion of a particular behaviour or disease within a specific population at a given time. For example, the prevalence of diabetes among adults in Canada in 2023 indicates how many adults in the provinces or territories had been diagnosed with diabetes at that time.

Health determinants

The determinants of health encompass a range of factors that shape the health outcomes of individuals and populations. Among these, the social determinants of health play a critical role, including factors such as income, racialized status and immigrant status. These elements influence the environments in which people are born, grow up, live, work and age, and they interact in ways that can significantly affect overall health and well-being.

This report explores several population-level health indicators, including health outcomes (e.g., perceived health, chronic diseases), health behaviours (e.g., fruit and vegetable consumption, substance use) and access to health care (e.g., having a regular health care provider), all of which are profoundly impacted by these determinants of health. Since the next Census of Population will take place in May 2026, the most recent profiles for the distribution of the determinants of health across the population are based on the 2021 Census. This section summarizes the cross-cutting themes related to the selected health determinants emerging from this report.

Key findings

- **Geography and rurality:** In most of the Atlantic provinces, the prevalence of chronic diseases was higher, and proportionally fewer adults reported having very good or excellent perceived health and mental health or consuming fruits or vegetables five or more times per day, compared with the average across all provinces. A higher share of adults in rural areas than in population centres reported very good or excellent mental health, but chronic disease prevalence was higher in rural areas. Proportionally fewer adults in rural areas had dental insurance and had visited an oral health professional in the past year.

- **Household income:** A larger share of higher-income than lower-income adults reported very good or excellent perceived health and mental health; a smaller share reported having chronic diseases. Although cigarette smoking and cannabis use were less common among higher-income adults, heavy drinking was more common. Proportionally fewer lower-income Canadians had a regular health care provider, and a greater percentage had unmet needs for home care.

- **Age:** The prevalence of most chronic diseases examined increased with age. Unlike very good or excellent perceived health, which decreased with age, very good or excellent perceived mental health rose and was highest among those aged 65 and older. The prevalence of anxiety and mood disorders was lower among older adults than those aged 18 to 34, a larger share of whom used cannabis daily or almost daily and vaped in the past 30 days, and a smaller share of whom consumed fruits or vegetables five or more times per day. Having a regular health care provider was less common among younger adults.

- **Sex at birth and gender:** A smaller share of women than men reported very good or excellent perceived health and mental health and a larger share had unmet home care needs. Proportionally more men vaped in the past 30 days, smoked cigarettes daily or occasionally, were heavy drinkers and used cannabis daily or almost daily, and fewer consumed fruits or vegetables five or more times per day. A larger share of females than males reported having chronic diseases, and females were projected to have higher lung cancer incidence in 2024.

- **Sexual orientation:** The prevalence of mental health disorders and substance use was higher among people who reported their orientation as lesbian, gay, bisexual or another orientation that is not heterosexual (LGB+) than heterosexual people. A lower share of LGB+ people reported very good or excellent perceived health and mental health or had a regular health care provider.

- **Disability:** Proportionally fewer adults with a disability than those without disabilities reported very good or excellent perceived health and mental health, and more used cannabis daily or almost daily, smoked cigarettes daily or occasionally, and reported having a chronic disease and long-term COVID-19 symptoms.

- **Immigrants:** Immigrants had healthier substance use behaviours than non-immigrants, reporting lower alcohol consumption in the past week and a lower prevalence of heavy drinking, cigarette smoking (daily or occasionally), vaping (in the past 30 days) and cannabis use (daily or almost daily). A higher share of recent immigrants reported very good or excellent perceived health than immigrants who were admitted more than 10 years ago.

- **Racialized populations:** Most of the chronic diseases examined were more prevalent among non-racialized people, compared with racialized populations.

- **Indigenous populations:** Indigenous groups had a lower life expectancy and higher infant mortality rates than the non-Indigenous population. Arthritis, high blood pressure and asthma were the most prevalent chronic diseases among Indigenous groups, while mood and anxiety disorders were more prevalent among low-income Indigenous people. A lower share of Indigenous adults and children had a regular health care provider, and a higher share reported unmet needs.

Geography and rurality

Where a person lives can profoundly affect their health and well-being. For example, as explored in the Health outcomes section of this report, patterns of perceived health and mental health varied throughout Canada. Proportionally fewer adults living in the Atlantic provinces (except Newfoundland and Labrador) reported very good or excellent perceived health and mental health compared with the average across all provinces. The prevalence of having one or more chronic diseases was higher in the Atlantic provinces in 2023, with a larger share of people having high blood pressure, arthritis and mood disorders. In contrast, consistently from 2021 to 2023, proportionally more adults living in Quebec reported very good or excellent perceived health and mental health, and fewer reported having high blood pressure, arthritis and mood disorders.

Geography and rurality may influence diet and substance use through variations in access and availability, cultural norms, economic conditions, social environments, and policy regulations. The Health behaviours section shows that in 2023, the percentage of adults consuming fruits or vegetables five or more times per day was notably lower in the Atlantic provinces and Ontario compared with the average across all provinces, while it was higher in Quebec. The same year, vaping prevalence was higher in Alberta but lower in Ontario. In 2022, cigarette smoking and cannabis use were more prevalent across all three territories compared with the Canadian average.

A person's location can also determine the availability of health care facilities, providers and preventive services. Limited transportation options in some regions may hinder access to medical care and result in unmet needs.[5] This report reveals disparities in health care access across Canada, including in terms of regular health care providers, home care services, dental insurance and dental visits. In 2023, a lower proportion of people living in Quebec had a regular health care provider, though a higher proportion used home care services, than the average across all provinces. Additionally, a smaller share of Quebec residents than Ontario residents reported having dental insurance and having visited a dental professional in the past year.

Population centres typically have more health care resources, while rural or remote regions may experience shortages, leading to delayed care and poorer health outcomes. For example, from 2021 to 2023, fewer adults in rural areas reported very good or excellent perceived mental health compared with their counterparts in population centres. Meanwhile, in 2023, a greater proportion of rural residents had a regular health care provider than those in population centres. However, rural residents also experienced a higher prevalence of certain chronic diseases and risk factors, including high blood pressure, heart disease, diabetes, obesity and arthritis. Additionally, a lower proportion of adults in rural areas had dental insurance or had visited a dental professional in the past year, and a higher proportion experienced edentulism (having no natural teeth), compared with those living in population centres.

Household income

The interplay between income and health is complex, as education, employment, housing and environment are all often tied to income, and changes in one area can affect others, creating a web of influences. Considerable research has shown that health status improves with each step up in income.[6] From 2021 to 2023, there was a consistent increase in the percentage of adults reporting very good or excellent perceived health as household income levels rose, as discussed in the Health outcomes section.

In addition, higher income often provides a buffer against financial stress, contributing to better mental health.[7] This report highlights that a larger percentage of adults in the highest income quintile reported very good or excellent perceived mental health compared with those in the lowest quintile in 2023.

In many cases, higher-income individuals experience a lower prevalence of chronic diseases because they have better access to health care, healthier living conditions and more resources for maintaining a healthy lifestyle. In 2023, several chronic diseases and risk factors (high blood pressure, heart disease, stroke, diabetes, obesity, arthritis, anxiety and mood disorders) were less prevalent among adults in the highest household income quintile than among those in the lowest.

Personal choices and behaviours, influenced by income and access to information, significantly affect health. Individuals with higher incomes tend to have better access to nutritious food and health information, leading to greater awareness of substance use risks and healthier lifestyle choices.[8] This is reinforced in the **Health behaviours** section, which shows that in 2023, proportionally more adults in the highest-income households than

in the lowest-income households reported consuming fruits or vegetables five or more times per day, and fewer reported regular cigarette and cannabis use. However, this section also reveals a contrasting trend: a higher share of people in higher-income households were classified as heavy drinkers compared with those in the lowest-income households.

Low-income individuals in Canada may have less access to regular doctors because of regional disparities in health care availability, financial barriers and challenges related to health literacy.[9] Experiences of discrimination and the stress of financial instability can further discourage them from seeking consistent medical care. The **Access to health care** section reveals that in 2023, proportionally fewer adults in the lowest-income households had a regular health care provider compared with those in the highest income quintile. While the use of home care services was more prevalent among the lowest-income households, a larger percentage of low-income Canadians reported unmet needs for home care.

Age

Age significantly affects health in various ways, influencing both physical and mental well-being. Physically, as people age, certain functions of their bodies naturally begin to decline, making them more vulnerable to chronic health issues. Throughout the Health outcomes section, this report shows that in 2023, the prevalence of certain chronic diseases, such as high blood pressure, heart disease, stroke, diabetes, arthritis and cancer, increased with age. However, older adults also exhibit greater emotional resilience and life satisfaction because of their life experiences and coping skills.[10] This report finds that, unlike perceived health, which declined with age, perceived mental health increased with age; the share of people reporting very good or excellent mental health was highest among those aged 65 and older.

During adolescence and young adulthood, individuals are more prone to taking risks and may adopt unhealthy habits like smoking and poor eating, often because of peer pressure and social norms.[11] This report reveals that in 2023, vaping and cannabis use were more prevalent among younger adults aged 18 to 34 compared with older age groups. Fruit and vegetable consumption also varied by age, with proportionally fewer 18- to 34-year-olds consuming them five or more times per day, as shown in the Health behaviours section.

Young people may consider health services inaccessible because of inconvenient locations and hours, and fear of confidentiality issues may make them hesitant to seek help.[12] This report finds that a lower proportion of Canadians aged 18 to 34 than those aged 65 and older reported having a regular health care provider in 2023. Further details can be found in the **Access to health care** section.

Sex at birth and gender

This report examines health outcomes, health behaviours, substance use and access to care by sex at birth and gender, recognizing that both are crucial for identifying health disparities linked to biological and sociocultural factors.[13,14] Understanding these distinctions allows for a more comprehensive approach to health research and interventions. Life expectancy, infectious diseases, chronic diseases and mortality are presented in this report by sex, reflecting biological differences. Meanwhile, health behaviours, substance use, access to care, and perceived health and mental health are presented by gender, highlighting the influence of gender roles and expectations.

The Health outcomes section highlights notable trends showing that proportionally fewer women than men reported very good or excellent perceived health and mental health. In 2023, the most pronounced gender differences were observed among those aged 35 to 39 and 18 to 34. Across all age groups, a higher percentage of women consumed fruits or vegetables five or more times per day. A larger share of men than women reported regular vaping, cigarette smoking, drinking and cannabis use in 2023, as explored in the Health behaviours section. The Access to health care section shows that proportionally more women than men reported having a regular health care provider and using home care services, yet more women than men also reported unmet health care and home care needs.

In 2023, the prevalence of having one or more chronic diseases was higher overall among females than males, with heart disease and diabetes more common among males and arthritis more prevalent among females. These sex differences widened with age. In addition, overweight was more common among males, particularly those aged 35 to 49. The projected age-standardized incidence and mortality rates for all cancers combined were higher

for males, although lung cancer rates have recently begun to converge. While lung cancer mortality remained higher among males, females were projected to have a higher incidence rate in 2024. Colorectal cancer incidence and mortality rates have been steadily decreasing for both sexes. Lastly, proportionally fewer females reported that their long-term COVID-19 symptoms had resolved. Among those whose symptoms had resolved, females experienced symptoms for a longer average duration compared with males. Details are further explained in the **Health outcomes** section.

Sexual orientation

LGB+ individuals often have a higher prevalence of anxiety, depression and suicidal ideation, which may be associated with experiences of societal stigma, discrimination and isolation.[15] The Health outcomes section of this report finds that in 2023, the prevalence of self-reported diagnosed anxiety disorders was twice as high among gay or lesbian adults and more than three times as high among bisexual or pansexual adults, compared with heterosexual adults. Across all age groups (except for those aged 60 and older), anxiety was more prevalent among LGB+ adults than their heterosexual counterparts. In 2023, a lower percentage of LGB+ men and women reported very good or excellent perceived mental health, compared with their heterosexual counterparts.

In 2023, perceived health was lower among LGB+ adults aged 18 to 34, compared with their heterosexual counterparts. However, most of the chronic diseases examined were either similar or lower in prevalence among LGB+ adults than heterosexual adults.

The Health behaviours section reveals that in 2023, proportionally more LGB+ women than heterosexual women reported heavy drinking, while no differences were found among men. Additionally, cigarette smoking and vaping were found to be more prevalent among LGB+ women and among LGB+ people aged 18 to 34, who reported these behaviours in higher proportions than their heterosexual counterparts. Furthermore, a greater percentage of LGB+ people reported daily (or almost daily) cannabis use in 2023, compared with heterosexual adults, particularly among LGB+ young adults aged 18 to 34.

Some LGB+ Canadians have reported negative experiences with the health care system related to their sexuality, and, as a result, avoid or delay seeking care.[16] This report finds that proportionally fewer LGB+ adults had a regular health care provider compared with heterosexual Canadians in 2023. Further details are available in the Access to health care section.

Disability

Disability can limit employment opportunities, leading to financial stress and reduced access to health resources. People with disabilities may also experience social isolation because of mobility challenges or societal attitudes, which can negatively affect mental and emotional health.[17,18]

According to the Health outcomes section of this report, in 2023, proportionally fewer individuals with a self-reported disability had very good or excellent perceived health and mental health, compared with those without disabilities. Additionally, a greater share of adults with a disability had at least one chronic condition, with a higher prevalence of high blood pressure, heart disease, stroke, diabetes, obesity, arthritis and mood disorders. Furthermore, a larger percentage of adults with a disability had a regular health care provider and experienced long-term symptoms of COVID-19 than those without disabilities.

This report reveals that while alcohol consumption in the past week and heavy drinking were less prevalent among those with a disability in 2023, higher proportions of people with a disability reported cigarette smoking and cannabis use, compared with those without disabilities. This is further explored in the Health behaviours section.

Immigrant status

Many immigrants initially enjoy better health than native-born populations, a phenomenon known as the "healthy immigrant" effect, though this advantage tends to diminish over time.[19,20] This report highlights key aspects of this effect in the Health outcomes section. For instance, from 2021 to 2023, a greater share of immigrants reported very good or excellent perceived mental health compared with non-immigrants. However, it was found that proportionally fewer established immigrants, who were admitted to Canada more than 10 years

ago, reported very good or excellent mental health compared with their more recent counterparts. Nonetheless, the percentage of established immigrants reporting very good or excellent mental health was still greater than that of non-immigrants.

Over time, the prevalence of chronic diseases may increase among immigrants, influenced in part by aging, lifestyle changes and environmental stressors in their new country. This report reveals that while, in general, proportionally fewer immigrants than non-immigrants reported having at least one chronic disease in 2023, a larger percentage of those who were admitted to Canada more than 10 years ago reported having a chronic disease, compared with more recent arrivals. Notably, heart disease, obesity, arthritis, anxiety and mood disorders were less prevalent among immigrants than non-immigrants in 2023, yet these conditions were more common for established immigrants than for recent immigrants. While the prevalence of diabetes and obesity was higher among immigrants overall in 2023, those who were admitted more than 10 years ago had a higher prevalence of both, compared with recent immigrants. Additionally, a greater percentage of immigrants, both recent and established, were classified as overweight, compared with non-immigrants.

Many immigrants carry dietary habits from their home countries that can differ markedly from those in their new surroundings, influencing their nutrition and leading to either healthier or less healthy eating patterns. The Health behaviours section shows that a lower proportion of immigrants than non-immigrants consumed fruits or vegetables five or more times per day, with the lowest proportion among recent immigrants, rather than established immigrants.

The Health behaviours section highlights that immigrants had healthier substance use behaviours, reporting lower alcohol consumption in the week before the survey and a lower prevalence of heavy drinking, cigarette smoking (daily or occasional), vaping (in the past 30 days) and cannabis use (daily or almost daily), compared with non-immigrants. The prevalence of vaping was higher among immigrants who were admitted to Canada in the last 10 years, whereas the prevalence of cannabis use was higher among immigrants who were admitted to Canada more than 10 years ago. However, there were no differences in the prevalence of heavy drinking and cigarette smoking based on the time since immigration.

The Access to health care section indicates that from 2021 to 2023, the percentage of non-immigrants with a regular health care provider decreased, while there was no change among immigrants. However, when examined by time since immigration, the percentage with a provider was unchanged for established immigrants but increased for recent immigrants.

Although home care service use did not differ by immigrant status in 2023, a higher proportion of immigrants reported unmet needs for home care, particularly among those who have been in Canada longer, compared with more recent immigrants.

Racialized groups

The relationship between racialized identity and health is influenced by a blend of systemic, socioeconomic, cultural and environmental factors. These elements interact to create disparities in health outcomes among different racialized and ethnic groups.[21] This report examines health and health-related outcomes for adults aged 18 and older in the 10 largest racialized groups in Canada: South Asian, Chinese, Black, Filipino, Arab, Latin American, Southeast Asian, West Asian, Korean and Japanese.

While racialized groups often face unique stressors such as discrimination and social isolation that can adversely impact their health,[21,22,23] results in the Health outcomes section indicate that a higher percentage of several racialized groups—specifically South Asian, Filipino, Latin American and Japanese individuals—reported very good or excellent perceived health, compared with the non-racialized population. Additionally, higher shares of Filipino, Black, Latin American and South Asian people reported very good or excellent perceived mental health, compared with the non-racialized population. Notably, in 2023, most people in each of the 10 largest racialized groups rated their perceived health and mental health as very good or excellent, in proportions similar to or higher than those of their non-racialized counterparts.

High blood pressure, heart disease, obesity, anxiety and mood disorders were more prevalent among the non-racialized population than among most racialized groups in 2023. Moreover, arthritis was less common among all racialized groups compared with the non-racialized population from 2021 to 2023. However, a higher proportion

of South Asian and Black Canadians were classified as overweight compared with their non-racialized counterparts in 2023. Additionally, South Asian people had a greater prevalence of diabetes, while Chinese, Latin American, Japanese, Korean and West Asian adults reported lower diabetes prevalence relative to the non-racialized population. COVID-19 reinfection was most common among Black Canadians, compared with other racialized groups.

As presented in the Health behaviours section, while some racialized groups reported consuming fruits or vegetables five or more times per day in proportions comparable to the non-racialized population in 2023, lower shares of South Asian, Chinese and West Asian people did so. In addition, heavy drinking and cigarette smoking were more common among non-racialized adults, compared with most racialized groups. Vaping was less prevalent among Chinese, South Asian, Latin American, Black and Southeast Asian individuals, while it was more common among Arab adults, compared with non-racialized people. Furthermore, daily or almost daily cannabis use was notably less common among the South Asian, Chinese, Black, Filipino and Latin American groups compared with the non-racialized population in 2023.

Racialized and ethnic groups often face barriers to accessing health care, including economic challenges, lack of insurance and systemic discrimination within the health care system. Data revealed that in 2023, lower shares of Arab, Black, Korean, Latin American and Chinese adults had a regular health care provider compared with their non-racialized counterparts, while a greater proportion of Filipino adults had one. In addition, home care use was notably less common among Southeast Asian, Filipino, Latin American and Chinese adults relative to the non-racialized population. Smaller proportions of Chinese and Filipino adults reported unmet needs for home care, compared with the non-racialized population. Further details can be explored in the Access to health care section.

Indigenous populations

Indigenous groups across Canada experience health disparities that can be attributed to various social determinants of health. These determinants include systemic issues that impact everyday realities, such as access to suitable health care, high-quality education, affordable food and adequate housing.[24,25] Exposed to various inequities in the social determinants of health, Indigenous groups experience a disproportionate risk of poor health compared with non-Indigenous groups.[26,27]

Findings from the 2022 Indigenous Peoples Survey, a national survey on the social and economic conditions of First Nations people living off reserve, Métis and Inuit, reveal disparities in health indicators among Indigenous populations in Canada. As explored in the Health outcomes section, life expectancy at birth is notably lower among these populations, and infant mortality rates are higher. Chronic diseases are prevalent, especially arthritis, high blood pressure and asthma, with sex differences observed. Mental health issues are also widespread across Indigenous groups, with over one-quarter of Indigenous adults reporting anxiety or mood disorders, often exacerbated by low-income conditions. Access to health care remains a critical challenge, with many Indigenous individuals reporting unmet health care needs. Furthermore, Indigenous children experience poorer health outcomes, with high rates of respiratory infections and dental issues, often linked to inadequate social determinants of health. The COVID-19 pandemic disproportionately affected these communities, with mortality rates higher than in non-Indigenous populations,[28] emphasizing ongoing health inequities that need to be addressed.

Health outcomes

## 1.0 Health status

Key findings

- The share of Canadian adults reporting very good or excellent perceived health declined from 61.3% in 2020 to 52.2% in 2023.

- The decrease in perceived health since 2021 was especially prominent among those aged 65 and older (a 9.4 percentage point reduction from 2021 to 2023).

- Unlike perceived health, which declined with age, perceived mental health improved with age and was highest among those aged 65 and older.

- A lower proportion of adults living in the Atlantic provinces (except for Newfoundland and Labrador) reported very good or excellent perceived health and mental health compared with Canada overall (excluding the territories).

- In 2023, larger shares of all racialized groups reported very good or excellent perceived health and mental health than their non-racialized counterparts.

- Perceived health and mental health varied across population subgroups in 2023 and were lower among women (vs. men), the lowest-income households (vs. the highest) and those with a self-reported disability (vs. those without disabilities).

- Life expectancy increased for the first time in three years in 2023 but remained below levels observed before the COVID-19 pandemic.

Perceived health refers to an individual's overall health assessment, whether self-reported or provided by a proxy. It is measured on a scale from excellent to poor. The measure aligns with the World Health Organization's definition of health as complete physical, mental and social well-being. This report focuses on those who reported "very good" or "excellent" perceived health.

Perceived health

For each year from 2015 to 2020, roughly 60% of Canadian adults reported their perceived health as very good or excellent. This percentage then declined from 61.3% in 2020 to 58.8% in 2021 and subsequently decreased again to 53.8% in 2022 and to 52.2% in 2023 (Chart 1.0). The decline in very good or excellent perceived health since 2021 has been especially prominent among those aged 65 and older (9.4 percentage point reduction from 2020 to 2023). Perceived health also fell with increasing age, from 62.1% of 18- to 34-year-olds reporting very good or excellent health to 40.5% of those aged 65 and older, in 2023.

Chart 1.0
Canadians aged 18 and older reporting very good or excellent perceived health, by age group, 2021 to 2023

percent
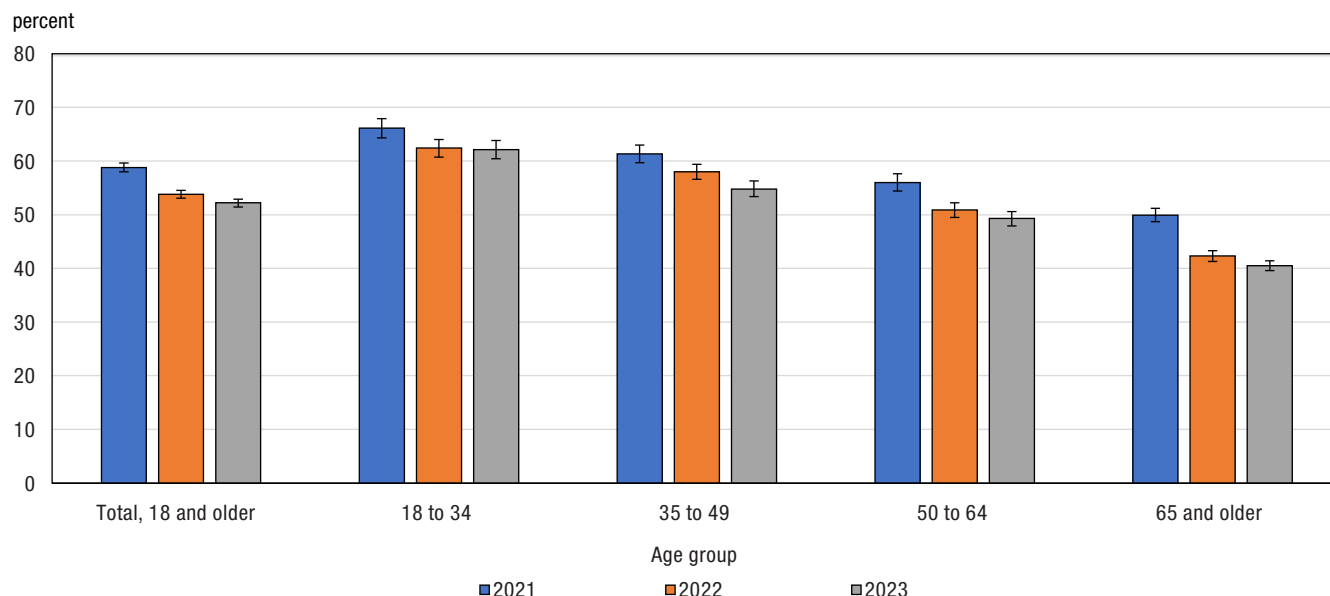
Note: Territorial data are not included in annual estimates.
Sources: Statistics Canada, Canadian Community Health Survey, 2021 to 2023; Table 13-10-0905-01 Health indicator statistics, annual estimates.

Patterns of perceived health varied throughout Canada (Chart 1.1). In 2023, a lower proportion of adults in the Atlantic provinces (except Newfoundland and Labrador) reported very good or excellent perceived health (ranging from 41.9% in New Brunswick to 46.7% in Nova Scotia) compared with Canada overall, excluding the territories (52.2%). In contrast, higher proportions of adults living in Quebec (55.7%) and Alberta (54.4%) reported very good or excellent perceived health, compared with Canada overall (excluding the territories). In 2022, when territorial data were available, a lower proportion of adults living in the Northwest Territories (45.6%) and Nunavut (45.5%) reported very good or excellent health compared with all of Canada (53.8%).

Did you know?

According to the 2022 Indigenous Peoples Survey (IPS), four in five Indigenous children aged 1 to 14 (80.1%), excluding those living on reserve, had very good or excellent health (78.6% of First Nations children living off reserve, 82.0% of Métis children and 77.3% of Inuit children).[24]

From 2021 to 2022, very good or excellent perceived health declined similarly among men (from 58.9% to 55.6%) and women (from 58.6% to 52.0%), and it further decreased in 2023 (to 53.9% for men and 50.5% for women). Gender differences in perceived health were largest among 35- to 49-year-olds; the proportion of women reporting very good or excellent health was 6 percentage points lower than that of men in 2023. In the same year, the share of people reporting very good or excellent perceived health was 20 percentage points lower among adults aged 18 to 34 whose reported sexual orientation is lesbian, gay, bisexual or another orientation that is not heterosexual (LGB+) than among their heterosexual counterparts.

Perceived health rose with increasing income quintiles. In 2023, a greater proportion of adults living in households in the highest income quintile (60.9%) reported very good or excellent perceived health compared with those in the lowest household income quintile (42.8%), an 18 percentage point difference. The same trend has been found since 2015. In recent years, there was an 18 percentage point difference in 2022 and a 20 percentage point difference in 2021.

In 2023, immigrants (51.2%) and non-immigrants (51.9%) did not differ in reporting very good or excellent health, consistent with the findings observed in 2021 and 2022. However, there are disparities in immigrants' perceived health when examined by period of immigration. For example, 61.1% of immigrants who were admitted to Canada in the last 10 years reported very good or excellent health, compared with 47.4% of immigrants who were admitted to Canada more than 10 years ago.

Among racialized groups, the share of people with very good or excellent perceived health was higher among the South Asian (56.3%), Filipino (58.7%), Latin American (61.2%) and Japanese (67.4%; this figure should be used with caution) groups, compared with the non-racialized population (51.7%).

In 2023, the percentage of people reporting very good or excellent perceived health was nearly three times lower among those with a self-identified disability (19.5%) than among those without a disability (56.4%).

Perceived mental health

Did you know?

The life changes that occur during the transition to adolescence and young adulthood can contribute to lower levels of self-rated mental health for some youth.[29] At the same time, the COVID-19 pandemic had a big effect on the lives of many Canadians, especially children and youth. School closures and physical distancing measures implemented during critical periods of social development may have been particularly impactful.

The longitudinal component of the 2023 Canadian Health Survey on Children and Youth (CHSCY) followed up with individuals who participated in the 2019 survey to see how their physical and mental health had changed over the past four years. Findings indicate that among the 88% of youth aged 12 to 17 who rated their mental health as good, very good or excellent in 2019, about one in five (21%) reported a decline to fair or poor by 2023. This type of decrease in perceived mental health was more common among older teenagers (aged 15 to 17), who were making the transition to young adulthood during the pandemic.

A consistent decline in the proportion of Canadians aged 18 and older reporting very good or excellent mental health was observed, from 68.2% in 2018 to 54.8% in 2022. However, this percentage remained relatively stable in 2023 (53.8%), except for 35- to 49-year-olds, among whom it continued to decline (from 52.9% in 2022 to 50.6% in 2023). Unlike perceived health, which decreased with age, perceived mental health increased with age; the share of people reporting very good or excellent mental health was highest among those aged 65 and older (62.2% in 2023).

Across all age groups, a lower proportion of women rated their mental health as very good or excellent compared with men in 2021, 2022 and 2023. Gender differences in mental health were largest between women and men aged 18 to 34 (the share of women in this age group reporting very good or excellent mental health was 12 percentage points lower than that of men in 2023). In 2023, compared with heterosexual men (58.7%) and women (51.9%), a lower percentage of LGB+ men (39.3%) and women (23.2%) reported very good or excellent perceived mental health.

Did you know?

Mental health is an integral component of health and well-being with documented disparities among Indigenous people, especially younger people.[30] These disparities exist in the context of complex factors, including intergenerational trauma rooted in harmful colonial policies.[31] The 2022 IPS explored the mental health of Indigenous children aged 14 and younger as reported by a parent.[24] Most children had very good or excellent mental health: 67.7% of off-reserve First Nations children, 69.9% of Métis children and 72.3% of Inuit children. According to the CHSCY, the corresponding percentage for non-Indigenous children of the same age was 86.0%.

For those aged 15 and older, the 2022 IPS found that 34.5% of First Nations people living off reserve, 39.6% of Métis and 37.6% of Inuit reported very good or excellent mental health.[32] When asked whether their mental health had worsened during the pandemic, 39.0% of First Nations people living off reserve, 39.5% of Métis and 25.8% of Inuit aged 15 and older reported much or somewhat worse mental health. First Nations, Métis and Inuit women were more likely than men to report that their mental health had worsened during the pandemic.

Patterns of perceived mental health varied among adults across Canada in 2023. Like perceived health, a lower proportion of adults living in the Atlantic provinces (except for Newfoundland and Labrador) rated their mental health as very good or excellent than in Canada overall, excluding the territories (Chart 1.1). Every year from 2021 to 2023, lower proportions of adults in Ontario, Saskatchewan and British Columbia reported very good or excellent mental health, compared with Canada overall (excluding the territories). In contrast, a higher proportion of adults in Quebec reported very good or excellent mental health each year, compared with Canada overall (excluding the territories). From 2021 to 2023, reports of very good or excellent mental health were 3 to 5 percentage points higher among rural Canadians compared with their counterparts in population centres.

Chart 1.1
Canadians aged 18 and older reporting very good or excellent perceived health and perceived mental health, by province (2023) or territory (2022)
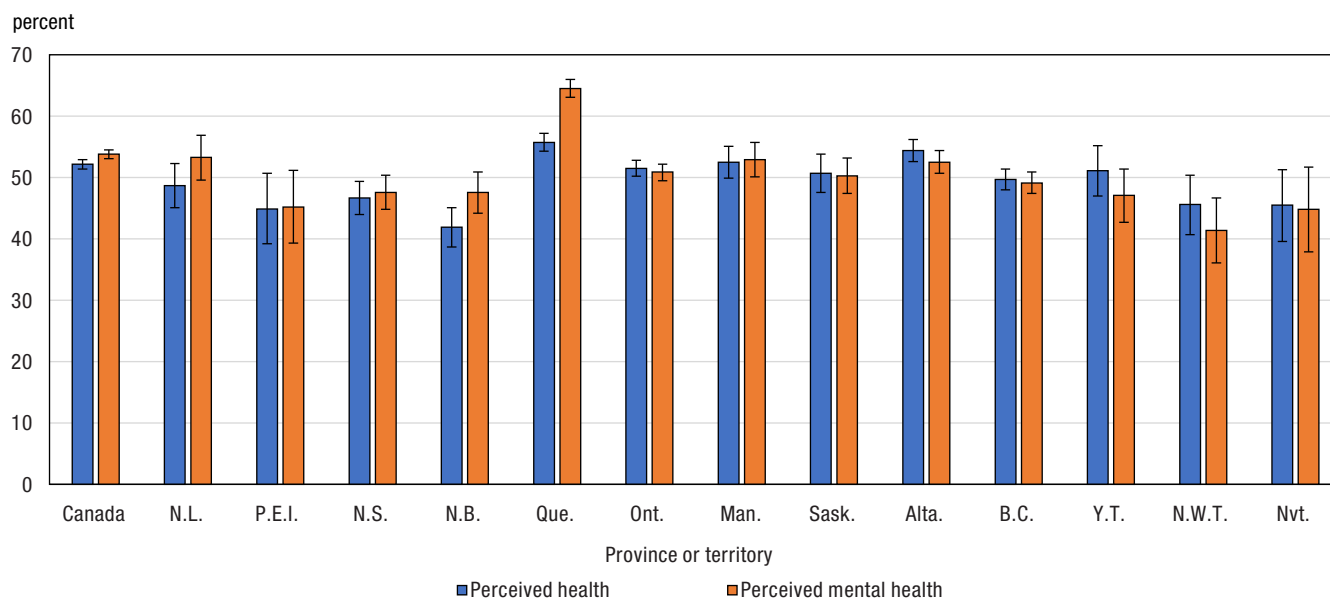

Note: Estimates for Canada exclude the territories.
Sources: Statistics Canada, Canadian Community Health Survey, 2022 and 2023; Table 13-10-0905-01 Health characteristics, annual estimates.

In 2023, a greater proportion of adults living in households in the highest income quintile (57.1%) reported very good or excellent mental health compared with those in the lowest household income quintile (50.9%). The same trend was found in 2022, but the gap appeared to be closing in 2023 (10% difference between the highest and lowest income quintiles in 2022 vs. 6% difference in 2023).

From 2021 to 2023, a higher proportion of immigrants reported very good or excellent mental health than non-immigrants (Chart 1.2). In 2023, 58.2% of immigrants reported very good or excellent mental health, compared with 51.7% of non-immigrants. Proportionally fewer immigrants who were admitted to Canada more than 10 years ago reported very good or excellent mental health (57.4%), compared with those who were admitted more recently (62.8%) (Chart 1.2).

Chart 1.2
Canadians aged 18 and older reporting very good or excellent mental health, by immigrant status and period of immigration, 2021 to 2023

percent
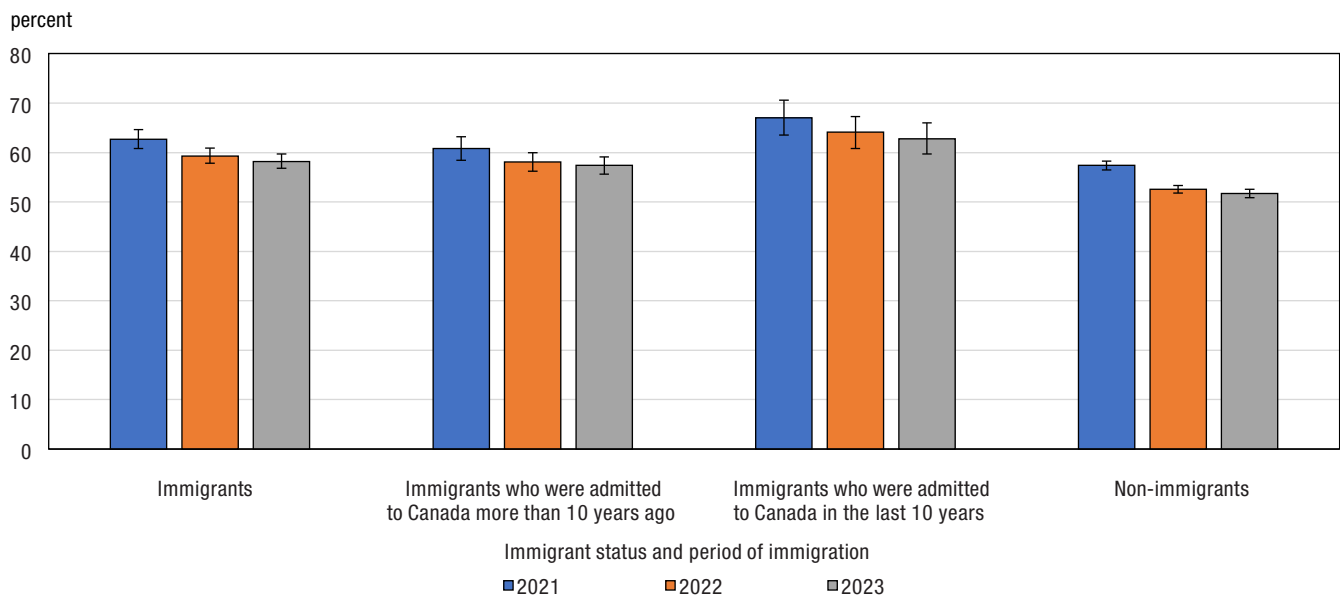
Notes: Territorial data are not included in annual estimates. Immigrants include people who are, or who have ever been, landed immigrants or permanent residents. They have been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this category. Immigrants who were admitted to Canada in the last 10 years include people who first obtained landed immigrant or permanent resident status on the survey date or in the 10 years before. In 2022, for example, this category includes people who obtained landed immigrant status from 2012 to 2022. Immigrants who were admitted to Canada more than 10 years ago include people who first obtained landed immigrant or permanent resident status more than 10 years prior to the survey date. In 2022, for example, this category includes people who obtained landed immigrant status in 2011 or before. Non-immigrants include people who are Canadian citizens by birth.
Sources: Statistics Canada, Canadian Community Health Survey, 2021 to 2023; Table 13-10-0880-01 Health indicators by visible minority and selected sociodemographic characteristics: Canada excluding territories, annual estimates.

Perceived mental health varied across racialized groups. Despite declines in very good or excellent mental health for most groups from 2021 to 2022, a higher proportion of Filipino (66.3%), Black (63.3%), Latin American (60.6%) and South Asian (59.9%) people reported very good or excellent mental health in 2023 compared with the non-racialized population (52.8%).

In 2023, a lower proportion of Canadians aged 18 and older with a self-identified disability (31.8%) reported very good or excellent mental health compared with those without disabilities (56.4%).

Did you know?

The intersections of gender and other sociodemographic characteristics significantly influence mental health outcomes. According to a study using data from two cycles of the Canadian Community Health Survey (2019 annual data and data from September to December 2020), about 2.6 million women and girls, or approximately 16%, had three or more intersecting characteristics, such as low income, unemployment, immigrant status, Indigenous identity, racialized group membership, LGB+ sexual orientation and disability.[33] When multiple characteristics intersected, poor mental health outcomes for diverse groups of women and girls became more pronounced. For example, compared with women and girls who did not report having any of these characteristics, those with one characteristic were two times more likely to report fair or poor perceived mental health, while those with two characteristics were two and a half times more likely and those with three or more characteristics were almost three times more likely.

Some characteristics increased this risk even more. Notably, women and girls with a disability were 7.8 times more likely to report having fair or poor mental health, compared with those without any intersecting characteristics, while those identifying as LGB+ were 5.6 times more likely and those with an Indigenous identity were 3.6 times more likely.

Note: Non-binary people were not redistributed into the women and men categories in this study.

Life expectancy at birth

Changes in life expectancy at birth in Canada stem from various factors. Life expectancy rises when there are fewer deaths overall or when deaths occur at older ages, or both. Conversely, it declines when there are more deaths, when deaths happen at younger ages, or through a combination of these factors.

Did you know?

By decomposing the differences in life expectancy by cause of death, it is possible to identify some of the potential causes driving the recent change in life expectancy in Canada. In 2022, the increase in deaths among younger age groups can be attributed in part to deaths under investigation by a coroner or medical examiner, which are typically unintentional injuries (e.g., substance-related toxicity deaths), suicides and homicides.

Such deaths are classified as "other ill-defined and unspecified causes of mortality" until a final cause of death is determined.

Following three years of continuous decline, life expectancy at birth in Canada rose from 81.3 years in 2022 to 81.7 years in 2023, marking an increase of 0.4 years.[34,35] Despite the gain, life expectancy was still 0.5 years lower than in 2019, before the pandemic (82.2 years). The rise was more pronounced for males (0.5 years) than for females (0.4 years), with life expectancy reaching 79.5 years for males and 83.9 years for females.

Did you know?

The vital statistics databases that are used to create the life expectancy indicator do not include information about the Indigenous identity of individuals. To generate estimates specifically for the Indigenous population, a research study used linkages between the long-form census questionnaire and the Canadian Vital Statistics – Death database.[25] The study found that from 2016 to 2019, life expectancy at birth was lower among First Nations people with Indian Status (75.4 years), Métis (81.7 years) and Inuit (71.6 years) compared with the non-Indigenous population (85.6 years). Life expectancy was higher among females than males for all groups.

In 2023, notable increases in life expectancy at birth were seen in Ontario, Quebec, British Columbia, Alberta, Nova Scotia and New Brunswick.[34,35]

Did you know?

There are wide variations in life expectancy across various subnational geographic areas. However, little is known about these variations at very detailed levels of geographic disaggregation in Canada. A recent study on life expectancy expanded the boundaries for such analyses by focusing on variations across the smallest possible geographic areas (census tracts), for people living in metropolitan areas.[36] It found that life expectancy can differ by up to two decades across census tracts in the largest Canadian cities. The strength of associations with socioeconomic factors varied significantly, specifically in Canada's largest cities. This suggests that municipal factors, as well as provincial and federal factors, play a role.

2.0 Sexual and reproductive health

Key findings

- The crude birth rate declined from 9.7 live births per 1,000 population in 2021 to 8.8 in 2023 across all provinces and territories.

- The total fertility rate in Canada declined from 1.44 children per female aged 15 to 49 in 2021 to 1.26 in 2023.

- Stillbirth rates increased from 8.6 per 1,000 total births in 2021 to 8.8 in 2023, corresponding to 3,106 stillbirths in 2023. Rates varied across the country, from 3.3 per 1,000 total births in Manitoba to 28.5 in the Northwest Territories.

- While the infant mortality rate in Canada declined from 5.3 per 1,000 live births in 2000 to 4.6 in 2023, it remains higher than in other countries of the Organisation for Economic Co-operation and Development.

- In 2023, the maternal mortality rate increased to 11.65 per 100,000 live births, a high for the period since comparable statistics have been available.

Crude birth rate

In 2023, there were 351,477 live births in Canada (excluding Yukon)—a decrease from 351,679 in 2022 and 370,155 in 2021.[37] The **crude birth rate** in Canada is defined as the number of live births per 1,000 population. As previously reported, the crude birth rate was 9.7 in 2021 and has declined further since then (9.0 in 2022 and 8.8 in 2023).[38]

The crude birth rate was lower in 2023 than in 2019 across all provinces and territories. In 2023, Newfoundland and Labrador (5.9 live births per 1,000 population) and Nova Scotia (6.9) had the lowest crude birth rates, while Nunavut (19.5) had the highest.

Fertility rate

The **total fertility rate** (an estimate of the average number of live births a female can be expected to have in her lifetime, based on the age-specific fertility rates of a given year) declined to 1.44 children per female aged 15 to 49 in 2021, and it continued to decrease in 2022 (1.33) and 2023 (1.26). Since the total fertility rate required to maintain a population is 2.1 children per female, the Canadian population will mainly rely on international migration for continued growth.[36]

At the provincial and territorial level, Nunavut had the highest total fertility rate in 2023 (2.48 children per female), making it the only jurisdiction with a fertility rate above the population replacement rate. British Columbia and Yukon had the lowest rates, at 1.00 and 1.01 children per female, respectively.

The **age-specific fertility rate** is the number of live births per 1,000 females in a specific age group. From 2021 to 2023, age-specific fertility rates declined among females in all age groups below 45, with the largest decrease seen for those aged 25 to 29, from 81.1 live births per 1,000 females in 2019 to 64.3 in 2023. Those aged 45 to 49 saw a small increase from 0.8 live births per 1,000 females in 2019 to 0.9 in 2023.

Stillbirths

A **stillbirth** is the death of a fetus at or after 20 weeks of pregnancy or weighing 500 grams or more.[39] Stillbirths increased from 8.6 per 1,000 total births in 2021 to 8.7 in 2023, corresponding to 3,106 stillbirths in 2023.[40] The rate ranged from 3.3 per 1,000 total births in Manitoba to 28.5 in the Northwest Territories. Risk factors associated with stillbirths include maternal weight, smoking and age.[41]

The rate of stillbirths in multiple deliveries is much higher than that in single deliveries. In Canada, the rate of stillbirths was 8.4 per 1,000 births for single deliveries and 19.4 for multiple deliveries in 2023.[38] The largest difference was in British Columbia, where the stillbirth rate was 14.3 per 1,000 births for single deliveries and 42.3 for multiple deliveries.

Infant mortality

Infant mortality includes deaths before the age of 1 and consists of neonatal mortality (deaths in the first 27 days of life) and post-neonatal mortality (deaths up to age 1). In 2023, neonatal mortality accounted for 73.5% of all infant deaths in Canada.[42]

The top five causes of neonatal mortality have remained consistent since 2018: congenital malformations; disorders related to short gestation and low birth weight; complications of pregnancy; complications of the placenta, cord and membrane; and intrauterine hypoxia and birth asphyxia.[43] The causes of post-neonatal mortality can be structural or functional birth defects, infections, lack of oxygen, immaturity (not fully grown), or sudden infant death syndrome.[44] Risk factors of both neonatal and post-neonatal mortality include low maternal education, inadequate housing, lack of access to health care, food insecurity, poverty and unemployment.

While the infant mortality rate in Canada declined from 5.3 per 1,000 live births in 2000 to 4.6 in 2023, it remains higher than in other countries of the Organisation for Economic Co-operation and Development.[42,45]

> **Did you know?**
>
> Indigenous identity is not captured on birth records. Linking Canadian Birth Census Cohort data and Census of Population records enables infant mortality rates to be calculated for Indigenous and non-Indigenous populations.
>
> A national study found that from 2014 to 2016, the infant mortality rate of the total Indigenous population (7.7 per 1,000 live births) was higher than that of the non-Indigenous population (4.6) by a factor of approximately 1.8.[25] From 2014 to 2016, the infant mortality rate was twice as high among First Nations people with Indian Status living on reserve (10.0 per 1,000 live births; this figure should be used with caution) and three times as high among Inuit (13.5; this figure should be used with caution), compared with the non-Indigenous population (4.2).

Maternal mortality

Maternal mortality rates are critical measures of maternal health. Maternal mortality rates reflect shifts in the demographics of the childbearing population in Canada and associated risk factors, including advanced maternal age, prevalence of medical comorbidities, and a growing refugee and immigrant population.[46]

Maternal mortality includes deaths from obstetric causes that occurred within one year of delivery or the end of a pregnancy. It is typically divided into mortality during two periods: (1) during pregnancy or within 42 days of delivery or the end of the pregnancy, or (2) from 42 days to one year after delivery or the end of the pregnancy.

As previously reported, the maternal mortality rate showed an overall upward trend from 2000 (3.05 per 100,000 live births) to 2020 (9.15).[47] In more recent years, it fluctuated downwards to 8.16 per 100,000 live births in 2021 and 7.96 in 2022. However, in 2023, the maternal mortality rate increased to 11.65 per 100,000 live births, a high for the period since comparable statistics have been available.

Maternal mortality during pregnancy or within 42 days of delivery or the end of the pregnancy dropped from 8.04 per 100,000 live births in 2020 to 6.26 in 2022. However, in 2023, it increased to 9.38 deaths per 100,000 live births. Mortality from 42 days to one year after delivery or the end of the pregnancy rose from 1.39 per 100,000 live births in 2020 to 2.84 in 2023.

Spotlight on sex education and information

Sex education

According to waves 12 and 13 of the Canadian Social Survey, in 2024, over 7 in 10 women (71.6%) and men (71.8%) aged 15 and older reported that they received sex education during their time in elementary or high school.

More than three in five people aged 15 to 24 who indicated that they received sex education during their time in elementary or high school (62.0%) reported that it was "very helpful" or "helpful" (as opposed to "unhelpful" or "very unhelpful") in terms of preparing them for a healthy life.

Sources of sexual and reproductive health information

When asked where they typically get information about sexual and reproductive health, over half (50.4%) of people aged 15 and older cited health care providers as a source of information (Chart 2.0). This was followed by the media (34.2%), friends (17.9%) and family (16.5%). More than one in five people (22.1%) reported that they do not get information about sexual and reproductive health from any source.

Chart 2.0
Sources of sexual and reproductive health information among Canadians aged 15 and older, 2024
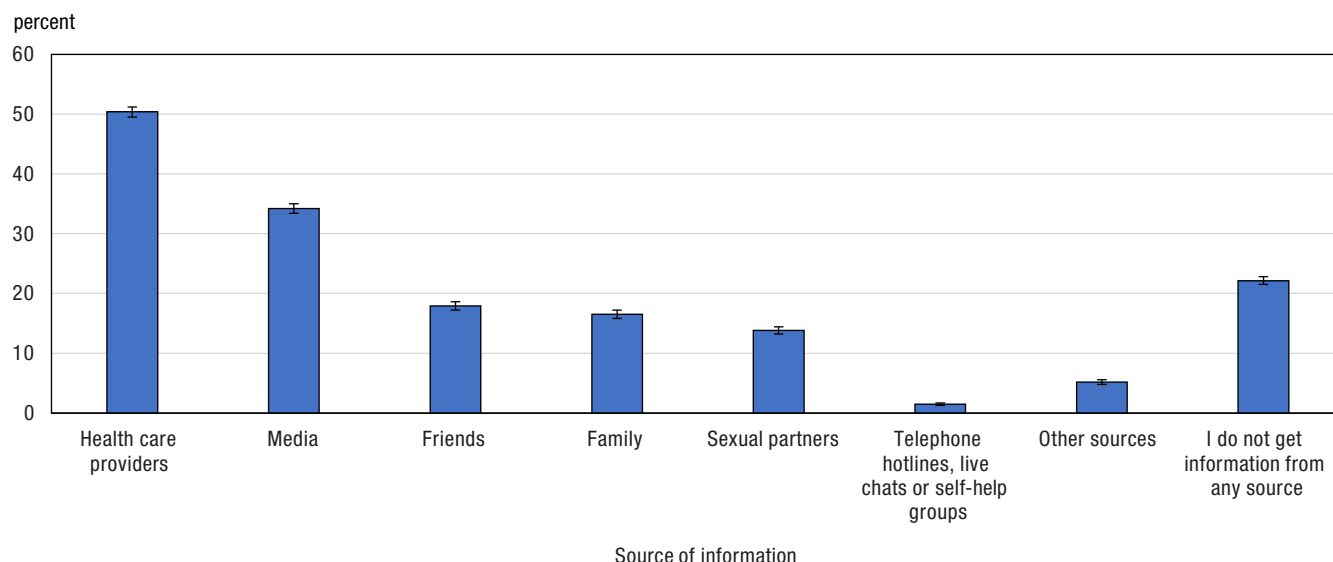
Notes: Territorial data are not included in annual estimates. Respondents could select more than one answer. As a result, the total is greater than 100%.
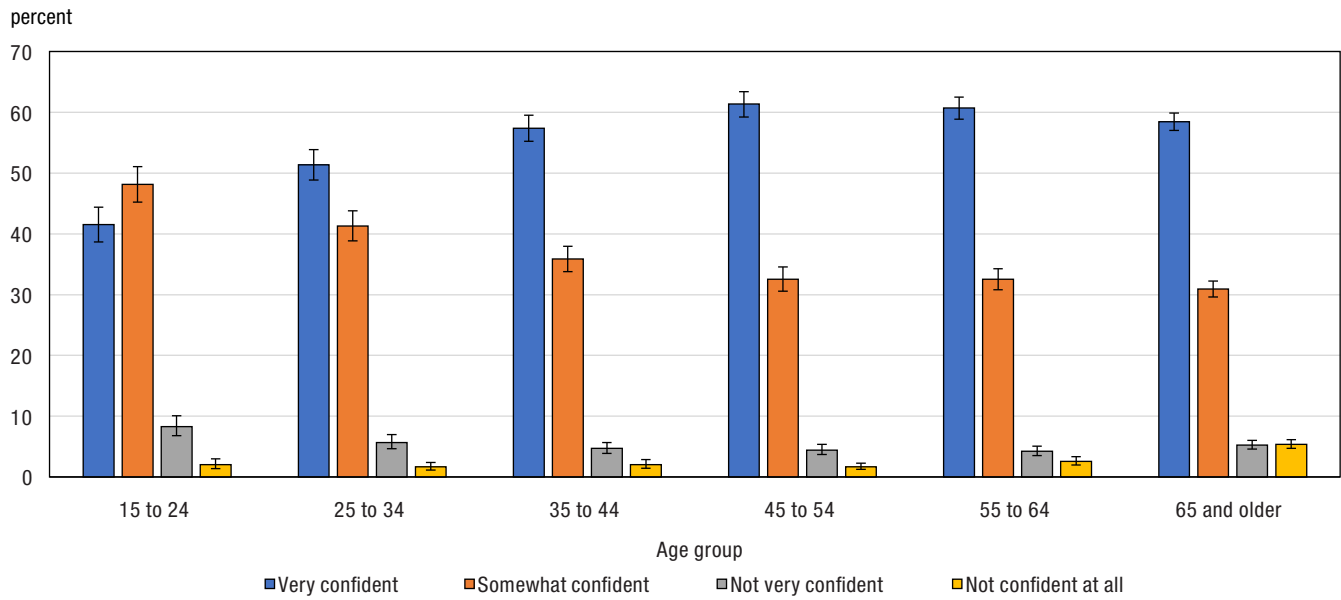**Source:** Statistics Canada, Canadian Social Survey, 2024.

While one in two people reported getting information about sexual and reproductive health from health care providers, a larger share of younger people (i.e., those aged 15 to 34) than their older counterparts also reported getting information from the media, friends, family and sexual partners. For example, the proportion of 15- to 34-year-olds who reported getting information from the media (49.9%) was almost double that observed among those aged 35 and older (26.8%).

Information needed to make healthy decisions about sexual and reproductive health

Most women (91.3%) and men (92.5%) reported that they were very confident (54.5% of women and 56.1% of men) or somewhat confident (36.8% of women and 36.4% of men) that they have the information they need to make healthy decisions about their sexual and reproductive health. People aged 15 to 24 (41.5%) were proportionally the least likely to report being very confident in this regard (Chart 2.1).

Chart 2.1
Canadians aged 15 and older who reported that they have the information they need to make healthy decisions about their sexual and reproductive health, by level of confidence and age group, 2024

percent

Note: Territorial data are not included in annual estimates.
Source: Statistics Canada, Canadian Social Survey, 2024.
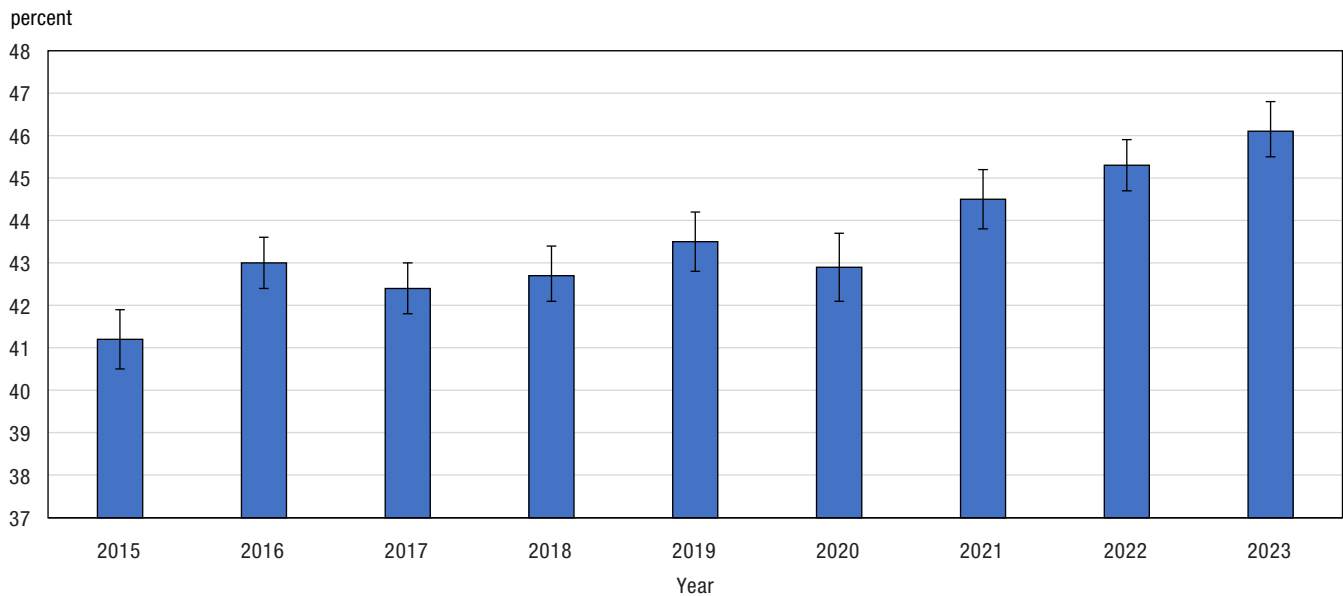
3.0 Chronic diseases

Key findings

- In 2023, almost half of Canadian adults had one or more selected chronic diseases (46.1%). Some of the most common were arthritis (20.6%) and high blood pressure (19.9%).

- Chronic disease risk factors such as overweight (35.5%) and obesity (30.2%) were also prevalent.

- The prevalence of most chronic diseases has been stable since 2021, but that of mental health conditions has grown:

  ▶ The share of people reporting diagnosed anxiety disorders increased from 10.3% in 2021 to 14.8% in 2022.

  ▶ The proportion of those reporting diagnosed mood disorders also rose, from 10.0% in 2021 to 11.7% in 2022 and 13.0% in 2023.

  ▶ The prevalence of both conditions was higher among people whose reported sexual orientation is lesbian, gay, bisexual or another orientation that is not heterosexual and among younger people.

- The prevalence of most selected chronic diseases (high blood pressure, heart disease, stroke, diabetes, arthritis and cancer) increased with age.

- Proportionally more adults in rural areas than in population centres had high blood pressure, heart disease, diabetes, obesity and arthritis.

- A higher proportion of Canadians in the lowest income quintile reported high blood pressure, heart disease, stroke, diabetes, obesity, arthritis, anxiety and mood disorders, compared with those in the highest quintile.

- Proportionally more non-immigrants than immigrants experienced heart disease, obesity, arthritis, anxiety and mood disorders.

- A greater share of non-racialized individuals had high blood pressure, heart disease, obesity, arthritis, anxiety and mood disorders, compared with most racialized groups.

- The proportion of adults with disabilities reporting high blood pressure, heart disease, stroke, diabetes, obesity, arthritis and mood disorders was higher than that of individuals without disabilities.

- Almost half (45%) of Canadians were projected to be diagnosed with cancer in their lifetime.

- While age-standardized incidence and mortality rates for all cancers combined were projected to decrease from previous years, they remained 13% and 37% higher, respectively, for males than females.

- The lung cancer mortality rate remained higher among males, but females were expected to have a higher incidence rate in 2024 than males.

Chronic diseases can affect activities of daily living, reduce quality of life and increase the risk of mortality. A variety of factors affect chronic disease incidence and prevalence, including age and behavioural risk factors such as tobacco use, diet and physical inactivity.

Prevalence of one or more selected chronic diseases

The prevalence of having one or more selected chronic diseases has increased over the last eight years (Chart 3.0), from 41.2% of Canadians aged 18 and older in 2015 to 46.1% in 2023 (over 14 million people). The chronic diseases considered in this trend analysis are arthritis, high blood pressure, diabetes, cancer (ever diagnosed), heart disease (ever diagnosed), stroke and mood disorders.

Chart 3.0
Canadians aged 18 and older reporting one or more selected chronic diseases, 2015 to 2023

percent

Notes: Estimates for Canada exclude the territories. The chart shows Canadians aged 18 years and older who reported one or more of the following chronic diseases: arthritis, high blood pressure, diabetes, cancer (ever diagnosed), heart disease (ever diagnosed), stroke and mood disorders. In the previous report, anxiety was included among these conditions. However, because of content changes in the 2023 Canadian Community Health Survey, anxiety data are based on only five provinces, and anxiety was therefore excluded from "one or more selected chronic diseases."
Sources: Statistics Canada, Canadian Community Health Survey, 2015 to 2023.

The prevalence of having one or more chronic diseases varied across Canada. In 2023, it was higher in the Atlantic provinces (59.0% in Newfoundland and Labrador, 55.8% in Prince Edward Island, 54.2% in Nova Scotia, and 55.0% in New Brunswick) and Manitoba (49.4%) compared with Canada overall (excluding the territories). In contrast, a lower proportion of adults in Quebec reported having a chronic disease (43.1%). In 2022, the prevalence of having a chronic disease was lower in Nunavut (36.7%) than in Canada overall (45.3%). A higher proportion of rural Canadians reported having at least one chronic disease compared with those living in population centres (52.2% in rural areas vs. 45.0% in population centres in 2023).

In 2023, the prevalence of reporting one or more chronic diseases also differed by sociodemographic characteristics. For example, prevalence was higher among females (48.9%) than males (43.3%) and among adults aged 65 and older (79.6%) compared with those aged 18 to 34 (21.0%). The same year, a greater share of Canadians with a disability (76.7%) reported having one or more chronic diseases, compared with those without disabilities (42.2%).

A larger proportion of non-immigrants (49.0%) reported having at least one chronic disease in 2023 compared with immigrants (41.5%). Among immigrants, a higher percentage of those who were admitted to Canada more than 10 years ago (49.6%) reported having a chronic disease, compared with more recent immigrants (21.5%). Additionally, in 2023, the prevalence of having one or more chronic diseases was higher among the non-racialized population (51.0%) than among all racialized groups.

Cardiovascular disease

Cardiovascular disease is a general term describing diseases that affect blood vessels or the heart. Cardiovascular disease risk can be reduced by eating healthy, doing adequate physical activity and limiting substance use.[48] Two of the most common cardiovascular diseases are heart disease and stroke, with high blood pressure being a risk factor for both.

High blood pressure

Untreated or uncontrolled high blood pressure can cause heart attacks, stroke, heart failure, dementia, renal failure and blindness.[49] Risk factors for high blood pressure include sedentary behaviours, obesity and high sodium consumption.[50]

In 2023, 19.9% of Canadians aged 18 and older reported having high blood pressure (Table 3.0). While a slight increase occurred from 2020 to 2021 (from 18.3% to 19.1%) and from 2021 to 2022 (to 20.2%), there were no changes in 2023 (19.9%) (Chart 3.1). However, the prevalence of high blood pressure increased with age consistently from 2015 to 2023. In 2023, the prevalence of high blood pressure ranged from 2.7% among Canadians aged 18 to 34 to 45.0% among those aged 65 and older.

A higher prevalence of high blood pressure was seen in the Atlantic provinces (25.0% to 27.5%) and Saskatchewan (22.5%), and a lower prevalence was observed in Quebec (18.4%), Alberta (18.4%) and British Columbia (18.0%), compared with all of Canada, excluding the territories (Table 3.0).

Table 3.0
Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by province (2023) or territory (2022)

|	Overweight (BMI 25.00 to 29.99)	Obesity (BMI 30.00 or greater)	Arthritis	High blood pressure	Diabetes	Heart disease	Stroke
				percent			
Canada	**35.5**	**30.2**	**20.6**	**19.9**	**8.0**	**6.3**	**1.2**
N.L.	34.6	41.1*	29.7*	27.5*	11.1*	8.4*	1.4
P.E.I.	34.2	39.7*	25.3*	25.0*	10.0	7.0	2.2
N.S.	33.9	38.3*	27.1*	24.8*	10.5*	8.7*	1.6
N.B.	32.6*	41.1*	26.0*	27.0*	9.1	6.4	1.0
Que.	36.2	29.1	18.1*	18.4*	8.2	6.6	1.0*
Ont.	35.6	30.0	20.8	20.5	8.1	5.9*	1.4
Man.	34.7	35.1*	23.4*	21.0	7.7	6.7	1.3
Sask.	32.6*	40.2*	21.3	22.5*	9.2	7.5*	1.1
Alta.	36.9	31.2	20.6	18.4*	7.5	5.1*	1.0
B.C.	34.7	24.3*	20.1	18.0*	6.8*	6.4	1.2
Y.T.	33.3	33.2	23.2	16.1*	5.7*	3.9*	1.3
N.W.T.	31.5	44.9*	17.0*	17.0*	7.4	3.8*	0.8
Nvt.	30.1	32.8	10.5*	17.5	2.0	5.3	F

F too unreliable to be published
* significantly different from the 2023 Canada (excluding territories) estimate (for provinces) or 2022 Canada estimate (for territories)
Notes: Estimates for Canada exclude the territories. Body mass index (BMI) is derived by dividing the respondent's self-reported body weight (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches. A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis.
Sources: Statistics Canada, Canadian Community Health Survey, 2022 and 2023.

Chart 3.1
Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by year, 2015 to 2023

percent
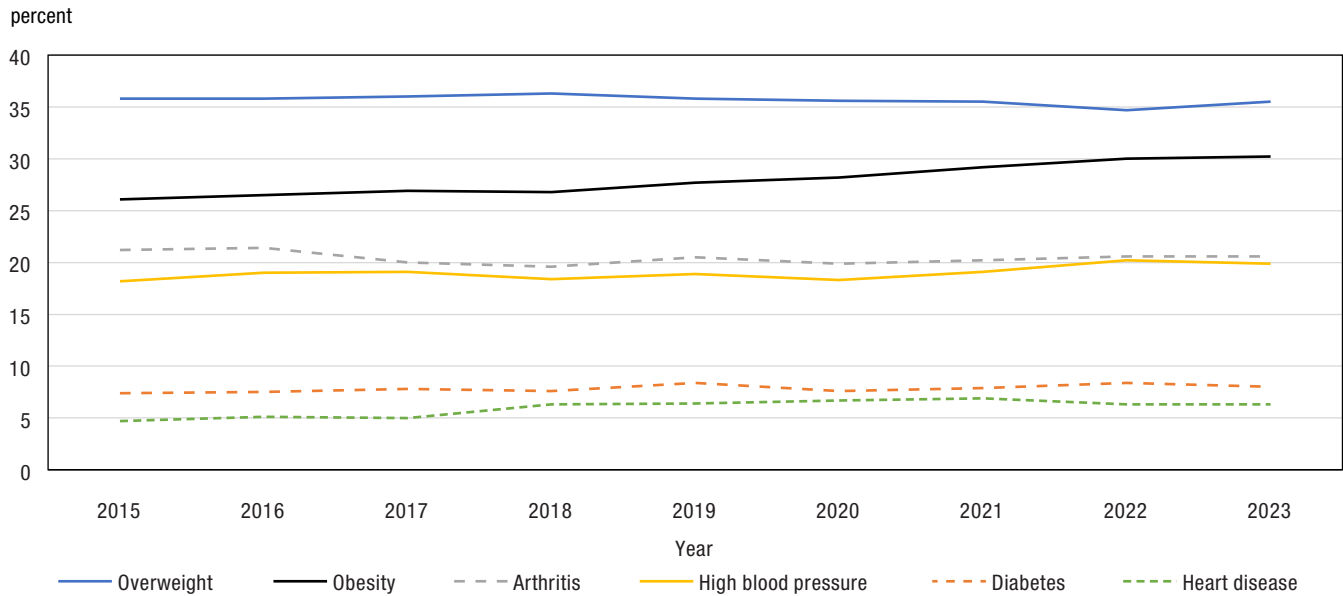
Notes: Estimates for Canada exclude the territories. The question on heart disease changed across Canadian Community Health Survey cycles. From 2015 to 2017, the question was "Do you have heart disease?" (referring to a current diagnosis only). From 2018 to 2021, the question "Did you ever have heart disease?" (lifetime diagnosis) was added. From 2022 to 2023, the wording was changed to "Have you ever had a heart attack?" instead of heart disease. Body mass index is derived by dividing the respondent's self-reported body weight (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches. A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis.
Sources: Statistics Canada, Canadian Community Health Survey, 2015 to 2023.

From 2015 to 2023, rural Canadians consistently had a prevalence of high blood pressure 3 to 6 percentage points higher than those living in population centres (22.1% vs. 19.4% in 2023, Chart 3.2).

Chart 3.2

Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by rural area or population centre, 2023

percent

Chronic disease or risk factor

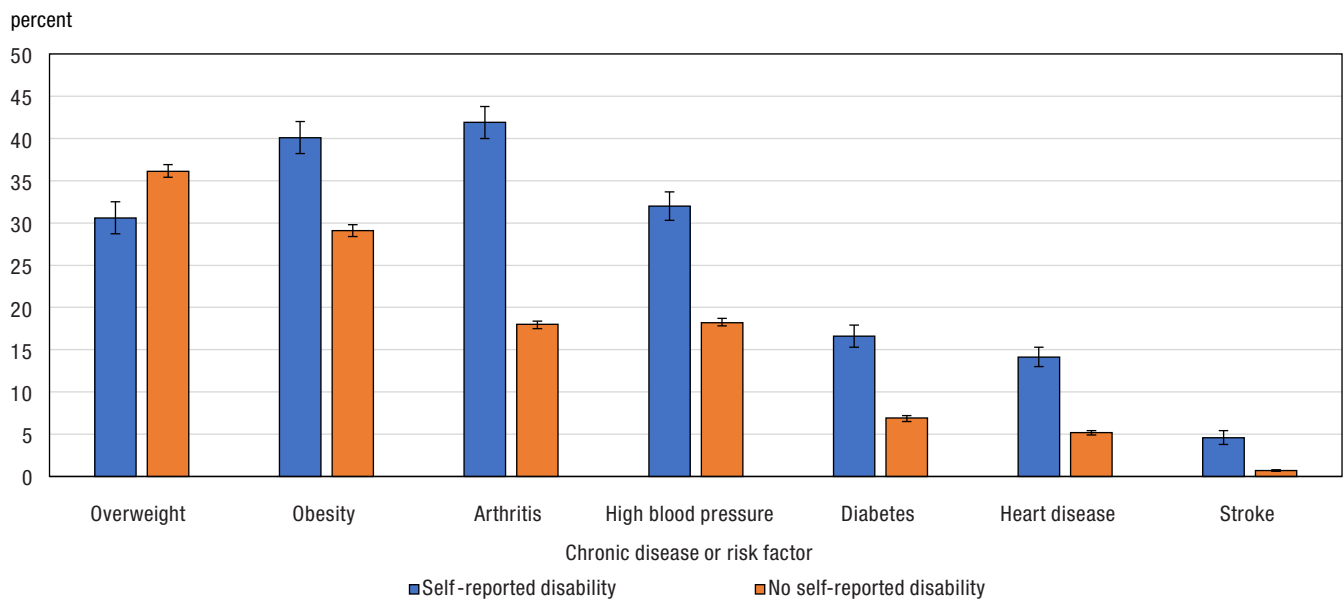■ Population centre   ■ Rural area
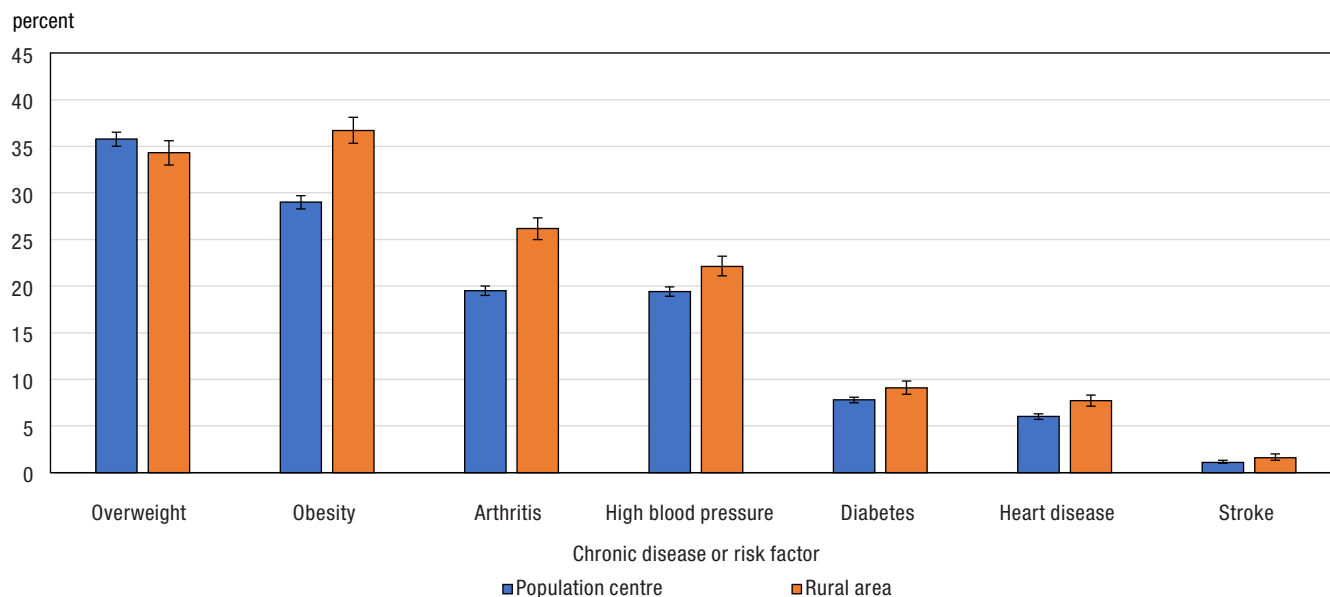
Notes: Territorial data are not included in annual estimates. A population centre has a population of at least 1,000 and a population density of 400 persons or more per square kilometre, based on population counts from the current Census of Population. All areas outside population centres are classified as rural areas. In contrast, rural areas are those with a population of less than 10,000. Body mass index is derived by dividing the respondent's self-reported body weight (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches. A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

A greater proportion of Canadians aged 18 and older in the lowest income quintile (23.2%) reported having high blood pressure compared with those in the highest quintile (16.9%) in 2023. The same trend has been seen since 2015. In addition, a higher prevalence of high blood pressure was found among those who reported having a disability (32.0%) compared with those who did not (18.2%) in 2023 (Chart 3.3).
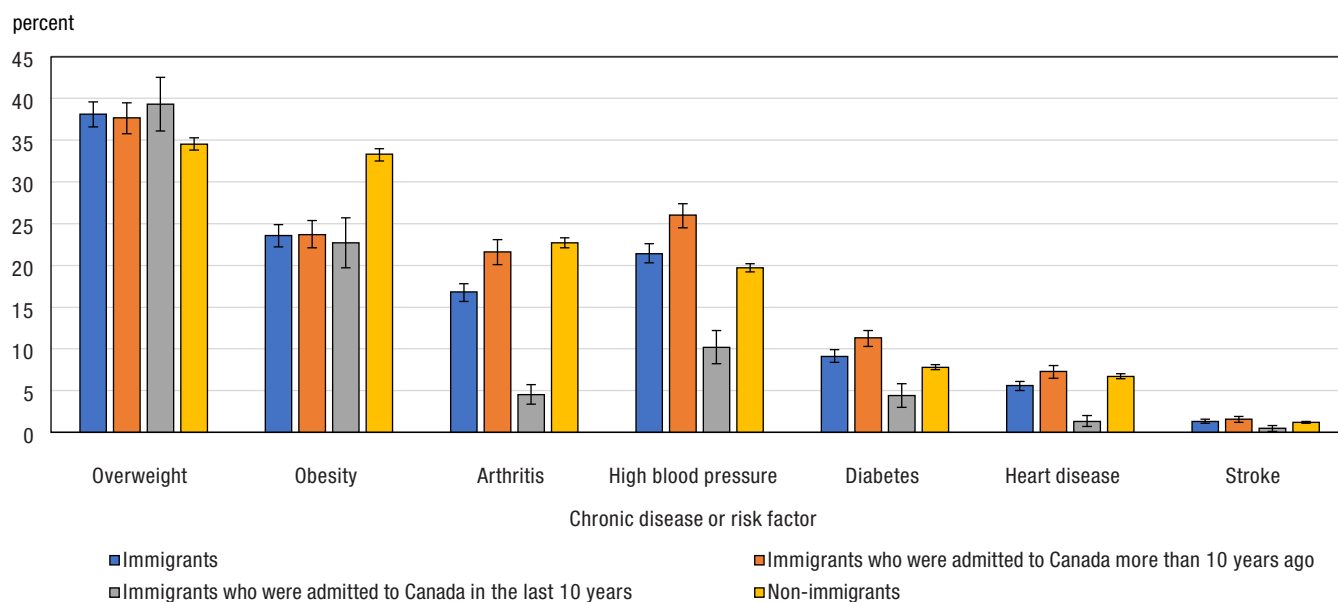
Chart 3.3
Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by self-reported disability status, 2023

percent

Chronic disease or risk factor

■ Self-reported disability   ■ No self-reported disability

Notes: Territorial data are not included in annual estimates. Body mass index is derived by dividing the respondent's self-reported body weight (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches. A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

High blood pressure also varied among other subpopulations. Immigrants who were admitted to Canada more than 10 years ago had over double the prevalence of high blood pressure (26.0%) compared with more recent immigrants (10.0%) (Chart 3.4).

Chart 3.4
Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by immigrant status and period of immigration, 2023

percent

Chronic disease or risk factor

- ■ Immigrants
- ■ Immigrants who were admitted to Canada more than 10 years ago
- ■ Immigrants who were admitted to Canada in the last 10 years
- ■ Non-immigrants

Notes: Territorial data are not included in annual estimates. Body mass index is derived by dividing the respondent's self-reported body weight   (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches.   A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis. Immigrants include people who are, or who have ever been, landed immigrants or permanent residents. They have been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this category. Immigrants who were admitted to Canada in the last 10 years include people who first obtained landed immigrant or permanent resident status on the survey date or in the 10 years before. In 2022, for example, this category includes people who obtained landed immigrant status from 2012 to 2022. Immigrants who were admitted to Canada more than 10 years ago include people who first obtained landed immigrant or permanent resident status more than 10 years prior to the survey date. In 2022, for example, this category includes people who obtained landed immigrant status in 2011 or before. Non-immigrants include people who are Canadian citizens by birth.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Table 3.1 shows a lower prevalence of high blood pressure across most racialized groups compared with the non-racialized population in 2023.

Table 3.1
Prevalence of selected chronic diseases and risk factors among Canadians aged 18 and older, by racialized group, 2023

	Overweight (BMI 25.00 to 29.99)	Obesity (BMI 30.00 or greater)	Arthritis	High blood pressure	Diabetes	Heart disease	Stroke
			percent				
Non-racialized population	**35.2**	**33.2**	**24.2**	**21.3**	**8**	**7.2**	**1.3**
Racialized population	**36.4**	**20.8***	**9.8***	**15.9***	**7.6**	**3.5***	**0.8***
South Asian	40.8*	21.3*	9.3*	16.3*	10.8*	4.8*	0.9
Chinese	27.1*	9.5*	10.3*	15.6*	6.3*	3.3*	0.6*
Black	41.4*	32.4	8.2*	16.8*	6.8	2.7*	1
Filipino	38.9	19.1*	11.7*	22.3	8.7	1.3*	F
Arab	34.5	28.6	11.5*	11.3*	6.3	5.6	F
Latin American	38.3	30.5	9.6*	12.1*	5.5*	2.3	F
Southeast Asian	35.6	17.7*	8.4*	15.5*	8.5	1.8*	F
West Asian	38.6	28.4	12.6*	8.3*	2.8*	4.8	F
Korean	38.9	5.9*	9.4*	15.4	2.9*	F	F
Japanese	23.3^E*	14.1^E*	10.9*	22.2	4.0*	F	F
Multiple racialized groups	35.4^E	20.1^E*	4.3*	13.6	4.7	F	F
Racialized groups, not included elsewhere	F	F	13.6^E*	F	9.9^E	F	F

^E use with caution
F too unreliable to be published
* significantly different from the non-racialized population
Notes: Territorial data are not included in annual estimates. Indigenous respondents are removed from the non-racialized category. Body mass index (BMI) is derived by dividing the respondent's self-reported body weight (in kilograms) by their height (in metres) squared. This excludes pregnant females and people shorter than 3 feet or taller than 6 feet 11 inches. A correction factor is applied to adjust for underestimates in weight and overestimates in height. According to the World Health Organization and Health Canada guidelines, the index for body weight classification for the population aged 18 and older is 25.00 to 29.99 for overweight; 30.00 to 34.99 for obese, class I; 35.00 to 39.99 for obese, class II; and 40.00 or greater for obese, class III. Obesity classes are grouped for the purposes of this analysis.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Heart disease

Heart disease remained the second leading cause of death in Canada, accounting for 57,890 deaths in 2023. In 2022 and 2023, 6.3% of Canadians aged 18 and older reported having ever been diagnosed with heart disease or having had a heart attack (Table 3.0). This percentage has remained relatively stable since 2018 (6.3%) (Chart 3.1). Heart disease was more prevalent among males; in 2023, 7.9% of males reported having heart disease, compared with 4.7% of females. Sex differences in heart disease were observed across most age groups, and these differences widened with age. For example, in 2023, heart disease was 1 percentage point more prevalent in males aged 35 to 49 than females in the same age group but nearly 9 percentage points more prevalent in males aged 65 and older than their female counterparts.

Across the provinces, in 2023, people in Newfoundland and Labrador (8.4%), Nova Scotia (8.7%), and Saskatchewan (7.5%) had a higher prevalence of heart disease compared with Canada overall, excluding the territories (6.3%). Meanwhile, people in Ontario (5.9%) and Alberta (5.1%) had a lower prevalence of heart disease (Table 3.0). In 2022, the prevalence of heart disease was lower in Yukon (3.9%) and the Northwest Territories (3.8%) compared with Canada (6.3%). A higher proportion of rural Canadians (7.7%) reported having heart disease than their counterparts in population centres (6.0%) in 2023 (Chart 3.2). The same trend has been observed consistently since 2018.

The prevalence of heart disease also varied by sociodemographic factors. In 2023, 8.8% of Canadians in the lowest household income quintile reported having heart disease, compared with 5.1% in the highest quintile. This trend has been consistent since 2018. Immigrants had a lower prevalence of heart disease than non-immigrants from 2020 to 2023, but this trend was not consistent before 2020. In 2023, those who were admitted to Canada more than 10 years ago (7.3%) had a higher prevalence of heart disease than recent immigrants (1.3%) (Chart 3.4). Additionally, most racialized groups had a lower prevalence of heart disease compared with the non-racialized population in 2023 (Table 3.1). The same year, those who reported having a disability (14.1%) had a higher prevalence of heart disease than those who did not (5.2%) (Chart 3.3). In addition, bisexual and pansexual Canadian adults (2.8%) had a lower prevalence of heart disease than heterosexual adults (6.3%).

Stroke

Stroke, also called cerebrovascular disease, is a sudden loss of brain function that occurs when a blockage prevents blood from flowing to the brain. Stroke was in the top five leading causes of death in Canada from 2019 to 2023, accounting for 13,833 deaths in 2023.

No changes in stroke prevalence have been observed since 2015—1.2% of Canadian adults reported suffering from the effects of a stroke in 2023 (Chart 3.1). Stroke prevalence was higher among 50- to 64-year-olds (1.1%) and those aged 65 and older (3.4%), compared with those aged 18 to 34 (0.2%) in 2023. Prevalence also varied by income and disability status. In 2023, 2.1% of Canadians in the lowest household income quintile reported having had a stroke, compared with 0.7% of those in the highest quintile, and 4.6% of people with a disability reported having had a stroke, compared with 0.7% of those without disabilities (Chart 3.3). Some racialized groups had a lower prevalence of stroke than the non-racialized population in 2023 (Table 3.1).

Endocrine and metabolic disorders

Diabetes

Diabetes is a chronic disease that occurs when the body is unable to produce enough insulin or properly use it.[51] Diabetes can lead to many complications, including cardiovascular disease, vision loss or blindness, kidney failure, nerve damage, problems with pregnancy, oral disease, and depression.

In 2023, 8.0% of Canadians aged 18 and older reported having type 1, type 2 or gestational diabetes (Table 3.0). This percentage had increased from 2018 (7.6%) to 2019 (8.4%) but declined in 2020 (7.6%) and has been stable since (Chart 3.1). Like other chronic diseases, the prevalence of diabetes increased with age. In 2023, it was lowest among 18- to 34-year-olds (1.4%) and highest among adults aged 65 and older (17.6%). Males (9.0%) had a higher prevalence of diabetes than females (7.1%) in 2023. A similar trend was found in 2021 and 2022, with the prevalence of diabetes being around 2 percentage points higher in males. Sex differences in the prevalence of diabetes were observed at older ages (50 and older), and they widened with age. For example, in 2023, the prevalence of diabetes was 2.7 percentage points higher in males aged 50 to 64 but 5.7 percentage points higher in males aged 65 and older, compared with their female counterparts.

Across the provinces, people in Newfoundland and Labrador (11.1%) and Nova Scotia (10.5%) had a higher prevalence of diabetes, and those in British Columbia had a lower prevalence (6.8%), compared with Canada overall, excluding the territories, in 2023 (8.0%) (Table 3.0). A similar trend was seen in 2021 and 2022. In 2022, Yukon also had a lower prevalence of diabetes (5.7%) compared with Canada overall (8.4%). The prevalence of diabetes was similar in rural areas and population centres from 2015 until a difference emerged in 2022 and 2023. In these years, a higher percentage of Canadians living in rural regions reported having diabetes compared with those in population centres (9.1% vs. 7.8% in 2023, Chart 3.2).

The prevalence of diabetes also varied across different population groups of Canadians. In 2023, 10.1% of Canadians in the lowest household income quintile reported having diabetes, compared with 6.3% in the highest quintile. A similar trend has been seen since 2015. Diabetes prevalence was also much higher among those with a disability (16.6%) than among those without disabilities (6.9%) in 2023 (Chart 3.3). In the same year, 9.1% of immigrants had diabetes, compared with 7.8% of non-immigrants (Chart 3.4). From 2021 to 2023, immigrants who were admitted to Canada more than 10 years ago had a 7 to 8 percentage point higher prevalence of diabetes than more recent immigrants. Compared with the non-racialized population (8.0%), South Asian people had a higher prevalence of diabetes (10.8%), whereas Chinese (6.3%), Latin American (5.5%), Japanese (4.0%), Korean (2.9%) and West Asian (2.8%) people had a lower prevalence (Table 3.1).

Overweight and obesity

Overweight and obesity are risk factors for several chronic diseases, such as diabetes, high blood pressure, heart disease, stroke, arthritis and cancer. Obesity is also a chronic disease.

Body mass index (BMI), calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared, is a method of classifying body weight according to health risk. According to the World Health Organization and Health Canada guidelines, having a BMI of 25.00 to 29.99 (classified as overweight) is associated

with an increased health risk, and having a BMI of 30.00 or greater (classified as obese) is associated with a high health risk. A correction factor is applied to adjust for underestimates in weight and overestimates in height.[52]

In 2023, 35.5% of Canadian adults were classified as overweight and 30.2% had obesity (Table 3.0). The proportion of adults with overweight or obesity has remained stable since 2015 (Chart 3.1). In each year since 2015, the proportion of males who were overweight was higher than that of females. In 2023, 40.0% of males were classified as overweight, compared with 31.0% of females. Sex differences in overweight were largest among those aged 35 to 49 (12.3 percentage points higher in males). Although a greater proportion of males than females were classified as having obesity from 2015 to 2018, no sex differences in obesity were observed from 2019 to 2023.

Several provinces (all the Atlantic provinces, Manitoba and Saskatchewan) had a higher obesity prevalence than Canada overall, excluding the territories (Table 3.0). Notably, in Newfoundland and Labrador and New Brunswick, 41.1% of adults had obesity in 2023, compared with 30.2% in Canada overall, excluding the territories. Meanwhile, British Columbia had a lower percentage of adults classified as having obesity (24.3%) compared with Canada overall, excluding the territories, and a similar trend has been observed since 2015. In 2023, obesity prevalence was higher among adults in rural areas (36.7%) than among those living in population centres (29.0%) (Chart 3.2). A similar trend has been found since 2015.

The prevalence of overweight and obesity differed based on sociodemographic characteristics, often showing contrasting patterns. For instance, in 2023, individuals who reported having a disability had a lower prevalence of overweight (30.6%) than those without disabilities (36.1%). However, the prevalence of obesity was higher among those with a disability (40.1%) than among those without disabilities (29.1%) (Chart 3.3).

In 2023, a greater proportion of Canadians aged 18 and older in the highest income quintile were classified as overweight (37.8%), compared with those in the lowest quintile (33.3%). The same trend has been found since 2015. In contrast, obesity was more prevalent among those in the lowest quintile (30.1%), compared with those in the highest (27.1%) in 2023.

Since 2021, a higher proportion of immigrants have been classified as overweight, compared with non-immigrants (2 to 4 percentage points higher for immigrants). In contrast, obesity has been more prevalent among non-immigrants than immigrants since 2015. In 2023, 23.6% of immigrants were classified as having obesity, compared with 33.3% of non-immigrants (Chart 3.4).

Obesity prevalence was lower among some racialized groups compared with the non-racialized population in 2023 (Table 3.1). A higher proportion of South Asian (40.8%) and Black (41.4%) Canadians were classified as overweight in 2023 compared with non-racialized Canadians (35.2%). A similar trend was found for South Asian people in 2021 and 2022.

Musculoskeletal disorders

Arthritis

Arthritis is associated with mobility limitations and dependency in activities of daily living.[53] The prevalence of arthritis has remained stable since 2019 (Chart 3.1). In 2023, 20.6% of Canadian adults reported having arthritis (Table 3.0). Unlike other chronic diseases where the prevalence is higher among males, in 2023, the prevalence of arthritis was higher among females (24.4%) than males (16.7%), across all age groups. Like other chronic diseases, the prevalence of arthritis increased with age, ranging from 2.3% among 18- to 34-year-olds to 46.0% among those aged 65 and older in 2023. Arthritis prevalence was 16 percentage points higher among females aged 65 and older (53.5%) than among males in the same age group (37.6%).

The prevalence of arthritis varied across the provinces in 2023. People in all the Atlantic provinces and Manitoba had a higher prevalence of arthritis than those in Canada overall (excluding the territories), while Quebec was the only province where people had a lower prevalence of arthritis (18.1%) (Table 3.0). In 2022, the proportion of people with arthritis in the Northwest Territories (17.0%) and Nunavut (10.5%) was lower compared with Canada overall (20.6%). Arthritis prevalence was higher among adults in rural areas (26.2%) than among those living in population centres (19.5%) (Chart 3.2). A similar trend was found in 2021 and 2022.

Arthritis prevalence was higher among those who reported having a disability (41.9%) compared with those who did not (18%) (Chart 3.3). Like most other chronic diseases, a greater proportion of those in the lowest household income quintile reported having arthritis (25.4%) compared with those in the highest quintile (18.2%) in 2023. A similar trend has been observed since 2015.

Arthritis has remained more prevalent among non-immigrants than immigrants since 2015. In 2023, 16.8% of immigrants reported having arthritis, compared with 22.7% of non-immigrants (Chart 3.4). Among immigrants, 21.6% of those who were admitted more than 10 years ago reported having arthritis in 2023, compared with 4.5% of more recent immigrants. Similar trends were observed in 2021 and 2022. A lower proportion of people in all racialized groups reported having arthritis compared with the non-racialized population in 2023 (Table 3.1). Similar trends have been seen since 2015.

Did you know?

According to the 2022 Indigenous Peoples Survey, the most prevalent chronic diseases among First Nations people living off reserve, Métis and Inuit were arthritis, high blood pressure and asthma.

Table 3.1-2
Prevalence of common chronic diseases among First Nations people living off reserve, Métis and Inuit aged 15 and older, Canada, 2022

	Arthritis	High blood pressure	Asthma	Cancer	Diabetes	Heart disease	Chronic bronchitis, emphysema and COPD	Bowel disorders
				percent				
First Nations people living off reserve	22.9	19.6	16.3	5.8	10.6	5.6	5	11.2
Métis	24.1	20.6	15.3	7.2	9.4	6	5.5	12.5
Inuit	15.5	15.4	11.3	4	5.5	4.5	4.3	6.1

Note: COPD = chronic obstructive pulmonary disease.
Source: Statistics Canada, Indigenous Peoples Survey, 2022.

Arthritis, bowel disorders and cancer were more prevalent among First Nations, Métis and Inuit women compared with men. Similarly, asthma prevalence was higher among First Nations and Métis women than men. In contrast, diabetes was more common among Métis men than women. For First Nations people and Métis, heart disease and high blood pressure were more prevalent among men than women, and this trend was also observed for high blood pressure among Métis.

Cancer

Did you know?

An estimated 45% of Canadians are expected to be diagnosed with cancer in their lifetime.[54]

Cancer is not one disease, but a collection of over 100 distinct diseases that are complex and influenced by many factors, including genetics, lifestyle and the environment. As the leading cause of premature death (i.e., death before age 75) in Canada, cancer has a large impact on the health of Canadians and the Canadian health care system. The potential years of life lost (i.e., the number of years of potential life not lived) because of premature mortality from cancer from 2018 to 2020 reached approximately 1.3 million years.

Because of the time needed to gather and verify data, cancer statistics inevitably lag several years behind the present.[55] Short-term projections are calculated by extrapolating from historical trends into the future through statistical models. These estimates of incidence and mortality offer an up-to-date view of cancer's impact in Canada that is crucial for planning resources, conducting research and guiding cancer control programs.

In Canada, 247,100 new cancer cases were projected to be diagnosed in 2024. Lung cancer was projected to remain the most diagnosed cancer, with 32,100 new cases expected in 2024, followed by breast (30,800 cases), prostate (27,900 cases) and colorectal (25,200 cases) cancers. Combined, these four cancer types made up 47% of all new cancer cases expected in 2024.

In 2024, 88,100 people in Canada were expected to die of cancer. Lung cancer was projected to remain the most common cause of cancer death, with an expected 20,700 deaths in 2024, followed by colorectal (9,400 deaths), pancreas (6,100 deaths), breast (5,500 deaths) and prostate (5,000 deaths) cancers. Combined, these five cancers were expected to account for more than half (53%) of all cancer deaths in Canada in 2024.

Age-standardized incidence rates (ASIRs) and age-standardized mortality rates (ASMRs) per 100,000 people are presented in Table 3.2. Although the total ASIR and ASMR were projected to decrease from previous years for both males and females, the ASIR for all cancers combined was projected to be 13% higher among males than females in 2024. The ASMR for all cancers combined was projected to be 37% higher among males than females.

Table 3.2
Projected estimates of age-standardized incidence rates and age-standardized mortality rates for selected cancers, by sex at birth, Canada, 2024[1]

Type of cancer	Age-standardized incidence rate per 100,000 population			Age-standardized mortality rate per 100,000 population		
	Both sexes	Males	Females	Both sexes	Males	Females
All cancers combined[2]	**523.9**	**562.2**	**495.9**	**177.5**	**209.6**	**152.8**
Lung and bronchus	63.8	63.4	64.9	40.7	46.8	35.9
Breast	69.5	1.3	133.1	11.8	0.3	21.8
Prostate	…	119.7	…	…	22.7	…
Colorectal	53.1	63.0	44.2	19.2	23.7	15.3

… not applicable
1. Rates are age standardized to the 2011 Canadian standard population. The complete definition of the specific cancers included here can be found in Appendix 1, Supplementary Table 1, available at https://www.cmaj.ca/content/196/18/E615/tab-related-content.
2. The category "all cancers combined" includes in situ bladder cancer and excludes nonmelanoma skin cancer (neoplasms, not otherwise specified; epithelial neoplasms, not otherwise specified; and basal and squamous).
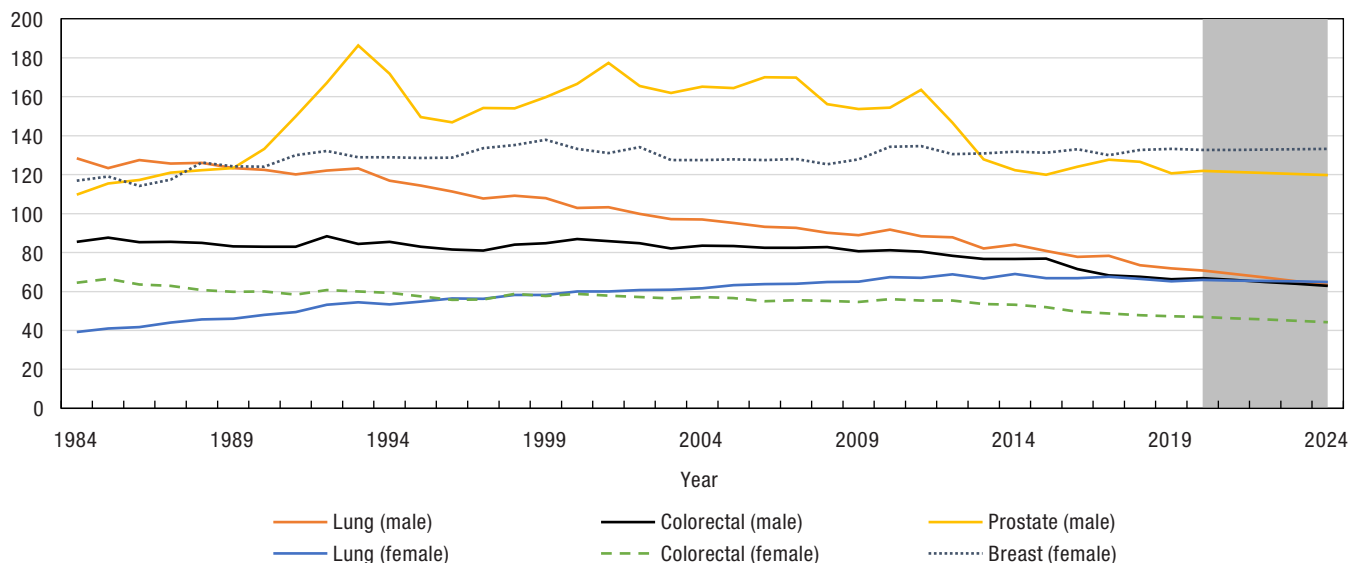**Note:** Projections for 2024 include Quebec.
Source: Brenner DR, Gillis J, Demers AA, et al. Projected estimates of cancer in Canada in 2024. CMAJ 2024. DOI: https://doi.org/10.1503/cmaj.240095.

Incidence and mortality rates over time for selected cancers

ASIRs (Chart 3.5) and ASMRs (Chart 3.6) are shown from 1984 to 2024 for selected common cancers. In the past, lung cancer incidence and mortality rates were higher among males than females, but this difference has recently been shrinking. While the lung cancer mortality rate remained higher among males than females, females were expected to have a higher incidence rate in 2024 than males. Incidence and mortality rates of colorectal cancer have been steadily decreasing for both males and females.

Chart 3.5
Age-standardized incidence rates for selected cancers, by sex at birth, Canada, 1984 to 2024

age-standardized incidence rate per 100,000 population

Lung (male) — Colorectal (male) — Prostate (male) — Lung (female) — Colorectal (female) — Breast (female)
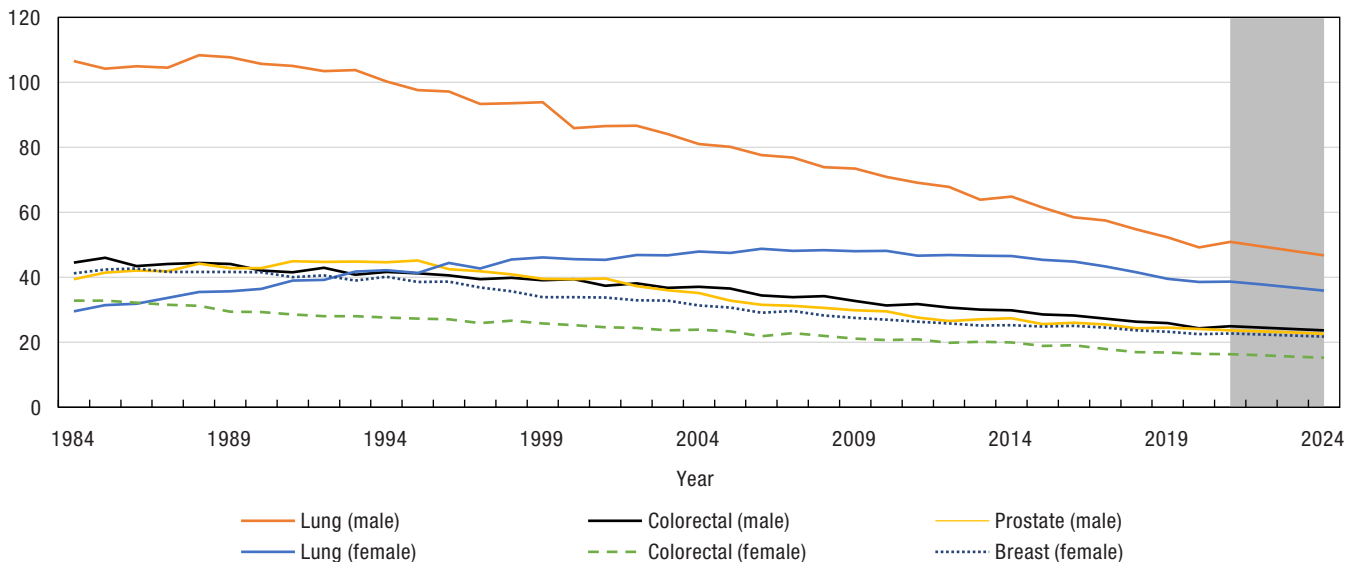
Notes: Rates were age standardized to the 2011 Canadian standard population. Shading indicates projected data from 2020 to 2024 for incidence and from 2021 to 2024 for mortality. Rates include Quebec.
Source: Brenner DR, Gillis J, Demers AA, et al. Projected estimates of cancer in Canada in 2024. CMAJ 2024.
DOI: https://doi.org/10.1503/cmaj.240095.

Chart 3.6
Age-standardized mortality rates for selected cancers, by sex at birth, Canada, 1984 to 2024

age-standardized mortality rate per 100,000 population

Lung (male) — Colorectal (male) — Prostate (male) — Lung (female) — Colorectal (female) — Breast (female)

Notes: Rates were age standardized to the 2011 Canadian standard population. Shading indicates projected data from 2020 to 2024 for incidence and from 2021 to 2024 for mortality. Rates include Quebec.
Source: Brenner DR, Gillis J, Demers AA, et al. Projected estimates of cancer in Canada in 2024. CMAJ 2024.
DOI: https://doi.org/10.1503/cmaj.240095.

4.0 Mental health

Mental health disorders

Mental illness is characterized by changes in an individual's thinking, mood or behaviour and is usually associated with significant distress or impaired functioning in social, occupational and other activities.[7] As with chronic physical health conditions, mental disorders can affect quality of life and can require ongoing management. There are several types of mental illness: mood disorders, anxiety disorders, schizophrenia and related disorders, personality disorders, substance-related disorders (e.g., alcohol abuse or dependence), eating disorders, and dementia. This report focuses on self-reported **anxiety disorders**, such as phobia, a panic disorder or generalized anxiety disorder, and **mood disorders**, including major depression, bipolar disorder, mania or dysthymia (chronic form of depression), that have lasted six months or more and have been diagnosed by a health care provider.

Anxiety disorders

A higher percentage of Canadian adults reported having a diagnosed anxiety disorder in 2022 (14.8%) than in 2021 (10.3%), and this share has been steadily increasing since 2015 (7.8%). In 2022, a higher proportion of women (19.1%) reported having been diagnosed with anxiety than men (10.5%), and this difference was observed across all age groups. A greater proportion of 18- to 34-year-olds (20.2%) reported having an anxiety disorder than older age groups in 2022. As observed in 2021, anxiety disorder prevalence in 2022 was twice as high among gay or lesbian adults (26.4%) and more than three times as high among bisexual or pansexual adults (46.0%) as among heterosexual adults (13.5%). Across all age groups except for those aged 60 and older, the prevalence of anxiety was higher among adults whose reported sexual orientation is lesbian, gay, bisexual or another orientation that is not heterosexual (LGB+) compared with their heterosexual counterparts (Chart 4.0).[13]

Anxiety disorders were more common among Canadians in the lowest household income quintile (18.8%) than the highest (11.0%). Proportionally fewer immigrants (9.0%) reported having an anxiety disorder in 2022 compared with non-immigrants (17.2%), and this 8 percentage point difference remained consistent from 2021. Among immigrants, a greater proportion of those who were admitted to Canada more than 10 years ago reported an anxiety disorder diagnosis (9.7%) than more recent immigrants (6.8%) in 2022. Overall, the prevalence of anxiety was higher among non-racialized Canadians than among most racialized groups in 2022.


Did you know?

The 2022 Mental Health and Access to Care Survey (MHACS) used a modified version of the World Health Organization's Composite International Diagnostic Interview to classify people with selected mood, anxiety or substance use disorders based on their reports of various symptoms and experiences. This differs from the Canadian Community Health Survey, which asks respondents whether they have a mental health condition that was diagnosed by a health professional.

A study using MHACS data found that the prevalence of mood, anxiety and substance use disorders was generally lower among South Asian, Chinese, Filipino and Black people in Canada than among non-racialized, non-Indigenous people. There were some variations in the magnitude of the differences depending on the type of disorder.[56]

Mood disorders

In 2023, 13.0% of Canadian adults reported having been diagnosed with a mood disorder (e.g., major depression, bipolar disorder or mania), an increase from 2022 (11.7%) and 2021 (10.0%), as part of a trend seen since 2015. A higher proportion of women (20.4%) reported having a mood disorder than men (12.0%) in 2023. In the same year, there was a higher prevalence of mood disorders among 18- to 34-year-olds (16.1%) than all older age groups. Compared with the 11.6% of heterosexual adults who reported having a mood disorder in 2023, the prevalence of mood disorders was twice as high among gay or lesbian adults (21.2%) and almost four times as high among bisexual or pansexual adults (41.4%). This trend has remained consistent since 2015. Across all age groups, mood disorders were more prevalent among LGB+ people than their heterosexual counterparts (Chart 4.0).[13]

Chart 4.0
Prevalence of self-reported diagnosed anxiety and mood disorders among Canadians aged 18 and older, by sexual orientation and age group, 2022 (for anxiety) and 2023 (for mood disorders)
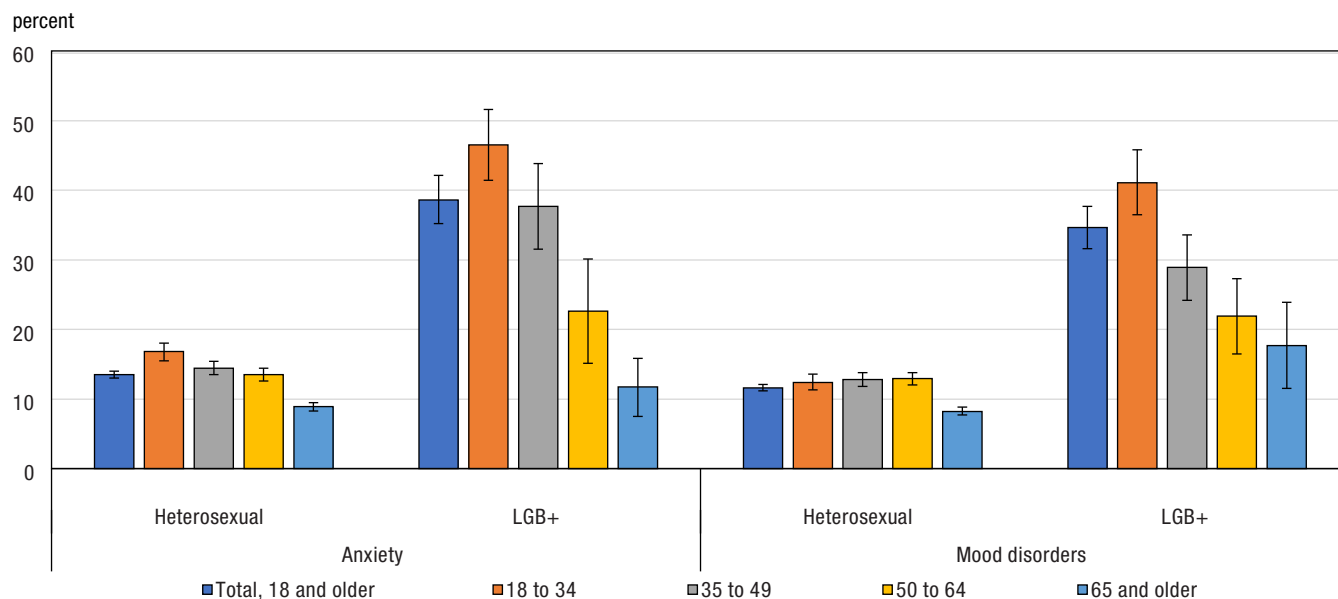
Notes: Territorial data are not included in annual estimates. Anxiety includes self-reported diagnoses of phobia, a panic disorder or generalized anxiety disorder. The 2022 Canadian Community Health Survey excluded obsessive-compulsive disorder from anxiety disorders. Mood disorders include self-reported diagnoses of major depression, bipolar disorder, mania or dysthymia (chronic form of depression). LGB+ includes people whose reported sexual orientation is lesbian, gay, bisexual or another sexual orientation that is not heterosexual. Estimates of sexual orientation are based on a survey question that includes four response categories: heterosexual, homosexual, bisexual and a write-in category to specify a sexual orientation. Write-in responses of "pansexual" are included in the bisexual category. Write-in responses that specify another sexual orientation that is not heterosexual are included in the LGB+ total.
Sources: Statistics Canada, Canadian Community Health Survey, 2022 and 2023.

Did you know?

A study using 2022 MHACS data found that 2SLGBTQ+ people aged 15 to 24 were 2.6 times more likely than their cisgender heterosexual peers to have met the diagnostic criteria for a mental health or substance use disorder and 4.8 times more likely to have considered suicide in the past year.[57]

The prevalence of mood disorders varies across the country. Fewer adults in Quebec reported having a mood disorder (9.4%) compared with the Canadian average excluding the territories (13.0%) in 2023, similar to the trend seen since 2019. Conversely, in 2023, a higher percentage of adults in Newfoundland and Labrador (17.4%), New Brunswick (16.8%), Nova Scotia (16.3%), and Alberta (15.0%) reported having a mood disorder, compared with Canada overall (excluding the territories). In 2022, a higher share of adults in Yukon reported having a mood disorder (17.2%) compared with the national average (11.7%).

In 2023, a greater proportion of adults in the lowest household income quintile reported having a mood disorder (17.1%) than in the highest quintile (10.9%). Immigrants had a lower prevalence of mood disorders than non-immigrants in 2021 (5.0% vs. 11.9%), 2022 (8.1% vs. 13.2%) and 2023 (8.4% vs. 15.0%). However, among immigrants, a larger percentage of those who were admitted to Canada more than 10 years ago (8.8%) reported having a mood disorder than immigrants who were admitted in the last 10 years (6.6%). Additionally, in 2023, a greater proportion of non-racialized Canadians reported having a mood disorder compared with most racialized groups. In the same year, mood disorder prevalence was three times as high among Canadians with a disability (35.4%) compared with Canadians without a disability (10.3%).

Did you know?

According to the 2022 Indigenous Peoples Survey, over one-quarter of First Nations people living off reserve (28.0%) and Métis (26.3%) and just under one-fifth of Inuit (18.3%) aged 15 and older reported having been diagnosed with an anxiety disorder. Similar proportions were found for those reporting mood disorders: 26.0% among First Nations people living off reserve, 23.4% among Métis and 18.0% among Inuit.

The prevalence of mood and anxiety disorders was higher among First Nations, Métis and Inuit women than men. Among First Nations people living off reserve, anxiety disorder prevalence was higher among those in low income (35.7%) than those not in low income (25.6%). The same pattern was seen among Métis (35.5% vs. 24.6%, respectively). Similar findings were observed for mood disorders, with a higher prevalence among those in low income than those not in low income: 31.7% compared with 24.2%, respectively, for First Nations people living off reserve and 33.0% compared with 21.7%, respectively, for Métis.

Note: Low income refers to the income situation of a person in relation to the low-income measure, after tax. People with after-tax income, less COVID-19 benefits, that is below this low-income line are in low income.

5.0 Oral health

Key findings

The 2023 to 2024 Canadian Oral Health Survey (COHS) found the following:

- Three in four Canadians aged 12 and older (72.3%) reported having visited an oral health professional in the past year.
- Two-thirds (65.5%) of Canadians aged 12 and older had dental insurance.
  - ▶ Proportionally more Canadians with insurance (80.8%) than without (56.0%) reported having visited an oral health professional in the previous year.
  - ▶ Proportionally fewer adults aged 65 to 79 (38.0%) and 80 and older (25.1%) reported having dental insurance compared with younger age groups.
- Approximately 7 in 10 Canadians (70.5%) brushed their teeth or dentures at least two times a day, and 3 in 10 (30.0%) flossed at least five times a week.
- Just over one in four Canadians (26.4%) had mouth problems "sometimes or often" in the past 12 months, including having persistent or ongoing mouth pain (21.6%) or avoiding eating certain foods (15.6%).
- Moreover, 4.4% of Canadians aged 18 and older reported having no natural teeth (edentulism). The share was higher among those who had last visited an oral health professional one year ago or more (10.0%), compared with those who had visited in the past year (1.8%).
- A higher percentage of people with a disability than people without disabilities reported edentulism (11.3% vs. 3.5%) and mouth problems (46.2% vs. 23.8%).

Oral health has been referred to as the gateway or window to perceived health and is considered to contribute to general well-being, on top of the mere absence of disease. Daily activities like eating, talking, smiling and creative contributions to society are determinants of an individual's well-being.[58]

Did you know?

The COHS is the first-ever national survey dedicated to oral health in Canada, collecting voluntary information directly from Canadians on their oral health. The survey was developed to address key oral health data gaps and help inform new federal investments in dental care, including the Canadian Dental Care Plan.

The target population for the COHS consists of Canadian households with adults aged 18 and older, as well as all household members aged 17 and younger, living in private dwellings. Cycle 1 was conducted from November 2023 to March 2024.

The survey covers several key aspects of oral health, including individuals' ability to pay for oral health care, experiences with the oral health care system, challenges finding oral health services, self-reported oral health and care needs.

Dental visits

Routine dental visits play an important role in maintaining oral health. The Canadian Dental Association suggests that a dental visit every six months is adequate for most people; however, the frequency of visits is based on an individual's needs and risk of oral diseases.[59]

According to the COHS, approximately three in four Canadians aged 12 and older (72.3%) reported during the period from November 2023 to March 2024 that they had visited an oral health professional in the past year. This was down from 74.7% in 2018 but up from 65.4% in 2022, when compared with results from the Canadian Community Health Survey (CCHS).

The prevalence of dental visits in the past year varied across the provinces. Proportionally fewer Canadians (of all ages) living in New Brunswick (65.0%), Newfoundland and Labrador (68.7%), Quebec (69.0%), Manitoba (69.3%), and Saskatchewan (70.4%) reported having visited an oral health professional in the past year, compared with those in Ontario (74.5%). A higher proportion of Canadians living in population centres (72.9%) reported a visit, compared with those living in rural areas (67.0%).

Having had a dental visit in the past year varied by gender and across age groups in the 2023 to 2024 COHS (Chart 5.0). Compared with adults aged 18 to 34 (67.5%), proportionally more adults aged 35 to 49 (74.6%) and 50 to 64 (76.7%) had visited a dentist in the past year. The prevalence of having had a visit was highest among children aged 6 to 11 (88.6%) and youth aged 12 to 17 (87.6%), and lower among children younger than 6 (51.8%) and adults aged 80 and older (55.1%). Overall, the prevalence of dental visits varied by gender, with proportionally more women (73.8%) than men (70.6%) reporting having visited an oral health professional in the past year.

Did you know?

According to the 2021 Survey on Access to Health Care and Pharmaceuticals During the Pandemic, many Canadians aged 18 and older living in the provinces had difficulties accessing health care services or avoided non-emergency dental treatments during the pandemic because of fear of exposure to COVID-19. This led to the postponement of routine visits and examinations.[60]

Dental insurance

Having dental insurance is a crucial predictor of oral health care access and use, independent of income and sociodemographic factors.[61,62,63] The 2023 to 2024 COHS revealed that just under two-thirds (63.5%) of Canadians aged 12 and older had dental insurance, a little below the pre-pandemic level (64.6% in the 2018 CCHS) but up from 2022 (60.7% in the 2022 CCHS).[64]

The majority of Canadians of all ages with dental coverage in 2023 and 2024 had private insurance (61.6%), meaning they had a plan paid by an employer, a personally purchased plan, or a plan through a college or university. Meanwhile, 3.0% reported being covered exclusively by a public plan (i.e., a government-paid plan), and 31.0% reported having no dental insurance.

The 2023 to 2024 COHS showed that a higher percentage of Canadians with private or public dental insurance (80.8%) reported having visited an oral health professional in the previous year than those without insurance (56.0%).

Dental insurance coverage varied across the provinces. Compared with people in Ontario (66.9%), proportionally more Canadians living in Alberta (77.0%), Saskatchewan (76.1%) and Manitoba (72.1%) and proportionally fewer people living in Quebec (52.9%) reported having dental insurance. A higher percentage of those living in population centres (66.8%) reported having dental insurance compared with those living in rural areas (56.3%).

Proportionally more children aged 0 to 5 (82.7%) and 6 to 11 (78.8%), youth aged 12 to 17 (76.9%), and adults aged 35 to 49 (75.3%) had dental insurance, compared with younger adults aged 18 to 34 (67.3%) (Chart 5.0). In contrast, proportionally fewer adults aged 65 to 79 (38.0%) and 80 and older (25.1%) reported having dental insurance, compared with younger age groups.

Did you know?

Using data from the 2019 and 2020 Canadian Health Survey on Seniors, researchers found that among seniors who had not visited a dental professional in three years, 56.3% deemed it unnecessary and 30.8% identified cost as the major barrier.[60] After sociodemographic characteristics were controlled for, insured seniors were over two times more likely to have had a dental visit in the past 12 months (adjusted odds ratio [OR]: 2.27; 95% confidence interval [CI]: 2.03 to 2.54) and were less likely to avoid dental visits because of cost (OR: 0.18; 95% CI: 0.12 to 0.28), compared with their uninsured counterparts.

Similarly, the 2019 Canadian Health Survey on Children and Youth found that children and youth with dental insurance were nearly three times more likely (OR: 2.94; 95% CI: 2.60 to 3.33) to have visited a dental professional in the past 12 months than uninsured children and youth.[61] Having dental insurance (OR: 0.19; 95% CI: 0.16 to 0.21) was protective against barriers to seeing a dental professional because of cost.

Chart 5.0
Proportion of Canadians who visited an oral health professional in the previous 12 months and had dental insurance, by age group, 2023 to 2024
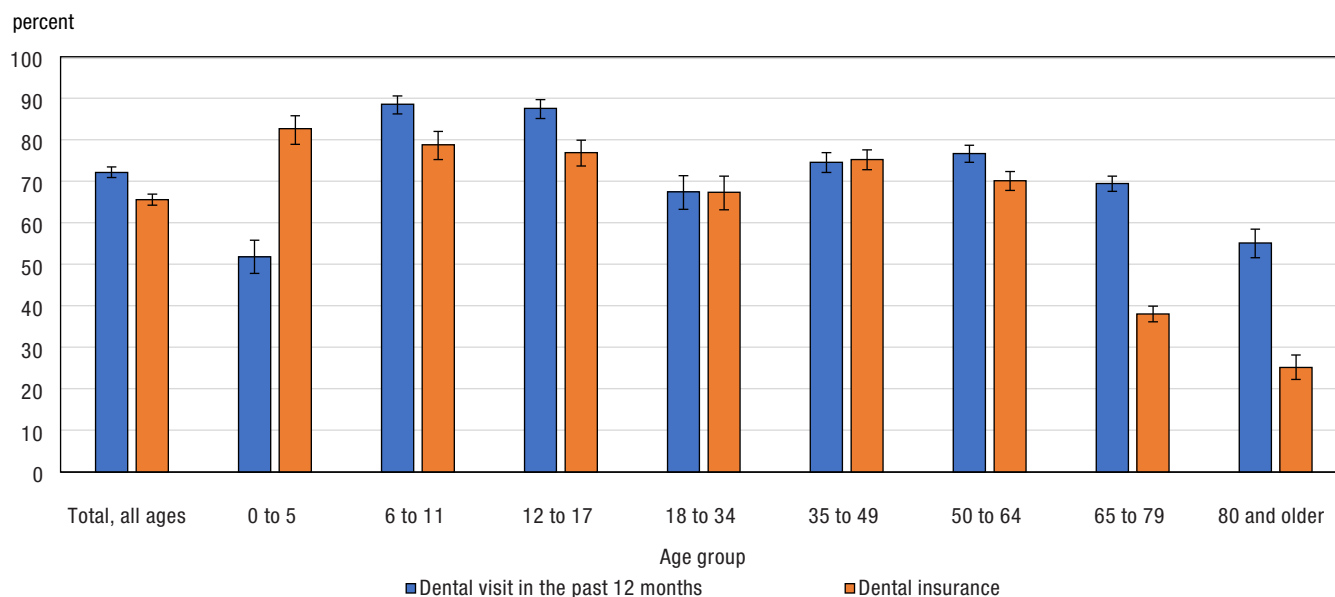
Notes: Estimates exclude those living in the territories. Dental visits include visits to any oral health professional, including dentists, denturists, dental hygienists and any other dental specialists. Dental insurance is defined as respondents having all or part of their dental expenses covered by any insurance plan or government program. Private insurance includes plans through an employer (including those partially paid or sponsored by an employer), private plans (including personally purchased plans), and plans through colleges and universities. Public insurance includes government-paid plans (e.g., children's or seniors' dental programs; the Régie de l'assurance maladie du Québec; and the Non-Insured Health Benefits program for First Nations people and Inuit, which includes individuals living on and off reserves).
Source: Statistics Canada, Canadian Oral Health Survey, 2023 to 2024.

Oral health behaviours

Good oral hygiene, including regular brushing and flossing, can help prevent tooth decay and inflammation in the gums.[57,65] According to the 2023 to 2024 COHS, approximately 7 in 10 Canadians of all ages (70.5%) brushed their teeth or dentures at least two times a day, and 3 in 10 (30.0%) flossed at least five times a week. A larger share of women reported brushing at least two times a day (76.2%) and flossing at least five times a week (34.1%), compared with men (64.6% and 25.8%, respectively).

Mouth problems

Mouth problems can have a significant impact on people's daily lives by decreasing their quality of life.[56] Being in a prolonged state of oral pain can cause functional and psychological problems. Furthermore, avoiding certain foods because of pain or other mouth problems can result in lower food intake overall, leading to weight loss, insomnia, irritability and low self-esteem. Mouth problems can also result in time and productivity losses at school or in the workplace.[66]

According to the 2023 to 2024 COHS, just over one in four Canadians of all ages (26.4%) had mouth problems "sometimes or often" in the past 12 months, including having persistent or ongoing mouth pain (21.6%) or avoiding eating certain foods (15.6%).[63]

Mouth problems were more prevalent among women (29.0%) than men (23.8%) and among those aged 65 to 79 (35.3%) than those aged 18 to 34 (26.3%).[63] Proportionally fewer children aged 0 to 5 (9.4%) and 6 to 11 (15.3%) and youth aged 12 to 17 (15.3%) had mouth problems sometimes or often, compared with adults aged 18 to 34.

A higher percentage of people with a disability (46.2%) reported having mouth problems, compared with people without disabilities (23.8%) (Chart 5.1).

Edentulism

The loss of all natural teeth (also known as toothlessness or edentulism) can lead to changes in eating patterns, nutrient deficiency, involuntary weight loss and speech difficulty.[67] It also increases the risk of chronic diseases such as cardiovascular disease and diabetes, significantly affecting overall health and well-being if left uncorrected.

Overall, the 2023 to 2024 COHS found that 4.4% of Canadians aged 18 and older had lost all their natural teeth.[63] Edentulism was more common among those who had last visited a dentist one year ago or more (10.0%), compared with those who had visited in the past year (1.8%). Toothlessness increased with age. A higher percentage of adults aged 65 to 79 (10.7%) and 80 and older (24.6%) reported edentulism, compared with those aged 18 to 34 (1.6%).

Edentulism varied across the provinces. Proportionally more adults in Quebec (8.3%), New Brunswick (6.6%), Saskatchewan (5.6%), Nova Scotia (5.4%), and Newfoundland and Labrador (5.3%) reported toothlessness, compared with those in Ontario (2.9%).[63] Edentulism was also more prevalent in rural areas (8.3%) than in population centres (3.9%).

A higher percentage of people with a disability (11.3%) reported edentulism, compared with those without disabilities (3.5%). Most notably, for older adults aged 65 to 79, edentulism was nearly 7 percentage points higher among those with a disability (16.1%) than those without disabilities (9.5%).

Chart 5.1
Canadians with mouth problems in the past 12 months and with no natural teeth, by disability status, 2023 to 2024

percent
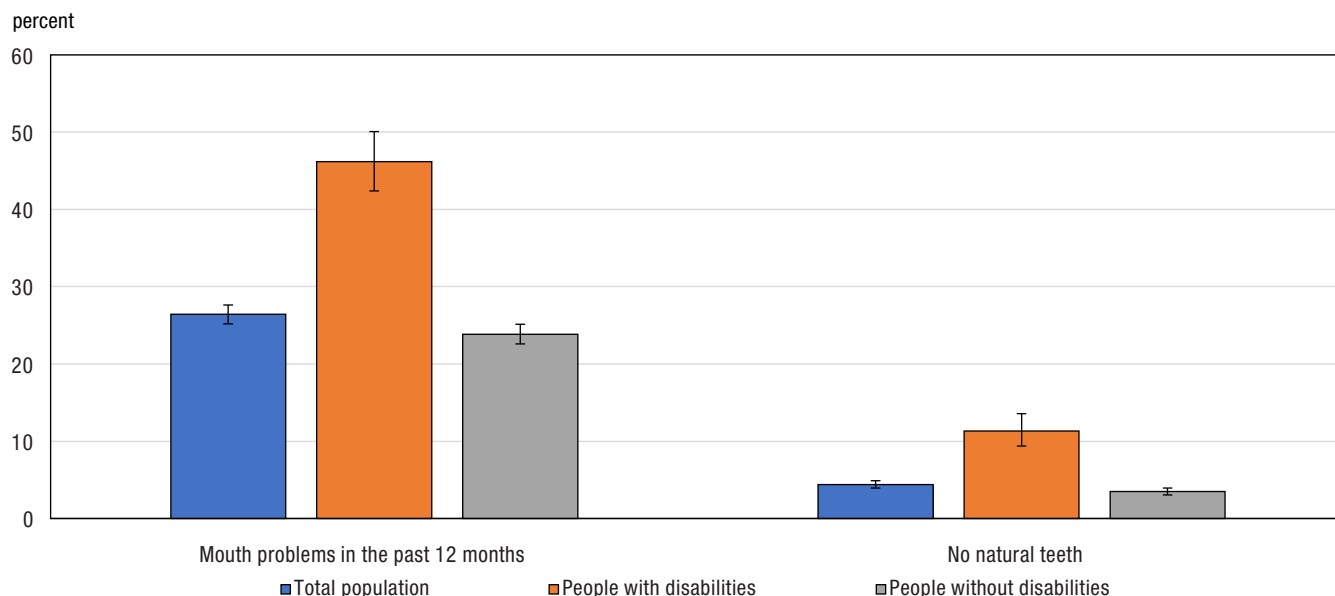
Notes: Estimates exclude those living in the territories. People with mouth problems in the past 12 months include those who reported having persistent or ongoing mouth pain or avoiding eating certain foods. People with disabilities, as defined by the Canadian Survey on Disability, are people with long-term difficulties or conditions, such as vision, hearing, mobility, flexibility, dexterity, pain, learning, developmental, memory or mental health impairments, that limit their daily activities inside or outside the home, including at school, at work or in the community in general.
Source: Statistics Canada, Canadian Oral Health Survey, 2023 to 2024.

Spotlight on Indigenous children's oral health

Dental services are especially important to prevent tooth decay that can lead to pain and infection in children and adversely impact speech and self-image.[56] Indigenous children experience oral health inequity linked to accessibility, availability and affordability barriers, and programs are seeking to eliminate disparities.[68]

According to a study using the 2022 Indigenous Peoples Survey (IPS), a similar percentage of Indigenous children aged 1 to 5 (86.2% of First Nations children living off reserve, 87.7% of Métis children and 75.2% of Inuit children) had visited a dental professional in the past 12 months for a check-up or cleaning, compared with their older counterparts aged 6 to 14 (86.1% of First Nations children living off reserve, 89.2% of Métis children and 80.0% of Inuit children) (Chart 5.2).[26] However, having visited a professional in the past year for toothaches, tooth decay or cavities was more prevalent among older First Nations children living off reserve and Métis children, compared with their younger counterparts.

Chart 5.2
Proportion of Indigenous children who visited an oral health professional in the previous 12 months, by Indigenous identity and age group, 2022
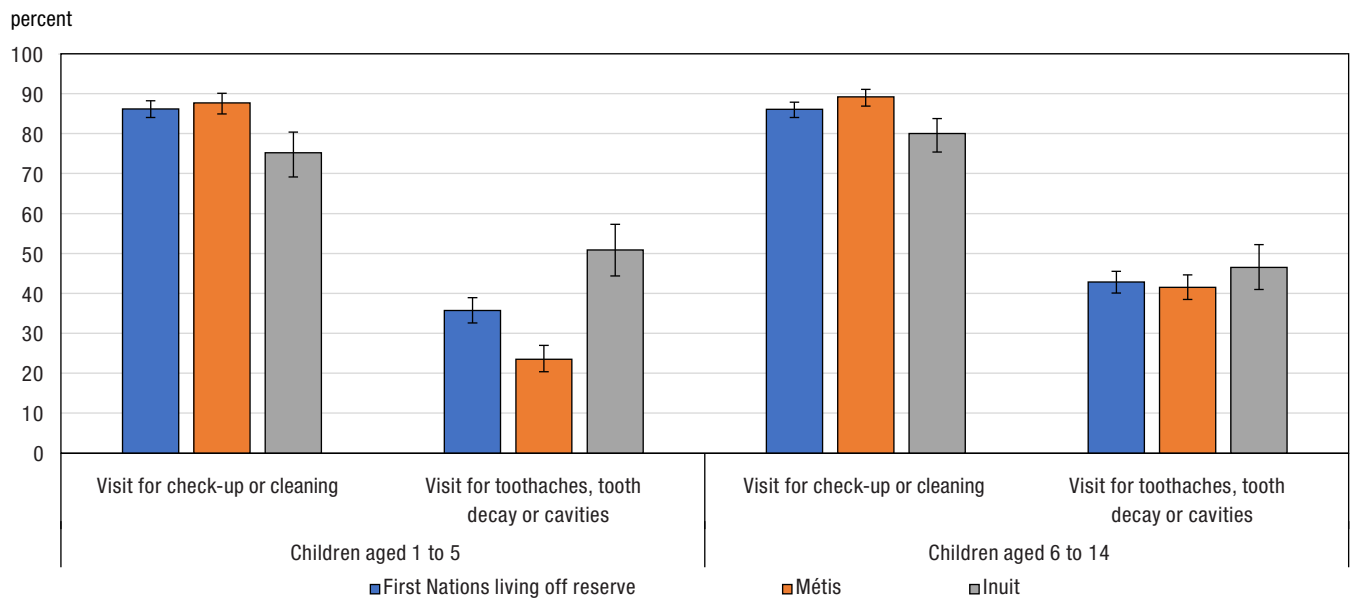
Notes: The question about visiting a dental professional in the past 12 months was asked of those who had ever seen a dental professional. Error bars represent 95% confidence intervals.
Source: Statistics Canada, Indigenous Peoples Survey, 2022.

Chart 5.3 shows that 23.7% of First Nations children living off reserve, 11.9% of Métis children and 42.2% of Inuit children aged 1 to 5 were affected by early childhood cavities.[26] A higher proportion of First Nations children living off reserve (36.5%) and Métis children (28.2%) aged 6 to 14 were affected by early childhood cavities than their younger counterparts aged 1 to 5.

Chart 5.3
Early childhood cavities, by Indigenous identity and age group, Canada, 2022

percent
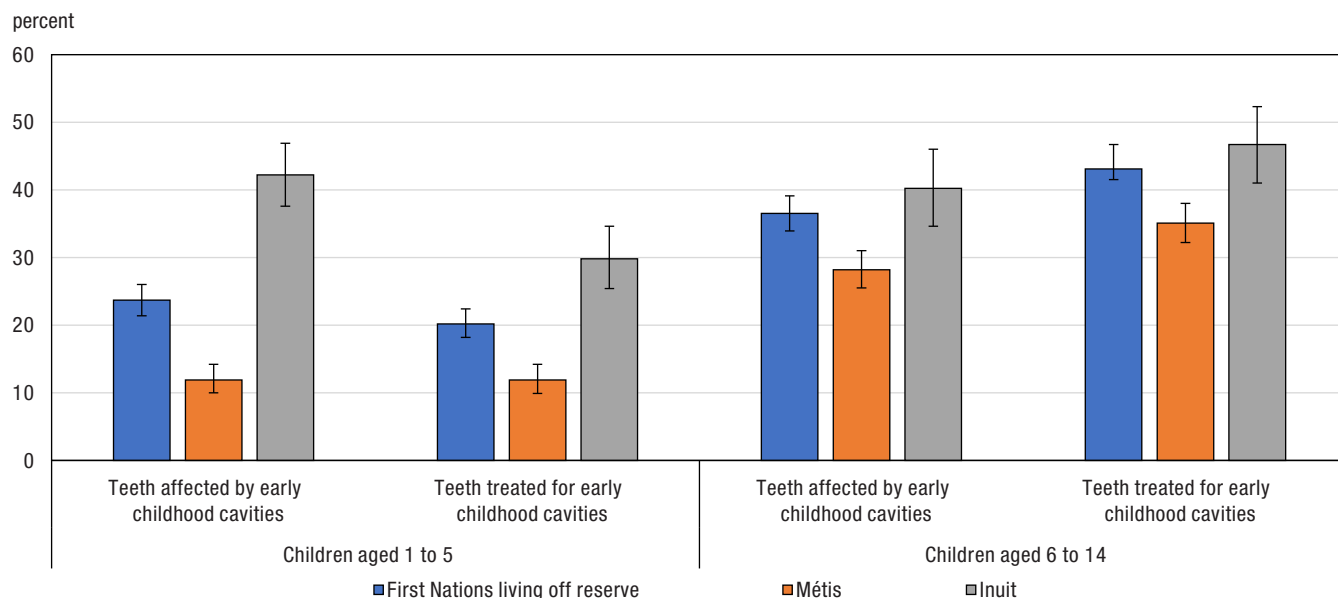
Note: Error bars represent 95% confidence intervals. The person most knowledgeable about the respondent was asked "Have the child's teeth been affected by (or treated for) early childhood cavities?" Early childhood cavities are commonly known as early childhood caries. This is a chronic condition that occurs in children under the age of 6, where one of more of the primary teeth are decayed, missing or have filled teeth surfaces. Bottle tooth decay is an example of early childhood caries.
Source: Statistics Canada, Indigenous Peoples Survey, 2022.

The 2022 IPS showed that 15.6% of Inuit children aged 1 to 14 needed dental care in the past 12 months but did not receive it, with higher unmet dental care needs among Inuit children living in Inuit Nunangat (20.3%) than among those living outside Inuit Nunangat (4.2%). Meanwhile, 6.1% of First Nations children living off reserve and 5.5% of Métis children had unmet dental care needs. Cost, lack of availability at the time required or in the area, and COVID-19 were the top reasons given for unmet dental care needs among parents of Indigenous children aged 14 and younger.

According to the 2022 IPS, during their most recent visit to a dental care professional, most First Nations children living off reserve (57.0%) and Inuit children (82.1%) used government programs, including the Non-Insured Health Benefits (NIHB) program, to cover dental care costs. Since Métis are not eligible for the NIHB program, the proportion of Métis children who used a government program to pay for dental visits was much lower (21.6%). The majority of Métis children (70.2%) had private insurance, whereas less than half of First Nations children living off reserve (43.4%) and fewer Inuit children (18.6%) had private insurance. Less than one-quarter (21.5%) of First Nations children living off reserve, 32.5% of Métis children and 8.9% of Inuit children paid for dental care out of pocket.

6.0 Infectious diseases

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi. These diseases can spread from the environment or be transmitted directly or indirectly from one person to another, resulting in illness. Factors associated with infectious diseases are varied and include sanitation and water supply, environmental and climate change, education, agriculture, trade, tourism, transport, industrial development, and housing.[69] This report focuses specifically on COVID-19 infections.

Key findings

- As of June 2023, about two in three Canadian adults said they had had at least one confirmed or suspected case of COVID-19 (64.4%). Many had been infected more than once since the pandemic started.

- Higher shares of some racialized groups reported multiple COVID-19 infections, with Black Canadians being the most affected.

- About 3.5 million Canadian adults reported having long-term symptoms after a COVID-19 infection (11.7%). Of these, 2.1 million were still dealing with symptoms as of June 2023 (6.8%), and nearly half said their symptoms had not improved over time (49.7%).

- More than one in five Canadians with long-term symptoms who were in school or working had missed days of school or work (22.3%), averaging 24 days missed.

- About 40% of people with long-term symptoms faced difficulties accessing the health care they needed.

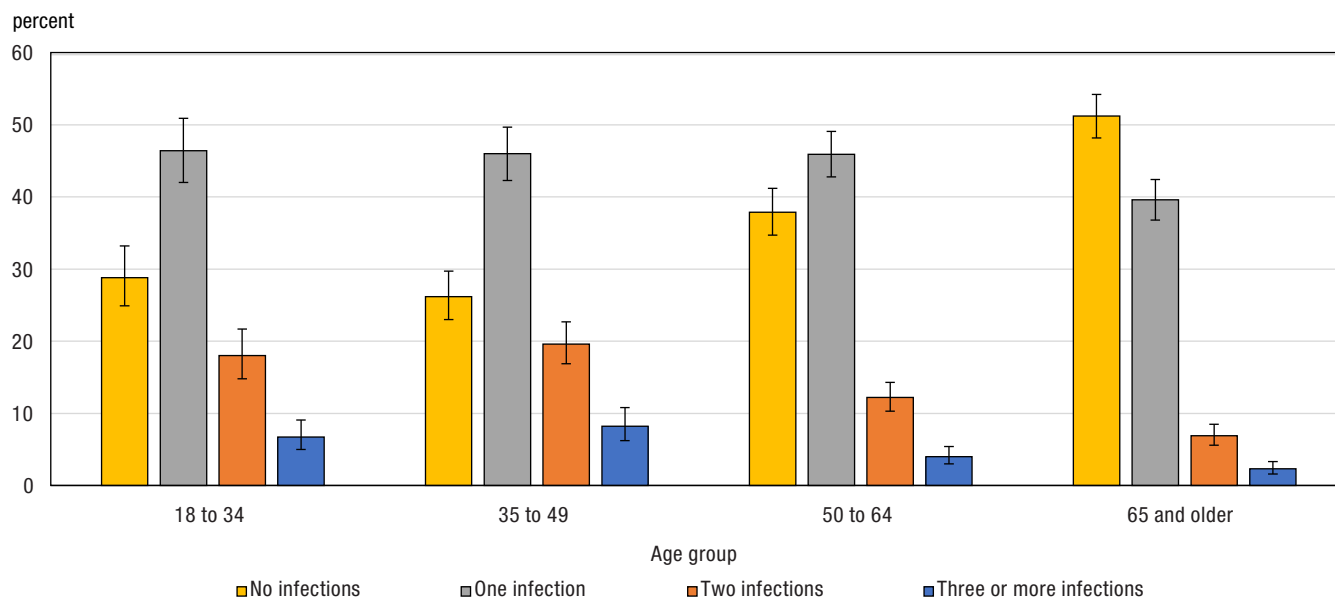
COVID-19 infection rates

According to a study using data from the Canadian COVID-19 Antibody and Health Survey, the percentage of Canadian adults who had tested positive for COVID-19 or suspected an infection increased from 38.7% in the summer of 2022 to 64.4% by June 2023.[70] By this time, 44.6% of Canadians had experienced one infection, 14.4% had had two infections and 5.4% had had three or more infections.

Did you know?

These numbers likely underestimate the true number of infections, as people are not always aware they have been infected. According to Cycle 2 of the Canadian COVID-19 Antibody and Health Survey, nearly half of Canadians who had antibodies from a previous infection had not tested positive or suspected they had been infected.[71]

Proportionally fewer adults aged 65 and older (2.3%; this figure should be used with caution) reported having had three or more infections, compared with those aged 18 to 34 (6.7%) and 35 to 49 (8.2%) (Chart 6.0).[70] A higher proportion of females than males reported having had a previous COVID-19 infection, but equal shares of both sexes reported having had multiple infections.

Chart 6.0
Number of self-reported COVID-19 infections, by age group, June 2023

percent

Notes: Some estimates do not add up because of rounding. The estimate for three or more infections among those aged 65 and older needs to be interpreted with caution.
Source: Statistics Canada, Canadian COVID-19 Antibody and Health Survey Follow-up Questionnaire, 2023.

Reinfection reporting also differed across racialized groups. Proportionally more Black Canadians (30.3%) reported having had multiple infections than Canadians with Latin American (21.7%), Chinese (18.3%), Filipino (17.9%), Arab (12.1%) and West Asian (9.1%) backgrounds.[70]

Did you know?

Indigenous people found innovative solutions to safeguard those at risk of severe COVID-19 infection, prevent the spread of the virus and curb social isolation, while ensuring continued cultural engagement.[72,73,74] These efforts faced challenges from a history of long-standing structural inequalities, such as overcrowded homes, a lack of access to clean water, insufficient medical facilities to house those with infections, health care and Internet access barriers, and the heavy burden of various chronic diseases.[70,75] To support efforts, government and service agencies ensured access to personal protective equipment and vaccines, prioritizing Indigenous communities.[76] Despite these efforts, Indigenous people experienced higher rates of infection (including severe infection), hospitalization, intensive care admission and mortality compared with non-Indigenous people.[77,78]
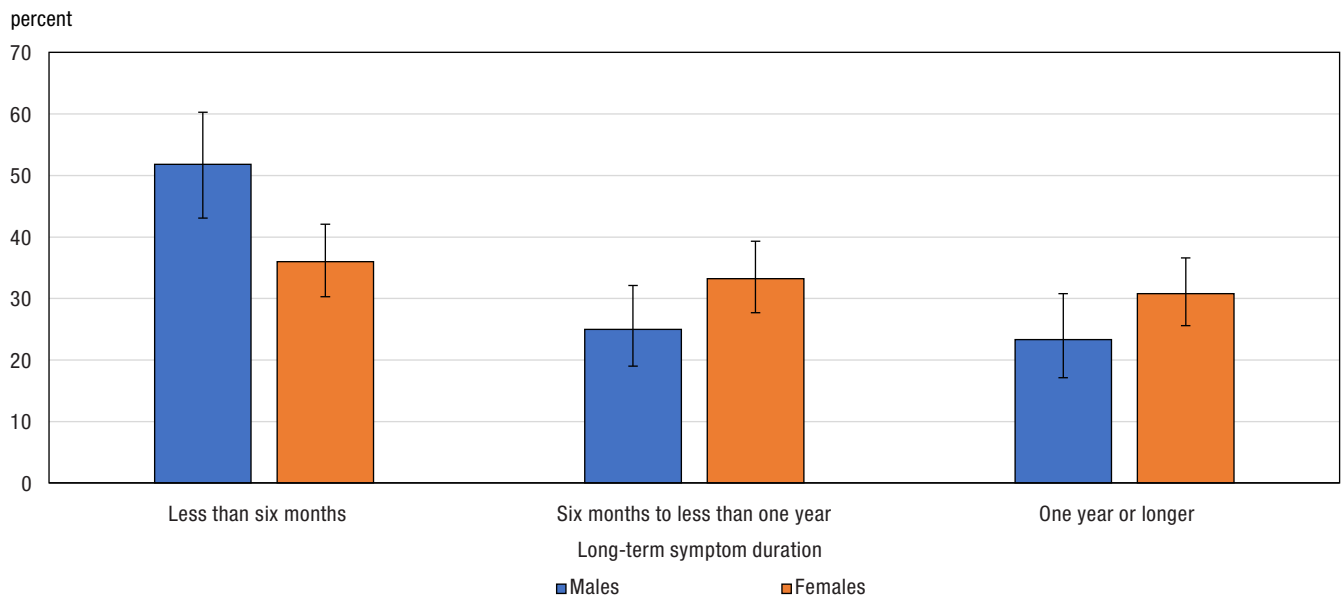

Long-term COVID-19 symptoms

As of June 2023, 19.0% of Canadian adults who had been infected with COVID-19 reported experiencing symptoms lasting three or more months after the infection.[70] This represented 11.7% of the total adult population, or 3.5 million Canadians, in the 10 provinces. The burden was significant: 6.8% of all Canadian adults, or 2.1 million people, continued to experience these long-term symptoms. The most frequently reported symptoms were fatigue (65.5%), brain fog (39.0%) and shortness of breath (28.0%).

Some Canadians were at greater risk of experiencing long-term COVID-19 symptoms. The proportion of adults with a disability reporting such symptoms was higher than that of adults without disabilities (26.8% vs. 18.3%). Similarly, proportionally more adults with one or more chronic diseases before the pandemic reported long-term COVID-19 symptoms than those without chronic diseases (24.7% vs. 14.0%).

Among Canadians still experiencing COVID-19 symptoms, about 70.0% reported having symptoms every day or almost every day at their worst. Additionally, 21.7% said they were often or always limited in their daily activities by these symptoms. Overall, 49.7% of those with ongoing symptoms reported no improvement over time.

Chart 6.1 shows that proportionally fewer females reported a resolution of their long-term symptoms (33.0%), compared with males (53.1%), and females also tended to experience their symptoms for a longer duration.

Chart 6.1
Symptom duration for Canadians reporting long-term COVID-19 symptoms, by sex at birth, June 2023

Note: Some estimates do not add up because of rounding.
Source: Statistics Canada, Canadian COVID-19 Antibody and Health Survey Follow-up Questionnaire, 2023.

Impact on school and work attendance

Long-term symptoms of COVID-19 affected many Canadians' livelihoods and education.[70] Among Canadian adults who ever experienced long-term symptoms and were employed or attending school, 22.3% missed days. On average, they missed 24 days of school or work, translating to 600,000 Canadians missing a total of about 14.5 million days.

Among employed adults with long-term COVID-19 symptoms, 5.3% applied for disability benefits or workers' compensation because of their symptoms, and 93.8% of those who applied received benefits or compensation. The most common industries for working Canadians with long-term symptoms were health care and social assistance (17.5%); professional, scientific and technical services (17.1%); and educational services (10.3%).

As of June 2023, approximately 100,000 Canadian adults had been unable to return to work or school because of their COVID-19 symptoms.

Challenges in accessing health care

As of June 2023, 46.9% of Canadian adults who reported experiencing long-term COVID-19 symptoms also stated that they had consulted a health care provider about those symptoms.[70] Family doctors and nurse practitioners were the primary points of contact, with 82.8% of those who sought health care consulting one of these professionals. Other frequently consulted health care services for long-term symptoms included specialist medical doctors (20.0%), pharmacists (18.7%) and emergency departments (17.0%). On average, those who sought health care for long-term symptoms consulted two different services.

According to the Canadian COVID-19 Antibody and Health Survey Follow-up Questionnaire, 39.7% of those who consulted a health care provider reported at least one difficulty accessing services. Of the 800,000 Canadians who faced difficulties, one in five did not receive the needed service because of these challenges. The most common problems were long waits between booking and receiving care (49.4%), appointment cancellations or delays because of the pandemic (39.6%), and trouble getting referrals (35.2%). Consulting a health care professional does not always ensure adequate treatment. In fact, 66.4% of those with long-term COVID-19 symptoms felt they did not receive sufficient treatment, service or support. Among the Canadian adults needing health care for their long-term symptoms, 12.5% reported receiving comprehensive treatment. Meanwhile, 5.7% of those still experiencing symptoms as of June 2023 had received a post-COVID-19 condition diagnosis.

Did you know?

It is well documented that Indigenous children face greater risk for serious respiratory conditions tied to the social determinants of health, including living in overcrowded homes that have poor ventilation and need major repairs.[79,80] According to the 2022 Indigenous Peoples Survey, 7.1% of First Nations children living off reserve, 8.3% of Métis children and 6.5% of Inuit children aged 1 to 14 had been diagnosed with a respiratory infection such as tuberculosis, pneumonia, respiratory syncytial virus or bronchiolitis in the past 12 months.[24] Respiratory infections were more common among younger Indigenous children aged 1 to 5 (12.7%) than older children aged 6 to 14 (5.2%), excluding those living on reserve. Preventing, diagnosing and treating lung conditions are important for the immediate and long-term health of children.

7.0 Mortality

The previous version of *Health of Canadians* presented crude mortality rates from 2000 to 2020. While these are accurate for yearly death incidence, they are not ideal for year-to-year comparisons.[81] In this report, **age-standardized mortality rates (ASMRs)** are presented (standardized to the 2021 Canadian population). ASMRs remove the effects of differences in the age structure of a population, allowing for better comparisons over time.

Key findings

- The ASMR (for all causes of death) generally declined from 2000 to 2019 but increased sharply in 2020, the year in which the COVID-19 pandemic reached Canada. From 2020 to 2021 the ASMR decreased but has fluctuated since.

- Cancer and heart disease remained the two leading causes of death in Canada, accounting for 43.7% of deaths in 2023.

- The number of COVID-19 deaths increased from 14,617 in 2021 to 19,906 in 2022, the highest number recorded since the beginning of the pandemic, but dropped by 60% in 2023 to 7,963 deaths.
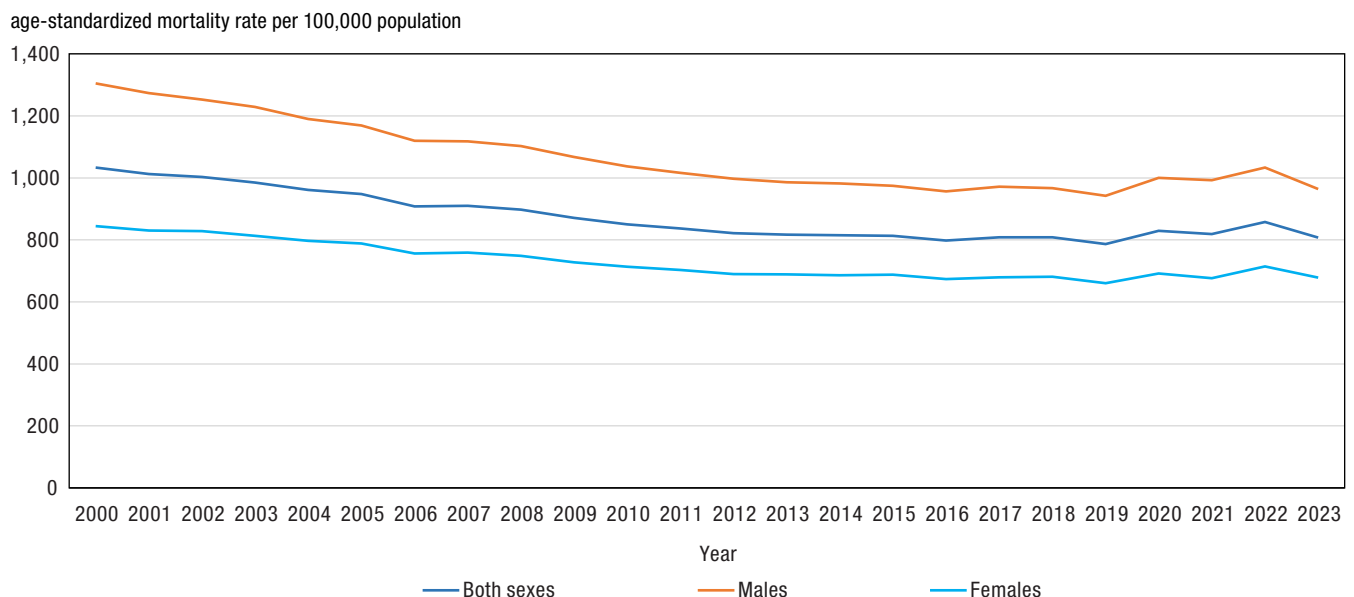

Age-standardized mortality rates

The ASMR generally declined from 2000 (1033.7 deaths per 100,000 population) to 2019 (786.3) (Chart 7.0).[82] However, in 2020, the year in which the COVID-19 pandemic reached Canada, there was a spike in the ASMR (829.6 deaths per 100,000 population). From 2020 to 2021 the ASMR decreased (819.1 deaths per 100,000 population), but it has fluctuated since.

From 2000 to 2023, the ASMR was consistently higher among males than females (Chart 7.0).

Chart 7.0
Age-standardized mortality rate per 100,000 population, by sex at birth, 2000 to 2023

age-standardized mortality rate per 100,000 population

Source: Statistics Canada, Table 13-10-0800-01 Deaths and mortality rate (age standardization using 2011 population), by selected grouped causes.

Leading causes of death

In Canada, cancer and heart disease remained the leading causes of death, together accounting for 43.7% of deaths in 2023, up from 42.4% in 2022.

Other prominent causes of death in 2023 included accidents (unintentional injuries), cerebrovascular disease (stroke), chronic lower respiratory diseases, COVID-19, diabetes mellitus, influenza and pneumonia, Alzheimer's disease, and chronic liver disease and cirrhosis (Table 7.0). In total, these 10 causes (including cancer and heart disease) accounted for 221,147 deaths, or 67.8% of all deaths.

COVID-19-related deaths rose from 14,617 in 2021 to 19,906 in 2022, marking the highest toll since the start of the pandemic. However, in 2023, COVID-19 deaths decreased by 60% (7,963 deaths). Still, COVID-19 continued to disproportionately affect older individuals in 2023. Approximately 7 in 10 COVID-19 deaths (69%) were of people aged 80 and older, while one-quarter of deaths were of those aged 65 to 79.

Deaths from influenza and pneumonia also saw an increase, rising from 4,139 in 2021 to 6,363 in 2023. Deaths from these illnesses had reached an all-time low in 2021, largely because of public health measures aimed at reducing COVID-19 transmission.

Table 7.0
Top 10 leading causes of death, Canada, 2023

Rank of leading cause of death[1]	Leading causes of death [ICD-10][2]	Number of deaths
1	Malignant neoplasms (cancer) [C00-C97]	84,629
2	Diseases of heart [I00-I09, I11, I13, I20-I51]	57,890
3	Accidents (unintentional injuries) [V01-X59, Y85-Y86]	20,597
4	Cerebrovascular diseases [I60-I69]	13,833
5	Chronic lower respiratory diseases [J40-J47]	12,994
6	COVID-19 [U07.1, U07.2, U10.9]	7,963
7	Diabetes mellitus [E10-E14]	7,273
8	Influenza and pneumonia [J09-J18]	6,363
9	Alzheimer's disease [G30]	5,231
10	Chronic liver disease and cirrhosis [K70, K73-K74]	4,374

1. The ranking of the leading causes of death is based on the number of deaths.
2. World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).
Note: Deaths in Yukon are included for 2023.
Source: Statistics Canada. Table 13-10-0933-01 Leading causes of death, total population (age standardization using 2021 population).

Did you know?

A recent study found that the COVID-19 ASMR was 4.5 times higher among First Nations people than non-Indigenous people.[28] COVID-19 mortality rates were five times higher among First Nations females and two times higher among Métis females compared with their non-Indigenous counterparts. A higher proportion of COVID-19 deaths were among First Nations people and Métis with three or more comorbidities. Further analysis of various social determinants of health associated with COVID-19 mortality found that unsuitable and inadequate housing and lower income were risk factors for COVID-19 mortality among First Nations people and Métis in private dwellings.

Health behaviours

8.0 Health behaviours

Key findings

- In 2023, 21.6% of Canadians aged 18 and older living in the provinces reported eating fruits or vegetables five or more times per day, a proportion that did not change compared with 2021.

- A greater share of women (25.8%) than men (17.3%) reported eating fruits or vegetables five or more times per day in 2023 across all age groups.

- The proportion of adults who reported eating fruits or vegetables five or more times per day was lower for those in the lowest income quintile (20.4%), compared with those in the highest quintile (22.8%).

- In 2022, 90.3% of mothers who had had a baby in the previous five years initiated breastfeeding or gave breast milk to their baby, and 36.4% of them exclusively breastfed for at least six months.

Physical activity and sleep

Physical activity, sleep and nutrition are key pillars of health that work together to enhance overall well-being. Physical activity boosts cardiovascular health, strengthens muscles and improves mood.[83] Adequate sleep is crucial for recovery, cognitive function and emotional balance.[84] Proper nutrition fuels the body with the vitamins and minerals necessary for optimal performance and immune function.[85]

In 2026, Statistics Canada will release the first-ever results for directly measured sleep in Canada. Sleep and physical activity data are being collected using devices called accelerometers in Cycle 7 of the Canadian Health Measures Survey.[86]

Did you know?

Using six cycles of the Canadian Health Measures Survey (from 2007 to 2019) researchers found that while 45% of Canadian adults get the recommended 150 minutes of physical activity per week, some people have risk factors that may keep them from meeting the recommended amount.[88]

For example, women were less active than men, regardless of age, income, education level, family arrangement and health status. Older adults were less active than younger adults overall, but older adults with lower income, with lower education, who live alone and who smoke were less active than older adults without these risk factors. Younger Canadians were more active than older adults, but those with children in the household were less active than younger Canadians without children.

Did you know?

Based on data from the 2019 Canadian Armed Forces Health Survey, less than half (42%) of Regular Force members reported getting the recommended amount of sleep (7 to 10 hours).[89] Females were more likely than males to report a usual sleep duration in the recommended range (49% vs. 40%), but females were also more likely to report trouble falling or staying asleep (32% vs. 24%) and to say that sleep was not refreshing (64% vs. 58%). Difficulty staying awake was less frequently reported and did not differ between females (6%) and males (5%).

Nutrition

Maintaining a diet rich in fruits and vegetables contributes to a lower risk of chronic diseases, such as hypertension and type 2 diabetes, and a reduced risk of cancer and cardiovascular disease, which are two of the leading causes of death in Canada.[89,90]


Did you know?

Fruit and vegetable consumption is part of the Quality of Life Framework for Canada, which aims to measure what matters most to Canadians, to help drive evidence-based budgeting and decision making at the federal level.[2]

From 2015 to 2021, the percentage of adults who reported eating fruits or vegetables five or more times per day declined. However, the proportion remained stable from 2021 (21.8%) to 2023 (21.6%). In 2023, the percentage was higher in Quebec (27.1%) and lower in the Atlantic provinces (13.4% in Newfoundland and Labrador, 14.7% in Prince Edward Island, 16.7% in Nova Scotia, and 16.8% in New Brunswick) and in Ontario (19.1%). Consumption also varied by age. In 2023, the share of people who reported consuming fruits or vegetables five or more times per day was highest among Canadians aged 65 and older (24.5%) and lowest among younger adults aged 18 to 34 (17.6%). Across all age groups in 2023, a higher percentage of women reported eating fruits or vegetables five or more times per day (25.8%), compared with men (17.3%) (Chart 8.0).

Chart 8.0
Canadians aged 18 and older reporting eating fruits and vegetables five or more times per day, by age group and gender, 2023
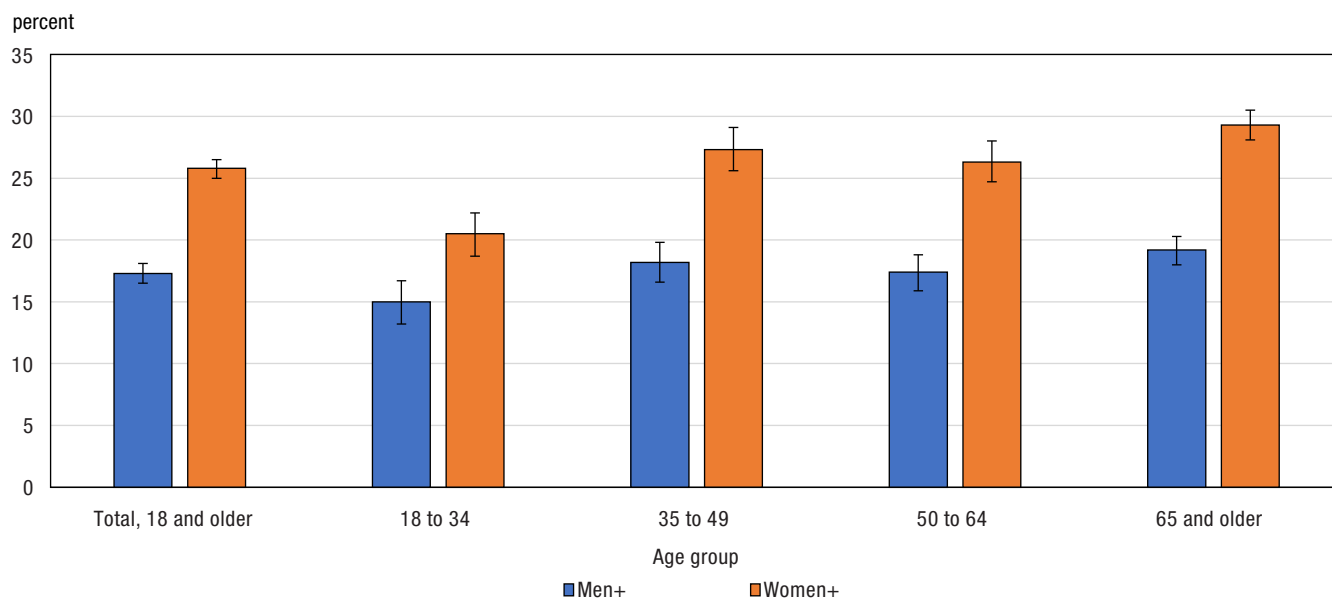
Notes: Territorial data are not included in total population estimates. "Men+" includes men, as well as some non-binary people. "Women+" includes women, as well as some non-binary people.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

The percentage of adults who reported eating fruits or vegetables five or more times per day was lower in 2023 among Canadians identifying as South Asian (14.3%), Chinese (19.9%) and West Asian (14.0%), compared with the non-racialized population (23.0%).

A smaller proportion of adults in the lowest income quintile (20.4%) than in the highest (22.8%) reported eating fruits or vegetables five or more times per day. However, the gap has narrowed, as the difference was 3 percentage points in 2023, compared with 5 percentage points in 2021 (19.1% vs. 24.0%).

A higher percentage of non-immigrants (22.2%) reported consuming fruits or vegetables five or more times per day in 2023, compared with immigrants (20.2%); this difference was also found in 2021. However, in 2023, a lower percentage of immigrants who were admitted to Canada in the last 10 years reported eating fruits or vegetables five or more times per day (17.0%), compared with immigrants who were admitted more than 10 years ago (21.7%). No difference was found in 2021 (19.3% vs. 19.9%).

Breastfeeding

Breast milk offers numerous benefits: it is generally easy to digest, and its composition adapts to fulfill the nutritional needs of growing infants.[92] Breastfeeding also provides protection against several infectious diseases during infancy, reduces the risk of sudden infant death syndrome, and may help lower the mother's risk of breast and ovarian cancers. For these reasons and others, both Health Canada and the World Health Organization recommend exclusively breastfeeding infants for the first six months. However, each parent's situation is unique, and they must decide on the best feeding method for their baby based on various factors.

In 2022, 90.3% of mothers who had had a baby in the previous five years started breastfeeding or gave breast milk (e.g., in a bottle) to their baby, a reduction from 93.8% in 2021. In 2022, a greater proportion of respondents in British Columbia (98.5%) and a lower proportion of those in Newfoundland and Labrador (71.7%) started breastfeeding or gave breast milk to their baby, compared with the rate for Canada overall (excluding the territories). Just over one-third of mothers (36.4%) exclusively breastfed their child for at least six months in 2022, down from 40.7% in 2021.

9.0 Substance use

Key findings

- In 2023, Canadian adults aged 18 and older reported the following drinking behaviours:
  - ▶ Over half (54.5%) reported having zero drinks in the week before the survey.
  - ▶ Proportionally more immigrants reported having zero drinks in the week before the survey (68.2%) than non-immigrants (48.5%).
  - ▶ A larger share of Canadians in the highest-income households reported having seven or more drinks in the week before the survey (21.5%) than those in the lowest-income households (10.7%).
  - ▶ Proportionally more men (19.3%) than women (11.1%) and more Canadians living in rural areas (19.2%) than those living in population centres (14.4%) reported having seven or more drinks in the week before the survey.
- Heavy drinking (having five or more drinks for men or four or more drinks for women, on one occasion, at least once a month in the past year) increased from 16.6% in 2021 to 21.0% in 2022, then decreased to 19.4% in 2023, among Canadians aged 18 and older.
- Daily or occasional cigarette smoking was down slightly from 12.5% in 2022 to 11.4% in 2023.
  - ▶ In 2023, proportionally more adults in the lowest income quintile reported smoking cigarettes daily or occasionally (16.0%), compared with those in the highest quintile (8.2%).
- In 2023, 6.2% of Canadian adults reported vaping.
  - ▶ Compared with non-racialized adults (6.5%), vaping was less common among Chinese (3.8%), South Asian (4.3%), Latin American (3.6%), Black (2.7%) and Southeast Asian (1.8%) adults and more common among Arab adults (11.8%) in 2023.
- The share of people reporting daily or almost daily cannabis use in the past 12 months decreased in 2023 (5.7%) from 2022 (6.5%).

Alcohol, tobacco and cannabis are commonly used substances that could lead to increased risk of chronic disease, including chronic liver disease, chronic respiratory disorders, certain cancers and cardiovascular diseases, and premature death.

Alcohol

Did you know?

In 2023, the Canadian Centre on Substance Use and Addiction released guidance developed by a panel of scientific experts recommending that adults aged 18 and older who drink alcohol should consider drinking less to reduce the risk of injury and violence, and many health problems that can shorten life.[94] This guidance presents a continuum of risk associated with weekly alcohol use:

- Zero drinks per week (no risk): Not drinking has benefits such as better health and better sleep.
- Two standard drinks or less per week (low risk): You are likely to avoid alcohol-related consequences for yourself or others at this level.
- Three to six standard drinks per week (moderate risk): The risk of developing several types of cancer, including breast and colon cancer, increases at this level.
- Seven standard drinks or more per week (increasingly high risk): The risk of heart disease or stroke increases significantly at this level.

Each additional standard drink increases the risk of alcohol-related consequences. A standard drink is 341 ml (12 ounces) of beer, cider, cooler or a ready-to-drink cocktail (5% alcohol); 142 ml (5 ounces) of wine (12% alcohol); or 43 ml (1.5 ounces) of spirits such as whisky, vodka or gin (40% alcohol).

Number of drinks in a week

In 2023, over half (54.5%) of Canadians aged 18 and older reported having zero drinks in the seven days preceding the survey, 15.2% had one or two, 15.2% had three to six and 15.1% had seven or more (Chart 9.0).

Proportionally more men (19.3%) than women (11.1%) and more Canadians living in rural areas (19.2%) than those living in population centres (14.4%) reported having seven or more drinks in the past week in 2023.

At the provincial level, a higher share of those living in Quebec reported having seven or more drinks in the past seven days (18.1%), compared with the national average (15.1%) in 2023. Conversely, a lower share of those living in New Brunswick (12.7%), Ontario (14.0%), Saskatchewan (12.5%) and Alberta (13.8%) reported having seven or more drinks in the past week.

Compared with non-immigrants (48.5%), immigrants more commonly reported having zero drinks in the past week (68.2%). A higher percentage of adults with a disability (65.1%) than those without a disability (51.9%) reported the same. Proportionally more lower-income adults than adults in the highest income quintile reported no alcohol consumption in the past week (67.3% vs. 41.7%) and fewer reported having seven or more drinks (10.7% vs. 21.5%).

Canada's low-risk alcohol drinking guidelines currently recommend no more than 2 drinks per day or 10 drinks per week for women and no more than 3 drinks per day or 15 drinks per week for men. A larger proportion of adults in the highest household income quintile (20.4%) exceeded these guidelines, compared with those in the lowest quintile (11.1%).[2]

Chart 9.0
Self-reported alcohol consumption per week among Canadians aged 18 and older, overall and by gender, 2023

percent

Number of drinks

■ Total population (excluding territories)   ■ Men+   ■ Women+
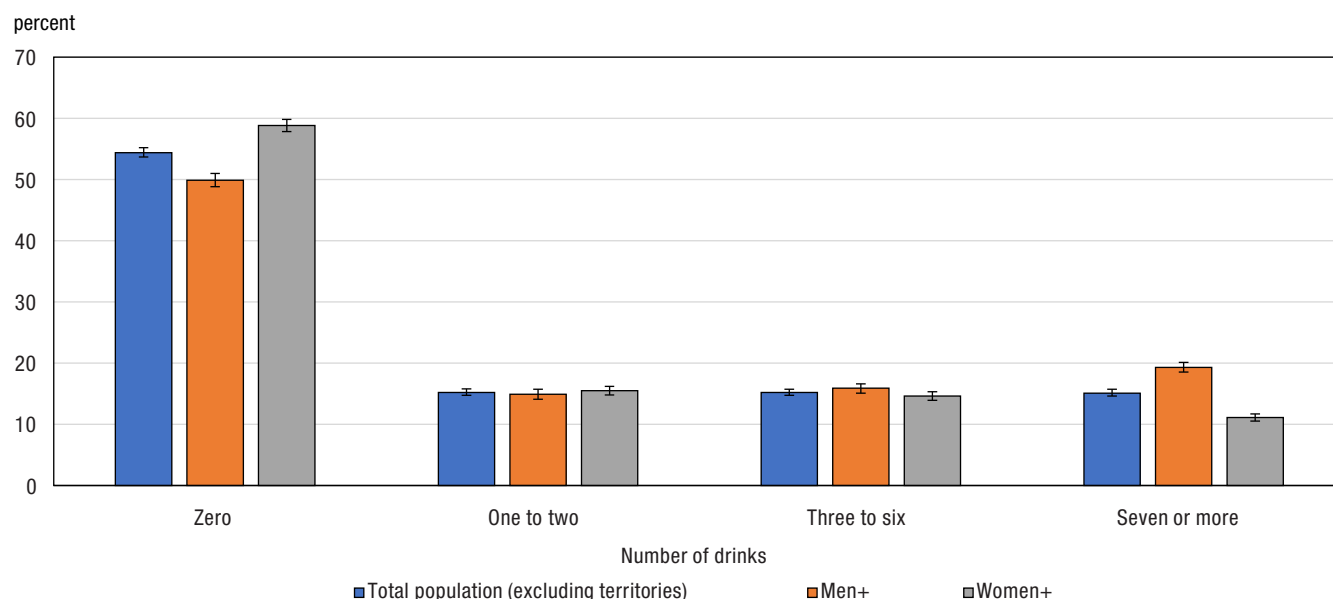
Notes: Territorial data are not included in total population estimates. Each drink represents a standard drink: 341 ml (12 ounces) of beer, cider, cooler or a ready-to-drink cocktail (5% alcohol); 142 ml (5 ounces) of wine (12% alcohol); or 43 ml (1.5 ounces) of spirits such as whisky, vodka or gin (40% alcohol). "Men+" includes men, as well as some non-binary people. "Women+" includes women, as well as some non-binary people.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Heavy drinking

The proportion of Canadians aged 18 and older who reported heavy drinking remained stable from 2015 to 2019, ranging from 19% to 20%, before falling in 2020 (17.7%). A further decline was observed in 2021 (16.6%), followed by an increase in 2022 (21.0%) and another decrease in 2023 (19.4%) (Chart 9.1). In 2023, heavy drinking did not differ between 18- to 34-year-old men (24.8%) and women (21.8%). However, with increasing age, a higher percentage of men were heavy drinkers compared with women (24.1% vs. 16.4% for 50- to 64-year-olds).

In 2023, proportionally more adults whose sexual orientation is lesbian, gay, bisexual or another orientation that is not heterosexual (LGB+) reported heavy drinking (25.3%), compared with heterosexual adults (19.5%). This trend was not observed in 2021 or 2022. Of note, the share of LGB+ women who were heavy drinkers (25.9%) was higher than that of their heterosexual counterparts (16.4%), whereas no sexual orientation difference was observed among men. A smaller share of adults with a self-reported disability were heavy drinkers (13.4%), compared with those without disabilities (20.3%).

Proportionally fewer immigrants than non-immigrants reported heavy drinking in 2021 (7.8% vs. 20.0%), 2022 (10.2% vs. 25.4%) and 2023 (9.4% vs. 23.4%) (Chart 9.3), a trend that has been seen since 2015. Also, a higher prevalence of heavy drinking was reported among non-racialized Canadians (22.9%), compared with all other racialized groups (apart from the Korean and Japanese groups, where there was no difference). In 2023, heavy drinking was more prevalent among people in the highest household income quintile (26.6%), compared with the lowest (14.5%) (Chart 9.2).

Tobacco use and vaping

Tobacco use

The proportion of daily or occasional cigarette smokers declined from 15.7% in 2019 to 12.7% in 2021, remained stable at 12.5% in 2022 and decreased again to 11.4% in 2023 (Chart 9.1). The decline in 2023 was observed for both men (13.4%) and women (9.5%) compared with 2022 (14.4% and 10.6%, respectively). Although smoking was less common among women than men and among younger adults (aged 18 to 34) than older adults, it was more common among LGB+ women (12.5%) and LGB+ younger adults (13.0%), compared with their heterosexual counterparts (9.1% and 9.4%, respectively).

The share of Canadians in the lowest income quintile who reported smoking cigarettes daily or occasionally (16.0%) was nearly twice as high as that of Canadians in the highest quintile (8.2%), in 2023 (Chart 9.2).

In 2022, a greater share of Canadians in the territories reported smoking cigarettes, compared with Canada overall. Proportionally fewer Canadians in British Columbia and more Canadians in Newfoundland and Labrador, Nova Scotia, and Quebec reported smoking cigarettes in 2022 and 2023.

From 2021 to 2023, the share of immigrants who were daily or occasional smokers was lower than that of non-immigrants, and no difference was found by period of immigration (Chart 9.3). Smoking was higher among non-racialized populations (12.7%), compared with all other racialized groups (except Arab and West Asian, where there was no difference). Proportionally more Canadians with a disability (17.1%) reported smoking, compared with those without disabilities (10.9%).

Vaping

In 2023, 6.2% of Canadian adults had used an e-cigarette or vaped in the previous 30 days, a proportion that was stable after a previous increase from 4.5% in 2021 to 5.7% in 2022 (Chart 9.1). Vaping prevalence was higher in Alberta (7.7%) and lower in Ontario (5.4%), compared with the average across all provinces in 2023.

In 2022 and 2023, vaping was most common among 18- to 34-year-old adults, about 13% of whom had used an e-cigarette or vaped in the previous 30 days, up from 10.0% in 2021. Proportionally more men (7.4%) than women (5.0%) reported vaping in 2023, and the difference was most notable among 18- to 34-year-olds (16.1% for men vs. 10.3% for women). Vaping was higher among gay or lesbian (10.3%) and bisexual or pansexual (12.1%) adults, compared with heterosexual adults (5.8%) in 2023. More LGB+ adults aged 18 to 34 (13.4%) and 35 to 49 (17.4%) vaped, compared with their heterosexual counterparts (5.8% and 12.8%, respectively).

In 2023, vaping was less common among immigrants (3.7%) than non-immigrants (7.0%). Among immigrants, vaping was lower among those who were admitted to Canada more than 10 years ago (3.3%), compared with more recent immigrants (5.4%). Compared with non-racialized adults (6.5%), vaping was less common among Chinese (3.8%), South Asian (4.3%), Latin American (3.6%), Black (2.7%) and Southeast Asian (1.8%) adults in 2023. However, a higher percentage of Arab adults (11.8%) reported vaping.

Cannabis

Daily or almost daily use of cannabis is strongly associated with adverse health outcomes, particularly related to mental health.[94,95] Since information on daily or almost daily cannabis use in the past 12 months began to be collected annually in 2019, the prevalence has remained stable (5.7% to 5.8%) until 2022, when it increased to 6.5%. It then decreased in 2023 back to 5.7% (Chart 9.1). Proportionally more young adults aged 18 to 34 reported cannabis use (8.1%), compared with all older age groups. Daily or almost daily cannabis use was higher among men across all age groups, particularly men aged 18 to 34 (9.8%), compared with women of the same age (6.2%). The share of bisexual or pansexual Canadians who reported using cannabis daily or almost daily was nearly three times as high as that of heterosexual Canadians in 2022 (18.1% vs. 6.2%) and 2023 (15.5% vs. 5.3%). Cannabis use was also greater among gay or lesbian adults (11.8%) than heterosexual adults (5.3%) in 2023. The same year, cannabis use was higher among LGB+ groups than heterosexual people across all age groups (except those aged 65 and older). Notably, cannabis use was almost 9 percentage points higher among LGB+ young adults aged 18 to 34 compared with their heterosexual counterparts (16.0% vs. 7.1%).

Differences by income have persisted since 2019, with proportionally more Canadians in the lowest household income quintile reporting daily or almost daily cannabis use, compared with those in the highest (6.8% vs. 4.9% in 2023) (Chart 9.2).

In 2022, people in Yukon (13.8%), the Northwest Territories (14.5%) and Nunavut (29.3%) used cannabis daily or almost daily at more than double the rate for Canada overall (6.5%). In 2023, daily or almost daily cannabis use was lower in Quebec (2.9%) and higher in Nova Scotia (8.2%), New Brunswick (6.6%) and British Columbia (6.1%), compared with Canada overall (excluding the territories).

Proportionally fewer immigrant adults reported using cannabis daily or almost daily compared with non-immigrants in 2021 (2.0% vs. 7.2%), 2022 (2.1% vs. 8.4%) and 2023 (1.6% vs. 7.5%). In 2023, among immigrants, a greater share of those who were admitted to Canada more than 10 years ago reported using cannabis daily or almost daily, compared with those who were admitted to Canada in the last 10 years (1.8% vs. 0.9%) (Chart 9.3).

Cannabis use was lower among the South Asian (1.9%), Chinese (1.1%), Black (4.5%), Filipino (1.4%) and Latin American (2.2%) groups, compared with the non-racialized group (6.7%).

Proportionally more Canadians with a disability (11.5%) reported using cannabis in 2023, compared with those without disabilities (5.0%).

Chart 9.1
Heavy drinking, current smoking, e-cigarette or vaping device use, and cannabis use among Canadians aged 18 and older, 2021 to 2023
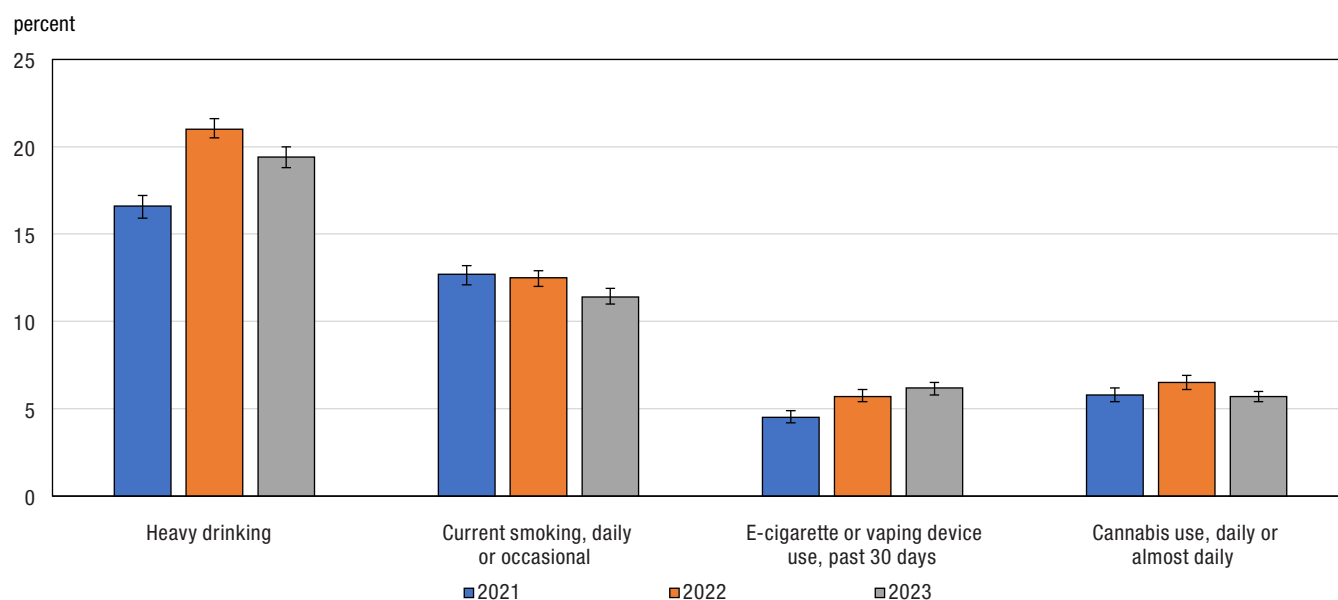
Notes: Territorial data are not included in annual estimates. Heavy drinking is defined as having five or more drinks for men aged 18 and older, or four or more drinks for women, on one occasion, at least once a month in the past year. Daily smokers are those who reported smoking cigarettes every day (excluding alternative smoking products), while occasional smokers are those who reported smoking cigarettes occasionally. This includes former daily smokers who now smoke occasionally.
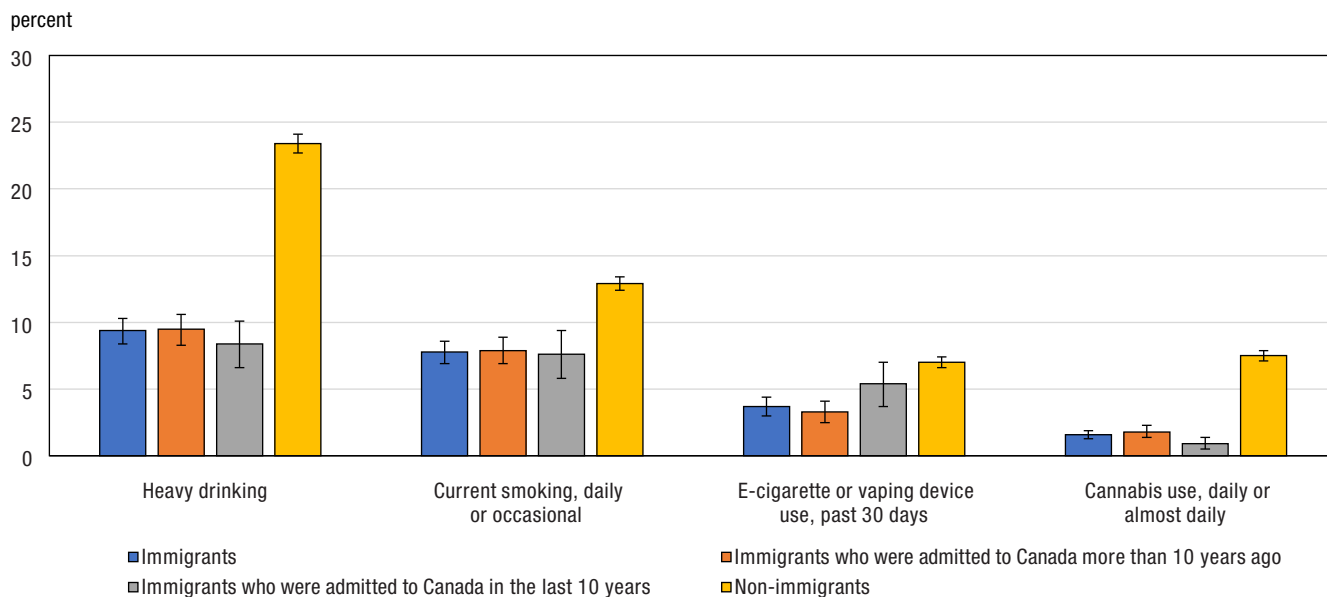**Sources:** Statistics Canada, Canadian Community Health Survey, 2021 to 2023; Table 13-10-0905-01 Health indicator statistics, annual estimates.

Chart 9.2

Heavy drinking, current smoking, e-cigarette or vaping device use, and cannabis use among Canadians aged 18 and older, by household income quintile, 2023
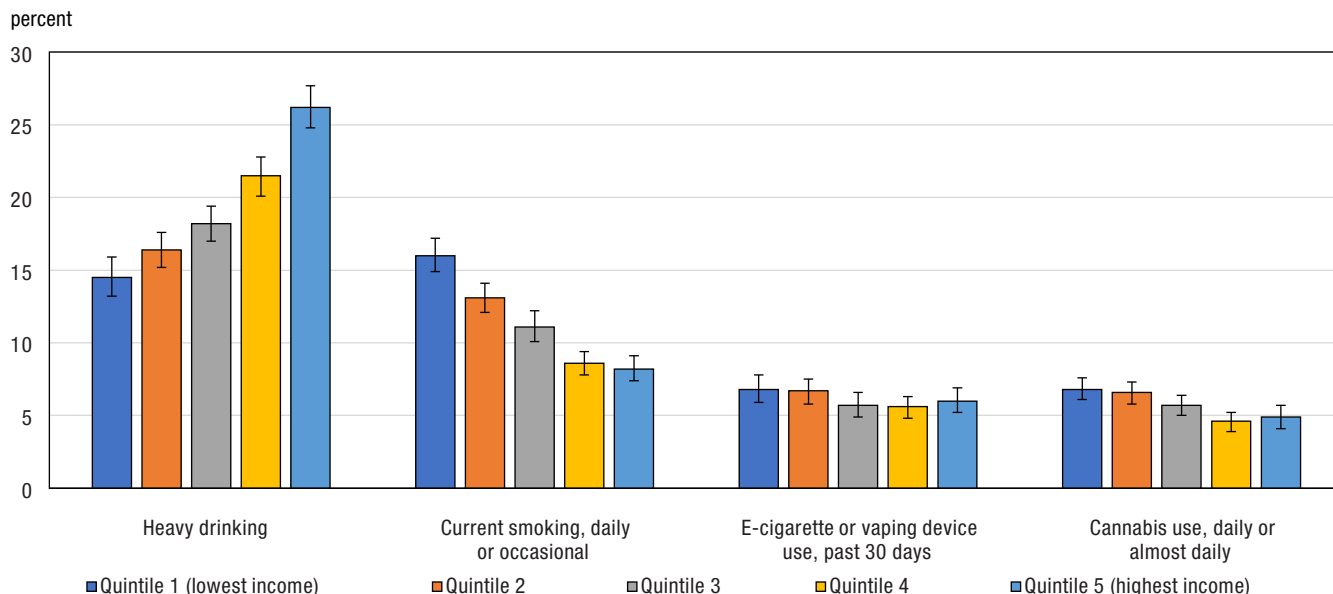
percent

■ Quintile 1 (lowest income)   ■ Quintile 2   ■ Quintile 3   ■ Quintile 4   ■ Quintile 5 (highest income)

Notes: Territorial data are not included in annual estimates. Heavy drinking is defined as having five or more drinks for men aged 18 and older, or four or more drinks for women, on one occasion, at least once a month in the past year. Daily smokers are those who reported smoking cigarettes every day (excluding alternative smoking products), while occasional smokers are those who reported smoking cigarettes occasionally. This includes former daily smokers who now smoke occasionally.
Source: Statistics Canada, Canadian Community Health Survey, 2023; Table 13-10-0906-01 Health indicator statistics, annual estimates, by household income quintile and highest level of education.

Chart 9.3

Heavy drinking, current smoking, e-cigarette or vaping device use, and cannabis use among Canadians aged 18 and older, by immigrant status and period of immigration, 2023

percent

■ Immigrants   ■ Immigrants who were admitted to Canada more than 10 years ago
■ Immigrants who were admitted to Canada in the last 10 years   ■ Non-immigrants

Notes: Territorial data are not included in annual estimates. Heavy drinking is defined as having five or more drinks for men aged 18 and older, or four or more drinks for women, on one occasion, at least once a month in the past year. Daily smokers are those who reported smoking cigarettes every day (excluding alternative smoking products), while occasional smokers are those who reported smoking cigarettes occasionally. This includes former daily smokers who now smoke occasionally. Immigrants include people who are, or who have ever been, landed immigrants or permanent residents. They have been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this category. Immigrants who were admitted to Canada in the last 10 years include people who first obtained landed immigrant or permanent resident status on the survey date or in the 10 years before. Immigrants who were admitted to Canada more than 10 years ago include people who first obtained landed immigrant or permanent resident status more than 10 years prior to the survey date. Non-immigrants include people who are Canadian citizens by birth.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Opioids, stimulants and illicit drugs

According to the 2022 Mental Health and Access to Care Survey, 7% of Canadians aged 15 and older reported having used an illicit drug or having used a medicine non-medically at least once in the past 12 months. This included substances such as club drugs, heroin, solvents and other illicit drugs, and the non-medical use of prescription sedatives, analgesics or stimulants. The proportion of adults aged 44 and younger (9.6%) reporting drug use was about 2.3 times that of adults aged 45 and older (4.2%). About 7.2% of the people who reported having used drugs met the diagnostic criteria for a substance use disorder.

Did you know?

The Canadian Wastewater Survey has been regularly collecting wastewater samples from municipalities across the country since 2019 to test for various drugs, such as stimulants. Stimulants include controlled drugs like cocaine ("coke"), methamphetamine ("crystal meth"), MDMA ("ecstasy") and amphetamines (e.g., "speed" or "uppers"). Amphetamines are also available by prescription to treat conditions such as attention deficit hyperactivity disorder. The survey found that amphetamine levels rose in the wastewater of several Canadian cities before 2023 but stabilized in 2023.[97] Conversely, cocaine levels continued to increase into 2023.

Access to health care

<div>

Key findings

- While most Canadians (82.8%) had a regular health care provider in 2023, this proportion was lower than in 2022 (85.8%).

- The share of Canadians aged 18 to 34 with a regular health care provider (73.6%) was nearly 20 percentage points below that of Canadians aged 65 and older (92.0%).

- Proportionally more women (86.6%) than men (78.9%) had a regular health care provider.

- In 2023, compared with the non-racialized population (83.8%), a lower proportion of Arab (77.5%), Black (72.3%), Korean (70.7%), Latin American (73.4%) and Chinese (80.4%) adults had a regular health care provider, whereas a greater proportion of Filipino adults (87.2%) had one.

- Close to 3 million Canadians aged 15 and older in the provinces reported unmet health care needs (9.2%) in 2022, an increase from the previous year (7.9%). Unmet needs were higher in the Atlantic provinces than the average across all provinces and higher among females than males.

- While nearly 1.4 million Canadians reported using home care services in 2023, 2.0% of Canadian adults, or more than 600,000 people, reported unmet home care needs.

- Among adults aged 65 and older, a greater proportion of women used home care services (12.1%), compared with men (8.5%).

- As in 2021 and 2022, the percentage of adults with unmet home care needs in 2023 was greater among Canadians in the lowest household income quintile (4.3%), compared with the highest quintile (1.2%).

</div>

10.0 Access to a regular health care provider

A **regular health care provider** is a health professional that a person regularly consults with when they need care or advice about their health. This can include a family doctor or general practitioner, a medical specialist, a nurse practitioner, or another health care provider.

After remaining stable at around 85% from 2017 to 2022, the proportion of Canadian adults who reported having a regular health care provider decreased to 82.8% in 2023. The types of health care providers Canadians regularly consulted with also changed from 2022 to 2023. Proportionally fewer people reported regularly consulting with a doctor or general practitioner (from 75.1% in 2022 to 68.8% in 2023), and more reported regularly consulting with a medical specialist (from 4.5% in 2022 to 5.3% in 2023) or another health care provider (from 3.6% in 2022 to 6.2% in 2023). The share who regularly consulted with a nurse practitioner did not change (2.5% in 2022 and 2023).

Access to a regular health care provider varied across Canada. A higher percentage of adults in Ontario (87.6%), Manitoba (84.9%) and Alberta (85.4%) had a regular health care provider in 2023, compared with Canada overall (excluding the territories). Conversely, a lower percentage of adults in Newfoundland and Labrador (78.1%), Prince Edward Island (73.1%), Nova Scotia (79.2%), and Quebec (74.2%) had a regular health care provider. In 2023, as in previous years, proportionally more Canadians in rural communities had a regular health care provider (84.2%), compared with those living in population centres (82.5%). In 2022, the proportion of Canadians with a regular health care provider was lower in Yukon (77.5%), the Northwest Territories (59.9%) and Nunavut (39.9%), compared with Canada overall (85.7%).

From 2021 to 2023, proportionally more women reported having a regular health care provider, compared with men (86.6% vs. 78.9% in 2023). In 2023, the percentage of 18- to 34-year-olds with a regular health care provider (73.6%) was lower than for all other age groups, while the proportion of those aged 65 and older was the highest (92.0%). Lower proportions of gay or lesbian (78.5%) and bisexual or pansexual (77.5%) adults had a regular health care provider, compared with heterosexual adults (82.8%), in 2023. Compared with Canadian adults without
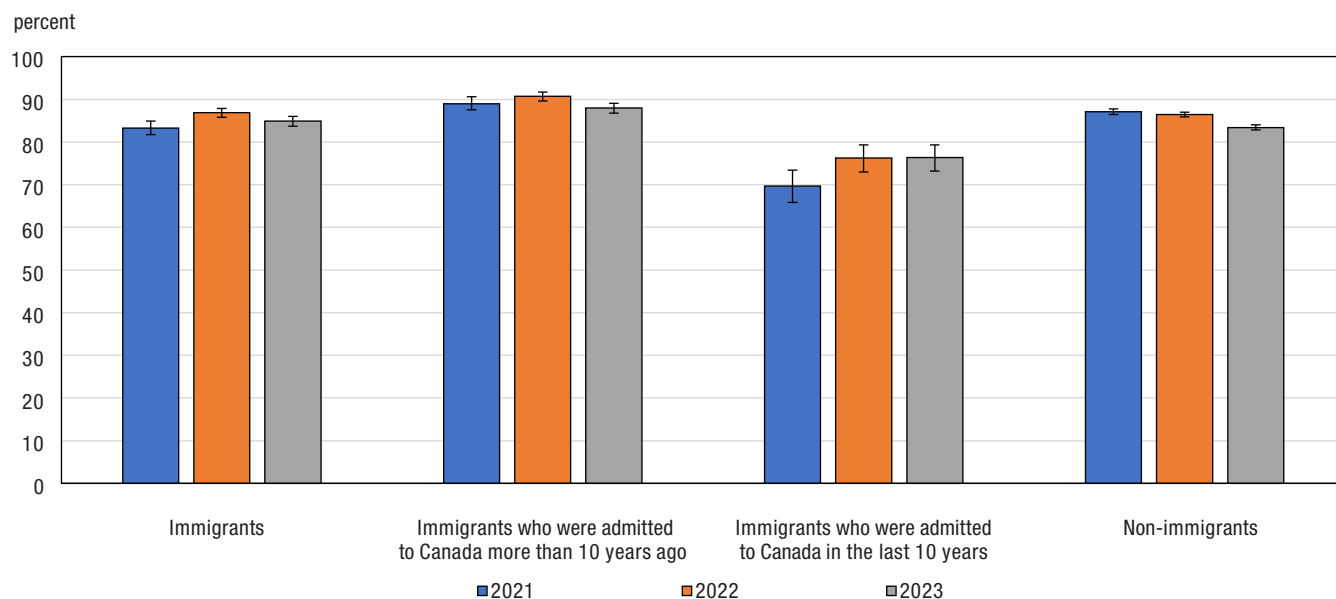
disabilities (81.8%), a greater proportion of those with a disability had a regular health care provider (89.8%) in 2023. Proportionally fewer adults in the lowest household income quintile (79.9%) than the highest (84.1%) reported having a regular health care provider.

In 2023, compared with the non-racialized population (83.8%), lower shares of Arab (77.5%), Black (72.3%), Korean (70.7%), Latin American (73.4%) and Chinese (80.4%) adults had a regular health care provider, whereas a greater proportion of Filipino adults (87.2%) had one.

Chart 10.0 shows that from 2021 to 2023 the percentage of non-immigrants with a regular health care provider dropped from 87.1% to 83.4%, whereas no change was seen among immigrants (83.3% to 84.9%). However, this varied by time spent in Canada. The proportion of immigrants who were admitted in the last 10 years with a regular health care provider increased from 69.7% in 2021 to 77.1% in 2023, while the percentage among immigrants who arrived more than 10 years ago stayed constant (89.0% in 2021 vs. 88.1% in 2023).

Chart 10.0
Canadians aged 18 and older reporting having a regular health care provider, by immigrant status and period of immigration, 2021 to 2023

Did you know?

Using combined 2017 to 2020 data from the Canadian Community Health Survey, a study found that higher proportions of First Nations people living off reserve (20.3%), Métis (17.9%) and Inuit (56.5%) aged 12 and older reported not having a regular health care provider, compared with non-Indigenous people (14.5%).[24] Among Indigenous and non-Indigenous people, proportionally more men than women and more younger adults (aged 18 to 34) than other age groups (aged 12 to 17, 35 to 64, and 65 and older) reported not having a regular health care provider. Younger adults aged 18 to 34 were the least likely to have a regular health care provider from 2017 to 2020, compared with all other age groups. This was the case for approximately one-quarter of First Nations (26.3%), Métis (24.7%) and non-Indigenous (25.1%) adults aged 18 to 34. Among Inuit, the proportion was much higher, with around two-thirds (66.0%) of adults aged 18 to 34 not having a regular health care provider. Access to a regular health care provider was lowest among those living in very remote areas, with half of First Nations people living off reserve (50.4%) and Métis (51.7%; this figure should be used with caution) and 8 in 10 Inuit (81.6%) not having a regular health care provider from 2017 to 2020. This was higher than the share among non-Indigenous people (30.1%).

11.0 Unmet needs for health care

According to the Canadian Income Survey, close to 3 million Canadians aged 15 and older in the provinces reported unmet health care needs (9.2%) in 2022, an increase from the year before (7.9%).[97] As observed in previous years, unmet needs varied across the provinces in 2022, with proportionally more people in the Atlantic provinces (12.6%) and British Columbia (10.9%) reporting unmet health care needs, compared with the Canadian average (Chart 11.0).

Chart 11.0
Canadians reporting unmet needs for health care, by province, 2021 (aged 16 and older) and 2022 (aged 15 and older)
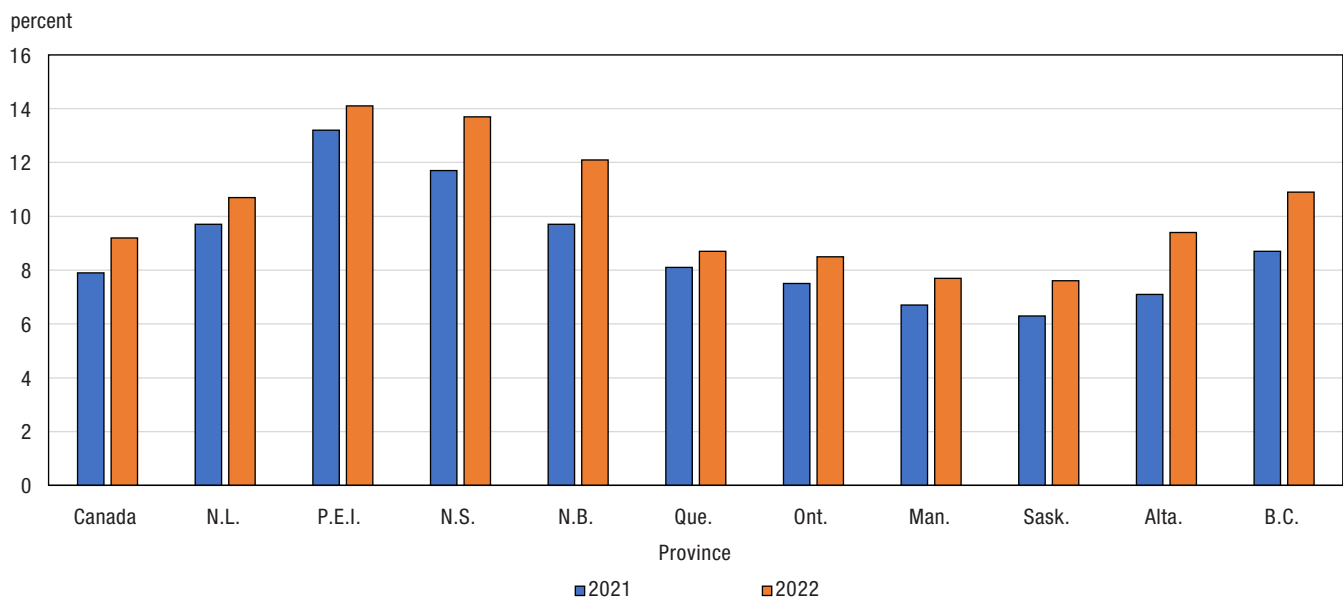
Notes: Territorial data are not included in annual estimates. The estimate for 2021 is for people aged 16 and older and that for 2022 is for people aged 15 and older because of a change in the target population.
Sources: Statistics Canada, Canadian Income Survey, 2021 and 2022; Table 13-10-0836-01 Unmet health care needs by sex and age group.

Unmet needs for health care also varied across age groups: 7.4% among 15- to 24-year-olds, 10.9% among 25- to 54-year-olds, 9.3% among 55- to 64-year-olds, and 6.5% among those aged 65 and older. Differences in unmet needs for health care were also observed by sex, with more females (10.4%) than males (8.0%) reporting a need in 2022.

Did you know?

In 2022, according to data from the Indigenous Peoples Survey, roughly one-quarter of First Nations people living off reserve (27.0%), Métis (24.4%) and Inuit (23.1%) aged 15 and older reported that they had needed health care in the previous 12 months but did not receive it.[24] First Nations women living off reserve, Métis women and Inuit women were more likely than men to report unmet needs for health care.

Furthermore, parents reported on unmet health care needs for their children aged 14 and younger in the past year. Roughly 1 in 10 First Nations children living off reserve (12.1%), Métis children (10.7%) and Inuit children (12.4%) had had health care needs that were not met. The most reported reasons for unmet health care needs among First Nations children living off reserve and Métis children were lengthy wait times or care not being available at the time required. Among Inuit children, the primary reasons for unmet needs were health care not being available in their area or at the time required.
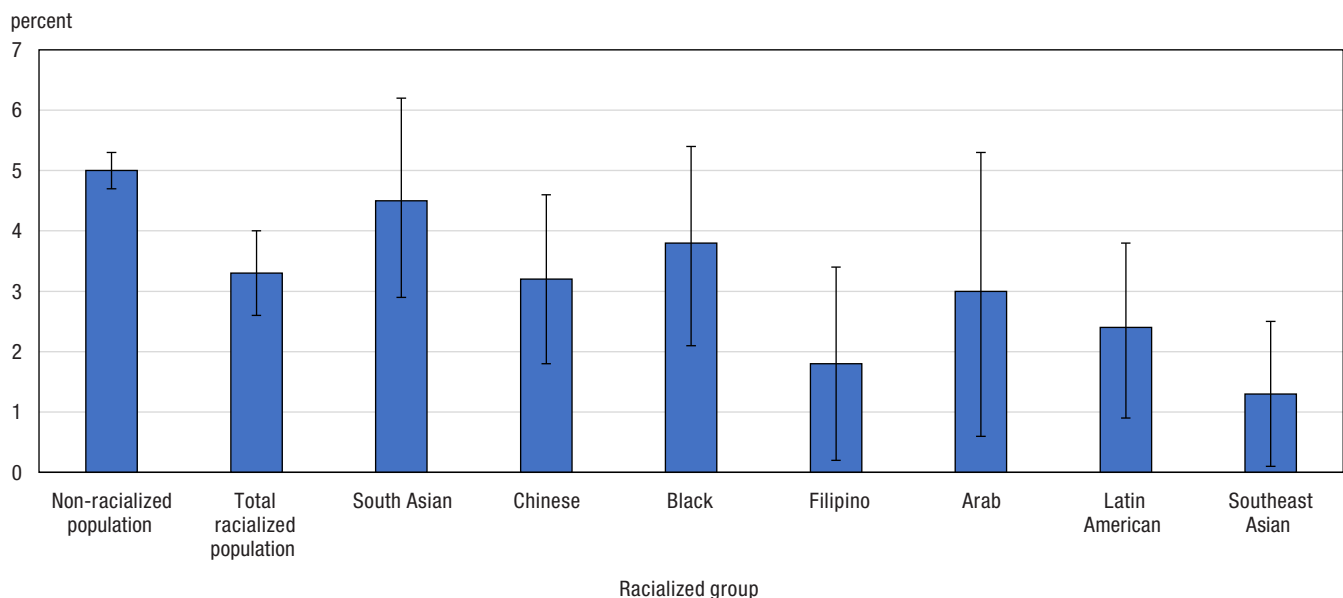
12.0 Use of home care services

Home care services enable people of all ages, but particularly older adults, to receive care in their homes rather than in a facility such as a hospital or long-term care facility.[98] **Home care services** are defined as services (e.g., nursing or health care, medical equipment or supplies, or help with personal care or other services such as transportation) received at home because of a health condition or limitation in daily activities. They do not include help from family, friends or neighbours. These types of services reduce pressure on the health care system, allow limited hospital resources to be directed to other uses and can help people continue to live at home.

In 2023, 4.5% of Canadian adults used home care services, an increase from 4.0% in 2022 and 3.2% in 2021. The percentage of adults who used home care services was higher in Quebec (5.2%) and lower in Saskatchewan (2.7%), Manitoba (3.3%) and British Columbia (3.7%), compared with Canada overall (excluding the territories).

The use of home care services increased with age from 1.9% among Canadians aged 18 to 34 to 3.2% among adults aged 35 to 64, and then up to 10.4% for the population aged 65 and older. Overall, a greater proportion of women (5.2%) than men (3.9%) used home care services.

The percentage of immigrants who reported using home care services increased from 2.8% in 2022 to 4.4% in 2023. Home care use varied by racialized group. A higher percentage of the non-racialized population used home care services in 2023 (5.0%), compared with Southeast Asian (1.3%), Filipino (1.8%), Latin American (2.4%) and Chinese (3.2%) adults (Chart 12.0). For adults aged 65 and older only, the use of home care services did not differ between the racialized (10.4%) and non-racialized (10.5%) groups.

Chart 12.0
Canadians aged 18 and older reporting home care use, by racialized group, 2023

Notes: Home care use includes those who received care services (e.g., nursing or health care, medical equipment or supplies, or help with personal care or other services such as transportation) at home because of a health condition or limitation in daily activities. Indigenous respondents are removed from the non-racialized category. The West Asian, Korean and Japanese groups are not shown because of small numbers.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Home care use also varied by income, with proportionally fewer adults in the highest income quintile using home care services (3.6%), compared with adults in the lowest (7.4%) and second-lowest (4.7%) quintiles.

Chart 12.1 shows that the proportion of adults with a disability (16.4%) who reported using home care services was more than five times greater than that of adults without disabilities (2.9%).

12.1 Unmet needs for home care

While nearly 1.4 million Canadians reported using home care services in 2023, not all those who needed these services could access them or received all the services they needed. The proportion of Canadian adults who reported unmet needs for home care was stable at 2.0% in 2023 after an increase from 1.6% in 2021 to 1.9% in 2022.

The percentage of adults who reported unmet needs for home care was lower among 18- to 34-year-olds (0.9%), compared with all older age groups. The highest percentage was among adults aged 65 and older, 3.8% of whom had unmet needs for home care. A greater proportion of women (2.5%) than men (1.6%) had unmet needs for home care in 2023, a trend that has remained constant since 2021.

The percentage of adults with unmet needs for home care varied by income. It was higher among Canadians in the lowest income quintile (4.3%), compared with the highest quintile (1.2%), in 2023. Similar results were observed in 2021 and 2022.

Proportionally more immigrants (2.6%) than non-immigrants (1.9%) reported unmet needs for home care. Among immigrants, the percentage with unmet needs for home care was higher for those who were admitted to Canada more than 10 years ago (2.7%), compared with those who were admitted in the last 10 years (1.6%). Unmet needs for home care were lower among Chinese (1.1%) and Filipino (1.2%) adults, compared with the non-racialized population (2.1%).

Chart 12.1 shows that shares also varied by disability status. A greater proportion of adults with a disability reported unmet needs for home care in 2023 (9.7%), compared with adults without disabilities (1.0%).

Chart 12.1
Canadians aged 18 and older reporting home care use and unmet needs for home care, by self-reported disability status
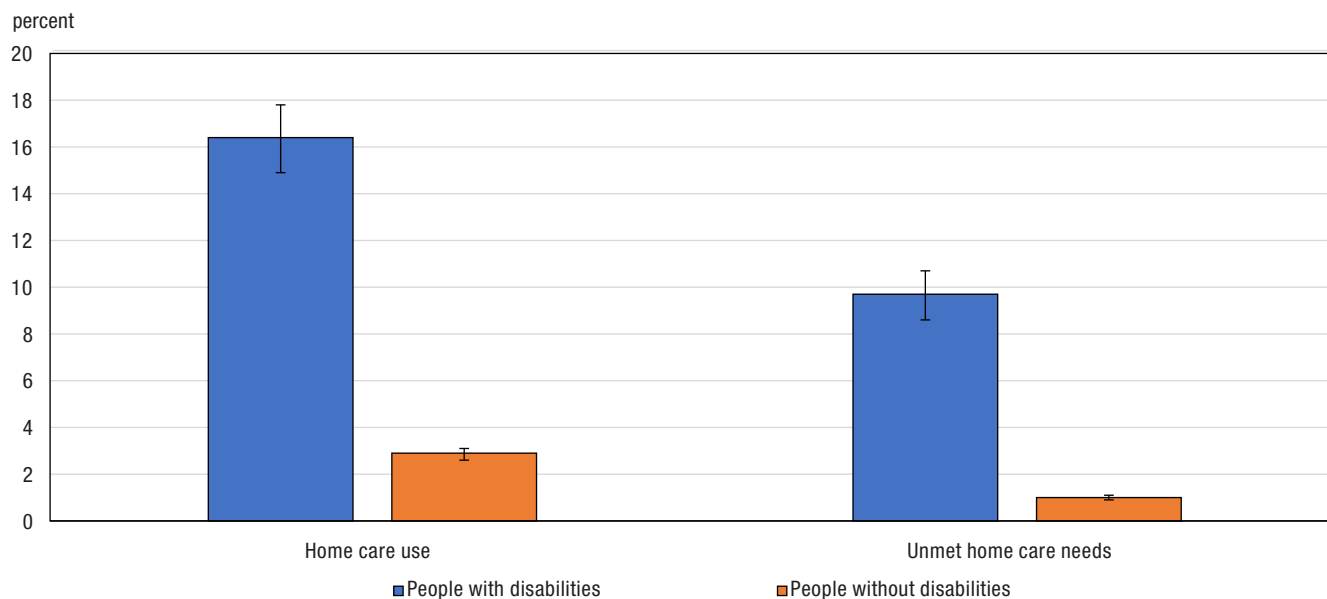
Note: Home care use includes those who received care services (e.g., nursing or health care, medical equipment or supplies, or help with personal care or other services such as transportation) at home because of a health condition or limitation in daily activities.
Source: Statistics Canada, Canadian Community Health Survey, 2023.

Glossary

Prevalence refers to the total number of cases of a particular disease or condition in a specific population at a given time. It is often expressed as a percentage or proportion and provides insight into how widespread a health issue is within that population.

Health outcomes

Excellent or very good perceived health includes respondents who answered "excellent" or "very good" to the question "In general, how is your health?" The question defines health as "not only the absence of disease or injury but also physical, mental and social well-being."

Excellent or very good perceived mental health includes respondents who answered "excellent" or "very good" to the question "In general, how is your mental health?"

The **crude birth rate** is the number of live births per 1,000 population.

The **total fertility rate** is an estimate of the average number of live births a female can be expected to have in her lifetime, based on the age-specific fertility rates of a given year. It is presented as the sum of a single year of age-specific fertility rates divided by 1,000. The **age-specific fertility rate** is the number of children per 1,000 females in a specific age group.

A **stillbirth** is the death of a fetus at or after 20 weeks of pregnancy or weighing 500 grams or more.

Infant mortality includes deaths before the age of 1 and consists of **neonatal mortality** (deaths in the first 27 days of life) and **post-neonatal mortality** (deaths up to age 1).

Maternal mortality includes deaths from obstetric causes that occurred within one year of delivery or the end of a pregnancy. It is typically divided into mortality during two periods: (1) during pregnancy or within 42 days of delivery or the end of the pregnancy, or (2) from 42 days to one year after delivery or the end of the pregnancy.

Anxiety includes self-reported anxiety disorders such as phobia, a panic disorder or a generalized anxiety disorder that have lasted six months or more and have been diagnosed by a health care provider. **Note:** Beginning with the 2022 Canadian Community Health Survey (CCHS), obsessive-compulsive disorder was excluded from anxiety disorders. In the 2023 CCHS, the question about anxiety was optional content and was asked in only five provinces (Nova Scotia, Quebec, Ontario, Manitoba and Saskatchewan). Since coverage across Canada is low, the 2023 annual estimates of anxiety are not presented.

Mood disorders include self-reported mood disorders such as major depression, bipolar disorder, mania or dysthymia (chronic form of depression) that have lasted six months or more and have been diagnosed by a health care provider.

Projected age-standardized cancer incidence rates and age-standardized cancer mortality rates are standardized to the 2011 Canadian standard population. The complete definition of the specific cancers included here and details of the projection methods can be found in Appendix 1, Supplementary Table 1, available at Projected estimates of cancer in Canada in 2024.

Overweight and obesity are based on self-reported height and weight. A body mass index (weight in kilograms divided by the square of height in metres) of 25.00 to 29.99 is classified as overweight and above 30 is classified as obese for respondents aged 18 or older. The World Health Organization thresholds by age and sex were used for respondents aged 15 to 17 to define obesity. Pregnant females were excluded. A systematic review of the literature concluded that self-reported data from adults underestimate weight and overestimate height, resulting in lower estimates of obesity than those obtained from measured data. Data from the 2005 Canadian Community Health Survey subsample, where both measured and self-reported height and weight were collected, were used to develop body mass index correction equations. The results in this report reflect overweight and obesity estimates adjusted using these equations.

Health behaviours

Fruit and vegetable consumption includes intake of fruits or vegetables five or more times per day. Respondents reported the frequency per day, per week or per month at which they consumed 100% pure fruit juice, fruits, dark green vegetables, orange-coloured vegetables, starchy vegetables and other vegetables. This measure does not consider the amount consumed.

Weekly alcohol consumption guidelines are provided by the Canadian Centre on Substance Use and Addiction. There is a continuum of risk associated with weekly alcohol use:

- Zero drinks per week (no risk): Not drinking has benefits such as better health and better sleep.
- Two standard drinks or less per week (low risk): You are likely to avoid alcohol-related consequences for yourself or others at this level.
- Three to six standard drinks per week (moderate risk): The risk of developing several types of cancer, including breast and colon cancer, increases at this level.
- Seven standard drinks or more per week (increasingly high risk): The risk of heart disease or stroke increases significantly at this level.

Each additional standard drink increases the risk of alcohol-related consequences. A standard drink corresponds to a certain amount of pure alcohol and is equivalent to 341 ml (12 ounces) of a 5% alcohol beer, cooler, cider or ready-to-drink beverage; or 142 ml (5 ounces) of 12% alcohol wine; or 43 ml (1.5 ounces) of 40% alcohol spirits (whisky, vodka, gin, etc.). **Note:** In the context of the Canadian Community Health Survey, a standard drink refers to a small bottle, draft or can of beer, cider or cooler; a glass of wine; or a cocktail or glass containing 1.5 ounces of liquor.

Risk zone percentages were based on reported alcohol consumption in the seven days prior to the date of the interview. Respondents who had never consumed any alcohol in their lifetime and respondents who had not consumed alcohol in the past year were included in the "No risk" category. Respondents were prompted to report the number of drinks consumed per day and may not have accounted for the different alcohol levels of the drinks they consumed. **Note:** Data on self-reported alcohol consumption indicated potential underreporting. Caution is advised when interpreting these data. For more information, see *The Daily—A snapshot of alcohol consumption levels in Canada: Half of Canadian adults reported not drinking any alcohol in the past seven days, 2023*.

Heavy drinking is defined as having five or more drinks for men aged 18 and older, or four or more drinks for women, on one occasion, at least once a month in the past year.

Daily smokers are those who reported smoking cigarettes every day (excluding alternative smoking products), while **occasional smokers** are those who reported smoking cigarettes occasionally. This includes former daily smokers who now smoke occasionally.

Vaping includes those who reported using an e-cigarette or vaping device in the past 30 days.

Cannabis use includes those who reported using cannabis daily or almost daily in the past 12 months.

Access to health care

A **regular health care provider** is a health professional that a person regularly consults with when they need care or advice about their health. This can include a family doctor or general practitioner, a medical specialist, a nurse practitioner, or another health care provider. **Note:** For the 2022 and 2023 cycles of the Canadian Community Health Survey, this indicator is based on the question "Which of the following health care providers do you regularly consult with?" From 2015 to 2021, the question was "Do you have a regular health care provider?"

Home care use includes those who received care services (e.g., nursing or health care, medical equipment or supplies, or help with personal care or other services such as transportation) at home because of a health condition or limitation in daily activities.

Health determinants

A **population centre** has a population of at least 1,000 and a population density of 400 persons or more per square kilometre, based on population counts from the current Census of Population. All areas outside population centres are classified as **rural areas**.

For **household income**, residents of each province were distributed into quintiles (five categories including approximately the same percentage of residents for each province) based on the adjusted ratio of their total household income to the low-income cut-off corresponding to their household and community size. This provides, for each respondent, a measure of their household income relative to the household incomes of all other respondents in the same province.

Sex at birth refers to sex assigned at birth. Sex at birth is typically assigned based on a person's reproductive system and other physical characteristics.

Gender refers to an individual's personal and social identity as a man, woman or non-binary person (a person who is not exclusively a man or a woman). Given that the non-binary population is small, data aggregation to a two-category gender variable (men+ and women+) is sometimes necessary to protect the confidentiality of responses. In these cases, individuals in the category "non-binary people" are distributed into the other two gender categories. "Men+" includes men, as well as some non-binary people. "Women+" includes women, as well as some non-binary people. For more information on the concept of gender, see the Gender of Person Reference Guide.

Sexual orientation refers to how a person describes their sexuality. **LGB+** includes people whose reported sexual orientation is lesbian, gay, bisexual or another sexual orientation that is not heterosexual. Estimates of sexual orientation are based on a survey question that includes four response categories: heterosexual, homosexual, bisexual and a write-in category to specify a sexual orientation. Write-in responses of "pansexual" are included in the bisexual category. Write-in responses that specify another sexual orientation that is not heterosexual are included in the LGB+ total.

Disability refers to those who self-identify as a person with a disability.

Immigrants include people who are, or who have ever been, landed immigrants or permanent residents. They have been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this category, while non-permanent residents are excluded. **Immigrants who were admitted to Canada in the last 10 years, or "recent immigrants,"** include people who first obtained landed immigrant or permanent resident status on the survey date or in the 10 years before. In 2022, for example, this category includes people who obtained landed immigrant status from 2012 to 2022. **Immigrants who were admitted to Canada more than 10 years ago, or "established immigrants,"** include people who first obtained landed immigrant or permanent resident status more than 10 years prior to the survey date. In 2022, for example, this category includes people who obtained landed immigrant status in 2011 or before. **Non-immigrants** include people who are Canadian citizens by birth.

Racialized populations are based on the "visible minority" variable. The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour." The racialized population includes the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese. **Note:** Indigenous respondents are removed from the "non-racialized" category.

Indigenous people are those who are First Nations people, Métis or Inuit. The *Constitution Act, 1982,* Section 35 (2), defines "aboriginal peoples of Canada" (referred to here as Indigenous peoples) as including "the Indian, Inuit and Métis peoples of Canada." First Nations people include Status and non-Status Indians.

References

1. Health Statistics Branch and Statistics Canada. Health of Canadians, (2023).

2. Statistics Canada. A snapshot of alcohol consumption levels in Canada: Half of Canadian adults reported not drinking any alcohol in the past seven days, 2023, (2024).

3. Public Health Agency of Canada. Key Health Inequalities in Canada: A National Portrait. Ottawa: Public Health Agency of Canada; 2018.

4. Statistics Canada. Population projections: Canada, provinces and territories, 2023 to 2073, (2024).

5. Gizaw Z, Astale T and Kassie GM. What improves access to primary healthcare services in rural communities? A systematic review. BMC Prim Care 2022. DOI: 10.1186/s12875-022-01919-0.

6. Public Health Agency of Canada. What Makes Canadians Healthy or Unhealthy? (2013).

7. Kirkbride JB, Anglin DM, Colman I, et al. The social determinants of mental health and disorder: evidence, prevention and recommendations. World Psychiatry 2024. DOI: 10.1002/wps.21160.

8. Coughlin SS, Vernon M, Hatzigeorgiou C, et al. Health Literacy, Social Determinants of Health, and Disease Prevention and Control. J Environ Health Sci 2020.

9. Health Canada. Certain Circumstances Issues in Equity and Responsiveness in Access to Health Care in Canada, https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-accessibility/certain-circumstances-issues-equity-responsiveness.html (2004).

10. Ooi LL, Liu L, Roberts KC, et al. Social isolation, loneliness and positive mental health among older adults in Canada during the COVID-19 pandemic. Health Promot Chronic Dis Prev Can 2023. DOI: 10.24095/hpcdp.43.4.02.

11. Steinberg L. Risk Taking in Adolescence: New Perspectives from Brain and Behavioral Science. Curr Dir Psychol Sci 2007. DOI: 10.1111/j.1467-8721.2007.00475.x.

12. Tylee A, Haller DM, Graham T, et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? The Lancet 2007. DOI: 10.1016/S0140-6736(07)60371-7.

13. Greaves L and Ritz SA. Sex, Gender and Health: Mapping the Landscape of Research and Policy. Int J Environ Res Public Health 2022. DOI: 10.3390/ijerph19052563.

14. Williams A, Lyeo JS, Geffros S, et al. The integration of sex and gender considerations in health policymaking: a scoping review. International Journal for Equity in Health 2021. DOI: 10.1186/s12939-021-01411-8.

15. Rauh K. Functional health difficulties among lesbian, gay and bisexual people in Canada, (2023).

16. Tjepkema M. Health care use among gay, lesbian and bisexual Canadians, (2008).

17. Employment and Social Development Canada. Disability Inclusion and Accessibility infographic – 2021, (2022).

18. Hébert B, Kevins C, Mofidi A, et al. A demographic, employment and income profile of persons with disabilities aged 15 years and over in Canada, 2022, (2024).

19. Lu C and Ng E. Healthy immigrant effect by immigrant category in Canada, (2019).

20. Sanou D, O'Reilly E, Ngnie-Teta I, et al. Acculturation and Nutritional Health of Immigrants in Canada: A Scoping Review. Journal of Immigrant and Minority Health 2014. DOI: 10.1007/s10903-013-9823-7.

21. Public Health Agency of Canada. Key Health Inequalities in Canada: A National Portrait – Executive Summary, (2018).

22. Public Health Agency of Canada. Inequalities in health of racialized adults in Canada, (2022).

23. Public Health Agency of Canada. Social determinants and inequities in health for Black Canadians: A Snapshot, (2020).

24. Yangzom K, Masoud H and Hahmann T. Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020, (2023).

25. Barbo G and Alam S. Indigenous people's experiences of primary health care in Canada: a qualitative systematic review. Health Promot Chronic Dis Prev Can 2024. DOI: 10.24095/hpcdp.44.4.01.

26. Arriagada P and Racine A. First Nations children living off reserve, Métis children, and Inuit children and their families: Selected findings from the 2022 Indigenous Peoples Survey, (2024).

27. Dion P, Tremblay M, Gagnon R, et al. Life Expectancy at Birth and Infant Mortality Rates of Indigenous Populations in Canada from 2004 to 2016. Can Stud Popul 2024. DOI: 10.1007/s42650-024-00081-5.

28. Kopp A, Kumar MB and Aitken N. COVID-19 mortality among First Nations people and Métis in private dwellings in Canada: An analysis of social determinants of health and health inequalities, (2024).

29. Statistics Canada. 2023 Canadian Health Survey on Children and Youth – Changes in the mental health of respondents from the 2019 survey, (2024).

30. Okpalauwaekwe U, Ballantyne C, Tunison S, et al. Enhancing health and wellness by, for and with Indigenous youth in Canada: a scoping review. BMC Public Health 2022. DOI: 10.1186/s12889-022-14047-2.

31. Bombay A. A call to end mental health disparities for Indigenous people. Lancet Psychiatry 2015. DOI: 10.1016/S2215-0366(15)00352-1.

32. Statistics Canada. Self-perceived mental health of First Nations people living off reserve, Métis and Inuit by age group and gender (2024). 10.25318/4110006701-eng.

33. Park J. Mental health among women and girls of diverse backgrounds in Canada before and during the COVID-19 pandemic: An intersectional analysis, (2024).

34. Statistics Canada. Deaths, 2023, (2024).

35. Statistics Canada. Life expectancy and other elements of the complete life table, single-year estimates, Canada, all provinces except Prince Edward Island (2023). 10.25318/1310083701-eng.

36. Wolfson M, Chapman D, Lee JH, et al. Extent and socioeconomic correlates of small area variations in life expectancy in Canada and the United States, (2024).

37. Statistics Canada. Table 13-10-0414-01 Live births, by place of residence of mother (2024).

38. Statistics Canada. Crude birth rate, age-specific fertility rates and total fertility rate (live births) (2024).

39. Public Health Agency of Canada. Chapter 7: Loss and Grief. Family-Centred Maternity and Newborn Care: National Guidelines. 2017.

40. Statistics Canada. Live births and fetal deaths (stillbirths), by type of birth (single or multiple) (2024).

41. Huang L, Sauve R, Birkett N, et al. Maternal age and risk of stillbirth: a systematic review. CMAJ 2008. DOI: 10.1503/cmaj.070150.

42. Statistics Canada. Infant deaths and mortality rates, by age group, (2023).

43. Statistics Canada. Leading causes of death, infants (2023). 10.25318/1310039501-eng.

44. Public Health Agency of Canada. Infographic: Inequalities in infant mortality in Canada, (2019).

45. Organisation for Economic Co-operation and Development. Infant mortality rates, (2022).

46. Cook JL, Sprague AE and members of the Society of Obstetricians and Gynaecologists of Canada's Maternal Mortality Pilot Project. Measuring Maternal Mortality in Canada: An Update on the Establishment of a Confidential Enquiry System for Preventing Maternal Deaths #savingmoms #savingbabies. J Obstet Gynaecol Can 2019. DOI: 10.1016/j.jogc.2019.07.018.

47. Statistics Canada. Number of maternal deaths and maternal mortality rates for selected causes, (2023).

48. World Health Organization. Cardiovascular diseases (CVDs), (2021).

49. Johns Hopkins Medicine. Resistant Hypertension, (2022, accessed June 22, 2023).

50. Centers for Disease Control and Prevention. High Blood Pressure Risk Factors, (2023, accessed June 22, 2023).

51. Public Health Agency of Canada. Diabetes: Overview, (2008, accessed June 23, 2023).

52. Connor Gorber S, Shields M, Tremblay MS, et al. The feasibility of establishing correction factors to adjust self-reported estimates of obesity. Health Rep 2008.

53. Statistics Canada. Arthritis. In: Healthy People, Healthy Places, https://www150.statcan.gc.ca/n1/pub/82-229-x/2009001/status/art-eng.htm (2010).

54. Canadian Cancer Statistics Advisory Committee. Canadian Cancer Statistics 2023, http://cancer.ca/Canadian-Cancer-Statistics-2023-EN (2023).

55. Brenner DR, Gillis J, Demers AA, et al. Projected estimates of cancer in Canada in 2024. CMAJ 2024.

56. Stephenson E. Mental disorders and access to mental health care (2023).

57. Kingsbury M and Findlay L. Mental health and access to support among 2SLGBTQ+ youth (2024).

58. Baiju RM, Peter E, Varghese NO, et al. Oral Health and Quality of Life: Current Concepts. J Clin Diagn Res 2017. DOI: 10.7860/JCDR/2017/25866.10110.

59. Canadian Dental Association. Dental Care FAQs, https://www.cda-adc.ca/en/oral_health/faqs/dental_care_faqs.asp.

60. Murphy K, Garriguet D and Rotermann M. Reported need for and access to oral health care services during the COVID-19 pandemic in Canada. Health Rep 2024. DOI: 10.25318/82-003-x202400200002-eng.

61. Moharrami M, Sano Y, Murphy K, et al. Assessing the role of dental insurance in oral health care disparities in Canadian adults (2024). 10.25318/82-003-x202400400001-eng.

62. Gondro JV, Murphy K, Clarke J, et al. Factors associated with the use of oral health care services among seniors in Canada (2024). 10.25318/82-003-x202400600002-eng.

63. Murphy K, Gondro JV and Moharrami M. Factors associated with the use of oral health care services among Canadian children and youth (2024). 10.25318/82-003-x202400400002-eng.

64. Statistics Canada. Dental visits returning to levels seen before the COVID-19 pandemic among Canadians in the provinces, 2023-2024, (2024).

65. Statistics Canada. Self-reported oral health problems in the Canadian population living in the provinces, November 2023 to March 2024, (2024).

66. Hayes A, Azarpazhooh A, Dempster L, et al. Time loss due to dental problems and treatment in the Canadian population: analysis of a nationwide cross-sectional survey. BMC Oral Health 2013. DOI: 10.1186/1472-6831-13-17.

67. Emami E, de Souza RF, Kabawat M, et al. The impact of edentulism on oral and general health. Int J Dent 2013. DOI: 10.1155/2013/498305.

68. Hussain A. Key Challenges for Indigenous Peoples of Canada in terms of Oral Health Provision and Utilization: A Scoping Review. Int J Dent 2022. DOI: 10.1155/2022/7511213.

69. Paul J. Introduction to Infectious Diseases. In: Paul J (ed) Disease Causing Microbes. Cham: Springer International Publishing, 2024, p.1.

70. Kuang S, Earl S, Clark J, et al. Experiences of Canadians with long-term symptoms following COVID-19. Insights on Canadian Society 2023.

71. Statistics Canada. Canadians' awareness of when they have COVID-19, May to August 2022, (2022).

72. Mashford-Pringle A, Skura C, Stutz S, et al. What we heard: Indigenous Peoples and COVID-19, (2021).

73. Clark K, Crooks K, Jeyanathan B, et al. Highlighting models of Indigenous leadership and self-governance for COVID-19 vaccination programmes. AlterNative: An International Journal of Indigenous Peoples 2024. DOI: 10.1177/11771801241235418.

74. Heck C, Eaker M, Cobos S, et al. Pandemic Impacts for Indigenous Children and Youth Within Canada: An Ethical Analysis. YOUNG 2021. DOI: 10.1177/11033088211032791.

75. Inuit Tapiriit Kanatami. The potential impacts of COVID-19 on Inuit Nunangat, (2020).

76. Indigenous Services Canada. Our response to COVID-19, (2024).

77. Indigenous Services Canada. Coronavirus (COVID-19) and Indigenous communities, (2023, accessed October 11, 2024).

78. Williams N, Alberton A and Gorey K. Morbid and Mortal Inequities among Indigenous People in Canada and the United States during the COVID-19 Pandemic: Critical Review of Relative Risks and Protections. Journal of Indigenous Social Development 2022.

79. Kovesi T. Respiratory disease in Canadian First Nations and Inuit children. Paediatr Child Health 2012. DOI: 10.1093/pch/17.7.376.

80. Halseth R and Odulaja O. Addressing the challenge of latent tuberculosis infection among Indigenous peoples in Canada: National Collaborating Centre for Aboriginal Health, 2018.

81. Statistics Canada. Age-standardized Rates, (2023).

82. Statistics Canada. Deaths and mortality rate (age standardization using 2011 population), by selected grouped causes, (2023).

83. Statistics Canada. Deaths, by age group and sex (2023). 10.25318/1310070901-eng.

84. Warburton DER, Nicol CW and Bredin SSD. Health benefits of physical activity: the evidence. CMAJ 2006. DOI: 10.1503/cmaj.051351.

85. Krause AJ, Simon EB, Mander BA, et al. The sleep-deprived human brain. Nat Rev Neurosci 2017. DOI: 10.1038/nrn.2017.55.

86. GBD 2017 Diet Collaborators. Health effects of dietary risks in 195 countries, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet 2019. DOI: 10.1016/S0140-6736(19)30041-8.

87. Statistics Canada. Canadian Health Measures Survey (Cycle 7) - Clinic Questionnaire, (2022, accessed June 22, 2023).

88. Colley RC, Guerrero M and Bushnik T. Intersecting risk factors for physical inactivity among Canadian adults, (2023).

89. Gilmour H, Lu D and Polsky JY. Sleep duration, sleep quality and obesity in the Canadian Armed Forces, (2023).

90. Aune D, Giovannucci E, Boffetta P, et al. Fruit and vegetable intake and the risk of cardiovascular disease, total cancer and all-cause mortality—a systematic review and dose-response meta-analysis of prospective studies. Int J Epidemiol 2017. DOI: 10.1093/ije/dyw319.

91. Boeing H, Bechthold A, Bub A, et al. Critical review: vegetables and fruit in the prevention of chronic diseases. Eur J Nutr 2012. DOI: 10.1007/s00394-012-0380-y.

92. Statistics Canada. Fruit and vegetable consumption/healthy eating environments, (2023, accessed October 11, 2024).

93. Statistics Canada. Overwhelming majority of Canadian women start breastfeeding soon after giving birth, and more than half stop within six months, 2022.

94. Canadian Centre on Substance Use and Addiction. Canada's Guidance on Alcohol and Health, Public Summary: Drinking Less Is Better, (2024).

95. Santaella-Tenorio J, Levy NS, Segura LE, et al. Cannabis use disorder among people using cannabis daily/almost daily in the United States, 2002-2016. Drug Alcohol Depend 2019. DOI: 10.1016/j.drugalcdep.2019.107621.

96. Weinberger AH, Pacek LR, Sheffer CE, et al. Serious psychological distress and daily cannabis use, 2008 to 2016: Potential implications for mental health? Drug and Alcohol Dependence 2019. DOI: 10.1016/j.drugalcdep.2019.01.010.

97. Statistics Canada. Stimulants in the wastewater of Canadian cities: provisional results, January 2022 to May 2023, (2023).

98. Statistics Canada. Table 13-10-0836-01 Unmet health care needs by sex and age group, (2023).

99. Hango D. Support received by caregivers in Canada. Insights on Canadian Society 2020.