Mortality, Cause of Death and Life Expectancy of Chinese Canadians in Alberta

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ABSTRACT

Objective: To describe mortality, cause of death and life expectancy among Chinese (both immigrant and Canadian-born) and other Canadians in the Province of Alberta.

Methods: A Chinese surname list was applied to the Alberta Health Insurance Plan and Vital Statistics Birth registry databases to define the Chinese population, and to the Vital Statistics Death registry to determine deaths among Chinese in Alberta from 1995 to 2003. Age- and sex-specific mortality, cause of death and life expectancy were calculated.

Results: Of nearly 3 million Alberta residents, about 4% were Chinese in 2003. The age-adjusted mortality for Chinese was 4.2 per 1000 and for non-Chinese 6.2 per 1000 population. Infant mortality was lower for Chinese (4.9/1000 live births) than non-Chinese (6.2/1000 live births). Life expectancy at birth was 6.3 years longer for Chinese males compared to non-Chinese males (83.3 versus 77.0), and 5.4 years longer for Chinese females compared to non-Chinese females (87.9 versus 82.5). Cancer, heart disease and stroke were the leading causes of death for both Chinese and non-Chinese Albertans.

Conclusions: The Chinese ethnic population of Alberta had lower mortality and longer life expectancy than remaining Albertans, suggesting that the Chinese population has better health status than other Albertans. Reasons for the health gap between Chinese and non-Chinese populations should be further explored.

MeSH terms: Mortality; life expectancy; Chinese; Alberta

La traduction du résumé se trouve à la fin de l'article.

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The ethnic origins of Canadians are changing dramatically. Whereas immigrants in the period of early settlement and growth of this country were principally from Europe, in recent years immigrants have been increasingly from Asia. According to Census data, prior to 1961, 91% of all immigrant residents came from Europe and 3% from Asia. In 2001, only 42% of all immigrant residents of Canada came from Europe, whereas 37% were from Asia.¹ Thus Canada is becoming more racially and ethnically diverse.

Alberta is the fourth most frequent provincial destination of immigrants in Canada. The 2001 Canadian population census showed that 11.2% of the Alberta population were visible minorities and Chinese constituted the largest minority group, accounting for 30.0% of all visible minorities.¹ It has been predicted that this ethnic group will be the fastest-growing minority population in this country.² Growth in the immigrant and visible-minority population speaks to the importance of research and policy attention to ensure that optimal population health is achieved.

Previous Canadian studies³⁻⁶ reported health status in immigrants and visible minorities using self-reported health status and the presence of medical conditions from cross-sectional surveys as indicators of health status. Accuracy and reliability of self-reports is influenced by recall bias and cultural factors. Therefore, we conducted this study employing mortality and life expectancy as indicators to compare health status between Chinese and non-Chinese Canadians in the Province of Alberta, Canada.

METHODS

Study population

Our study population was restricted to residents of Alberta, Canada from 1995 through 2003. The population was defined with the Alberta Health Care Insurance Plan (AHCIP) registry database. This registry contains demographic information of all residents covered by the publicly funded universal provincial health insurance plan. All permanent residents are covered by the AHCIP except for registered First Nations persons, prison inmates, and members of the military and

the Royal Canadian Mounted Police, all of whom are the responsibility of the federal government. However, the AHCIP registry has been periodically updated with federal registry information on registered First Nations residents of Alberta and they were therefore included in our study population.

Vital Statistics Birth Registry data were used to define the population of less than one year of age. This was done because of possible incompleteness in the AHCIP registry for infants of less than one year since registration of infants with the registry may sometimes be delayed until some time after birth. Therefore, the complete Alberta population was defined by combining the AHCIP and Vital Statistics Birth registries.

Mortality

Mortality was defined with the Alberta Vital Statistics Death registry for the years 1995 to 2003. Information in the death registry is derived from the Death Registration form, medical certificate of death, and the medical examiner's certificate of death (where appropriate). The registry captures deaths that occur within Alberta but may miss some Alberta residents who died outside of Alberta.

Chinese ethnicity

Ethnicity is not available in either the AHCIP or Vital Statistics data. Therefore, a validated list of Chinese surnames⁷ was matched to the surnames recorded in the AHCIP registry to identify residents of Chinese origin, including Chinese Canadians born in Canada, China or other countries. The surname list was also matched to the surnames in the Vital Statistics Birth and Death registries from 1995 to 2003 to identify births and deaths of Chinese Albertans. All remaining unmatched individuals were grouped as non-Chinese. We employed a comprehensive surname list⁷ which combined published Chinese surname lists,⁸⁻¹² and was validated in the Canadian population.

Statistical analysis

Population counts on June 30th of each year from the AHCIP and newborn counts of each year from the Vital Statistics Birth registry were used as denominators for rate calculations. Rates were directly age-standardized according to the 1996

TABLE I

Chinese Population in Alberta: Comparison Between Self-identification in 2001 Census and Identification by Use of a Surname List with Alberta Registries

	Census			Registry			Ratio*
	Total	Chinese	%	Total	Chinese	%	
Overall	2,920,335	98,980	3.4	3,040,312	101,605	3.3	0.97
Sex							
Male	1,461,020	47,920	3.3	1,519,036	49,284	3.2	0.99
Female	1,459,315	51,060	3.5	1,521,276	52,321	3.4	0.98
Age							
0-14	613,585	20,155	3.3	611,275	18,456	3.0	0.92
15-24	430,505	15,335	3.6	444,032	15,156	3.4	0.96
25-44	937,040	30,535	3.3	959,663	32,911	3.4	1.05
45-64	654,875	22,625	3.5	687,411	24,053	3.5	1.01
≥65	284,335	10,335	3.6	318,252	11,027	3.5	0.95

* Ratio = proportion of Chinese estimated in Alberta Health Insurance Plan and Vital Statistics Birth registries divided by proportion of Chinese estimated in 2001 census

Figure 1. Chinese and non-Chinese population distributions, Alberta, 2003

Canadian Census population. Causes of death among Chinese and non-Chinese Canadians were grouped using Alberta's 120 cause-of-death categories which is a slight modification of Statistics Canada's Tabulation List for mortality.¹³ Leading causes of death were ranked using age-adjusted rates. All analyses were performed internally at Alberta Health and Wellness.

RESULTS

Table I compares Chinese population counts in 2001 between the Census (self-identification) and the AHCIP and Birth registries. Overall, the proportion of ethnic Chinese was slightly lower defined with the surname list (3.3%) than in the 2001 Census (3.4%). The difference was similar across sex and age. By age group, the name list identified 3.0% of 0-14 year olds as

Chinese compared to 3.3% in the Census (ratio name list/Census = 0.92). For all other age groups, the ratios were near 1.0.

Figure 1 shows the distribution of the Chinese and non-Chinese population by age and sex. This figure demonstrates that the Chinese population was somewhat younger, with a noticeable population "bulge" between the ages of 35 and 54. This bulge may reflect the influx of immigrants in the last two decades, and immigration policies which favour those who are likely to be economically productive.

The age-adjusted mortality in 2003 was 4.18/1000 for Chinese and 6.19/1000 for non-Chinese (see Table II). The discrepancy in age-adjusted mortality between Chinese and non-Chinese was consistent from 1995 through 2003 (see Figures 2-4 for females, males and both sexes). For both sexes combined, the Chinese death

TABLE II

Age-adjusted Mortality Rate, Alberta in 2003 (per 1000 population)

Sex	Chinese			Non-Chinese			Rate Ratio* (Chinese vs. Non-Chinese)
	Population	Death	Rate (1/1000)	Population	Death	Rate (1/1000)	
Female	55,973	222	4.41	1,511,757	8577	5.98	0.74
Male	52,698	194	3.93	1,512,473	9361	6.30	0.62
All	108,671	416	4.18	3,024,230	17,939	6.19	0.68

* Rate ratio of Chinese vs. non-Chinese = Chinese mortality/non-Chinese mortality

Figure 2. Female age-adjusted mortality for Chinese and non-Chinese, Alberta, 1995-2003 (per 1000 female population)

Figure 3. Male age-adjusted mortality for Chinese and non-Chinese, Alberta, 1995-2003 (per 1000 male population)

rate was as low as 53% of the non-Chinese in 1997, up to a maximum of 68% in 2003.

Figure 5 presents age-specific mortality rates. From age 40, the gap in mortality rates between Chinese and non-Chinese

began to increase. In the age group of 40 to 64, the Chinese mortality rate was about 55% of the non-Chinese rate. Infant mortality per 1000 live births was lower for Chinese (4.9/1000) than non-Chinese

(6.2/1000) during 1995 to 2003. Not surprisingly, given the lower death rates for Chinese, the life expectancy at birth was estimated to be 6.3 years longer for Chinese males compared to non-Chinese males (83.3 versus 77.0), and 5.4 years longer for Chinese females compared to non-Chinese females (87.9 versus 82.5).

As with non-Chinese, the top five causes of death for Chinese Albertans were cancer, heart disease, stroke, accidents and chronic obstructive pulmonary disease (see Table III). The age-/sex-standardized mortality rates for these causes of death were lower for Chinese than non-Chinese.

DISCUSSION

In this study, we found the Chinese population was much healthier than non-Chinese residents of Alberta, Canada. Mortality for both sexes and in all age groups was lower by as much as 50% for Chinese compared to non-Chinese. Life expectancy was 6.3 years longer for Chinese males and 5.4 years longer for Chinese females compared to non-Chinese. The first five leading causes of death ranked the same between Chinese and non-Chinese Albertans, though death rates from each of the causes were lower for Chinese than non-Chinese.

There are several possible explanations for lower mortality in Chinese compared to non-Chinese residents of Alberta. First, there could be an out-migration of older Chinese, either back to their home countries following the Chinese tradition of preferring to die where one was born, or to other Canadian provinces, such as British Columbia or Ontario, where there are larger better-established Chinese communities. These persons may still have a record in the AHCIP registry but their death record would be missing, resulting in lower death rates. We would likely see this happen more commonly for deaths due to chronic conditions (such as cancer, chronic lower respiratory disease), resulting in a larger difference in mortality between Chinese and non-Chinese in these causes of death than deaths due to acute conditions (such as stroke, accidents). However, our study did not support this speculation, since the mortality gap between Chinese and non-Chinese remained similar for both chronic and acute conditions.

Second, the surname list may identify ethnic Chinese people differentially between the AHCIP registry and Vital Statistics Death registry. The low mortality could result if the surname list was more sensitive in identifying Chinese in the AHCIP than in the Vital Statistics registry. To examine this possibility, the AHCIP registry and Vital Statistics Death data were linked using a combination of surname, sex and date of birth. Over 90% of death records were linked, and the proportion of Chinese among the linked records (1.9%) was similar to that among unlinked records (2.0%). Therefore, it is unlikely that the surname list differentially identified Chinese in the AHCIP registry compared to the Vital Statistics Death registry.

Third, there may in fact be lower mortality among Chinese than non-Chinese Albertans. Immigrant populations are generally healthier than native-born Canadians.³⁻⁵ This is partly because of the process of gaining immigrant status, which requires that applicants be in good health and employable. Furthermore, younger and healthier persons are more likely to emigrate from their original countries. Chen et al.³ noted that the prevalence of chronic conditions was 57% in native-born Canadians, 37% in recent non-European immigrants and 51% in non-European immigrants of over ten years residency. Other studies^{4,5,14} that have looked at chronic conditions, disability, and health services use report similar patterns: health of recent immigrants tends to be better than longer-duration immigrants which tends to be better than native-born residents.

Sheth et al.^{15,16} estimated mortality for Canadians of Chinese, South Asian, and all other origins aged 35 to 74 years. Chinese had mortality rates of 6.01 per 1000, compared with 7.61 for South Asians and 10.94 for all other Canadians. However, there is also evidence that this generally better health deteriorates as immigrants are in Canada longer.¹⁴ Singh et al.¹⁷ in a study of United States (US) immigrant populations noted that immigrant Chinese had slightly lower life expectancy than US-born Chinese, but both were higher than the total US-born population. Among males, life expectancy for all US-born was 71.5 years, for US-born Chinese 81.6 years, and for foreign-born Chinese 80.6 years;

Figure 4. Both sexes age-adjusted mortality for Chinese and non-Chinese, Alberta, 1995-2003 (per 1000 population)

Figure 5. Age-specific Chinese and non-Chinese mortality, Alberta, 1995-2003 (per 1000 population)

among females these were 78.6, 87.1 and 85.9 years, respectively. These findings are consistent with data reported in this study.

Infant mortality was also found to be lower for Chinese compared to non-Chinese residents in Alberta. There is little published research on this finding. However, a similar finding was reported in the US where the infant mortality for infants born to foreign-born immigrant Chinese was 3.4 per 1000 live births, compared to 7.3 for the US-born population.¹⁷

This study had three major limitations. First, only one ethnic population was stud-

ied and compared to all other Albertans which includes a number of ethnic minorities: Aboriginal (5.5% of non-Chinese in Alberta), South Asian (2.2%), Filipino (1.2%) and black Canadians (1.1%).¹⁸ Populations with different ethnic origins may be shown to have different mortality and health profiles than Chinese.¹⁹ Second, the Chinese surname list we employed to define the Chinese population has about 80% sensitivity and positive predictive value. In the process of development of the surname list, Chinese surnames that were commonly shared with non-Chinese (e.g.,

TABLE III

Top 10 Leading Causes of Death in Chinese and Non-Chinese Residents of Alberta, 2001-2003

Rank	Cause of Death	ICD-10 code	Number of Deaths	% of Total Deaths	Mortality Rate* (1/100,000)
Chinese Residents					
1	Cancer	C00-C97	2304	100.0	
2	Diseases of the heart	I00-I09,I11,I13,I20-I51	762	33.1	128.1
3	Stroke	I60-I69	500	21.7	88.0
4	Unintentional injury (accidents)	V01-X59,Y85-Y86	230	10.0	40.6
5	Chronic lower respiratory diseases	J40-J47	102	4.4	17.1
6	Nephritis and nephrosis (kidney disease)	N00-N07,N17-N19,N25-N27	62	2.7	11.2
7	Diabetes	E10-E14	50	2.2	8.6
8	Vascular and unspecified dementia	F01-F03	46	2.0	7.9
9	Influenza and pneumonia	J10-J18	40	1.7	7.3
10	Diseases of arteries, arterioles, and capillaries	I70-I78	36	1.6	6.6
			24	1.5	6.0
Non-Chinese Residents					
			105,082	100.0	
1	Cancer	C00-C97	28,788	27.4	300.4
2	Diseases of the heart	I00-I09,I11,I13,I20-I51	26,598	25.3	244.5
3	Stroke	I60-I69	7628	7.3	85.2
4	Unintentional injury (accidents)	V01-X59,Y85-Y86	5030	4.8	45.6
5	Chronic lower respiratory diseases	J40-J47	4640	4.4	39.1
6	Diabetes	E10-E14	2502	2.4	22.7
7	Diseases of arteries, arterioles, and capillaries	I70-I78	2726	2.6	22.0
8	Suicide (intentional self-harm)	X60-X84,Y87.0	2648	2.5	20.3
9	Influenza and pneumonia	J10-J18	1826	1.7	17.2
10	Vascular and unspecified dementia	F01-F03	1642	1.6	16.7

* The age-sex standardized mortality rate according to the age/sex distribution of 1996 Canadian census

Lee) were excluded to gear the list towards identifying true Chinese despite missing some Chinese. For each demographic grouping (Table I), the proportion identified as Chinese was very close between the Census and the registries, indicating that the surname list was a valid method for identifying Chinese. Misclassification of Chinese might result in underestimating the difference in mortality between Chinese and non-Chinese. Third, only one province's population was analyzed. Generalizability of these findings to other provinces should be further assessed because Alberta's population is younger than other Canadian provincial populations. We encourage researchers to employ a similar methodology to explore ethnic population health in other provinces, particularly in British Columbia, Ontario and Quebec.

In conclusion, the Chinese population appears to be healthier than non-Chinese in Alberta, having a lower mortality and a longer life expectancy. Cancer, heart disease and stroke are the major causes of deaths, accounting for 64.8% of total deaths among Chinese Albertans. Our study demonstrated the feasibility of identifying Chinese by using a surname list. Measures of population health status can then be compared between Chinese and non-Chinese, to assist policy-makers in understanding the needs of ethnic populations. This is important since ethnic populations may differ in health status and

health care needs because of genetics, culture, health behaviours, or the stresses of immigration itself.

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RÉSUMÉ

Objectif : Décrire la mortalité, les causes de mortalité et l'espérance de vie chez les personnes d'origine chinoise (immigrants et Canadiens de naissance) et les autres Canadiens vivant en Alberta.

Méthode : Pour définir la population d'origine chinoise, nous avons cherché une liste de noms de famille chinois dans les bases de données du régime d'assurance-santé et du registre des naissances de l'Alberta. Pour calculer la mortalité dans la population d'origine chinoise en Alberta entre 1995 et 2003, nous avons consulté le registre provincial des décès. La mortalité, les causes de mortalité et l'espérance de vie ont été calculées par âge et par sexe.

Résultats : Sur les près de 3 millions de résidents de l'Alberta, environ 4 % étaient d'origine chinoise en 2003. Le taux de mortalité rajusté selon l'âge chez les personnes d'origine chinoise était de 4,2 p. 1 000, et pour les non-Chinois, de 6,2 p. 1 000. La mortalité infantile était plus faible dans la population d'origine chinoise (4,9 p. 1 000 naissances vivantes) que dans la population non-chinoise (6,2 p. 1 000 naissances vivantes). L'espérance de vie à la naissance était plus longue de 6,3 ans chez les hommes d'origine chinoise que chez les hommes d'autres origines (83,3 ans c. 77 ans), et elle était plus longue de 5,4 ans chez les femmes d'origine chinoise que chez les femmes d'autres origines (87,9 ans c. 82,5 ans). Pour les personnes d'origine chinoise comme pour tous les Albertains, les principales causes de mortalité étaient le cancer, les maladies coronariennes et les AVC.

Conclusion : Les personnes d'origine chinoise en Alberta ont un taux de mortalité plus faible et une espérance de vie plus longue que les autres Albertains, ce qui donne à penser que l'état de santé de la population chinoise est meilleur que celui des autres Albertains. Les raisons de cet écart de santé entre les populations d'origine chinoise et non chinoise mériteraient d'être étudiées.

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IN MEMORIAM

Russ Kisby, B.A.P.E. M.Ed., LL.D (Hon).

Former President of ParticipACTION and CPHA member, Russ Kisby died peacefully at home on Friday, July 20, 2007.

Russ was born in Yorkton, Saskatchewan in 1940 and raised in Saskatoon. He graduated from the University of Saskatchewan's College of Physical Education in 1963 and later earned a master's degree in community leadership and development in the United States. His professional career began at the Montreal and National YMCA before joining the newly launched ParticipACTION in 1972. He became President in 1978, and remained in that position until retirement in 2001.

Russ was instrumental in the publication of a special supplement to the Canadian Journal of Public Health in 2004 entitled, "ParticipACTION. The Mouse That Roared: A Marketing and Health Communications Success Story", which featured contributions from researchers, educators, marketing and health promotion consultants, and leaders in the field of active living, and was a fascinating overview of the entire movement.

With the re-launch of ParticipACTION in 2006, he continued to contribute to this unique Canadian movement as an advisor.

Russ was admired nationally and internationally for his professional contributions as a leader in health promotion, physical fitness and social marketing. He received numerous awards, including the R. Tait McKenzie Honour Award (CAHPERD); Government of Canada 125 medal; University of Saskatchewan Honorary Doctor of Laws degree; World Sport For All Award and Sport For All Pioneer Award. He was named as one of the 100 most influential graduates from the University of Saskatchewan, and the Russ Kisby Physical Activity and Health Promotion Laboratory was recently opened at the UofS College of Kinesiology. Those who knew Russ will appreciate that he never lost his love of life or his infectious sense of humour throughout his lengthy illness. He had successfully fought a 5-year battle against cancer, but his heart succumbed to damage caused by the radiation treatments.

Donations can be made payable to the University of Saskatchewan, citing the Kinesiology Aboriginal Student Award established by Russ and his wife, Merle (University Advancement, Rm223 Kirk Hall, 117 Science Place, Saskatoon, SK, S7N 5C8 or www.usask.ca/advancement). In keeping with Russ' philosophy and approach to life, it was requested that all donations be followed by a brisk fitness walk.