Literature Review — Chronic Condition Prevalence in Ontario

Prepared by Arun Acharya, 2025

Introduction

This literature review accompanies the report **"Chronic Condition Prevalence in Ontario: Patterns of Inequity and Comparison with Canada."** Its purpose is to position the 2019–2020 Ontario findings within the wider public-health literature on chronic disease and health equity in Canada. Rather than replicating the Ontario report's statistics or rankings, this review synthesises national and provincial evidence to show how those results align with and extend existing knowledge.

National Burden of Chronic Disease

Chronic diseases are a leading cause of death, disability and health-care spending in Canada. Population-based data indicate that a large proportion of Canadian adults live with at least one chronic illness and that these conditions account for most deaths [1]. Such burdens are not evenly shared: Indigenous peoples, low-income populations and racialised communities bear higher rates of chronic disease because of disparities in access to health-promoting resources and the social determinants of health [1]. National surveys also demonstrate that the likelihood of having multiple chronic conditions increases markedly with age, is slightly higher among women, and is strongly associated with lower income and education [4]. Behaviours such as smoking, physical inactivity and unhealthy diets consistently correlate with increased disease risk. Collectively, these findings underline the importance of addressing both lifestyle factors and structural inequities.

Ontario-Specific Evidence

Provincial studies echo these national patterns while revealing nuances relevant to Ontario. A decomposition analysis of linked survey and administrative data covering 2005–2011/12 showed that household income explains most of the variation in multimorbidity prevalence, with age, marital status and physical inactivity contributing smaller shares [3]. The authors observed that socio-economic disparities persisted over the study period despite policy efforts, illustrating the entrenched nature of health inequities. Public Health Ontario's burden report confirms that chronic diseases remain Ontario's primary causes of death and that treating major conditions such as cancers, cardiovascular diseases, chronic lower respiratory diseases and diabetes costs more than $10 billion annually [5]. The report emphasises that modifiable risk factors—including tobacco use, alcohol consumption, physical inactivity and unhealthy diet—are more common among people with low socio-economic status, poor mental health or Indigenous identity [5]. These insights demonstrate how social circumstances shape disease patterns in the province.

Comparisons and Gaps

Most existing analyses rely on data collected up to 2015 or earlier, whereas the Ontario report under review draws on the 2019–2020 cycle of the Canadian Community Health

Survey. This temporal update is significant because it captures more recent trends, particularly in the years immediately preceding the COVID-19 pandemic. The report also adds nuance by examining specific conditions—such as sleep apnoea, musculoskeletal disorders and mood disorders—that are often aggregated in broader measures of multimorbidity. Its findings that Ontario's overall prevalence closely resembles national averages, yet internal disparities by age and income remain stark, reinforce the dominant role of these social determinants. Furthermore, the explicit health-equity lens distinguishes this analysis from many earlier studies: by quantifying differences across age, sex and income groups, it highlights domains where gaps are minimal (e.g., sex differences) versus substantial (e.g., income gradients). Compared with interprovincial analyses that pool data across provinces or focus on composite outcomes, this Ontario-specific perspective provides a detailed picture of disease burden within Canada's most populous province and identifies where targeted interventions may yield the greatest benefits.

Policy and Equity Frameworks

Health-equity frameworks guide interpretation of these patterns. Public Health Ontario defines health equity as the absence of systematic, avoidable and unjust differences in health and calls for interventions that reduce inequities related to income, social status, race, gender and education [2]. Its strategic plans emphasise data-driven policies and collaborative efforts to advance equity across the province. The Canadian Institute for Health Information similarly stresses that collecting and reporting socio-demographic data is essential for identifying disparities, informing strategies and monitoring progress [6]. These frameworks, along with the Canadian Public Health Association's commitment to fair opportunities for health, provide the rationale for focusing on age- and income-sensitive actions. They also underscore the need for robust surveillance systems that can support equity-oriented decision-making at provincial and national levels.

Conclusion

The literature consistently shows that chronic diseases impose a substantial and inequitable burden across Canada and Ontario. National surveys and provincial studies link lower income, limited education, physical inactivity and other social determinants with higher disease risk. Analyses specific to Ontario reveal persistent income gradients in multimorbidity and highlight the roles of modifiable risk factors and social context. By delivering updated, condition-specific estimates and explicitly assessing disparities across age, income and sex, the Ontario report complements this evidence base. Its key contribution is demonstrating that, while overall prevalence mirrors national patterns, internal inequities remain pronounced. These insights reinforce the need for equity-oriented health policies prioritising older adults, low-income groups and communities facing systemic disadvantage. Future research should continue to monitor post-pandemic trends, integrate race and ethnicity into analyses and evaluate the effectiveness of targeted interventions aimed at reducing socio-economic gaps in chronic disease burden.

References

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