HEALTH DISPARITY IN SASKATOON

Analysis to Intervention

Executive Summary

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EXECUTIVE SUMMARY

The overall objective of our report is a) to describe the extent of health disparity in the Saskatoon community, b) to determine the causes of health disparity, c) to explain that health disparity is mostly preventable and d) to use evidence from other jurisdictions to present policy options for consideration.

A study conducted by the Saskatoon Health Region in 2006 compared the health status of residents within Saskatoon's six low income neighbourhoods to the rest of the city and found substantial disparities in suicide attempts, mental disorders, injuries and poisonings, diabetes, chronic obstructive pulmonary disorder, coronary heart disease, chlamydia, gonorrhoea, hepatitis C, teen births, low birth weights, infant mortality and all cause mortality. Although disparity in health outcomes by socioeconomic status is well known, the magnitude of the disparity in health outcomes is shocking for a city in the western world. For example, the infant mortality rate in Saskatoon's low income neighbourhoods was 448% higher than the rest of the city; which is worse than developing nations.

Upon completion of the research, over 200 community consultations were initiated with various government representatives, academics, community groups and community associations. The purpose of the consultations was to transfer knowledge of the vast disparity in health to the Saskatoon community and to gather opinion on what needs to be done to help alleviate this complex problem. As a result of these consultations, a number of regional initiatives were implemented.

The initial Health Disparity by Neighbourhood Income study led to more comprehensive research to examine the relationship between socioeconomic status and health status in Saskatoon residents. These additional studies have demonstrated that income status often has the strongest independent association with disparity in the prevalence of diseases or disorders in Saskatoon residents. Utilization of physician or mental health services had limited (if any) association in preventing disease prevalence. As well, behaviours also had limited independent associations with health outcomes; mainly because the prevalence of risk behaviours is often associated with income status. The results from Saskatoon are consistent with the results from other jurisdictions in that the determinants of health (and behaviours) fall mainly outside the health care treatment sector. A new finding also materialized through the more comprehensive research. Aboriginal cultural status was found to have a much more limited association (if any) with poor health outcomes or risk behaviours after statistical adjustment for other variables like income status. This suggests that the health status of Aboriginal residents in Saskatoon can be improved substantially with appropriate social intervention. For example, the 2007 Saskatoon School Health Survey found that Aboriginal children between the ages of 10-15 were initially 181% more likely to suffer from depressed mood than Caucasian children. However, after statistical adjustment for other variables like socioeconomic status, Aboriginal children were only 13% more likely to have an independent association with depressed mood. Here is another example. In the Saskatoon Health Region, the prevalence of lifetime suicide ideation (thoughts) is 11.9%. Reviewing by income, 6.1% of high income Caucasians and 3.8% of high income Aboriginal people had lifetime suicide ideation.

The rationale for the more comprehensive research was to establish a finite number of determinants which were independently associated with health disparity in Saskatoon. Given the

reality of limited human and financial resources, it is important to ascertain the main determinants of health of which a positive return on investment is likely. If the main determinants of health responsible for health disparities are variables like income status and educational status, a comprehensive and coordinated set of policy options will be required to reduce extensive health disparity in Saskatoon.

In order to develop this comprehensive and coordinated approach to reducing extensive health disparity in Saskatoon, two additional actions were taken. First, 5000 residents from Saskatoon were contacted at random by telephone to determine which health and social disparity interventions they were willing to support. Second, over 10,000 abstracts and articles were reviewed from across the world for evidence based policy options to reduce health and social disparity. These evidence based policy options were then matched to levels of public support from the Saskatoon population. Policy experts from various government agencies, academic institutions and community groups were able to review our report prior to production, verify that the statistics were correct and ensure the evidence-based policy options were realistic in a Saskatchewan context. Through this process, an additional 100 consultations occurred.

The final results show that a number of relatively simple policies could be implemented that would have a substantial impact on reducing health disparity. For example, 26.3% of all children aged 0-2 years (and 20.1% of all children) in Saskatchewan live in poverty. The impending result of poverty in children is substantial health disparity in youth of all ages; ranging from unacceptable high mortality rates in infants to alarming differences in health and social outcomes in adolescents. If we were to implement a child poverty protection plan, modelled after the Canada Pension Plan that reduced poverty in seniors from 58% to 6%, we could substantially reduce child poverty in Saskatchewan. In our survey of 5000 Saskatoon residents, 83.8% supported strengthening early intervention programs for children, like poverty reduction. It is important to note, however, that the evidence based policy options in this report should be viewed in combination rather than in isolation. Some policy options are to address immediate needs, while others are long term strategies that address macro level social structures. For example, short term income and housing stability measures are intended to provide the necessary support and stability to low income residents to allow longer term educational and employment initiatives to have a realistic chance of success.

In total, 46 evidence based policy options are presented. The policy options to reduce health and social disparity are within the general categories of income, education, employment, housing and health care.

Significant health disparities are inconsistent with Saskatchewan values. In addition to the excess burden of illness on those who are already disadvantaged, health disparities threaten the cohesiveness of our community, challenge the sustainability of our health system and have an impact on the economy. These consequences are avoidable and can be successfully addressed. Our research shows that many of the evidence based policy options presented for discussion already have strong public support; including a wide range of general support from agencies and community groups.

CREDITS

Research team

Christina Scott, Tanis Kershaw, Wendy Sharpe, Norman Bennett, Josh Marko, Lynne Warren, Terry Dunlop, and Gary Beaudin.

Professional guidance

Professor Johan Mackenbach and Dr. Anton Kunst from Erasmus University in the Netherlands.

Funding

The Canadian Institutes for Health Research for their financial support of the grant titled "Reducing Health Disparity in Saskatoon" (grant # 149320).

Art work

Permission to use the image titled "The Broadway Bridge" displayed on the cover was obtained from The Glen Scrimshaw Gallery. For more information about the artist and his prints contact Glen Scrimshaw at gallery@glenscrimshaw.com.

Cover design and layout by DBlack Communication Inc.

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For copies of the full report

Copies of the full report can be obtained from the Saskatoon Health Region Public Health Observatory website:

http://www.saskatoonhealthregion.ca/your_health/ps_public_health_pho_about.htm

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October 2008