Health Disparity Knowledge and Support for Intervention in Saskatoon

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ABSTRACT

Background: A number of reports suggest that we need to determine public understanding about the broad determinants of health and also determine public support for actions to reduce health disparities in Canada.

Methods: A cross-sectional random survey of 5,000 Saskatoon residents was used to determine knowledge about health determinants and health disparity and then determine public support for various interventions to address health disparity.

Findings: Saskatoon residents understand most of the determinants of health except they understate the importance of social class and gender. Saskatoon residents do not have a good understanding of the magnitude of health disparity between income groups. A majority believe risk behaviours are mostly individual choices and are not associated with income status. Most residents believe even small differences in health status between income groups is unacceptable and a majority believe that something can be done to address health disparity by income status. Interventions proposed by residents to alleviate health disparity were evidence-based, including work-earning supplements and strengthening early intervention programs. Logistic regression revealed that greatest support for transferring money from health treatment to health creation services (like affordable housing and education) came from young Aboriginal males with low income.

Interpretation: Saskatoon residents have knowledge of health determinants and have a strong desire to support health disparity intervention. More knowledge transfer is required on the magnitude of health disparity based on income status. Broad-based health disparity intervention in Saskatoon appears possible.

MeSH terms: Income; income distribution; socioeconomic factors; health; health knowledge and attitudes

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

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A wide range of factors other than health care have an impact on health. These factors include, but are not limited to, income, social status, education, employment, working conditions, social support networks, physical environment, genetics, personal health practices, healthy child development, genetics, gender and the communities we live in.[1-14]

Health disparities refer to differences in health status that occur among population groups defined by specific characteristics.[4] A limited number of determinants contribute the most to health disparities.[4] Income status is recognized as one of those key determinants.[1,3,4] A recent report from Saskatoon found vast disparity in health status by neighbourhood income for numerous disorders.[12]

The *British Medical Journal* called income inequality and health "the Big Idea" and suggested that the health of a society is not judged by overall wealth as much as by how evenly that wealth is distributed through taxes and transfers.[15] For example, 58.2% of Canada's seniors would live in poverty without government transfers. As a result of government programs, only 5.7% of seniors in Canada live in poverty.[1] As such, there is good reason to believe that by addressing a few important conditions, we can reduce health disparities.[4]

Prior to initiating action, it is important to determine the degree of consensus on public values and priorities for reducing health disparities.[4] One federal/provincial committee recommended strengthening public understanding about the broad determinants of health and determining public support for actions to reduce health status disparities.[3] Another national report concluded that little is known about 1) the Canadian public's views on what factors influence health, 2) if people consider that factors like income, education, housing or social support could influence health, and 3) whether the public believes that health could be improved by addressing these factors.[5]

One paper from Canada suggests that the most important factors that contribute to health are diet (82%), physical activity (70%) and proper rest (13%).[5] When prompted, only one in three reported that economic and social conditions had an impact on health.[5] Another paper suggests 19.6% of residents in Alberta view income and social status as contributors to health status.[16] No papers were found that reviewed public knowledge on magnitude

of health disparity between population groups. One paper from Canada reviewed poverty-related policies and found greatest public support for child care programs and least support for increased welfare allowance.[17]

The purpose of the current study was to randomly contact Saskatoon residents to determine their knowledge of health determinants and health disparity and then determine which public policy actions they would support to help alleviate health disparity by income and socio-economic status.

METHODS

Sample size for the telephone survey was calculated with the following assumptions: 1) the standard error, variance and coefficient of variation should not exceed 0.075 of the proportion, 2) the smallest value of the proportion for which the required precision was to apply was 0.05 and 3) the population size of the Saskatoon Health Region was 287,448 in 2004.[18] With these assumptions, a sample size of at least 3,512 was required. Since a high level of precision was desired, a decision was made to use a sample size of 5,000.

Names and telephone numbers of 10,000 Saskatoon residents were generated by a third party specializing in random lists of phone numbers. The original sample included an equal gender split and equal numbers of residents from each of the ten electoral wards in Saskatoon. The questionnaire was pre-tested with residents with low education status. From April to July of 2006, five contract workers randomly contacted 5,000 Saskatoon residents. Each household was contacted up to five times before discontinuing. Respondents who answered the telephone were asked to participate if they were over the age of 18. The survey was conducted in English. Information on gender was collected on those who refused to participate.

The questionnaire had five sections: a) which factors affect how healthy we are,[1] b) are people with low income more or less likely to suffer medical conditions in comparison to people with middle income, c) are certain behaviours individual choices or do they result from how much money we make, d) which interventions would help address health disparity in groups with low income, and e) what are acceptable levels of

health disparity by income, can something be done about health disparity, how would we pay for new services and would you support limiting health care treatment expenditures in order to transfer money to health prevention services or health creation services like education and affordable housing.

Binary logistic regression was used to describe the relationship between the outcome variable of answering yes or no to "would you support transferring money from health care treatment resources to health-creating services like education and affordable housing" and all demographic explanatory variables. Stratification was used

to assess for confounding and effect modification in the first step of model building.[19] A hierarchical well-formulated front-wise modelling approach was used instead of a computer-generated stepwise algorithm.[19] The unadjusted effect of each covariate was determined and then entered one step at a time based on changes in the -2 log likelihood and the Wald test.[20] The final model includes factors with beta values for which the p values were less than 0.05.[20] Confounding was tested by comparing the estimated coefficient of the outcome variable from models containing and not containing the covariates.[20] Interaction was assessed

TABLE I
Demographic Characteristics of Random Phone Survey Sample (N=5000)

Characteristic	n (%)
Age group	
18-39	326 (26.5%)
40-69	2064 (41.3%)
≥65	1169 (23.4%)
Refused	441 (8.8%)
Gender	
Male	1529 (30.6%)
Female	3471 (69.4%)
Education status	
Did not complete high school	696 (13.9%)
High school completed	1281 (25.6%)
University degree or technical diploma	2631 (52.6%)
Refused	392 (7.8%)
Employment status	
Professional/ Management	821 (16.4%)
Clerical/ Sales/ Service	774 (15.5%)
Student/ Homemaker	619 (12.4%)
Manual/ Construction/ Transport/ Farmer	362 (7.2%)
Retired/ Semi-retired	1439 (28.8%)
Unemployed	202 (4.0%)
Other	363 (7.3%)
Refused	420 (8.4%)
Cultural status	
Caucasian	3746 (74.9%)
Aboriginal (First Nations or Métis)	346 (6.9%)
Other	493 (9.9%)
Refused	415 (8.3%)
Annual family income	
<$25,000	820 (16.4%)
$25,000-$49,999	944 (18.9%)
$50,000-$99,999	829 (16.6%)
≥$100,000	268 (5.4%)
Refused	2139 (42.8%)
Neighbourhood income[12] (Proxy for individual income)	
Low-income neighbourhoods (LICO)[25]	587 (11.7%)
Medium-income neighbourhoods	4055 (81.1%)
High-income neighbourhoods	358 (7.2%)
Missing	N/A
Urban or rural	
Urban	4748 (95.0%)
Rural	252 (5.0%)

TABLE II
Which Factors Affect How Healthy We Are? (N=5000)

Variable	n (%)
Income	4117 (82.3%)
Education	4255 (85.1%)
Employment	4277 (85.5%)
Social status	2933 (58.7%)
Housing	4063 (81.3%)
Community you live in	3802 (76.0%)
Recreation	4543 (90.9%)
Nutritious food	4893 (97.9%)
Gender	1553 (31.1%)
Genetics	4295 (85.9%)

TABLE III

Are People with Low Income More or Less Likely to Suffer from the Following Conditions in Comparison to People with Middle Income? (N=5000)

Condition	Much Less Likely n (%)	Less Likely n (%)	Equally Likely n (%)	More Likely n (%)	Much More Likely n (%)	Do Not Know n (%)
Mental illness	56 (1.1%)	433 (8.7%)	2427 (48.5%)	1535 (30.7%)	211 (4.2%)	338 (6.8%)
Suicide attempt	36 (0.7%)	325 (6.5%)	1837 (36.7%)	2121 (42.4%)	293 (5.9%)	388 (7.8%)
Injuries	38 (0.8%)	398 (8.0%)	2177 (43.5%)	1767 (35.3%)	170 (3.4%)	450 (9.0%)
Diabetes	23 (0.5%)	254 (5.1%)	1814 (36.3%)	2293 (45.9%)	317 (6.3%)	299 (6.0%)
Breathing problems	26 (0.5%)	260 (5.2%)	2452 (49.0%)	1744 (34.9%)	173 (3.5%)	345 (6.9%)
Heart disease	19 (0.4%)	300 (6.0%)	2578 (51.6%)	1617 (32.3%)	164 (3.3%)	322 (6.4%)
Stroke	20 (0.4%)	350 (7.0%)	2892 (57.8%)	1246 (24.9%)	124 (2.5%)	368 (7.4%)
Cancer	19 (0.4%)	270 (5.4%)	3598 (72.0%)	682 (13.6%)	73 (1.5%)	358 (7.2%)
Sexually transmitted infections	16 (0.3%)	156 (3.1%)	1617 (32.3%)	2441 (48.8%)	393 (7.9%)	377 (7.5%)
HIV/AIDS	15 (0.3%)	126 (2.5%)	1790 (35.8%)	2267 (45.3%)	395 (7.9%)	407 (8.1%)

TABLE IV

Do You Believe That Certain Behaviours Are Individual Choices or Do They Result from How Much Money We Make? (N=5000)

Behaviour	Mostly Individual Choice n (%)	Mostly How Much Money We Make n (%)	Both n (%)	Do Not Know n (%)
Alcohol abuse	2482 (49.6%)	104 (2.1%)	1683 (33.7%)	731 (14.6%)
Illegal drug use	2779 (55.6%)	100 (2.0%)	1455 (29.1%)	666 (13.3%)
Smoking	3383 (67.7%)	46 (0.9%)	995 (19.9%)	576 (11.5%)
Lack of physical activity	3158 (63.2%)	131 (2.6%)	1162 (23.2%)	549 (11.0%)

TABLE V

If Health Status Does Differ by Income, Which Variables Would Help Address Health Disparity in Groups with Low Income? (N=5000)

Variable	n (%)
Employment equity programs	3374 (67.5%)
Increasing minimum wage	3566 (71.3%)
Increasing union membership for workers	1668 (33.4%)
Increasing pension amounts to seniors	3907 (78.1%)
Increasing welfare amounts to above poverty level	2764 (55.3%)
Increasing welfare amounts to above poverty level for parents with children	3304 (66.1%)
Creating work-earning supplements for welfare recipients	4205 (84.1%)
Strengthening early intervention programs for infants	4190 (83.8%)
Creating more subsidized daycares and pre-schools	3298 (66.0%)
Increasing funding for education	3836 (76.7%)
Creating more after-school or after-work literacy programs	3833 (76.7%)
Providing more subsidized trades training for adults	4115 (82.3%)
Providing more health care treatment programs	3581 (71.6%)
Providing more health prevention programs	4099 (82.0%)
Providing more health services in schools	3458 (69.2%)
More subsidized quality housing	3338 (66.8%)
More subsidized quality housing for parents with children	3743 (74.9%)
More subsidized transit	3427 (68.5%)
More subsidized recreation	3246 (64.9%)
More subsidized nutritious food	3235 (64.7%)
More subsidized nutritious food for children	3850 (77.0%)
Creating more community groups and social support networks	3434 (68.7%)
Encouraging more volunteers in community	3618 (72.4%)
More ability to influence government decisions	3822 (76.4%)
More control for Aboriginal groups over Aboriginal land base	2142 (42.8%)
More control for Aboriginal groups over Aboriginal health programs	2320 (46.4%)
More control for Aboriginal groups over Aboriginal social programs	2678 (53.6%)
More self determination for Aboriginal groups	3004 (60.1%)

with product terms.[20] R^2 was used to determine the proportion of variance in the outcome variable explained by the knowledge of the explanatory variables but not as a measure of the appropriateness of the final model.[20] Goodness-of-fit of the final model was assessed by the Hosmer-Lemeshow statistical test.[20] The final results were presented as adjusted odds ratios with 95% confidence intervals.[19] All analyses were performed with an SPSS 13.0 software package.[21]

Ethics approval was obtained from the Behavioural Ethics Committee of the University of Saskatchewan.

RESULTS

We contacted 7,699 Saskatoon residents in order to obtain a sample size of 5,000 (65% overall response rate). There was a difference between responders and non-responders in terms of gender (males 62%, females 69%; p=0.000). Responder demographics were similar to 2001 census information except for gender, which had significantly more representation from females (Table I).

More than 75% of residents believed that income, education, employment, housing, the community you live in, recreation, nutritious food and gender are associated with health. The factors with the largest support were nutritious food (97.9%) and recreation (90.9%). The variables with the least support were social status (58.7%) and gender (31.1%) (Table II).

A majority of residents believed that disease incidence was equally likely between income groups for mental illness, injuries and poisonings, breathing problems, heart disease, stroke and cancer. A majority of residents believed suicide attempts, diabetes, sexually transmitted infections and HIV/AIDS were more likely in low-income groups (Table III).

Behaviours like alcohol abuse, illegal drug use, smoking and lack of physical activity were believed to be mostly individual choices (49.6% to 67.7% support) and not associated with income status (Table IV).

Residents believed that the interventions that would help the most to address health disparity in groups with low income include creating work-earning supplements for welfare recipients (84.1%), strengthening early intervention programs for infants (83.8%), providing more subsidized trades training for adults (82.3%) and providing more health prevention programs (82.0%). The interventions with the least support

included increasing union membership for workers (33.4%) and more control for Aboriginal groups over their own land base, their own health programs and their own social programs (42.8% to 53.6% support) (Table V). Stratification on these final three questions revealed significant differences based on responder cultural status (on average 25% more support from Aboriginals in comparison to Caucasians; p=0.000 for all three questions).

A majority of residents believed that even small differences in health status between income groups is unacceptable (most prefer 0%) and also believed that something can be done to address health disparity by income status (83.2%). Measures taken to address health disparity should come from re-distribution of current taxes (69.8%) but not new taxes. Assuming limited financial resources to pay for new services, 34% of residents supported transferring money from health care treatment resources to either health prevention services or health-creating services like education or affordable housing (Table VI).

Binary logistic regression was used to determine if any variable had an independent effect on the outcome of answering yes to the question "would you support transferring money from health care treatment resources to health-creating services like education and affordable housing". In the final regression model, females, Caucasians and cultural groups other than Aboriginals, those with family income higher than $25,000 per year and age groups greater than 40 years of age were significantly less likely to support transferring money from health care treatment to health creation services. In the final model, gender was not a confounder but cultural status was. The R^2 of the final model was .448 suggesting reasonable explanation of the proportion of variance in the outcome variable explained by the knowledge of the explanatory variables. The goodness-of-fit test result (p=0.903) suggests that the final model is appropriate and that the predicted values are accurate representations of the observed values in an absolute sense (Table VII).

DISCUSSION

It appears that most Saskatoon residents understand most of the determinants of health, although there is an emphasis on

TABLE VI
Policy Implications for Health Disparity Action (N=5000)

1. If health status does differ by income level, what would be an acceptable amount of difference in disease incidence between low-income groups and middle-income groups? (N=5000)

Percent Difference	n (%)
0%	1805 (36.1%)
10%	469 (9.4%)
25%	680 (13.6%)
50%	816 (16.3%)
100%	171 (3.4%)
200%	21 (0.4%)
Do not know	1038 (20.8%)

2. If health status does differ by income level, can something be done to address health disparity?

Yes	4160 (83.2%)
No	378 (7.6%)
Do not know	462 (9.2%)

3. Which measures would you support to address health disparity by income level?

Increase taxes	452 (9.0%)
Do not increase taxes but re-distribute current taxes	3490 (69.8%)
Neither; nothing can be done	316 (6.3%)
Do not know	742 (14.8%)

4. Assuming limited financial resources to pay for new services, would you support transferring money from health care treatment resources to health prevention services?

Yes	1686 (33.7%)
No	2415 (48.3%)
Do not know	899 (18.0%)

5. Assuming limited financial resources to pay for new services, would you support transferring money from health care treatment resources to health-creating services like education and affordable housing?

Yes	1679 (33.6%)
No	2384 (47.7%)
Do not know	937 (18.7%)

TABLE VII
Independent Variables Associated with Supporting the Transfer of Money from Health Care Treatment to Health-creating Services

Dependent Variable:
Answering yes or no to the question "would you support transferring money from health care treatment resources to health-creating services like education and affordable housing?"

Independent or Explanatory Variables:

	Beta	SE	Unadjusted OR	Adjusted OR (95% CI)	Significance
1. Gender					
Male (Ref*)					
Female	0.211	0.088	1.258	1.235 (1.038-1.468)	0.017
2. Cultural Status					
Aboriginal (Ref*)					
Caucasian	0.783	0.147	3.246	2.189 (1.639-2.922)	0.000
Other	0.528	0.192	2.136	1.696 (1.165-2.470)	0.006
3. Annual Family Income					
<$25,000 (Ref*)					
$25,000-$49,999	0.317	0.108	1.530	1.373 (1.111-1.696)	0.003
$50,000-$99,999	0.518	0.116	1.883	1.679 (1.338-2.106)	0.000
≥$100,000	0.470	0.159	1.805	1.600 (1.171-2.185)	0.003
4. Age Group					
18-39 (Ref*)					
40-64	0.220	0.092	1.545	1.246 (1.040-1.494)	0.017
≥65	0.299	0.122	1.507	1.349 (1.061-1.714)	0.014

* Reference category

behaviours like eating nutritious food and being physically active. The importance of social class and gender are understated.[4,8] No attempts were made to question how poverty influences health.

Saskatoon residents are correct about the non-association between cancer and income status.[10] They are not correct that disease incidence is equally likely between income groups for mental illness, injuries and poisonings, breathing problems, heart disease and stroke.[6,10,12-14] The magnitude of the association between suicide attempts, diabetes, sexually transmitted infections and HIV/AIDS and income status is underestimated.[12-14] For example,

chlamydia incidence is 332% higher and gonorrhoea incidence is 676% higher in Saskatoon's low-income neighbourhoods in comparison to the rest of the city.[12]

As well, it appears that Saskatoon residents are not aware of the social determinants of behaviour, choosing instead to believe that behaviours like smoking are mostly individual choice.

In terms of proposed interventions, Saskatoon residents were most willing to support earning supplements for welfare recipients and strengthening early intervention programs for infants. Both are evidence-based. Two successful pilot programs for earning supplements were recently completed in British Columbia and New Brunswick.[22,23] Early childhood development programs obtain short- and long-term health and social benefits while saving up to eight dollars for every dollar invested.[1] Comparatively, less support was observed for subsidized food and recreation, despite the near-unanimous opinion that these are major determinants of health. Unfortunately, some Saskatoon residents do not understand the benefits of Aboriginal self determination. The Royal Commission on Aboriginal Peoples recommended Aboriginal control over services as one of four key principles for any health strategy to reduce disparity.[24]

Large increases in health care expenditure (up 55% from 1997 to 2003 in Canada) have not reduced health disparities.[4] As well, it is estimated that over 20% of all health care spending is attributable to income disparities.[4] As such, a regression equation was used to help explain which demographic groups would support transferring money from health care treatment to health creation services like affordable housing and education. Greatest support was obtained from young Aboriginal males with low income. The least support came from middle-aged Caucasian females with middle income.

One limitation of the study is a large refusal rate of respondents to disclose family income. In such cases, neighbourhood income is provided as a proxy.

In summary, Saskatoon residents have a reasonable understanding of health determinants and support evidence-based interventions to address health disparity. Additional knowledge transfer is required on the magnitude of health disparity between income groups and the importance of self determination for Aboriginal Peoples.

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RÉSUMÉ

Contexte : Plusieurs études suggèrent qu'il faudrait analyser 1) ce que le public connaît des grands déterminants de la santé et 2) s'il appuie les mesures de réduction des disparités sur le plan de la santé au Canada.

Méthode : Au moyen d'une enquête aléatoire transversale auprès de 5 000 résidents de Saskatoon, nous avons évalué les connaissances des déterminants de la santé et des disparités sur le plan de la santé. Nous avons ensuite évalué l'appui du public à diverses mesures de réduction des disparités sur le plan de la santé.

Résultats : Les résidents de Saskatoon connaissent la plupart des déterminants de la santé, mais sous-estiment l'importance de la classe sociale et du sexe. Ces résidents connaissent mal l'ampleur des disparités sur le plan de la santé entre les catégories de revenu. La majorité croit que les comportements à risque sont pour la plupart des choix personnels sans lien aucun avec le revenu. La plupart des résidents considèrent cependant que même des écarts minimes dans l'état de santé selon les catégories de revenu sont inacceptables, et la majorité croit qu'il faut faire quelque chose pour réduire les disparités sur le plan de la santé associées au revenu. Les répondants ont suggéré des mesures éprouvées pour réduire les disparités sur le plan de la santé, dont les suppléments du revenu de travail et le renforcement des programmes d'intervention précoce. Une analyse de régression logistique a montré que ce sont les jeunes hommes autochtones à faible revenu qui sont le plus en faveur des mesures, comme le logement abordable et l'instruction, qui nécessitent des transferts budgétaires entre les soins de santé et les services de « création de la santé ».

Interprétation : Les résidents de Saskatoon connaissent les déterminants de la santé et appuient solidement les mesures de réduction des disparités sur le plan de la santé. Il faudrait accroître le transfert des connaissances sur l'ampleur des disparités sur le plan de la santé entre les catégories de revenu. Des mesures générales de réduction des disparités sur le plan de la santé sont envisageables à Saskatoon.