HEALTH DISPARITY IN SASKATOON: ANALYSIS TO INTERVENTION

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EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

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 war torn nations like Bosnia.

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. Access to 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 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; which was statistically non-significant. Here is

another example. In the Saskatoon Health Region, the prevalence of lifetime suicide ideation (thoughts) is 11.9%. Of low income Caucasians, 17.5% had a lifetime suicide ideation in comparison to 6.1% of high income Caucasians. Of low income Aboriginal people, 33.1% had lifetime suicide ideation in comparison to 3.8% of high income Aboriginal people. In other words, 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 independent determinants 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 are variables like income status and educational status, it will take a much more comprehensive and coordinated approach to reduce extensive health disparity in Saskatoon.

In order to develop a comprehensive and coordinated approach to reduce 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 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 the affected government agencies and community groups and associations were able to review this report, 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.

A number of relatively simple policies could be implemented that would have a substantial impact on population health. 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. It is important to note, however, that the evidence based policy options in this report should be viewed collaboratively 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 allow longer term educational and employment initiatives to have a realistic chance of success.

Saskatchewan residents understand firsthand the problem of poverty and the need to work together as a community to solve complex problems. Saskatchewan was the hardest hit province in the Great Depression from 1929 to 1939. At that time, two thirds of Saskatchewan's' rural population was on social assistance and 290 out of 302 municipalities required government assistance. As a result of impoverished conditions, very few people could afford necessary health services. It is from this collective despair and hardship that innovative solutions were found. After ten years of difficult negotiation, Matt Anderson initiated a regional health insurance plan for the municipality of McKillop, the town of Strasbourg and the villages of Bulyea and Silton on January 1, 1939. Mr. Anderson bridged consensus within his regional municipality, negotiated contracts with private practice physicians (including a 50% cost reduction for services) and hospitals and received legislative authority from the provincial government to levy a local tax of $5.00 per person per annum. Within two years, five other municipalities initiated their own regional plans. By 1946, the Government of Saskatchewan had adopted universal hospital services and in 1962 Medicare with physician services became compulsory. The regional plan initiated by Matt Anderson in 1939 became the pride of Saskatchewan when it was adopted throughout Canada in 1972.

In his book, The End of Poverty, the world renown economist Jeffrey Sachs suggests that we should not state what amount of aid someone in need will receive. Instead, we should determine what someone needs in assistance and then raise the required amount. Sachs notes that the problem is not public opposition to greater aid but rather a lack of leadership to ask the public for greater efforts. If Saskatchewan can pioneer something as complex and ground breaking as Medicare, perhaps Saskatchewan can pioneer other social initiatives like having the lowest levels of child poverty in the world.

Moral reasons aside, it is in our collective interest to reduce social disparity. Section 2.9 uses a linked dataset to demonstrate that low income residents consume an extra $179 million in healthcare costs than if they were middle income. This does not include the additional costs for social services and corrections. Research from British Columbia found that proactive housing for homeless individuals would save $17,985 per person in health, social and correctional costs on an annual basis.

The overall purpose of this report is to describe the extent of health disparity in the Saskatoon community, to determine the causes of health disparity, to explain that health disparity is mostly preventable and to suggest that evidence based policy options with sufficient public support should proceed into action.

MAIN RESEARCH FINDINGS

1. Residents that live in the six low income neighborhoods of Saskatoon are:

a) 1458% more likely to attempt suicide,
b) 1389% more likely to have Chlamydia,
c) 3360% more likely to have hepatitis C,
d) 676% more likely to have gonorrehea,
e) 154% more likely to have a teenager give birth to a child
f) 448% more likely to have an infant die in the first year

in comparison to higher income residents

2. Children aged 10-15 years old that live in the six low income neighbourhoods are:

a) 180% more likely to report low self report health
b) 200% more likely to be depressed
c) 250% more likely to be anxious
d) 190% more likely to have suicidal thoughts
e) 41% more likely to have low self esteem
f) 1140% more likely to be smoking already
g) 200% more likely to be using alcohol already
h) 190% more likely to be using marijuana already
i) 80% more likely to be physically inactive
j) 60% more likely to be bullied

in comparison to higher income children

3. After statistically controlling for other variables (demographics, other socioeconomic status, cultural status, disease intermediaries, other health disorders, behaviours, like stress and healthcare utilization) low income residents in Saskatoon are:

a) 50% more likely to report low self report health,
b) 196% more likely to have diabetes,
c) 118% more likely to have heart disease,
d) 367% more likely to have suicidal thoughts,

e) 130% more likely to be a daily smoker,
f) 72% more likely to have a child that is not fully immunized
g) 107% more likely to have a child that is depressed.

4. After statistically controlling for other variables, Aboriginal cultural status no longer has a statistically significant association with low self report health, diabetes prevalence, heart disease prevalence, lower child immunization rates and depressed mood. After controlling for other variables, Aboriginal cultural status retains a statistically significant association with suicide ideation and daily smoking; albeit a greatly reduced association.

The reduction in association between Aboriginal cultural status and a health disorder or risk behaviour after controlling for other factors:

a) 21% less likely to report low self report health
b) 24% less likely to have diabetes
c) 4% less likely to have heart disease
d) 184% less likely to have suicidal thoughts
e) 186% less likely to be a daily smoker
f) 64% less likely to have a child that is not fully immunized
g) 168% less likely to have a child that is depressed.

SUMMARY OF EVIDENCE BASED POLICY OPTIONS

A. Overall:

Evidence Based Policy Option #1 – Develop a Multi-Year, Targeted Plan to Reduce Poverty

Develop an effective plan to reduce poverty and health inequality for Saskatoon and Saskatchewan that includes a multi-year approach with concrete measurable targets, broad support and an evaluation plan.

B. Income Disparity:

Evidence Based Policy Option #2 – Set Measurable Goals to Reduce Poverty

The following goals should be considered for the City of Saskatoon:

- Reduce Low Income Cut-Off (LICO) households from 17.1% to 10% in five years
- Reduce the number of children living below LICO from 20.1% to 2% in five years

Evidence Based Policy Option #3 – Ensure no Child Lives in Poverty

Parents with children who are on social assistance should have their shelter allowances and their adult allowances (i.e., food, clothing) doubled in order to raise children to the LICO.

Evidence Based Policy Option #4 – Create a Child Poverty Protection Plan

Establish a Child Poverty Protection Plan to reduce poverty in children in Saskatchewan.

Evidence Based Policy Option #5 – New Legislation to Eliminate Child Poverty

Establish a legislative requirement in Saskatchewan to eliminate child poverty.

Evidence Based Policy Option #6 – Remove Work Earning Clawbacks

Work earning supplements should be coupled with the removal of work earning clawbacks to transition return to work and promote voluntary withdrawal from social assistance.

Evidence Based Policy Option #7 – Index Social Assistance Rates to Inflation

Social assistance rates should be increased as recommended in policy option #3 and then index future rates to inflation.

Evidence Based Policy Option #8 – Change Lower Limit Tax Exemptions

Change the lower limit tax exemption for low income workers and offset the revenue loss by removing the lower limit tax exemption for higher income earners.

Evidence Based Policy Option #9 – Review Program Effectiveness of Social Services

The Ministry of Social Services should consider reviewing the effectiveness of its programs in order to accomplish its long term objectives.

Evidence Based Policy Option #10 – Increase Public Understanding of Social Determinants of Health

Enhance the understanding of the general public about the determinants of health and the economic costs of not proactively addressing poverty.

Evidence Based Policy Option #11 – Increase Support for Parents on Leave

Increase the Employment Insurance rate for new parents on parental leave from 55% to 80% of employment income prior to leave.

Evidence Based Policy Option #12 – Create a Single Resource for Those Unable to Work

Consolidate income assistance and disability providers into one resource with identical and equitable assistance rates for those unable to work.

C. Education Disparity:

Evidence Based Policy Option #13 –Set Measurable Goals to Reduce the Number of Children Not Attending School

We should set a goal to reduce the number of children not in school from 690 children under the age of 19 to no more than 100 children under the age of 19 by 2010.

Evidence Based Policy Option #14 – Increase High School Graduation Rates

We should set a goal that 90% of Aboriginal children graduate from high school within 10 years (or by 2017) up from the current graduation rate of 48%.

Evidence Based Policy Option #15 – Increase Support for Community Schools

Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health.

Evidence Based Policy Option #16 – Universal Child Care for Low Income Parents

Child care should be provided to all low income parents at no direct cost in community schools in low income neighbourhoods.

The pre-school and pre-kindergarten programs should be expanded in community schools in low income neighbourhoods and be provided at no direct cost to low income parents.

Evidence Based Policy Option #17 – KidsFirst should include children most in need

The *KidsFirst* program should include children and families that are in most need.

Evidence Based Policy Option #18 – Reserve Education Placements for Low Income Students

Learning institutions like SIAST should allocate 10% of their existing skills training vacancies to adults who have been on social assistance for more than one year to take the program at no cost.

The skills training sessions should be adapted to include academic support and if required support from health services (i.e., mental health).

Evidence Based Policy Option #19 – Redirect Funds from Ineffective to Effective Programs

Re-allocate funding from job search initiatives with limited success to skills enhancement programs.

Evidence Based Policy Options #20 – Affordable Tuition for Students

Cap the student portion of university tuition fees while increasing the provincial portion in funding. The student portion for low income students should be waived altogether.

Evidence Based Policy Option #21 – Change the Legal Drop Out Age

Increase the age that a youth can legally stop attending school from 16 years old to 18 years old; unless high school graduation has already been obtained.

Evidence Based Policy Option #22 – Cap Annual Health Care Spending Increases

Cap the annual growth of the health care treatment sector at 5%, instead of 10%, in order to re-distribute financial resources to health enhancing activities like education.

D. Housing Disparity:

Evidence Based Policy Option #23 – Set Measurable Goals to Create More Access to Affordable Housing

Reduce the number of people on the waiting list for affordable housing from 2,150 to zero in four years (2011).

Evidence Based Policy Option #24 – Expand Affordable Housing Projects

The City of Saskatoon should continue to examine the benefits of development of a Land Trust, designating surplus city land to affordable housing projects, inclusionary zoning, improving the speed of approval process for affordable housing and a five year tax abatement for affordable housing projects/units.

Evidence Based Policy Option #25 – Reserve 10% of New Development for Affordable Housing

Any developer that purchases land from the City of Saskatoon should set aside 10% of the new development for affordable housing.

Evidence Based Policy Option #26 – Expand Not-for-Profit Housing Authorities

The provincial government should consider purchasing 20 abandoned or neglected multifamily and apartment buildings in the heart of Saskatoon's six low income neighbourhoods, renovate them and transfer the title to not-for-profit housing authorities with the eventual goal of transferring title to home ownership.

The provincial government should consider adopting this policy for at least four years to address chronic housing shortages.

Evidence Based Policy Option #27 – Support for Home Ownership

The provincial government should consider investing in a Saskatoon-based home ownership pilot program to convert 31 multi-units provincially owned affordable rental units to home ownership. A long-term rent-to-own program should be considered to increase the number of households in stable, safe, affordable housing.

Evidence Based Policy Option #28 – Create a Youth Homelessness Prevention Strategy

Develop and implement a permanent and comprehensive youth homelessness prevention strategy to eradicate youth homelessness in Saskatoon.

In addition to the need for overall service coordination, the province of Saskatchewan should consider converting and targeting 125 affordable housing units to supportive housing for at risk and homeless youth.

Evidence Based Policy Option #29 – Develop a Long-term, Consolidated, Comprehensive, Interagency Social Housing System for Hard to House Individuals

Develop a long term, consolidated, comprehensive, interagency social housing system in Saskatoon and Saskatchewan for hard to house individuals; including those living with mental health problems and addictions.

Evidence Based Policy Option #30 – Build Community Acceptance for Affordable Housing

Develop a communication strategy to overcome the stigma of affordable housing in order to gain community acceptance.

Evidence Based Policy Option #31 – Increase Monthly Shelter Allowances

The Saskatchewan government should consider increasing monthly shelter allowances for all households receiving income assistance to match the 2008 average monthly rental rate and also include the total monthly cost for utilities.

In addition, shelter allowance rates should be reviewed bi-annually and compared to current average monthly rates and brought up to market standards when necessary.

Evidence Based Policy Option #32 – Renewed Federal Responsibility for Social Housing

The federal government needs to restore funding for social housing to the levels established prior to 1986.

E. Employment Disparity:

Evidence Based Policy Option #33 – Setting Measurable Goals: More Work for Aboriginal People

Aboriginal representation in the workforce should increase to 15% of full time service jobs, 15% of management positions and 15% of professional workplaces within 10 years; or by 2017.

Evidence Based Policy Option #34 – Increase Minimum Wage

The minimum wage should be increased to $10 per hour in order to encourage employment, make work more attractive than employment assistance, and lower the amount of children living in poverty.

Evidence Based Policy Option #35 – More Control for Aboriginal People over Employment and Academic Programs

More control for Aboriginal people over their own employment and academic programs.

Evidence Based Policy Option #36 – Support Aboriginal Owned Businesses

Support the creation of Aboriginal owned businesses by signing preferred supplier contracts.

Evidence Based Policy Option #37 – Comprehensive Return to Work Programs

Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required.

Evidence Based Policy Option #38 – Social Assistance as a Transition to Work…When Possible

Use Social Assistance as a transition to work when possible with enhanced benefits that are time sensitive (i.e., five years) to ensure that they achieve their intended results.

F. Disparity in Health Services:

Evidence Based Policy Option #39 – Health Disparity Reduction: A Health Sector Priority

Make health disparity reduction a health sector priority in the Saskatoon Health Region.

Evidence Based Policy Option #40 – Integrated Planning for Disparities Reduction

Integrate disparity reduction into all health programs and services in the Saskatoon Health Region.

Evidence Based Policy Option #41 – Intersectoral Action

Engage other sectors (i.e., education, social services) in health disparities reduction other than health care treatment.

Evidence Based Policy Option #43 – Knowledge Infrastructure

Strengthen knowledge development and exchange activities of health disparity.

Evidence Based Policy Option #43 – More Health Resources in Low Income Neighbourhoods

The number of health resources in Saskatoon's low income neighbourhoods should, at the very least, be proportionate to the size of the population; let alone to the disproportionate number of health disorders.

Evidence Based Policy Option #44 – Integrated Health Services in Low Income Neighbourhoods

The Saskatoon Health Region should offer integrated and comprehensive services in Saskatoon's six low income neighbourhoods including public health, mental health, addictions and primary care services.

G. Disparity within Cultural Groups

<u>Evidence Based Policy Option #45 – Aboriginal Self Determination</u>

Aboriginal people in Saskatchewan should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal people.

<u>Evidence Based Policy Option #46 – Ensure Federal Responsibility for "Registered Indians"</u>

The federal government must assume its full constitutional responsibility for all "Registered Indians" under Section 91(24) of the Constitution Act, 1867. Jurisdiction and responsibility must go together.

Summary

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.