

Health Inequities: the Tsunami of Health Care?

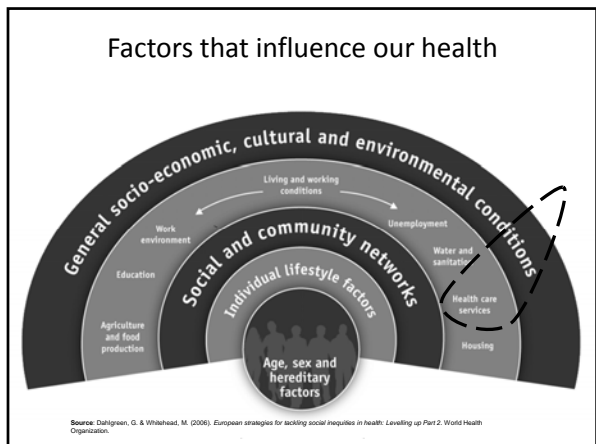
Chronic Disease Prevention and Management Conference June 2010

Dr. Cory Neudorf
Chief Medical Health Officer
Saskatoon Health Region

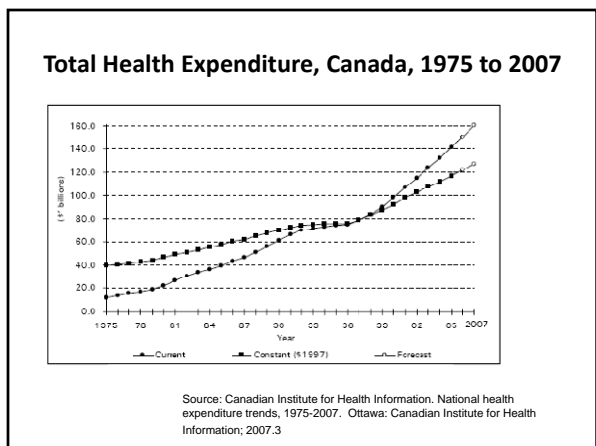
Outline

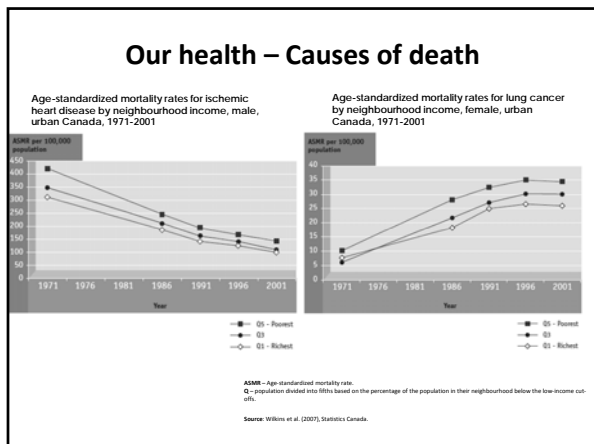
- Health Inequity reporting at International, National and local levels
- Statistics: the elements of a building tsunami
 - Increased health spending vs total spending,
 - Population demographic projections,
 - Age specific prevalence of chronic conditions,
 - Health inequity in outcomes
- What can we do about it?
 - Advocate for policy change (SDOH) (political will/public support)
 - Shift emphasis / balance more toward prevention and primary care
 - Chronic disease management / health care equity audit approach
- What if we do nothing?





The Statistics





BOX 3.2: INVESTING FOR HEALTH AND ECONOMIC RETURN, CANADA

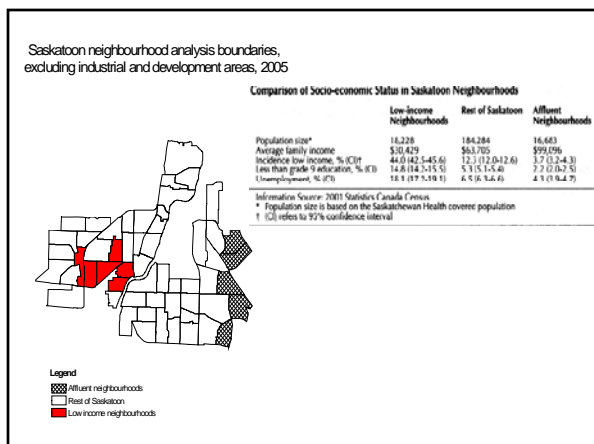
A study in Canada shows that reducing health disparities has the potential for major economic benefits resulting from a reduction both in health-care needs and in the costs of lost productivity.

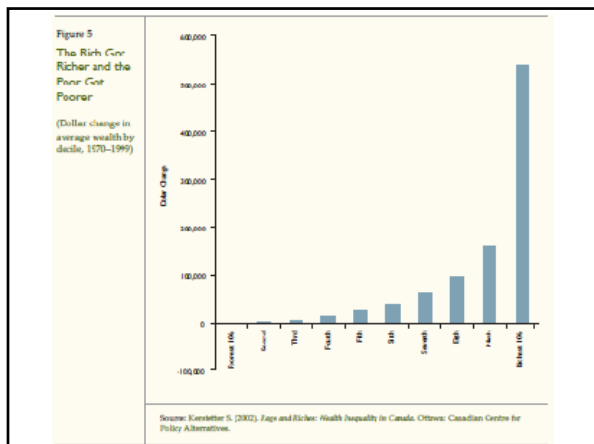
Health-care spending in Canada is about 120 billion Canadian dollars per year (with the institutionalized population accounting for 26 billion Canadian dollars and the household population accounting for 94 billion Canadian dollars). The lowest income quintile of the household population accounts for approximately 31% of the 94 billion Canadian dollars, approximately

double the utilization of the highest-income quintile. The study reported that if the health status and utilization patterns of those in the lower-income groups equalled those with middle income, significant savings on health-care costs could be possible.

In addition, the study reported that better health enables more people to participate in the economy. Reducing the costs of lost productivity by only 10-20% could add billions of dollars to the economy.

Source: Health Disparities Task Group, 2004





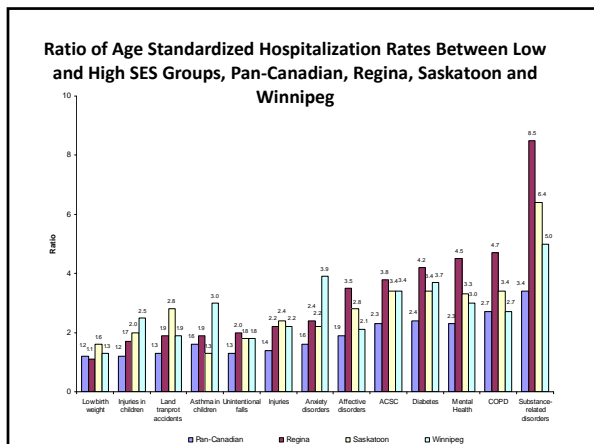
Income and Health, selected results

In comparison to high income residents, low income residents in Saskatoon (2005 data) are:

- 1389% more likely to have chlamydia
- 3360% more likely to have Hepatitis C
- 1549% more likely to have a teen birth
- 448% more likely to have an infant die in the first year

Full immunization 46% vs 95% high income

Health Issue	Rate Ratio Core : Total Saskatoon	Rate Ratio Core : Affluent
Hospitalizations		
Suicide Attempts	3.75 (275%)	15.58 (1458%)
Mental Disorders	1.85 (85%)	4.27 (327%)
Injuries and Poisonings	1.54 (54%)	2.46 (146%)
Diabetes	3.98 (298%)	12.86 (1186%)
COPD	1.38 (38%) n/s	1.53 (53%) n/s
Coronary Heart Disease	1.34 (34%)	1.70 (70%)
Stroke	1.33 (33%) n/s	1.82 (82%) n/s
Cancer	0.89 (no difference) n/s	1.02 (no difference) n/s

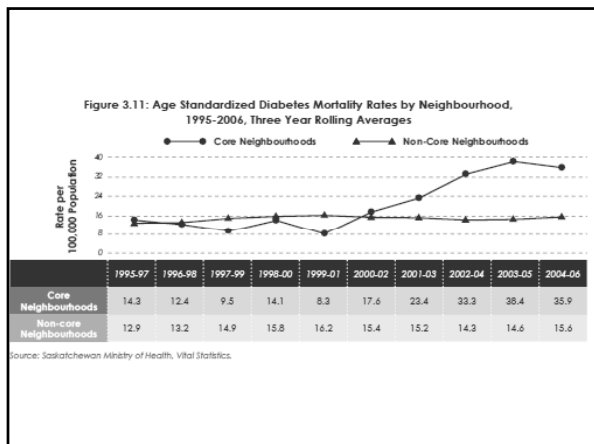


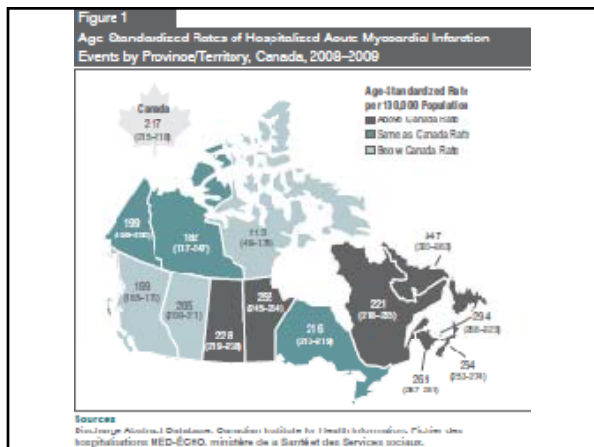
Demographics

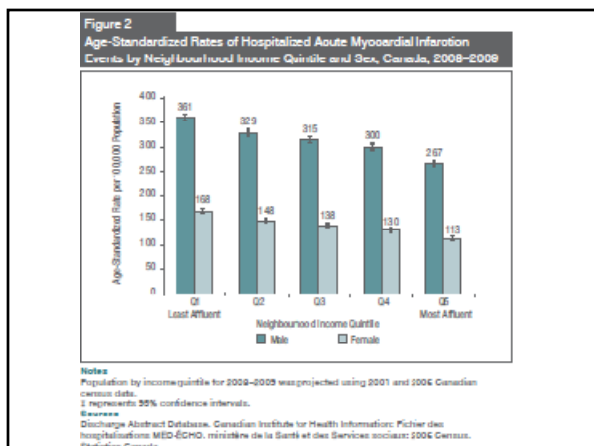
Table 1.1: Population Structure, Saskatoon Health Region, 2008

Age Group	0-14	15-24	25-44	45-64	65-74	75+	Total	% of Region's Population
SHR Total	18.1%	15.0%	27.6%	25.9%	6.3%	6.6%	298,271	100%
City of Saskatoon	17.7%	15.4%	28.9%	25.5%	6.0%	6.5%	218,578	73.3%
Rural SHR	19.2%	14.2%	24.9%	26.7%	7.3%	7.6%	79,798	26.7%
Saskatoon CMA	18.3%	15.2%	29.0%	25.5%	5.9%	6.1%	249,010	83.5%
Core Neighbourhoods	21.5%	16.2%	31.2%	23.0%	4.5%	3.7%	16,861	5.7%
Non-Core Neighbourhoods	17.4%	15.3%	28.7%	25.7%	6.1%	6.7%	201,712	67.6%
Registered Indian Status	34.5%	21.3%	30.5%	11.9%	1.3%	0.5%	18,274	6.1%
Non Registered Indian Status	17.1%	14.6%	27.6%	26.8%	6.7%	7.2%	280,097	93.9%

Source: Saskatchewan Ministry of Health Covered Population.







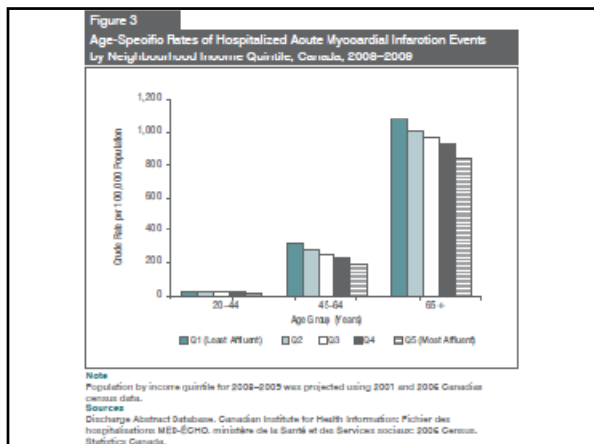
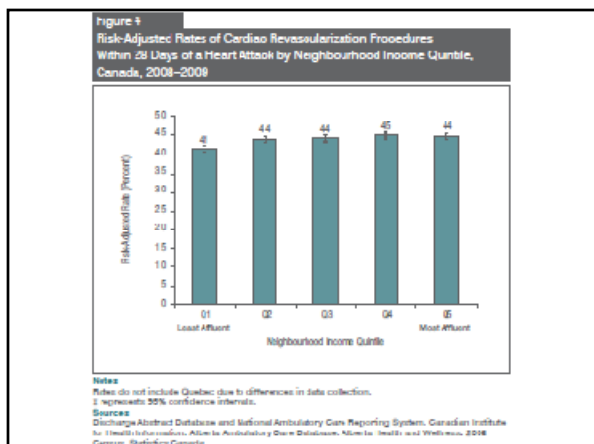
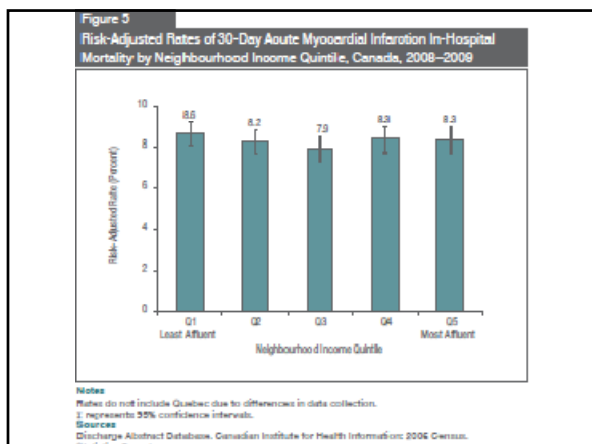


Table 2
Characteristics of Heart Attack Patients on Admission to Hospital by Neighbourhood Income Quintile, Canada, 2008-2009

	Quintile 1 (Least Affluent)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Most Affluent)
Age (Years), Median	71	71	71	70	70
Female, ^a Percent	39.8	37.7	35.6	34.4	33.3
Comorbidities, ^b Percent					
Shock	1.8	1.6	1.6	1.6	1.5
Heart Failure ^c	15.2	13.9	13.1	12.9	11.9
Acute Lung Edema	0.3	0.4	0.3	0.5	0.3
Cardiac Dysrhythmia ^d	8.3	8.2	7.6	7.7	7.2
AMI in the Preceding Year ^e	6.9	6.2	5.9	5.2	5.4
Diabetes ^f	31.0	29.0	25.7	25.9	24.9
Renal Disease ^g	7.3	6.7	6.1	6.2	5.7
Cancer	0.9	0.9	0.9	0.8	0.9
COPD ^h	4.1	3.3	3.1	2.8	2.7
Hypertension ⁱ	4.6	4.2	3.8	4.0	4.4
Admitted to a Facility With On-Site Revascularization Services, ^j Percent	34.2	33.3	34.0	34.0	35.9

Notes:
 * Statistically significant ($p < 0.05$) as per chi-square test.
 † If coded as a significant comorbidity at the time of hospitalization in Discharge Abstract Database. Please refer to the Canadian Coding Standards for the definition of significant comorbidity.¹⁶
 ‡ Quebec is not included due to differences in data collection.
 § COPD: chronic obstructive pulmonary disease.
Sources: Discharge Abstract Database, Canadian Institute for Health Information; 2006 Census, Statistics Canada.





Health Inequity: the Health System response

- The availability of universal health insurance has not eliminated extensive health disparities
- Large increases in health care spending in Saskatchewan has led to very few actual service enhancements and have not reduced health disparities
- CIHI report - 20% of total health care spending may be attributed to income disparity alone. As such, Saskatchewan could save approx. \$ 640 million annually in health care costs if income equity was achieved

Reducing Health Disparities : Role of Health Sector - Complications

- Low income groups use less preventative services even when provided at no direct cost
- Low income groups have more complex needs yet have less access to continuous care or a familiar provider
- Low income groups less likely to receive optimal care
- Low income groups less likely to be referred to a specialist
- An episode-oriented medical and hospital system that focuses on discrete events and crises is often unable to address the more complex and continuous needs of at-risk populations

**Examples of Health System responses:
SHR**

- A. Health disparities reduction has been made a health sector priority in the Saskatoon Health Region, and is being integrated into SHR programs and services
- B. Health care Equity Audits are being done by SHR services and departments
- C. The number of health resources available in Saskatoon's low income neighbourhoods has been increasing, but needs to be proportionate to the needs in those neighborhoods (Equal service for equal need).
- D. Health services are becoming more integrated and comprehensive in Saskatoon's low income neighbourhoods (including public health, mental health, addictions and primary care services.)

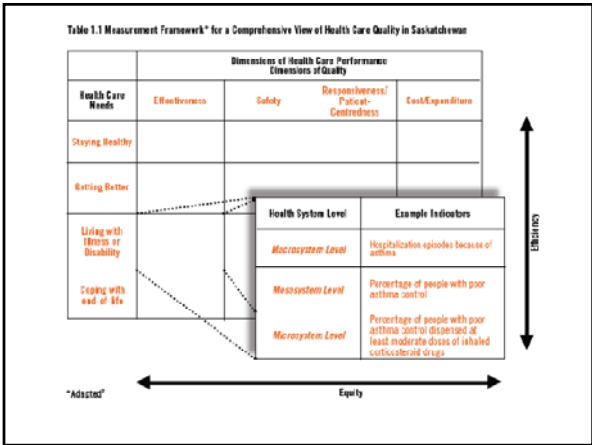
What Else Can the Health System Do?

- Recommend an All-of-Government approach to this issue. Work to make "Reducing the Gap" or "Equity Till 18" a foundational goal.
- Make it clear that it is a political choice to set the poverty rate in a jurisdiction.
 - E.g. "The Minister of Finance can choose what level of poverty we will live with" M. Marmot 2008
- Don't let special interest groups sway resolve by claiming "now is not the time"
 - Largest gains in Life expectancy in UK came in the 2 decades of world war (social solidarity leading to the welfare state) therefore there is opportunity in our current economic crisis. M.Marmot 2008
- Need 2 things to effect change on health inequities:
 - Community support
 - Political will
- Reducing the Gap is an ethical imperative, not a partisan issue, but it needs to be translated into whatever language is understood by the various sectors to which you are speaking. Different ideologies may support different elements within an overall strategy. E.g. Business sector, religious community, Gov't, etc

What Else Can the Health System Do?

- Support ongoing research- e.g. costs of poverty vs. interventions, relative contributions of various determinants, identifying disparities in urban and rural areas and in specific risk groups, monitor public support
- Support evaluation of interventions being tried (for sufficiency and effectiveness)
- Promote regular reporting on progress – report cards, repeated health disparities reports to monitor situation
- Promote mechanisms that allow or encourage inter-ministerial solutions
- Become aware, and educate politicians about the causes and solutions
- Adopt what has worked in other provinces, or work together with other provinces to collectively ask for federal policy changes
- Take part in National and North American planning in response to WHO Commission report
- Change what you can in your own sphere of influence (home, workplace, neighbourhood, community, etc) locally, provincially, nationally, globally
- Carry out Health Care Equity Audits and act on them

Health Care Equity Audits



Health care equity program Objectives

Identify The Problem

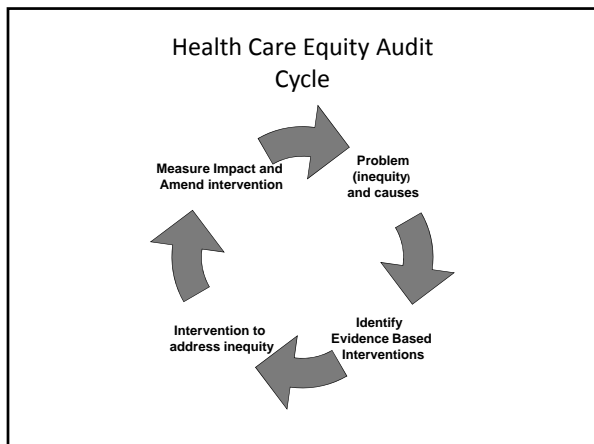
- To identify systematic inequities in access to and uptake of needed health care services in Saskatoon Health Region.
- To understand the factors which contribute to these inequities in SHR

And the Solution

- To identify interventions that have been shown to work to address these factors reduce the inequities
- To promote their implementation in SHR
- To evaluate impact of interventions implemented to reduce inequities identified

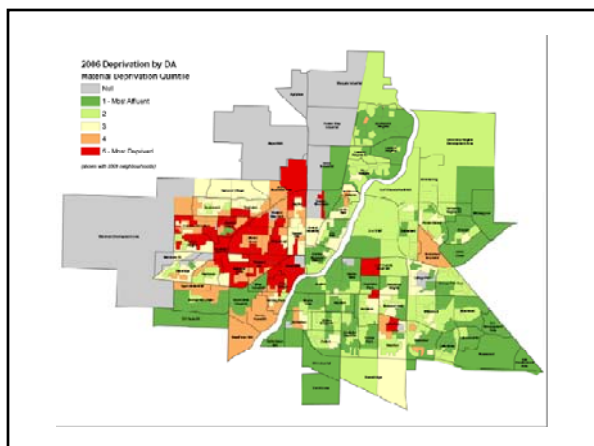
Mainstream the Approach

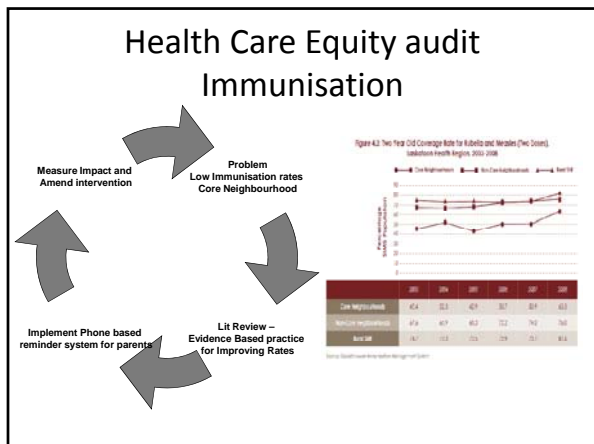
- To develop a health care equity audit tool to form integral part of the quality assurance programs of the health Region
 - Audit tools with evidence based guides to intervention options



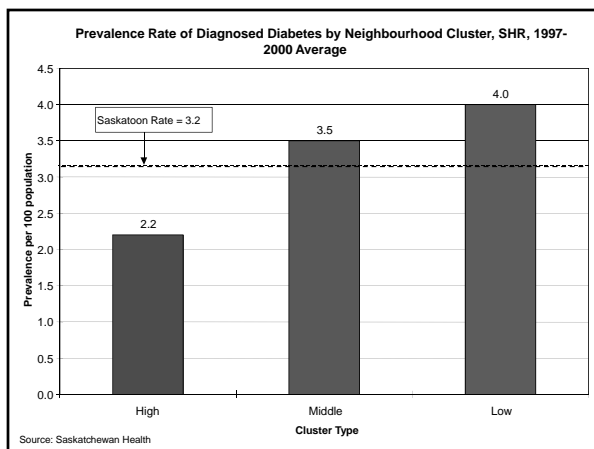
Saskatoon Health Region Strategic Plan 2009 / 10

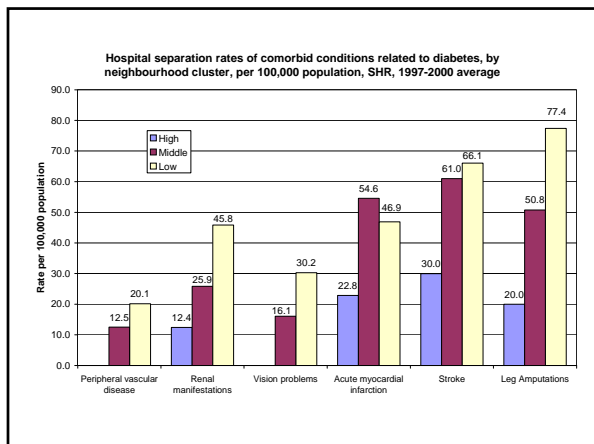
- By 31 March 2010 to have completed health care equity audits in 3 areas of the health regions work.
- Immunisation
- Diabetes
- Surgical Procedures












Quality of Care for Diabetes - Saskatchewan 2005/2006

Income	≥ 2 A1c tests %	A1c ≤7%	L Limb Amputation Per 1000	Hypo/Hyper admission Per 1000	ESRD Per 1000
Lowest 20%	35.1	46.3	4.8	5.4	2.8
Highest 20%	42.1	51.5	2.3	3.6	1.6
RIS	31.3	43.6	8	8.2	4.8



Saskatoon Health Region

Summary table for crude rate, percentage of diabetics with hospitalizations for following reasons, 2004/05-2006/07 combined

	Acute MI	Coronary Heart Disease	Stroke	End Stage Renal Disease	Glycemia	Renal Disease	Peripheral Circulatory Disease	Hospitalization any cause	Death any cause
Core Nhds	1.6	5.4	1.5	0.9	0.9	2.7	0.9	28.9	3.5
Middle Inc Nhds	1.4	5.1	1.3	0.3	0.6	2.3	0.7	27.8	3.4
Affluent Nhds	0.7	3.2	0.7	0.2	0.6	1.2	0.1	22.3	1.7

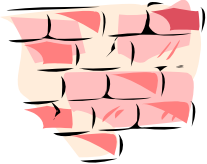
Barriers to Quality Healthcare

Patient

- Affordability
- Family responsibilities
- Emotional stress
- Demands of work
- Language
- Lack of awareness

Service

- Availability of service
- Culturally insensitive services
- Complexity of access
- Bad experience of service
- Discrimination
- Clinical practice




Health Care Equity Audit Surgical procedures (City Residents)

Procedures

- Cataract
- Hysterectomy
- Hip Replacement
- Knee Replacement
- Cardiac revascularization
- Back Surgery
- Caesarean section

Analysis

- Age specific procedure rates
- Age specific readmission rates
- Waiting times
- Age specific Length of in patient stay
- % day case
- **Populations**
 - Gender
 - Area of residence
 - Cultural background



Health System Response - Summary

- While our health is only 20-30% determined by the Health System, we need to do our part in reducing inequity by acting on what is within our power to change – the balance of services we provide, the equity dimension of quality, and providing equal service for equal need
- We also need to support and advocate for policies and programs in other sectors that determine the other 70-80% of people's health

The cost of inaction

- A Tsunami of ill, elderly baby boomers with unrealistic expectations of the health care system's responsibility to "fix" them will make treatment costs unsustainable in the present model of care
 - More pressure from the wealthy to privatize so they can pay to get the best timely service while the rest of the system erodes
 - Continued tax cuts will further undermine the public services that determine our health, including health care
 - Most people get the worst of both sides (poor access to publicly funded tertiary treatment and an underfunded primary care and prevention system).
- The "Early warning system" has sounded: we still have time to move to higher ground!
