



Health Disparity in Saskatoon:

Moving beyond reports to
Reducing the Gaps

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Setting the stage for the day:

■ Morning:

- Introduction to Social Determinants of Health (SDOH) reports and activities
- Presentations (local examples and tools)

■ Afternoon:

- Small group work on taking action and next steps



Introduction

National and International Work on Health Inequalities/Inequities

WHO Commission on the Social Determinants of Health Final Report August 2008 “Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health”

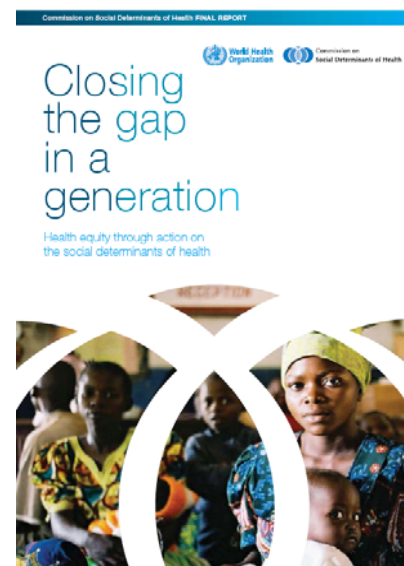
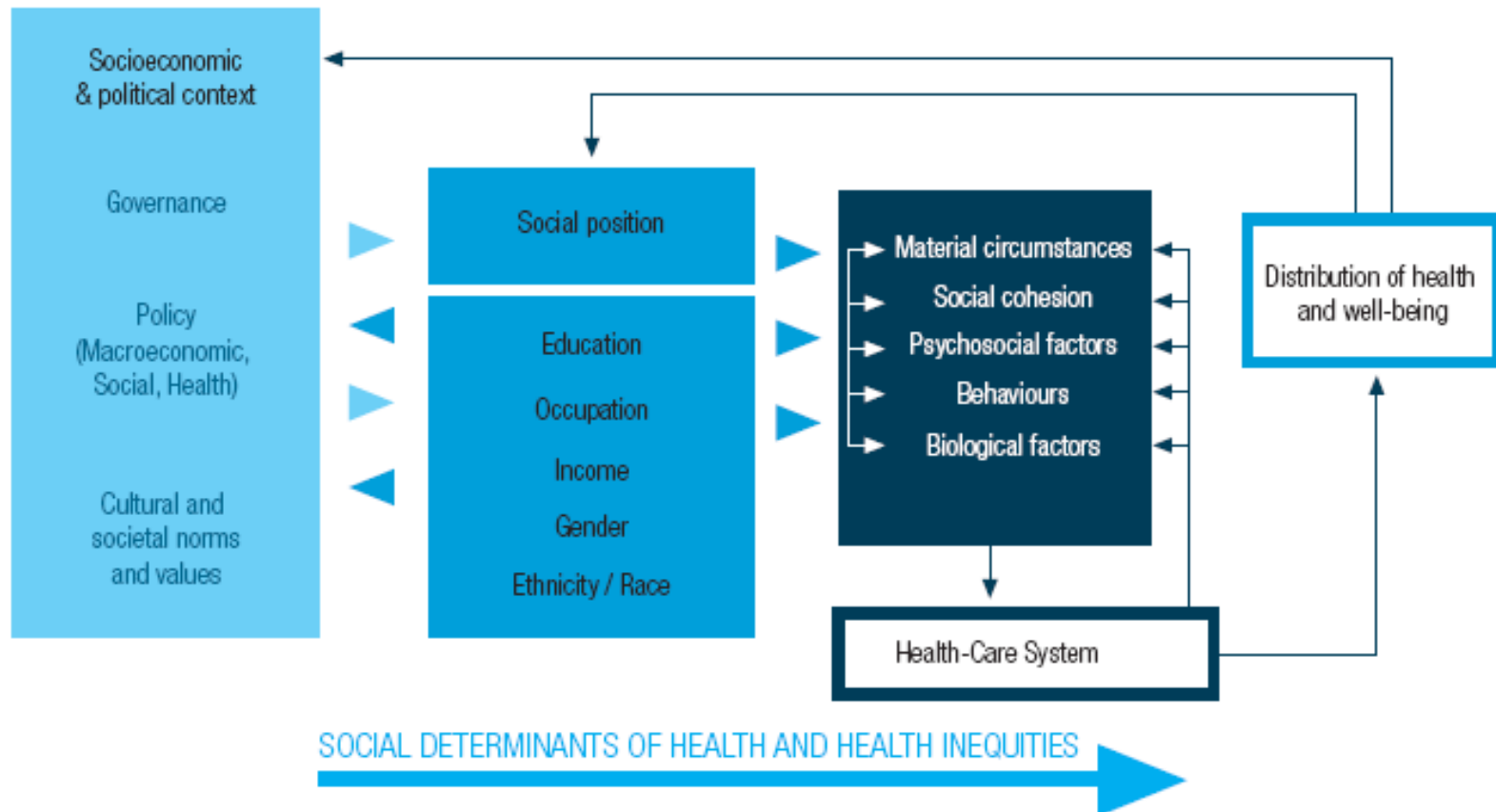
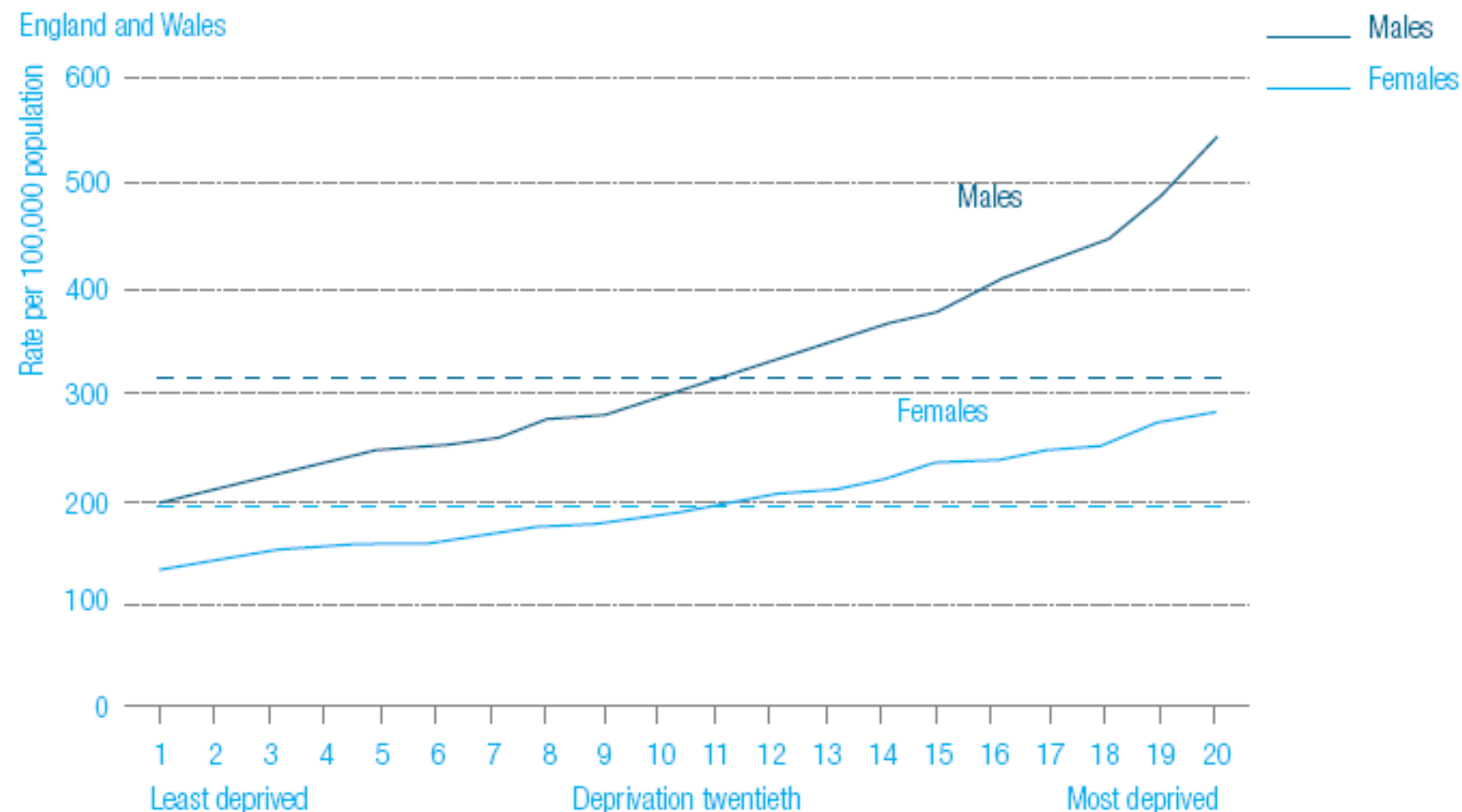


Figure 4.1 Commission on Social Determinants of Health conceptual framework.



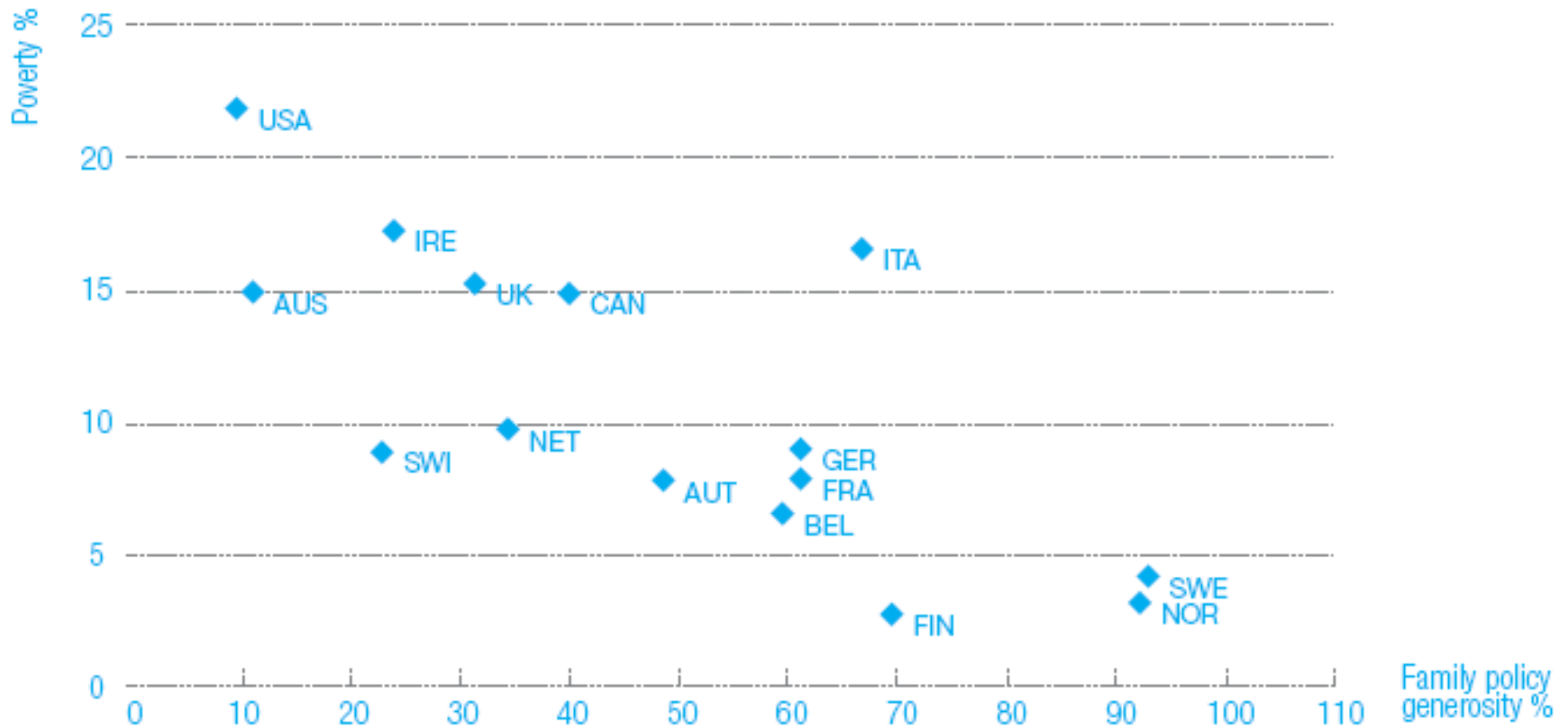
Source: Amended from Solar & Irwin, 2007

Figure 2.3: Death rates, age standardized, for all causes of death by deprivation twentieth, ages 15–64 years, 1999-2003, United Kingdom (England and Wales).



Dashed lines are average mortality rates for men and women in some areas of the United Kingdom (England and Wales).

Total family policy generosity and child poverty in 20 countries, circa 2000.

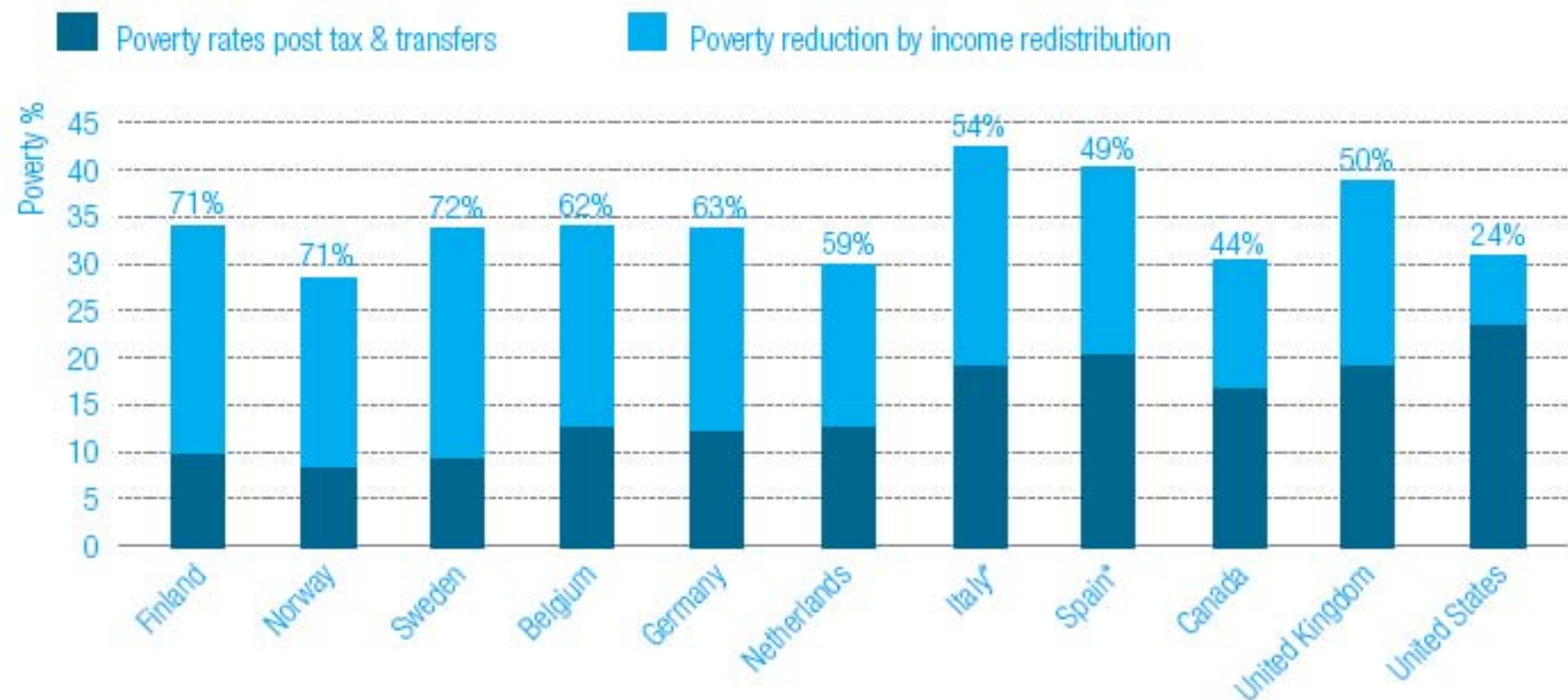


Net benefit generosity of transfers as a percentage of an average net production worker's wage.

The poverty line is 50% of median equivalized disposable income.

AUS = Australia; AUT = Austria; BEL = Belgium; CAN = Canada; FIN = Finland; FRA = France; GER = Germany; IRE = Ireland; ITA = Italy; NET = the Netherlands; NOR = Norway; SWE = Sweden; SWI = Switzerland; UK = the United Kingdom; USA = the United States of America.

Figure 3.2: Proportion relatively poor pre- and post-welfare state redistribution, various countries.



Poverty threshold = 60% of median equivalent disposable income.

*For these countries, the poverty threshold before redistribution is calculated on incomes net income taxes.

Data from the Luxembourg Income Study.

Reprinted, with permission of the authors, from Lundberg et al. (2007) citing Ritakallio & Fritzell (2004).



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



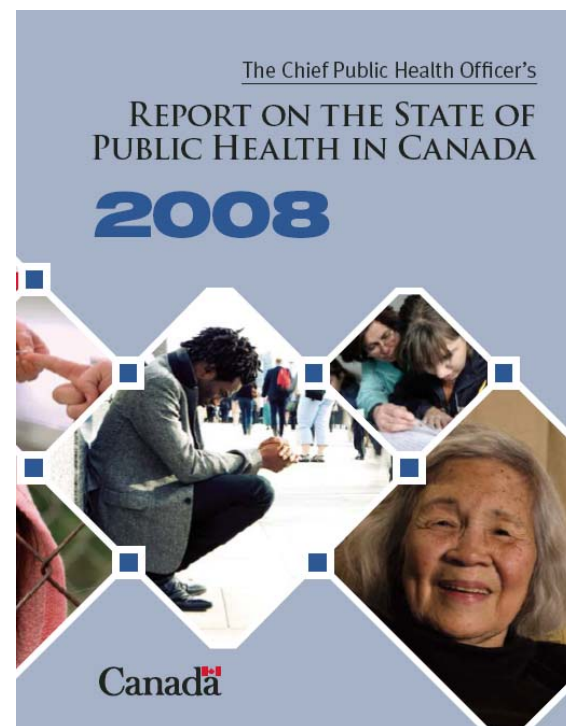
WHO Commission Recommendations

Three principles of action

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

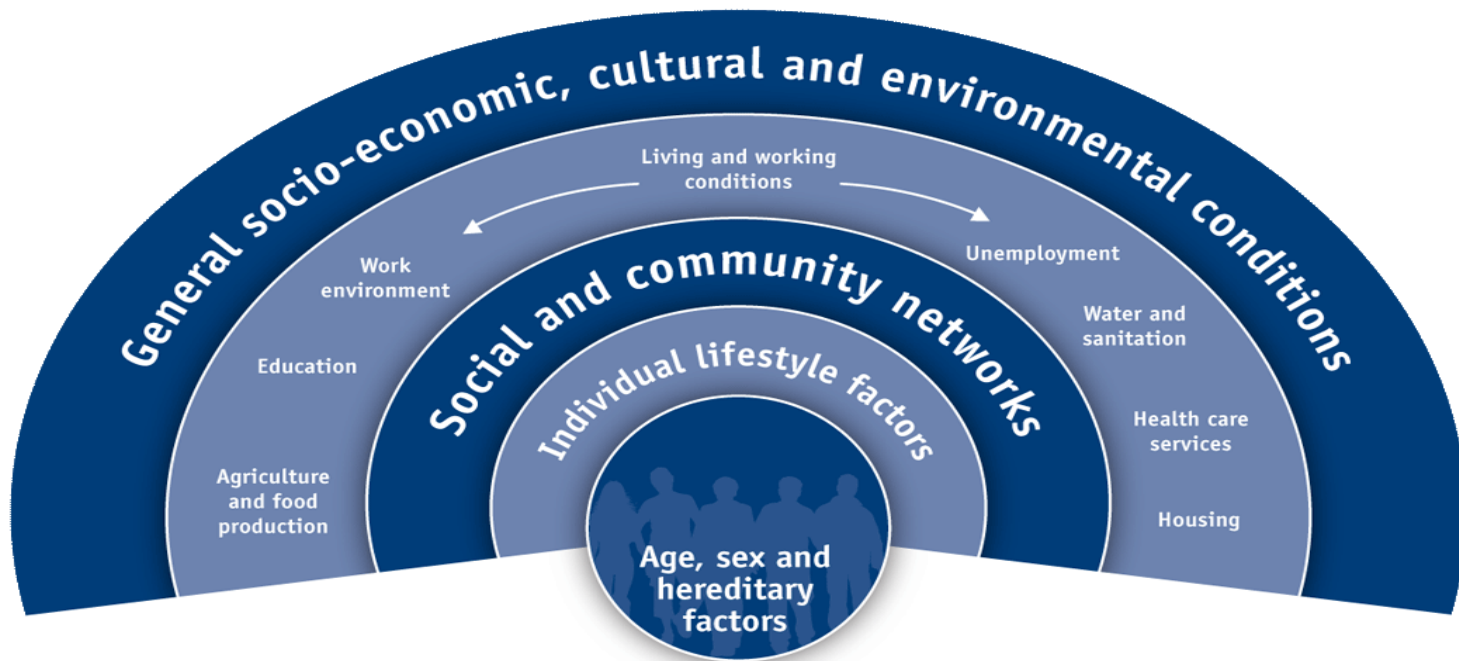
National and International Work on Health Inequalities/Inequities

- “CPHO Report on the State of Public Health in Canada” May 2008



CPHO Report: Public health in Canada

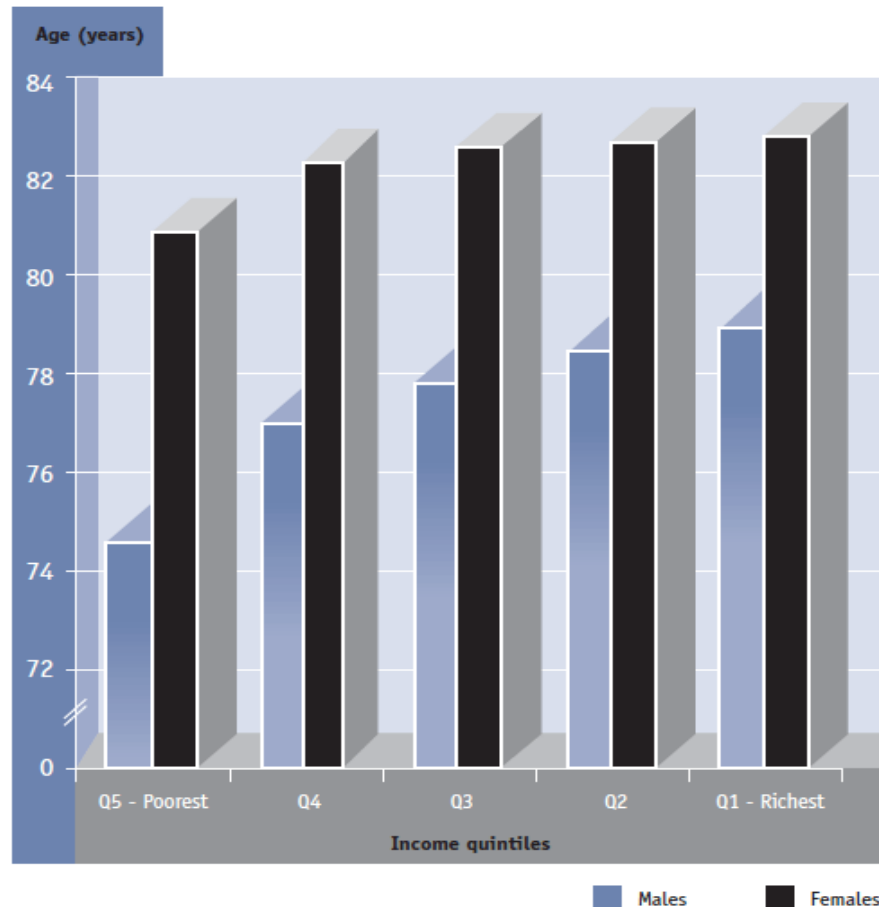
Factors that influence our health



Source: Dahlgren, G. & Whitehead, M. (2006). *European strategies for tackling social inequities in health: Levelling up Part 2*. World Health Organization.

Our health – Life expectancy

Life expectancy at birth by neighbourhood income and sex, urban Canada, 2001

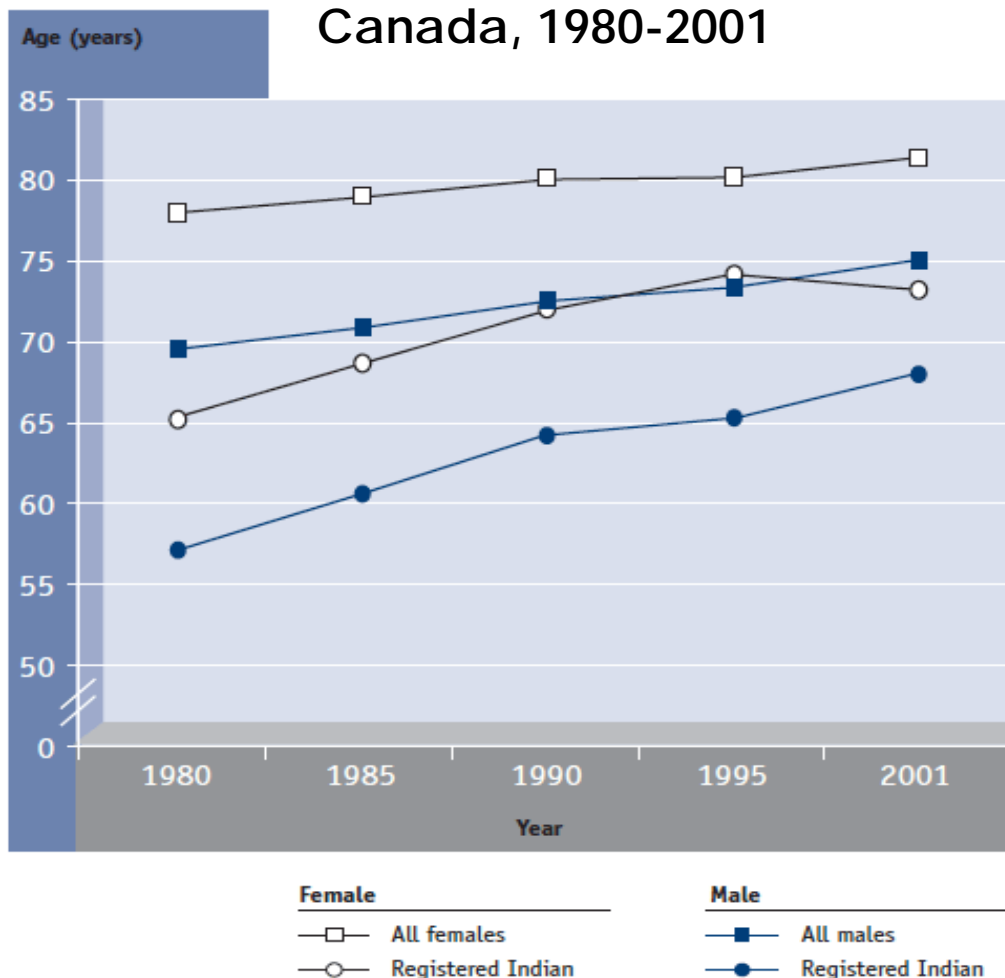


Q – population divided into fifths based on the percentage of the population in their neighbourhood below the low-income cut-offs.

Source: Wilkins et al. (2007), Statistics Canada.

Our health – Life expectancy

Life expectancy at birth by sex, Registered Indian and general population, Canada, 1980-2001

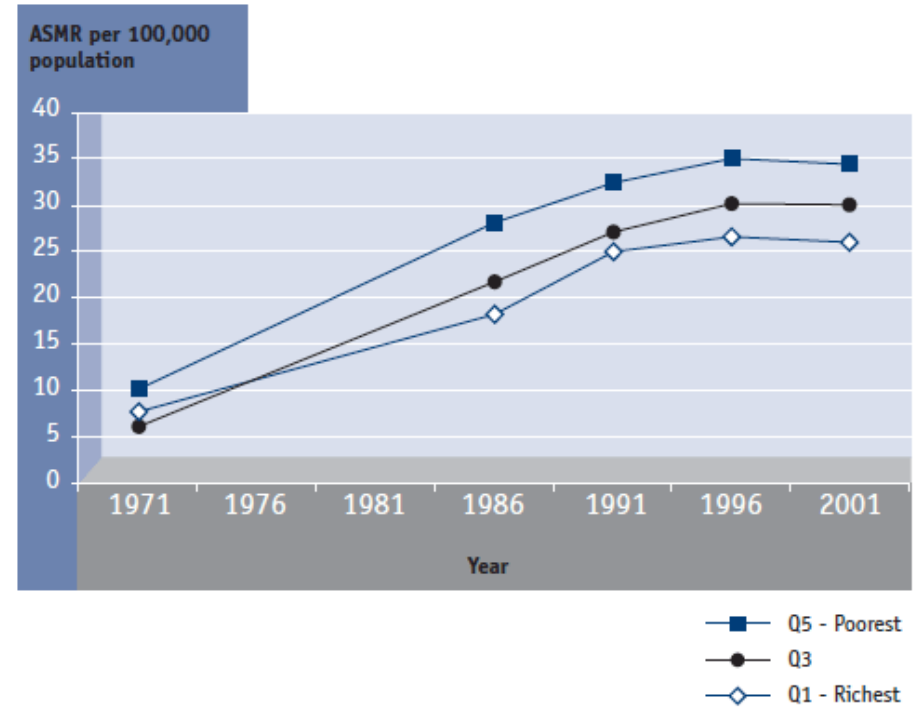
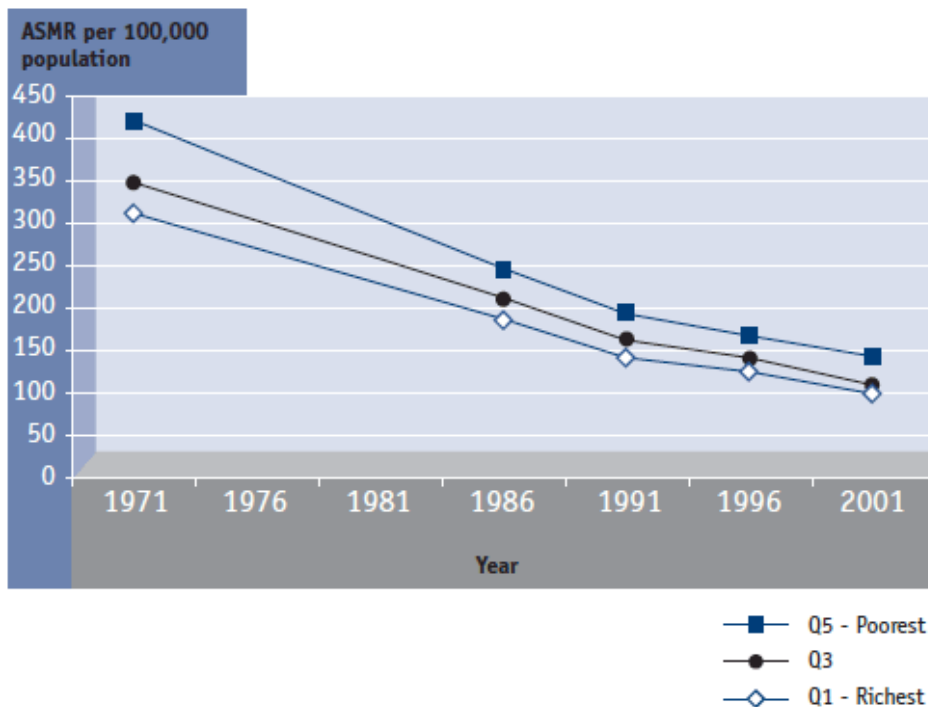


Source: Indian and Northern Affairs Canada, Basic Departmental Data, 2004.

Our health – Causes of death

Age-standardized mortality rates for ischemic heart disease by neighbourhood income, male, urban Canada, 1971-2001

Age-standardized mortality rates for lung cancer by neighbourhood income, female, urban Canada, 1971-2001



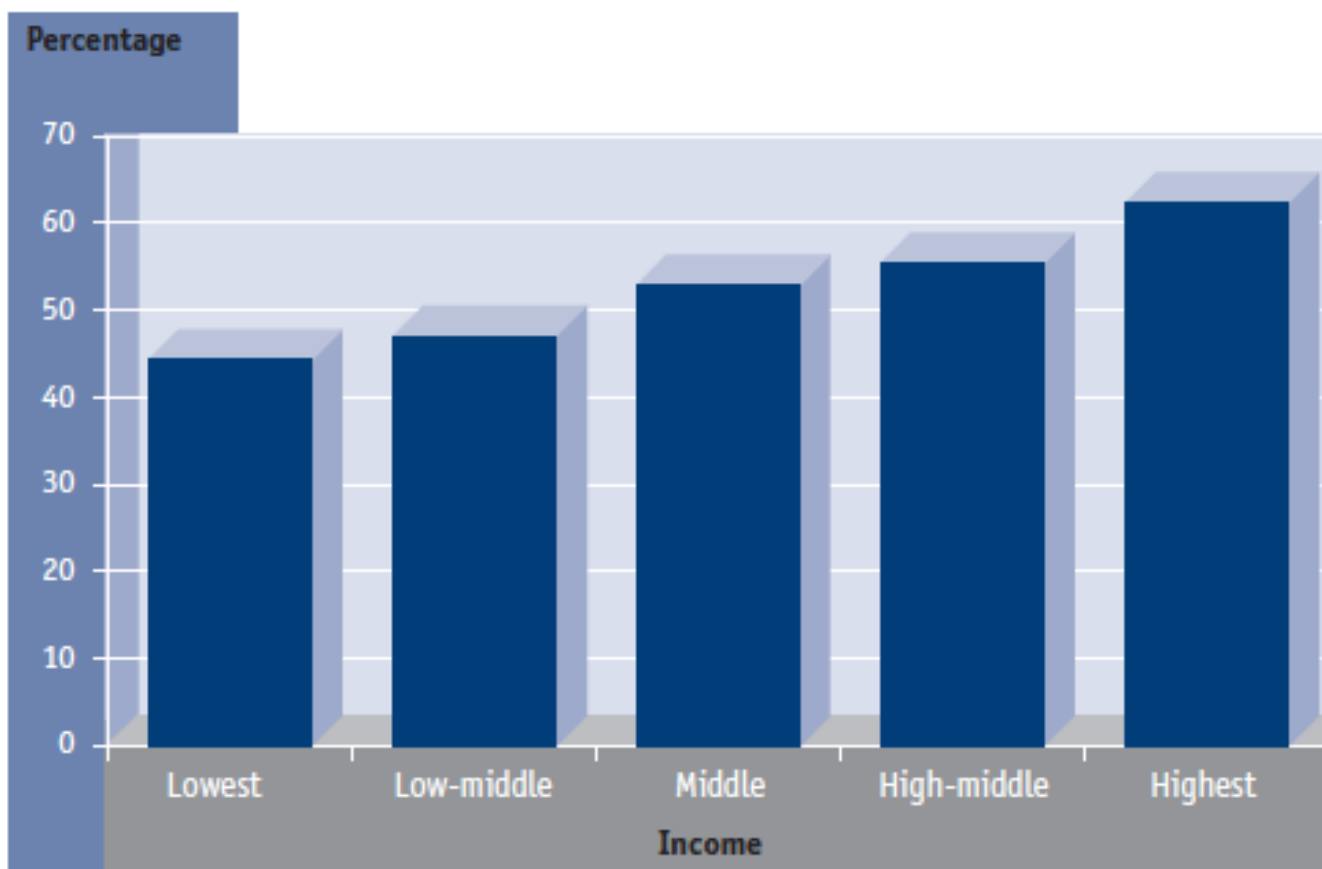
ASMR – Age-standardized mortality rate.

Q – population divided into fifths based on the percentage of the population in their neighbourhood below the low-income cut-offs.

Source: Wilkins et al. (2007), Statistics Canada.

Health behaviours

Percentage of the general population aged 12+ years who were physically active by income, Canada, 2005



Addressing inequalities

Making a difference to reduce health inequalities involves these priority areas for action:

■ **Social investment**

- Canada can build on its strong policy foundations to further reduce the gap that contributes to health inequalities

■ **Community capacity**

- Strong communities are critical. Broad social policy and investments are needed to complement and support community efforts

■ **Inter-sectoral action**

- All levels of government, the private and non-governmental sectors, and international organizations can work together towards integrated, coherent policies and actions to effectively prevent and improve upon health inequalities

■ **Knowledge infrastructure**

- Reducing health inequalities requires building knowledge: better information about specific sub-populations/regions; a greater understanding of how determinants interact; and stronger insight into how to apply proven practices from other jurisdictions

■ **Leadership**

- Leadership across all sectors is crucial to reducing health inequalities.

Moving forward

■ Foster collective will and leadership

- If Canadians want to be the healthiest population in the world, addressing health inequalities must become a priority
- Working across sectors and jurisdictions, health inequalities can be reduced through: recognizing role of prevention and promotion; developing indicators and measurement tools; recognizing health as a shared responsibility; and engaging leaders

■ Reduce child poverty

- Some of the greatest returns on investment are those targeted to the early years
- Reducing child poverty requires examination of: income redistribution policies and initiatives required for healthy childhood development; developing better opportunities for children (e.g. housing, education); targeting interventions for children at-risk; and adopting best practices from other jurisdictions

■ Strengthen communities

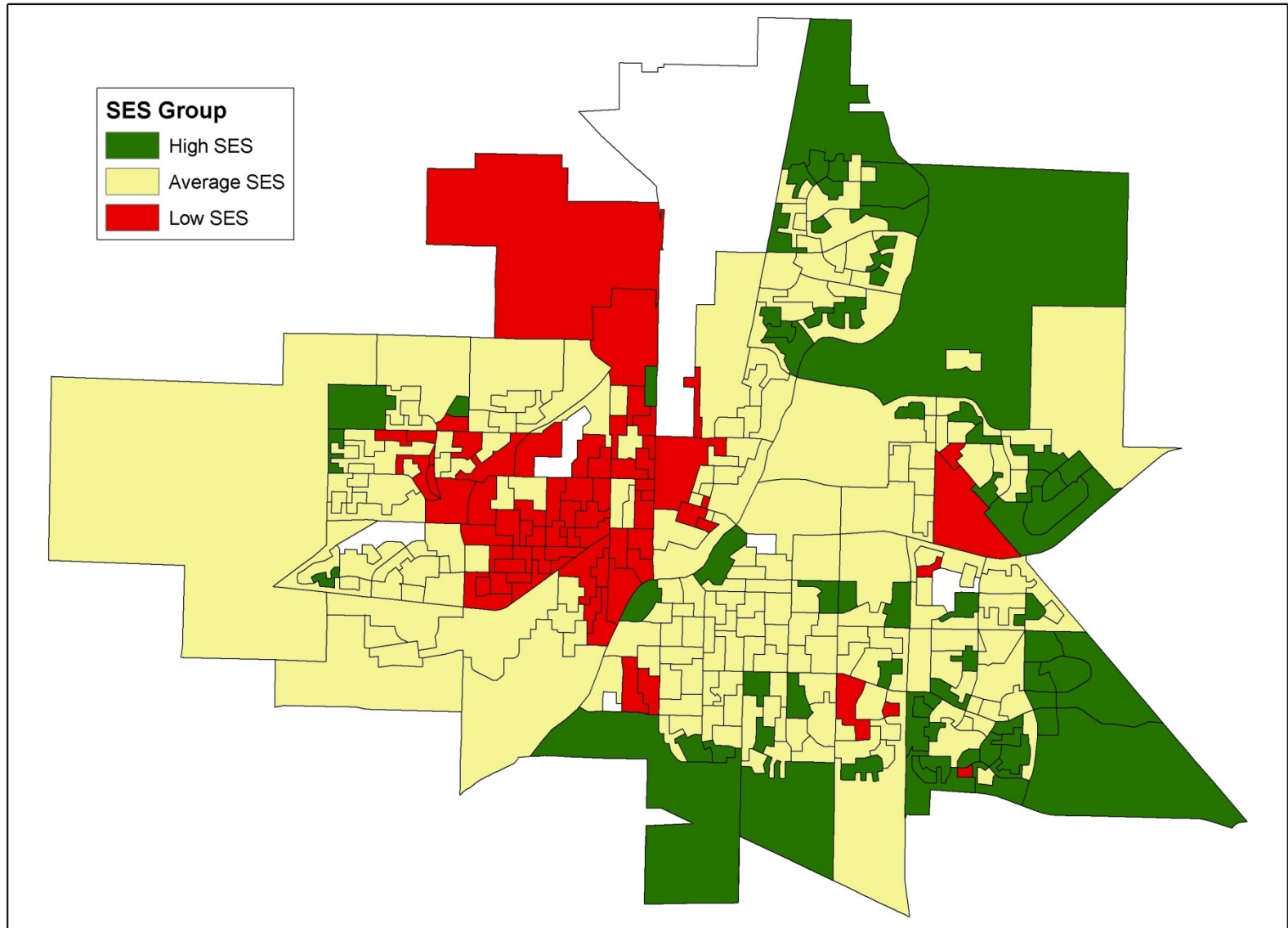
- Communities are where all sectors and players can easily converge to establish local priorities and develop shared strategies for addressing health inequalities
- Enhance Canadian communities by: working collaboratively to support community efforts; improving access to skills/resources; sharing multi-level data; and supporting the replication of proven successful initiatives

Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada Nov. 2008

A collaboration between the
Canadian Population Health Initiative and the
Urban Public Health Network



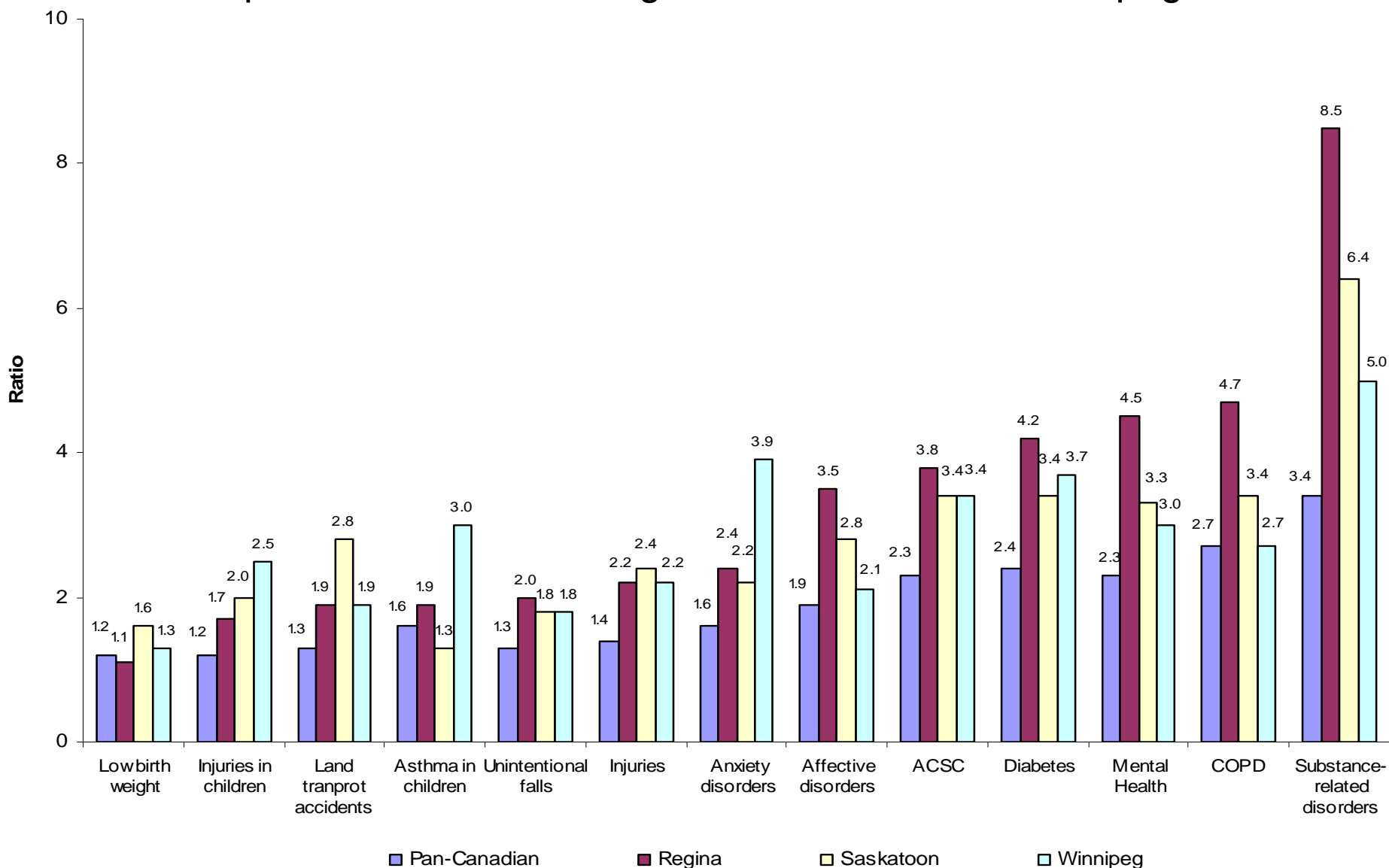
Saskatoon Analysis of Dissemination Areas by Deprivation Index Quintiles





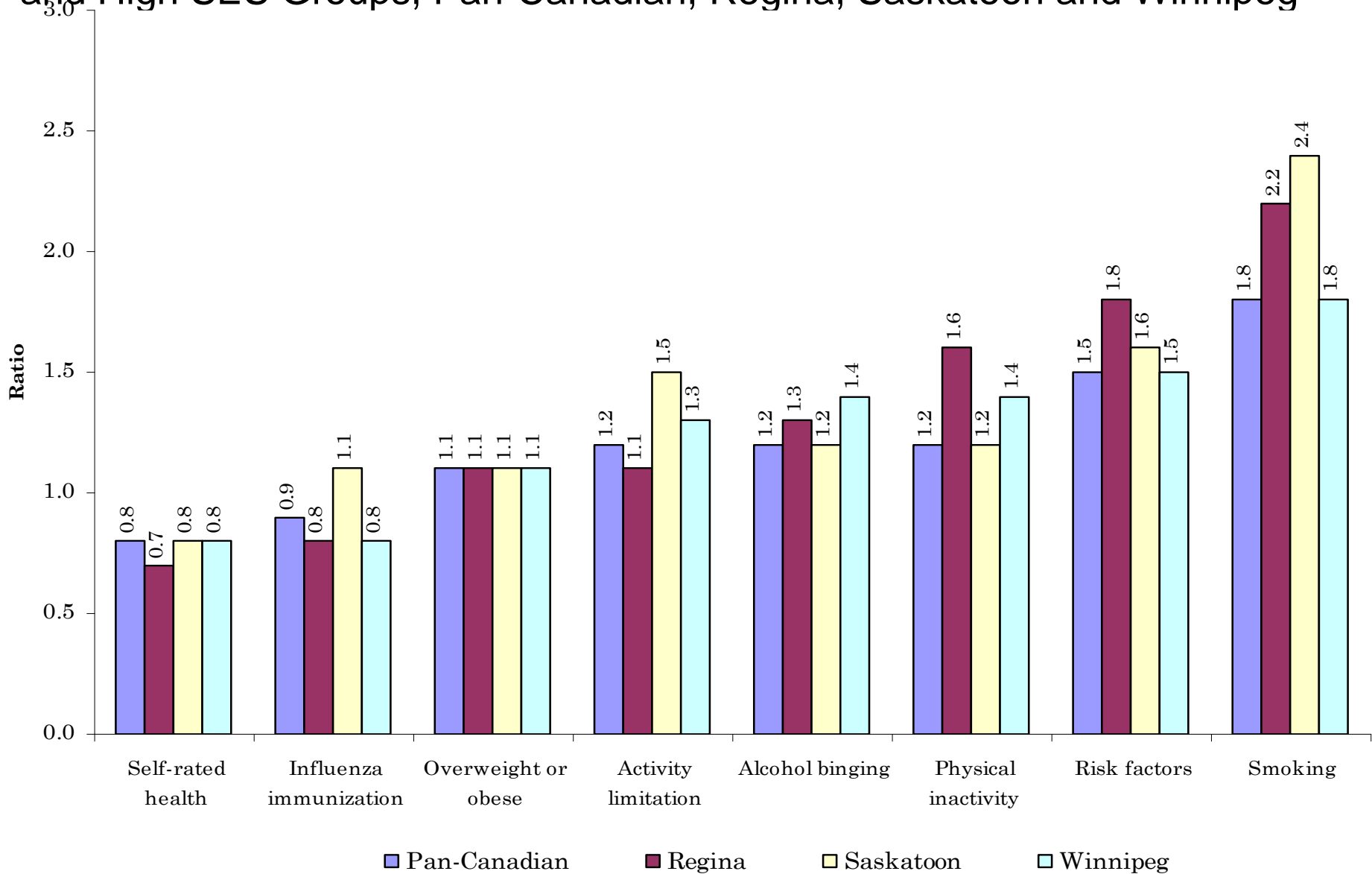
Pan-Canadian, Regina, Saskatoon and Winnipeg Comparison

Ratio of Age Standardized Hospitalization Rates Between Low and High SES Groups, Pan-Canadian, Regina, Saskatoon and Winnipeg



Source: RQHR presentation on CPHI study

Ratio of Age Standardized Self-Reported Health Percentages Between Low and High SES Groups, Pan-Canadian, Regina, Saskatoon and Winnipeg



Source: RQHR presentation on CPHI study

HEALTH DISPARITY IN SASKATOON

Analysis to Intervention



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Introduction

In 2006, the Saskatoon Health Region conducted a Health Disparity by Neighbourhood Income study and found substantial health disparities between 6 contiguous low income neighbourhoods and the rest of Saskatoon

Over 200 knowledge transfer / community consultations and presentations occurred following the release of this initial study

A number of regional and provincial initiatives were announced

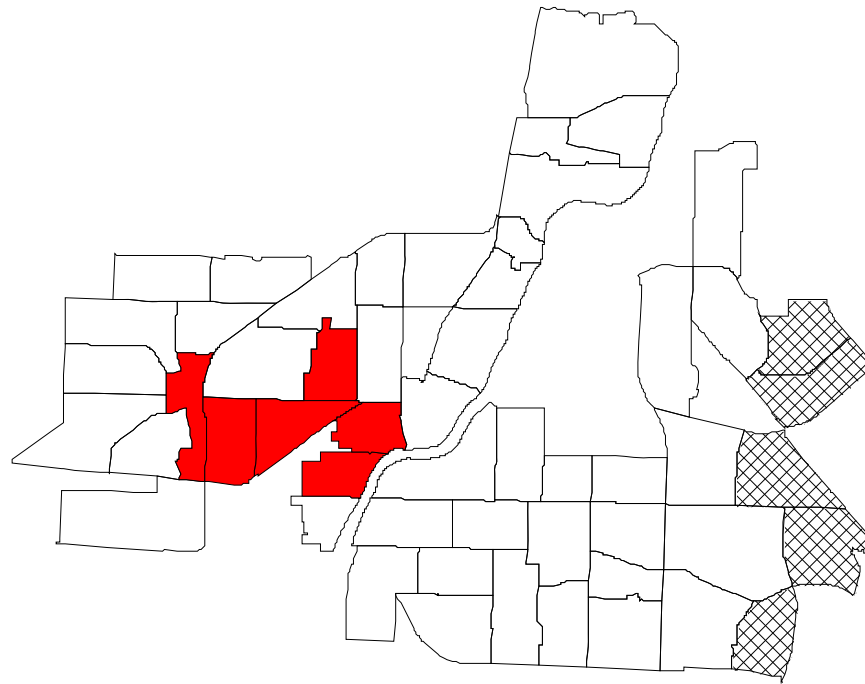
This led to further local and national research:

- **2 Meta-analyses (SES and health, risk behaviour)**
- **9 Research papers reviewing variables independently associated with health disparity in Saskatoon**
- **Review of 10,000 abstracts and articles for evidence based policy options**
- **Surveyed 5000 Saskatoon residents at random**
- **100 Community presentations with opportunities for feedback prior to release**
- **CPHI / UPHN report on urban health and poverty**




Objectives of the Saskatoon Report, November 2008

- Describe the extent of health disparity in Saskatoon
- Determine the main drivers of health disparity in Saskatoon
- Discuss evidence from other jurisdictions on policy options; matched to levels of public support

Saskatoon neighbourhood analysis boundaries, excluding industrial and development areas, 2005



Legend

-  Affluent neighbourhoods
-  Rest of Saskatoon
-  Low income neighbourhoods

Income and Health, selected results

In comparison to high income residents, low income residents in Saskatoon are:

- 1458% more likely to attempt suicide
- 1389% more likely to have chlamydia
- 1186% more likely to be hospitalized for diabetes
- 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

Survey Data Summary

- 5000 respondents in and around Saskatoon with representation from Inner city (including interviews with homeless people and those without telephones), rest of Saskatoon, and rural residents.
- Response rate 62%. Representative by age, income, neighbourhood, cultural status.

F slightly > M

Survey Data Summary

- 80% of people agree that the poor are more likely to suffer from poor health
- However, they tend to assume it is only in areas such as suicide attempts, diabetes, HIV/STI's, while they feel there would be no difference for mental illness, injury, heart disease, breathing problems, stroke and cancer
- If health status does differ by income, they believe an “acceptable level” would be:
 - 0% 49% of people
 - 10% 12% of people
 - 25% 17% of people
 - 50% 20% of people
 - >100% 4% of people

Income Disparity in Saskatoon

- **17.1 % of Saskatoon residents live below the LICO (Low Income Cut-Off)**
- **20.1% of the children under the age of 18 live below the LICO**
- **26.3% of children aged 0-2 live below the LICO**

Examples of Evidence Based Options

A. Set measurable goals to reduce poverty

e.g.

- **Reduce poverty in children from 20% to 2% in five years**
- **Reduce poverty in all residents from 17% to 10% in 5 yrs**
- **In Ireland, a target was set to reduce poverty from 15 to 10%. Within 4 yrs, the rate fell to 5%. The target was achieved by goal setting coupled with increases in social assistance payments, educational initiatives and employment programs**

Examples of Evidence Based Options cont...

B. Ensure no child lives in poverty

e.g.

- Parents with children on social assistance should have their shelter allowances and adult allowances doubled – to raise children above the LICO. For example, a lone parent with 2 children receives \$725 per month from Social Services for shelter, food, clothing etc
- Prioritization of children was a key strategy in poverty reduction plans in UK, Sweden and Quebec

Examples of Evidence Based Options cont...

C. Create a Child Poverty Protection Plan

- **With Canada Pension Plan, only 6% of seniors live in poverty instead of 58%**

Various funding options are available, such as:

- **Exempting 500,000 residents, \$6 from every worker and \$5 from every business per week would fully fund the Child Poverty Protection Plan. This plan would bring every child \$1 above the poverty line**

Examples of Evidence Based Options cont...

D. Remove work earning clawbacks

- **Every dollar earned beyond \$ 125 by a parent is subtracted from Social Service benefits**
- **In 2 Canadian provinces and 3 American states, the most effective initiative to promote return to work was work earning supplements (Govt cost= \$ 110 per applicant but return= \$ 2405 per year)**
- **Quebec has expanded this initiative from 100,000 people to 536,000 low/middle income households**

Examples of Evidence Based Options cont...

E. Change lower limit tax exemptions

- **To offset revenue loss, remove the lower limit tax exemption for high income earners**
- **In the UK, tax credits (along with a change to the minimum wage) resulted in 800,000 fewer children living in poverty as well as the highest employment and lowest unemployment rate in the G8**

Support from the Community

Survey of 5000 residents:

- 83.8% support early intervention programs for children (i.e. poverty reduction)
- 84.1% support work earning supplements

Income inequity and health is “The Big Idea” . The health of a society is not based on overall wealth but more on how evenly that wealth is distributed through taxes and transfers (BMJ, 1996).

2. Education and Health

In comparison to higher educated residents, Saskatoon residents with less than high school graduation are:

- 55% more likely to have diabetes
- 30% more likely to have suicide ideation
- 141% more likely to have heart disease
- 40% more likely to be daily smokers

Education Disparity in Saskatoon

- **Approximately 690 children below the age of 19 do not attend school in Saskatoon**
- **10.7% of all adults between the ages 20-24 do not have a high school diploma and are not in school**
- **48% of Aboriginal adults between 20 and 24 do not have a high school diploma and are not in school**

Examples of Evidence Based Options

A. Increase support for community schools

- **Provide health and social services in community schools in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve overall health.**
- **Research demonstrates that children that access school-based health centers are more likely to stay in school, have better attendance and graduate while having improved health**

Examples of Evidence Based Options

B. 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 a high school graduation has already been obtained.

Rationale:

This is the same law recently adopted in New Brunswick.

Examples of Evidence Based Options cont...

C. Cap health care treatment spending increases

- Cap annual growth at 5%, instead of 10%, in order to redistribute resources to activities such as education
- Japan has the best health outcomes in the world despite the lowest expenditures for health care (7% of its GDP compared to 14.5% in USA). In Japan, limiting growth for healthcare treatment costs resulted in more money for intellectual development; which transferred to superior health outcomes

Other options include increases in revenue generation to allow increases in other program areas while continuing investments in health. This needs public dialogue and support. Other countries have made this choice as a society but Canadians have been loathe to increase taxes.

Support from the Community

Survey of 5000 residents:

- 82% support more health promotion programs (health promotion in schools)
- 66% support more subsidized day cares and pre-schools
- 82.3% support more subsidized trades training
- 41.3% support transferring healthcare treatment costs to health enhancing activities like education
- 10% support for raising taxes

“A society that spends so much on healthcare that it cannot or will not spend adequately on other health enhancing activities may actually be reducing the health of its population” (Evans, 1994).

3. Employment and Health

In comparison to adults that work, Saskatoon adults that are not working are:

- 132% more likely to have diabetes**
- 272% more likely to have heart disease**
- 133% more likely to have high blood pressure**

Employment Disparity in Saskatoon

- In 2007, our Aboriginal unemployment rate was 17.6% in comparison to 4.4% for non Aboriginal residents
- Aboriginal residents account for 15% of overall population; but only 8.3% of civil service and 2.5% of professional workforce

Examples of Evidence Based Options

A. More employment for Aboriginal people

- **Aboriginal representation in civil service jobs and management positions should be increased to 15%**
- **Ireland's plan - provide education then targeted employment to marginalized groups (20% jobs in low income neighbourhoods reserved for local residents). Their 10 year goal was to reduce unemployment from 11.3 to 6% through education then targeted employment. Within four years, the unemployment rate was 4%**

Examples of Evidence Based Options cont...

B. Social assistance as a transition to work

- The United States mandated return to work after two years of social services with termination of all benefits after 5 years. 50% returned to work but 50% did not
- A made in Saskatchewan alternative could offer enhanced benefits for education, skills training and employment for five years. The client would revert back to the previous benefit schedule (not termination of benefits) if return to work was not achieved after five years

Support from the community

Survey of 5000 residents:

- 67.5% support employment equity programs
- 71.3% support increasing the minimum wage
- 82.3% support more subsidized trades training

“It has been said that the measure of any society is what it does for its least fortunate group” (Waiser, 2005).

3. Housing and Health

Housing Disparity in Saskatoon

- 2,150 people on waiting list for affordable housing units in 2006
- Deficit of 5,900 affordable housing units
- 6,400 homeless individuals (see definition)

Examples of Evidence Based Options

A. Expand affordable housing initiatives

- The provincial government could purchase 20 neglected apartment buildings, renovate them and transfer the title to not-for-profit housing authorities.
- In British Columbia, housing for homeless people saved \$ 17,895 per person per year in overall costs (health, social services and correctional costs included)
- Integrating supportive housing with health services in San Francisco resulted in drop in emergency room usage by 58%, inpatient days fell by 57% and there was a near elimination of residential mental health services

Support from the community

Survey of 5000 residents:

- **68.8% support more subsidized quality housing for adults without children**
- **74.9% support more subsidized quality housing for parents with children**

“I need not say anything more than if the issue of housing is not addressed, then it is unlikely that any provincial mental health reform will have an impact on the problem of escalating mental health illness in society” (Kirby Senate Report, 2006).

4. Aboriginal Cultural Status and Health

- Many studies in Canada report that Aboriginal cultural status is the primary risk factor for essentially all poor health outcomes and risk behaviors. The problem with simple baseline statistics is that it leaves the impression that health disparity is not preventable in our Aboriginal population
- First Nation males live 7.4 years less compared to other Canadian males and First Nation females live 5.2 years less than other Canadian females

Aboriginal Cultural Status and Health in Saskatoon

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

Examples of Evidence Based Options

A. Aboriginal self determination

- **Royal Commission on Aboriginal Peoples concluded self government is the key to ending the cycle of poverty and despair**
- **In British Columbia, the suicide rate was 108.4 per 100,000 First Nations youth aged 15-24. If a reserve community had some level of self government, the suicide rate was 18.2 per 100,000. If a reserve community had some control over self governance, land claims, education and health services, the suicide rate was 0 per 100,000 youth aged 15-24**

Support from the community

Survey of 5000 residents:

➤ **60.1% support more self determination for Aboriginal groups**

“The biological explanation for inequalities between cultural groups is wrong but, unfortunately, we are not told what the correct explanation is” (Diamond, 1999).

5. Health Care and Health in Saskatoon

- The Availability of fully insured Medicare has not eliminated extensive health disparities
- Large increases in health care spending in Saskatchewan – approx. 10% increase every year – have not reduced health disparities and very few actual service enhancements
- 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 Evidence Based Options

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

- Leadership on disparities reduction within the health sector is needed to facilitate the roles of the health sector and to support growing awareness and policy action in other sectors to achieve health gains.

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

- The health system is a determinant of health. If health care and public health programs and services do not include a focus on the needs of disadvantaged individuals, population and communities, there is a risk of increasing rather than decreasing health disparities.

Examples of Evidence Based Options

C. The number of health resources in Saskatoon's low income neighbourhoods should be proportionate to the size of the population and its disproportionate number of health disorders. This may require incentives from provincial and local government.

**Health Equity Audits should be done by RHAs
Health Impact Assessments should be used as a lens in screening potential policy changes at all levels of government**

Examples of Evidence Based Options

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

A component of this option was presented in policy option #15 – integrated and comprehensive services in community schools. Health disparities in Canada persist among lower socioeconomic residents despite higher overall use of health services. Large increases in overall health care spending have been unable to reduce health disparities. As such, services need to be accessible but effective as well.

- In the Netherlands, it was recognized that persons from lower SES require a different approach to care in order to achieve similar health outcomes

Support from the community

Survey of 5000 residents:

- 82% support more health promotion programs (i.e. health promotion in schools)

“At quite an early stage in any analysis it becomes apparent that many of the conventional explanations of the determinants of health – of why some people are healthy and others not – are the best seriously incomplete if not simple wrong” (Evans, 1994).

Evidence Based Policy Options

- **Need to work in combination instead of in isolation**
- **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**



Summary of Reports

Strong public support for a number of initiatives to reduce health and social disparity in Saskatoon.

Greatest public support is for interventions that involve children.

Strong support from community agencies and the human service sector to working on finding solutions in program and policy change.

Summary

- **“Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. ...Reducing health inequities is, ...an ethical imperative. Social injustice is killing people on a grand scale.” (Marmot, 2008).**

Moving Beyond Reports to Reducing the Gaps

- First report (2006)
 - Used for awareness raising using local data
 - Community responds in asking for:
 - Solutions
 - Context of where we are compared to other cities in Canada
 - Need to target initial investments in areas of greatest need
- A local coalition has worked together to identify common goals and initiatives over the last few years. Initial focus areas have included:
 - A school based, inter-sectoral service delivery model in 6 core middle schools (initial focus on primary care, mental health and physical activity promotion)
 - A focus on increasing employment options in partner agencies
 - Increase local services centres (primary health centres, leisure services, grocery store, businesses)
 - Change our approach to serving individuals from the CORE (cultural sensitivity, transportation issues, home visits, seamless delivery, involve elders, etc) Building Health Equity Team

Moving Beyond Reports to Reducing the Gaps

- National reports in 2008 give context
 - Present across urban Canada
 - worse in the prairies
 - Gradient effect
 - Momentum for change developing globally
- Analysis to Action report 2008
 - Summarizes results on main causal factors
 - Reviews evidence based policy options that have worked to reduce the Gap elsewhere
 - Suggests how these could apply in Saskatchewan
 - Solicits the support of agencies, groups and decision makers in working together to find solutions

Moving Beyond Reports to Reducing the Gaps

■ Next steps in 2009

- Regional Intersectoral Committee facilitating the development / adoption of a Community Action Plan on Social Determinants of Health
- Hold multiple public forums, focus groups with diverse interest groups to get their perspectives and ideas, and arrive at consensus on things we can do immediately, or advocate for collectively
- Knowledge translation opportunities (like this one!) to build public awareness and support
- Start working within the Health Region on a health system response to health disparities using “health equity audit” model
- Continue regular monitoring to measure progress

What Can We Do?

- Recommend an All-of-Government approach to this issue. Work to make “Reducing the Gap” or “Equity Till 18” a foundational goal.
 - E.g. 3 priority areas for action in UK:
 - Increase social and economic supports (income, education, etc)
 - Improve access to health services for the poor (esp. primary care and targeted interventions on lifestyle related issues)
 - Support people to improve their lifestyles (make it easier for people to make healthy choices) Allen Johnson (UK Sec of State) Nov 2008
- Make it clear that it is a political choice to set the poverty rate in a jurisdiction.
 - E.g. “The Min 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

What Can We Do?

- 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 – how will they benefit economically (reduced costs overall), morally/ethically, workforce stability and productivity, labour availability
 - Religious community – poverty and social justice issues in 2000+ verses in the Bible, historical role of the church in solutions
 - Gov't – cross ministerial approaches, overall decrease in costs to government over time. Healthy Public Policy approach (Health Impact Assessment (QC), Health Equity Audit (UK), Equity Impact Review (USA) Needs to be a plank in all party platforms as an overarching strategy, not individual solutions advanced in silos
 - Aboriginal government issues – discrimination is underlying contributor, self governance helps.

What Can We 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

Credits

Research Team

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