TRACKING HEALTH AND HEALTHCARE IN MANITOBA

A summary of the report The 2013 RHA Indicators Atlas by Randy Fransoo, Patricia Martens, The Need To Know Team, Heather Prior, Charles Burchill, Ina Koseva, Angela Bailly and Elisa Allegro

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There's good news and bad news in The 2013 RHA Indicators Atlas by the Manitoba Centre for Health Policy (MCHP). The good news is that Manitobans are getting healthier and living longer. The bad news is that the health gap between rich and poor continues to widen.

The report analyzes more than 70 measures (indicators) about the health of Manitobans and their use of healthcare services. It compares results from 2011/12 to those from 2006/07, and also looks back at comparable results published in our previous Indicators Atlas reports, giving us a picture of health trends spanning almost 20 years.

The gap continues to widen because the health of people living in lower-income areas either stayed the same or didn't improve as much as it did for others over the past five years. Fortunately, health status in lower-income areas didn't decline further, as we saw in the 2009 report, but the gap is still widening, and that's an ongoing concern.

These Indicator Atlas reports are designed to help Manitoba Health and the Regional Health Authorities (RHAs) understand the health status and needs of the people they serve. Researchers and planners on *The Need To Know* Team (an ongoing collaboration led by MCHP) were involved in every step, deciding how to analyze the indicators, and checking preliminary results. This team includes representatives from every RHA, plus Manitoba Health and MCHP. The Community Health Assessment Network (CHAN) also contributed by helping to select and prioritize indicators to be included.

Table 1: Changes in Indicators of Mortality

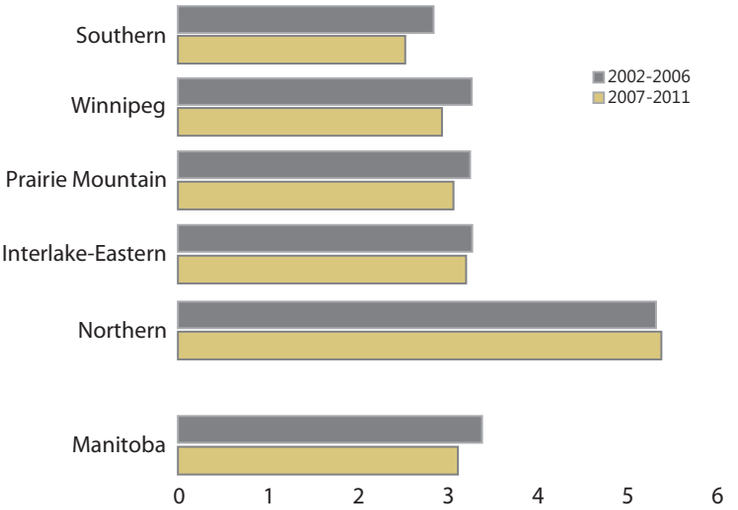
Indicators:	2007	2011
Male Life Expectancy (Years)	76.5	77.5
Female Life Expectancy (Years)	81.5	82.2
Total Mortality Rate per 1,000 residents, per year	8.43	7.88
Premature Mortality Rate per 1,000 residents, per year	3.38	3.12

Longer lives but not for everyone

By every measure, Manitobans are living longer (Table 1). Life expectancy increased between 2006 and 2011, continuing a long-term trend. Men now live 77.5 years on average (one year longer than they did five years ago) and women 82.2 years (an increase of about half a year).

And fewer people are dying young. The premature mortality rate (PMR), which measures how many people died each year before reaching age 75, is considered the best single indicator of a population's health and its need for healthcare. The PMR declined for the province overall, from 3.4 to 3.1 deaths per 1,000 people under 75. (Figure 1)

Figure 1: Premature Mortality Rate (PMR) in Manitoba



But this improvement happened in only three regions (Southern, Winnipeg, and Prairie Mountain). In Northern and Interlake-Eastern regions, the rate of premature death stayed the same.

Major diseases: mostly decreasing

In other good news, the prevalence of many major diseases and chronic conditions also decreased (Table 2). Prevalence is the percentage of the population with a given disease, and a drop in prevalence can translate into big changes in healthcare needs. For example, 7,055 fewer Manitobans were living with respiratory disease in 2011/12 compared to 2006/07, and 2,108 fewer were living with ischemic heart disease (narrowing of the arteries that can lead to heart attack)—even though Manitoba's population grew and got older.

We haven't seen this pattern of improvement over so many indicators in past reports. Something about the health of Manitobans has changed. Are prevention efforts working better? Is frontline care improving? Are Manitobans with chronic conditions getting better at managing their health problems? All of these are likely contributors. The data used in this study can't answer all these questions, but they clearly document the changes and raise questions for future research.

Table 2: Changes in Indicators of Disease

Indicators Getting Better:	2007	2011
Total Respiratory Morbidity Prevalence	10.8%	9.54%
Ischemic Heart Disease Prevalence	8.80%	7.92%
Hypertension Incidence per 100 residents, per year	3.40	3.09
Diabetes Incidence per 100 residents, per year	0.91	0.85
Indicators Getting Worse:	**2007**	**2011**
Hypertension Prevalence	24.8%	25.6%
Diabetes Prevalence	9%	10.0%

Fast Facts

The 2013 RHA Indicators Atlas has a wealth of information. Here are a few more highlights. Results are for 2011/12 compared to 2006/07.

Every year in Manitoba

79.1% visited a doctor

65.7% filled a prescription

11.9% of age 75+ are in nursing homes

6.3% of all Manitobans were hospitalized

Demographics:

* Manitoba's population grew by 6.9%, but the number of older adults (65 and older) grew by 9.3%. We are aging.

Nursing homes:

* A lower percentage of people age 75 and older are living in nursing homes (11.9% vs 13.1%) but those who are need a higher level of care.

Mental health:

* The prevalence of mood and anxiety disorders (23.5%), dementia (10.3%), and substance abuse (5.3%) did not change.

High-profile procedures:

* Rates of hip and knee replacement surgery increased, as did two common cardiac procedures: catheterizations and stent insertions.
* Surgery rates for cataracts and coronary artery bypass remained stable.

MRI scans:

* The use of MRI scans among adults doubled again, as it had in our 2009 report, meaning the rate has quadrupled since 2001.

Adult Immunizations (age 65+):

* Influenza immunizations rates decreased from 62.3% to 56.6%.
* Pneumonia immunization rates decreased from 68.5 to 65.8%.

Physician visits:

* The total number of visits to physicians went up, but the population increased even more, so the number of visits per person decreased from 4.7 to 4.4 per year.

Hospital admissions and readmissions:

* A lower percentage of people were hospitalized (6.3%, down from 6.9%) and fewer were back in hospital within 30 days of being discharged (8.5% of all hospital episodes were readmissions, down from 9.3%).

Hospital use matches need:

* Hospitalization rates varied dramatically by income group. In urban areas, only 4.4% of people in the highest-income areas were hospitalized at least once, compared to over 6.7% for those in the lowest-income areas. For rural residents, the numbers were all higher, and ranged from 5.9% in the highest-income areas to 10.3% in lowest-income areas.

Other diseases studied:

* The prevalence of arthritis was stable over time, at 21%.
* Osteoporosis prevalence decreased from 12% to 10%.
* Heart attack and stroke rates also decreased: from 4.4 to 4.1 heart attacks per 1,000 residents age 40+ per year, and from 2.9 to 2.7 strokes.

Diabetes and high blood pressure

The picture is a bit different for two chronic conditions much in the news. The prevalence of diabetes and high blood pressure both rose by about 1%—a large increase for diabetes (from 9% to 10%) but a relatively small increase for high blood pressure (from 24.8% to 25.6%). While this may sound like bad news, there is actually a good news story underneath. Other recent research has shown that the mortality rate for people with diabetes has been decreasing significantly. That is, we're getting better at keeping people with diabetes alive longer, which is likely the main reason why prevalence is going up. Similar changes may also affect the prevalence of high blood pressure.

At the same time, the incidence rates for both diseases went down, meaning fewer people were newly diagnosed between 2006/07 and 2010/11. If these lower rates are sustained or decrease even further, then the prevalence of these conditions will also decline in the long term. Another positive change was the decrease in a major complication of diabetes: the percentage of people with diabetes who had a lower-limb amputation declined from 1.6% to 1.3%.

In all these findings, there are important regional differences. For example, the incidence rates for diabetes were dramatically (up to five times) higher in some parts of rural RHAs compared to the province as a whole. Several districts in the Northern RHA and one in Interlake-Eastern, areas where the prevalence of diabetes was already high, had the highest rates of new cases being diagnosed. This kind of data reminds health planners about a significant though familiar problem that may need more attention.

The system is serving those in need

The report also looks at how Manitobans use healthcare services and analyzes that data by region and income group. Given the widening gaps in health, it's important that the healthcare system be responsive to those needs, and that seems to generally be the case. Use of hospital care was strongly related to health status, which in turn is related to income. People with more health problems use more hospital services, a good indication that the universal healthcare system is working as it should.

On the other hand, seeing a doctor was not as consistently related to health status or income. However, this finding might be affected by two factors: not all primary care is provided by physicians, and not all physician visits are coded into the data system.

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Mixed picture on quality of care

A number of indicators in the report tell us whether people are getting the care that's recommended for their age or condition(s). These quality-of-care indicators didn't show a lot of difference by RHA or by income group, which is good news since everyone should receive the same quality of care. But the results suggest there is room for improvement, especially for residents of lower-income areas. For example:

Over time, fewer Manitobans age 65 years and older got a flu shot: 56.6% in 2010/11, down from 62.3% in 2006/07. Every region saw a decrease but lower-income areas had the lowest vaccination rates.

Among heart attack patients, poorer people were less likely than wealthier people to be taking a beta-blocker, a drug recommended for most patients after a heart attack. This difference was bigger in rural areas, where 77.0% of the lowest-income patients got beta-blockers versus 85.6% of the highest-income patients. In urban areas, the rates were 82.0% and 86.7%, respectively.

More people with diabetes received an eye exam (37.5%, up from 33.9%). This is a positive trend because diabetes can lead to vision loss if complications are not caught early. But residents of lower-income areas, where rates of diabetes tend to be higher, were less likely to have an eye exam.

Finally, fewer patients newly prescribed an antidepressant saw their doctor regularly (at least three times over the next four months). The rate didn't vary much across regions or by income, but the generally low rate and the decrease (54.5%, down from 57.3%) are concerns, since everyone taking medication for depression should be closely monitored.

Much more in print and online

The full report, available on MCHP's website, compares the five current RHAs with results for the province as a whole, along with the former 11 RHAs (the regions were reorganized in 2012). It also presents findings for the 70 districts of the rural health regions, plus Winnipeg's 25 neighbourhood clusters and Churchill. The "Data Extras" online include spreadsheets with the data behind the graphs in the report, and results by income quintile and regional planning zones. We hope these findings will be useful for ongoing efforts to improve the health of all Manitobans.

The Manitoba Centre for Health Policy is a unit of the Department of Community Health Sciences at the University of Manitoba's Faculty of Medicine. MCHP conducts population-based research on health services, population and public health and the social determinants of health.

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