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Manitoba RHA Indicators Atlas 2009: Health Improving, but not for Everyone

MANITOBA CENTRE FOR HEALTH POLICY

Summary of report:
Manitoba RHA Indicators Atlas 2009

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- The health of most Manitobans continues to improve. Life expectancy is up and premature mortality rates are down.
- The health of people living in the lowest income areas (residents of the core area of Winnipeg and northern Manitoba) did not improve and may be getting worse.
- The gap between the healthiest and the least healthy Manitobans widened.

Life expectancy in Manitoba is up to 76.3 years for men and 81.5 years for women.

That's the average length of life from birth, and it's based on Manitoba data for 2001 to 2005. According to the Manitoba Centre for Health Policy's *Manitoba RHA Indicators Atlas 2009*, the figures are up over the previous five years by more than half a year for both men and women.

This increase might seem small, but even small differences suggest big gains in our health. For example, if all cancer was wiped out, life expectancy would likely increase by only about three and a half years. To gain a half year in just five years is noteworthy, especially since it has been improving for years.

Unfortunately, life expectancy did not go up for all Manitobans (see Table 1). It actually decreased slightly for the North, an area which includes Burntwood, Churchill and NOR-MAN Regional Health Authorities (RHA). Life for residents of the least healthy RHA (Burntwood) was an average nine years shorter for men and seven years shorter for women than for residents of the healthiest RHA (South Eastman). Incidentally, once past young adulthood, men start to catch up with women.

Life is also shorter for the poor, especially the urban poor in Winnipeg and Brandon. For men in the lowest income city neighbourhoods, life expectancy is 10 years less than for their richer counterparts.

You may be surprised to hear that shorter life expectancy, or 'premature death,' is one of the best indicators of the overall health of a population. MCHP uses the Premature Mortality Rate (PMR) to track people's health status and their need for healthcare, to compare people's health status in different parts of the province and to examine changes over time. The PMR is based on the number of people who die before they reach age 75, so higher PMRs mean more premature death. It turns out that areas with a high PMR also have high rates of disease and poor health. This information helps to show where needs are greatest and if health services are addressing needs appropriately.

Table 1: Life expectancy from birth in Manitoba

By location	Men (years)	Women (years)
Manitoba	76.3	81.5
Winnipeg	76.9	81.8
Brandon	76.9	82.7
Rural South	77.6	82.7
Mid	76.1	81.5
North	71.1	76.8
By neighbourhood income		
Rural highest	79.7	84.0
Rural lowest	73.0	79.3
Urban highest	81.3	85.0
Urban lowest	71.3	79.7

MCHP's methods: Collaborating with users

A major aim of this report is to help RHA managers plan health services for their communities, so representatives from all 11 of Manitoba's RHAs were involved in this project from the start. Members of *The Need To Know* Team and the Community Health Assessment Network advised MCHP on what they needed and reviewed results. They helped select 105 indicators to be used in the planning and policy process, along-side information from CancerCare Manitoba and Manitoba Health and

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Healthy Living. For an idea of what's in the 2009 Atlas, see Fast Facts, next page.

This report updates an earlier atlas published in 2003. Similar to that report, it takes a population-based approach. Results are based on routinely collected administrative data available anonymously for almost all Manitoba residents. Indicators are based on contacts with the healthcare system, for example, a doctor's visit or hospitalization. Indicators are reported according to where people live and for two time periods (usually 2000/01 and 2005/06).

However the last chapter is based on a random sample of Manitobans who participated in the Canadian Community Health Survey conducted by Statistics Canada. Unlike the rest of the report, it does not include people living in First Nations communities.

Comparing results for RHAs or districts within an RHA is one way to highlight which programs are doing well and which ones need some attention. However, if one RHA has more seniors while another has more children, you would expect patterns of disease and healthcare use to be quite different. To allow fair comparisons between areas and over time, MCHP adjusted results as if each area had the same proportion of old and young; men and women. For example, when not adjusted, Burntwood RHA's stroke rate did not seem out-of-line compared to the provincial average. However, when its youthful population was taken into account, stroke rates were more than double the Manitoba average. The altered view of risk could have important implications for health programs.

Wherever possible, results are given for all 11 RHAs and their districts or neighbourhoods, three larger areas (North, Mid, Rural South) and the entire province. Results are also reported by neighbourhood income. This is a vast amount of information, so some of it is on the website rather than in the published report.

Top three causes of death differ by age and area

Circulatory diseases (including heart disease and stroke) remained the most common cause of death in Manitoba, although they accounted for a lower proportion than in the last atlas. Cancer and respiratory diseases came next.

Table 2: Top causes of death, 2001-2005

Cause of death	All deaths in Manitoba (%)	Premature deaths in Manitoba (%)	Premature deaths in the North (%)
Circulatory	33.6	24.6	20.2
Cancer	27.2	36.0	20.9
Respiratory	8.1	5.1	5.6
Injury	6.4	12.0	23.5

Together, these three accounted for almost 70% of deaths in Manitoba (see Table 2).

Looking at premature deaths in Manitoba, injuries become much more prominent. For those under age 75, cancer was the leading cause of death, followed by circulatory diseases and injuries. In the North, injury caused almost a quarter of premature deaths, followed by cancer and circulatory diseases.

Tracking trends in disease

There were dramatic downward trends for strokes, heart attacks and diabetes-related lower-limb amputations (see Table 3). Stroke rates went down by almost 25%. Heart attacks and amputations were down roughly 13% each. There were almost 2,000 fewer strokes and 1,000 fewer heart attacks over the five years ending in 2005/06 compared to the previous five-year period. The number of diabetes-related amputations actually increased, but the rate dropped because the number of people diagnosed with diabetes increased more.

Some of this reduction in life-threatening events was likely due to enhanced screening and early detection. Over the same time period, there were 38,500 more people diagnosed with hypertension, 19,000 more with diabetes and 11,000 more with osteoporosis. At first glance this might seem like bad news. The increased diagnoses cannot be explained by the fact that people are living longer. After age-and sex-adjusting, the increases remained in the neighbourhood of 15-30%. However, if the increases were due to earlier detection, there's potential to prevent some serious complications and premature death down the road.

Although decreases in arthritis, ischemic heart disease and respiratory disease were small, these sometimes affected many people. For example, because arthritis is so common, a tiny drop in prevalence meant 3,375 fewer arthritis sufferers.

Over the five years studied, one in 10 seniors over age 55 experienced dementia, and almost a quarter of people over age 10 had a diagnosis of one or more of five mental illnesses in a cumulative index. The increase in the rate of this index was driven by depression and anxiety, since the other components either went down (substance abuse) or remained stable (personality disorders and schizophrenia).

Most disease rates were highest for residents of the lowest income neighbourhoods, especially in the core area of Winnipeg and in northern Manitoba. Obviously, disease trends affect healthcare use. Tracking health status and healthcare use together is an important way to evaluate how well services meet needs.

Tracking trends in healthcare use

People with poorer health probably need more healthcare. People living in the least healthy and lowest income areas received more hospital care, more of some surgical procedures and a greater variety of prescriptions.

Fast Facts

The 2009 Atlas covers a lot of ground. To give you a taste of what is in the report, here's a "did you know" type of fact from each chapter. Unless indicated, results are for 2005/06.

Demographics

- The North had more children than the rest of Manitoba (40% versus 28%) and fewer seniors (5% versus 14%).

Population health status and mortality

- About 40% of all deaths were premature, i.e., they occurred before age 75.

Prevalence of physical illness

- Asthma prevalence increased until the late 1990s while bronchitis decreased after 1994/95. What used to be labelled bronchitis may now be called asthma.

Mental illness

- Depression, anxiety and dementia were the three most common mental illnesses.

Physician services

- Manitobans visited a doctor an average of almost five times a year, not very different than in the last atlas. Over time, children and young adults visited their doctor a little less, while seniors visited a little more.

Hospital services

- The downward trend in hospitalizations and length of stays slowed down from prior reports, suggesting rates are stabilizing.

High profile surgical and diagnostic services

- Over the five years measured, MRI scan rates doubled, while hip and knee replacements increased by 28% and 39%, respectively. Heart bypass and cataract surgery rates, however, appear to be levelling off.

Use of home care services

- More people used home care, but for about the same length of time as in the past.

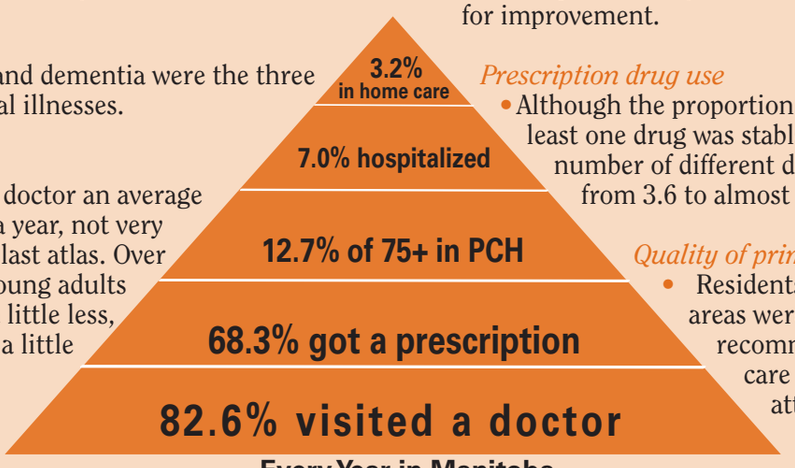
Use of personal care homes

- Fewer people used nursing homes; waiting times to enter fell; and average stays were shorter. Given our aging population, this likely means that people are living at home longer. The increasing availability of home care services supports this positive trend.

Preventive and other services

- Over one in 10 Manitobans called Health Links / Info Sante for health advice over a two-year period. Use was uneven though, with 17.4% of Winnipeggers but only 3.7% of Burntwood residents calling the toll-free line.

- Two-thirds of seniors (65+) got a flu shot in 2005/06. This is up from five years earlier but there's still room for improvement.



Prescription drug use

- Although the proportion of people prescribed at least one drug was stable at 68%, the average number of different drugs prescribed went up from 3.6 to almost four in 2005/06.

Quality of primary care

- Residents of lower income areas were less likely to get recommended follow-up care for diabetes and heart attacks.

Results from the Canadian Community Health Survey (2000-05)

- More than one in five Manitobans over age 12 said they currently smoke (22.7%). Almost as many (17.5%) reported having five or more alcoholic drinks at least once a month. The smoking rate was slightly higher than the national average, while drinking was lower. And both were associated with health status – the greater the smoking and drinking rates, the poorer the health status.

- Contrary to most reports, low-income residents had higher physical activity levels than high-income residents. This is likely because work, travel and leisure-time activities were included in the tally, whereas most studies use only leisure-time activity.

Table 3: Disease trends in prevalence over five years			
Diseases that went down (age; years of data)	**Prevalence for period ending 2000/01**	**2005/06**	**% Change over 5 years**
Stroke (40+; 5 years)	4.1/1000	3.1/1000	↓ 24.4
Diabetes-related lower limb amputation (19+ with diabetes; 5 years)	1.86%	1.63%	↓ 12.4
Heart attack (40+; 5 years)	5.3/1000	4.6/1000	↓ 13.2
Substance Abuse (10+; 5years)[1]	5.4%	4.9%	↓ 9.3
Respiratory diseases (all ages; 1 year)	12.4%	11.6%	↓ 6.5
Ischemic Heart Disease (19+; 5 years)	9.0%	8.5%	↓ 5.6
Arthritis (19+; 2 years)	20.9%	20.2%	↓ 3.3
Diseases that went up			
Diabetes (19+; 3 years)	6.7%	8.7%	↑ 29.9
Osteoporosis (50+; 3 years)	10.3%	12.7%	↑ 23.3
Anxiety (10+; 5 years)[1]	6.1%	7.4%	↑ 21.3
Hypertension (19+; 1 year)	20.6%	23.7%	↑ 15.0
Depression (10+; 5 years)[1]	16.9%	19.1%	↑ 13.0
Cumulative mental illness (10+; 5 years)[1]	22.4%	24.3%	↑ 8.5
Dementia (55+; 5 years)	10.0%	10.8%	↑ 8.0

[1] Cumulative mental illness included depression, anxiety disorders, personality disorders, schizophrenia and substance abuse.

Without drug coverage, poorer Manitobans would probably have low prescription drug use despite high needs, so results like this suggest the Manitoba Pharmacare Program is working. Other services did not respond as well to people's health needs. For example, residents of RHAs with poorer health would be expected to see their doctors more often. This relationship did not occur, although incomplete data may be an issue. The link between doctor visits and area-level income was also inconsistent – the urban poor saw doctors more often, but the rural poor saw them less often. And contrary to what seems appropriate, MRI scan rates were lowest in the least healthy and lowest income areas. This was also the case for some screening services such as mammograms for breast cancer and Pap tests for cervical cancer.

Manitoba's growing gap in health status

Money may not buy happiness, but it seems to get you better health and a longer life. Once again, residents living in areas where average household income was lower had poorer health. And because health for those already doing well improved, while it stayed the same or deteriorated for those doing the least well, the gap in health status actually grew in the short time span that this report covers.

The gap in health status between the north and south, rich and poor, is not new, but the fact that it is growing is disturbing. This is clearly something that needs to be addressed within the healthcare sector and beyond it as well.

Putting evidence into action

The health of the population of Manitoba continues to improve, but unfortunately, this is not the case for everyone.

Healthcare providers and decision makers will find plenty of information on health status and healthcare use and the relationship between them in this report. The focus is on presenting a broad picture of the health of Manitobans, not on how or why results came about, or what to do about them. That is better addressed within each RHA. Healthcare planners, policy-makers, clinicians and others can use this report and the more detailed results on MCHP's website, along with their understanding of their communities, to plan for the future health needs of their residents.

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YOU CAN DOWNLOAD IT FROM OUR WEB SITE: http://www.umanitoba.ca/faculties/medicine/units/mchp/
OR ORDER IT FROM MCHP: PH. (204) 789-3819; FAX (204) 789-3910; EMAIL reports@ cpe.umanitoba.ca
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