Summary of Key Findings from the 2014 Community Health Assessment Report for The Winnipeg Health Region

The 2014 Community Health Assessment Report describes population and community characteristics, health status, determinants of health, and healthcare access, utilization and quality across the Winnipeg health region which administratively includes the small northern community of Churchill. This volume presents an overview of the indicators for the Winnipeg Regional Health Authority (WRHA – the Region) and health inequalities across the Region.

HEALTH STATUS

The Region's population has been growing over the past decades and continues to grow: the projected population will reach 1,070,300 in 2042, a 45.8% increase from the observed population in 2013 (734,187). More importantly, the senior population's proportion (aged 65 years and older) will increase from 14% in 2012 to 20% in 2042.

Nearly 60% of residents aged 12 years and older reported very good or excellent self-perceived health, but only 38% of them reported a high score on mental health. Self-perceived health is relatively stable over time and similar to that for other large urban health regions (Peer Group A)[1] and the national average.

> Overall, health in the Region is improving, but improvements are needed in some areas

Mortality has been decreasing and life expectancy has been increasing. However, life expectancy at birth (77.8 years for males and 82.2 years for females in 2007-09) was lower and premature mortality rate (2.93 per 1,000 in 2011/12) was higher than the national average (2.59 per 1,000 in 2011/12).

Circulatory system disease, cancer, respiratory system disease, injury and poisoning, and mental illness are the top five causes of deaths in the Region.

Genital chlamydia and gonorrhea are the two most commonly reported bacterial sexually transmitted infections in the Region and in Canada as well.

There is some good news for chronic diseases: hypertension, ischemic heart disease, acute myocardial infraction, and stroke incidence rates decreased over time; while diabetes incidence rate remained relatively stable.

Mental and substance disorders are a significant contributor to disease burden. In 2007/08-2011/12:

- 25% of residents aged 10 years and older were treated for a mood and anxiety disorder;
- 5% of residents aged 10 years and older were treated for substance abuse;
- 10% of residents aged 55 years and older lived with dementia.

Injuries are one of the leading causes of hospitalizations and deaths and accounted for 7.5% of all hospitalizations and 6.5% of all deaths in the Region during 2007-12.

The Region is facing a large challenge in trying to improve early life development and health:

- In 2011, 23.9% of newborns in Winnipeg and 41.2% of newborns in Churchill were exposed to at least one of the five prenatal risk factors [maternal alcohol drinking, maternal smoking, maternal anxiety/depression, family financial difficulties during pregnancy, and mother's low educational status (less than high school)];
- 8.1% of babies were born prematurely during 2005/6-2008/09 and 8.2% of newborns were considered small-for-gestational-age during 2007/08-2008/09;

In the 2010/11 school year, 28% of Winnipeg kindergarten children (around age 5) and 33% of Churchill kindergarten children were not ready for grade 1 in one or more of the five domains measured by the Early Development Instrument (EDI).

For example, Regina Qu'Appelle RHA, Saskatoon RHA, Capital District Health Authority (Halifax NS), Region de Laval (Quebec). Refer to the following URL for the entire list: http://www12.statcan.gc.ca/health-sante/82-228/search-recherche/lst/page.cfm?Lan=E&GeoLevel=PEER&GEOCODE=01

A large proportion of residents are not practicing healthy behaviors or not using preventive services

Compared to residents in other large urban health regions and the overall Canadian population, the Region's residents are doing better with respect to rates of tobacco smoking and physical activity, but worse in other health behaviors. In 2011/12:

- 19.2% of the Region's residents aged 12 years and older smoked daily or occasionally versus 21.6% in other large urban health regions in Canada;
- 56.7% of the Region's residents aged 12 years and older reported being physically active or moderately physically active (leisure + travel activities only) versus 54.8% in other large urban health regions and 53.8% in Canada;
- 22% of the Region's residents aged 12 years and older had an indicator for binge drinking in the past year versus 19.1% in other large urban health regions and 18.2% in Canada;
- 39.1% of the Region's residents aged 12 years and older consumed fruit and vegetables five or more times per day versus 42.4% in other large urban health regions and 40.5% in Canada;
- 54.2% of the Region's residents aged 12 years and older were overweight/obese versus 54.1% in other large urban health regions and 52.3% in Canada.

In 2007/08, more than one quarter of children aged 2 years in Winnipeg and Churchill did not have complete immunization coverage; nearly one third of children at age 7 in Winnipeg did not have complete immunization coverage. Older adult (65 years and older) influenza immunization coverage in Winnipeg was 63% in 2007/08 and in Churchill was 57% in 2007/08); these rates are lower than the national target (80%, 2010).

Women's cancer screening participation rates in Winnipeg are slightly lower than the national benchmarks, and even lower in Churchill.

In 2008/09, 82.5% of mothers initiated breastfeeding soon after their child's birth, a slight decrease from the past. However, data on breastfeeding duration are not available.

Substantial inequalities in health status remain

Within the Region, factors that impact health (e.g., education, employment, income, and other socio-economic factors) are unequally distributed.

Generally, higher income communities have better health across the Region:

- Residents in lower income communities are more likely to die and to die at an earlier age. During 2007-11, there was a nearly 17-year difference in female life expectancy and a 15-year difference in male life expectancy between the lowest income neighborhood cluster (NC) of Point Douglas South and the highest income NC of River East N. The premature mortality rate (PMR) in the lowest income NC was 5-fold higher than that of highest income NC in 2007-2011.
- Lower household income was associated with higher infant mortality rates; there were 4 times more deaths in children in Downtown and Point Douglas community areas (low income) compared to the highest income areas of the Region.
- Lower income community residents are more likely to be diagnosed and treated for chronic diseases such as hypertension, diabetes, and ischemic heart disease.
- Lower income communities tended to have higher mental disorder and substance abuse prevalence.
- Intentional and unintentional injuries hospitalization rates for residents living in the lowest income quintile are more than double than that for those living in the highest income quintile.
- Newborns from families in lower income communities are more likely to be exposed to known risk factors prenatally and more likely to be born prematurely.
- Dental extractions are the removal of teeth, in hospital, from young children with severe tooth decay. Anesthesia beyond levels available in a dentist's office is required. Nine times (9x) more children living in the lowest income quintile of the Region require hospital-based dental extractions than those children living in the highest income quintile.

Gaps in healthcare access, utilization, and quality exist

In 2011/12, 14.6% of families reported not having a family medical doctor.

Overall, the utilization of ambulatory care has been relatively stable. The availability and quality of ambulatory (primary) care in the Region has improved, but provision of primary care remains a challenge to those living in low income communities.

In 2011/12, 5.5% of Winnipeg residents and 11.1% of Churchill residents were hospitalized at least once in a year; 7% of hospitalized patients in Winnipeg and 9% of those in Churchill were readmitted within 30 days of discharge.

In 2011/12, 3% of Winnipeg residents aged 75 years and older were newly admitted to PCHs. The median waiting time was 3.5 weeks for those admitted from hospital and 7 weeks for those admitted from the community.