Priority Health Needs Rooted in Social Issues

Medical schools have the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals and the public (WHO, 1995). The faculty of a medical school should ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting and treatment of the medical consequences of common societal problems (CACMS, 2015).

Centering medical school programming and curriculum content on pressing social issues that have health implications will enable College of Medicine (CoM), University of Saskatchewan graduates to respond directly to the health needs of the communities they serve. The Division of Social Accountability, CoM performed a document review to identify local, regional and national priorities rooted in pressing social issues. These priorities - set by health care organizations, health regions and governments - were based on health system data, community consultations and well established inequities in health.

Pressing social issues that have health implications and are of particular concern for Saskatchewan include:

- **Indigenous health inequities**
- **poverty, and**
- **mental health, stigma and suicide risk**

These issues do not exist in isolation; there is considerable overlap between them. The social determinants of health (SDoH) are at the foundation of these issues. Understanding health inequities experienced by Indigenous peoples, those in poverty and populations disproportionately affected by mental illness cannot be done without due recognition to the underlying social factors.

Indigenous health inequities

Globally, Indigenous populations face poorer overall health outcomes and continue to experience disparities across most health indicators when compared to other populations[2]. In Canada, Indigenous communities are more likely to experience poor health outcomes in essentially every indicator possible[2]: infant and young child mortality; maternal morbidity and mortality; infectious disease; malnutrition and stunted growth; shortened life expectancy; HIV/AIDS; tuberculosis; obesity and Type 2 diabetes; hypertension, cardiovascular and heart disease; disability; accidents; interpersonal violence, homicide and suicide; mental health issues; and diseases caused by environmental contamination[3]. Historically Saskatchewan has shown some of the most extreme health outcome disparities when comparing Indigenous with non-Indigenous populations[4]. As the Indigenous population continues to grow at a faster rate (expecting to increase to 32.4% in Saskatchewan by 2045[3]) the health status of Indigenous peoples continues to be an important focus for researchers, healthcare professionals and policy makers.

The root of these disparities is incredibly complex, lying in the historical and on-going economic, social and cultural marginalization of Indigenous communities and sitting largely outside the typically

constituted domain of health[3]. Beyond the healthcare-specific barriers of access to timely, preventative and culturally appropriate care, Indigenous people experience inequities in the social conditions that determine health: poverty, poor physical environment, fewer employment opportunities, weaker community infrastructure, etc[5]. These are referred to as the social determinants of health. The history of Indigenous peoples in Canada is one of colonialism and has had intergenerational effects: all Indigenous groups have suffered losses of land, language, self-determination, identity and culture and have shared experiences of racism, discrimination and social exclusion – much of which is ongoing today.

Commitment to reducing these disparities exists at the local, provincial and national levels. Provincially within Saskatchewan, in 2008 the Government of Saskatchewan (together with the Government of Canada and the Federation of Sovereign Indigenous Nations) signed a memorandum of understanding (MOU) to improve the health and well-being of Indigenous peoples, eliminate disparities, and develop a *10-Year Indigenous Health and Wellness Plan*[6]. The Saskatoon Regional Health Authority and the Aboriginal Health Council followed with an MOU of the Aboriginal Health Council in 2010, with the goal of closing the gaps between the Indigenous population and non-Indigenous populations by improving health outcomes and experiences of care for Indigenous peoples and promoting the integration of culturally appropriate health services[7].

Commitment also exists in the area of research. The Indigenous Peoples' Health Research Centre (IPHRC) is working to improve and strengthen the quality of Indigenous health research and the health of Indigenous people[8], and the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) acknowledges northern and Indigenous health as a key priority area in its efforts to address health inequities through population health intervention research[9]. Building capacity for Indigenous health research is also a strategic goal of the Saskatchewan Health Research Foundation (SHRF)[10].

At the national level, organizations dedicated to improving the health outcomes and health equity of Indigenous peoples have been established by the Canadian government, including the National Collaborating Centre for Aboriginal Health[3] and the First Nations and Inuit Health Branch[11] of Health Canada. One of the Canadian Institutes of Health Research (CIHR) ten signature initiatives is "Pathways to Health Equity for Aboriginal Peoples". Through Pathways, CIHR and partners (including SHRF) aim to contribute to the creation of better preventative health services, healthier communities and health equity for First Nations, Métis and Inuit peoples in Canada[12].

Health training should embrace and Indigenous worldview and a holistic definition of health and well-being[7]. Curriculum programming related to Indigenous health inequities should highlight the interconnectedness between these health disparities and their rooting in historical policies (i.e., residential schools, the 60s scoop, Indian Act, etc.) and the social determinants of health. *The Truth and Reconciliation Commission of Canada: Calls to Action* call upon the Canadian healthcare system to "recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients"[13]. The TRC also calls directly upon Canadian medical schools to require all students to take a course dealing with Indigenous health issues, including the history and legacy of residential schools, the UN Declaration of the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous teachings and practices and notes that this will require skills-based training in intercultural competency, conflict resolution, human rights and anti-racism. Further, in the *Aboriginal Health Strategy 2010-2015* the Saskatoon Health

Region outlines guidelines developed by Aboriginal physician Dr. Janet Smyley to provide direction and guidance health and social service providers who work in Indigenous communities.

Under these recommendations, health professionals should:

- have a basic understanding of the appropriate names for the various groups of Indigenous peoples in Canada,
- be familiar with traditional geographic territories and Indigenous languages,
- have basic knowledge of the current socio-demographics and recognize that the related challenges that have significant impact on health status,
- recognize the need to provide health services for Indigenous people as close to home as possible,
- have a basic understanding of governmental obligations and policies regarding the health of Indigenous people in Canada and the disruptive impact of colonization on health and well-being, and
- recognize the need to support Indigenous individuals and communities in the process of self-determination[7].

In spite of considerable health challenges, Indigenous peoples continue to demonstrate incredible resilience and growing capacity for addressing these inequities[4]. Cultural and traditional principles, values and beliefs need to be at the forefront of delivering the supports and services to improve the Indigenous healthcare experience[7]. In affiliation with the Regina Qu'Appelle Health Region, the All Nations Healing Hospital, recognizes the importance of community-oriented, integrated health services that incorporate cultural support (e.g., ceremony, cross cultural education, access to elders)[31]. A strengths-based approach to community health is key for positive work with Indigenous communities, and community members need to be meaningfully engaged in identifying priorities as well as appropriate solutions.

Poverty

The research on health inequalities between richer and poorer Canadians is well established[16]. Researchers consider socioeconomic status (SES) to be the most important determinant of health[14] and income as the single most important determinant of disease and disorder in our communities[15]. Canadians spend more than $200 billion (40% of most provinces' budgets) annually on publicly funded healthcare, yet inequalities in access to care and health outcomes persist; in general, richer Canadians tend to be healthier and live longer than poorer Canadians[16]. Those living in or near poverty suffer a host of poorer health outcomes[15] including low birth weight, diabetes, heart disease, injury and/or poisoning, coronary heart disease, chronic pulmonary disease, mental health disorders, asthma and suicide[15].

Since the early 2000s, these economic inequalities have persisted or have widened[16]. In 2012, the top 10% of Canadians owned almost half (47.9%) of all wealth while the bottom 50% of Canadians owned less than 6%[17]. According to the 2006 census, some northern Saskatchewan towns are considered to be amongst the poorest in the country[18]. In 2014 there were 160,000 people in Saskatchewan living in poverty; 14.8% of our population lacked the income needed to afford basic necessities[1]. But poverty is not experienced equally across the generalized population. Some groups, such as women, children, lone

parent families, Indigenous peoples, recent immigrants, rural, and individuals living with disability, are more likely to experience poverty than others[18]. For children in Indigenous families in 2010 the poverty rate was 59.0%[1].

Poverty costs. The economic cost of Poverty in Saskatchewan was recently calculated to be $3.8 billion annually in heightened service use and missed economic opportunities[15]. Increased disease prevalence among lower socioeconomic individuals has led to disproportionately high utilization of hospitals, physicians and medications[2]. In Saskatchewan, poverty costs $420 million a year in heightened health care service usage[15]. Beyond creating severe health inequities among our population, poverty jeopardizes the sustainability of our healthcare system, costs our economy dearly and it threatens to undermine the very cohesiveness of our communities[15]. The good news is, income status is modifiable.

Poverty reduction is a priority at the local, provincial and national levels. Results of a 2008 Saskatoon health disparity study led to policy changes at the Saskatoon Health Region and increased financial resources to six low income neighbourhoods. A host of local agencies (i.e., University of Saskatchewan Department of Pediatrics, United Way, Catholic and Public School Boards, Saskatoon Tribal Council, City of Saskatoon, etc.) also dedicated resources to Saskatoon's low income neighbourhoods and the Government of Saskatchewan allocated $40 million dollars for low income subsidized housing[2]. In Regina, the Regional Anti-Poverty Ministry (RAMP) continues to advocate for the changes outlined in Poverty Free Saskatchewan's 2010 *Let's Do Something About Poverty* report in the wake of startling statistics[32].

In addition to financial support to address this social issue, the Government of Saskatchewan declared in the 2014 Speech from the Throne its commitment to develop a Poverty Reduction Strategy and an advisory group was formed to provide recommendations. The group engaged (through roundtable discussions, online survey, meetings) with health regions, government representatives, First Nations and Métis organizations, the education sector, childhood development agencies, individuals with lived experience and organizations that serve vulnerable populations in development of the strategy. Six key areas of action outlined in the recommendations are:

1. income security,
2. housing and homelessness,
3. early childhood development and child care,
4. education, skills training and employment,
5. health and food security, and
6. vulnerable families and individuals[18].

The Government of Saskatchewan adopted the strategy in 2016 with the aim of reducing the number of residents who experience poverty for two or more years by 50% by the end of 2025[18].

At the national level, Canada joined a number of nations in 2011 in a commitment to implement the Rio Political Declaration on Social Determinants of Health[19], acknowledging that social and health equity is achieved through action on the social determinants of health and is a shared responsibility of all sectors of government. The declaration states: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[19].

Curriculum programming related to poverty should emphasize socioeconomic status as the most important social determinant of health and outline the extent - and growing level - of the disparity at the local, regional, national and global levels across various social groups with implications for a host of health outcomes. Screening and interventions for poverty and incorporation of patients' socioeconomic status into clinical decisions should be included in the medical curriculum. Tools like those in *Poverty: A clinical tool for primary care in Ontario* could be utilized in teaching and clinical training[33]. Education about poverty interventions at the community level (i.e., housing, social assistance, government benefits programs, etc.) and the role of other professionals (e.g., social workers) and community organizations (e.g., free tax clinics) should also be included[20]. Training for health advocacy (e.g., teaching medical students and residents about how to influence the system and advocate for polices that will address poverty) is a professional responsibility and a promising avenue for change[21]. Opportunities for experiential, community-engaged and inter-professional learning is a way of supplying real-time education on how the social, political and economic conditions impact the health of individuals and populations[22].

Mental illness, stigma and suicide risk

In any given year, one in five Canadians experience a mental health problem or illness[23] and 7 million Canadians will need help for mental health concerns in a given year[24]. Every single Canadian is affected by mental health issues, either directly with firsthand experience or indirectly through someone they know[24]. Of the 4,000 Canadians who die annually as a result of suicide, most were confronting a mental health problem or illness[24]. Mental illness costs the Canadian economy an estimated $33 to $50 billion per year in lost productivity. Dementia prevalence is expected to increase to 1.1 million by 2038, at the tune of $153 billion dollars[25]. The World Health Organization predicts that by 2030 the economic burden of depression alone will exceed the costs of all other physical diseases[26].

Mental illness is experienced disproportionately across various social groups, including Indigenous peoples, those of low socioeconomic status, children and youth. In 2000, the suicide rate for Indigenous populations in Canada was 24.1 (per 100,000 population) in comparison to the national average of 13.2 and was concluded in a 2005 report to be the leading cause of death among those aged 10 to 44 years[28]. Indigenous youth commit suicide 5-6 times more often than non-Indigenous youth[23]. An overwhelming majority of people with mental health disabilities are living in poverty[28]. Poverty reduction is identified as a necessary component of the federal government's mental health strategy for Canadians[29] - recovery is not possible without "the fundamental elements of community to which [everyone] should have access: housing, education, income and work"[23]. Socioeconomic status intersects with age in that low socioeconomic status youth are 2.5 times more likely to suffer from depressed mood or anxiety than youth with higher socio-economic status[2]. The World Health Organization predicts that by 2020 childhood and adolescent mental health problems will become one of the leading causes of morbidity, mortality and disability among children worldwide[2].

Provincially, mental health and addictions is identified by the Saskatchewan Ministry of Health as a strategy to close the health disparity gap, with the goal of increasing access to quality mental health and addictions services and reducing wait time for outpatient and psychiatry services by March 31, 2019[27]. The Government of Saskatchewan's *10 Year Mental Health and Addictions Action Plan* outlines a vision to (i) ensure mental health and addictions support is available across the lifespan with services that are easily accessible through any point of entry and are responsive to client, family and caregiver needs; and

(ii) ensure "[a]ll residents of Saskatchewan will have access to appropriate and coordinated mental health and addictions services that promote recovery to the greatest extent possible, improve mental well-being, and ultimately enhance the overall health and vibrancy of our communities and our province"[26].

At the federal level, the Mental Health Commission of Canada, in close consultation with people living with the mental illness, families, stakeholder organizations, government and experts, drafted the first mental health strategy for Canada. The strategy recognizes that greater attention must be paid to promotion and prevention and highlights six strategic directions:

1. promote mental health across the lifespan and prevent illness wherever possible,
2. foster recovery and well-being for people of all ages,
3. provide access to the right combination of services,
4. reduce disparities in risk factors and access to services and strengthen the response to diverse community needs,
5. work with Indigenous peoples to address their mental health needs, acknowledging their distinct circumstances, rights and cultures, and
6. mobilize leadership, improve knowledge and foster collaboration at all levels[23].

Medical professionals need to be attuned to the different experiences of mental health across diverse social groups, and work to modify services, treatments and support to make them more welcoming and effective[23]. Significant barriers to seeking and obtaining appropriate help exists not only among Indigenous people, youth, and individuals with low socioeconomic status, but also immigrants, refugees, francophones and individuals who experience stigma and discrimination on the basis of gender, sexual orientation, disability, ethnicity and culture. Training around mental health services and resources, appropriate screening tools, brief interventions and clear clinical pathways should be provided to future healthcare professionals. Team-based health care training that includes mental health and addictions counsellors and consultant psychiatry can improve access to specialized care and improve outcomes[26]. Health advocacy also has a role to play (e.g., promotion of community health initiatives and mental health resources) and adapting the service culture to one which is more person- and family-centered promotes recovery and enhances service. The Mental Health Commission of Canada's family and caregiver guidelines provide evidence-based best practices to service providers[30].

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