



2015

OUR CITY

A Peg Report on Health Equity



How Are We Doing?

At a glance.

The following report outlines how we are doing on a number of indicators related to health equity. This table provides an overview of the information that follows. The second column indicates the gap between the area with the highest rate and the area with the lowest rate, and the third column indicates whether this gap is getting wider or narrower. Within Winnipeg, there are significant inequities in health status and, in many cases, the gap is widening. In the data that follows, there is a clear relationship between health status and economic and social circumstances. In fact, the table below shows growing inequity in nearly half of the indicators.

PEG INDICATOR	GAP BETWEEN AREAS WITH HIGHEST AND LOWEST RATES	CHANGE IN GAP	LEGEND
Life Expectancy at Birth – Females	18.9 Years	NO CHANGE	Gap is decreasing
Life Expectancy at Birth – Males	17.8 Years		Gap is increasing
Teen Births	20x		Gap is increasing
Pregnancies with Three or More Risk Factors	4x		
Readiness for School	2x		NO CHANGE No change in gap
Children's Hospitalization Rate Due to Injuries	4x		
Hospital Days Used in Long Stays	2x		Note: The standard threshold used is 3 per cent. Where the gap has changed by less than 3 per cent, the trend is set at no change. The choice of 3 per cent as the threshold is subjective. The earliest and most recent data points available in each time series were used – time periods vary by indicator.
Heart Attack	2x		
Stroke	2x		
Diabetes Prevalence	2x		
Premature Mortality Rate	2x		



Peg, Winnipeg’s community indicator system, is rooted in the premise that while caring is important, it is not enough.

We need to measure how we are doing as a community so we can celebrate progress and – in areas where change is not in the right direction or at the pace we desire – work harder or differently to achieve the kind of city we want our children and grandchildren to inherit. In this, our second annual report, we take a closer look at what some key health indicator data tells us about our community.

Health is a state of physical, mental, social, and spiritual well-being. On average, Winnipeggers enjoy good health, living longer and healthier lives than previous generations. Within our city, however, there are significant inequities in health status and, in many cases, the gap appears to be widening. In the data that follows, there is a clear relationship between health status and economic and social circumstances.

This report is intended to stimulate conversation and inspire collective effort on complex and difficult issues. A desire for change is shared by many, and there is much we can build on. Guided by the strength and wisdom of our community, including policy-makers, systems leaders, service providers, and those who demonstrate resiliency despite significant barriers, we can do better. And we must.



Connie Walker

President & CEO
United Way of Winnipeg

Scott Vaughan

President & CEO
International Institute for Sustainable Development

Milton Sussman

President & CEO
Winnipeg Regional Health Authority



The City of Winnipeg is a proud partner and supporter of Peg and its efforts to measure how we are doing as a city and inspire action.

The information provided in Peg allows us to examine ourselves more closely. With this key piece of community infrastructure, we are able to see where we are making progress, as well as take stock of where we face challenges. This report, with a focus on the health of our city, does just this.

Overall, we have so much to be proud of when it comes to improved health conditions. However, as this year’s report reveals, there remains room for improvement in some areas, calling us to take action to work differently, collaboratively, and in partnership with all sectors to improve the health outcomes for all Winnipeggers. The information presented in this report is sure to spark conversation about change in our community. And with access to reliable and credible data through Peg, we will be able to see how we are making progress on these important issues over time.

I commend the Institute for Sustainable Development (IISD), United Way of Winnipeg, the Winnipeg Poverty Reduction Council (WPRC), and the Winnipeg Regional Health Authority (WRHA) for collaborating to raise awareness about the health status of our residents and our communities. Together, we all have a part in improving the health, economic, and social circumstances of all citizens in our city.

Mayor Brian Bowman

City of Winnipeg

Map and Figures

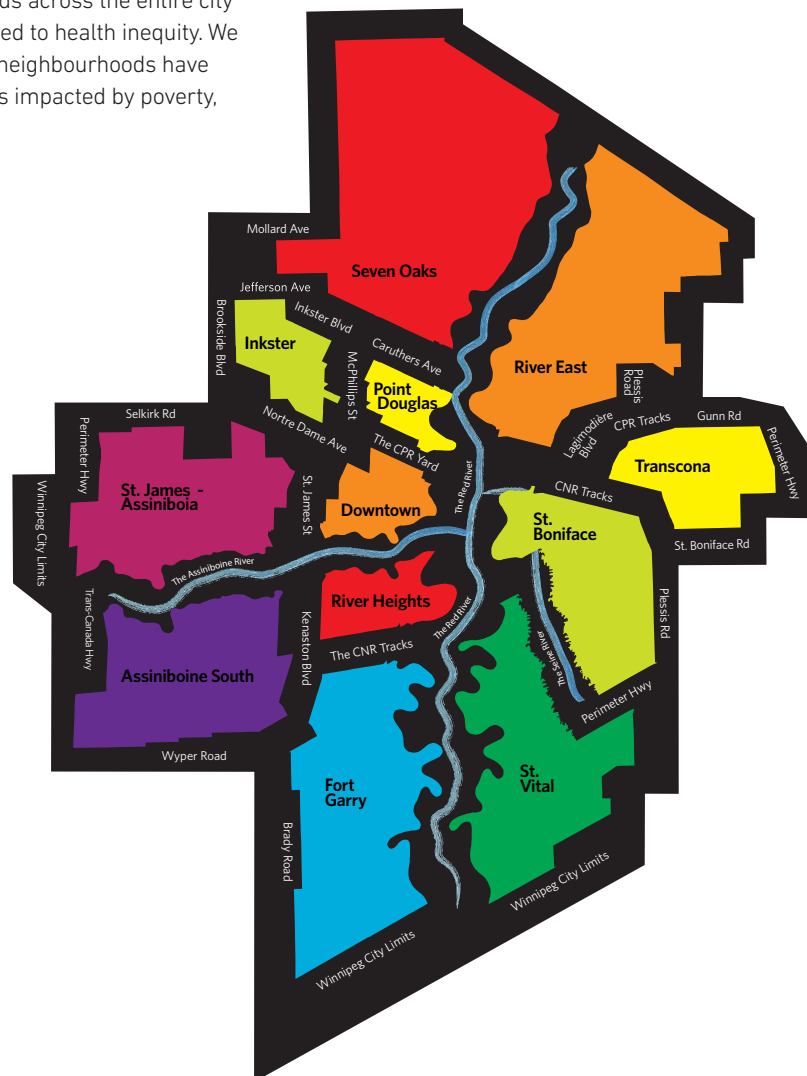
12 WINNIPEG COMMUNITY AREAS

The data in this report, as well as in Peg, is organized around Winnipeg's 12 community areas and the 25 neighbourhood clusters within them. These boundaries are defined by the City of Winnipeg and the Winnipeg Regional Health Authority (WRHA). While East and West St. Paul are not a part of the City of Winnipeg, they are part of the WRHA and therefore included in the data in this report.

When data is presented by geographical area, it is easy to assume that poverty and issues related to health inequity occur only in the inner city. However, while poverty is concentrated in the inner city, we recognize that individuals and families in many neighbourhoods across the entire city experience poverty and issues related to health inequity. We also acknowledge that while some neighbourhoods have a higher concentration of individuals impacted by poverty,

there is also a strong sense of pride, engagement and resilience in these communities.

To provide a broader perspective, this report provides data by income quintile whenever possible. Income quintiles are formed by splitting the population into five groups, with the same number of people in each group, based on income. In effect, this shows how the indicators are affected by people's incomes (whether they are in the highest fifth of the population, lowest fifth, etc.) regardless of the community in which they live.



A vision for a healthy community is one where everyone experiences their best possible health and well-being. When we all have access to the social and economic conditions that shape our well-being throughout life, we have health equity – that is, all people having the opportunity to reach their full health potential.

People often think of health as an individual matter and of health differences as being the result of choices within the control or willpower of individuals. We assume that the way to improve a community's health is to change individual behaviours.

Data and research paint a different picture. Life circumstances profoundly affect how much individual control people actually have over their lives. Opportunities for health begin where we live, learn, work and play – opportunities such as employment, income sufficient to meet needs, good beginnings for children, learning throughout life, freedom from racism, affordable housing, well-planned urban spaces, and accessible public transportation.

The conditions to achieve health and well-being are not experienced evenly by all. There are differences in health associated with different social and economic circumstances. These differences are measured through health problems that can be counted, like hospitalizations or deaths, and then compared to available measures of social and economic conditions, like neighbourhood income. We understand that income is not the only condition that affects health, but it is one we have data for. These indicators point to health inequities or gaps in health status within our city.

In Winnipeg – an overall healthy, vibrant city – there are gaps between groups experiencing the highest and lowest health status, and gradients in between. The data shows that some

of these gaps are getting wider. This report shines a spotlight on 14 health and wellness indicators, exploring how they are affected by income. The first focus is on a 'big-picture indicator' - life expectancy at birth. In addition to projecting an age of death, this indicator speaks to the impact of unfavourable conditions from birth, and health burdens throughout life, at both an individual and community level. The second section explores a set of selected indicators providing insight into conditions that contribute to different opportunities for health, showing the connection between health, income, employment, education, and housing. The final set of indicators map out differences in health outcomes across one's lifetime.

The information in these indicators allows us to shift our gaze and start a new conversation. It opens the door to looking deeper into historical dynamics and circumstances, to working differently to close health gaps and to promote health equity. It encourages us to take action to close gaps and to work towards better health for all in our community.

A vision for a healthy community is one where everyone experiences their best possible health and well-being. When we all have access to the social and economic conditions that shape our well-being throughout life, we have health equity – that is, all people having the opportunity to reach their full health potential.



The Big Picture: Life Expectancy at Birth

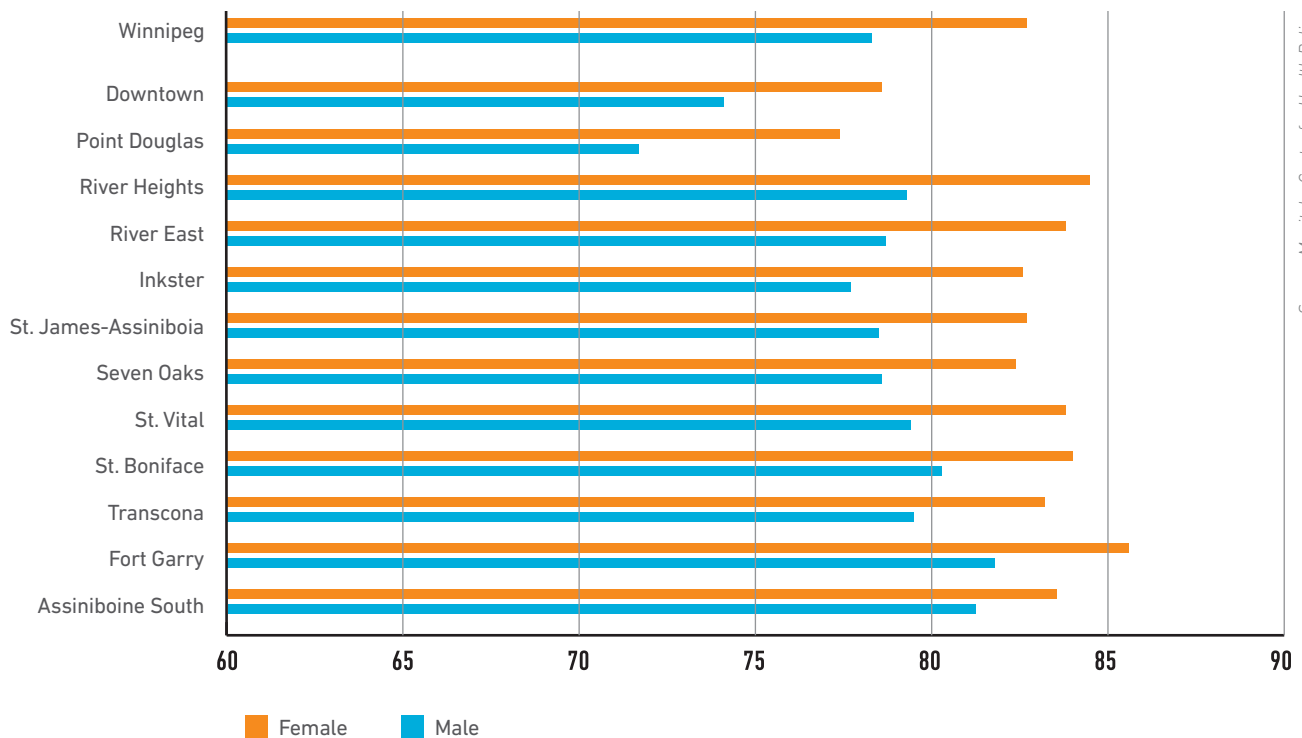
Life expectancy gives us a big-picture view of health across a lifetime. Life expectancy estimates length of life, and is influenced by opportunities and health problems throughout life.

LIFE EXPECTANCY AT BIRTH

Life expectancy at birth is an estimate of how long, on average, people can expect to live (from birth). Across Winnipeg, life expectancy at birth varies significantly. The life expectancy of babies born to the wealthiest 20 per cent of Winnipeggers is 8 to 10 years longer than those born to the lowest 20 per cent. When compared by geographic area, the difference between community areas with the highest and lowest life expectancies

is also 8 to 10 years – the highest being 81.8 years for men and 85.6 years for women, and the lowest being 71.8 years for men and 77.4 years for women. These differences are even bigger when comparing smaller geographies at the neighbourhood cluster level (subsets of community areas) with 18 years (men) to 19 years (women) difference in life expectancy.

Life expectancy at birth (years), 2007–2011



Source: Manitoba Centre for Health Policy

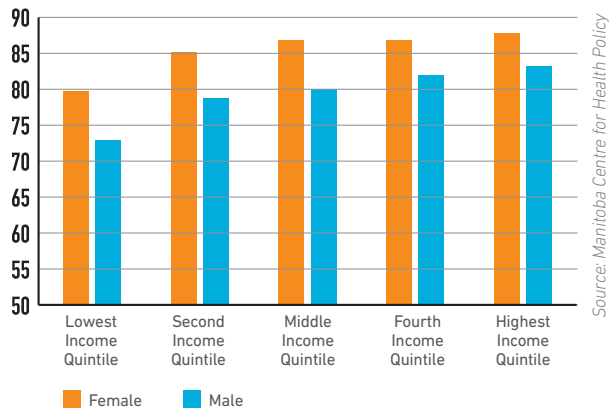
Videos

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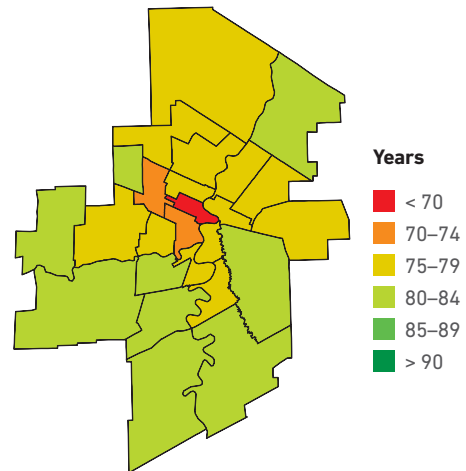
www.youtube.com/mypegCIS

for stories related to Peg indicators.

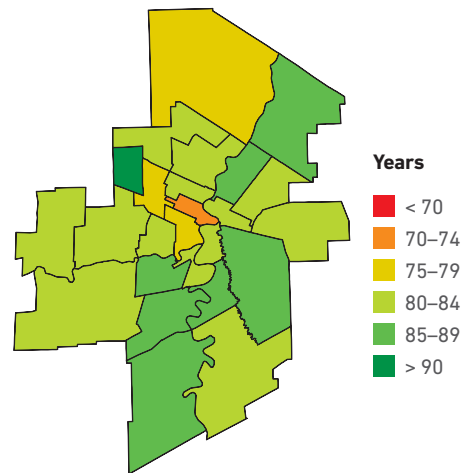
Life expectancy at birth (years), 2007–2011



Male life expectancy map



Female life expectancy map



WHY THIS MATTERS

Life expectancy is one of our most basic indicators of well-being. The large differences in life expectancy observed in Winnipeg indicate that some people are disadvantaged from the beginning. The social and economic circumstances in the earliest years, and throughout the life course, contribute greatly to our life expectancy, and gaps in life expectancy indicate that opportunities for health and well-being are not equally shared. This report is a step towards better understanding root causes.



Conditions for Health

There are a number of personal, social, and economic conditions that influence health and illness. Factors that combine over time – such as past personal experiences and current social and financial circumstances – all weave together and impact our daily lives and opportunities. In this section, we highlight five socioeconomic indicators that set the stage for health: **Median Household Income, Socioeconomic Factor Index, Employment, Education, and Core Housing Need.**

MEDIAN HOUSEHOLD INCOME

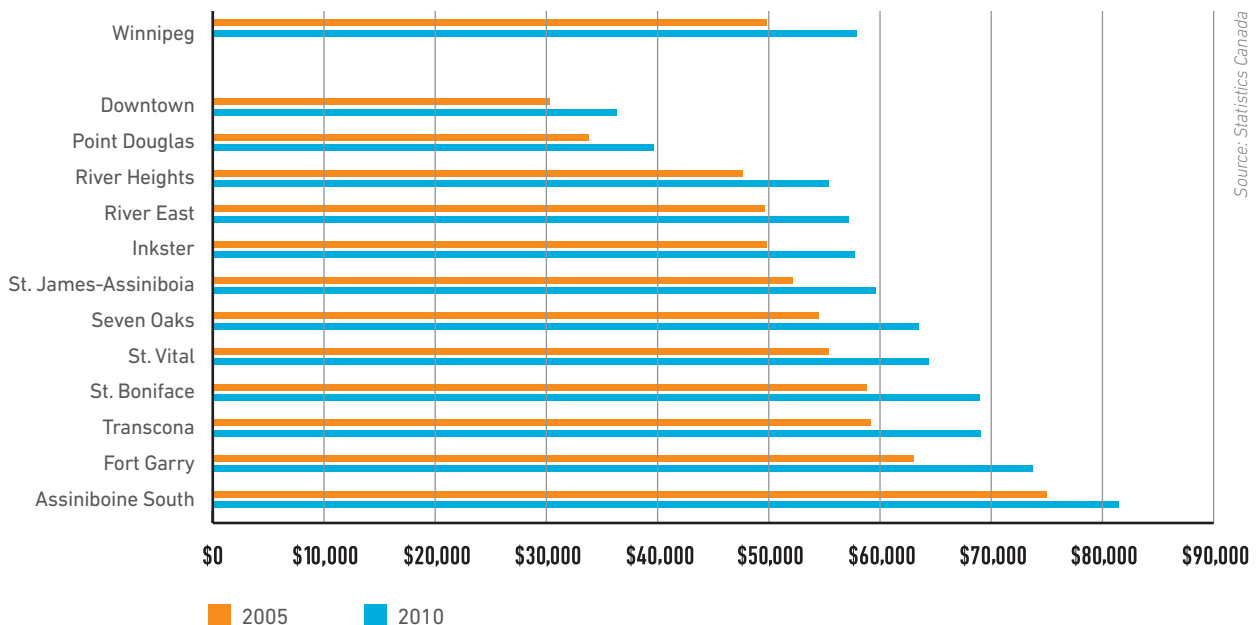
Median household income is a measure of the total income (before tax) of all members of a household. A household is defined as a person or a group of persons who live in the same residence. The median income is the income level where half of households in the area have incomes above that amount and half have incomes below that amount. Median income is considered to be a better indicator than average income because it is not affected by unusually high or low incomes.

While income is not the only social and economic condition that affects health, it has been found to

show the same patterns as other socioeconomic factors in relation to health outcomes. Because of this, the community areas have been ordered from lowest to highest median income within the graphs in the report.

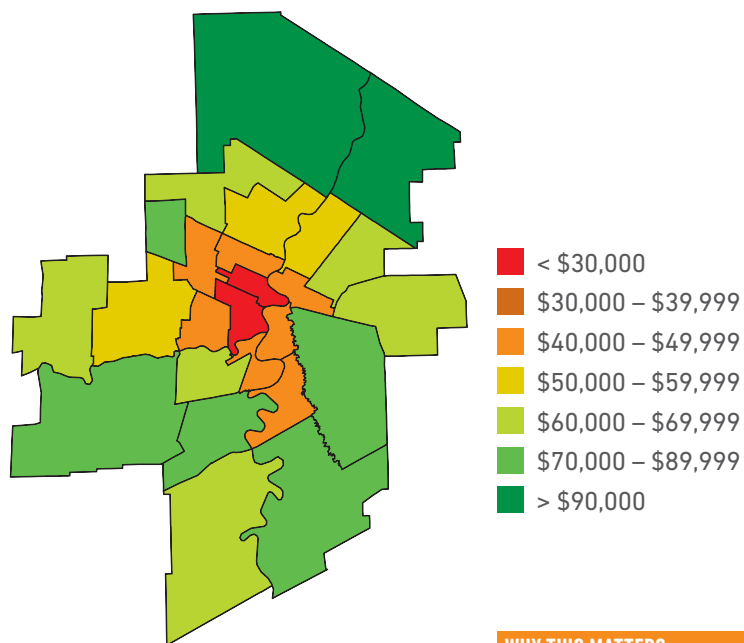
At \$81,000, the community area with the highest median household income is more than twice that of the community area with the lowest income at \$36,000 (2010). This jumps to a threefold difference if one compares neighbourhood clusters. Low income occurs in pockets throughout all community areas, but is more common in the inner city.

Median household income (\$)





Median household income map
(Canadian Dollars)



WHY THIS MATTERS

A higher level of household income enables people to meet basic needs and access quality housing, nutritious food, education, transportation, health, entertainment, and recreation. It can also protect people from discrimination. Low income is a cause of significant stress and anxiety, and limits people's opportunities and choices. Families who live in low-income households often face stigma and discrimination in their day-to-day lives. Many people working full time or more in low-paying jobs still do not make enough income for healthy living. Living in a low-income neighborhood can be a barrier to feeling included and participating fully in community life. Income inequality has negative impacts on a whole community. It is also associated with higher levels of social problems and worse health outcomes.

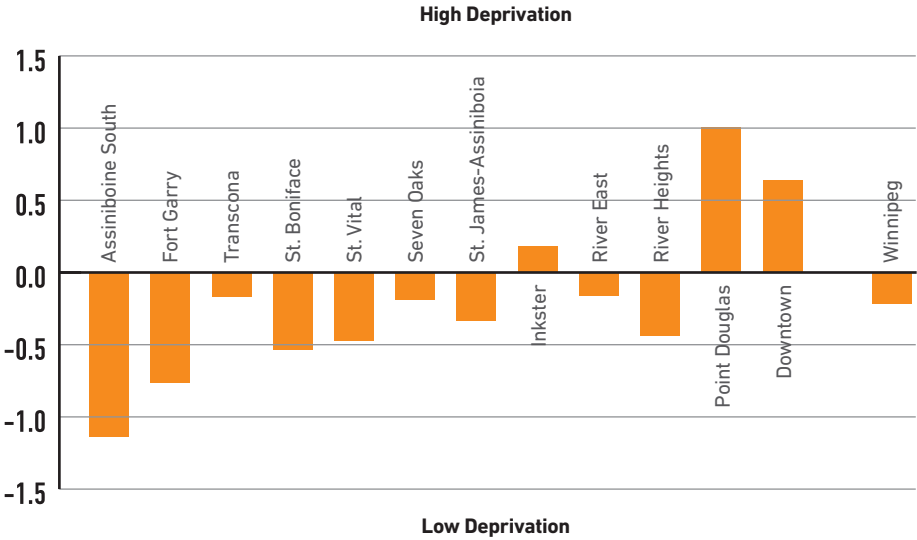


SOCIOECONOMIC FACTOR INDEX

The **socioeconomic factor index (SEFI)** is a combined measure that reflects the socioeconomic factors or circumstances that influence health and illness. It uses four variables: **unemployment rate, high school graduation rate, average household income,** and **proportion of single parent households.** Combined measures give a sense of the cumulative impacts of disadvantage.

SEFI scores range from approximately -5 to +5, and a value of zero represents the Manitoba average. Lower scores (below the line) indicate more favourable conditions for health and wellness, while higher scores (above the line) indicate greater disadvantage.

Socioeconomic Factor Index (SEFI), 2006



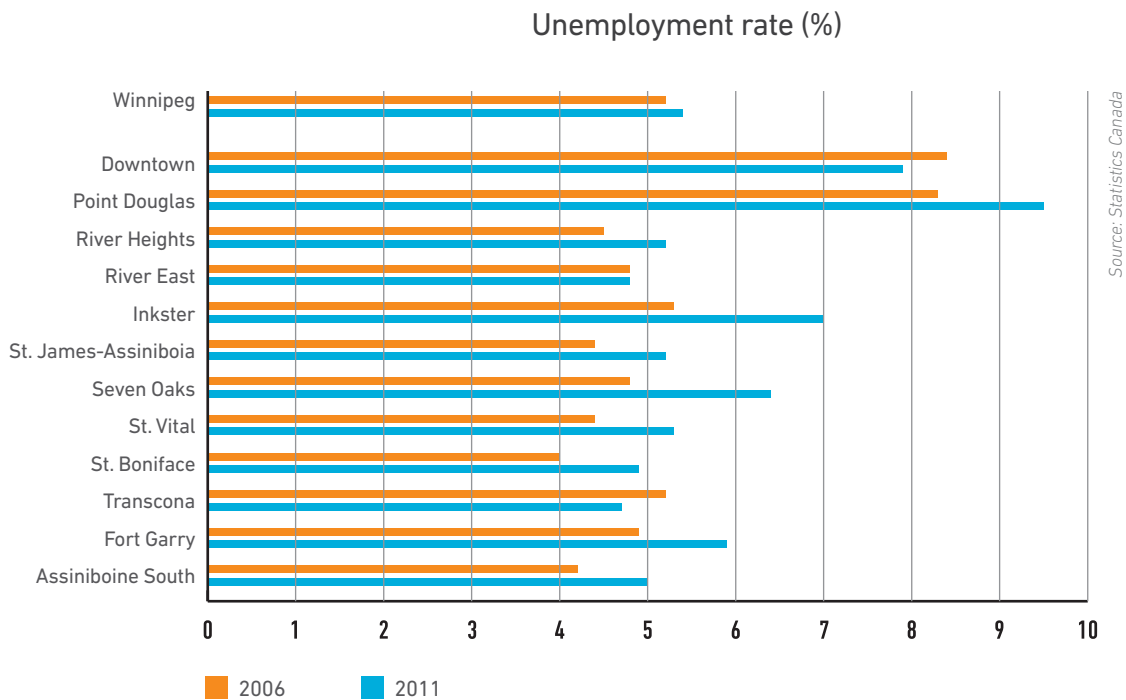
Source: Manitoba Centre for Health Policy

WHY THIS MATTERS

If we consider socioeconomic factors like income or education separately, sometimes we fail to realize that people who are disadvantaged in one way are more likely to be disadvantaged in multiple ways. Different kinds of disadvantage combine and interact, and create additional barriers to health and opportunity. This data clearly shows which neighbourhoods within Winnipeg experience greater disadvantage than most, and where, as a community, we may need to work together in new ways to address the complexities of this challenge.

UNEMPLOYMENT RATE

Winnipeg has lower **unemployment rates** than the national average – overall unemployment rates in Winnipeg have been below 6 per cent since the late 1990s, while national rates have remained higher. However, the unemployment rate varies widely between Winnipeg's community areas – with the highest unemployment rates more than double the lowest.



WHY THIS MATTERS

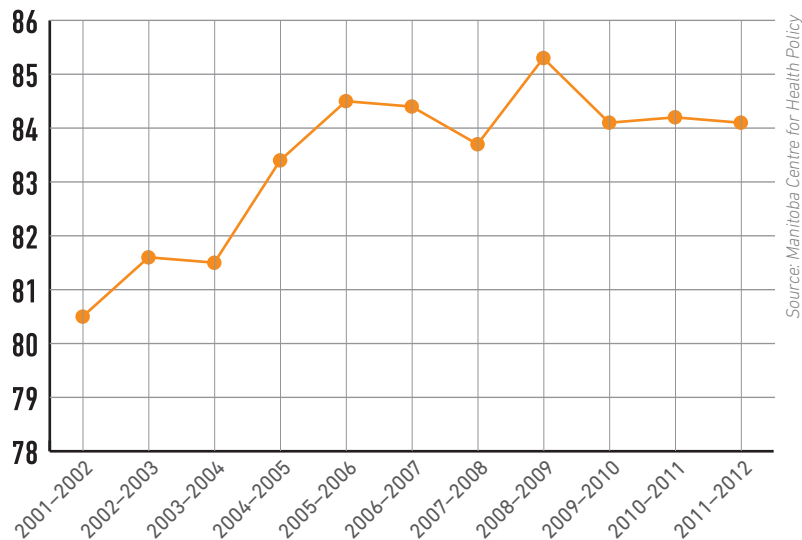
Unemployment can cause significant harm to both mental and physical health, affecting income and many other aspects of personal well-being, family dynamics, and community life. Chronic unemployment affects families and communities across generations. In addition, part-time and temporary work without benefits or job security negatively impacts the health and well-being of individuals, families, and communities.



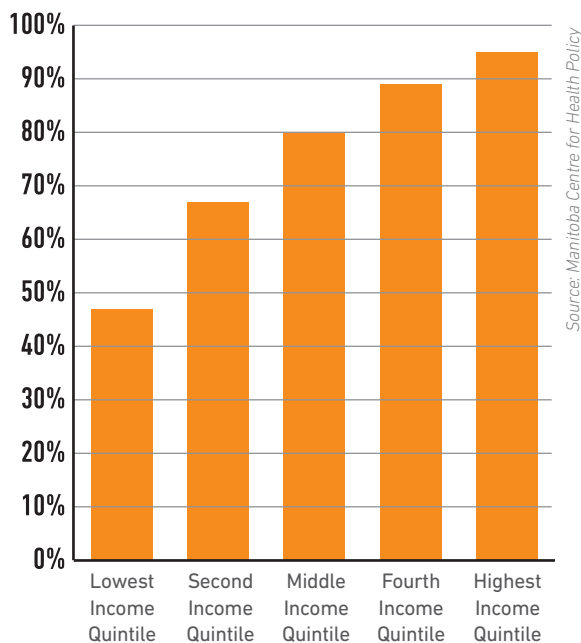
HIGH SCHOOL GRADUATION

Winnipeg's **high school graduation rate** measures how many students complete high school within six years of starting grade nine. After increasing in the mid-2000s, the rate has remained steady at about 84 per cent. This percentage is not evenly distributed across Winnipeg. In the lowest income quintile, graduation rates were only 47 per cent in 2009–2010, compared to over 95 per cent in the highest income quintile (using a four-year graduation rate). This gap has increased over time. There was a 42 per cent difference between the highest and lowest community area graduation rates in the 2009–2010 academic year.

Six-year high school completion rate (%)



Four-year high school completion rate (%), 2009–2010



WHY THIS MATTERS

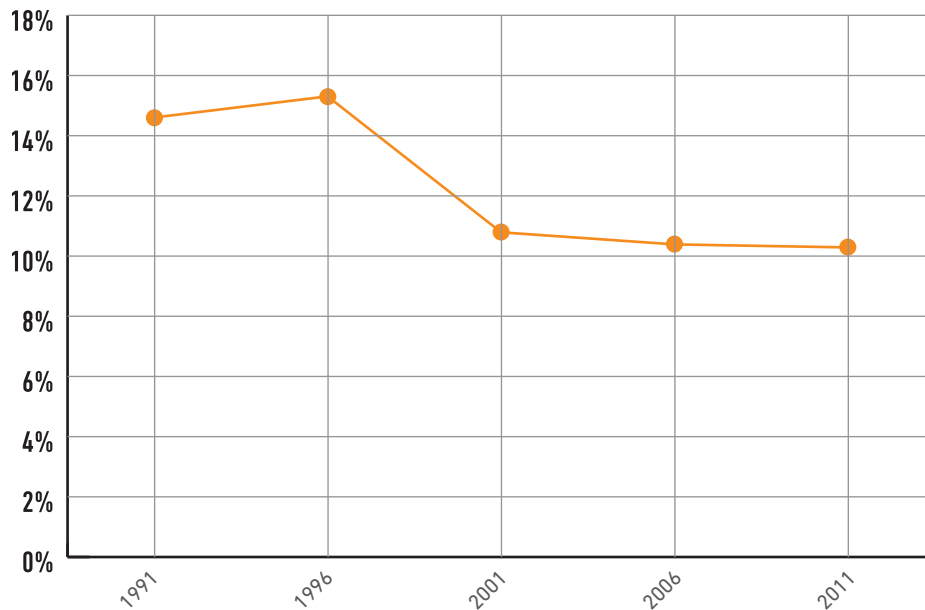
Education is strongly associated with long-term health and quality of life. Education and learning can be seen as a doorway out of poverty. High school graduation is commonly perceived as a minimum requirement for a well-paying job and higher education. Students who arrive at school hungry, without enough sleep, or experiencing significant stress, are not ready to learn. There is growing evidence that investing in education, and removing barriers for youth at school, is an effective way to improve health.

Education affects adults as well as children. We recognize that adult learners are accessing education and actively seeking learning opportunities that will contribute to productive livelihoods. This creates the conditions for children to have role models within their families, and for families to plan their future together.

CORE HOUSING NEED

Core housing need measures the number of households where housing: i) costs more than 30 per cent of its income, ii) requires major repairs, or iii) is not big enough for the number of occupants. In 2011, 10.3 per cent of Winnipeg households were in core housing need, down significantly from the 1990s, but similar to rates from 2001 and 2006. Compared to other major urban centres in Canada, Winnipeg performs well on this indicator for homeowner households, at 9.5 per cent. However, when isolating for rental households, more than double that proportion (24 per cent) meet at least one of the three conditions for core housing need. Just over 9.3 per cent of Winnipeg dwellings were in need of major repair in 2011, an increase from 8.5 per cent in 2006. There are three and a half times as many dwellings in need of major repair in Point Douglas, the community area with the highest repair needs, compared to Seven Oaks, which has the lowest.

Core housing need



Source: Canada Mortgage and Housing Corporation

WHY THIS MATTERS

Housing is a foundation of healthy communities. Living in unsafe, unaffordable, or insecure housing increases the risk of ill health. Housing requiring major repairs may have safety risks or environmental concerns that create or impact acute and chronic health conditions. Unmet core housing need creates instability and stress that negatively impacts mental and physical health.



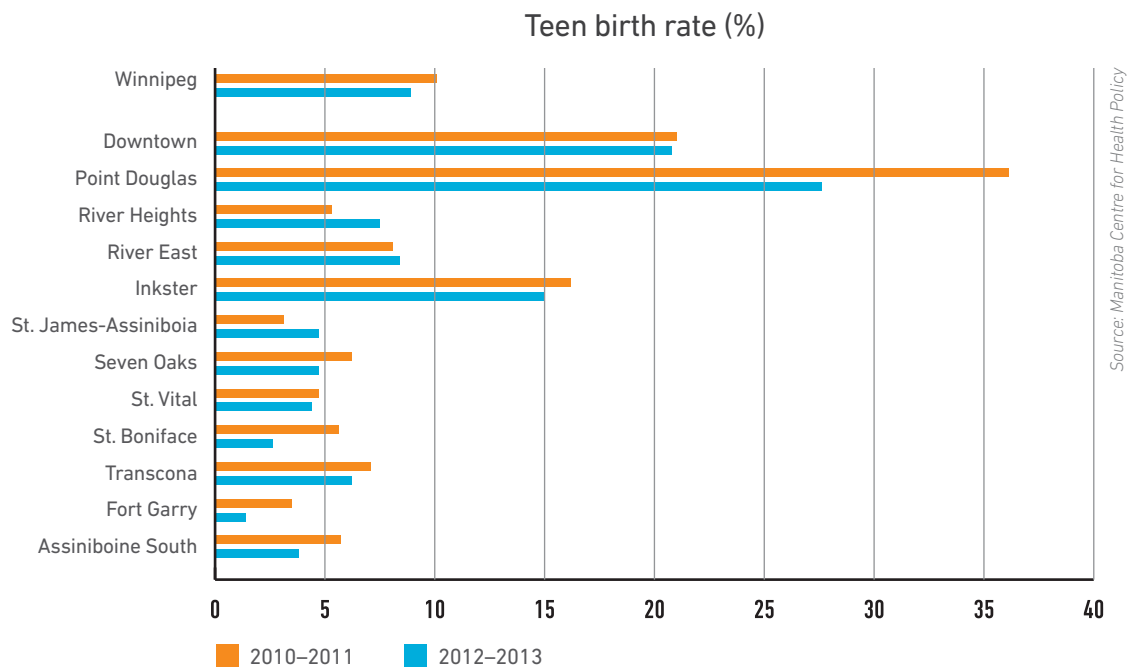
Health Equity Over Life Stages

The following Peg indicators highlight gaps in health across the life course: **Teenage Births, Pregnancies with Factors That Put Families at Risk, Readiness for School, Children’s Hospitalizations Due to Injuries, Hospital Days Used in Long Stays, Heart Attack and Stroke, Prevalence of Diabetes, and Premature Mortality.**

TEENAGE BIRTHS

The **teen birth rate** represents the number of live births by females aged 15 to 19 years divided by the total female population the same age. About 14 per thousand female teens in Canada gave birth in 2010, compared to 9 per thousand in Winnipeg (2012–2013).

Teen births in Winnipeg have been dramatically declining over the last decade, and declined further between 2010–2011 and 2012–2013 from 10.1 to 8.9 births per thousand. In most community areas the teen birth rate declined or stayed about the same over the most recent three years of data, and Point Douglas, the community area with the highest rate, had the largest decrease. Even with this decrease, the teen birth rate differs significantly between community areas, from 27.6 births per thousand in Point Douglas to 1.4 births per thousand in Fort Garry.



WHY THIS MATTERS

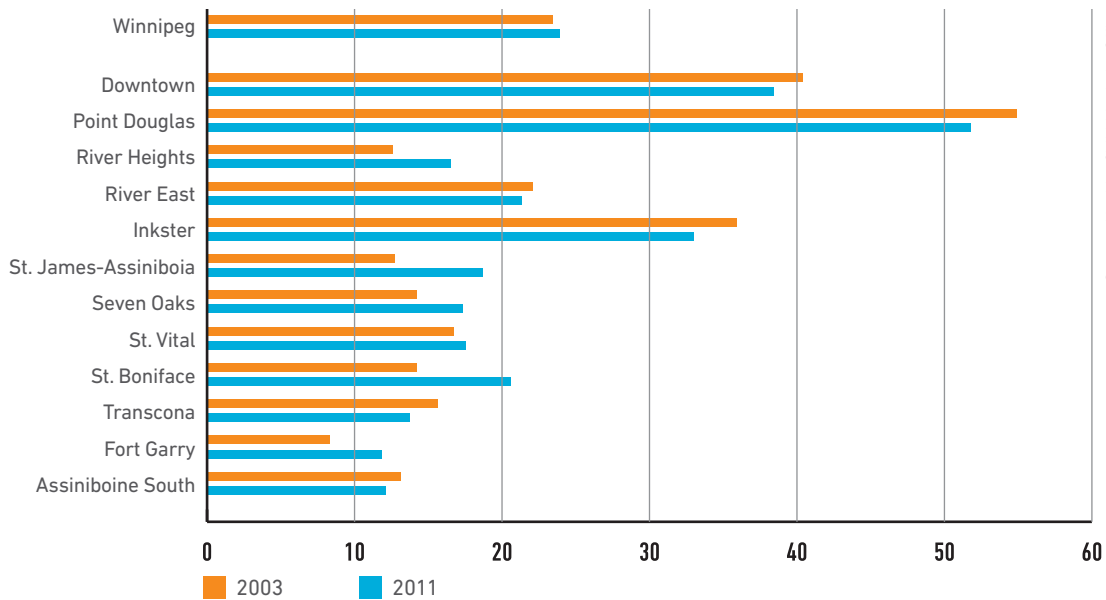
Viewing health through the life cycle begins even before birth. Some view the health of an individual and their community as being rooted in generations before conception. Many teens who are mature and well-supported make excellent parents. However, along with the joy of a new life come many challenges that, without adequate support, can impact the health of children and families. Children of teen mothers experience greater risk of hospitalization or death during childhood, and they are also more likely to experience poor academic achievement and not graduate from high school.

PREGNANCIES WITH FACTORS THAT PUT FAMILIES AT RISK ▼

In Winnipeg, public health nurses are in contact with all families following the birth of a child. This service includes the implementation of the Families First Screening Tool. This is an entry point to additional public health supports for families, and factors identified during the screen are also useful to look at community well-being. Risk factors, such as alcohol or tobacco use, mental health issues, financial challenges, and mothers who have not completed high school, can be analyzed individually or in combination. **Pregnancies with three or more risk factors** are more likely to result in newborns with developmental challenges, and signal which families might benefit from additional support during the early years.

In 2011, nearly one in four pregnancies in Winnipeg (24 per cent) had three or more risk factors. However, the rate is just over double the city average in Point Douglas (52 per cent), which is more than four times the rate in Fort Garry and Assiniboine South (12 per cent).

Pregnancies with factors that put families at risk (%)



WHY THIS MATTERS

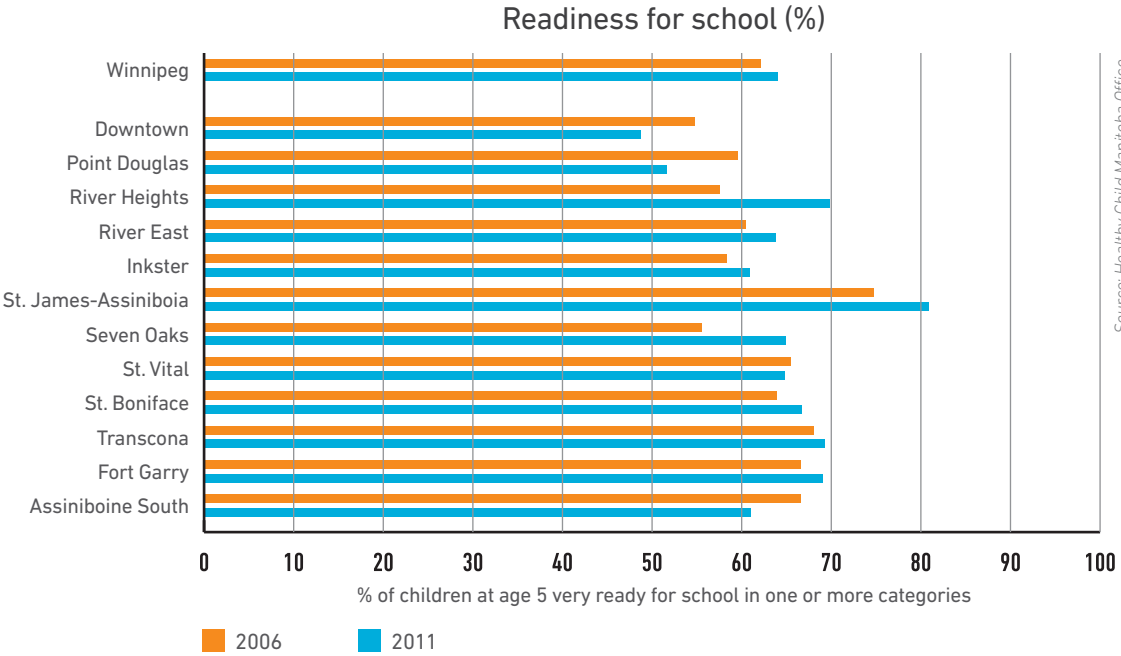
Growth and development during pregnancy and within the first years of life can profoundly impact health and well-being in the longer term. It is therefore critical that all children have the opportunity for a good start – before birth and in their early years. Supports for pregnant women and parents benefit the health of both the children and family, as well as the overall community.



READINESS FOR SCHOOL 

Readiness for school is an indicator based on a teacher-completed checklist that assesses kindergarteners' readiness for school in five areas: i) physical health and well-being, ii) social competence, iii) emotional maturity, iv) language and cognitive development, and v) communication skills and general knowledge.

Overall, 64 per cent of Winnipeg children were 'very ready' in one or more area in 2010-2011, which has remained steady over time. The two community areas with the lowest rates are Downtown (48.7 per cent) and Point Douglas (51.6 per cent).



WHY THIS MATTERS

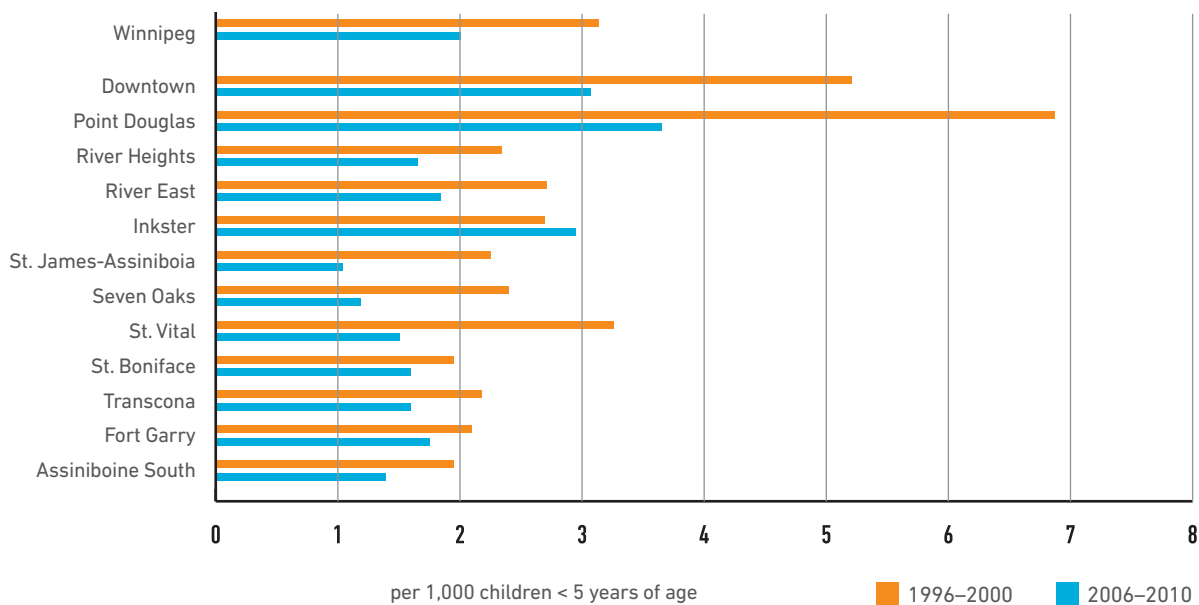
Children born to teenage mothers, children in families with previous reliance on governmental income assistance, and families involved with the child welfare system have been found to be four times more likely to have lower readiness scores. Low scores are also associated with future negative health outcomes such as obesity, mental illness, and heart disease. It has been shown that the greater the socioeconomic gap within a community, the greater the gap in early child development. However, appropriate supports for early learning opportunities and support for families have been shown to enhance readiness for school and opportunity.

CHILDREN'S HOSPITALIZATIONS DUE TO INJURIES



Children's hospitalizations due to injuries shows the number of hospitalizations due to injuries in children under the age of five, per thousand children. It is a measure of the relative safety of children's environments. Children's injuries have seen a significant decline over the years between 1996-2000 and 2006-2010, falling from 3.1 per cent to 2.0 per thousand in Winnipeg. Rates have decreased in every community area with the exception of Inkster, which has stayed about the same. The community areas with the highest injury rates had the largest declines. Although the gap has narrowed, there remains a 3.5 times difference between rates in the highest and lowest community areas.

Children's hospitalizations due to injuries in children under the age of 5



WHY THIS MATTERS

Examples of injuries that may result in hospitalization for children under the age of five include falls, fractures, and burns. The decline of the injury hospitalization rate for children under five years of age, and the narrowing of the gap, shows that it is possible to improve the safety of children. While we are demonstrating progress, even more can be done to ensure all children have safe, nurturing environments in which to grow and thrive.

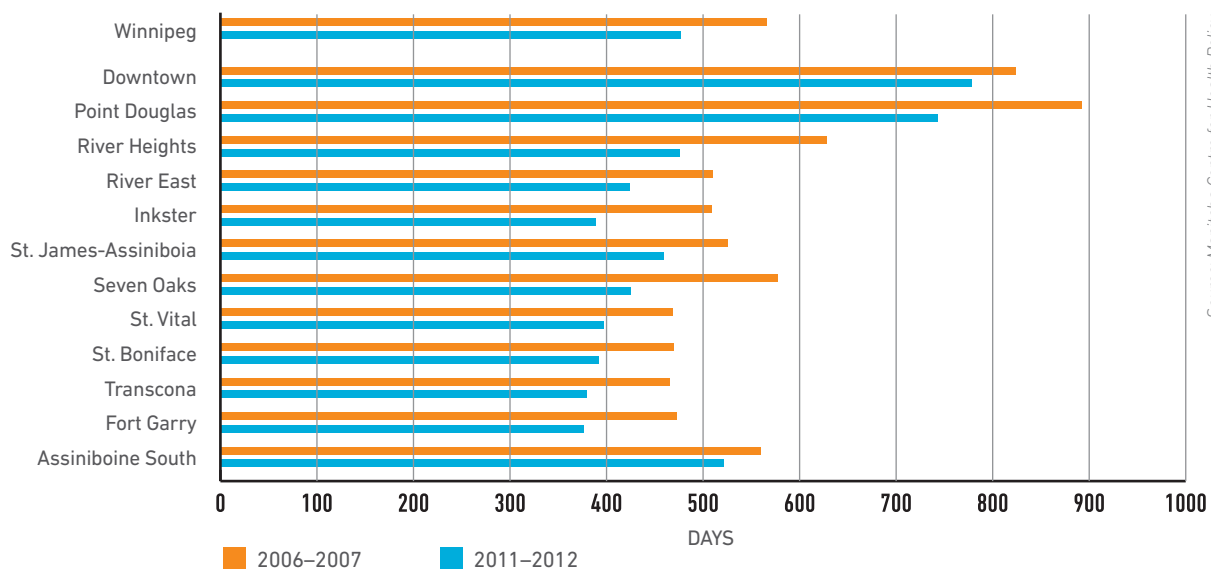


HOSPITAL DAYS – LONG STAY HOSPITALIZATIONS

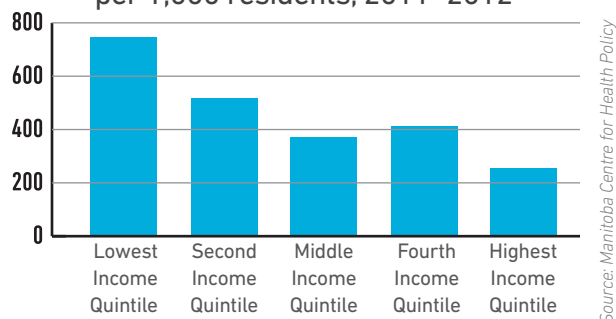
Hospital days used in long stay hospitalizations is the combined total number of days spent in hospital* for all residents who were hospitalized between 14 and 365 days, per thousand residents per year. This indicator measures health problems serious enough to need hospital care, as well as medical and social complexities impacting discharge from hospital, including lack of appropriate housing or care arrangements. In 2011–2012, the number of hospital days in Winnipeg was 477 per thousand residents, slightly down from 566 in 2006–2007. Most community areas had hospital days close to the Winnipeg rate, but the Downtown and Point Douglas community areas had rates double those of most higher-income community areas.

*All Winnipeg hospitals are included in these figures. Personal care homes, nursing stations, and long-term care facilities are excluded.

Number of hospital days used in long stays per 1,000 residents



Number of hospital days used in long stays per 1,000 residents, 2011–2012



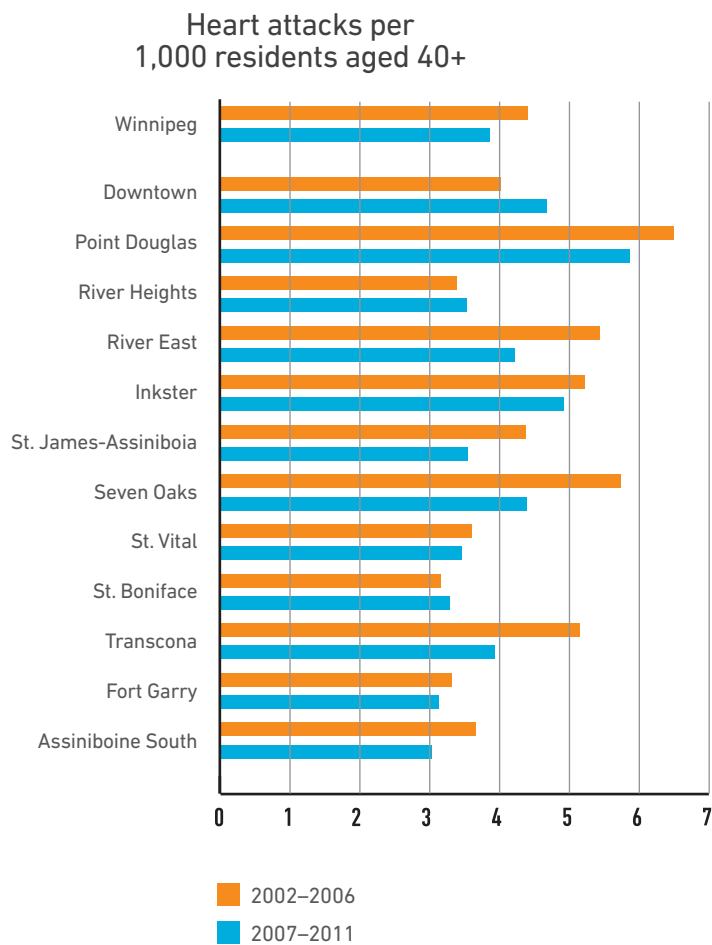
WHY THIS MATTERS

Longer hospitalizations occur for more serious and complicated health problems, as well as due to a lack of appropriate housing or care arrangements in the community.

HEART ATTACK

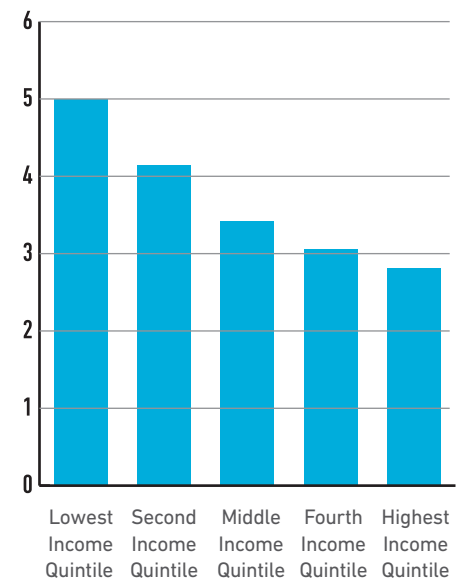


The rate of hospitalization or death due to a **heart attack** in the population aged 40 and over in Winnipeg was 3.8 per thousand residents in 2007-2011. That is a decrease from 4.3 per thousand in 2002-2006. The highest heart attack rate occurs in Point Douglas, and is double the rate in Assiniboine South. Winnipeggers in the lowest income quintile were 77 per cent more likely to have a heart attack than those in the highest income quintile.



Source: Manitoba Centre for Health Policy

Heart attacks per 1,000 residents aged 40+, 2007-2011



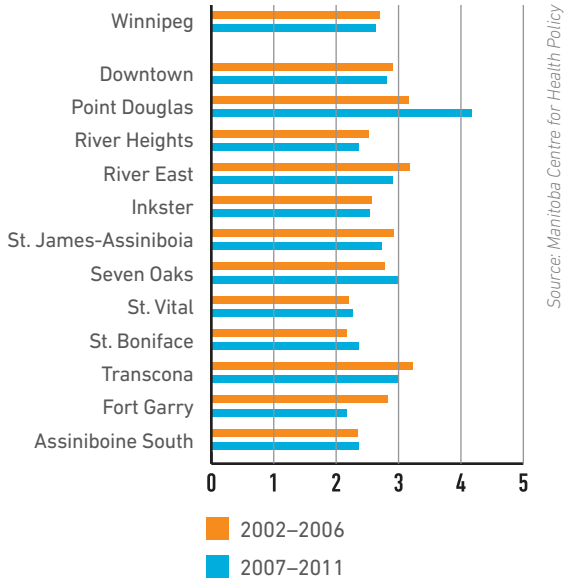
Source: Manitoba Centre for Health Policy



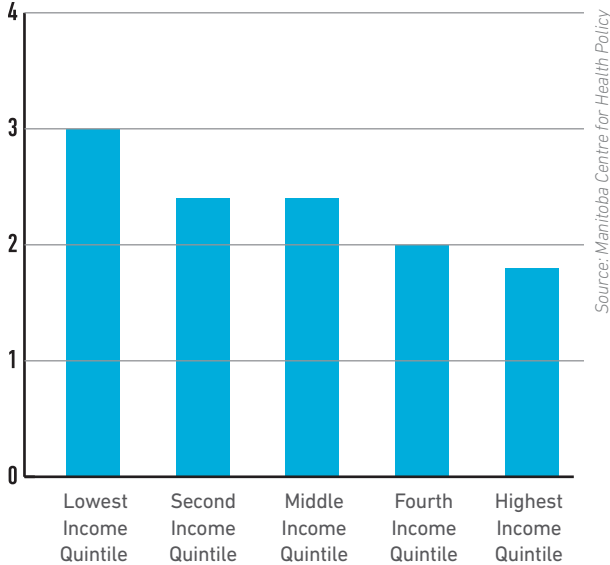
STROKE 

The rate of hospitalization or death due to a **stroke** (in the population aged 40 and over) in Winnipeg was 2.6 per thousand residents aged 40 and over in 2007-2011. It has decreased slightly since 2002-2006 when the rate was 2.7 per thousand. People living in Point Douglas have the highest rate of stroke; double the rate compared to people living in Fort Garry. Winnipeggers in the lowest income quintile were 64 per cent more likely to have a stroke than those in the highest income quintile.

Strokes per 1,000 residents aged 40+



Strokes per 1,000 residents aged 40+, 2007-2011



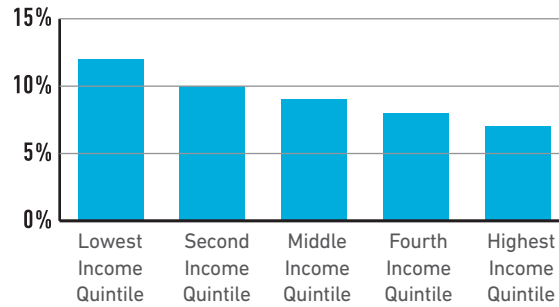
WHY THIS MATTERS

Cardiovascular diseases, such as heart attack and stroke, are the leading causes of death globally, and represent a third of all deaths in Winnipeg in any given year. These diseases are also a leading cause of hospitalization and adult disability. Heart attacks and strokes are associated with social and economic disadvantage. Opportunities for employment, income, education, and housing have enormous potential to reduce the unequal burden of heart disease and stroke.

PREVALENCE OF DIABETES

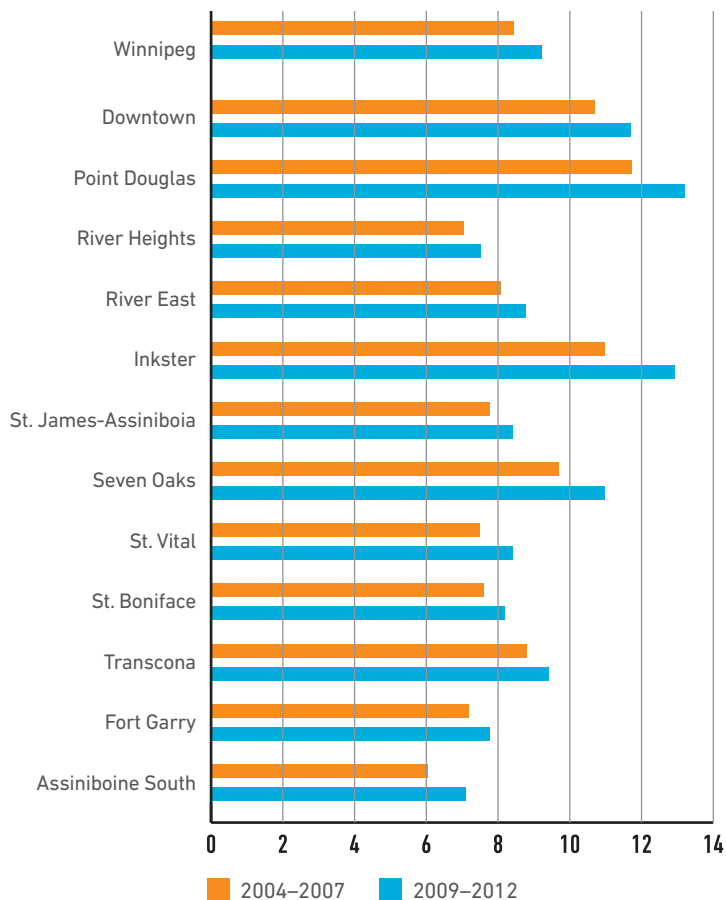
The **prevalence of diabetes** (new and existing cases) has continued to rise in Winnipeg from 8.4 per cent in 2004–2005 to 2006–2007 to 9.2 per cent in 2009–2010 to 2011–2012. Winnipeg residents in the lowest income quintile are 79 per cent more likely to have diabetes as those in the highest income quintile. Diabetes is twice as common in Point Douglas (13.2 per cent) compared to Assiniboine South (7.1 per cent).

Prevalence of diabetes (%),
2009–2010 to 2011–2012



Source: Manitoba Centre for Health Policy

Prevalence of diabetes (%)



Source: Manitoba Centre for Health Policy

WHY THIS MATTERS

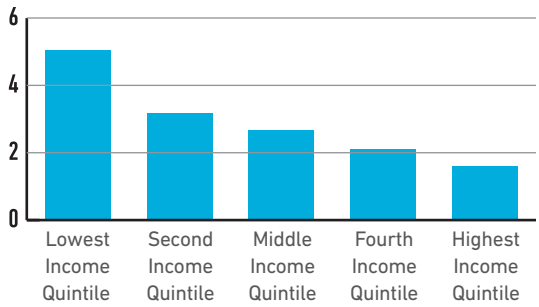
Not only are lower-income Winnipeggers more likely to have diabetes, they are also more likely to experience serious consequences of diabetes. Winnipeggers with diabetes in the lowest income quintile were more than 2.5 times more likely to have lower limb amputations (1.6 per cent) compared to those in the highest income quintile (0.6 per cent). Complications of diabetes, such as amputations, are less likely with access to good health care and if daily needs are met, like healthy food, blood sugar testing supplies, exercise opportunities, and healthy ways to cope with stress.



PREMATURE MORTALITY 

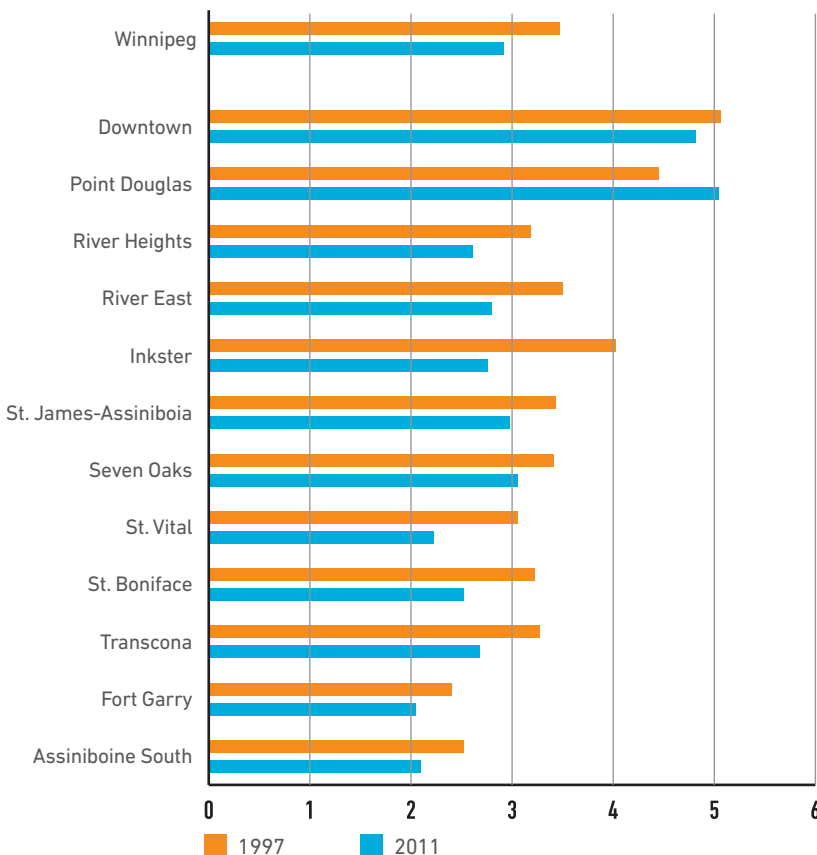
Premature mortality rate measures deaths before age 75 out of all residents under age 75 per year. The premature mortality rate in Winnipeg was 2.9 per thousand residents in 2011, a decrease from 3.47 per thousand in 1997. Winnipeg's premature mortality rate is slightly higher than the national rate (2.3 per thousand). The main causes of premature death in Winnipeg are cancer, circulatory diseases, and injury/poisoning. Winnipeg residents in the lowest income quintile are 3.1 times more likely to die prematurely as those in the top income quintile, and the gap has increased. In Point Douglas, the premature mortality rate (5 per thousand) is 2.5 times higher than Fort Garry (2.1 per thousand). The community area gap has also widened.

Premature mortality rate (deaths per 1,000 residents under age 75), 2007-2011



Source: Manitoba Centre for Health Policy

Premature mortality rate by community area



Source: Manitoba Centre for Health Policy

WHY THIS MATTERS

About 70% of premature deaths in Canada are considered avoidable – two-thirds through prevention and one-third through earlier detection and better treatment. The higher burden of premature mortality on lower-income Winnipeggers indicates that prevention and treatment opportunities are being missed.

Where Do We Go From Here?

A careful look at the indicators presented in this report shows a consistent pattern: economic and social disadvantage results in lower health status, and the inequity is growing for a number of indicators. This observation comes from looking both at community area and income quintile data.

In analyzing the impacts on health status, we see the relationship between daily circumstances like income, housing, employment, and education on health outcomes. This influence is felt from the beginning of a child's life and throughout all life stages.

Poverty is but one of several complex and interacting factors that impact on health. Other barriers that may disadvantage people from achieving their best possible health include social class, disability, gender identity, racism and other socially determined circumstances. The recent Truth and Reconciliation Commission Report emphasizes the impact of racism, colonization, and residential schools on the state of health for Indigenous people in Canada. Although Peg indicators are not available by Indigenous or non-Indigenous status, the neighbourhoods at the lowest end of the health gap tend to have a larger Indigenous demographic. Work towards increasing health equity must address multiple barriers to be effective.

It is possible to work together to effect greater change. Building awareness, understanding, and reconciliation,

being open to changing attitudes and perspectives, and realizing that each of us has a role to play in this equation are important steps toward better addressing health gaps that exist in our community. The impact of poverty on health and well-being is complex, and the inequities that exist in our community cannot be closed through health care alone.

It is possible to work together to effect greater change. Building awareness, understanding, and reconciliation, being open to changing attitudes and perspectives, and realizing that each of us has a role to play in this equation are important steps toward better addressing health gaps that exist in our community.

The information Peg provides can help to call attention and further inspire collective action. Whether it is through individual acts of caring and respect, engaging supportively in our communities, or working across sectors with the aspiration to leverage bold system changes, every action can make a difference and lead to positive change. A more equitable Winnipeg without gaps will be better for everyone – a city where everyone belongs and a place we are all proud to call home.

Peg will help us monitor our progress and success.

STATUS OF INDICATORS



■ Gap is decreasing (5)
■ Gap is increasing (5)
■ No trend (1)

Peg is a community indicator system that was developed to inspire action and create change through tracking key measures of well-being. Peg measures the health of our community year-over-year in ways that count. Our mission is to build the knowledge and capacity of Winnipeggers to work together to achieve and sustain the well-being of current and future generations.

Peg publishes annual reports, with the first report focusing on our city's overall well-being. This second report on health and the impacts of poverty was developed in partnership with the Winnipeg Poverty Reduction Council (WPRC) and the Winnipeg Regional Health Authority (WRHA).

For more information:

Peg: www.mypeg.ca

Winnipeg Poverty Reduction Council: www.wprc.ca

Winnipeg Regional Health Authority: Health for All
www.wrha.mb.ca/about/healthequity

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