Putting it All Together for Health Equity

Based on the presentation delivered for the launch of the Foundation Standard and Population Health Assessment and Surveillance Protocol

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Newspaper: November 14, 2015

"Targets Met: Release of new Ontario Public Health Atlas shows gaps in infant mortality, premature deaths, chronic diseases reduced by more than 10% in all heath units. This includes >300 premature deaths, and 1,600 new cases of diabetes avoided as the health gap narrows between high and low income communities.

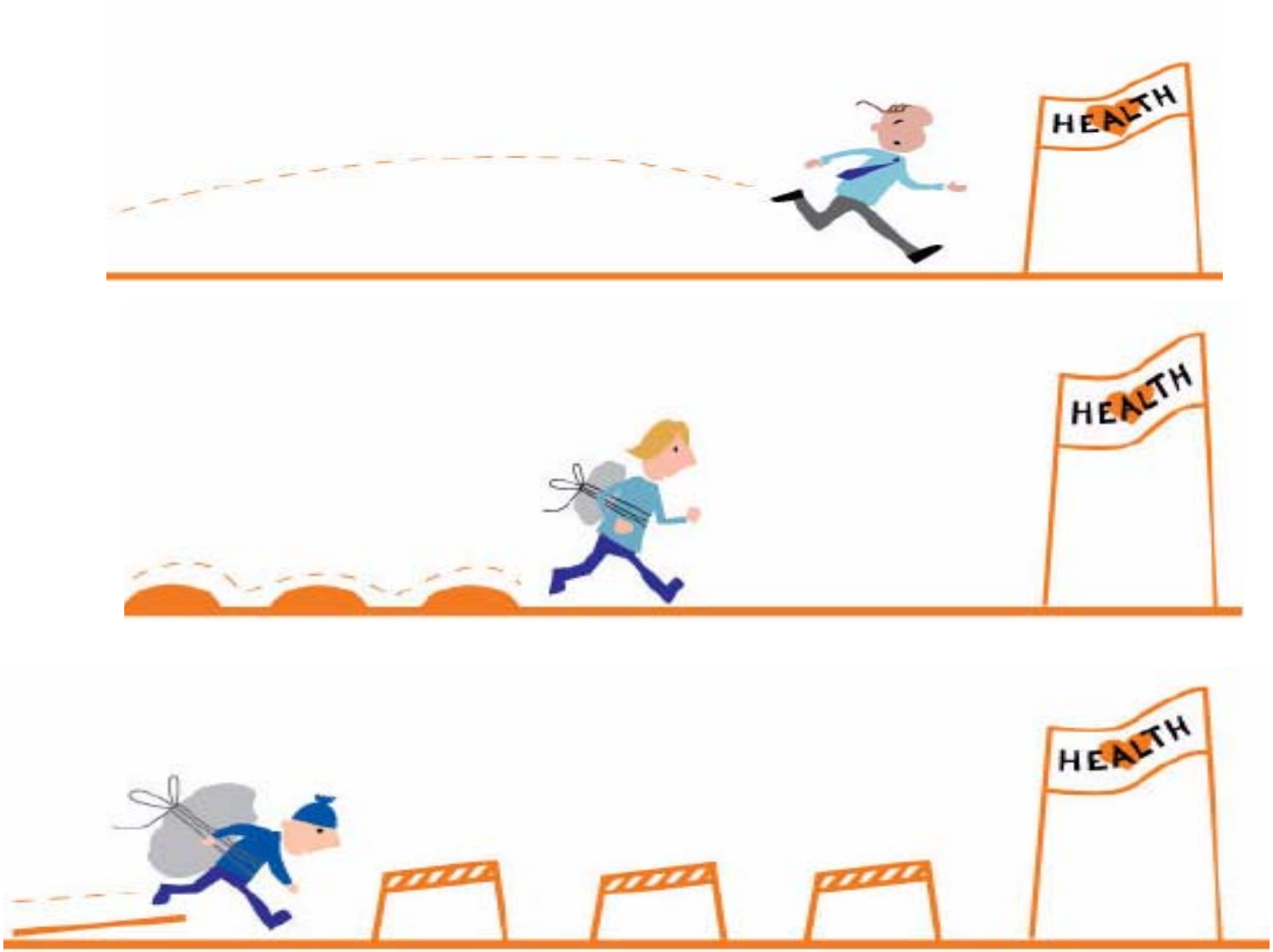
Interviewed this morning, Ontario's Minister of Health noted the poverty reduction strategy helped to make this happen – with raising minimum wage & social assistance rates, reinvestment in social housing, child care, and removing barriers to dental care. Coalitions in several heath units produced local Health Inequality Reports and jointly set health equity targets, advocacy strategies & action plans. A spokesperson for one of these coalitions said improvements are just beginning to result from their "Agenda for Equity"

(calculations are based on Wilkins (2008) mortality data for 2001 and ICES diabetes incidence data for 2004-05.

Equity Foundations in OPHS

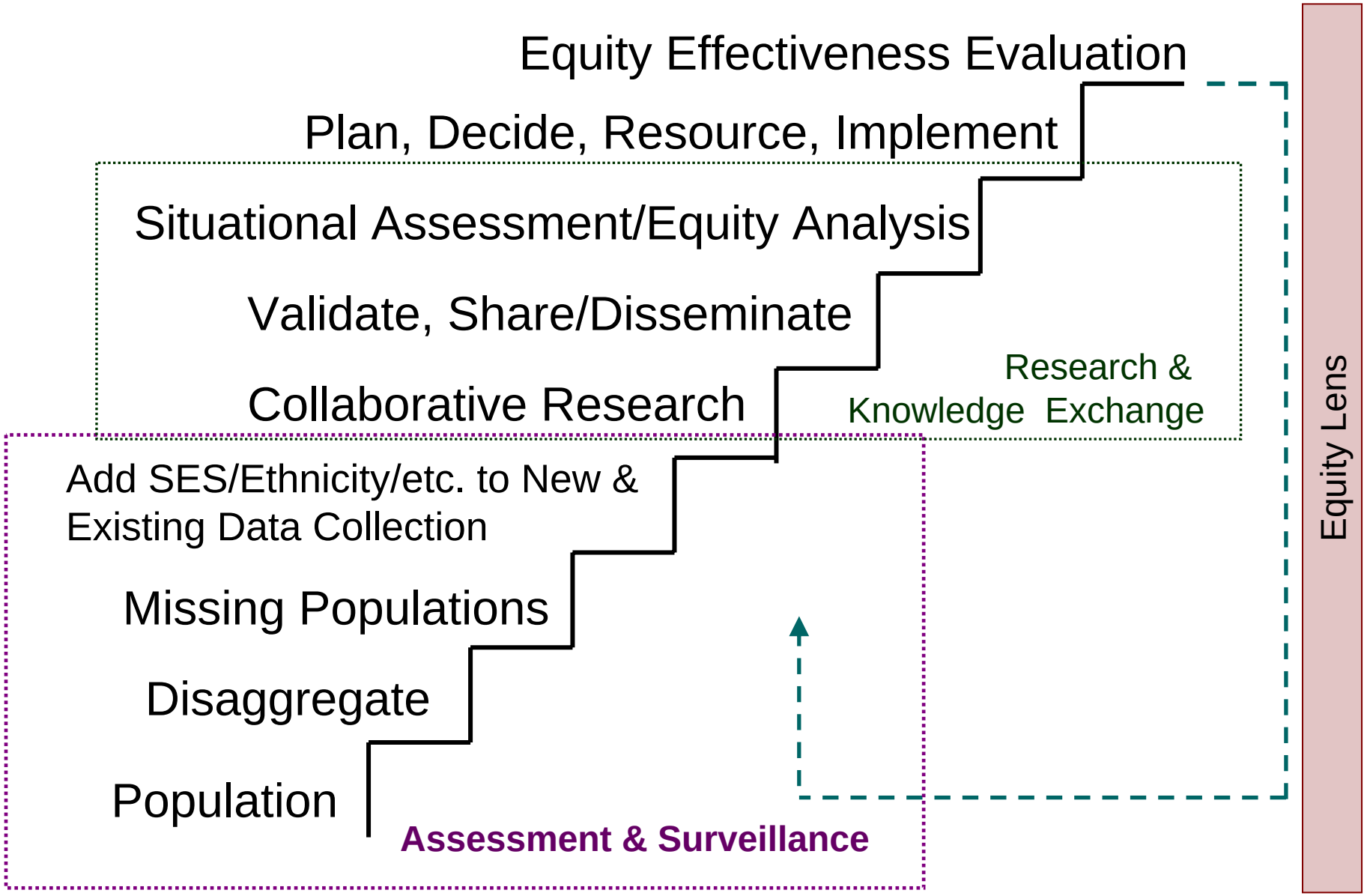
- Plan, deliver, manage and evaluate programs to reduce inequities in health
- Identify priority populations
- Tailor strategies
- Examine accessibility of programs and reduce barriers
- Share Knowledge and use partnerships and collaboration to engage the community

Health Burden & Access Barriers (Hurdles) Widen Equity Gap



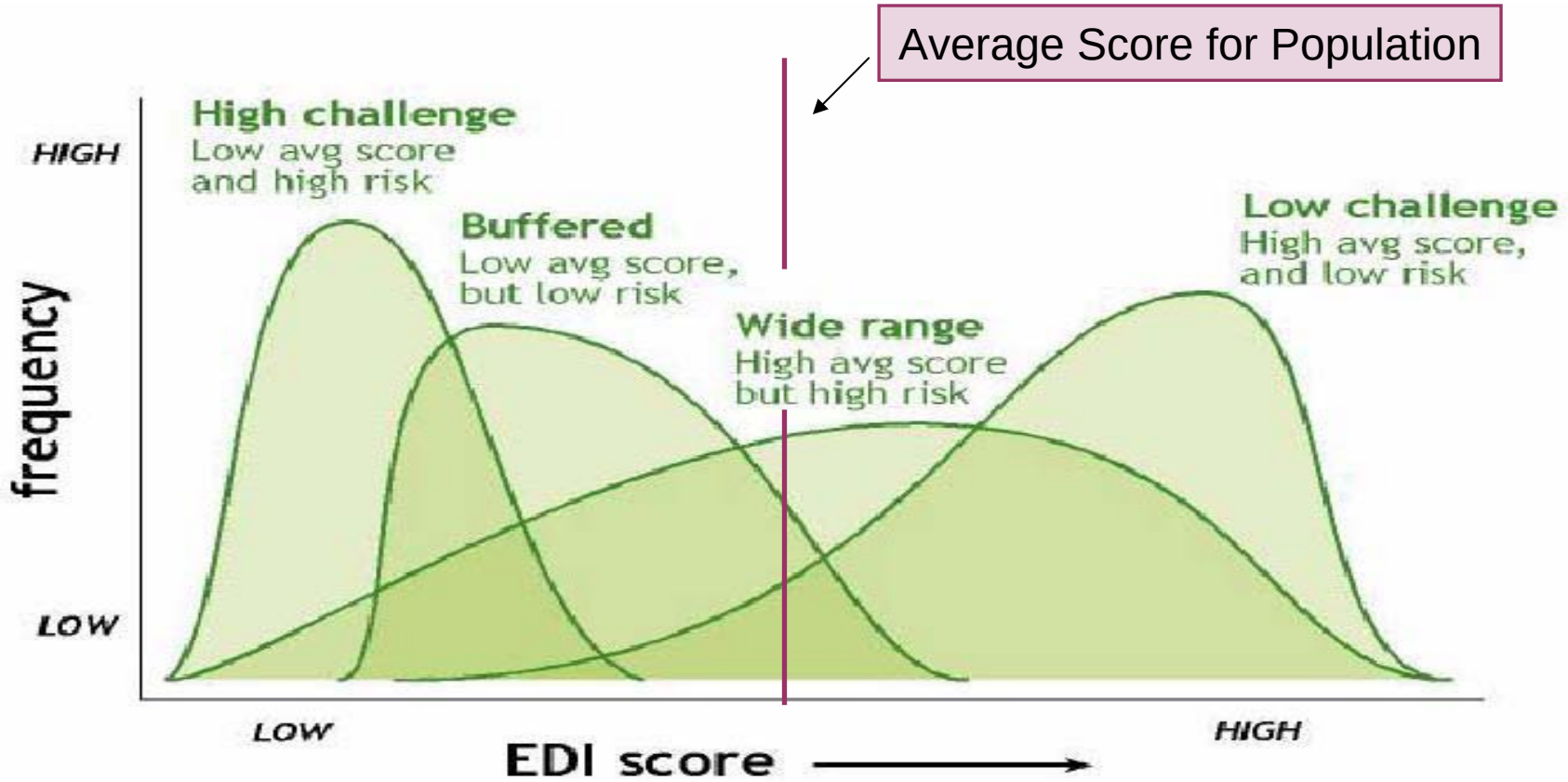
People figures from Denmark's National Strategy to Reduce Social Inequalities in Health (2007)

Equity Escalator: Equity Lens



Examples from: *Steps to Equity. Ideas and Strategies for Health Equity in Ontario 2008-2010*, Nov 2008 (Handout)

Disaggregate the Average



Unpacking or Disaggregating the data by people or place exposes inequalities….only a minority have the rate reflected by the average. Planning effective strategies depends on understanding and responding to different needs and opportunities.

http://www.playvictoria.org/assets/your~community/pdfs/community_reports_earlyyears.pdf

Age Standardized Mortality Rates, (Deaths/100,000), 2001 Ontario CMAs

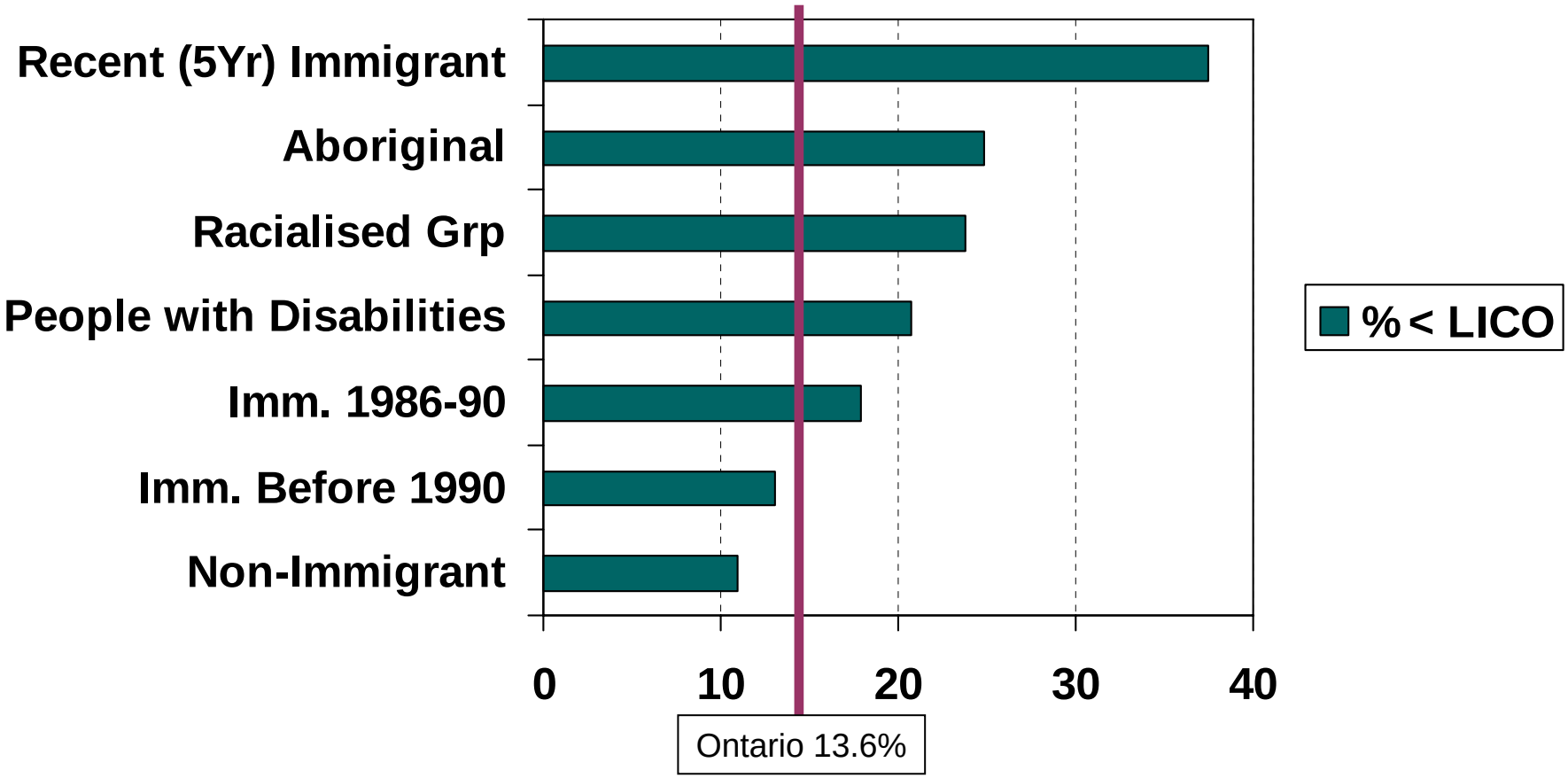
Gender & Cause of Death	Low Income Neighbourhood	Highest Income Neighbourhood
Infants <1 yr	71.5	49.8
Ischemic Heart Disease: Males	146.3	103.3
Ischemic Heart Disease: Females	67.1	59.1
Lung Cancer: Males	62.7	40.1
Lung Cancer: Females	33.8	25.1
Diabetes: Males	26.6	16.7
Diabetes: Females	17.4	10.1
Accidents/Pois./Violence: Males	48.6	36.6
Accidents/Pois./Violence: Females	22.1	17.2

Data Provided by R. Wilkins, Statistics Canada, Health Information and Research Division, October 2007. For the methods, see Wilkins R, Berthelot JM, Ng E. Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. Health Reports 2002; 13 (Supplement): 45-71.
www.statcan.ca/english/freepub/82-003-SIE/2002001/pdf/82-003-SIE2002007.pdf

Disaggregate/Assessment

Which Populations are Lower Income?

% Low Income, Ontario 2001 Census



Information from the 2006 Census (not yet available for all the above groups) shows increasing rates of low income and widening income disparities.

Source: 2001 Statistics Canada Census, CCSD Urban Poverty Project. www.ccsd.ca

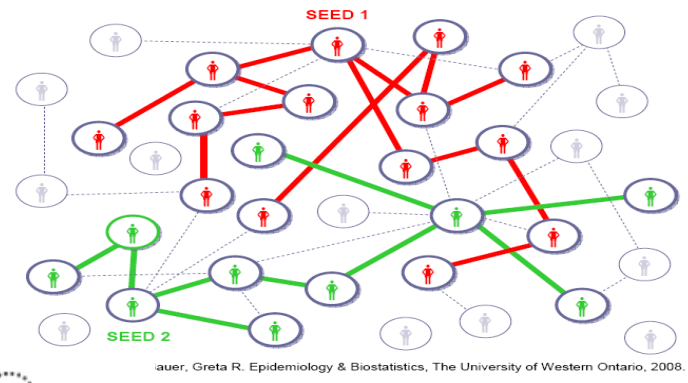
Disaggregate/Assessment

Compile information for Marginalized/Missing Populations

Kitchen Table Interviews: Low Income Isolated Families: Huron Country

Fact Sheets on Immigrant Health compiled from several data sources, Region of Waterloo

We are Visible: Ethno Racial Women with Disabilities speak out about healthcare issues. Ethnoracial People with Disabilities Coalition. Resources at: www.ryerson.ca/erdco

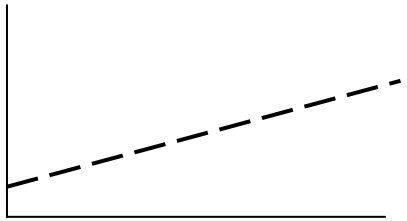


TransPULSE (HIV study): respondent-driven sampling, community soundings provider survey & in-depth interviews www.transpulse.ca

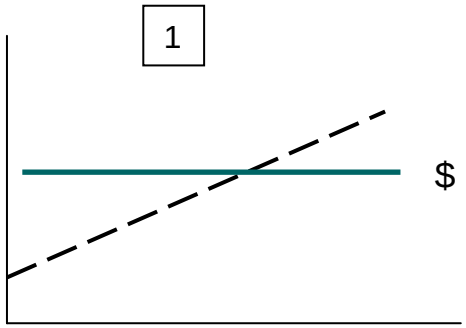
Situational Assessment:

Using information from diverse sources and methods to understand the needs and opportunities to improve the health of people who are homeless or marginally housed

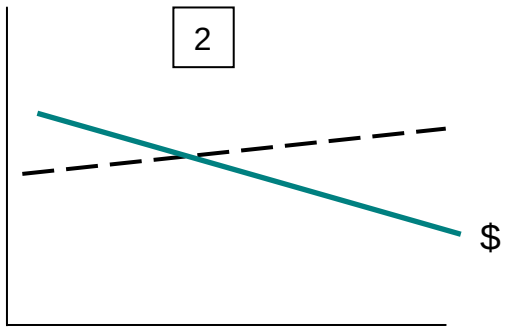
Equitable Allocation of Resources



The dashed line represents health status with populations with worse health, lower SES, more access barriers having the lowest levels of health.

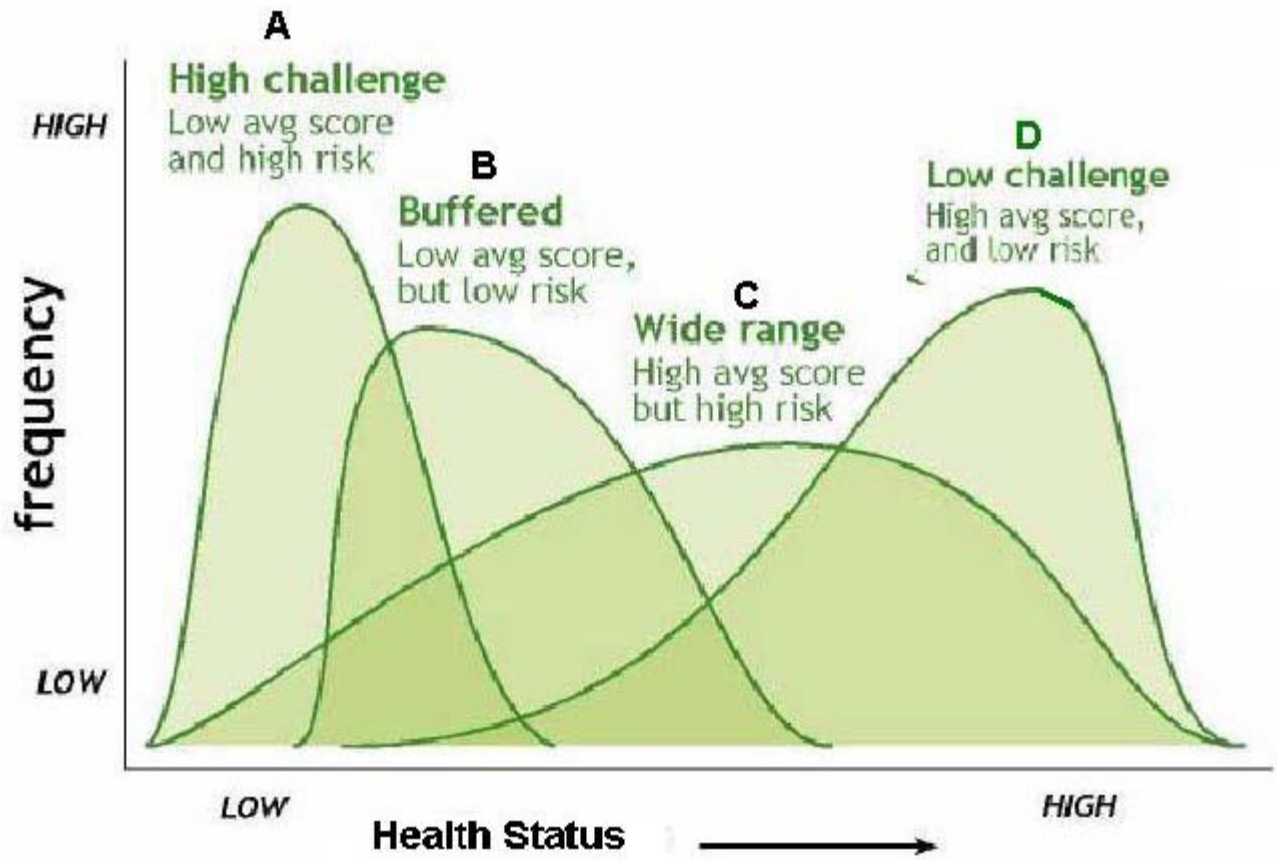


If resources were used **equally** according to the per capita distribution of the population across areas, without regard to social determinants of health, access barriers or heath status, this would likely **widen existing health inequalities** as advantaged groups were better able to benefit from the programs.



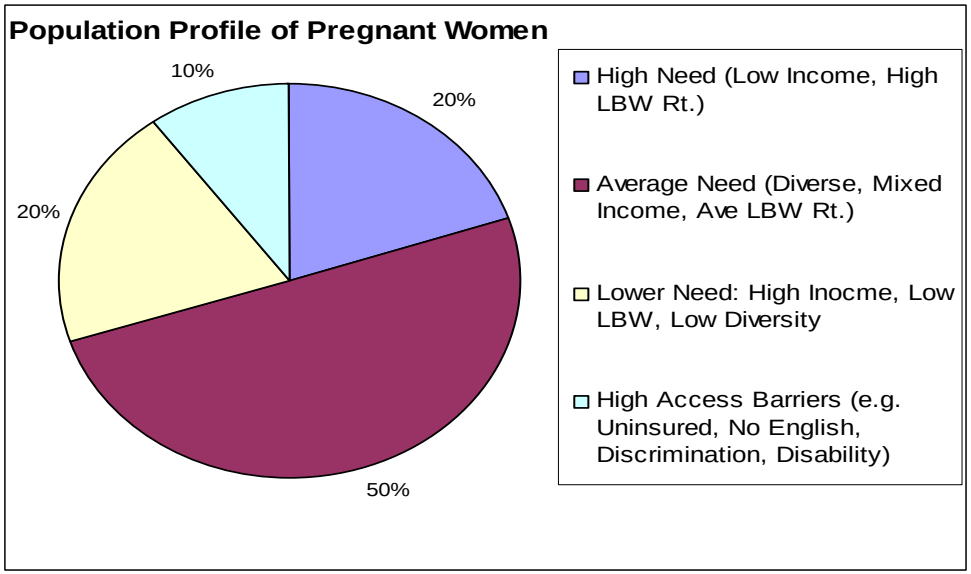
If resources were used **equitably** according to the different access to social determinants of health, access barriers or heath status among different population groups or areas, this would likely **reduce existing health inequalities**, improving the health of the worst off the most, while at the same time bringing the health of all groups up.

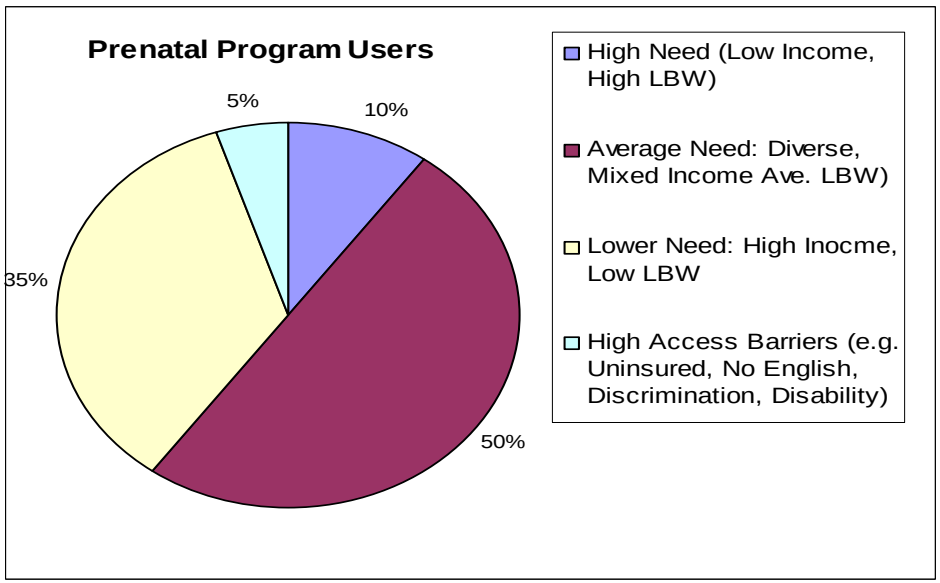
Equitable Allocation of Resources



- greater intensity of investment & tailored investment strategies for Population A
- focus on reducing access barriers for Population B
- wide outreach in multiple channels for Population C (which would also provide exposure to Population D)

Compare Population served with Priority Populations





Suppose a Health Unit identified Priority Populations for Prenatal Programs to be low income women, ethnic groups with a high rate of LBW, recent immigrant/low English fluency women, and young women who smoke or were marginally housed and aimed for >50% of program users to be from 30% of the population of Pregnant women with (High Need and/or High Access Barriers)

If the Health Unit analyzed the profile of program users and found that these priority populations made up less than their target, this could indicate that access barriers remain. The program user profile could vary for different programs – eg. prenatal classes may be more likely to be attended by higher educated English speakers with the profile as shown in the graph on the left, whereas outreach for pre-natal nutrition may result in users more on target.

Evaluate

Triangulated Multi-method Program Evaluation

Harm Reduction Needle Exchange Evaluation

- Analysis of user statistics, needles out,
- Interviews with sample of frequent users >5 visits
- Interviews with low/one-time users
- Local Community/Neighbourhood Views on the program

Interviews with high and low users identifies reasons why some groups among the priority populations were not benefiting from the program, identifying access barriers that could be addressed, and which groups the program was effective for, as basis for growing and changing.

London, Ontario

Evaluate

Key Equity Questions

Program Evaluation

Who is accessing/ benefiting from our programs? Who is not?
What are the barriers, differential impacts?
What can we do to change that?

Knowledge Exchange

Who are the community stakeholders that we can exchange knowledge with? How can we engage them, learn from them?
Are we relevant? Understood? Is our information useful?
Is there a sense of community ownership over this knowledge?

Research

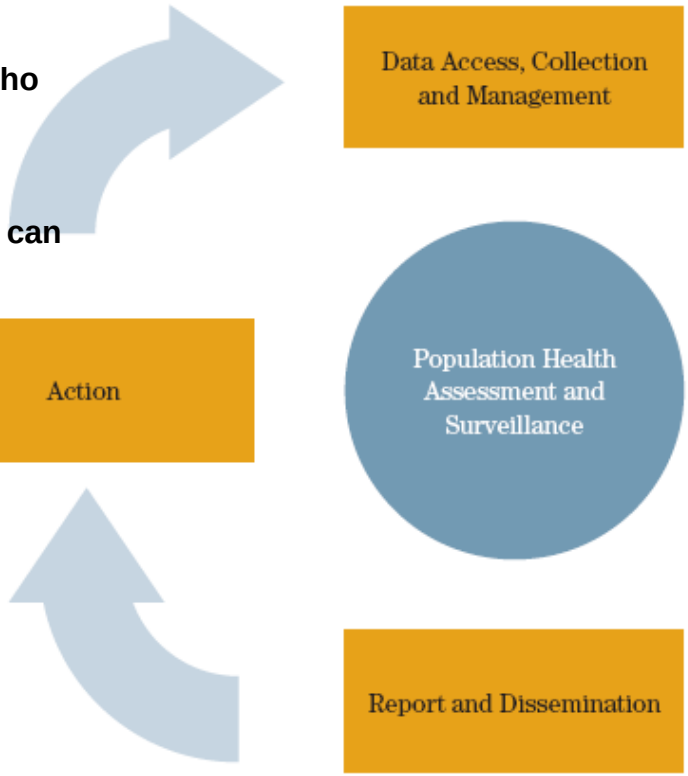
Why are some people at greater risk?
Where are the people we need to learn more about? How can we reach and engage them in our inquiry?
What is the lived experience of specific groups?
How does that experience relate to health outcomes and our goals?
How are our actions relevant to specific populations?

Assessment & Surveillance

What are the unique social and environmental conditions of this community?
Who is at risk?
How can we design data collection to learn more about relationships between SDOH and health outcomes, behaviours, and knowledge?

How can we improve our surveillance systems and build ones that collect data we need?

Integrating Equity into Population Health Assessment and Surveillance Cycle



Who are we serving? Who are we missing?
Are there differential impacts, benefits, unintended effects. What can we change to reduce unequities?

Social and environmental conditions
Identify at-risk groups
Revise data collection to better expose inequities

Identify Priority Populations.
Why are some people at greater risk?
How can we reach and engage them in our inquiry?
What is the lived experience of specific groups?
How experience relate to health outcomes and goals?
Impact of our actions on specific populations?

-Tailor strategies
- Invest Equitably
- Reduce Access barriers

Who are the community stakeholders that we can exchange knowledge with? How can we engage them, learn from them?
Are we relevant? Understood? Is our information useful?
Is there a sense of community ownership over this knowledge?

Back to the Future: 2015-2020

<table>
<tr><th colspan="5">Ontario Health Observatory (fictional website)</th></tr>
<tr><td>Health Equity Atlas for Ontario</td><td colspan="2">Topic-based Health Unit Reports
Health Equity
Nutritious Food Basket
Other</td><td colspan="2">Equity Performance Measures</td></tr>
<tr><td colspan="5">Priority Populations (A Collection of Resources Compiled by PHUs)</td></tr>
<tr><td>Refugees
Recent Immigrants</td><td colspan="2">Ethno-cultural and Racial Groups
(Link to Ontario in Colour)</td><td>People Who Are Homeless or Marginally Housed</td><td>Sexual Orientation
Lesbian, Gay, Bisexual, Trans-sexual</td></tr>
<tr><td>Aboriginal</td><td>Seniors</td><td>Children/Youth</td><td>Rural Population</td><td>Gender Identity
Male, Female, Transgender, Two-spirited</td></tr>
<tr><td>Low Income</td><td>Low Literacy</td><td>Limited English Fluency</td><td>People with Disabilities</td><td>Link to more…..</td></tr>
</table>

Key comments for the guidance document from the SDOH perspective

- SDOH well incorporated throughout with good interpretation of the population health approach
- No concern regarding data and literature
- Addressing health inequities/priority populations
- Need to integrate key messages throughout the requirements
- Dilemma regarding target populations vs. priority populations

Additions and suggestions

- Describe the role of public health with respect to health inequities
  - avoid applying SDOH to special programs and policy advocacy only
  - Incorporate into surveillance, health promotion interventions, collaboration, policy…
- Provide specific steps to identification of priority populations
- Apply the same steps to all requirements
- Apply health inequity lens to program evaluation
- Provide as many examples as possible re addressing health inequities

Resources added:

- A paper overview of the issue (similar to the presentation – making the case and offering examples and key questions
- A tool with steps for identification of priority populations, for neighbourhoods and populations
- A planning framework that:
  - uses situational assessment with specific focus on priority populations and most suitable practices
  - Acknowledges stakeholder perspectives and evaluation as legitimate data sources

- Questions/Comments
- Discussion