

alPHa-OPHA Health Equity Workgroup

Health Equity Indicators

Draft for Consultation

February 8, 2013



Potential Health Equity Indicators

Preamble:

The social determinants of health (SDOH) are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics¹.

Health inequality refers to the differences, variations, and disparities in the health achievements of individuals and groups². Health inequity describes inequalities in health that are deemed to be unfair or stemming from some form of injustice. Because identifying health inequities involves normative judgment, science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair².

The evidence shows that in general the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum which means that health inequities affect everyone¹. Health disparities have the consequences of avoidable death, disease, disability, distress and discomfort; but are also costly for the health system and society, threaten the cohesiveness of community and society, challenge the sustainability of the health system, and have an impact on the economy³.

Prior to considering the following measures, Public Health Units should decide what social determinants they will consider given their local context from the variety of sources that are available^{4 5 6 7}.

1. World Health Organization. Social determinants of health. Key concepts. *World Health Organization home page*. 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html. Accessed Oct 22, 2012.
2. Kawachi I, Subramanian S, Almeida-Filho N. A glossary for health inequalities. *J Epidemiol Community Health*. 2002;55:647–652.
3. Health Disparities Task Group. *Reducing Health Disparities –Roles of the Health Sector:Discussion Paper*: Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security; 2004. Available from:http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf.
4. CSDH. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. 2008. Available from: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html.
5. Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health. Background document to WHO – Strategy paper for Europe*. Stockholm: Institute for Future Studies; 1991. Available from: <http://www.framtidsstudier.se/wp->

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6. Public Health Agency of Canada. *What Makes Canadians Healthy or Unhealthy?* 2012. Available at: <http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#secondreport>. Accessed Oct 23, 2012.
7. World Health Organization. *Social Determinants of Health: The Solid Facts*. 2nd ed. Copenhagen: World Health Organization; 2003. Available from: <http://www.euro.who.int/en/what-we-publish/abstracts/social-determinants-of-health.-the-solid-facts>.

FOR DISCUSSION

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Indicator 1: What percentage of Board of Health reports on health status includes disaggregation of data by social determinants of health (SDOH) where possible?

$$\frac{\text{Number of board of health health status report disaggregated by SDOH}}{\text{Number of board of health health status reports for which disaggregation by SDOH is possible.}}$$

Data sources: Self report by Board of Health/Public Health unit

Definitions and Notes: This measure is intended as a self assessment tool within the health unit to evaluate performance on reporting by SDOH where possible. This measure should not be used for inter-PHU comparison because not all measures may be disaggregated in each health unit.

Board of Health reports are health status reports that are intended to meet the reporting requirement of the Ontario Public Health Standard's foundational standard under the Population Health Assessment and Surveillance Protocol

http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/population_health_assessment.pdf.

Social determinants of health include elements of economic and social condition that influence the health status of individuals or groups of individuals so should be explicitly linked to health status. A descriptive report of the economic and social elements alone would not qualify (e.g. a demographic report of economic disparity in a public health region in the absence of a specific health status measure such as the incidence of a particular disease).

Limitations: Smaller health units may have difficulty disaggregating on social determinations of health and producing robust estimates of health status due to small sample sizes. This would depend on the data source.

Not all measures used in health status reports (e.g. hospitalization/ER visits) are directly linked to information on social determinants. Health status measures can be linked to social determinants through an area-level analysis. This analysis method requires a construction of a geographical analysis frame where the different geographical units can have social advantage attributed to them (e.g. wealthy and poor neighbourhoods). Not all health units may have the resources to do this or to be able to construct geographic units that are useful.

Some health units may not report on some health status measures by SDOH if they've determined that SDOH does not routinely influence those measures.

Division between reports may be arbitrary. For example, one health unit may generate a single annual report on many issues and another health unit may generate two or more reports that contain the same

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quantity of information. This bias is preferential to Boards of Health that generate many reports, regardless of the quantity of information they contain.

A single report on a large topic may not have all measures analysed by social determinants. This may misrepresent the extent to which the report addresses the SDOH analysis.

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Indicator 2: What is the percentage of Board of Health reports on health status that include an analysis of the social determinants of health (SDOH) for a specified time period?

$$\frac{\text{Number of board of health reports on health status that include an analysis by SDOH over time}}{\text{Number of Board of Health reports on health status that are disaggregated by SDOH}}$$

Data sources: Self report by Board of Health/Public Health unit

Definition and Notes: The description of the health status measure should be done over time for the social determinant of interest (e.g. education). The analysis should include a method of determining whether any differences are due to chance.

Individual health status measures may be the topic of board of health reports at different frequencies within the health unit (e.g. yearly, every 2 years). At a minimum, the report should include previously reported data where possible.

Limitations: Data on social determinants primarily come from the Canadian Census Long Form (up to 2011) and the National Household survey (2011 onward). This means the framework for the social determinant (e.g. income) may change less often (every 4 years) than the measure of interest (e.g. hospitalization). This indicator does not require a re-calculation of social determinants at the same frequency of the health status measure being reported if it's not practical.

Smaller health units may have to combine multiple years of data in order to develop robust health status estimates by SDOH. This threatens the validity of the time series requirement. However, at a minimum, previously reported data should be included where possible.

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Indicator 3: Does the current operations plan of the Board of Health incorporate identification and planning for priority populations? If yes, what is the process?

1. Identification of priority populations	Select
a. Standardized and explicit process (e.g. specified in a policy and procedure for operational planning).	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Standardized and explicit template (e.g. separate column for priority population).	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Other (please describe).	

2. Process for identification of priority populations	Select
d. Health unit has a list of selected priority populations that applies for all programs and services for the entire health unit.	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Health unit has a comprehensive list of possible priority populations (e.g. list of 10 subgroups) for consideration.	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Health unit relies on staff/management to interpret definition of priority population.	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Health unit's definition of priority population (tick all that apply)	Select
g. Based on increased rates of diseases, health outcomes or risk factors regardless of whether it is socially produced (e.g. women, youth, pregnant women, education)	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Based on only "socially-produced" differences in health outcomes/risk factors (e.g. income, housing, education)	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Based on only qualitative data. Please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. No standard, explicit or agreed-upon interpretation of definition (i.e. inconsistent)	<input type="checkbox"/> Yes <input type="checkbox"/> No

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k. Other:

4. Planning for priority populations	Select
l. Priority populations are identified, but programs/services are not modified for this group.	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Once priority populations are identified, and existing programs and services are modified to reach these groups, specific action/activities are created to meet the unique needs of that priority population.	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. If yes, what percentage of programs and services has been modified?	
o. N/A - we do not identify priority populations.	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Performance measurement and evaluation	Select
p. Programs and services are monitored and evaluated to determine how they are meeting the needs of priority populations. Please give examples:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Data sources: Documentation or records of plans (e.g. service plans, program plans, program operational plans etc.

Definition and Notes: The OPHS defines priority populations as “those populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level”. The OPHS does not distinguish between those at risk due to socially-produced factors (e.g. low income, limited education, unemployed, poor housing, discrimination due to culture, race or sexual orientation) and those at risk for biological or physiological reasons (e.g. genetics, sex, age). Question #3 is intended to assess how PHU’s have interpreted the OPHS’ definition of priority populations.

Identification and planning for priority populations may occur through service plans, program plans or program operational plans.

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Background and Context: Different groups (e.g. based on age, race, gender, education level, income) have different health outcomes and risk factors as well as different needs.

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Indicator 4a: Does the BOH have a mechanism to ensure that operational planning includes a health equity assessment of programs and services?

Questions	Response
1. Health equity assessment of programs and services is encouraged by the BOH.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Health equity assessment of programs and services is required by the BOH.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The BOH provides a standardized health equity assessment tool for staff to assess programs and services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Please list and/or attach any health equity assessment tools used in the development of your operational plans. <i>Insert link</i>	

Data sources: The survey questions would likely be completed by a representative from senior management familiar with the health unit's planning process.

Definitions and Notes: Operational plans are the documents used by staff to ensure that public health programs and services have been systematically identified with associated activities and resourced for a period against defined outputs or outcomes¹.

Boards of Health may have layers of operational plans that describe activities of teams within a service area (for example dental services), teams within Program Divisions (for example Health Promotion) or broad activity areas (for example child health). This indicator assesses whether staff preparing those plans are expected to systematically consider health equity when planning and evaluating public health programs and services. The mechanism could be a prompt within the operational plans to outline equity focused activity or a specification to use a standard equity tool in the planning process. Examples of tools that can be accessed to structure the consideration of health equity in program and service review are listed below.

¹ Excerpt from the Ontario Public Health Organizational Standards
http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/docs/org_stds.pdf

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Indicator 4b: How have programs and services changed or been developed based on the health equity assessment?

Questions	Response
1. Have any BOH programs or services changed as the result of a health equity assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Please describe any changes to BOH programs or services based on a health equity assessment.	

Data sources: The survey questions would likely be completed by a representative from Senior management familiar with the health unit's planning process

Definitions and Notes: The planning cycle includes an expectation to modify programs and services based on evaluations and assessments to meet community needs². Health equity assessment can be part of the actions to ensure that programs and services meet community need.

² Excerpt from Ontario Public Health Organizational Standards:

Public health units are expected to undertake their operational duties in a way that demonstrates an understanding of the local community's context, openness to the community and its needs, and innovation to address emerging needs or gaps in services.

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Indicator 5: Does the Board of Health's (BOH) strategic plan describe how equity issues will be addressed?

Questions	Response
1. What time period (in years) does the current strategic plan cover? Please give dates.	
2. Is the achievement of health equity promoted in your strategic plan? If yes, please provide text.	
3. Does the strategic plan describe how equity issues will be addressed? If yes, please explain.	
4. Does the strategic plan include outcome targets? If so, please include.	

Data sources: Survey of Boards of Health, to be completed by the Board Chair or designate.

Definitions and Notes: This indicator relates to the new requirement in the Organizational Standard for strategic plans to address health equity³.

Limitations: The current organizational standards document does not address the scenario where Boards of Health are parts of regional governments which may have broader strategic plans which implicitly govern public health operations.

³ Requirement 3.2 outlines the elements of the strategic plan. The plan must describe how equity issues will be addressed in the delivery and outcomes of programs and services. Ontario Public Health Organizational Standards, February 18, 2011.

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Indicator 6: Does the Board of Health (BOH) participate in local poverty reduction efforts?

Questions	Response
1. Is your BOH involved in local poverty reduction efforts?	
2. If yes, please describe type of activities.	
3. If yes, please describe any local outcomes.	

Data sources: Survey questions most likely completed by the Medical Officer of Health or designate.

Definitions and Notes: This question pertains to the provincial Poverty Reduction Strategy
<http://www.children.gov.on.ca/htdocs/English/breakingthecycle/report/index.aspx>

Many communities have established local coalitions and partnerships to work with local partners and stakeholders. This question would establish whether the board of health is engaged in local efforts.

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Appendix A

Samples

Sample Reference Guides:

- Sudbury & District Health Unit Health Equity Checklist Reference Document
<http://www.sdhu.com/uploads/content/listings/SDHUHealthEquityChecklist-ReferenceDocument-2007.pdf>
- USAID Checklist for Health Equity Programming
http://www.mchip.net/sites/default/files/Checklist%20for%20MCHIP%20Health%20Equity%20Programming_FINAL_formatted%202_.pdf
- Jeanette Vega *Steps towards the health equity agenda in Chile draft Background Paper 25* World Conference on Social Determinants of Health 2011,
http://www.who.int/sdhconference/resources/draft_background_paper25_chile.pdf See pp. 25-28

Sample Health Equity Assessment Tools:

- MOHLTC HEIA—includes public health unit specific Supplement
<http://www.health.gov.on.ca/en/pro/programs/heia/tool.aspx>
- Sudbury & District Health Unit Health Equity Access Checklist
<http://www.sdhu.com/uploads/content/listings/SDHUHealthEquityChecklist-2007.pdf>

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Appendix B

Methods for identifying priority populations

Effectively identifying and addressing inequities among priority populations requires a combination of approaches and efforts of staff, community stakeholders and those directly affected in the community. Lack of existing or sufficient data related to the determinants of health and other drivers of inequities is a key challenge in Ontario and other jurisdictions (pg. 41 [Health Equity Impact Assessment \(HEIA\) - Ministry Programs - Health Care Professionals - MOHLTC](#) 2012). The following examples include both quantitative and qualitative methods and data sources to assist with identifying priority populations.

Examples of methods and data sources to help determine priority populations

Review of epidemiological data from:

- Health status reports.
- The Rapid Risk Factor Surveillance System (RRFSS).
- Integrated Public Health Information System (iPHIS).
- Canadian Community Health Survey (CCHS).
- Census data (typically obtained via data requests).
- Data and reports from other local, regional, provincial and national sources.
- Geographic Information Systems (GIS) to analyze and visualize neighbourhood characteristics.

Grey literature (project/program reports, informal practice guidelines, recommended or promising practices, etc.).

Qualitative evidence from other jurisdictions and coalitions, partners and front line staff who work with priority populations. This includes assessments of the built environment such as housing, transportation and access to food. It is vital to include tacit knowledge from those with lived experiences sometimes referred to as kitchen table talk or tea time. This method maximizes reach, trust and impact.

Program evaluation results to assess who public health interventions are reaching, how they are benefiting, as well as gaps in reach and benefits.

References

1. Ministry of Health and Long-Term Care. Health equity impact assessment. Ministry of Health and Long-Term Care 2008, 2012. Available from: URL: <http://www.health.gov.on.ca/en/pro/programs/heaia/tool.aspx>
2. Hyndman B, Tyler I, Seskar-Hancic D. A proposed equity assessment framework for Ontario's public health units. 2011.

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3. Region of Waterloo. Public Health. Process for Determining Priority Populations. Available at: <http://chd.region.waterloo.on.ca/en/search/index.aspx?strSearch=process%20for%20determining%20priority%20populations> Retrieved on November 9, 2012.
4. Seskar-Hencic D, Patychuk D. Putting it all together for health equity. 2008.

FOR DISCUSSION