



First Steps to Equity

Ideas and Strategies
for Health Equity in
Ontario, 2008-2010

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Equity Through New Public Health Standards

With this document, we celebrate the launch of new Ontario Public Health Standards that include identifying, reporting and using information about health inequities and tailoring strategies to inform actions that meet the needs of priority populations. This document provides some ideas, steps, examples and resources to support people and organizations working for equity in health in Ontario. Equity in Health is about eliminating unnecessary/avoidable, and unfair/unjust differences in health among population groups and communities.

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Your comments and contributions of ideas and examples for supplementary documents are welcome and invited. Send to: dpatychuk@sympatico.ca

You are invited to use the information here freely by including a reference to this document as:

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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

Identifying and meeting the needs of priority populations is a key strategy for reducing the health inequities.

Population health assessment, surveillance, research and program evaluation can all contribute to health equity. This document demonstrates some

steps and examples that show how this is already happening or can be expanded based on the new standards and requirements in the Foundational Standard and Population Health Assessment and Surveillance Protocol

In this document, we also discuss knowledge transfer along with community engagement as they relate to supporting the gathering and use of the information that addresses health inequities. Communities, professional partners and collaborations also play a critical role in extending the reach of the health assessment and surveillance beyond Public Health.

Then and Now

1997 Mandatory Program and Services Guidelines

- Desired actions and changes captured in the Equal Access Standard
- Offered an opportunity to modify and adjust public health programs for populations that may experience barriers to services
- Provided requirements that were open for different interpretations, not specific and not attached to other program standards.
- Did not clearly define measures of success

As a consequence:

- Health Units had no clear path to identification of issues, priorities, and actions
- There was no consistency in the interpretation and application of the requirements of this general standard
- Equal access actions and priority populations resulted from experiential, not assessment-based choices
- Actions across health units were well intentioned, but for the most part intuitive
- Appraisal of achievement was based on the mere presence of actions, not their evaluation

2008 Ontario Public Health Standards

- Health Inequities and social determinants of health are integrated into mandates for Boards of Health – including to identify and report publicly on health inequities
- Programming is expected to be dependent on evidence and experience
- Requirements state specific expectations
 - Assessment and surveillance are explicit, directive and broadly applied to all standards
 - Identification of priority populations is required for all programs and is visible in all program standards;
 - Boards of Health are directed to deliver focused interventions and tailor strategies to the needs of priority populations
- Several standards have measurable program-specific expectations

Why are these changes important?

- Diversity competent population health assessment and surveillance require the use of a new lens – health inequity lens
- There is no “general population.” To achieve impact and minimize risks, we need to be fully aware of who makes up the “population”
- To overcome health inequities, we need a paradigm shift: the focus of public health interventions on priority populations is the only meaningful way of achieving population health goals
- Our actions, tools and methods, whether in protection; promotion or prevention need to be accessible, meaningful, diversity-competent, and innovative.

Moreover...

- Strong health inequity evidence reaches beyond health program benefits
- Public Health Sector has the sole responsibility and opportunity to report on health inequities
- To advocate for health equity-based public policy, it is essential to provide strong evidence. Therefore Public Health work continues with:
 - Communicating with the community; professional partners; decision makers;
 - Multiplying impacts by replicating similar evidence across the province; showing consistency and relevance in a variety of contexts
 - Explaining the implications and making the links to actions more explicit

Vision: A Possible Future Scenario for Ontario 2015

To help realize the potential of the OPHS and protocols for supporting planning and action to achieve health equity in Ontario, we begin with a vision of the future – of where we could be on our journey by December 2010...and 2015.

Let's jump ahead in time. Imagine it is 2015. You still have your job in your health unit because you like it so much. You pick up a newspaper on your way to the bus, subway or go station one morning and here are the headlines:

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 health 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 health 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"

To get to this place....by 2010, ...

- Most public health units had goals or objectives for reducing health inequities visible in planning, reporting, priority setting, resource allocation, and evaluation.
- In response to the new standards, health units across Ontario initiated systematic surveillance focused on health disparities
- Some health units engaged in community-based research to build on and expand knowledge about local health needs, access barriers and effective strategies with populations not well reflected in surveys, vital statistics and other health data sets.
- In a number of cases in-depth, qualitative approaches were used to better understand the lived experiences of populations that experience barriers to health
- Health units spearheaded transformation of their health promotion, prevention and protection services to provide tailored and meaningful service to groups that had been systematically excluded from the mainstream service delivery
- In some cases, the shared knowledge mobilized communities to form advisory groups to support populations e.g. Aboriginal, Newcomer Parents, Marginally Housed, etc.
- Health units began to build on each other's knowledge about specific populations and engaged in :
 - knowledge exchange around optimal practices for learning about local needs
 - engaging local groups in adapting or validating information produced through their research, monitoring, and evaluation activities
 - partnerships with other sectors to spread the knowledge and influence policy and programming decisions beyond public health.
 - All health units had integrated equity perspectives into staff and manager training, professional development and performance.

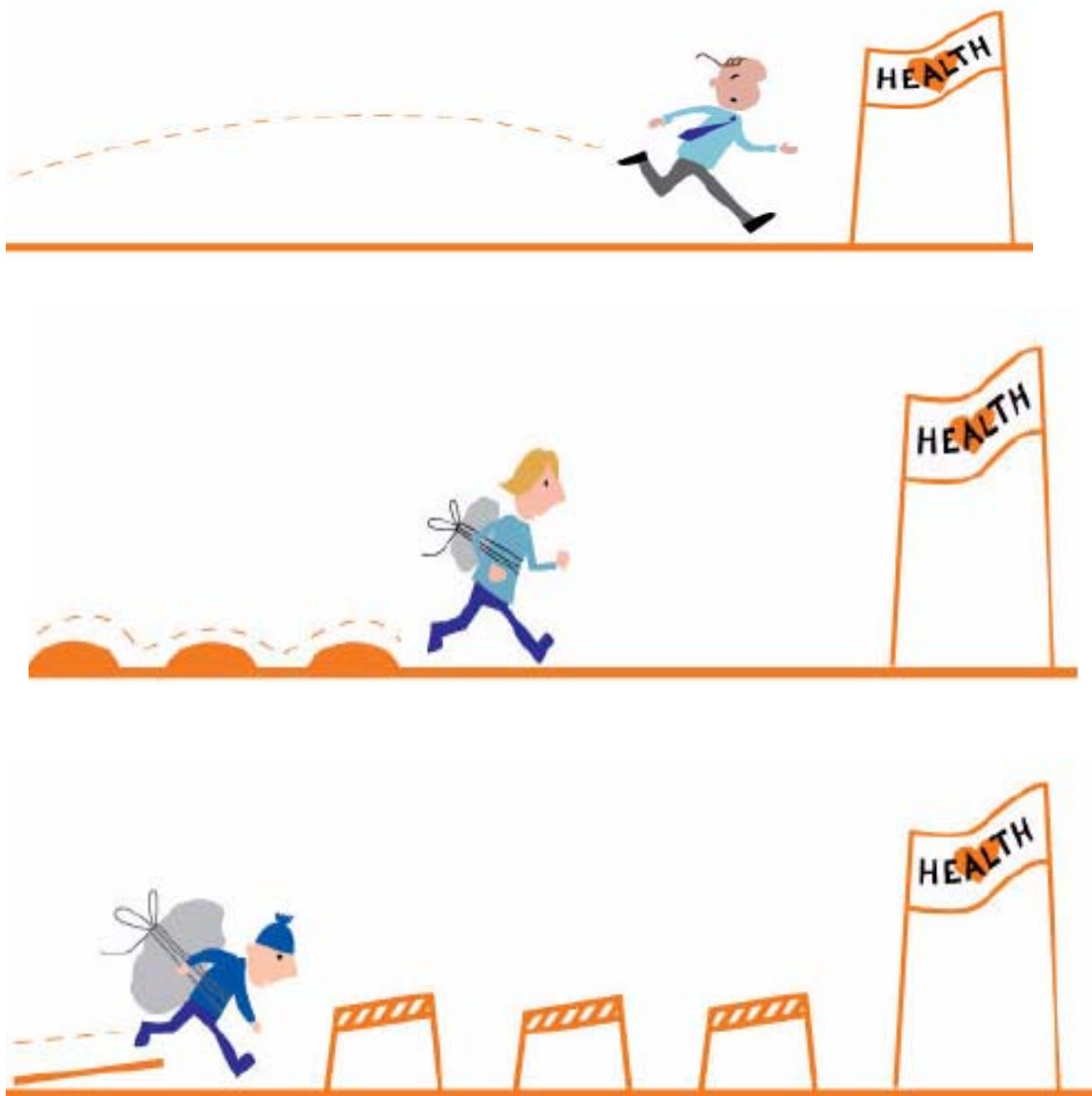
* calculations in scenario are based on Wilkins (2008) mortality data for 2001 and ICES (2004-05) diabetes incidence

**Where did we Start: A Depiction of the Health Inequities
Health Burden and Access Barriers (Hurdles) Widen Equity Gap**

For every standard/mandate that we have, there are population groups that we are less likely to reach in order to meet our goals; that have more barriers to access; and are less likely to benefit from what we do.

To improve population health by addressing health inequities, who should we focus on and what should we do? What do we need to know?

Who has greater barriers and risks? Are people differently affected by our approaches? What can we do to change that?

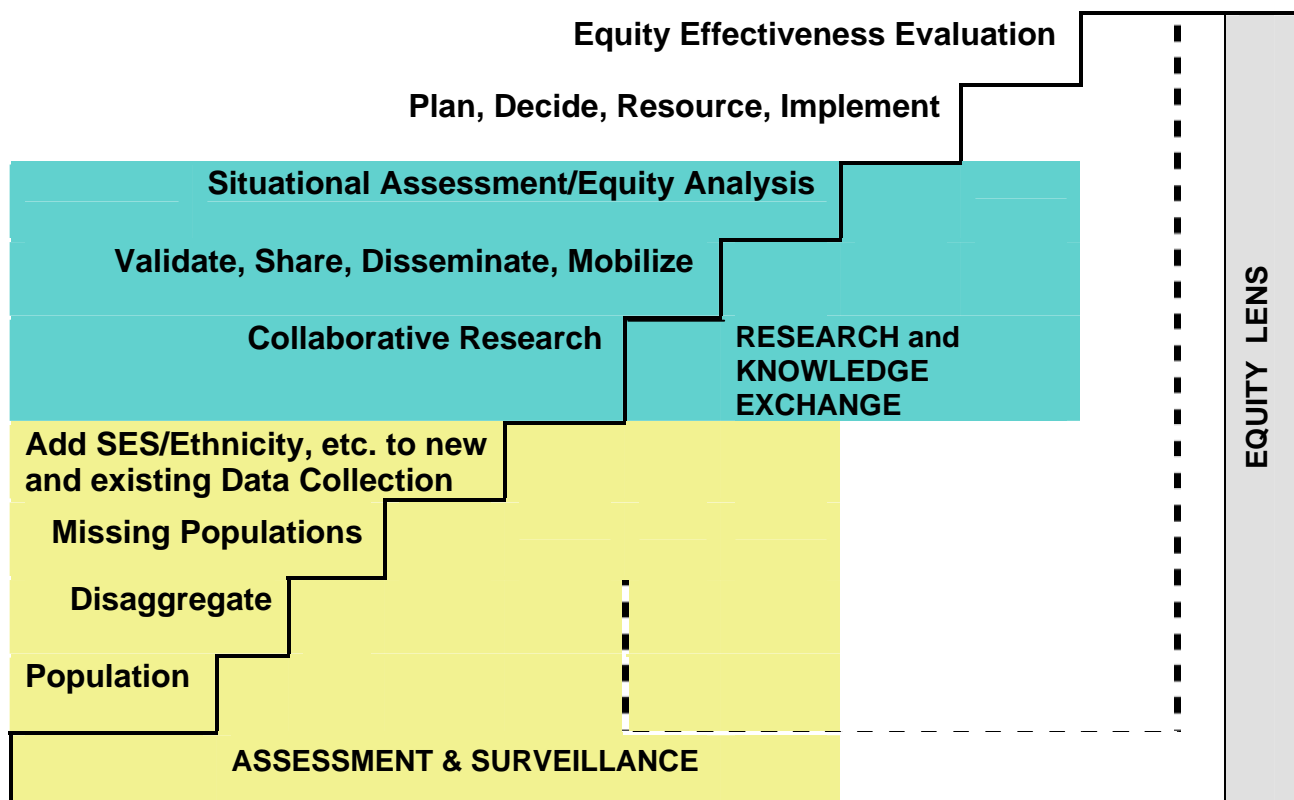


People figures from Norway's National Strategy to Reduce Social Inequalities in Health, 2007.
http://www.regjeringen.no/pages/1975150/PDFS/STM200620070020000EN_PDFS.pdf

Equity Escalator: An Equity Lens in the Foundational Standard

The Foundational Standard and the Population Health Assessment and Surveillance Protocol provide the concept and steps toward responsible, evidence-based public health practice.

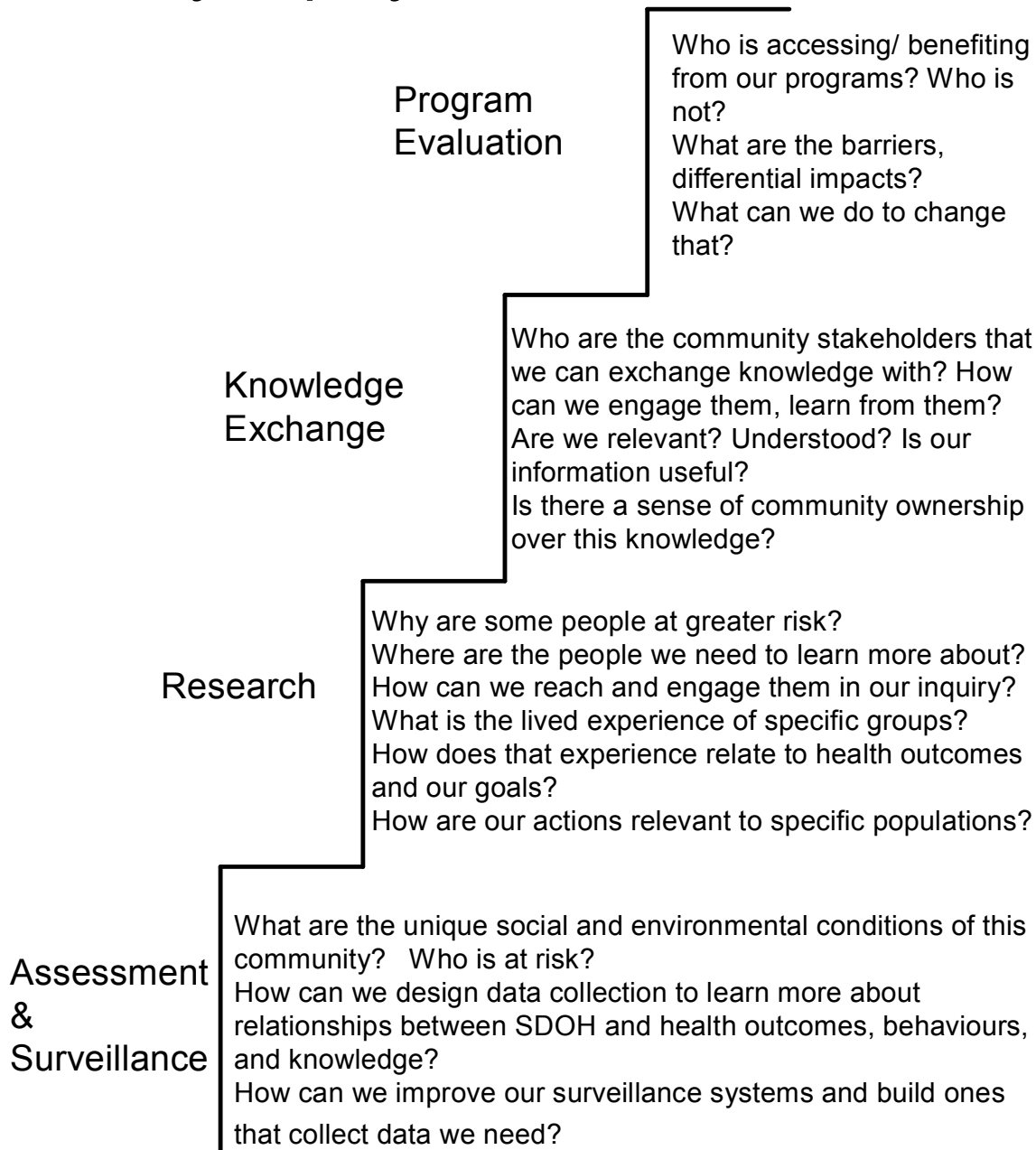
By introducing an equity lens in our health assessment, analysis and planning activities, we are more likely to understand what unique barriers and burden some populations face and what programming, social and environmental conditions need to be addressed in order to minimize those. The following image displays the key steps in surveillance, population health assessment, research, planning, and evaluation activities. For each of these steps, we need to consider equity-based questions that would guide us to better understanding and addressing health inequities.




Key Steps in the In the Foundational Standard and Assessment Cycle

The staircase includes key equity questions for each of the components of the Foundational Standard. Additional equity questions are included on page 18 that also address planning. These questions can also be inserted into the topics in the Population Health Assessment and Surveillance Cycle diagram described in the Protocol.

Key Equity Questions





Step 1. Assessment and Surveillance

Equity-focused assessment and surveillance relies on gradual peeling of the layers of data in search for the relationships that expose health inequities. The key questions and considerations include the following:

- Understanding the context
 - What's unique about the community?
 - What are the general demographic and health indicators
 - Describing community-specific social determinants of health
- Finding the common denominators? For example...
 - Starting with Income which consistently surfaces as the main factor that differentiates positive from negative health outcomes.
 - Moving to the next layer may reveal other SDOH playing a role: e.g. racial discrimination, linguistic and cultural barriers, immigration status, gender-bias, social exclusion (LBGT, disability, etc.)
 - Examining who is in the groups that are consistently showing poor health or greater access barriers
- How would we do this and what are the products?
 - Health Impact Reports; Health Status Reports on specific groups; Mapping and spatial analysis
- Disaggregate the population – (e.g. track, analyze and report by population group, and by place and over time).

Define “population” in a way that captures all of the dimensions of diversity and intersecting identities, whether that is a diversity flower, the population bubbles, or a list of population groups. Data that can be presented as a “bell curve” and may also be broken up into distinct population groups (See Figure 2).

Ways of exposing, measuring and identifying inequities are evolving and vary according to purpose and data availability from simple neighbourhood income quintiles that show a gradient, to the more complex measures (e.g. relative index of inequality).

Mortality rates in lowest and highest neighbourhood income quintiles are one example of income-linked health inequities (Table 1). This isn't a new approach (e.g. babies born in low income neighbourhoods in Ontario cities in 1986 were twice as likely to die in infancy as a baby born to parents living in wealthy neighbourhoods; life expectancy for males was 5.3 years less for males in low income compared to high income neighbourhoods).¹

Looking at low income rates shows which groups are more likely to be low income. Additional analysis can look at the make up of each income quintile. Other studies such as the gender-based Power Study (to be released in December) show self-rated health and health behavior differences by income, home language, ethnoracial groups, education, etc. This unpacking health inequalities reveals which groups are more at risk and some opportunities to support healthy practices among some low income groups.

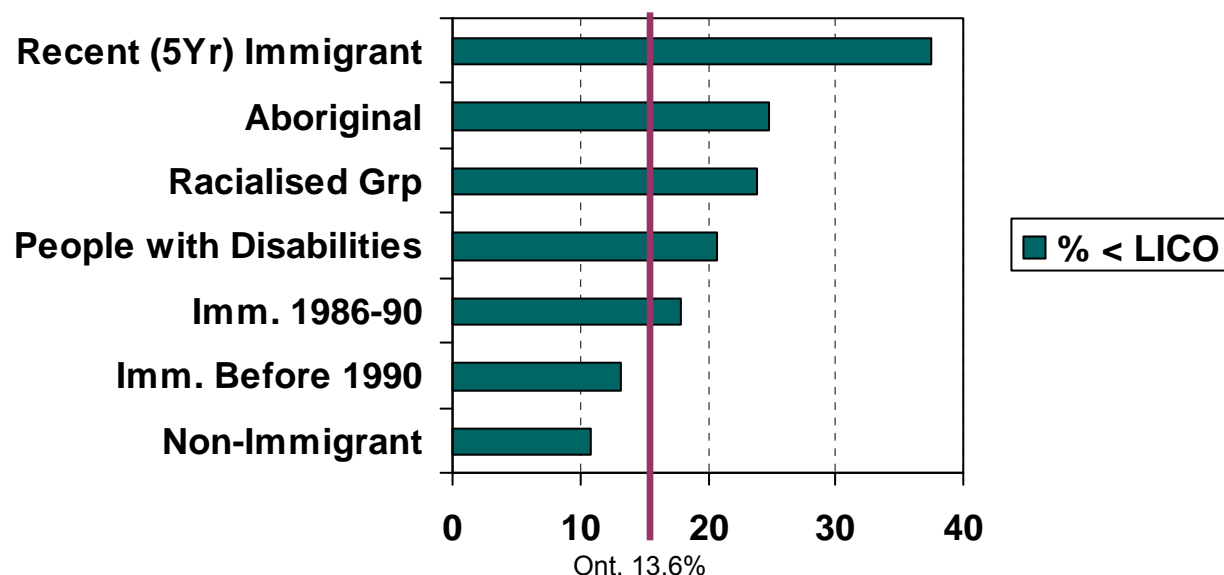
¹ Premier's Council on Health Strategy. 1991. Nurturing Health. Ontario.

Disaggregating Population Data to Expose Inequities - Examples

Table 1. Age Standardized Mortality Rates, (Deaths/100,000), 2001 Ontario CMAs

Gender & Cause of Death	Low Income Neighbourhood	Highest Income Neighbourhood	Rate Ratio
Infants <1 yr	71.5	49.8	1.44
Ischemic Heart Disease: Males	146.3	103.3	1.42
Ischemic Heart Disease: Females	67.1	59.1	1.14
Lung Cancer: Males	62.7	40.1	1.56
Lung Cancer: Females	33.8	25.1	1.35
Diabetes: Males	26.6	16.7	1.59
Diabetes: Females	17.4	10.1	1.72
Accidents/Pois./Violence: Males	48.6	36.6	1.33
Accidents/Pois./Violence: Females	22.1	17.2	1.28

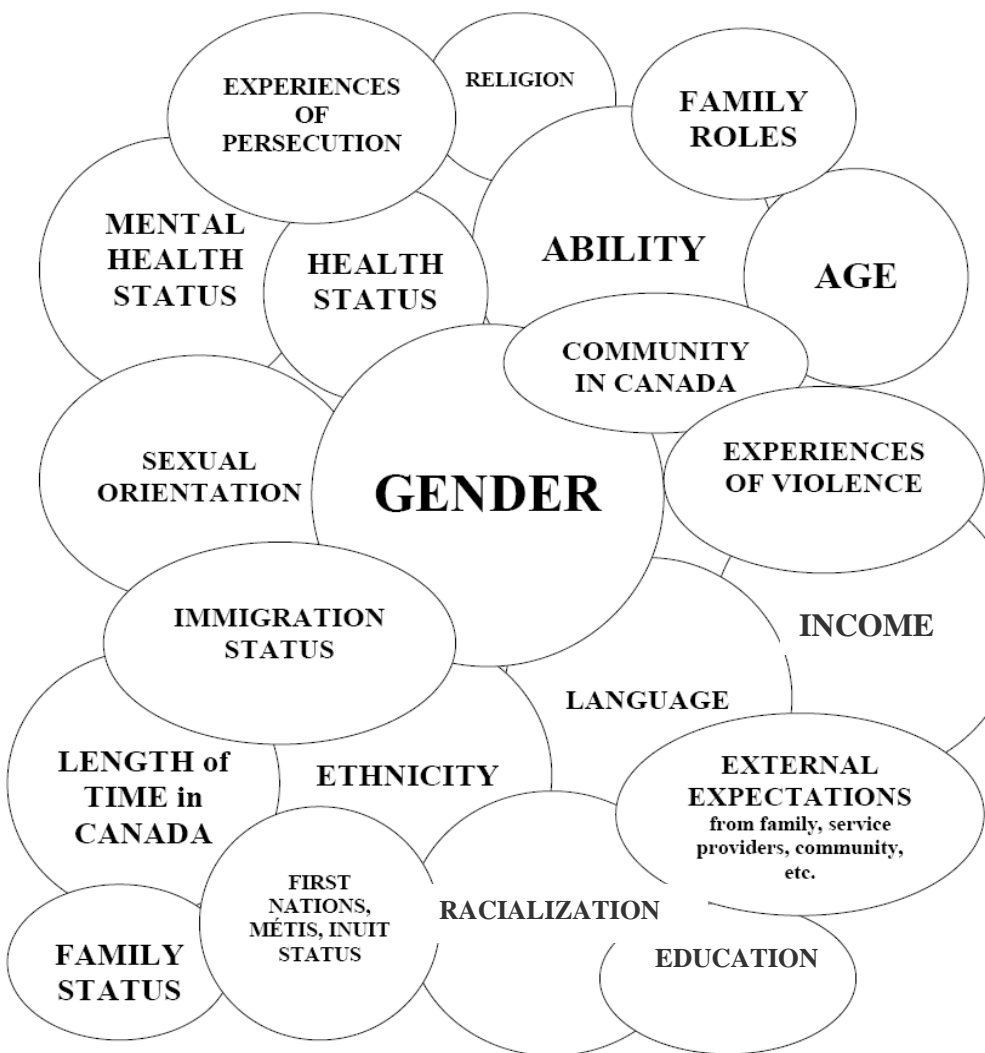
Figure 1. Which Populations are Lower Income?
% Low Income, Ontario 2001 Census



Information from the 2006 Census for proportion of individuals with incomes below the low income cut-off (LICO) (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
 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

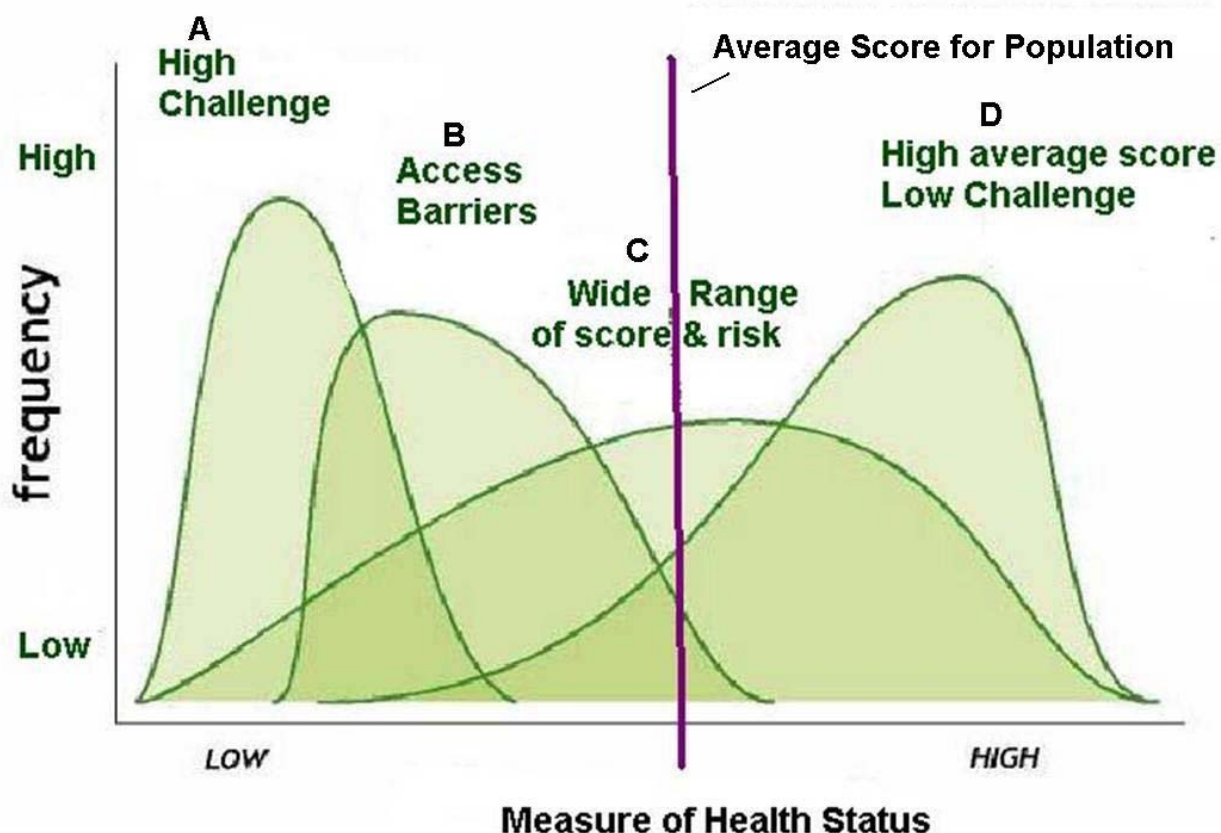
Figure 2. The Population is diverse with many intersecting identities



Adapted from: Canadian Council for Refugees.
www.webnet/~ccr

The interplay of these characteristics define health risks, access to services, and health status and need to be taken into account in population health.

Figure 3. Unpacking the Bell Curve



As this example adapted from analysis of Early Development Instrument (EDI) scores shows, when we start to peel the layers, unpack the data or disaggregate by people or place we begin to see that there are population group inequalities. There is no “general population”...only a minority has the rate reflected by the average. For example, there are population groups with high challenges in terms of lack of access to social determinants of good health and greater burden of illness. Other population groups have high access barriers and low to average overall scores on health measures. Other population groups may fall along the whole range of a bell curve with varying diversity, needs and health status, while other populations have low challenges, lower risk and better health status. Planning effective strategies will depend on understanding and responding to different needs and opportunities among the population groups.

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

Step 2. Research

If the data is not available, or we can not get to the conclusions that point to the relationships, how else do we identify the issues and problems?

Quantitative and qualitative research enables us to dig deeper and look for the relationships.

- Surveillance gives a broad picture – to learn more and get more in-depth picture, and what we may need to do, we need to ask more questions...
- When would we use research?
 - When there is no data base, when population is inaccessible, and
 - When there is data, to get in-depth perspective and try to understand why

- How would we do it?

There are many ways, brief and complex, quantitative and qualitative. Some examples may include the following types of inquiries:


- In-depth studies and priority population-tailored surveys
- Going into the community to ask questions- kitchen table talk; participatory research to maximize reach, trust, and impact
- Case Studies and other Qualitative inquiries – these are particularly helpful to assist us in
 - learning about the lived experiences of populations we are interested in, and
 - Make connections to our role, mandate, actions

Some examples in the case studies include collaborative research to support planning for Marginalized or Populations that are hidden or missing in the data bases available for analysis (e.g. census, health data, surveys).

See the list of studies that find ways of using traditional epidemiological data sets in ways that reveal ethno-racial health inequities (Table 2).

Triangulation is used in many types of research from measurement (including two or more methods) to check if they yield the same result; to enhance the comprehensiveness of information; contextualize data; and deepen understanding. Triangulation is useful in synthesis, and analysis to support planning and decision making. Different types of triangulation include:

- data triangulation – the use of a variety of data sources
- investigator triangulation – different evaluators, scientists, experts, etc., with complementary skills or experience
- theory triangulation – using multiple perspectives to interpret a single set of data
- methodological triangulation – multiple methods (e.g. interviews, observations, questionnaires, documents)



Step 3. Knowledge Mobilization

Knowledge Mobilization in the context of health inequities includes engaging with community in research and action, as well as in knowledge exchange and mobilization.

What:

- A surveillance, planning, and knowledge mobilization strategy includes vision, goal or purpose linked to local needs identified by community participants
- Knowledge exchange and mobilization are only meaningful if community is engaged
- Local communities are key players in “health for all” & reducing health inequities through advocacy and policy change

How:


- Engage community stakeholders to create a sense of ownership
- All stages of inquiry benefit from community input: study design, implementation, generation of recommendations; use of the findings; steps to action;

Why:

- Community-based research needs to be participatory, action driven, meaningful to those whose issues it addresses
- community input is to ensure research, evaluation, programs & services are relevant to community needs and priorities
- community capacity building and supportive community environments are health enhancing and health protective
- policy/advocacy is most effective when there is strong public involvement
- research in service to the community benefits from the added value of experiential knowledge
- Public Health research transcends Public Health programming – it goes beyond and it needs to be not only understood, but also owned by the community
- policy significance is as important as statistical significance and identified at the same time as calculating confidence intervals
- active dissemination to support advocacy

See the Street Health Knowledge Mobilization example in the case studies.

Many collaborative and community based research state knowledge exchange and mobilization objectives from the outset.



Step 4. Equity - based Evaluation

Program and policy evaluation serve as an important complementary data source to enable us to relate acquired data to our actions. This step defines questions that are critical for equity-based inquiry.

Equity-based evaluation includes questions that examine our successes and challenges in working with priority populations and our ability to find ways to provide accessible and meaningful interventions. Some of the questions we need to ask include the following:

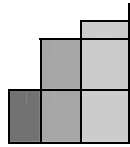
- Who are we reaching now?
- Who is included and who is excluded?
- Where are the populations we are concerned about?
- What is unique about them?
- How can we reach them?
- How can we learn more about them and with them?
- Who else does this matter to? Who are the stakeholders?
- Are our actions accessible and meaningful?
- Are we making a difference?
- What are our successes and challenges in reaching out and making a difference?

A variety of types of evaluative inquiries could assist us in gathering this information. Some of them are:

- Program evaluation studies
- Needs assessments
- Environmental Scans
- Stakeholder Perspectives
- Program monitoring and administrative data
- Staff perspectives
- Health Equity Program Audits/Assessments

Appendix A is an example of a rapid equity-focused impact assessment that is relevant to public health planning and evaluation in Ontario.

Don't let the measurable drive out the relevant
Albert Einstein



Using Situational Assessments to put Population Health Assessment and Surveillance information together – Key steps and stages for Decision Making to address health inequities

- The steps and stages featured in the escalator can all be integrated through situational assessments. Situational Assessments serve as a way of synthesizing gathered information and acknowledging multiple sources of data and information.
- **Situational Assessments help to determine priority populations and suitable practices** and policy directions by examining the interplay of the following evidence sources:
 - surveillance & assessment data,
 - association between health status and SDOH
 - research findings
 - literature review
 - evaluation results
 - stakeholders' perspectives (e.g. staff, community, other HUs; partners)
 - community, organizational and other context

This approach is defined by the following principles:

- Good evidence is both quantitative and qualitative; research driven and experiential.
- Good evidence may be obtained from existing sources and through research and program evaluation, using a variety of methods and sources
- The context, strategic directions, unique community characteristics and circumstances, and political and stakeholder perspectives, are legitimate contributors to analysis and decision making;
- Principles of Need, Impact, Capacity, and Partnership and Collaboration

Situational Assessment: Examples

Example: People who are Homeless or Marginally Housed

The list below includes are only some of the many studies and reports using quantitative and qualitative methods from multiple sources that provide information about people who are homeless or marginally housed and living in Toronto. This collection of resources and the active engagement of stakeholders provide an opportunity for **comprehensive** situational analysis to understand needs and opportunities and to inform the planning public health strategies for addressing housing, homelessness and health.

<p>Quantitative Studies:</p> <p>Street Needs Assessment Survey Inclusion Research projects Tracking/Profile of Shelter Users Peer-reviewed published research: Mortality Rate among Shelter Users; Chronic Disease among People who are Homeless Homeless users in food bank surveys Analysis of Mental Health hospitalizations among the Homeless (CIHI) Tracking of deaths among the homeless Homeless tracking in public health data (TB) Street Health Survey (OHS & CCHS comparisons)</p>	<p>Qualitative Studies</p> <p>Arts-informed community-base research (8 presented together in October 2008)</p> <hr/> <p>Mixed Method Research</p> <p>In from the Streets. Housing and the health and well-being of formerly homeless older adults – mixed method triangulated study (National Research Program of the National Homelessness) Housing Solutions for People with HIV/AIDS</p>
<p>Expert Opinion</p> <p>Public Inquiry into Deaths among the Homeless Coroner's Inquests into Deaths of Homeless</p>	<p>Evaluations</p> <p>TB DOT program among the Homeless Evaluation of Needle Exchange for Street Involved Evaluation of Young Parents No Fixed Address</p>

Example: Climate Change

A recent critical analysis of the body of knowledge concerning risk and opportunities presented by climate change is an example of a situational analysis. Contributing authors were directed to draw on:

- peer-review published research (the primary source material)
- grey literature: NGO and non-NGO reports as often the only place to access the most recent and locally relevant information
- local practitioner knowledge: it complements information from scientific sources
- inclusion of traditional/Aboriginal knowledge (in all three sources above).

Authors were also directed to identify key knowledge gaps. Peer review from the perspective of science and policy experts guided the final version of the report.

From Impact to Adaptation: Canada in a Changing Climate From Impact to Adaptation: Canada in a Changing Climate CHAPTER 2 **Background Information: Concepts, Overviews and Approaches**
 Lead authors: F.J.Warren and P. Egginton http://adaptation.nrcan.gc.ca/assess/2007/ch2/5_e.php

How Can an Equity Vision be Achieved? Using a Health Equity Lens.

Here we offer some key questions for Health Units to consider when going through the steps we described. The paths to addressing health inequities are diverse and unique for each community. These questions are general, key guidelines for using and applying Health Equity Lens in Population Health Assessment and Surveillance Protocol.

Here is the somewhat expanded list of questions to ask when collecting data and developing new systems:

- What can we ask so we could learn about relationships between SDOH and health outcomes, behaviours, and knowledge?
- Do we have the data? Can we collect the data in such a way to be able to see the meaningful links?
- How can we improve our surveillance systems and build the ones to collect the data we need?
- What other data can be acquired and how?

Questions to ask when analyzing & interpreting data

- What can we say about the relationships between socio-demographic factors and health outcomes, health behaviours, health knowledge?
- If we can't say much, where should we go for more information? What other methods can we use?
- Who else does this matter to? Who else can help in this learning? What can we do to engage them and learn from them?

Questions to ask when sharing the information

- Who are the stakeholders?
- Who is the audience?
- What do they need to know? How can we respond to their needs in a meaningful way?
- What can we do to help the stakeholders make sense of the data?
- What else we and the community need to know?

Questions to ask when planning a program or strategy (and also when evaluating it)

- What is the initiative trying to do?
- Is there evidence of inequality (e.g. access to positive social determinants of health, burden of illness, barriers that will prevent some population groups from participating)?
- Who may be disadvantaged by this initiative (the potential for programs to widen disparities if access barriers are not addressed)?
- Unanticipated impacts (e.g. if action not taken at all levels from individual to community to policy; or single issue versus comprehensive)
- What are the equity recommendations for implementation?
 - Tailor strategies to reduce access barriers, outreach to priority populations, invest equitably to reduce inequitable benefits and outcomes, etc.

(See Appendix A. Rapid Equity-focused Health Impact Assessment)

Case Studies: Marginalized, Hidden or Missing Populations

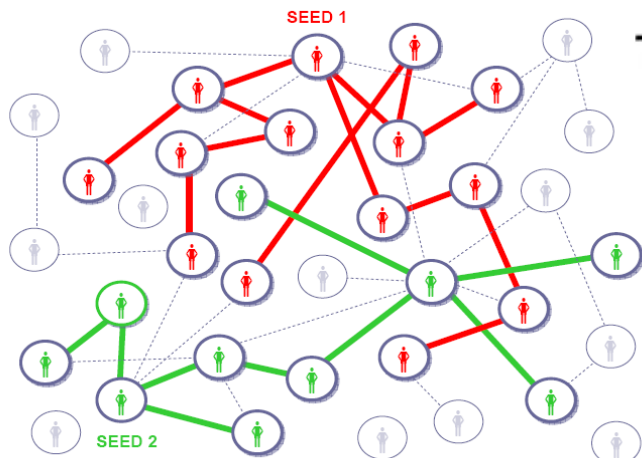
Primary Research – New Data Collection



Kitchen Table Interviews: Low Income Isolated Families: Huron County Trust Before Change: Findings of the Perinatal and Child Health Survey of Low-Income and Isolated Families.

Huron County Health Unit, Rural Response for Healthy Children, Pathways to Self-Sufficiency, and the Huron-Bruce Early Years Centre partnered together to learn more about the experiences of low-income and isolated families with young children in Huron County. Semi-structured kitchen-table interviews were conducted with low-income and isolated families to provide parents with an opportunity to talk about their experiences raising children in Huron County. The project provided insight into what needs were not being met, and recommendations were made for health, social, and childcare service providers to improve program planning and delivery to better support families.

Primary Research – New Data Collection and Multimethod Research



Bauer, Greta R. Epidemiology & Biostatistics, The University of Western Ontario, 2008.



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

Sixteen phase project that began with community soundings in Guelph, Ottawa and Toronto in 2006, includes surveys of surveys 1000 trans people in Ontario (Phase II), and 80 follow-up interviews in 2009.

Qualitative Research: Rural Health Study.

This study was designed to understand more about the determinants of health in the four unique rural townships surrounding the three core cities in the Waterloo region and to give us ideas about how to improve and maintain rural health. Key informant interviews in the summer of 2001 with service providers and other community members shaped the study and identified a steering committee. Approximately seventy focus groups and interviews with a wide variety of rural residents from all four townships. The information was analysed using NVivo, a qualitative data analysis computer program. Themes appeared and the findings were useful for health, housing, transportation and social services planning.

Case Studies: Marginalized, Hidden or Missing Populations

Mobilizing for New Data Collection: Aboriginal Roundtable

Toronto Public Health has started an engagement process with the Aboriginal Community in Toronto with a roundtable of service providers and researchers. From two initial meetings, a smaller "data" group has formed, led by 2 qualitative researchers who are also Aboriginal. Over the summer, this workgroup has proposed to the larger roundtable group that the next step should be to investigate the City of Toronto's Aboriginal undercount. With the approval of the larger roundtable, this data group is moving forward and drafting a complete proposal. Members of TPH have been supporting this organic process, letting the community lead the process.

Compiling Information: Qualitative Research



"We are Visible: Ethno Racial Women with Disabilities speak out about healthcare issues." In collaboration with the Ontario Women's Health Network (OWHN), the Ethno Racial People with Disabilities Coalition of Ontario (ERDCO) is seeking to update its 1997 publication "We Are Visible." Women who identify as an ethno-racial woman with a disability and live in Ontario are invited to participate by either filling out a survey form (requires about 1 hour), or taking part in a

focus group (requires about 2 hours). Other tools and resources are available from: Ethnoracial People with Disabilities Coalition. www.ryerson.ca/erdco. See also www.accessalliance.ca for collaborative community-based research with refugee and racialized newcomer populations.

Secondary Research – Multiple Secondary Sources



Fact Sheets on Immigrant Health compiled from several data sources, Region of Waterloo. A series of three fact sheets that used Census, Canadian Community Health Survey and several other secondary data sources obtained evidence on the health status of immigrants upon arrival to Canada in comparison to non-immigrant population, unemployment rates, and the health status of immigrants 10 years after arrival. In addition to public health programming, this population health assessment has been used as a key evidence base for the formation of the regional network that brings together employers, service and government sectors to jointly increase employment prospects

social for immigrants and influence related provincial and federal policies

Research and Knowledge Mobilization

THE STREET HEALTH REPORT 2007

Street Health is a community-based organization providing nursing, mental health and outreach services to homeless people in Toronto for over 20 years. The Street Health Report is based on:

- a survey of 368 homeless Toronto adults winter 2006/07
- extensive collaboration with community, academic and institutional partners, employing a team of peer researchers with lived experience of homelessness.
- portrait photographs with a sub sample of the study

participants were used to create a photo and sound exhibit, as well as a 9-minute film entitled *Street Health Stories*

- findings on causes of homelessness, daily living conditions of homeless people, physical and mental health of homeless people, use of health care, barriers to health care.
- outlines an action plan consisting of targeted solutions to improve the health of homeless people and to ultimately end homelessness.

Builds on the Street Health Report which first used a methodology developed by York Institute for Social Research; and which used questions in the Ontario Health Survey and compared street survey respondents with OHS total Toronto respondents of comparable age.

www.streethhealth.ca. The *Street Health Stories* film is available on You Tube.

The Project received the Centre for Urban Health Initiatives 2008 award for Community Based Research.

Actions:

- over 20 meetings with government representatives (provincial and municipal), Toronto Public Health, Toronto Central LHIN Board and Council, Toronto Police Services, hospital managers and committees and community agencies, UN Special Envoy.
- report disseminated broadly & to staff in above organizations
- over 60 presentations and deputations
- over 40 media events – newspaper and radio

Results as of Oct 31, 2008:

- UN Special Envoy reported housing situation “a national crisis:
- Toronto Police Services incorporated findings on homelessness and police violence in their 2008 Environmental Scan, which will inform the Toronto Police Service business plan.
- Influenced advocacy of Board of Health (on access to oral health), influenced advocacy of Toronto Police Services Board (on supportive housing)
- "TC LHIN incorporated key findings and recommendations into their Health Equity Strategy and their conference for health managers and service providers on health equity, making the report a key theme of the conference and using it as a framework for discussing how to improve health care access in the region."
TC LHIN Education and Research Council considers requesting hospitals and universities in LHIN to incorporate needs of homeless into health care provider curriculum
- MOHLTC – Kingston – steps taken to eliminate the practice of requiring a 3 month wait for OHIP for people who are homeless and unable to prove residency.
- Advising Health Canada's Chief Dental Officer, other cities, etc. on how to do a street health survey.

Table 2. Examples of Quantitative Analysis of Ethno-racial Health Inequalities Using Available Data

- Analysis of population health surveys (Smith K et al, 2007; Steele L et al, 2007) see also Bierman et al through: www.thepowerstudy.ca
- Analysis according to client data on "language spoken" such as where collected in a hospital (John-Baptiste A, et al, 2004);
- Categorizing client's names into ethnoracial groups for survey analysis and chart reviews (Gupta M, et al, 2002);
- Using the recency of obtaining an OHIP card among non-infants as an indicator of recency of immigration for creating comparative analysis of use of OHIP services, hospitalization or cancer screening in communities with low rates of inter-provincial mobility (Urquia M, et al 2007, Lofters et al, 2007);
- Using census tract of residence to create geographically defined populations according to income, immigration or ethno-racial variables (Hardwick & Patychuk, 1999)
- Creating a multi-variable composite index that includes the determinants of health (health resources index, activity friendly index, urban marginalization index (Glazier et al, 2008.; Matheson et al, 2006)

Some of this research should become part of routine provincial population health reporting, e.g. analysis of health needs, mortality and morbidity rates and services received by income quintiles; and, analysis of each round of the Canadian Community Health Survey separately and combined to obtain adequate sample size for valid analysis of intersecting dimensions of oppression, vulnerability or marginalization

Steele L, Dewa C & Lee K. 2007. Socioeconomic status and self-reported barriers to mental health service use. *The Canadian Journal of Psychiatry* 52(3), 201-207.

John-Baptiste A, Nagle GN, Tomlinson, G, Alibhai S, Etchells E, Cheung A, Kapral M, Gold W, Abrams H, Bacchus M, & Krahn M. 2004. The effect of English language proficiency on length of stay and in-hospital mortality. *Journal of General and Internal Medicine* 19:221-228.

Gupta M, Doonay A, Singh N, Anand A, Raja F, Mawji F, Kho J, Karavetian A, Qilong Y, & Yusuf, S. 2002. Risk factors, hospital management and outcomes after acute myocardial infarction in South Asian Canadians and matched control subjects. *Canadian Medical Association Journal*, 166(6): 717-722.

Urquia M, Frank JW, Glazier RH & Moineddin R. 2007. Birth outcomes by neighbourhood income and recent immigration in Toronto. *Health Reports* 18(4). Statistics Canada.

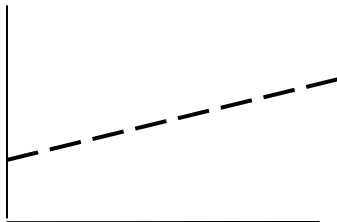
Lofters A, Glazier RH, Agha MH, Creatore MI, Moineddin R. 2007. Inadequacy of cervical cancer screening among urban recent immigrants: a population-based study of physician and laboratory claims in Toronto, Canada. *Prev Med*. 4(6);536-42

Hardwick D & Patychuk, D. 1999. Geographic mapping demonstrates the association between social inequality, teen births and STDs among youth. *The Canadian Journal of Human Sexuality* 8(2): 77-90

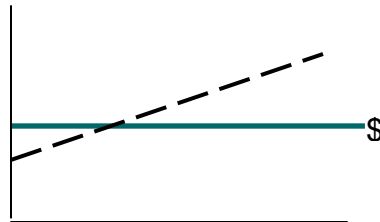
Glazier RH, Booth GL, Gozdyra P, Creatore MI, Tynan M. editors. 2007 *Neighbourhood Environments and Resources for Health Living – A Focus on Diabetes in Toronto*. ICES Atlas. Toronto: Institute for Clinical Evaluative Sciences

Matheson F, Moineddin R, Dunn J, Creatore MI, Gozdyra P, Glazier RH. Urban neighborhoods, chronic stress, gender and depression. *Soc Sci Med* 2006;63:2604-16

Equitable Allocation of Resources: Demonstrations

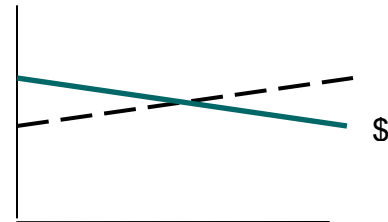


The dashed line represents health status with populations with worse health, lower SES, more access barriers having the lowest levels of health.



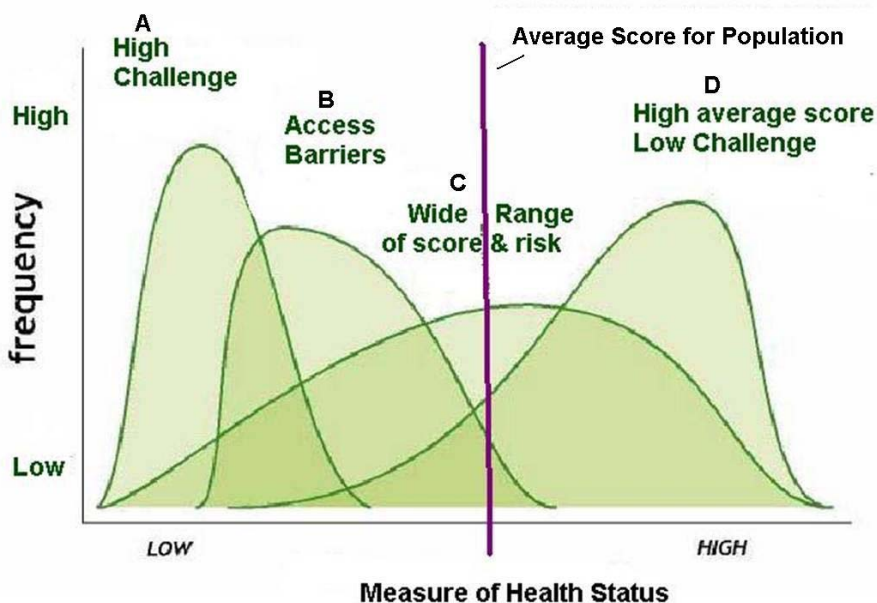
A

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 health status, this would likely **widen existing health inequalities** as advantaged groups were better able to benefit from the programs.



B

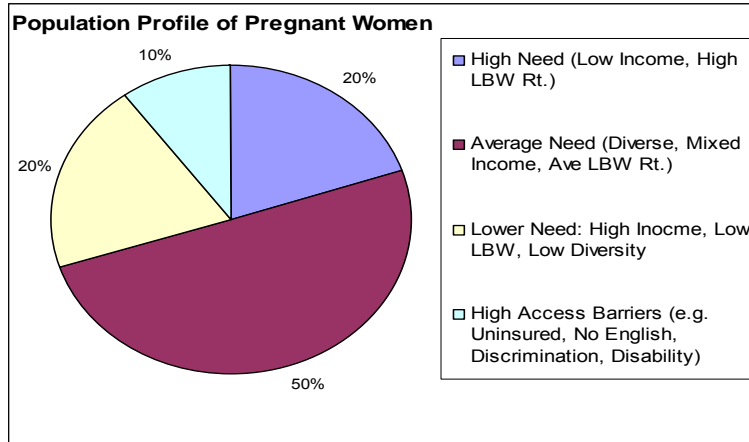
If resources were used **equitably** according to the different access to social determinants of health, access barriers or health status among different population groups or areas, this would likely **reduce existing health inequalities**, improving the health of the worst off the most, while at the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



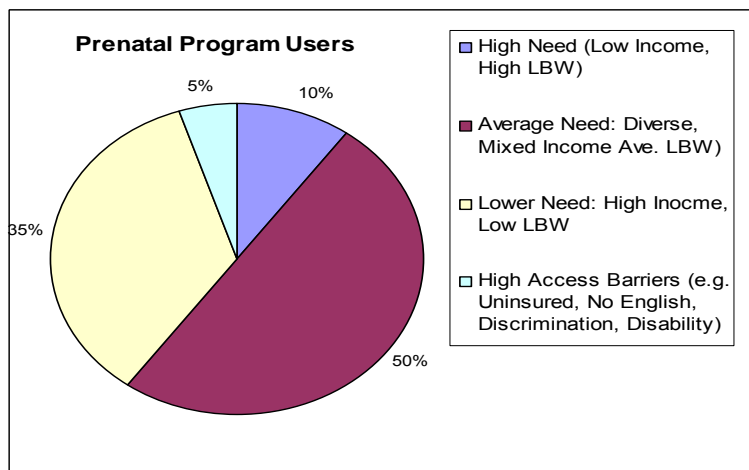
Back to our example of the population groups: equitable investment of resources would include:

- greater intensity of investment & tailored 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)

Case Study: Hypothetical



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 this estimated 30% of the population of Pregnant women with (High Need and/or High Access Barriers)



If they analyzed the profile of program users and found that these priority populations made up less than their target, this could indicate access barriers. 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. Comparing program users with

intended priority populations is a useful tool in planning and evaluation of effectiveness of strategies to reach priority populations through reducing access barriers.

Case Example: Triangulated Multi-method Program Evaluation

Harm Reduction (Needle Exchange) Evaluation conducted in London, Ontario, included multiple sources of data:

- Analysis of user statistics, needles out,
- Interviews with sample of frequent users (>5 visits)
- Interviews with low/one-time users, and
- 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 a basis for improving, growing and changing.

(London Ontario)

Back to the Future

By 2010, we may have compiled a lot of evidence about health inequities, priority populations, and effective strategies for reducing health inequalities. If we compile what we are doing to achieve health equity into one location, it might look like this:

Ontario Health Observatory (fictional website)				
Health Equity Atlas for Ontario	Topic-based Health Unit Reports			Equity Performance Measures
	<ul style="list-style-type: none"> ▪ Health Equity ▪ Nutritious Food Basket ▪ Other 			
Priority Populations (A Collection of Resources Compiled by PHUs)				
Refugees Recent Immigrants	Ethno-cultural and Racial Groups (Link to Ontario in Colour)		People Who Are Homeless or Marginally Housed	Sexual Orientation Lesbian, Gay, Bisexual, Trans-sexual
Aboriginal	Seniors	Children/ Youth	Rural Population	Gender Identity Male, Female, Trans-gender, Two- spirited
Low Income	Low Literacy	Limited English Fluency	People with Disabilities	Link to more.....

This vision may include collaborations with other sectors and organizations to produce an Ontario Atlas of Population Health Inequalities by 2010. This central location could have a link to every health unit's report on the cost of the nutritious food basket, health equity reports and indicators, and a virtual Health Equity Report Card where legislation and policies are monitored for their impact on health equity – a kind of virtual health inequality impact assessment watch site. This would be similar to the health observatories that already exist in UK and US.

To minimize the use of resources, instead of initiating new research projects to fill local gaps, health units can take studies done elsewhere to their priority populations, conduct validation sessions and collaborative planning and only pursue additional research and data collection if new issues and questions emerged from that process.

The fast pace of advances in technology and systems for data analysis might result in linked data bases and automated analysis of core equity indicators and performance measures in the future. Then epidemiologists and analysts would spend less time cleaning data sets...and more time with analysis. Future Public Health epidemiological analysis would increasingly be multidisciplinary drawing on multiple social/health science disciplines to use a variety of methods in quantitative and qualitative research.

Appendix A. Rapid Equity Focused Health Impact Assessment
Australian Better Health Initiative
INITIATIVE: LIFESTYLE INTERVENTIONS FOR HIGH RISK DIABETES
3.1.1 Community based diabetes prevention program - pilot

Potential Size of Impact: Medium
 Likelihood of Impact: Speculative

Populations Affected	Whole of Population	Age	Gender	Socio-economic Position	Ethnicity	Place of residence
Identified in Proposal						√
Added in Appraisal		√		√	√	√

What is the initiative trying to do?

This strategy aims to develop and evaluate pilot community-based diabetes prevention strategies to increase intensive lifestyle interventions for those at high risk of diabetes. The initiative is based on evidence from programs in Finland and the U.S. It is proposed the pilot operate in two areas, one rural and one metropolitan. It is not clear how the community component of the program will be implemented as the current focus is currently on working at an individual level.

Is there evidence of inequality?

There is clear evidence of differences in risk related to rurality, disadvantaged communities, and some cultural and linguistic groups. There is also likely to be system inequity in capacity to deliver these programs in equitable ways. There is a higher prevalence of impaired glucose tolerance in lower socioeconomic communities, but lower rates of both screening and referral of people with pre-diabetes to diet/physical activity programs.

Who may be disadvantaged by the initiative?

Lifestyle interventions disadvantage those with less capacity and resources to access such programs and implement suggested lifestyle changes, who are generally those at greater risk of diabetes. This may be compounded by lack of health workers to undertake assessment and referral tasks. The involvement of private referral services (eg dieticians or physical activity programs) and the threshold cost of these services which will act as a barrier to referral will be more of an issue in disadvantaged communities

Unanticipated impacts

For community initiatives to be fully equitable (especially in reaching the disadvantaged) these need to be within an integrated primary health care framework that links all chronic disease programs with community based initiatives. This ecological approach is not mentioned here and may lead to limited improvements, particularly for more disadvantaged groups.

Equity Recommendations for implementation

- Focus of initiatives* requires clarity regarding the individual service delivery focus or the ecological model of the Finnish program, as disadvantaged communities are more likely to benefit from a more ecological and integrated approach.
- Network with other jurisdictions* to access and share learnings about diabetes prevention programs conducted throughout Australia.
- Focus on priority populations* should be in areas where there are sizeable pockets of disadvantage. Focussing the program across an entire area is unlikely to be able to achieve change.
- Assessment advice and referral* to be based on referral points that have low or no cost, and timely access (that is, short or no waiting times).
- An analysis of barriers* to screening for high risk (pre diabetes) and referral should be conducted for low SES groups in each locality.
- Establishing goals* requires the use of bi-lingual educators.

http://www.hiaconnect.edu.au/files/Rapid_EFHIA_of_ABHI.pdf .

Appendix B. Health Equity Audits

Health authorities across the UK are required to include strategies to address national health inequalities targets in their plans and performance targets. Centrally coordinated tools support local health authorities in developing strategies, setting targets, and measuring performance by providing access to equity audit tool kits, community health profiles, baskets of local indicators, health needs maps, national standards, population comparators, indices of deprivation scores and ranking, and research. Much of this is provided through twelve public health observatories (nine in England) that vary in scope and location (university, hospitals, public health, city).

Example: Equity Audits and Equity-focused Health Impact Assessments (Box)

Health Equity Audits (HEAs) are a required activity of local health planning areas. HEAs systematically review inequities in the causes of ill health, and in access to effective services and their outcomes for a defined population. Actions make services more equitable thereby reducing inequalities. Many of these Equity Audits address public health issues that are relevant to public health in Ontario, e.g. Coronary Heart Disease, smoking cessation, access issues, home visiting and children's services, diabetes, maternity and infant health, sexual health, cancer, mental health, teenage pregnancy, Black and minority ethnic groups, etc. The types of inequities included were those based on geography/deprivation index, age, gender, and ethnicity.

An **equity lens** refers to 'a metaphorical pair of glasses that ensures people ask 'who will benefit?' (Signal 2002). An equity lens would be applied throughout the development cycle to ensure that the proposal was developed, implemented and evaluated taking due account of equity.

An **equity audit** is used to identify the differential needs of targeted population groups usually in local areas and to set priorities. It would be conducted during the needs assessment and planning. The principal function of EFHIA is to assess a specific proposal (be it a policy or practice) at an appropriate stage in its development, when there is still an opportunity to modify it, to ascertain

- How it will (or does) impact differentially on groups within the population?
- What the nature of those impacts might be (or are)?
- Whether the differential impacts will be (or are) inequitable?
- In the light of the findings, what, if any, recommendations or changes should be made to it so that inequities are reduced and positive impacts are enhanced?

Ideally EFHIA is undertaken prospectively so that changes can be made before the proposal

- Whether the differential impacts will be (or are) inequitable?
- In the light of the findings, what, if any, recommendations or changes should be made to it so that inequities are reduced and positive impacts are enhanced?

Ideally EFHIA is undertaken prospectively so that changes can be made before the proposal is finalised and implemented – hopefully reducing the potential for inequalities in health status to arise or worsen. Despite the potential for confusion with evaluation however EFHIA can also be used retrospectively where it is being used *as a way of looking backwards in order to move forwards*.

[http://notes.med.unsw.edu.au/CPHCEWeb.nsf/resources/CHETRErpts1to5/\\$file/EFHIA_Framework.pdf](http://notes.med.unsw.edu.au/CPHCEWeb.nsf/resources/CHETRErpts1to5/$file/EFHIA_Framework.pdf)

* Health Development Agency. 2005. Health equity audit. A baseline survey of primary care trusts in England. Ww.hda.nhs.uk

Appendix C. Equitable Resource Allocation in Public Health

Experience with public health needs-based resource allocation in Ontario suggests:

- There are precedents for needs-based/needs-adjusted resource allocation that aims to achieve service equity, reduce access barriers and minimize avoidable inequalities in health
- Resource allocation strategies that do not take differences in need, access barriers, health status into account, can have the effect of widening inequities and in some cases have been shown to increase risk or worsen health (e.g. bicycle injuries among children)
- Tools and strategies exist which can be used to ensure equitable investments to provide a better chance for all residents to achieve optimum health
- Models require stakeholder critique and evaluation to ensure that:
 - the best available evidence and indicators are used and these are sensitive to disparities;
 - the weighting of variables is appropriate to their relevance for predicting health needs and service costs;
 - the transformation of indicators and weights results in the fairest possible distribution;
 - that organizations and communities are not penalized for having made progress in improving health and reducing health inequalities;
 - stakeholders have an opportunity to see the impact of changing variables, formulas, etc., to understand the tradeoffs that may need to be made to achieve a model that provide the fairest outcomes for all communities; and to make suggestions that can be considered by those producing the model.
 - A commitment be made to improve models over time, including efforts to correct deficiencies in available data and indicators.

Recommendation:

- That all levels of government: use resource allocation models that address differences in needs of residents in different communities and aim to reduce health disparities among population groups; involve stakeholders in reviewing assumptions, model inputs (rates, indicators, calculations), and impacts in order to achieve transparency, fairness and understanding of the strengths and limitations of decision options: and, seek to improve resource allocation models over time (e.g. by correcting data deficiencies).

Demonstration Equitable Funding

Needs-adjusted approaches to Public Health funding have been used in Ontario since 1996. A method that was first developed for distributing budget cuts¹ was adapted and used for allocating funds for new programs such as Heart Health and Healthy Babies, Healthy Children. In 2000, the model was reviewed and updated² to provide the province with a tool that could be used in developing future funding levels for provincial/municipal cost-shared public health programs or in deciding how future resources could be allocated.

The approach recognizes that equal allocations or per capita allocations could widen inequalities among health unit populations with unequal needs or unmet needs. Key indicators of service needs and service costs used in the model were:

- **percent low income:** (strongly related to differences in health status and a good predictor of the need for health services;
- **premature mortality:** (potential years of life lost before age 75); represents deaths most amenable to prevention by public health strategies;
- **linguistic diversity:** recognizes it costs more to make services accessible to ethnoracially diverse populations; and
- **geographic dispersion:** rural and northern health units have costs associated with travel distances and satellite offices.

Each indicator for each of the then 37 health units was standardized to the provincial average and then multiplied to create an Equity Adjustment Factor (EAF) for each health unit. The population of each health unit is multiplied by this factor. The budget for allocation includes at least two components: a fixed amount for per capita allocation and an amount to be distributed according to differences in needs (equity budget). Each health unit's share of the fixed total budget is its percent of the total provincial population. The equity budget is divided among health units based on each health unit's share of the sum of all health units' equity adjusted populations.

In allocating funding for Healthy Babies Healthy Children, the model used:

- **children age 0-4** as the population variable;
- **low birthweight rate and percent low income families with children** as the needs indicators; and,
- **linguistic diversity and geographic dispersion** as the service cost indicators.
- The fixed/equity ratio was 40% per capita and 60% needs-adjusted per capita. The original formula (1997/98) has undergone some adjustments as the program has expanded and evolved (e.g. addition of a base amount, updating census and birth data, inclusion of a low education indicator, square rooting the indicators for some of the values to narrow the variation and adding the postpartum public health nursing component).

For examples on how this model has been adapted for programs within a health unit and in other health services contact dpatychuk@sympatico.ca.

¹ Towards Equitable Funding of Public Health, 1996

² Provincial Funding Formula Work Group, 2000

Using Spatial Techniques to select sites or allocate resources

Using Spatial Techniques to Assess Accessibility of Sexual Health Resources

This study examined the relationship between accessibility of sexual health service sites and sexual transmitted infections (STI) rates in Toronto neighbourhoods. Spatial techniques to assess the distribution of services and STI rates were used to identify priority areas for planning. Sexual health services appeared to be concentrated in areas of high STI rates. However, pockets of opportunity (i.e. high STI incidence rates and low accessibility) were also identified. Further exploration is underway to identify youth-friendly non-traditional sites for condom distribution that may reduce access barriers.

A Few Resources

- University of Michigan School of Public Health - Free downloadable course available through www.sph.umich.edu/iscr/mphtc/courses
Measuring Health Disparities Computer-based Course MHDID0806.
This course examines the language of health disparity to support common understanding and shows how to calculate different measures of health disparity
- An Alberta website that has compiled useful resources: <http://www.health-in-action.org/node/200>
- A few Ontario websites with Health Equity information:
www.HealthEquityCouncil.ca
www.wellesleyinstitute.com/issues/health-equity/overview
- Tackling Health Inequities Through Public Health Practice: A Handbook for Action Edited by Richard Hofrichter. W.K. Kellogg Foundation ©2006
http://www.naccho.org/topics/justice/upload/NACCHO_Handbook_hyperlinks_000.pdf
- Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an emergency (useful for other programs as well)
http://www.bt.cdc.gov/workbook/pdf/ph_workbook_draft.pdf
- Various documents on Health Equity Audits can be accessed on PHO sites via <http://www.pho.org.uk>; • *Health Equity Audit Made Simple* is available on the Health Development Agency site at <http://www.hda.nhs.uk>
- Centre for Health Equity Training, Research and Evaluation. School of Public Health and Community Medicine, University of New South Wales has many useful documents beyond the ones references in the previous pages (Rapid Equity-focused health impact assessments, and Equity-Focused health impact assessment) See also Health and Equity Profiles, Project Report 2003 (Harris and Harris). <http://notes.med.unsw.edu.au/CPHCEWeb.nsf/page/Reports>
- Undoing Racism in Public Health: A Blueprint for Action in Urban MCH. Provides guidance, tools and resources.
<http://webmedia.unmc.edu/community/citymatch/CityMatCHUndoingRacismReport.pdf>