Access Alliance
Multicultural Health and Community Services

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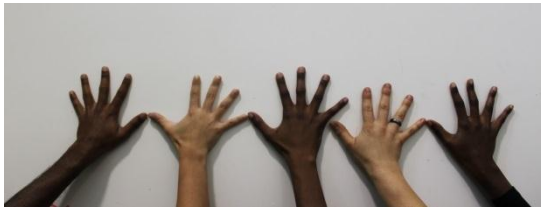

Equity Indicator

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Equity Indicators for Access Alliance:

Equity indicators will ensure health with dignity for the vulnerable populations i.e. '… populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level'[1]. This includes those at risk due to *socially-produced factors* (e.g. low income, limited education, unemployment/ precarious employment, poor housing, discrimination due to culture, race or sexual orientation) and those at *risk for biological or physiological reasons* (e.g. genetics, sex, age)[1].

Vulnerability = ∑(Social vulnerability + Biological vulnerability).

Equity interventions will address:

1. Structural dimension
    a. Organizational Culture[1,2]
        i. Does the current operational plan of Access Alliance incorporate identification and planning for priority populations? If yes, what is the process?
        ii. Does Access Alliance have a mechanism to ensure that operational planning includes a health equity assessment of programs and services?
        iii. How have programs and services changed or been developed based on the health equity assessment?
        iv. Does Access Alliance's strategic plan describe how equity issues will be addressed?
        v. Does Access Alliance participate in local poverty reduction efforts?
        vi. Does Access Alliance staff reflect the diversity of the community?[2]
            a) % of staff that reflect center priority populations (e.g., culturally, linguistically, etc.)
            b) Evidence of culturally-specific programming
            c) % of clients from vulnerable groups aligned with community
            d) % of population needs-based planning
        vii. Is Access Alliance organized to support socio-cultural competency?
            e) Increase in % of clients being offered services in their language of choice
            f) Increase in % of encounters that involve discussion of a psychological or social issue (rather than only medical)
            g) Evidence of staff education on social inequity or cultural safety
            h) Client satisfaction stratified by determinants of health

[1] Ontario Public Health Association. (Oct 2013). Health Equity Indicators.
[2] AOHC. [Jun 2015]. Model of Health and Wellbeing Evaluation Framework & Data Entry Manual.[PPT]
http://www.aohc.org/sites/default/files/documents/C4_Richmond%20D_Eval%20Framework%20DEM%20AOHC%20Conference%202015.pdf

b. Sociodemographic Dimension[3,4]
    i. Race/Ethnicity
    ii. Country of origin
    iii. Gender
    iv. Sexual Orientation
    v. Education
    vi. Poverty (Household Income/ # persons support by income)
    vii. Religious or spiritual affiliation
    viii. Language of contact

2. Marginalization Dimension[3,4,5]
    i. *Residential instability* (living alone, youth 5-15 years, persons per dwelling, living in an apartment building, married, home owner, moved within last 5 years)
    ii. *Deprivation* (education, employment, lone-parent families, receiving government assistance, LICO, homes needing major repair);
    iii. *Dependency* (child or old age, labour force participation)
    iv. *Ethnic concentration* (recent immigrants, visible minorities).
    v. Food security

[3] AOHC. [Jun 2015]. Model of Health and Wellbeing Evaluation Framework & Data Entry Manual [PPT]. http://www.aohc.org/sites/default/files/documents/C4_Richmond%20D_Eval%20Framework%20DEM%20AOHC%20Conference%202015.pdf

[4] World Health Organization (2008). 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. Geneva. http://www.who.int/social_determinants/final_report/en/index.html.

[5] Pan-Canadian Public Health Network, Indicators of Health Inequalities, August 21, 2009. [cited June 19, 2012] Available at: http://www.phn-rsp.ca/pubs/ihi-idps/pdf/Indicators-of-Health-Inequalities-Report-PHPEG-Feb- 2010-EN.pdf

3. Health and Wellness Dimension[5]
    a. Self-rated Health indicators (used to gauge perceived health and well-being of those ages 12 and over, unless otherwise stated):[2]
        i. Self-rated physical health
        ii. Self-rated mental health
    b. Behavioural, psychosocial, and biological factors (Ages 18 and over- three or more of the following self-reported variables)[6]
        i. Overweight (BMI>24.9)
        ii. Physical inactivity
        iii. Currently smoking
        iv. Binge drinking
    c. Ages 65 and over
        i. influenza immunization
        ii. Participation and activity limitations
        iii. HbA1C
4. Community Development and Health Promotion Dimension
        i. Level of satisfaction of the clients with the programs / services
        ii. Sense of Belonging[7] (AOHC Be Well- CIW)
        iii. Community Vitality (AOHC Be Well- CIW)
        iv. Percentage of programs designed to reflect community needs
        v. Frequency of community consultations and methods
        vi. Percentage of programs providing access to the targeted members of the community

[6] Provincial Health Services Authority. (March 2013). Promoting Health Equity - Choosing Appropriate Indicators: Literature Scan.p7, Vancouver BC.

[7] Wellbeing Assessment. (Jan 2016). AOHC Be well survey for CIW

Literature Review/ Environ Scan

A. Canada

For Canada, the following indicator dimensions have been identified as priorities in tracking inequities: *income/SES, age, gender, education, ethnicity, Aboriginal status and geography (rural/urban)*. **[Pan-Canadian Public Health Network, Indicators of Health Inequalities, August 21, 2009. [cited June 19, 2012] Available at: http://www.phn-rsp.ca/pubs/ihi-idps/pdf/Indicators-of-Health-Inequalities-Report-PHPEG-Feb-2010-EN.pdf]**

The indicators used in both the **CAN-Marg and ON-Marg** are:

i) *Residential instability* (living alone, youth 5-15 years, persons per dwelling, living in an apartment building, married, home owner, moved within last 5 years);
ii) *Deprivation* (education, employment, lone-parent families, receiving government assistance, LICO, homes needing major repair);
iii) *Dependency* (child or old age, labour force participation); and
iv) *Ethnic concentration* (recent immigrants, visible minorities).

[Matheson F, et al. (may 2012). CAN-Marg – Canadian Marginalization Index, User Guide, Version 1.0. Centre for Research on Inner City Health. St. Michael's Hospital. Retrieved from: http://crunch.mcmaster.ca/documents/CAN-Marg_user_guide_1.0_FINAL_MAY2012.pdf.]

B. Ontario

B1. Ontario Public Health Association

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. 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.

- Does the current operational plan of the BoH incorporate identification and planning for priority populations? If yes, what is the process?
- Does the BOH have a mechanism to ensure that operational planning includes a health equity assessment of programs and services?
- How have programs and services changed or been developed based on the health equity assessment?
- Does the Board of Health's (BOH) strategic plan describe how equity issues will be addressed?

- Does the Board of Health (BOH) participate in local poverty reduction efforts? **[Ontario Public Health Association. (Oct 2013). Health Equity Indicators.]**

B2. Association of Ontario Health Centres (AOHC)

1. Do centre staff reflect the diversity of the community?	• % of staff that reflect centre priority populations (e.g., culturally, linguistically, etc.) • Evidence of culturally-specific programming • % of clients from vulnerable groups aligns with community • % population needs based planning
2. Is the centre organized to support socio-cultural competency?	• Increase % of clients being offered services in their language of choice • Increase in % of encounters that involve discussion of a psychological or social issue (rather than only medical) • Evidence of staff education on social inequity or cultural safety • Client satisfaction stratified by DOH
Race / ethnicity	• Required Equity Indicators* Accessibility, Health Equity
Country of Origin	• Required Equity Indicators* Accessibility, Health Equity
Household income	• Required Equity Indicators* Accessibility, Health Equity
# persons support by income	• Required Equity Indicators* Accessibility, Health Equity
Education	• Required Equity Indicators* Accessibility, Health Equity
Household composition	• Required Equity Indicators* Accessibility, Health Equity
Disabilities	• Required Equity Indicators* Accessibility, Health Equity
Sexual Orientation	• Required Equity Indicators* Accessibility, Health Equity
Religious or spiritual affiliation	• Required Equity Indicators* Accessibility, Health Equity
Type of Housing	• Required Equity Indicators* Accessibility, Health Equity
Language of Contact	• Required Equity Indicators* Accessibility, Health Equity

[AOHC. [Jun 2015]. Model of Health and Wellbeing Evaluation Framework & Data Entry Manual.[PPT]. http://www.aohc.org/sites/default/files/documents/C4_Richmond%20D_Eval%20Framework%20DEM%20AOHC%20Conference%202015.pdf]

C. Toronto

C1. Toronto Public Health

The fifteen key indicators of health inequality by income include life expectancy at birth, premature mortality, self-rated health, low birth weight, readiness to learn, teen pregnancy, smoking, physical inactivity, overweight/obesity, disease measures (lung and breast cancer, CVD, Chlamydia, gonorrhoea) and dental visits. [**An Unequal City: Income and Health Inequalities in Toronto: 2008**]

C2. Toronto Central LHIN

Indicators specific to Toronto Central - Local Health Integration Network (TC-LHIN) priority populations:

1. Length of physical restraint use among patients with mental illness, pressure ulcer rate (to address issues of the elderly) and lower extremity amputations among patients with diabetes.
2. Health outcomes that include:
    (a) Mortality: infant mortality and/or under 5 mortality, maternal mortality, adult mortality and LEB
    (b) Morbidity: at least three nationally relevant morbidity indicators, such as prevalence of obesity, *diabetes*, under-nutrition and HIV
    (c) Self-rated mental and physical health
4. Measures of inequity, with sex, *at least two* social markers (e.g. education, income, occupational class, ethnicity/race), at least one regional marker (e.g. rural/urban; province), at least one summary measure of absolute health inequities between social groups, and one summary measure of relative health inequities between social groups.

C3. St. Michael's Hospital *indicators* are:

1. Equity in hospital care: cultural concordance between patients and staff, accessibility of language services, patient satisfaction, perforated appendix rate, minimally invasive cholecystectomy rate, use of analgesics for pain management, and rate of death within 30 days of hospital admission for acute myocardial infarction. [**Gallaher G, et al, Measuring Equity of Care in Hospital Settings: From Concepts to Indicators (2009). St.Michael's Hospital [cited July 10, 2012] from: http://www.stmichaelshospital.com/pdf/crich/measuring_ equity.pdf**]

D. British Columbia

Self-reported health indicators (used to gauge perceived health and well-being of those ages 12 and over, unless otherwise stated):

1. *Self-rated health*, physical inactivity, smoking, alcohol intake, overweight or obese (ages 18 and over),
2. *Risk factors* (ages 18 and over - three or more of the following self-reported variables: physical inactivity, BMI of 25 or more, current smoker or binge drinker), influenza immunization (ages 65 and over); and
3. *Participation* and *activity limitation* (ages 65 and over).[p7]

Three Key Areas of Equity in Health Care As outlined in Towards Reducing Health Inequities:

1. Availability of services
    a. timely diagnostic and treatment services
    b. lack of primary care physicians
    c. limited availability of specialty services, such as mental health and substance use programs, and obstetrics, maternity, and gynecological services within urban centres, services may be unavailable due to limited hours of operation, long waiting lists, or because they are not covered under Medicare
2. Accessibility of services
    a. literacy, language, gender, ethnicity, and geography
    b. health literacy (language, use of jargon or advanced vocabulary, web-based rather than paper media, complexity of the health care system)
3. Acceptability of services
    a. culturally competent services and safe spaces
    b. respectful and responsive to the diverse health beliefs, practices, and cultural and linguistic needs of patients Health literacy and cultural competency have emerged as key components underlying the availability, accessibility, and acceptability of the health system.

[Provincial Health Services Authority. (March 2013). Promoting Health Equity - Choosing Appropriate Indicators: Literature Scan. Vancouver British Columbia]

E. World Health Organization: Health Equity Framework

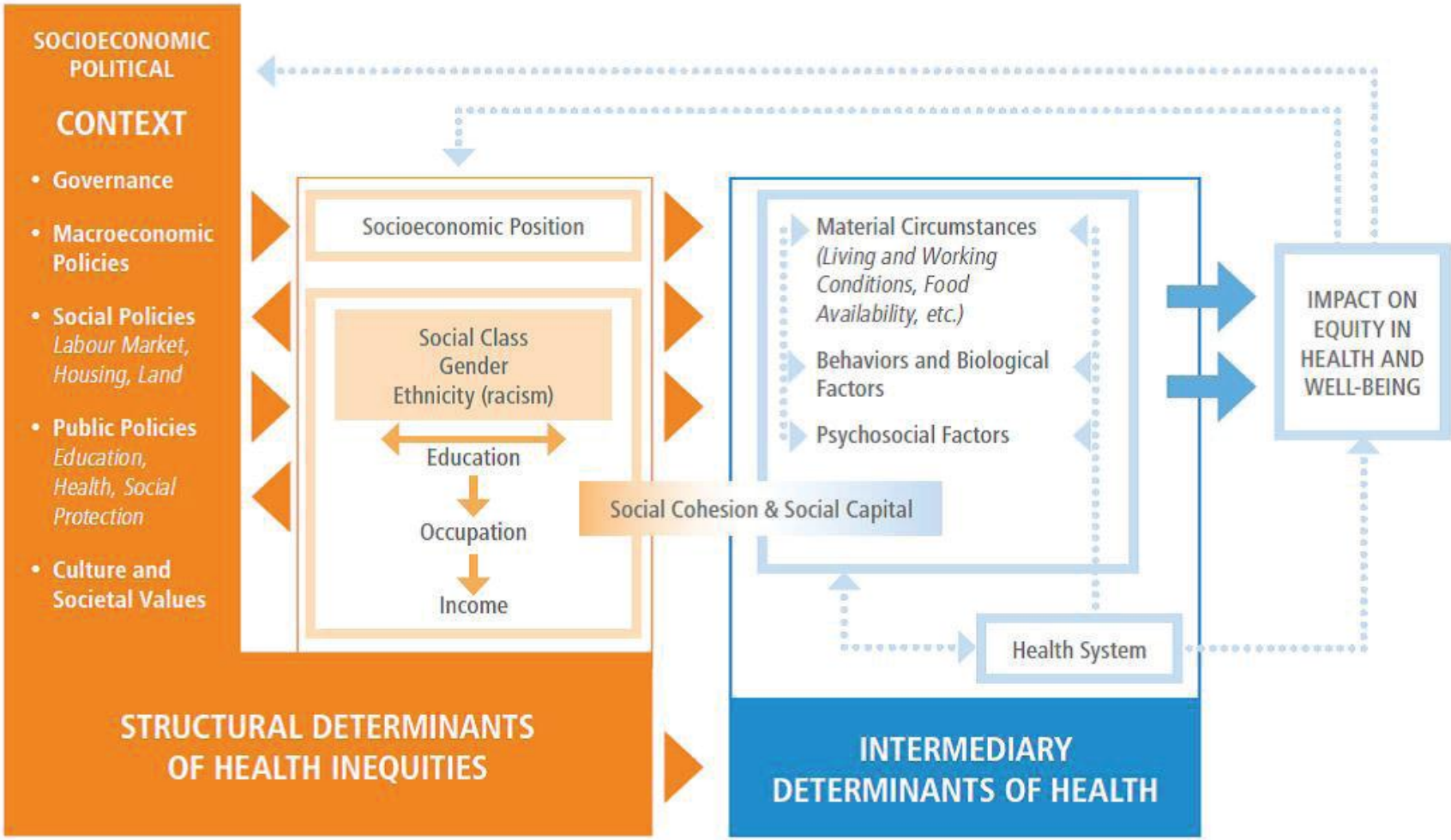
1. **Structural**
    a. Socioeconomic political
        i. Governance
        ii. Macroeconomic policy
        iii. Social policy, e.g., labour market, housing land policy
        iv. Public policy, e.g., education, employment
        v. Culture and social value
    b. Socioeconomic position
        - Class, Gender, Ethnicity, Education, Occupation, Income

2. **Intermediary determinants**
    a. Material circumstances
        i. Living and working conditions
        ii. Food availability
        iii. Behaviours and biological factors
        iv. Psychosocial factors

3. Cross Cutting Equity Dimension	**Definition**
Income Quintile	Can measure income or more broadly, SES, in 20% increments
Aboriginal vs. Non-Aboriginal	
Urban vs. Rural	Statistical area classification (SAC), which codes census subdivisions.
Immigrant vs. Non-Immigrant	
Persons below Low-Income Cut-off vs. Persons above LICO	LICO identifies households below which a family would be spending at least 20% or more than an average family on food, shelter and clothing.
Education level of education (elementary to secondary to university	
Ethnicity	
Homelessness	Definition needs to be developed
Age	Can be measured as specific age, or within groupings
Gender	male/female or broader categories that include lesbian, gay, bisexual, trans-gendered
Employment Ratio of employment to population	
Neighbourhood Deprivation	Various options available, including INSPQ Deprivation Index, CAN-Marg, VANDIX

[World Health Organization. (2008). 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. Geneva 2008. http://www.who.int/social_determinants/final_report/en/index.html.]

Figure 2. Conceptual framework of the social determinants of health



Source: Solar and Irwin, 2010[6]