Health Equity Indicators

October 2013

HEALTH EQUITY INDICATORS

CONTENTS

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 politics.[1]

Health inequality refers to the differences, variations, and disparities in the health achievements of individuals and groups.[2] 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 unfair.[2]

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 everyone.[3] 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 economy.[4]

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. [5][6][7][8]

At least four key roles have been identified for public health action on health determinants to reduce health inequities[9]:

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[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] 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

[4] 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.

[5] 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.

[6] 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-content/uploads/2011/01/20080109110739filmZ8UVQv2wQFShMRF6cuT.pdf.

[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.

[8] 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.

1. To assess and report on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities/inequities.
2. To modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations (i.e., do planning and implementation of existing programs considering inequities).
3. To engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs (i.e., when looking at the collectivity of our programming for 'x', where are the gaps?).
4. Lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in health determinant/inequities.

This report provides readers with possible indicators that could be used at the local public health level in Ontario to document and measure board of health activity and action on health equity. These indicators may function in two ways:

1. To describe the level of compliance with considering the determinants of health as outlined by the Ontario Public Health Standards (OPHS) and Organizational Standards; and
2. To promote self-reflection and quality improvement in the integration of social determinants and reducing health inequities in health unit work.

It is our hope that rather than being viewed as a "score", these indicators will provide a basis for a health unit to measure progress towards maximizing the engagement in all four roles to reduce health inequities.

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[9] National Collaborating Centre for Determinants of Health. (2010). Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. Available from: http://nccdh.ca/images/uploads/Environ_Report_EN.pdf

INDICATOR 1

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

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

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

Notes: The Population Health Assessment and Surveillance Protocol of the Ontario Public Health Standards state that information may range in depth and breadth from an e-mail or a summary sheet with brief highlights to a comprehensive report.[10] For the purposes of this indicator, comprehensive reports which are released publically should be included. In the report, the social determinants of health must be explicitly linked to health status. A descriptive report of the economic and social elements alone, while it may be important, would not qualify for this indicator (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).

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 every health unit and the selection and frequency in which health measures are reported may also vary in accordance with local priorities and needs.[11] In terms of the timeframe in which reports should be counted, the health unit should select a relevant time frame in which to report to get the best estimate of the extent to which the reporting includes disaggregation by social determinants (for example, annually, on a cycle based on data updates, or a scheduled report structure). This period may vary from health unit to health unit.

This indicator should not be considered as representative of the extent or depth to which a health unit is addressing health inequities. However, purposeful reporting has been identified as a promising practice to assist local public health programs in reducing social inequities.[12] This reporting may include the relationships between health and social inequities in all health status reporting; presenting publicly and intentionally the evidence about health inequities which may be considered part of a strategy for change (e.g., stratify findings by socio-economic status (SES) versus controlling for it) and can also help

[10] Population Health Assessment and Surveillance Protocol. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/population_health_assessment.pdf

[11] Ibid.

[12] Sutcliffe, Snelling, Laclé. Implementing local public health practices to reduce social inequities in health. EXTRA/FORCES Intervention Project. Sudbury & District Health Unit, 2010. Available from http://www.sdhu.com/uploads/content/listings/FINALIPPRSDHUMay2010.pdf

track changes over time (i.e., are the disparities getting better or worse over time?).[13] Some or all of these elements may be present in a health status report.

Limitations: Smaller health units may have difficulty disaggregating on social determinants 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 quantity of information. As well, 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.

[13] National Collaborating Centre for Determinants of Health. (2010). Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. Available from: http://nccdh.ca/images/uploads/Environ_Report_EN.pdf

INDICATOR 2

Does the current operational 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).	☐ Yes ☐ No
b. Standardized and explicit template (e.g. separate column for priority population).	☐ Yes ☐ 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.	☐ Yes ☐ No
e. Health unit has a comprehensive list of possible priority populations (e.g. list of 10 subgroups) for consideration.	☐ Yes ☐ No
f. Health unit relies on staff/management to interpret definition of priority population.	☐ Yes ☐ 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)	☐ Yes ☐ No
h. Based on only "socially-produced" differences in health outcomes/risk factors (e.g. income, housing, education)	☐ Yes ☐ No
i. Based on only qualitative data. Please describe:	☐ Yes ☐ No

j. No standard, explicit or agreed-upon interpretation of definition (i.e. inconsistent)	☐ Yes ☐ No
k. Other:	

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.

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.

INDICATOR 3A

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.	☐ Yes ☐ No ☐ Unable to determine
2. Health equity assessment of programs and services is required by the BOH.	☐ Yes ☐ No ☐ Unable to determine
3. The BOH provides a standardized health equity assessment tool for staff to assess programs and services.	☐ Yes ☐ No ☐ Unable to determine
4. Please list and/or attach any health equity assessment tools used in the development of your operational plans. *Insert link, copy tool or append to survey.*	

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 outcomes.[14]

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 is 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

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

tools that can be accessed to structure the consideration of health equity in program and service review are listed in Appendix A.

This question asks about the availability of a tool for public health practice in the organization to help the field understand the baseline routine use of health equity assessment. It does not ask about the nature or quality of the tool's implementation, which are also important. Use of a health equity assessment tool can develop and progress as knowledge, skills, and the number of people dedicated to using the tool grow. In addition, organizations can enable the use of health equity assessment by promoting its use, requiring it use and or allocating financial, human or material resources to support its use. Given the baseline use of health equity assessment determined by this question, the quality of implementation could be surveyed in the future.

INDICATOR 3B

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?	☐ Yes ☐ No ☐ Unable to determine
2. Please describe one or 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 needs.[15]

Health equity assessment can be part of the actions to ensure that programs and services meet community need. This question allows for submission of qualitative examples of any program changes resulting from use of health equity assessment. This can help contribute to the evidence base of the impact health equity impact assessment.

[15] 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.

INDICATOR 4

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 equity.[16]

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.

[16] 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.

INDICATOR 5

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

Questions	Response
1. Is your BOH involved in local poverty reduction efforts?	☐ Yes ☐ No ☐ Unable to determine
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. As income is a powerful social determinant of health, poverty reduction has been prioritized as an area for local board of health action.

Many communities have established local coalitions and partnerships to work with local partners and stakeholders. For example, in Hamilton, this work is being done by the Hamilton Roundtable for Poverty Reduction. In Peterborough, it is the Peterborough Poverty Reduction Network that is taking the lead. In Ottawa, city council has created a strategy. Local boards of health will be able to determine whether a local poverty reduction network or strategy exists. This question would establish whether the board of health is engaged in local efforts. Example of possible activities that would be captured by this indicator include work on policy, such as a living wage policy or by-law; advocacy to increase social assistance rates; producing a local poverty report card to document local progress etc.

If no local poverty reduction efforts exist, this indicator could still be used to capture work, and any results, that the board of health is doing independently.

CONCLUSION:

As a result of the consultation, several changes have been made to the final version of the indicators. Explanations and examples have been added, for example, to the indicator regarding poverty reduction work, to clarify the question and rationale. The original indicator #2, on trends over time, has been removed and recommended for deployment at a later time. Indicator #3, on priority populations has been edited to remove duplication.

The health equity indicators are now ready to be field tested. We will continue to monitor and refine these initial five, with the hope that new indicators may be developed over time, as public health's work on health equity matures and evolves.

The alPHa-OPHA Health Equity Work Group is very grateful to everyone who took the time to participate in the survey and provide us with feedback to help shape the final version.

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%20_2_.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

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/heia/tool.aspx

2. Hyndman B, Tyler I, Seskar-Hancic D. A proposed equity assessment framework for Ontario's public health units. 2011.

3. Region of Waterloo. Public Health. Process for Determining Priority Populaitons. Available at: http://chd.region.waterloo.on.ca/en/search/index.aspx?strSearch=process%20for%20determining%20priority%20popualtions Retreived on November 9, 2012.

4. Seskar-Hencic D, Patychuk D. Putting it all together for health equity. 2008.

APPENDIX C

Indicator removed from this version following consultations; it is provided for information only

Indicator: What is the percentage of Board of Health reports on health status that include an analysis of the social determinants of health (SDOH) in the last five years?

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

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.

APPENDIX D

Summary of Results from Indicator Survey

In the fall of 2012, the alPHa-OPHA Health Equity Working Group developed a set of potential indicators that could be used to document and measure the work of Ontario's Boards of Health in addressing health equity and the social determinants of health. These indicators were derived directly from requirements articulated in the Ontario Public Health Standards and the Ontario Public Health Organizational Standards. The indicators were meant to facilitate shared learning across public health units in the province embarking, for most, on activities and work that is new or has been, up until now, not formally documented or shared.

Six potential health equity indicators were developed by a small working group. A consultation with the field was undertaken in February 2013 to determine how feasible and useful these indicators might be for boards of health and their employees.

To launch the consultation, OPHA hosted a webinar on February 13 to allow for a thorough discussion of the proposed indicators. Over 100 people attended the webinar and the slides were posted on the OPHA site for further reference.

A request to have one person from each health unit participate in a survey was sent out to all Medical Officers of Health on February 8. In the end, a total of 36 individuals responded.

Not all Indicators were addressed by every individual. Respondents were asked to identify on a scale of 1 to 5 whether:

1 - their health unit had the capacity to collect the information specified by the Indicator and;

2 – the Indicators usefulness to guide health unit action to reduce health inequities.

In each instance respondents were given an opportunity to provide feedback and to clarify their ranking. In every instance the number of comments received was less than those that responded to the survey question however, much of the feedback was specific, thoughtful and revelatory.

Results:

For Indicators 1, 2, 3, 4a, 5 and 6, over 50% of the surveyed group felt that their health unit had a "high" to "very high" capacity to collect the information specified by the Indicator. In one instance, that of Indicator 4b (a question about how programs and services had been changed due to the use of a health equity impact assessment tool), respondents were mostly unsure whether their health units would be able to gather the data necessary to inform the Indicator.

In contrast, when surveyed as to the importance of Indicator 4b, 42.4% selected it as being useful and another 27.3% felt it was "extremely useful" to guide health unit action to reduce health inequities. Only

12.1% felt the Indicator would have little to no usefulness. This demonstrated the uncertainty related to the feasibility and indicated a need to pilot this indicator before finalizing it for further use.

When requested to respond regarding each Indicators' usefulness to guide health unit action to reduce health inequities, Indicators 3, 4a and 4b were most highly ranked. Respondents were unsure about the usefulness of Indicator 6 and fewer than 50% felt that it was "useful" or "very useful" and 42% were unsure. A review of the comments revealed that more clarification was needed, and this has been now done. In addition, respondents asked for more examples to illustrate anti-poverty work that could be done by board of health staff.

Fewer than 50% of the respondents indicated that Indicator 2 would be "useful" or "extremely useful". Approximately 33% felt that it was not useful. Feedback suggested that the Indicator was too similar to Indicator 1 and was open to interpretation and this may have affected responses. In conclusion, indicator 2 has been removed from the final set of indicators and may be more useful at a later time, once boards of health have been reporting on the social determinants of health long enough to show trends over time.

In general, there were requests for clarification and many comments that indicated a lack of clarity around what exactly an Indicator was attempting to measure. In response to this, more examples as well as definitions for all key terms have been added. Following is a brief summary of responses for each Indicator and general question.

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

Of the 36 responses to this question 52.7% identified that the health unit's capacity to collect information specified by Indicator 1 was “high” to “very high”. Fifty percent (50%) of the respondents indicated that this Indicator was “useful” to “extremely useful” in guiding their health unit's actions to reduce health inequities. Approximately 16.7% were neutral and the remaining 19.4% indicated “low” to “not at all useful”.

There were a total of 28 comments. The respondents identified several issues with the wording of the Indicator which they felt could be confusing and open to interpretation. There were repeated requests for clarification of key terms like "capacity", "SDOH", "possible" and "report". Health units' inability to collect the necessary data because of size or the lack of an epidemiologist was also highlighted as obstacles to using this Indicator. There was a suggestion to add constraints to the denominator so that it reads "where practical" or "where relevant".

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?

Sixty percent (60%) of the respondents identified their health unit as having a “high” to “very high” capacity to collect the information specified by Indicator 2. Approximately 44.4% felt that this Indicator would be “useful” to “extremely useful” in guiding their heath unit’s actions to reduce health inequities. Twenty-two percent (22.2%) were either unsure or neutral with the remaining 33.3% indicating this was “low” to “not at all useful”.

There were twenty-six comments. There were concerns that this Indicator would be difficult to determine without the availability of the long-form census. However, some commented that although very similar, it was more useful than Indicator 1 because it includes greater analysis. As with Indicator 1 there were issues with the wording which some felt was vague and that it would benefit from the use of simpler more direct language.

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?

There were 35 responses to this question. Over sixty-two percent (62.8%) indicated that their health unit's capacity to collect information specified by Indicator 3 was "high" to "very high". Over fourteen percent (14.2%) indicated a capacity that was "low" to "very low". Over seventy-one percent (71.4%) of the survey group rated this Indicator as either “useful” or “extremely useful” in guiding health unit action to reduce health inequities. 8% felt it had little to no use at all.

There were twenty-two comments. There were concerns about the flow of the options accompanying this question and it was deemed necessity to revisit the order in which they flow. Overall responses were mixed with some units indicating that they were developing a template to aid this process while others indicated a lack of capacity to take action. Once again there was a need to define key terms, in this case "priority populations".

Indicator # 4a: Does the Board of Health have a mechanism to ensure that operational planning includes a health equity assessment of program and services?

62.8% of the 35 who responded to this Indicator determined that their health unit's capacity to collect information specified by Indicator 4a was "high" to "very high". Twenty percent (20%) anticipated challenges to collecting this information. 74.2% agreed that this Indicator would be "useful" to "extremely useful" in guiding their health unit's action to reduce health inequities. 11.4% ranked it as "low" to "not at all useful" with the remainder signaling that they were either neutral or unsure.

There were 17 comments. Among the survey group several indicated that their health unit either had or was working to develop an HEIA and other tools. There were some conflicting opinions around the need and readiness to identify a standardized option. No one commented that it was unnecessary however, concerns were expressed about the appropriateness of a tool for all divisions/departments given inherent organizational politics. Furthermore, there was some disappointment that the question is merely a start and fails to go beyond simply acknowledging the existence of a mechanism.

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

Of the 33 responses a third (33.3%) believed their health unit had the capacity to collect this information while 27.2% were either unsure or neutral. The remaining 39.3% indicated either "low" to "very low" capacity in this regard. As to whether this Indicator would be useful in guiding their health unit's actions to reduce health inequities, 69.6% of responses ranked the Indicator as being "useful" to "extremely useful". Additionally 18.1% were either neutral or unsure.

There were 21 comments. The respondents identified capacity as a significant factor in a health units ability to apply this Indicator. They predicted that the process of collecting the information could be extremely labour intensive yet not necessarily fruitful. Several responses rejected the idea of implementing this as an annual evaluation and suggested that changes over time should be the goal. Other feedback indicated that the questions/statements related to the Indicator were clear.

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

There were 34 responses of which 64.7% felt that their health unit had a "high" to "very high" capacity to collect the information specified. 52.9% agreed that Indicator 5 was either "useful" or "extremely useful" to guiding their health unit's actions towards reducing health inequities. 29.4% were neutral or unsure and the remaining 17.6% felt it would have little to no use in this regard.

There were 23 comments. The respondents felt that the required information would not be found in a strategic plan but instead is more suited to an "operational" plan. Responses indicated that a number of health units use the strategic plan to outline the direction that will be pursued but not necessarily "how". Furthermore, there were concerns that this Indicator is too high level in that it would measure an acknowledgement of the issues but does little to guide actions that reduce health inequities. Finally, suggestions were made as to how the question could be reframed to satisfy the intent of the Indicator.

Indicator # 6: Does the Board of Health participate in local poverty reduction efforts?

Of the 35 responses to this question 65.7% felt that their health unit had a high to very high capacity to collect information specific to this Indicator. Approximately 17.1% were unsure or neutral and the remaining 17.1% had “low” to “very low” capacity. 42% identified this Indicator as “useful” to “extremely useful” to help guide health units’ actions towards reducing health inequities and an equal percent was either unsure or neutral about the same. Only 14.2% felt that this Indicator had little to no use at all.

There were 24 comments. Overall, responses indicated uncertainty with regards to the purpose of this Indicator. Specific objections were that it seemed too general. The respondents admitted to being perplexed as to how the Indicator would help to measure and improve performance over time. Greater clarification is needed with regards to terminology and the use of the concept "poverty reduction." Those surveyed repeatedly requested a rationale for examining solely this concept and few came to the realization that most issues of inequity can be traced back to poverty. Therefore, it may be beneficial to clarify this in the questions or backgrounder document. Also, the Indicator could benefit from examples of activities that Boards of Health participate in and the intensiveness and or level of their involvement, to facilitate understanding of the question.

General question # 1: Please specify any additional Indicators that should be used to track public health unit activities to reduce health inequities.

There were 15 responses. The respondents suggested creating Indicators that measure training efforts for health equity; that measure the number of HEIAs completed per year or the number of HEIA actions/evaluations completed per year; that measure advocacy efforts related to public health or with regards to the nutritious food basket; and that measure efforts to engage priority populations in program and or service development.

General question # 2: Please specify any revisions to additional sections of the health equity Indicators documents.

There were eight responses. The respondents suggested including more examples as part of the Indicators. There were several calls for a more concrete rationale for the existence of the document and the purpose of the Indicators such as what they would be used for. Furthermore, a definition of priority populations that is consistently applied was requested.

General question # 3: Please note any additional comments you have regarding the proposed health equity Indicators and accompanying information.

There were 17 responses. The responses were varied and in some cases contradictory. They spoke to individual perspectives of health units and did not embrace an overarching theme. There were questions about the applicability of these Indicators for all PHUs given that some are further along than others. In particular, it was noted that the Indicators were not exhaustive and in some cases limited to “yes”/”no” responses which was constrictive.