COVID-19: Health Equity Perspectives

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The Social Determinants of Health Division is **PHAC’s focal point** for advancing knowledge and action on the social determinants of health and health equity.

**Key areas of activity** include:

- Health inequalities measurement, monitoring, and reporting
- Sex and Gender-Based Analysis Plus (including COVID-19 response)
- Health Impact Assessment
- Community-based funding (Mental Health of Black Canadians)
The health of Canadians is primarily influenced by the social, economic, and physical circumstances in which we live. These factors are known as the social determinants of health (SDOH), and include:

- income and income distribution
- employment and working conditions
- food security
- housing
- Disability (barriers to inclusivity)
- social exclusion
- gender (discrimination)
- race (racialization and racism)
- Indigenous identity (colonization, discrimination)
- sexual orientation and identity (LGBTQ2+ discrimination)

Health inequities – unfair, systematic, and avoidable differences in health status – are driven by inequities in these SDOH.

Contrary to early media commentaries referring to COVID-19 as “the great equalizer”, the pandemic has revealed and amplified the pervasive and persistent social and health inequities that exist within Canada.
Health Inequities in Canada Prior to COVID-19

Selected findings from PHAC’s Health Inequalities Data Tool (health-infobase.canada.ca/health-inequalities):

Social Determinants of Health

The prevalence of:

- **Food insecurity** among those Newfoundlanders and Labradorians living with severe functional impairment is **5.8 times** that of residents without impairment.

- Youth (aged 15-24) not in school or employed among Inuit inside Inuit Nunangat and First Nations living on reserve in Newfoundland is **3.0 and 2.8 times** that of non-Indigenous residents, respectively.

Behavioural Risk Factors

The prevalence of:

- Moderate to high physical activity levels among **low-income Newfoundlanders and Labradorians** is **0.7 times** that of high-income Newfoundlanders and Labradorians.

- Smoking among **low-income Newfoundlanders and Labradorians** is **1.9 times** that of high-income Newfoundlanders and Labradorians.
Health Inequities in Canada Prior to COVID-19 (cont’d)

Selected findings from PHAC’s Health Inequalities Data Tool (health-infobase.canada.ca/health-inequalities):

### Underlying Health Conditions

The prevalence of:

- **Obesity** among **low-income women in Newfoundland** is 1.7 times that of high-income women in Newfoundland.

- **Diabetes** among **low-income Newfoundlanders and Labradorians** is 2.2 times that of high-income Newfoundlanders and Labradorians.

### Mental Health

The prevalence of self-reported *fair or poor mental health* among:

- **Low-income Canadians** is 4 times that of high-income Canadians.

- **Canadians who identify as gay/lesbian or bisexual** is 1.7 and 3.1 times that of heterosexual Canadians, respectively.
Some Canadians are disproportionately affected by COVID-19, in terms of greater risk of:

- exposure and infection
- developing severe complications (including death)
- being impacted by the unintended social, economic, and health consequences of the public health response

Understanding of “COVID-19 vulnerability” continue to evolve as new evidence emerges


Increased vulnerability due to pre-existing social and/or material deprivation
e.g., low income, housing insecurity, unstable employment, stigma and discrimination

Increased vulnerability due to age and/or pre-existing health conditions
e.g., diabetes, obesity, hypertension, cardiovascular disease, asthma

Increased vulnerability due to employment in an high-risk occupation
e.g., healthcare, service industries, sanitation, public safety, food/agriculture

Among marginalized communities, vulnerabilities often intersect
In Toronto, COVID-19 is disproportionately affecting racialized groups...

COVID-19 case rate per 100,000 by ethno-racial group (data to August 16, 2020; N=4,560)

...as well as people living in lower income households

COVID-19 case rate per 100,000 by income group (data to August 16, 2020; N=2,672)

Social and Health Inequities Increase Vulnerability to COVID-19: Early Evidence from Montreal

In Montreal, confirmed COVID-19 cases are disproportionately concentrated in some neighbourhoods, such as Montréal-Nord and Ahuntsic-Cartierville.

Total confirmed COVID-19 cases per 100,000 people
As of June 8, 2020

These neighbourhoods are characterized by:

...large populations of racialized people

...low household incomes

...a high proportion of front-line workers

...families living in overcrowded housing

COVID-19 and Modifiable Behavioural Risk Factors for Chronic Disease

Prior to the COVID-19 pandemic, only 35% of 5- to 17-year olds met physical activity recommendations within the Canadian 24-Hour Movement Guidelines for Children and Youth, and fewer than one in five adults met the Canadian Physical Activity Guidelines.

With physical distancing and self-isolation restrictions, the prevalence of physical inactivity, sedentary behaviour, unhealthy eating, isolation, and lack of community support may be increasing for some Canadians.

- Also other factors that put some Canadians more at risk of chronic diseases may remain high following the resolution of the pandemic

It is more important than ever to address the social determinants and behavioural risk factors for poor health and health inequities given the potential benefits for overall health, well-being, and resilience during and following the COVID-19 pandemic.

Tools for Applying a Health Equity Lens to COVID-19 Response, Adaptation, and Recovery Efforts

- Developed by the Ontario Ministry of Health to support equity-based improvements in policy, planning, program or service design and decision-making

### HEIA Template
The numbered steps in this template correspond with sections in the HEIA Workbook. The workbook with step-by-step instructions is available at www.ontario.ca/healthequity.

<table>
<thead>
<tr>
<th>Step 1. SCOPING</th>
<th>Step 2. POTENTIAL IMPACTS</th>
<th>Step 3. MITIGATION</th>
<th>Step 4. MONITORING</th>
<th>Step 5. DISSEMINATION</th>
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<tbody>
<tr>
<td>a) Populations: Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.</td>
<td>b) Determinants of Health: Identify determinants and health inequities to be considered alongside the populations you identify.</td>
<td>Unintended Positive Impacts</td>
<td>Unintended Negative Impacts</td>
<td>More Information Needed</td>
</tr>
</tbody>
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- Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)
- Age-related groups (e.g., children, youth, seniors, etc.)
- Disability (e.g., physical, blind/deaf, disabled or hard of hearing, visual, intellectual/developmental, learning, mental illness, addiction/substance use, etc.)
- Ethno-racial communities (e.g., racialized or cultural minorities, immigrants and refugees, etc.)
- Francophone (including new immigrant francophones.)
Tools for Applying a Health Equity Lens to COVID-19 Response, Adaptation, and Recovery Efforts (cont’d)

- Analytical tool for assessing the differential impacts of programs and initiatives on diverse groups of women, men and non-binary people

- Government of Canada-wide commitment to apply GBA+ to all federal policy and program activities, including PHAC’s COVID-19 responses

- Online training course and learning resources available at: https://cfc-swc.gc.ca/gba-acs/index-en.html