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When it comes to pandemics, no one can be left out

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The Wellesley Institute released today a research and policy report from Thomas Appleyard titled: *Bridging the Preparedness Divide: A Framework for Health Equity in Ontario's Emergency Management Programs***.** The report is available on the Wellesley Institute's web site at www.wellesleyinstitute.com.

One conclusion rings loud:

While everybody is affected by a pandemic, everyone is not affected equally. People with compromised health face greater risks, and those with less income have less ability to take the practical steps to mitigate their risk. For instance, people living in homeless shelters with dozens or even hundreds of others cannot simply "stay at home and avoid contact with others" – which is advice commonly given during pandemics.

Pandemic planning, and emergency responses when a pandemic hits, must be viewed through an equity lens. This policy paper raises critical questions and poses some key answers.

Bracing for a possible pandemic

As the world braces for a possible swine flu pandemic in the spring of 2009, the two questions that naturally arise are:

- What are the pragmatic steps that Ontario needs to take to ensure that ***all Ontarians*** are equally protected; and,
- If a pandemic is realized, how can we ensure ***all Ontarians*** will get equal access to the support and services (medical and non-medical) they require?

All Ontarians deserve equal attention when it comes to pandemic planning and pandemic resources, but not all Ontarians are equal when it comes to health status, nor are they equally able to take necessary steps to protect themselves or their families.

The Wellesley Institute recently published powerful new research which shows that the poorest Ontarians have substantially worse health outcomes, including respiratory illnesses[1]. Other research shows that recent immigrants, especially those from racialized communities, and Aboriginal people, also have lower health outcomes. Poverty and race are two factors that generate different health outcomes.

With the global health alert edging towards a full-blown pandemic, there is not the luxury of a long planning period to identify issues and set in place solutions. With a possible swine flu pandemic looming larger, emergency plans need to include an equity lens – which means that dollars and other resources need to flow to measures that will meet the special requirements of disadvantaged communities.

Ontario has recognized the critical need for health equity in its overall health care planning, but the government has not adequately addressed the specifics of health equity when it comes to pandemic responses.

The need for equity

In February 2009, the Wellesley Institute identified the need to examine Ontario's Emergency Management Program through a health equity perspective. As Canada's

[1] See *Sick and Tired, The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario* (2009) and *Poverty Is Making Us Sick, a Comprehensive Survey of Income and Health in Canada* (2008), both available from the Wellesley Institute web site .

leading pragmatic think tank focused on advancing urban health, the Institute has been at the forefront of examining the health equity landscape and developing innovative and implementable recommendations for reducing the health gap.

To this end, the Wellesley Institute commissioned Thomas Appleyard, an expert in emergency preparedness, to work with its staff to provide analysis and recommendations. These programs must be especially sensitive to equity issues as people who are marginalized and disadvantaged due to the impact of lower incomes, less education, newcomer status or other social determinants of health are the most at risk.

Building on the Ontario Government's commitment to reducing health disparities, further innovative equity work was undertaken by the Wellesley Institute's Dr. Bob Gardner for a new equity lens by which to view the health system and which defines health disparities as

"…differences in health outcomes that are ***avoidable, unfair, and systematically*** *related to social inequality and disadvantage."*

A brief history

In December of 2003, the Ministry of Health established an Emergency Management Unit to plan and coordinate provincial responses to emergencies that affect and impact health. In 2004, the province released the Ontario Health Plan for an Influenza Pandemic, and has updated it annually since.

In 2008, the Ministry of Labour announced a new influenza pandemic compliance strategy, which provided legal teeth to some preparedness requirements for our health system.

This pandemic influenza plan is the only emergency plan outlining responsibilities throughout the health system that the Emergency Management Unit has released. For this reason, there is particular emphasis on pandemic influenza in the examples and discussion in our report.

The policy aftermath of SARS also led to the establishment of Ontario's Agency for Health Protection and Promotion, which is currently building its infrastructure to play a leadership role in health emergencies. Meanwhile, health organizations of all stripes are fit-testing employees for respirators, stockpiling personal protective equipment, and developing plans for a range of health emergencies.

Building equity into our plan

The Ontario Health Plan for an Influenza Pandemic similarly recognizes the need to address health inequalities. The plan states:

"The [Ministry of Health and Long-Term Care], the Ministry of Community and Social Services, and local social service providers are developing a strategy to support vulnerable Ontarians and help ensure timely access to influenza assessment services."

The plan establishes equity as an ethical principle guiding the implementation of the plan; however, the brief discussion is essentially limited to health care access for patients and the obligation of health care institutions to ensure a sufficient supply of materials. There is also particular focus on the issues of antiviral and vaccine access. A more comprehensive, rigorous and deep approach to health equity is both required and possible. For example, a health-equity based approach to public health measures such as temporarily closing schools would outline what can be done to ensure that

school-based food programs are adequately replaced in the community.

Consequently, there is a need to identify people at risk through an equity lens. This is not to suggest that people in prisons, homeless shelters, overcrowded housing or people whose jobs entail exposure to the public during such an emergency must be top priority for vaccine. But unless factors such as exposure are listed as a consideration for prioritization, aggressive targeted campaigns for these groups are highly unlikely to emerge.

Findings and recommendations

Our findings indicate that four components are critical to health equity in this situation.

1) A clear expectation and modeling from public authorities that emergency management programming needs to include health equity considerations. For example, when[community mental health and addictions agencies are serving clients who are dependent on food banks, they should work with the food banks to ensure that clients will be able to get food during a pandemic.
2) A multi-sectoral coordinated approach to emergency management must be coordinated to ensure that people do not fall through the cracks in our system.
3) A parallel process for personal preparedness campaigns must complement institutional activities to ensure that the response to pandemics do not fail in part because the affected population is more vulnerable than authorities might assume.
4) An active and well-resourced role for the primary health care system must be the foundation upon which highly qualified staff (including training in disaster response), quick mobilization, priority to the protection of highly vulnerable persons, a rich vision of the mandate, an expansion of the tasks normally assumed by professionals, and the strategic positioning of home care services is built.

The Wellesley Institute has found that there is some evidence that general or universal health promotion programs can widen disparities as their messages tend to be taken up more by the more affluent and educated. In this case, **the disparity is the Preparedness Divide.**

For example, a health equity approach to planning will consider access to food during a large health emergency as a public resources priority. The concurrent focus on health equity and emergency management provides an opportunity to bring these fields together in a way that has not yet occurred in Ontario. Considering difference in vulnerability based on exposure to risks, likelihood of harm based on exposure and likelihood of receiving adequate care for harms would be very useful for the health sector.

It is through these actions that our research indicates that our public health authorities receive the best return on their actions and the public at large is best served including the marginalized and disadvantaged.

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The Wellesley Institute is dedicated to advancing urban health.

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