Briefing to Standing Committee on Health: Canada's COVID-19 response

Comments made by Dr. Kwame McKenzie, 7 July 2020

Wellesley Institute
advancing urban health

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Thank you for inviting me to speak at this briefing of the Standing Committee on Health.

I am the CEO of Wellesley Institute which is a think tank that aims to improve health and health equity through research and policy development focussed on the social determinants of health.

This morning you should have been given the executive summary of a briefing note we have submitted to the Standing Committee. The executive summary gives more detail on the recommendations I am making today. The full briefing note gives background and references to my comments.

I would like to thank Erica Pereira, the Procedural Clerk, for getting the executive summary translated so quickly.

A fair response

Survival for those on the Titanic, over a century ago, was directly related to their social status. 60% of those in first class lived, 42% of those in second class and only 24% of those in third class. The Titanic's escape plan was the same for everyone. But third-class passengers were in lower internal berths and had difficulty getting to lifeboats. The huge death toll was because there was not an adequate plan for them – though they were the passengers most in need.

Fast forward 108 years to Canada's COVID-19 response. This has been very good. But, like the Titanic we have not yet developed an adequate plan for our highest risk populations such as people in congregate living settings, those with lower incomes and racialized populations.

Our initial response was focused on flattening the curve, not who was under the curve. If we had focused on both we would have had a better response and we would have saved thousands of lives.

We now need four groups of actions to ensure that current and future responses to pandemics are equitable:

1) We need legislation that ensures that our public health responses, our health response and our social policy responses produce equitable outcomes;

2) We need equity-based Federal and Provincial COVID-19 health and public health plans;

3) We need equity-based social policy and recovery plans which ensure that the most hard-hit populations are served properly; and,

4) We need data streams, research and capacity building to ensure that we have good socio-demographic, race and ethnicity information on which to build and monitor public health, health and social policy interventions.

Recommendation 1. Legislate equity

We have seen significant racial disparities in infection rates and deaths in previous pandemics. During the H1N1 influenza pandemic in Ontario the South East Asian population were 3 times more likely to be

infected, the South Asian population 6 times and the black population were 10 times more likely than anyone else.

Despite this, we did not change our systems to collect socio-demographic data. And, we did not do research or sit with communities to find out why the disparities exist.

So, we went into COVID-19 without surveillance systems or knowledge that would help us identify and deal with racialized health disparities.

And then we set up a Titanic response, a one-size-fits-all, colour and culture blind pandemic plan which was predictably going to exacerbate health inequities.

Some have argued that this was negligent, I say that this should not be legal.

We have legislation for things that we care about. We do not leave them to the largesse of professionals, public servants or politicians. If we want public services to produce equitable health responses we should enshrine this in enforceable law.

Recommendation 2. Equity-based Federal and Provincial COVID-19 health plans

We would have a fairer response if we took a health equity approach to what is left of the first wave, to any second wave and to the recovery.

A health equity approach aims to decrease avoidable disparities between groups. It ensures that people with similar needs get the same pandemic response and people with greater needs get a bigger response.

There are plenty of evidence-based tools, such as health equity impact assessment, that could be used. They have been shown to be effective in public health in Canada.

But, working with at risk communities to develop strategies that allow them to protect themselves from COVID-19 will be vital.

Recommendation 3. Equity-focussed social policy and recovery plan

A heath equity approach recognizes that the risk of illness and the ability to recover are not linked to health interventions alone but also to the social determinants of health.

The Canadian Medical Association has calculated that 85% of our risk of illness is linked to social determinants such as income, housing, education, racism and access to healthcare. This offers significant policy opportunities for improving health. Many health disparities are avoidable.

COVID-19 harms health through the disease itself, side effects of the public health response, healthcare changes such as cancelled operations and the economy. These interact with the social determinants of health so that some parts of our populations are harder hit than others. Canada's Black populations have been hardest hit by COVID-19.

Our pandemic social policies and recovery plan need to be developed so that they decrease inequality and reach the hardest hit. Decreasing differential risk linked to the social determinants of health is an important intervention.

A focused recovery plan for the hardest hit populations would improve our response and make our at-risk populations more resilient.

Recommendation 4. Data, research and capacity building

Numbers have been vital in the fight against Covid-19. We have relied on the number of cases, deaths and the R- number to monitor the effectiveness of our strategies.

Numbers are also useful in indicating whether our interventions are working for everyone. To do this, we need disaggregated data.

We need better data streams on race and ethnicity and other social determinants of health for COVID-19 and for health in general. We need similar data for social policy. These data need to be good quality and there needs to be good data governance and accountability. Communities want a say in the control and use of their data.

Wellesley Institute recommends that Canada collects individual level socio-demographic data for COVID-19 including race and ethnicity; that Canada urgently undertakes innovative analyses with existing data to get as accurate a picture of disparities as possible; and, that Canada develops a strategy for ongoing socio-demographic data collection (including race and ethnicity), in health and for social policy.

But data is not an end in itself. Data has to be linked to meaningful strategies to try to decrease disparities. This will mean engagement with communities, research and action to develop equitable public health and social policy interventions.

Conclusion

Public health is the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society. Health equity interventions and the concept of the social determinants of health are important tools for helping us organize the best pandemic response. They are also a sound basis for health and social policy.

The one size fits all strategy led to a huge death toll on the Titanic. So far it has led to a significantly increased death toll for some groups in Canada's COVID-19 pandemic.

If we want a COVID-19 response and health system more fitting of the 21st century, we need legislation which ensures equity, we need equity based covid-19 pandemic plans, we need social policy and recovery plans focussed on decreasing current inequities and we need data streams and research which allow us to properly identify risk groups, build appropriate interventions and monitor their impact.

If we can put these in place we will move our good response to a great response and we will save lives.

Thank you
Dr. Kwame McKenzie