# *A Health Equity Lens Contributes to an Effective Pandemic Response: A Canadian Regional Perspective*

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As cases of COVID-19 began to increase in Ontario, Canada, throughout 2020, early evidence from surveillance and media highlighted disproportionately higher rates of COVID-19 infection, hospitalization and mortality among racialized and low-income populations. This disproportionate impact on underserved populations calls for a shift in approach away from what has traditionally occurred in health protection, that is the use of a universal approach which assumes everyone is affected and benefits equally from the same type and intensity of interventions. In this article, public health agencies are, therefore, being called to consider moving away from using a purely universal approach, often used in the control of communicable diseases, and apply a more tailored approach and use principles of health equity and proportionate universalism to reduce COVID-19 cases and their impacts among underserved groups and address health inequities exacerbated by the pandemic. We highlight examples from York Region Public Health, one of the largest health units in Ontario, to demonstrate areas of possible impact of this paradigm shift. It is clear that with a health equity lens applied to the pandemic response, the impact of COVID-19 can be further reduced and health inequities that predated the global pandemic can improve.

**Keywords:** health equity; public health; underserved populations; health promotion; COVID-19; social determinants of health

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## BACKGROUND

Health equity, a foundational part of public health, allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are (National Collaborating Centre for Determinants of Health, 2020). Health equity is where individuals and communities have the opportunity to reach their fullest health potential; however, advancing and achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust. Many underlying causes of health inequities relate to social and environmental factors which can include, but are not limited to: income, social status, race, gender, physical environment and education (Public Health Ontario, 2022).

In this commentary, we present arguments that demonstrate the importance of adopting a health equity lens to achieve an effective and equitable public health response to a pandemic situation and how it necessitates moving away from a purely universal approach to a robust response that better meets the needs of the community. Moving away from a purely

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universal approach may include instead using tailored interventions or proportionate universalism to support prevention and treatment. Taking such approaches typically involves identifying and ensuring interventions are informed by individuals that best understand the unique needs and challenges of their own communities. The ability to apply such a health equity lens requires an emergency response structure that balances responsive actions with equity planning considerations. This paper will illustrate the considerations involved in applying such an approach and how these were integrated by York Region Public Health (YRPH), a regional health department supporting one of the largest Public Health jurisdictions in Canada.

At YRPH, the Health Emergency Operations Centre (HEOC) was convened in January 2020, to facilitate coordination of the pandemic response. Over several months of HEOC coordinating and responding to high rates of COVID-19 and its impacts among underserved populations, YRPH's HEOC identified the need to apply a health equity lens. Our COVID-19 cases were being disproportionately represented in a number of geographic locations which prompted members of the community, as well as organizations servicing those areas, to advocate for additional community support, as well as concentrated public health efforts to reduce the higher transmission rates within their local communities. Without dedicated staff resources to address various health equity issues and to coordinate activities within HEOC, a need was identified and in June 2020, PH formed a Health Equity Collaborative that consists of a public health and preventive medicine physician, health equity program manager, two health equity public health nurses and a health promoter. Prior to the COVID-19 response, each of these respective roles had been dedicated to building and establishing networks within the community and among organizations that work closely with underserved populations within York Region. The work of this program was strongly guided by the National Collaborating Centre for Determinants of Health (2013a) framework for integrating health equity into public health practice: assess and report (e.g., identifying socioeconomic factors correlated with high infection rates, collecting race and income-based data on confirmed COVID-19 cases), modify and orient interventions (e.g., ensuring communications materials are accessible), partner with other sectors (e.g., engaging with social services to ensure wrap-around supports for cases), and to participate in policy development (e.g., advocating for policies that may provide paid sick time to ensure compliance with self-isolation).

## THE COVID-19 PANDEMIC HAS NOT AFFECTED EVERYONE EQUALLY AND A UNIVERSAL AND PRIMARILY HEALTH PROTECTION APPROACH DOES NOT SUFFICIENTLY ADDRESS TRANSMISSION

In practice, health equity has been applied to the control of chronic or noncommunicable diseases given their multifactorial etiologies and a clear recognition of the disproportionate impact of these diseases (e.g., obesity, heart disease) on underserved populations (Cancer Care Ontario and Public Health Ontario, 2012). Health equity itself fits within the primordial prevention which addresses those underlying economic, social and environmental factors that lead to chronic disease (Ministry of Health and Long-Term Care [MOHLTC], 2018).

Communicable diseases, on the contrary, are often treated in practice as if they are more "universal" in nature, affecting everyone equally and programming related to communicable diseases often may take on a more health protection-based approach (e.g., responding to case and contact management and enforcement activities applied universally) (Semenza & Giesecke, 2008).

However, since the start of the COVID-19 pandemic, there has been growing evidence that existing underserved populations are disproportionately affected by COVID-19 and have higher rates of infection, hospitalization and mortality from COVID-19, compared with those who are not marginalized (Government of Canada, 2020; Public Health Ontario, 2020). Contributing factors to the growing disproportionate rates and more severe health outcomes of COVID-19 specifically experienced by equity-seeking groups, likely include, but are not limited to:

- Preexisting health disparities linked to socioeconomic factors (e.g., precarious work without paid sick leave) (Government of Canada, 2020; Public Health Agency of Canada [PHAC], 2020)
- Inequities in accessing health care and social services (e.g., access to testing sites) (PHAC, 2020)
- Barriers to following COVID-19-related public health recommendations (e.g., language barriers; socioeconomic conditions such as crowded housing, limited access to transit, ability to secure personal protective equipment; (Bambra et al., 2020; PHAC, 2020)
- Psychosocial aspects negatively impacting health (e.g., racism or sexism) (Government of Canada, 2020; PHAC, 2020)

Without concerted action to address the above factors transmission will continue to occur within impacted communities. For example, as COVID-19 cases decreased following the first wave, underserved communities continued to experience an increase in cases in the summer of 2020 (Regional Municipality of York, 2020). Most notably, this was observed among seasonal temporary foreign farm workers, where crowded living conditions exacerbated spread and transmission within this group. This demonstrates that although total cases may fall, underserved communities continue to be susceptible and unintentionally become carriers and transmitters of COVID-19 in the larger community. This may also remain true in light of differences in vaccine uptake among different groups, including low-income and racialized groups (University of Toronto: RiskLab, 2020).

## A HEALTH EQUITY APPROACH USING TAILORED APPROACHES AND/OR PROPORTIONATE UNIVERSALISM FACILITATES A MORE ROBUST PANDEMIC RESPONSE

A proportionate universalism approach means resources and services are available and accessible proportionate to the degree of need (Carey et al., 2015). At times, this may be accompanied by more tailored interventions that differ from universal approaches, because they more specifically prioritize and address the unique assets and needs of high-risk populations.

To better understand who these groups are in York Region that may be differentially affected by the pandemic, the Health Equity team participated in several stakeholder consultations between August and September 2020. Leaders of local community and service agencies, such as those that provide wraparound services (health care, social services, settlement services, mental health supports), were consulted as proxies for the communities they serve, as were professional public health staff who continued to serve groups at high risk for infection and disease burden in York Region.

Key discussion topics with stakeholders included:

- Resident experiences during the different stages of the pandemic
- Awareness and understanding of public health information
- Dissemination of information within local communities
- Opportunities to improve reach to underserved populations during and post pandemic

These discussions highlighted priority populations within York Region that were disproportionately impacted by the public health measures, as well as some of the major barriers these populations were experiencing since the start of the pandemic.

The conversations with stakeholders revealed that many of the universal public health actions taken during the pandemic (e.g., awareness raising/education, testing, case and contact management, masking policies) were not accessible and perhaps even harmful to those most underserved. For example, recommendations not to carpool were challenging for some essential workers without access to a vehicle to maintain and may have resulted in a greater risk of exposure on public transit. Also, health messaging for individuals to stay home if they were experiencing symptoms was especially challenging for individuals without access to paid sick time. From a broader perspective, health promotion messages relied heavily on electronic messaging through social media posts and frequent website updates, placing individuals with limited access and use of technology at a greater disadvantage.

It became evident that most often the missing piece was a more tailored approach. Tailored approaches (sometimes termed in the literature as targeted approaches) use selection criteria, such as income, neighborhood, health, or employment status, to tailor eligibility and access to programs and services for priority subgroups within the broader population (Marmot, 2013). Tailored approaches are based on a belief that structural factors (e.g., classism, sexism, racism and colonization) are barriers to equitable access to the determinants of health, and interventions directed to disadvantaged members of society are needed to close the health gap (National Collaborating Centre for Determinants of Health, 2013b). Tailored approaches and proportionate universalism can be complementary, as both can have a more explicit focus on the Social Determinants of Health with the ultimate goal being to achieve greater health equity. Proportionate universalism implies a need for the same type of action across society, albeit with varying intensity (e.g., promoting the same key messages but using print materials, radio and TV versus only digital communication), whereas tailored approaches may imply different sorts of interventions depending on the subgroup that is the target audience (e.g., promoting more tailored key messages about commuting to work keeping in mind an audience without access to personal vehicles) (Public Health Ontario, 2015). Either way, it is increasingly evident that a strictly universal approach can overlook socioeconomic factors and differences in structural ability to benefit from an intervention.

**TABLE 1**
**Interventions Actioned by York Region's Health Emergency Operations Centre (HEOC) Aimed at Improving Equity Among Priority Population Groups in the COVID-19 Pandemic Response**

| *Priority population* | *Intervention* |
|---|---|
| Congregate living facilities and group homes | Proactive COVID-19 testing of long-term care homes, congregate living facilities (such as shelters) and group homes in York Region |
| COVID-19 cases and contacts | Development and launch of a health equity training module for front line case management staff regarding socioeconomic data collection as the province of Ontario mandated the collection of sociodemographic data of COVID-19 cases; training was integrated into the mandatory orientation pathway for all case management staff |
| General vulnerable populations | Advocating for resources that may improve reach to vulnerable populations (e.g., language translation, print or radio messaging), and working with community leaders to improve this messaging |
| Low-income populations | Developing regional policy related to mandatory masking in York Region and the inclusion of equity considerations for low-income populations; as a result of this policy, over 300,000 masks were procured by York Region and distributed to vulnerable residents via food banks, shelters and other community agencies ahead of mandatory masking bylaws directed by the province. |
| General vulnerable populations | Development of a guidance tool to support HEOC communications partners to incorporate an equity lens in communication materials to ensure accessibility in communication products. The guidance tool was developed to provide tailored messaging during the COVID-19 response to meet the needs of diverse populations |
| General vulnerable populations | Exploring mobile supports and services for populations with limited access to services (e.g., testing, rapid testing opportunities, vaccination clinic planning) |
| Individuals isolating | Strengthening community resources and support referrals (e.g., emergency housing or food support) for individuals required to isolate |
| Temporary foreign workers | Input was provided on a proposed provincial policy for accommodation standards for federal temporary foreign workers; input involved advocating for the provision of clean drinking water, access to adequate health care supports (including mental health), provision of translated materials where needed, and accessibility of housing accommodations for this population. |
| Underhoused population | Development of guidance and support materials for the setup and operation of York Region's first isolation center for individuals who are underhoused in collaboration with York Region social services |

*Note.* HEOC = Health Emergency Operations Center.

With a health equity approach to inform the York Region HEOC response, tailored as well as proportionate universalism approaches were, therefore, identified and actioned in collaboration with membership among the HEOC, as well as relevant community stakeholders. Examples of specific interventions are further described in Table 1.

## IMPLICATIONS FOR PRACTICE AND CONCLUSIONS

During the present emergency response, the team experienced how the balance between health protection and health promotion can shift almost entirely to a health protection focus. Volatility of the response, capacity constraints and the historical application in practice of health protection to communicable disease threats, all contribute to this change. Unfortunately, this can lead to health equity being unintentionally sidelined during periods of higher acuity response or in resource-constrained settings. Ensuring that an equity-based approach does not remain overlooked requires strong organizational leadership, a willingness to dedicate resources to this work and an organizational acceptance of the importance of health equity.

Health equity is a foundational part of public health work and should not be ignored as part of the global pandemic response. A health equity approach, which

includes more tailored interventions and/or a proportionate universalism approach, facilitates an effective pandemic response by better supporting underserved populations and informing decision-makers of community needs. When framed thoughtfully, programs, services and data can support subpopulations, empower collective action and grow partnerships. An interdisciplinary team that brings together the skills of health promoters, public health nurses, senior leadership and emergency management will help to ensure that the core knowledge and competencies in the areas of social determinants of health, community engagement and crisis management are foundational to any health equity approach. Health promoters and public health nurses can leverage their skills in conducting needs assessments/situational assessments and use frameworks such as the IAP2 Federation's (2021) effective public participation framework and tools such as the Health Equity Impact Assessment (MOHLTC, 2021) to help inform and identify inequities in programming and ensure a community-driven response. Meanwhile, senior leadership can help ensure health equity and a focus on underserved groups are core to the organization's vision, mission and values to ensure prioritization during times of resource constraint; managing priorities in a crisis with health equity top of mind can help to redirect resources to best support an equitable response that continues to meet the demands of an ever-changing environment. Furthermore, a possible unintended benefit of implementing a health equity lens at the forefront is a better-informed workforce on the socioeconomic impacts of a crisis like COVID-19. As practitioners of public health, recognizing interactions between these factors and insights will continue to be instrumental in effective pandemic response, recovery efforts and to shape a healthier postpandemic society.

## Author Contributions

Authors contributed equally to the overall concept, design, writing, and review of the commentary. Specific details from the lens of York Region Public Health were provided by all authors who contributed to the draft and provided significant content support. All authors contributed to the key points and learnings, and critically revised multiple versions before submission. All authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

## Statement on Ethics

The engagement of service providers to inform an equitable COVID-19 response was a key and regular business activity for the health equity team. According to the York Region Internal Research Review Committee (IRRC) policies, analysis that is part of regular business practice of the program does not require ethics review, nor informed consent. Furthermore, personal or personal health information was not collected, and the population of interest (service providers) did not meet the IRRC definition of "underserved" or "vulnerable population."

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