Sudbury & District Health Unit
Service de santé publique

Priority Populations Primer

A few things you should know about social inequities in health in SDHU communities

Our health is influenced by a broad range of factors. These include genetics, individual lifestyles and behaviours, as well as the physical, social, and economic environments in which we live. It is important that we understand and act on these diverse determinants of health.

It is critical, however that we also understand that they do not have the same impact on everyone within our communities. Some individuals and groups are at greater risk of negative health outcomes due to their social and/or economic position within society.

Differences in health status experienced by different groups of people that are systematic, socially produced and unfair or unjust are defined as *health inequities*. For example, extreme heat events can result in negative health outcomes for all who are exposed. However, those who are homeless, poorly housed, and/or without access to transportation to cooling centres are at much greater risk for heat related illness than those who live in air-conditioned homes. In this example, those who are homeless or poorly housed would be considered a *priority population* – at greater risk of a socially produced health inequity.

Health equity Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

Whitehead M, Dahlgren G., 2006

Health inequities are differences in health status experienced by various individuals or groups in society that are systematic, socially produced (and therefore modifiable), and are judged to be unfair or unjust.

Public Health Agency of Canada, 2007

Priority populations are those population groups at risk of socially produced health inequities.

SDHU OPHS Program Planning Path, 2009

Some individuals and groups are at greater risk of negative health outcomes due to their social and/or economic position within society.

Examples of priority populations who may be at increased risk of socially produced health inequities include:

- People living on low incomes
- Aboriginal people
- Those with limited education
- Unemployed or underemployed people
- Those living in rural, remote and/or isolated communities
- People living with disabilities and/or mental illness
- People who are homeless or precariously housed
- Those who may be discriminated against due to culture, race, language, sexual orientation etc.

A few things you should know about SDHU communities…

- Poverty affects:
  - 13% of households in the City of Greater Sudbury (CGS)
  - 10% of households in Sudbury District
  - 8% of households in Manitoulin District
  - About 2,050 children under the age of 6 in the SDHU area

Incidence of Low Income by Select Groups in the City of Greater Sudbury, 2005

Selected Groups	Incidence of Low Income
Total population	13%
Unattached (living alone/with non-relatives)	36%
Couples (married or common-law)	5%
Female lone-parents	35%
Male lone-parents	16%
All seniors (65+)	8%
Seniors (65+) (living alone/with non-relatives)	26%
All children (<18)	15%
Children 0–5 years	20%

Source: A Social Profile of Greater Sudbury, Social Planning Council of Sudbury, 2009

- 17% of SDHU area adults (aged 25–64) have not completed high school.
- In 2006, 8% of adults in the CGS were unemployed, compared to 11% in Manitoulin District and 12% in Sudbury District. However, given current economic challenges, it can be assumed that these numbers have grown.
- 27% of SDHU residents report French as their mother tongue. This percentage varies from 28% in the CGS, to 3% in Manitoulin District.
- Almost 10% of SDHU residents identify themselves as Aboriginal. This includes 39% of Manitoulin District residents.
- 26% of SDHU households report spending more than 30% of their income on shelter costs. More tenant-occupied households in the SDHU area spent more than 30% of household income on housing than owner-occupied households. 16% of private dwellings in Manitoulin district were identified as requiring major repairs compared to 8% of private dwellings in the CGS.

Source: Demographic Profile: Sudbury & District Health Unit, 2008, unless otherwise noted.

Important note: The ways in which social inequities in health occur (their "causal pathways") are complex and include many social and economic factors (for example, income, education, language, distribution of power and resources, discrimination, etc.). Therefore, it is important to note that the demographics reported above may not always result in social inequities in health.

How do the characteristics of our communities translate into health inequities?

The following examples illustrate just a few of the ways in which differences in social and economic conditions may give rise to social inequities in health. They highlight differences in health-related behaviours among different members of our communities; behaviours are one important mechanism through which social inequities in health occur.

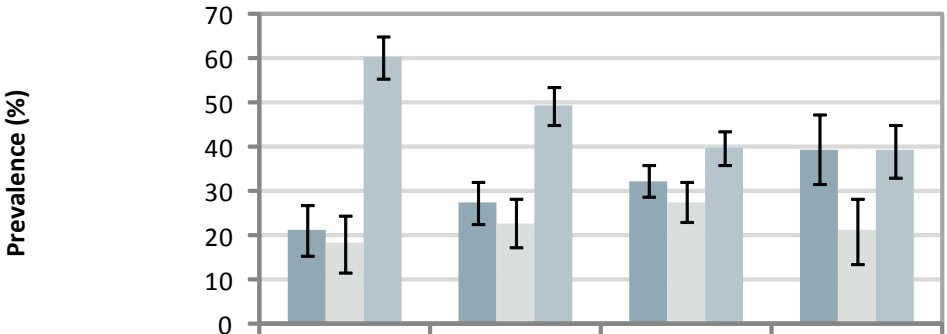
> "Health status improves at each step up the income and social hierarchy."
>
> *PHAC*

Income

Physical Activity by Household Income, SDHU, 2003–2007

In 2003–2007, there was a clear trend of decreasing physical inactivity with increasing household income. 60% of individuals with incomes less than $20,000 reported being physically inactive, compared to 50% and 40% of those with household incomes of $20,000–$49,999 and $50,000 +, respectively.

Physical Activity Index by Household Income Group, SDHU, 2003–2007



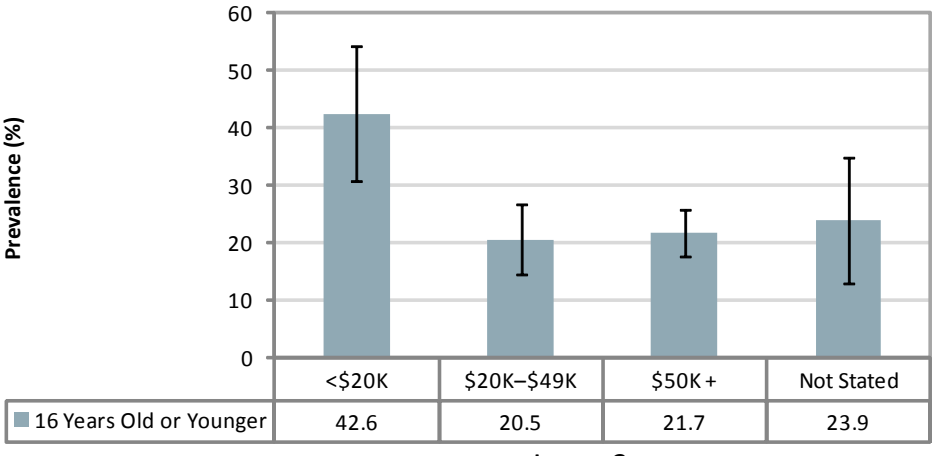
	<$20K	$20K–$49K	$50K +	Not Stated
Active	21.5	27.6	32.5	39.5
Moderately Active	18.3	23.0	27.7	21.2
Inactive	60.3	49.5	39.8	39.2

Source: Canadian Community Health Survey, 2003, 2005, and 2007.

Age of Sexual Debut by Household Income, SDHU, 2003–2007

43% of individuals living in households with incomes less than $20,000 per year reported having first had sexual intercourse at 16 years of age or younger. This rate is twice as high as reported by persons from households with higher incomes.

Sexual Debut Prior to 17 Years of Age, by Household Income Group, SDHU, 2003–2007



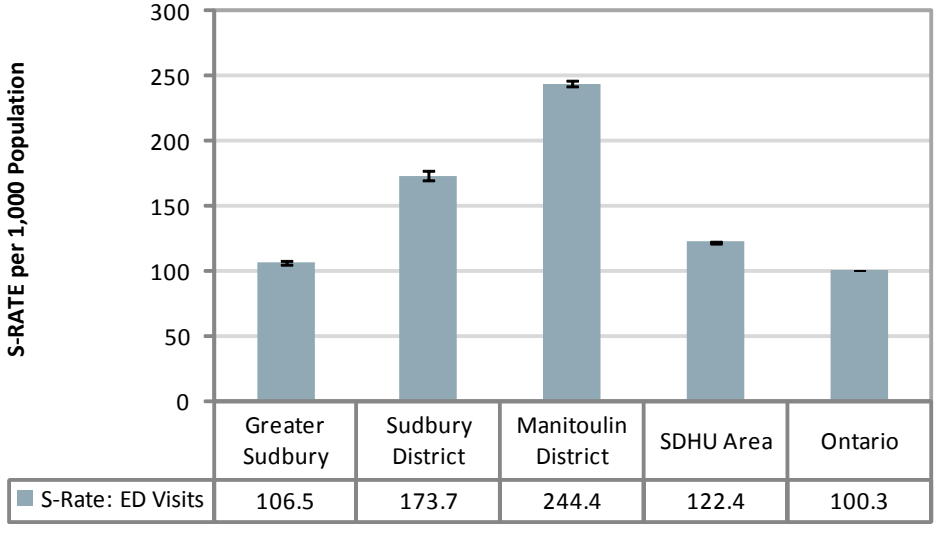
Source: Canadian Community Health Survey, 2003, 2005, and 2007.

Place

Rate of Injury-Related Emergency Department Visits by Place, 2004–2006

In 2004–2006, the overall age-standardized rate of injury-related emergency department visits in the SDHU area was 122 per 1,000 population per year. However, there was significant geographic variation in this rate throughout the SDHU area. The rate within the City of Greater Sudbury was 107 per 1,000. The rate within the Manitoulin District was more than double that, at 244 per 1,000.

Age-Standardized Rate of Injury-Related Emergency Department Visits, Various Geographic Regions, 2004–2006.



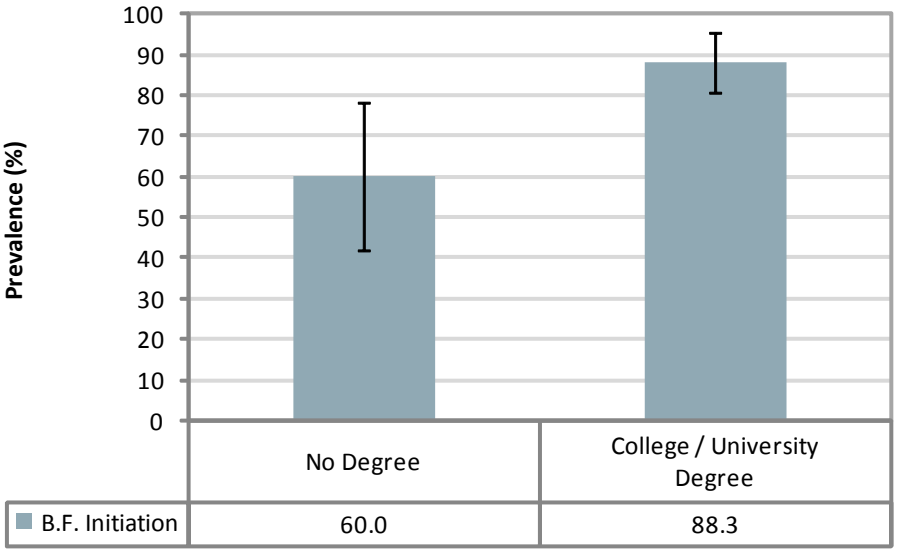
Source: Provincial Health Planning Database, extracted 2009.

Education

Breastfeeding Initiation by Educational Attainment, SDHU, 2003–2007

88% of mothers (that is, with a child under 5 years of age) with a college/university diploma/degree tried breastfeeding their last baby. This is significantly higher than mothers without a diploma/degree (60%).

Breastfeeding Initiation, by Educational Attainment, SDHU, 2003–2007

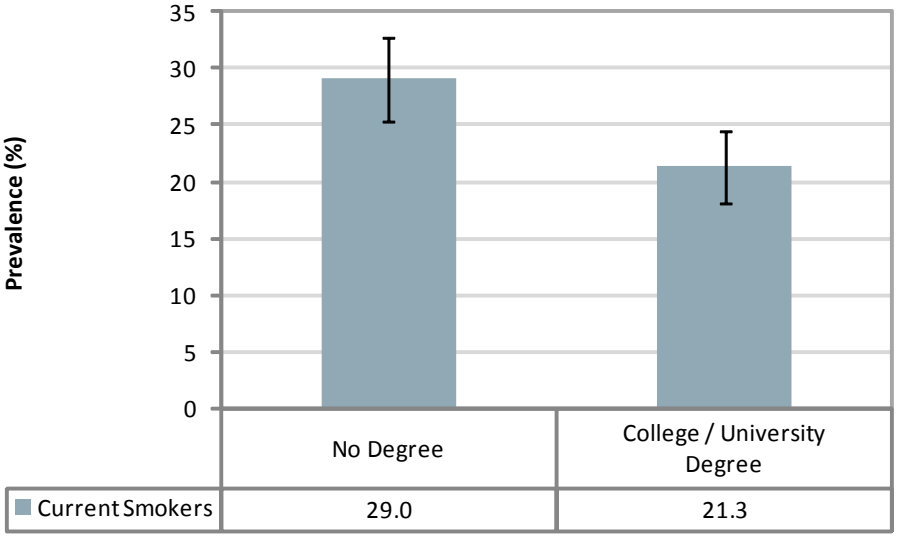


Source: Canadian Community Health Survey, 2003, 2005, and 2007.

Current Smokers by Educational Attainment

21% of individuals with a college/university degree reported that they currently smoke. This is significantly lower than those persons without a college/university diploma/degree (29%).

Current Smokers by Educational Attainment, SDHU, 2003–2007



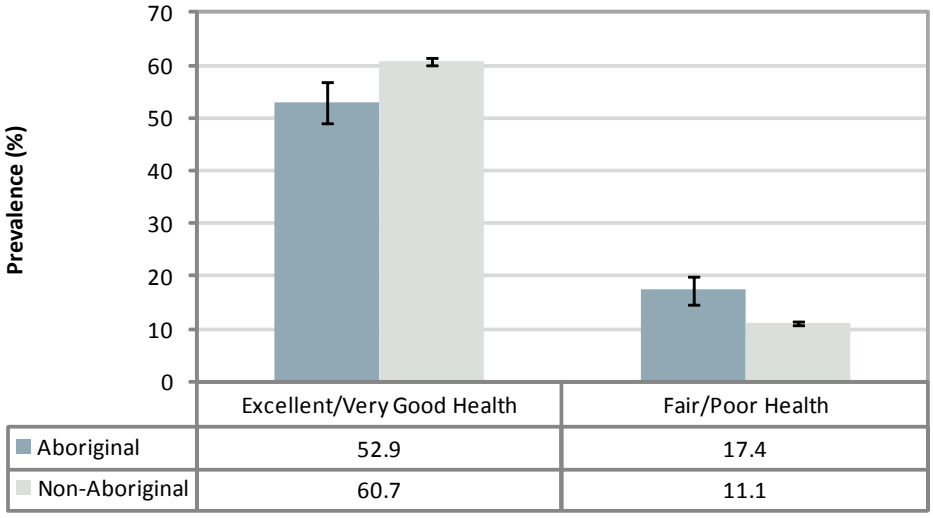
Source: Canadian Community Health Survey, 2003, 2005, and 2007.

Aboriginal identity

Self-Perceived Health/ Mental Health by Aboriginal Identity, SDHU, 2003–2007

Individuals who identify themselves as Aboriginal have a significantly poorer perception of their health and mental health status, compared to those who do not identify themselves as Aboriginal. 53% of Aboriginal people rate their health as 'excellent' or 'very good', compared to 61% of non-Aboriginal people. Conversely, 17% of Aboriginal people describe their health as 'fair' or 'poor', compared to 11% of non-Aboriginal people. Similar discrepancies are observed for self-rated mental health status.

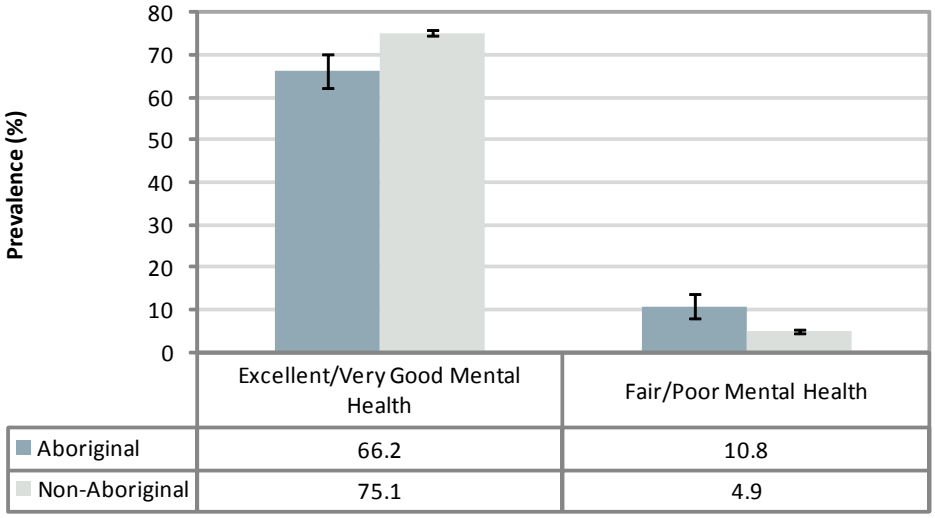
Self-Perceived Health, Aboriginal vs. Non-Aboriginal, SDHU, 2003–2007



	Excellent/Very Good Health	Fair/Poor Health
Aboriginal	52.9	17.4
Non-Aboriginal	60.7	11.1

Source: Canadian Community Health Survey, 2003, 2005, and 2007.

Self-Perceived Mental Health, Aboriginal vs. Non-Aboriginal, SDHU, 2003–2007



	Excellent/Very Good Mental Health	Fair/Poor Mental Health
Aboriginal	66.2	10.8
Non-Aboriginal	75.1	4.9

Source: Canadian Community Health Survey, 2003, 2005, and 2007.

What does this mean to us and the work that we do in public health?

Use existing knowledge about priority populations to help shape our programs

Armed with knowledge about the people who live in our communities and the ways in which they may be at greater risk for poor health outcomes, we can design, adapt and implement our programs in ways that are more likely to meet their needs. If we know, for example, that people living on low incomes are less likely to be physically active, we might dedicate more resources to the promotion of physical activity opportunities that are no-cost or low-cost. It might also be important to identify the neighbourhoods that are most affected by poverty and to partner with other agencies in order to connect with individuals who live on low incomes.

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Help to build our knowledge about priority populations and effective public health practice

While we have some knowledge and data to help us identify priority populations within the SDHU catchment area, there is a great deal that we still need to know. We can help to build our knowledge about priority populations by:

- Sharing stories about the work that we do and the ways that we've seen health inequities demonstrated in the field;
- Keeping track of the information that we wish we had. As we better understand our data needs, we can begin to develop a plan for how to obtain it;
- Include a *health equity* component into program evaluations. Ask the questions, "Is this program/activity having the same impact on all members of our community? Are there certain groups who are benefiting more/less from this program than others?"

Share our stories.

How do I learn more about priority populations within my program area?

Look to existing reports and data collected by your teams

The resource library in the Resources, Research, Evaluation and Development (RRED) Division houses a wide range of internal and external reports that may provide you with insight into potential priority populations. Examples of a few reports that may be useful include: the *Health Status Report: Sudbury & District Health Unit*, *Demographic Profile: Sudbury & District Health Unit*, *Demographic Profiles—Branch Office Areas: Sudbury & District Health Unit*, the *Second Report on the Health of Francophones in Ontario*, and a variety of program evaluations. These reports and others can be easily accessed electronically through the SDHU website or through the Resource Centre. Additionally, your team or division may regularly collect data that could be analysed to assist you in the identification of priority populations specific to your programming. Look to existing databases to help answer questions such as, "Who is/isn't accessing our programs and services? Are certain groups more likely to report unhealthy behaviours, exposures or outcomes?"

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Talk to your RRED resource person

Each program standard area (for example, Child Health, Safe Water, Infectious Diseases) is connected to a staff member from SDHU's RRED Division. (If you are unsure of who your RRED representative is, check with your team Health Promoter or Manager.) While this person may not be able to provide you with immediate answers to your questions, he/she will be able to find out whether or not certain data are available and how it may be accessed. For instance, SDHU Surveillance Reports have been created for a variety of program topic areas. Sometimes, it may be possible to further analyse the data from these reports by income, or other demographics. This would allow you to get a better sense of the differential health outcomes experienced by different members of our communities. In other cases, your RRED representative may be aware of specific resources related to priority populations and effective practice for working with these groups. Feel free to approach your resource person with your questions or comments.

Each program standard area is connected to a staff member from the RRED Division.

For more information about *priority populations* and SDHU's efforts to reduce social inequities in health, contact Stephanie Lefebvre: lefebvres@sdhu.com, 705 522-9200, ext. 277.