

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

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Executive Summary

The COVID-19 response has not affected all parts of the population equally. Existing disparities in health and the social determinants of health have interacted with our public health interventions, changes in medical care, social policy and the economic downturn to increase inequities.

Equity has not been prioritised in Canada's COVID-19 pandemic response to date. Inadequate leadership, data and research has meant that we have not protected the lives of racialized and indigenous populations, those with low incomes and those living in long-term care or congregate living as well as we could have.

International reports and emergent data from Canada tell us that the Black population is likely to have suffered more harm than any other because of COVID-19.

It is unacceptable that Canada prides itself on its diversity and does not offer equitable protections for its diverse populations. A better Canadian first wave COVID-19 pandemic strategy would have been based on an evidence informed and data driven, health equity approach which engaged communities. This should be the template for any subsequent waves and the recovery.

A recovery plan which focusses specifically on the hardest hit communities would reduce the health and social inequities exacerbated by the pandemic.

However, we need legislative changes and investment in the development of good quality socio-demographic data streams if we are to be able to identify at risk groups and produce, deploy, and monitor the progress of interventions.

Four groups of actions are recommended to ensure that current and future responses to pandemics are equitable: Legislation; Equity based Pandemic Plans; Equity Based Social Policy and Recovery Plans; and, Improved Data and Research.

1) Legislation

We need strong legislation that ensures that our public health responses, our health response and our social policy responses produce as equitable outcomes as possible.

If we want our public responses to crises to be equitable this needs to be enshrined in law. It should not be legal for public services to produce inequitable responses to serious health challenges. Public services should promote race relations, they should produce equitable access to services and equitable outcomes of services and they should be required to collect data to prove that they are compliant.

Further legislation or regulation should bind the Federal Government to require proof of compliance with health-based equity and race relations standards in hiring, promotion and service delivery before making transfers and payments to third parties such as Provinces and contractors.

2) Equity based COVID-19 health and public health plans

There needs to be a clear and published plan focussed on promoting health equity in COVID-19 at each level of government. There also needs to be someone who is tasked with that job and has the right seniority and resources to deliver.

There are evidence-based tools such as health equity audit and health equity impact assessment which should be used to help produce such plans. There is evidence of their utility and effectiveness world- wide and growing evidence in public health in Canada. Working with communities will be vital to better understand difficulties with implementing existing public health and social policy pandemic interventions and to try to generate innovative solutions that improve outcomes.

3) Equity based social policy and recovery plan

In addition to public health plans there needs to be a health equity lens taken to all associated Federal, Provincial and Territory responses to COVID-19. Taking a health equity lens to policies that impact the social determinants of health is necessary to facilitate a fairer response and to make sure that equity-based health and public health plans are not undermined by social policy that promotes inequality.

Our current social policies produce health disparities. Wellesley Institute suggests a new normal where our recovery plans promote affordability, equity and inclusion. It suggests that we can make our communities more robust by a higher aspiration of promoting thriving rather than just surviving. This would mean that the recovery should produce good jobs, employment rights, better wages, affordable housing and a revitalized benefits system which ensures that Canada does not allow people to live in government sponsored poverty. Canada needs to: right-size its health and social services sector; produce clear enforced standards for long-terms care and reconsider the shelter system.

But the recovery needs to focus on those communities that have been hardest hit; particularly Canada's Black populations. If we do not want these communities to fall further behind, we need a focused recovery plan. There should be specific carve-outs to ensure that funding reaches the most at risk populations and there should be an evaluation to ensure that it helps build recovery.

4) Data and research

There is no excuse in 2020 in Canada for not having robust socio-demographic and race and ethnicity data. But socio-demographic data is not an end in itself. It needs to be linked to action to decrease disparities. There needs to be accountability and communities want to be involved in the governance of their data.

Wellesley Institute was part of a group of Toronto community-based experts in socio-demographic data and health disparities which called on the Province of Ontario to do three things: collect individual level socio-demographic data for COVID-19 including race and ethnicity; undertake innovative analyses with existing data to get as accurate a picture of disparities as possible; and, develop a strategy for ongoing socio-demographic data collection. The same advice is given to the Federal Government.

COVID-19 socio-demographic data collection: Federal surveys that focus on race/ethnicity and COVID-19 should be undertaken urgently. These should be developed in conjunction with racialized populations.

All parts of the stimulus package and all parts of the COVID-19 social assistance package should collect socio-demographic data including race and ethnicity data to demonstrate equity in access and outcome of the programs.

Federal research funding programs should include specific calls for work on COVID-19 socio-demographic inequities and race/ethnicity. These calls and programs may need to include funds for outreach and capacity building.

Federal Government should work with Provinces to ensure socio-demographic data collection, including race and ethnicity, at COVID-19 testing, tracing and hospitalization.

Link and analyse existing data: Federal agencies such as CIHI and Statistics Canada should perform and publish COVID-19 analyses using existing sociodemographic information at the individual or area level.

Strategies for hardwiring socio-demographic data collection: Socio-demographic data including race and ethnicity data should be added to the short form census so that we have a full picture of Canada and a data set that can be linked to others such as health data to allow disaggregated analyses.

All Federal surveys should collect socio-demographic data including race and ethnicity data until such a time when linked census ethnicity data will be available.

All Federal surveys should include sufficient people from the major racial and ethnic groups so that meaningful disaggregated and intersectional analyses can be undertaken.

Federal research funding programs should build a pipeline of researchers from doctoral students through to post docs and Canada chairs who focus on health equity and health disparities and in particular on the health of Black populations.

The Federal Government should work with Provinces to produce good quality socio-demographic data including race and ethnicity for their health systems. One way of doing this is by facilitating the collection of race and ethnicity and other socio-demographic data at the time when people apply for and renew their provincial health insurance cards.

Background

Introduction

Survival for those on the Titanic in 1912 was directly related to their social status. 60 per cent of those in first class lived, 42 per cent of those in second class and only 24 per cent for those in third class (1).

The Titanic's escape plan was the same for everyone but third-class passengers in lower internal berths had more difficulty getting to lifeboats than others. The huge death toll was because they did not have an adequate plan for their most needy passengers.

Canada's COVID-19 our response has been good. In fact, our death rate of 23 per 100,000 is better than many other high-income countries (2). But, like the Titanic we did not have an adequate plan for our highest risk populations: people in long-term care, racialized populations and those with lower incomes.

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

Taking a health equity lens to what is left of the first wave, to any second wave and to the recovery will improve the outcome of our response.

Health Equity

A health equity approach aims to decrease avoidable illness disparities between groups. It does this by ensuring that there is equal access to and outcomes from interventions. It takes a needs-based approach. When people or groups have similar needs the focus is on making sure they have similar access and interventions work equally well (3). If a group has greater need then the response increases and the interventions may change to ensure that their needs are met. Health equity would not mean that everybody gets the same COVID-19 response, but, health equity should mean that the outcomes from the COVID-19 response are the same.

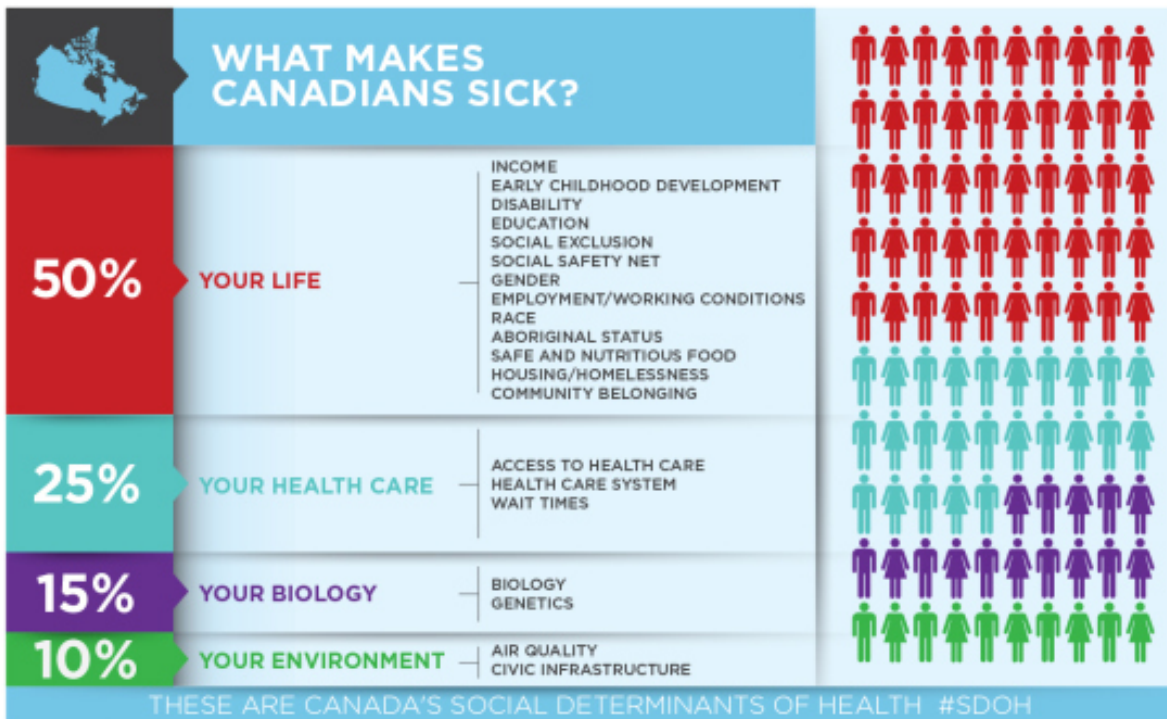
A health equity approach recognizes the risk of illness and the ability to recover are linked to social factors. Changes to the social determinants of health to promote wellbeing of vulnerable populations are considered important health equity interventions (3).

Social determinants of health

The Canadian Medical Association has calculated that 85 per cent of our risk of illness is linked to social determinants such as income, housing, education, racism and access to healthcare. The fact that 85 per cent of illness risk is linked to social factors offers significant policy opportunities for improving health. Many health disparities are avoidable. On the other hand, policy decisions such as austerity approaches increase health disparities and decrease the capacity of our health and social care sectors (4).

There are at least four main ways in which the COVID-19 pandemic adversely impacts health:

- 1) the disease itself;
- 2) the public health response;
- 3) changes in health services;
- 4) the economic downturn. (5)



These impacts interact with the social determinants of health so that the health outcomes are different for different parts of our population (5)

Impacts of the disease: Some populations such as racialized populations and indigenous populations are more impacted than others by the social determinants of health. They have multiple, intersecting factors such as racism, poverty and social exclusion which work together to increase their vulnerability to illnesses. They are more likely to be essential workers, for instance they are much more likely to work in long term care homes. They are also less well served by social, health and public health services. Existing disparities may interact with the COVID-19 response to increase infection rates and produce greater morbidity and mortality.

Impacts of the public health response: Those in congregate settings such as long-term care homes, the homeless and people in institutions find physical distancing difficult. But a bigger population is those living on the poverty line, in precarious work or in overcrowded homes. They are less able to follow current public health protocols which puts them at risk. And the harms of physical distancing and isolation such as stress, lower levels of exercise, substance misuse and domestic violence are more likely when people are overcrowded and when they have other social stressors such as workplaces that put them at risk or financial worries.

Impacts of changes in medical care: When hospitals and clinics moved into emergency mode, preventive medicine clinics shut down, outpatient visits and surgeries were cancelled, and some services moved to tele-health. Groups with existing health problems, those with existing access problems and those without good digital access are likely to have been hardest hit.

The economic downturn: The economic downturn will have direct impacts on health through stress, it may increase the risks of mental illness, suicide and substance misuse and it will also decrease access to care as health benefits are lost.

Canada's racialized groups (especially the black populations and indigenous groups), those in poverty and low paid people are likely to have been most impacted by all of these areas.

Data on impacts of COVID-19 on racialized groups

Morbidity and mortality: In the USA and UK you are 2-3 times more likely to get COVID-19 and 2-3 times more likely to die if you are of African or Caribbean heritage. (6, 7)

The emerging figures from Canada are similar.

Middlesex-London Public Health Unit report that 27 per cent of those who test positive are visible minorities compared to 17 per cent of the population. (8)

Toronto Public Health data shows that COVID-19 is more common in areas of the city with the highest black populations (9). And, Public Health Ontario have found that infection rates are three times higher in areas where there were more racialized people, that hospitalization rates and admission to ICU for covid-19 are 4 times higher and death rates are doubled. They also found that the mean age of infection was lower in these areas and the pandemic persisted in these areas when it had left others (10).

British Columbia figures from the COVID-19 survey are urgently awaited.

Quebec figures show that more people have died in Montreal Nord – a low income area with a high percentage of people of African and Caribbean heritage – than in the whole of British Columbia. In addition, the percentage of black people living in a Montreal neighbourhood is the strongest predictor of the rate of COVID-19 infection. (11)

There is little doubt that racialized people are more likely to get COVID-19 in Canada. They are also more likely to get sick and more likely to die than others. Black populations are likely to have been the worst effected ethnic group in Canada. The extent of these problems is becoming clearer as data is collected and analysed.

Impacts of the public health measures: Wellesley has not seen good data on differential mental health impacts, substance misuse, domestic violence or homelessness.

Impacts of healthcare changes: Wellesley has not seen good data on excess morbidity and mortality not from COVID-19 in Canada. The UK found that deaths from COVID-19 were increased by 2-fold in the Black and Minority Ethnic populations but all-cause mortality has increased by 4-fold. (7)

Economic Impacts: There are some data on the economic impacts. According to the poverty institute of Canada there was an estimated 16 per cent job loss for visible minorities and recent immigrants because of COVID-19. Nearly 350,000 people in this group lost their jobs between Feb 2020 and May 2020 (12). The total job loss for visible minorities is higher than low income workers and other groups such as indigenous people. A recent analysis has reported that a family living on CERB and with all other potential

benefits added is close to the poverty line as defined by the market based measure. But the MBM does not include everything that is needed for a good pandemic response such as broadband and extra cleaning supplies. In addition, a major expense is housing and the housing standard used in the development of the market based measure does not ensure that housing is sufficient for physical distancing. It is likely that people who are unemployed and on CERB may be above the poverty line but are living in COVID-19 poverty.

Public Health England investigated race and COVID-19. They concluded:

“The literature review and stakeholder feedback indicate that risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME (Black and minority ethnic) groups. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure. They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.” (7)

Towards an equitable COVID-19 response

Numbers have been vital in the fight against COVID-19. Numbers highlighted the problem and 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, the data need to be disaggregated. If you are part of an aggregated sum you can be invisible in the numbers, your story will not be told, your needs will not drive policy action and your needs will not be met.

Disaggregated data are particularly vital in a pandemic because our response is as strong as its weakest link.

But data is not an end in itself. Data has to be linked to meaningful strategies to try to decrease disparities. Data has to lead to action.

And there needs to be accountability around the collection and use of data to ensure that communities feel safe and properly engaged with the process. Communities are increasingly requesting data sovereignty and protections against commercial use of their data.

There have been some who have suggested that we do not need disaggregated socio-demographic data. Some public health officials and some politicians have said that everybody is important and so we do not need race or ethnicity data. And, some communities are worried that data may be misused. However, we do not have the correct data at present to properly identify at risk groups and to monitor the impact of our response.

Every doctor must take a good history from their patient. It makes sure that the doctor makes the right diagnosis and that they understand their patient’s particular circumstances. This information is vital to formulate the right plan, with the right treatment for the best possible outcome. A poor history leads to a poorer outcome.

The only difference in public health is that the patients are communities and populations and the history is data. If we do not have good data, we cannot develop effective strategies that work for communities and populations. We forego the best possible outcome.

We have already seen in Ontario that disaggregated data can save lives. Cancer Care Ontario were able to show that black women were not being screened for cancers. This allowed them to develop targeted public health strategies that decreased this disparity.

We should not have gone into COVID-19 without proper data streams to ensure proper populations surveillance.

During previous pandemics, racialized populations were more likely to be infected. A study of H1N1 influenza pandemic in Ontario reported that the South East Asian population were 3 times more likely to be infected, the South Asian population 6 times and the black population were a whopping 10 times more likely to test positive. (13)

Despite this, we did not change our systems to allow socio-demographic data collection. We did not do research or sit with communities to find out why. And, so we went into COVID-19 without surveillance systems which would help us identify racialized health disparities and without the understanding of the needs of different populations.

Because of this we set up a one-size-fits-all, colour and culture blind covid-19 response which was predictably going to exacerbate health inequities.

And, though the evidence started coming in, the briefings and the websites at both Federal and Provincial levels are still silent on the issue of race and COVID-19. There has been a lack of visible government leadership on this issue.

There has been progress. The Anti-Racism Secretariat at the Federal level is starting COVID-19 community roundtables to better understand what is needed going forwards. The Public Health Agency of Canada is collecting socio-demographic data in some of its surveys. Manitoba started collecting race based data, British Columbia collected race data as part of its COVID-19 survey and Ontario has agreed to collect data and at least three public health units have started.

But, we are almost through the first wave of a pandemic where a disproportionate number of racialized lives have been lost and where there was no plan for an equitable response. There are no firm plans in place to ensure that we are not in the same position for the second wave and we do not have a clear blueprint for equity in the recovery.

It is unacceptable that Canada prides itself on its diversity and does not offer equitable protections for its diverse populations.

Recommendations

Four groups of actions are recommended to ensure that current and future responses to pandemics are equitable: Legislation; Equity based Pandemic Plans; Equity Based Social Policy and Recovery Plans; and, Improved Data and Research.

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We need strong legislation that ensures that our public health responses, our health response and our social policy responses produce as equitable outcomes as possible.

If we want our public response to crises to be equitable this needs to be enshrined in law. It should not be legal for public services to produce inequitable responses to serious health challenges. Public services should promote race relations, they should produce equitable access to services and equitable outcomes of services and they should be required to collect data to prove that they are compliant. This approach has been effective in other jurisdictions (15,16)

Further legislation or regulation should bind the Federal Government to require proof of compliance with health-based equity and race relations standards in hiring, promotion and service delivery before making transfers and payments to third parties such as Provinces and contractors.

2) Equity based COVID-19 health and public health plans

There needs to be a clear and published plan focussed on promoting health equity in COVID-19 at each level of government. There also needs to be someone who is tasked with that job and has the right seniority and resources to deliver.

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But the recovery needs to focus on those communities that have been hardest hit, particularly our communities of people of African and Caribbean heritage. If we do not want these communities to fall further behind, we need a focused recovery plan. There should be specific carve-outs to ensure that funding reaches the most at risk populations and there should be an evaluation to ensure that it helps build recovery.

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Appendix 1: Letter to Ontario Ministry of Health and Ontario Health

April 28th, 2020

Dear Colleagues,

As a concerned group of experts in health equity, we believe that the Province should urgently modify three types of forms in order to facilitate socio-demographic data collection during the COVID-19 pandemic. These forms are: COVID-19 test requisition form; the forms used by Public Health Units to capture the data they need to notify PHO of the details of those who test positive; and, the forms for application and renewal of OHIP cards. At a minimum, the modifications should include questions on race, ethnicity, gender identity, sexual orientation and language. An Indigenous-led group should advance Indigenous questions and Indigenous data governance and management.

The Province should ensure that standardised questions are used for data collection. The Province should ensure that data is collected, analysed and reported to improve the pandemic response and should ensure that the data are accessible so that communities can also analyse them.

The current state of socio-demographic data collection in Ontario's COVID-19 response is poor. Recent news that Toronto Public Health, Peel Public Health, York Region Public Health, and Middlesex-London Health Unit are all expanding their data collection to include race and ethnicity is welcome. Collection of socio-demographic data by all public health units would help the pandemic response, and more systematic forms of data collection would allow a comprehensive picture to be drawn.

It is usual during pandemics to collect data to identify risk factors for infection and risk groups. This helps to understand and monitor the reach and effectiveness of interventions, and to ensure we are making progress towards our goals. Though health services were not mandated to collect data in the legislation linked to the Data Standards for the Identification and Monitoring of Systemic Racism, this does not mean the collection of data by clinicians, institutions, public health or government is illegal. In fact, the need for collection of socio-demographic data including race and ethnicity is included in Ontario's Public Health Standards, it is also considered good medical practice and some hospitals and CHCs are already doing it.

There are many reasons why some parts of our population may be at greater risk from COVID-19 than others. For instance, current political responses have not fully factored in historical social inequalities, as well as the inability of some groups to follow public health guidance due to personal, community or workplace circumstances.

We also know from previous pandemics, such as influenza H1N1, that there can be racial and ethnic differences in infection that require focussed action. Analyses reported that the East and South East Asian populations in Ontario were 3 times, South Asian 6 times and Black populations 10 times more likely to be infected even after a raft of socio-demographic factors were taken into account. Indigenous peoples were also disproportionately impacted by H1N1, representing 30 per cent of first wave hospitalizations and 20 per cent of total mortality.

But this is a new virus and we do not know all the mechanisms which may produce disparities between groups. In Ontario, we have a higher number of positive tests in women and higher risk of hospitalization in men. We have seen outbreaks in older people in long-term care, homeless people in the shelter system and expect people with disabilities living in institutional settings to be at high risk. Some USA cities have reported African Americans are twice as likely to be COVID-19 positive and twice as likely to die. The UK has seen 80 per cent increase rates of infection in Black and Minority Ethnic Groups. In that country 68 per cent of health service staff and all the doctors who have died are racialized. These findings argue strongly that identifying risk groups, and developing strategies to decrease their infection rates is one of the more important next steps in the COVID-19 response.

Socio-demographic data helps us to identify, monitor and develop strategies to address the impacts of COVID-19 within our most marginalized communities. This paper offers some options on socio-demographic collection for the Ontario COVID-19 response from leaders in the field.

Of course, socio-demographic data collection is as good as its implementation and the political will behind it. Past difficulties in implementation in the Canadian context should be taken with a pinch of salt. We have seen things that no-one thought were possible become possible in this pandemic. When there are clear compelling reasons for data collection and analysis, clinicians and public health units are more likely to deliver.

Our COVID-19 response is as strong as its weakest link. If one part of our community is not doing as well as others, then our ability to flatten the curve and keep everyone safe is compromised.

Yours sincerely

Kwame McKenzie, CEO Wellesley Institute

Sent on behalf of;

Angela Robertson, Paul Bailey, Ahmed Bayoumi, Corey Bernard, Andrew Boozary
Adalsteinn Brown, Cynthia Damba, Sane Dube, Ryan Hinds, Sophia Ikura,
Andrew Pinto, Gideon Quaison, Jennifer Rayner, Kandace Ryckman

Appendix 2

Collection of Sociodemographic Data for COVID-19 Response in Ontario: Options for Consideration

Data on socio-demographic variations in COVID-19 testing, incidence, hospitalization and mortalities is urgently needed by health system, social service and community partners to inform situational awareness, immediate action, and the design of targeted supports for marginalized communities. The gold standard for those who are ill, is for socio-demographic data to be systematically collected as part of all patients' health records. CHCs currently do this as do some hospitals. Clinicians and institutions should be reminded that this is good practice.

The purpose of this paper is to outline additional recommendations for provincial socio-demographic data collection in response to the COVID-19 pandemic.

In order to provide a fuller picture of the impact COVID-19 our main recommendation is a three-pronged strategy to augmenting existing data collection forms to include key socio-demographic variables.

A) Modification to include socio-demographic data collection in existing tools

We currently collect, age, sex and postal code data. Postal code data has been used to identify regions and areas most in need. Ontario has accepted that resources may be targeted at more needy areas. Previous pandemics have shown that geography does not give a full picture of need. It does not adequately measure income, socio-economic or risks linked to employment. In addition, some racialized groups, ethnic groups and Indigenous peoples are at increased risk even when area level factors are taken into account. We propose modification of three types of forms:

- I. COVID-19 Virus Test Requisition Form from Public Health Ontario. This information would be collected by the clinician submitting the requisition. Collection at this point is important to ensure the broadest possible capture of the population (positive and negative tests) from all care settings where testing may be ordered (e.g. hospital, assessment centres, long-term care facilities, etc.).
- II. Forms used for input of information into the integrated Public Health Information System on people who have tested COVID-19 positive. This information would be collected by public health professional completing contact tracing protocols. We note that Peel has a pilot scheme which has been collecting expanded data for three weeks, that Toronto Public Health has modernised their CORES system to include socio-demographics in COVID-19 cases, and, that Middlesex-London

and York Region Public Health Units have their own protocols for expanded socio-demographic data collection. The Province should ensure that all public health units collect data in the same way so that they can form a single data set that can be used for analyses.

- III. OHIP registration form. This information would be submitted as part of the form to renew or register for OHIP. While this information may not be collected quickly enough to inform current COVID-19 responses, it could lay the foundation for high quality, representative data to measure inequities at the population-level. This method would ensure the greatest opportunity for individuals to self-identify and would ensure that data is available to the broadest range of stakeholders.

In order to support feasibility of collecting additional information, we propose a minimum list of a streamlined set of questions be asked including race, ethnicity, gender identity, sexual orientation, and language. Race and ethnicity based data will allow us to monitor discrimination, identify and remove systemic barriers, address historical disadvantage and promote substantive equality. The list of questions could be expanded where feasible to collect more accurate socio-economic and socio-demographic data.

We also recommend an Indigenous led, Indigenous specific working group, comprised of First Nations, Inuit, Métis, and urban Indigenous organizational leaders and Indigenous scholars with content expertise to advance Indigenous questions and Indigenous data governance and management.

The modification of these types of forms allow us to collect accurate data which would ensure an optimal COVID-19 response. But, while these data are being collected in sufficient amounts to analyze, we can improve our understanding of disparities by using data we already have.

B) Maximize value of existing socio-demographic data

This includes an analysis of COVID-19 cases stratified by age, sex, and postal code to undertake an area-based analysis of the socio-demographic data collected by the Census or related indices. Postal code could be used to map cases of COVID-19 by geography. In areas of high population density where population size permits, data on COVID-19 patients should be reported at the most granular-level of geography possible (e.g., at the neighbourhood-level in the City of Toronto). Analyses should be quickly and broadly disseminated to communities and health system partners to inform their COVID-19 responses. However, it should be clear that there are limitations to the utility of these analyses.

There is an opportunity to pursue linkage of COVID-19 positive tests or hospitalizations in Toronto to existing socio-demographic data held by CHCs and other primary care organizations. CHC's are currently collecting sociodemographic data and have a data collaboration agreement with ICES. CHC's could then submit their sociodemographic data and COVID-19 data to be analyzed. Data from Ontario's primary care research networks (e.g. the University of Toronto Practice-Based Research Network [UTOPIAN]) are also now linked at ICES, and several members have been collecting sociodemographic data.

It is important to provide researchers with access to the data, and an ability to publicly report analysis on COVID-19 patients, such as linking COVID-19 positive tests or hospitalizations to Immigrant Refugee Citizenship Canada immigrant data base. Given the nature of approval processes through ICES an expedited process to account for use of data around monitoring and surveillance

will be needed that addresses the 1-3 year time-frame for uploads of ICES managed databases. Communities and community based researchers should have access to these data at as granular a level as

possible without sacrificing confidentiality. This improves the breadth and quality of analyses available for policy decisions and it improves engagement.

It is vital to ensure that Indigenous-identified COVID-19 data be collected, accessed and used in ways that respect Indigenous data governance principles and guidelines on ethics in research. With respect to ICES data holdings and Indigenous populations there is an existing platform of Indigenous and allied researchers and First nations, Inuit, Métis, and Indigenous health service policy partners that provides a strong basis for moving forwards.

C) Additional considerations

We offer a brief series of recommendations to ensure that sociodemographic data is collected, analyzed, report, and actioned in ways that do not further stigmatize marginalized communities. The Province's Data Standards for the Identification and Monitoring of Systemic Racism offers in depth guidelines.

In brief, the best data are those which are self-reported so that patients are able to self-identify their race and other identities.

The use of the data should also be explained and clarified to ensure patients understand the importance of why it is being collected. In addition, patients should be provided with resources that answer questions around data collection. These resources should be independent of the Ministry, hospital or university.

Training for the data collectors can be useful to ensure that the importance of data collection and the reasons for data collection are clearly understood and so that questions are asked in a consistent, accessible, and purposeful way to ensure quality.

Consultation with communities can be useful on options for not only data collection, but analysis, linkages and reporting, to prevent unintended consequences such as further stigmatization of vulnerable populations. This consultation needs representation from diverse communities to accurately identify and interpret nuances within the data that could lead to improved health outcomes.

Best practice is for data collection to be pursued in parallel with accountability to share how it is used with the communities. There is also a need to ensure that data collection is tied to a meaningful and deliberate plan for acting on that data, including any inequities or gaps that are identified. These plans should be informed and endorsed by the communities for which they directly impact.