Priority health equity indicators for British Columbia:

Selected indicators report
Executive summary

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Provincial Health Services Authority
Province-wide solutions. Better health.

Population and Public Health Program
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This report can be found at: www.phsa.ca/populationhealth

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Foreword

Overall, British Columbians are among the healthiest people in the world yet good health is not evenly distributed across our province.

We know that about 75% of our overall health is determined by social factors such as working or living conditions, income, and educational opportunities. These factors affect the rates of chronic disease and injury, contributing to health inequity or unfair differences in health and well-being for people of different groups.

Research has shown that the lower a person's socio-economic position, the higher his or her risk of poor health. Early adversity may be overcome by later improvements in social circumstances, however early experiences can leave a person more vulnerable to poor health later in life.

Health inequities have significant social and economic costs to individuals and to society as a whole.

The direct health system costs associated with providing care to a sicker and more disadvantaged population are substantial. These costs are dwarfed by the indirect costs of health inequities, such as lost productivity, lost tax revenue, absenteeism, family leave, and disability or premature death.

We are putting forward a snapshot of some current health inequities in BC and hoping to spark conversation about the value of this kind of information and the information needed to inform policy and practice.

Through a consensus process 52 equity indicators were identified. This report analyzes data for 16 of the 52 equity-related indicators across various population groups and sociodemographic and geographic dimensions. Collectively, this data begins to show patterns of inequity across the lifecourse, from early childhood and adolescence through to adulthood. As these patterns begin to emerge over time, we can start to understand which groups of people are being left behind, even as the average British Columbian continues to live a longer and healthier life.

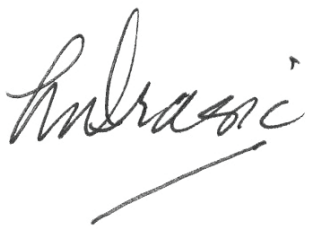
As you read this report, I hope you will consider:

- How you could use these findings in your work?
- What more is needed to monitor trends on health inequity?
- What would be helpful in creating action on promoting health equity?

Please send us your thoughts, ideas and perspectives on the questions we have posed. You can write to us directly at pph@phsa.ca.

Together, we all play a role in creating the right conditions and opportunities to support individuals and populations to reach their full potential for health.

Sincerely,



Lydia Drasic

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Executive summary

British Columbia is one of the healthiest provinces in Canada, ranking favourably among provinces and territories on several population health indicators. Despite this overall success, there is considerable evidence that health status varies greatly depending on geography, demographics and socio-economic status (SES).[1] Moreover, Aboriginal peoples, women and those living in rural and remote areas of BC are at greater risk of experiencing health inequities than other BC residents.[2]

Since the 2008 release of *Health Inequities in BC* by the Health Officers Council of BC, Population and Public Health (PPH) has worked in partnership with the Ministry of Health, regional health authorities, and agencies and organizations within and outside of Provincial Health Services Authority (PHSA) on health promotion and chronic disease prevention strategies aimed at reducing health inequities. In 2011, PPH released *Towards reducing health inequities: A health system approach to chronic disease prevention* that focused on actions the health system can take to reduce health inequities.[3] In support of developing health equity targets, PPH collaborated with health sector partners to develop a prioritized suite of health equity indicators for BC. This suite of 52 priority health equity indicators, released in 2014, could be used to provide evidence of health inequities in BC across various geographic, demographic and socio-economic dimensions, as a first step towards setting targets and creating future action on equity.[4]

This report is intended to contribute to and complement provincial health status reporting of the *BC's Guiding Framework for Public Health.*[5] By analyzing current data, 16 health equity indicators drawn from the priority suite are examined across selected geographic, demographic and socio-economic dimensions. To keep the report timely, PPH analyzed indicators and equity dimensions for which data was accessible and available. With the exception of life expectancy at birth, these indicators are drawn from sources that do not include data from on-reserve BC Aboriginal populations (Appendix 2). The selected indicators are organized into four chapters: life expectancy, early childhood development, adolescent health and general population health.

Life expectancy

Life expectancy at birth is used worldwide as a general measure of a population's health. Life expectancy of population groups can also indicate social conditions such as wealth, economic opportunity, healthcare and education.[6]

Key findings

Life expectancy in BC varies by sex, geographic region, and socio-economic status:

- Females are generally expected to live longer than males (85 and 81 years, respectively in 2013).
- People in central and northern parts of the province have shorter life expectancies.
- People living in high SES local health areas are expected to live nearly four years longer than people living in low SES areas (82.2 vs. 78.6 years respectively).

Early childhood development

The early years of a child's life have strong influences on lifelong health and social outcomes, including school success, economic participation, social citizenship and health.[7] Three priority health equity indicators from the Early Development Instrument (EDI) were examined using data from 2011/12 to 2012/13.

Key findings

The rate of BC children who are developmentally vulnerable during early childhood varies significantly by geographic region, sex, and neighbourhood levels of unemployment and income:

- Rates of language and cognitive development vulnerability varied by Health Service Delivery Area (HSDA), ranging from a low of 5.8% to a high of 13.5%.
- The rate of vulnerability in one or more EDI areas was higher in boys (40.3%) than girls (24.5%), and was higher in regions with higher unemployment (35.4%) than lower unemployment (29.8%).
- The rate of vulnerability in one or more EDI areas was highest among children in regions with the lowest income (45.3%).

Adolescent health

Adolescence is an important stage for healthy adult development. Promoting healthy practices and taking steps to better protect young people from health risks can prevent or reduce the impact of health problems in adulthood.[8] Using BC's Adolescent Health Survey data collected in 2013, five priority health equity indicators for the BC youth in Grades 7 to 12 were examined across three equity dimensions, sex, geographic region, and neighbourhood income level.

Key findings

Several key indicators of adolescent health (prevalence of physical and sexual abuse, discrimination, smoking, and substance use before age 15) vary significantly by geographic region and sex:

- Rates of substance use before the age of 15 differed by HSDA, ranging from the lowest (22%) to the highest (50%), a difference of 28%.
- Females reported higher rates of abuse (22%) and discrimination (41%), and slightly lower rates of smoking (9%) than males (13%, 30% and 11%, respectively).

General population health

Measuring general health and mental health can reveal a population's overall health and well-being, resiliency and social environments. Adult health and well-being are influenced by a complex set of social and environmental factors that include current living and working conditions, as well as early life experiences. Seven general health status and outcome indicators, all based on self-reported data from the Canadian Community Health Survey from 2007/08 to 2011/12, were examined across various geographic, demographic and socio-economic dimensions.

Key findings

Among the general BC population, the rates of different health and well-being indicators vary significantly by geographic region, sex, education and income:

- Obesity rates were more than three times higher in the HSDA with the highest rate (22.4%) compared to the one with the lowest rate (6.9%).
- Significantly higher rates of females reported mood/anxiety disorder (13.7%) and adequate fruit and vegetable consumption (48.6%) than males (7.7% and 36.4% respectively).
- People with at least a high school diploma reported significantly more favourable rates for a number of indicators than those with less than a high school education: positive perceived health (62.5% vs. 45.3%), positive perceived mental health (72.0% vs. 59.0%), adequate fruit and vegetable consumption (42.9% vs. 34.8%), leisure time physical activity (59.5% vs. 51.3%), mood/anxiety disorder (10.2% vs. 16.4%), adult obesity (12.2% vs. 17.3%) and current smoking (16.6% vs. 39.8%).
- People in the highest income group reported significantly more favourable rates than those in the lowest income group for a number of indicators: positive perceived health (71.9% vs. 47.8%), positive perceived mental health (78.8% vs. 59.2%), adequate fruit and vegetable consumption (47.9% vs. 35.8%), leisure time physical activity (69.3% vs. 48.2%), mood/anxiety disorder (7.9% vs. 17.4%) and current smoking (12.0% vs. 26.5%).

Conclusions and next steps

The results of analyzing 16 indicators from BC's priority health equity indicator suite demonstrate that some groups of British Columbians are doing noticeably better than others. The evidence provided here reveals some of the inequities various populations groups may face across geographic, demographic and socio-economic dimensions. Application of similar approaches by others at the health system or program levels could reveal important health inequities in service delivery and utilization. This type of information can inform policies and programs to reduce inequitable gaps and improve opportunities for good health across all population groups.

As a next step, PHSA PPH intends to engage our partners to explore how these findings can inform monitoring trends on health inequity. Additionally, working with a variety of partners, PPH also hopes to begin exploring how equity surveillance of the prioritized suite of equity indicators can inform action on promoting health equity.