Promoting Health Equity Indicators:

Summary of Health Authority Pilot Projects

**1.0 PURPOSE**

As part of the work towards developing a suite of health equity indicators for BC, pilot projects were undertaken with two health authorities Vancouver Island Health Authority (VIHA) and Interior Health Authority (IHA). The purpose of the pilots was:

*To test the process of generating data for 13 priority indicators to the lowest level possible and passing it on to health authorities for them to manipulate, contextualize and present in a way that meets their needs. In doing so the information needs, strengths, limitations, challenges and resource requirements of the process will be identified so that learnings can be used to inform remaining indicator development work.*

**2.0 EXPECTED OUTCOMES**

Expected outcomes included an identification of:

**2.1 Issues/limitations of data & data access**

**2.2 Data analysis & reporting capacity**

* What information (and in what format) PHSA should provide for the remainder of the indicators
* What support PHSA can provide to the health authorities once the information is passed on
* “Low hanging fruit” – i.e. circumstances in which a minimum amount of effort on one database might produce the desired result with regards to a particular indicator vs. circumstances in which a significant amount of work on one database would be required to produce the same result with regards to another indicator

**2.3 Time & resources required**

* Time and resources required to generate, manipulate, contextualize and present the data

**3.0 PHSA VS. HEALTH AUTHORITY ROLE**

* PHSA PPH pulled any and all data available at the lowest level possible for all 13 priority indicators and wherever possible stratified the data by the cross cutting equity dimensions.
* PHSA PPH provided templates and meta-data for all 13 priority indicators. PPH also, in a few cases, conducted logistical regression.
* Health Authorities conducted further analyses using their own data sources and/or applications and produced tabulations, charts, interpretations and/or reports based on their identified needs and priorities (e.g., strategic priorities, reporting commitments)[[1]](#footnote-1)

**4.0 RESULTS**

**4.1 Issues/Limitations of Data & Data Access**

The current process was hampered by a lack of appropriate data- this will be documented elsewhere. Generally, however, we were constrained to the CCHS PUMF files, which do not allow a fine level of geographical resolution. We also had access to some administrative data, but these data rarely contained information on the equity variables that we are interested in. Future attempts to use these health equity indicators need to obtain access to CCHS sharefiles which have been linked to the administrative databases. This will allow for the examination of the health system utilization and performance data found within the administrative sources, while utilizing the equity variable information found in the CCHS. The CCHS is designed to allow for these types of linkages, and these datafiles should be relatively easy to produce. Other sources of data need to be explored as well (e.g., data collected by particular programs, agencies or organizations), though these may not be available on a provincial level.

**4.2 Data Analysis & Reporting Capacity**

*4.2.1 Health Authority Capacity*

The pilot process identified that there are differences in the capacity to analyze and present the data that the Health Authorities (HAs) possess, as well as differences in the aims and desires of the HAs.

If the HAs all had full capacity, and full access to the data, then the role of the PHSA would be reduced to one of facilitation and assistance with standardized reporting. Note that the HAs should have access to the same data that the PHSA has access to[[2]](#footnote-2). In this case we would simply provide informational documents and advise as to how results are being presented. This advice is already being provided, as the other deliverables from the PHE project (e.g., standard definitions of indicators, assessments of data sources).

Since all of the HAs don’t actually possess full analytical capacity, the PHSA performed some of the data extraction and analyses, and then sent the results to the HAs, who then compiled and presented the results. This process seemed to work reasonably well - since the PHSA pulled the data, it would be straightforward to maintain consistency across the HAs.

This process will also be useful in the potential event that we obtain access to data that is restricted in the degree to which it may be shared – if we were not allowed to send data from one HA to another, it would be possible for the PHSA to run the analyses, and then send only the appropriate HA results to the HAs. This point is also relevant to the statistical modeling approach – the PHSA can run the entire model at the provincial level, and send results along, which then eliminates the need for each HA to run a provincial model, and then extract the portion which is relevant to themselves.

One clear issue with the pilot project is the addition of another link in the analysis chain. The process would be more efficient if each HA performed its own analyses. The back-and-forth nature of collaboration resulted in slower analyses times and increased resource utilization. The process would be more streamlined if the HAs had access to the data and an analyst, or alternately, if the PHSA performed all of the analysis. Since neither of these are likely (or desirable) it will be important going forward to work out a process for collaboration to streamline the analysis. One of the aims of the pilot was to provide suggestions as to how best to streamline the process. Initial suggestions are as follows:

1. PHSA should have code ready to run for standard indicators – both crude rates and statistical models.
2. PHSA extracts HA specific results in a format appropriate to the HAs and sends to the HAs.
3. RHAs identify other indicators and equity variables of interest and PHSA to determines feasibility of these new analyses.

*4.2.2 PHSA Capacity to Provide Standardized Support to the HAs*

When the PHSA PPH has an epidemiologist or statistician on staff there will be the capacity to assist with support for the HAs. Once a suite of indicators and equity variables is settled on, and once appropriate data sources have been identified (and acquired) it will be straightforward to produce standardized reports. If the HAs want data/results in a format that is different than the standard, then the PHSA analyst will need to assist, but formatting is relatively easy, and shouldn’t take much effort.

If the HAs need non-standard analyses, or data from non-standard sources, there is the possibility that the PHSA analyst will need to spend a fair bit of time on this issue. Throughout this pilot project, a number of indicators were proposed/requested, and if the PPH analyst did not have access to appropriate data, he simply did not produce the summaries. In the future, the PHSA analyst may need to negotiate access to data in order to produce a comprehensive suite of indicators. This would take considerable time and effort.

*4.3.3 Clarification of Data Utilization*

More work needs to be done with regards to clarifying how the data will be used at the provincial, regional and local level. IHA has a report planned, but this is really the first instance of such a report. The response to this report should be carefully noted. Then, we can take the well received aspects of it, and produce regular reports based on those. We need to tie any reports to new policies/ interventions/actions that HAs and the Ministry of Health are interested in pursuing.

**4.3 Time & Resources**

*To be received from HAs by April 30*

1. Health Authorities were free to disregard any of the data provided and bring more into the process as required for their own purposes. [↑](#footnote-ref-1)
2. There may be some costs associated with access. [↑](#footnote-ref-2)