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Bridging the Preparedness Divide

A Framework for Health
Equity in Ontario's
Emergency Management
Programs

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Bridging the Preparedness Divide:

A Framework for Health Equity in Ontario's Emergency Management Programs

*"The rich died and the poor died alike"*¹

- Reverend Eakin on the sinking of the Titanic in 1912

*"Perhaps no observation during the great influenza epidemic of 1918-1919 was more common than the familiar comment that 'the flu hit the rich and the poor alike.' ... Like many conclusions based on general impressions, this observation was true only in part ... there were marked and consistent differences in its incidence - with respect both to morbidity and to mortality - among persons of different economic status ... Apparently the lower the economic level the higher was the attack rate."*²

- Edgar Sydenstricker on the Spanish Flu in 1931

An equity lens on health

During the past year, The Ontario Government has ensured that the health system make definitive commitments to health equity, Furthermore, more research and policy support is now directed to the

¹ Biel, S. (1996) Down with the Old Canoe: A Cultural History of the Titanic Disaster W.W. Norton & Co. p.45

² Sydenstricker, E. (1931) The incidence of influenza among persons of different economic status during the epidemic of 1918. Public Health Reports, 46(4) p.154

task of reducing health equities among social groups.

Concurrently, there is a surge of commitment and new funding for emergency management programs in Ontario, both within and separate from our health system. There is significantly more capacity in Ontario to mitigate against, prepare for, respond to, and recover from emergencies than there was five years ago.

This paper will demonstrate that it is both critical, and possible, for these two trends – attention to equity in health planning, and an increased capacity to address emergencies – to be connected. It will argue that health equity is most threatened during emergencies, and that commitments made between emergencies ought not to be put aside in times of crisis. Rather, there is no time when these commitments are more important.

A Commitment to Health Equity

Rachlis (2007) outlined the recent history of commitments and achievements in the implementation of a health equity agenda in Ontario's health system. He cites the stated goal of the equity strategy as:

*"to minimize systematic and remedial disparities in health and social well-being between[sic.]groups of people who have different levels of underlying social advantage."*³

³ As cited in Rachlis, M. (2007) Delivering equity: Community-based models for access and integration in Ontario's health system. <http://wellesleyinstitute.com/files/healthequity/DeliveringEquityReport.pdf> p.7

Rachlis outlined that it is recognized that differences in health and wellbeing can only partly be attributed to health system factors, but that as the Federal / Provincial / Territorial Health Disparities Task Group noted

“The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities.”⁴

Rachlis notes that in 2006, the Ontario Health Care Quality Council identified equity as one of nine attributes of a high performing health system.⁵

Further innovative equity work undertaken by the Wellesley Institute’s Dr. Bob Gardner set the foundation for a new equity lens by which to view the health system. This paper will use the definition of health equities from Gardner (2008) as

“...differences in health outcomes that are avoidable, unfair, and systematically related to social inequality and disadvantage.”⁶ [emphasis in original]

⁴ As cited in Rachlis, M. (2007) Delivering equity: Community-based models for access and integration in Ontario’s health system. p.1

⁵ Rachlis, M. (2007) Delivering equity: Community-based models for access and integration in Ontario’s health system. p.6

⁶ Gardner (2008) Gardner, B. (2008) Health equity discussion paper. Retrieved from http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf p.4

An Increase in Health Emergency Management Capacity

Concurrent with the rise of attention and commitment to health equity, our health system has made considerable progress in developing emergency management capacity.

In December of 2003, the Ministry of Health established an Emergency Management Unit to plan and coordinate provincial responses to emergencies that affect and impact health. In 2004, the province released the Ontario Health Plan for an Influenza Pandemic, and has updated it annually since. The plan outlines preparedness requirements for most of the health system. In 2008, the Ministry of Labour announced a new influenza pandemic compliance strategy, which provided legal teeth to some preparedness requirements for our health system.

This pandemic influenza plan is the only emergency plan outlining responsibilities throughout the health system that the Emergency Management Unit has released.

For this reason, there is particular emphasis on pandemic influenza in the examples and discussion in this paper. An all-hazards Ministry plan – the Ministry Emergency Response Plan, was updated in 2007.

The policy aftermath of SARS also led to the establishment of Ontario’s Agency for Health Protection and Promotion, which is currently building its infrastructure to play a leadership role in health emergencies. Meanwhile, health organizations of all stripes are fit-testing employees for respirators, stockpiling personal protective equipment, and developing plans for a range of health emergencies.

This very positive momentum is unlikely to change soon. Lalonde was undoubtedly correct in saying “disaster management is

certainly one of the competencies that organizations in the health sector will have to develop in the years to come.”⁷

An Opportunity

A health equity lens has not yet consciously and consistently been applied to the major initiatives of the health system’s emergency management programs; however, there is clear recognition that this is needed, and the preliminary groundwork for such thinking has been done.

For example, the Ministry Emergency Response Plan recognizes the “Health and safety of health care workers and affected Ontarians, particularly vulnerable populations”⁸ [my emphasis] as a priority in the Ministry’s response to a health emergency. What is missing is a description of how vulnerable populations will be identified, how they can be included in planning, and what an effective strategy for meeting their health and safety needs could look like.

The Ontario Health Plan for an Influenza Pandemic similarly recognizes the need to address health equities. The plan states:

“The [Ministry of Health and Long-Term Care], the Ministry of Community and Social Services, and local social service providers are developing a strategy to support vulnerable Ontarians and help ensure timely access to influenza assessment

*services.”*⁹

The plan establishes equity as an ethical principle guiding the implementation of the plan; however the brief discussion is essentially limited to health care access for patients and the obligation of health care institutions to ensure a sufficient supply of materials¹⁰. There is also particular focus on the issues of antiviral and vaccine access. A more comprehensive, rigorous and deep approach to health equity is both required and possible. For example, a health-equity based approach to public health measures such as temporarily closing schools would outline what can be done to ensure that school-based food programs are adequately replaced in the community.

Similarly, Toronto Public Health’s influenza pandemic plan, by far the most comprehensive local plan in the country, states

*“in the next phase of planning, TPH will address the issues related to serving vulnerable populations such as immuno-compromised individuals, the frail elderly and the homeless.”*¹¹

It is time, then, for Ontario’s health care planners to develop and implement models of health equity applicable to emergency management, including frameworks for identifying and engaging vulnerable people within emergency management programs. According to Fothergill and Maestas “It is important that groups are not left out of the disaster-reduction process; people who are

⁷ Lalonde, C. (2007) Primary healthcare organizations facing a disaster: The Quebec experience. Disaster Prevention and Management, 16 1 p.43

⁸ Ministry of Health and Long-Term Care (2007) Ministry Emergency Response Plan p.52

⁹ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p. 11-2

¹⁰ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p. 2-9 – 2-10

¹¹ Toronto Public Health (2007) Toronto Public Health Plan for an Influenza Pandemic. P.8-2

marginalized in the early stages are marginalized later – they need to be part of the planning from the beginning.”¹²

Emergencies Exacerbate Preexisting Vulnerability

Emergencies are no longer understood as rare, unpredictable events where chaos reigns. Emergencies are quite common, and the way in which emergencies play out is rooted in social patterns established during non-emergency times. Furedi described disasters as “a normal feature of societies who are unable to deal with the hazards they confront.”¹³

Vulnerability during emergencies is predictable because it is firmly rooted in preexisting vulnerability. Fothergill and Maestas wrote “People’s vulnerability to natural hazards is determined not so much by the event itself but, by social, economic and political processes”¹⁴. Blumenshine and associates illustrate this point by stating that in the Katrina disaster “deaths, injuries, and illness occurred disproportionately among low-income persons in New Orleans because of economic and logistic constraints on their ability to respond to government recommendations.”¹⁵ Similarly, Furedi

wrote “Vulnerability is not a state of being that emerges in response to a disaster – it is something that precedes it.”¹⁶

This is certainly not to suggest that crises and emergencies are business-as-usual events. Images of New Orleans underwater, Toronto plunged into darkness, or lineups of people looking for water in Walkerton show the immensity of the challenges emergencies can bring. Rather, the observations outlined above suggest that inequities during emergencies are “*avoidable, unfair and systematically related to social inequality and disadvantage.*”¹⁷

A Model of Vulnerability

Blumenshine and associates provide a model of vulnerability related to pandemic influenza that our health systems should adopt in health emergency priority-setting activities as a health equity initiative.¹⁸ The

Marks, J. (2008) Pandemic influenza planning in the United States from a health disparities perspective. Emerging Infectious Diseases, 14(5) 709

¹⁶ Furedi, F. (2007) The changing meaning of disaster. Area: Journal of the Royal Geographic Society, 39 (4) p.488

¹⁷ Gardner (2008) Gardner, B. (2008) Health equity discussion paper. Retrieved from http://www.torontocentralhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf p.4

¹⁸ Blumenshine, P., Reingold, A., Ergerter, S., Mockenhaupt, R., Braverman, P. & Marks, J. (2008) Pandemic influenza planning in the United States from a health disparities perspective. Emerging Infectious Diseases, 14(5) 710

¹² Fothergill, A. & Maestas, E.G.M. (1999) Race, ethnicity and disasters in the United States: A review of the literature. Disasters, 23(2) p.168

¹³ Furedi, F. (2007) The changing meaning of disaster. Area: Journal of the Royal Geographic Society, 39 (4) p.487

¹⁴ Fothergill, A. & Maestas, E.G.M. (1999) Race, ethnicity and disasters in the United States: A review of the literature. Disasters, 23(2) p.156-157

¹⁵ Blumenshine, P., Reingold, A., Ergerter, S., Mockenhaupt, R., Braverman, P. &

authors describe that there are inequities among social groups in (1) the likelihood of exposure to the influenza virus, (2) the likelihood of contracting influenza if exposed and (3) the likelihood of receiving timely and effective treatment.

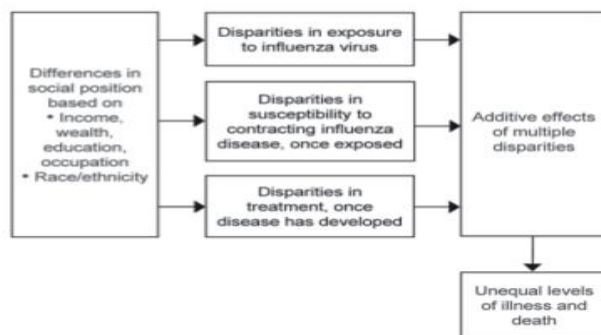


Figure. Possible sources of disparities during a pandemic influenza outbreak.

The model (herein referred to as Blumenshine's model) can help identify which groups are vulnerable, and therefore, according to the Ministry Emergency Response Plan, which groups are particular priorities.

It is noteworthy that the Canadian Pandemic Influenza Plan for the Health Sector identifies priority groups for vaccine access in the expected situation of shortages. Significantly, none of the groups that are identified in this model (those at high risk of exposure, those at high risk of infection, those at high risk of not receiving timely / adequate treatment) are specifically included. The list does include people at "increased risk of poor outcome due to the disease".¹⁹ The examples provided (pregnant women, adults and children with

chronic health conditions) suggest that the term "high risk" is understood to be based on health status factors that would lead to poor outcomes if an infection were to occur. This is consistent with the language in a previous version of the plan of a priority group as "persons at high risk of severe or fatal outcomes **following influenza infection.**" [author's emphasis]

The Blumenshine model is useful because it points out that people at high risk of exposure and people at high risk of infection upon exposure are other groups that ought to have priority for a preventative measure such as a vaccine. In addition, the likelihood of receiving timely and adequate treatment is a factor that ought to be included when determining outcome following an infection.

These ideas are not to suggest that people in prisons, homeless shelters, overcrowded housing or people whose jobs entail exposure to the public during such an emergency must be top priority for vaccine. But unless factors such as exposure are listed as a consideration for prioritization, aggressive targeted campaigns for these groups are highly unlikely to emerge. As Blumenshine and associate point out, "social disparities in vaccine coverage are likely to occur in the absence of careful planning to prevent them."²⁰

Blumenshine's model points out the importance of prioritizing people unlikely to receive adequate treatment. There is a wealth of literature on which groups do not receive equal access to health services in Ontario. In order to demonstrate the

¹⁹ Public Health Agency of Canada (2008) Canadian Pandemic Influenza Plan for the Health Sector. Retrieved from www.phac-aspc.gc.ca/cpip-pclpci/ann-d-eng.php#33

²⁰ Blumenshine, P., Reingold, A., Ergertter, S., Mockenhaupt, R., Braverman, P. & Marks, J. (2008) Pandemic influenza planning in the United States from a health disparities perspective. *Emerging Infectious Diseases*, 14(5) p.711

possible impact of the uptake of Blumenshine's model, this paper will briefly focus on two of these groups: non-citizen residents²¹, and Aboriginal people²².

In adopting Blumenshine's model, and prioritizing health care access for people who face barriers, statements such as the following would no longer have a place in the Ontario Health Plan for an Influenza Pandemic:

*"The MOHLTC will inform the organizations responsible for distributing / administering antivirals about their legal obligations to provide antivirals to all citizens"*²³ [author's emphasis].

*"The MOHLTC will work with local public health units to educate public health staff about their legal obligation to provide vaccine to all citizens"*²⁴ [author's emphasis].

As Ontario's Health Insurance Act states that health insurance "is available to all residents of Ontario"²⁵ [whether they are citizens or not], the statements in the health plan represent not only a threat to health equity, and to broader public health, but are also factually incorrect. The uptake of Blumenshine's model would lead planners away from such problems in emergency

plans.

Ontario's Aboriginal people face differences in risk of exposure, risk of infection upon exposure and risk of inadequate / untimely treatment. Aboriginal people fared extraordinarily poorly in the aforementioned Spanish Flu. The mortality rate among white Canadians was 6.1 / 1000. The mortality among Aboriginal people was >30 / 1000.²⁶

Far too many of the same risk factors exist today.

²¹ Asanin, J. & Wilson, K. (2008) "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada *Social Science & Medicine*, 66(6) p.1271-1283

²² Shah, C.P. (2005) Health status report of Aboriginal people in Ontario. Retrieved from www.aht.ca/files/HlthStatusAboEdFinal1.pdf

p.7

²³ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p.20-5

²⁴ Ministry of Health and Long-Term Care (2008) p. 20-6

²⁵ Ontario (2007) Health Insurance Act

²⁶ Mamelund, S.E. (n.d.) Geography may explain the adult mortality from the 1918-1920 influenza pandemic p.2-3 & 12. Retrieved from www.ed.lu.se/papers/mamelund.pdf p.12

Spanish Flu – Identified Reasons Why Aboriginal People Were at Higher Risk of Serious Illness and Death²⁷	Current Status of Ontario’s Aboriginal Population
High rates of tuberculosis as a result of residential schools	In Ontario, “Age standardized tuberculosis rates are eight to nine times higher within the First Nations population compared to the Canadian population.” ²⁸
High rates of lung and respiratory disease, particularly among children	Rates of pertussis among Aboriginal people are three times higher than the general population. Lung cancer rates in the Aboriginal population have doubled since 1980. ²⁹
Poor access to health care	50% of First Nations in Ontario state that they do not receive the same level of healthcare as the general Canadian Population. ³⁰

Spanish Flu – Identified Reasons Why Aboriginal People Were at Higher Risk of Serious Illness and Death²⁷	Current Status of Ontario’s Aboriginal Population
Inadequate housing	16% of people who use shelters in Toronto are Aboriginal. 24% of people living on the street in Toronto are Aboriginal. ³¹
Influenza can led to pneumonia. 40 – 50% of people who had both influenza and pneumonia died.	“Compared with the general population, First Nations people have four times the rate of hospital admissions for pneumonia.” ³²

Despite these enormous health equities, there is no information in The Canadian Pandemic Influenza Plan for the Health Sector, The Ontario Health Plan for an Influenza Pandemic or The Toronto Public Health Plan for an Influenza Pandemic specific for urban or rural Aboriginal people. “Generic plans assume Aboriginal populations to be part of mainstream populations, therefore these plans do not speak to the unique needs of the urban / rural Aboriginal populations (First Nations,

²⁷ Keln, M.E. (1999) British Columbia First Nations and the influenza pandemic of 1918-1919. *BC Studies*, 122 p.23-45

²⁸ Shah, C.P. (2005) Health status report of Aboriginal people in Ontario. Retrieved from www.aht.ca/files/HlthStatusAboEdFinal1.pdf p.5

²⁹ Shah (2005) p.5 & 40

³⁰ Shah (2005) p.6

³¹ Ward, J. (2008) Dealing effectively with Aboriginal homelessness in Toronto. Retrieved from www.toronto.ca/housing/pdf/dealing_effectively_aboriginal_homelessness.pdf

³² Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p.20-3

Métis and Inuit)³³ The uptake of Blumenshine's model would correct these problems in preparedness plans by pointing out the need for targeted programs.

It is important to note that Blumenshine's model is undoubtedly applicable to hazards beyond pandemic influenza, where exposure to the hazard, likelihood of harm caused by exposure and likelihood of receiving adequate care for the harm can be considered for any hazard.

Components of a Health Equity Model

The following is a proposal for the components of a health equity based approach to emergency planning. It is important to stress that a great deal more research is needed to validate these ideas. Many have argued that although there are good standards, there are no established best practices in the field of health emergencies³⁴, or even an agreed upon set of principles for the field.³⁵ These ideas are intended to stimulate dialogue, research and experimentation, and should be considered extensions of or additions to the programs that are in place in Ontario. These components are intended to assist in

³³ Noojimawin Health Authority (2008) An Emergency Preparedness Resource Toolkit for Aboriginal Organizations in Ontario p.5

³⁴ California Preparedness Education Network (2007) General disaster preparedness for primary healthcare providers. Retrieved from www.calpen.org/documents/Cal-PENModule1Standardized-revised3-07.ppt

³⁵ Etkin, D. & Davis, I. (2007) The search for principles of disaster management. Retrieved from http://training.fema.gov/EMIWeb/edu/docs/emp_rinciples/The%20Search%20for%20Principles%20of%20Disaster%20Management.doc

bridging the "preparedness divide"³⁶ among population groups.

The components that this paper will discuss are:

- 1) A clear expectation and modeling from public authorities that emergency management programming needs to include health equity considerations.
- 2) A multi-sectoral approach to emergency management
- 3) A parallel process for personal preparedness campaigns
- 4) An active and well-resourced role for the primary health care system

Standards and expectations

Under the Emergency Management and Civil Protection Act, all ministries are required to develop emergency plans and to implement associated public education. These plans are required to include Hazard Identification and Risk Assessments (HIRAs)³⁷. The inclusion of a HIRA is also a Canadian Standards Association standard for all public, private and non-profit organizations in their emergency management programs.³⁸

This requirement is an opportunity for action for the health sector to advocate an equity-based approach. It is in policy requirements that the message can be sent that a reduction in health equities that occur during and after emergencies is both critical and possible.

³⁶ Light, P.C. (2005) Homeland security's extreme makeover. Christian Science Monitor, October 12 p.9

³⁷ Ontario (2007) Emergency Management and Civil Protection Act

³⁸ Canadian Standards Association (2008) Emergency Management and Business Continuity Programs (Z1600-08)

Regarding the broader health system, Kouri has found that

*“Explicitness by [public authorities] on the goal of reducing health inequities is an important characteristic. It is a sign of commitment, as well as a way of explaining to the public the importance of the issues and raising awareness and understanding.”*³⁹

Similarly, Saunders and Monet stated “Statements from public officials announcing how important it is to exercise just and equitable distribution of resources and services during an influenza pandemic can also curtail injustice.”⁴⁰

The health sector can demonstrate how this is done by adding an analysis to HIRAs that specifies which groups face increased vulnerabilities because of specific hazards and risks. Blumenshine’s model, previously discussed, should be used to do this analysis.

Similarly, in public health emergency plans, an analysis of who could be particularly threatened by various public health measures could be an important step in reducing inequities during emergencies. The current Ontario Health Plan for an Influenza Pandemic does not do this. It states: “People who are symptom-free may be asked to maintain a modified quarantine, that is: they can leave the home to obtain essential supplies (e.g., food for the family)

³⁹ Kouri (2008) Addressing health disparities: Best practices from regional health authorities. Retrieved from: <http://wellesleyinstitute.com/files/addressinghealthdisparities.pdf> p.3

⁴⁰ Saunders, G.L. & Monet, T. (2007) Eliminating injustice towards disadvantaged populations during an influenza pandemic. *North Carolina Medical Journal*, 68(1) p.47

but not go to work”⁴¹. This statement suggests that an analysis of how quarantine will affect low-income workers has not been considered, despite the fact that low-income people are more likely to experience problems adhering to public health recommendations.⁴²

Public sector leaders can be unequivocal in their expectations that a health equity objective and analysis must be part of emergency management programs.

A multi-sectoral approach

Kouri stressed the importance of multi-sectoral strategies regarding non-medical determinants of health in a health equity strategy.⁴³ This is also true in emergency management programs.

For example, to follow up on the issue of work and quarantine, it is critical that public health authorities coordinate quarantine programs with income supports. Currently, employees under quarantine orders can apply for Employment Insurance, but the two-week waiting period applies (employers can cover this period with sick benefits). One problem with this is that the two-week waiting period is far longer than any

⁴¹ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p.6-4

⁴² Blendon, R.J., Koonin, L.M., Benson, J.M., Cetron, M.S., Pollard, W.E., Mitchell, E.W., Weldon, K.J. & Herrmann, M.J. (2008) Public response to community mitigation measures for pandemic influenza. *Emerging Infectious Diseases*, 14(5) p.782

⁴³ Kouri (2008) Addressing health disparities: Best practices from regional health authorities. Retrieved from: <http://wellesleyinstitute.com/files/addressinghealthdisparities.pdf> p.6

expected quarantine period for expected outbreaks.

Similarly, Ontario recently amended the Employment Standards Act to provide job security in the form of an unpaid leave for people following quarantine orders, but this only applies during a declared provincial emergency.⁴⁴ One problem with this is that the Ontario Health Plan for an Influenza Pandemic says that the ability to make orders such as quarantine is used “to mitigate an incident such as an outbreak of infectious disease from escalating to the level of a provincial emergency.”⁴⁵ In other words, there may be no protection for employees under quarantine orders because they will occur before an emergency is declared. It is easy to see how people will fall through the cracks in this system and it is critical that there is a multi-sectoral coordinated approach to policy problems such as this.

It is recognized that this can be a difficult task. Even within healthcare, coordination is an enormous challenge. This challenge may have been exacerbated with the implementation of Local Health Integration Networks, who fund major components of the health care systems, but are not geographically aligned with public health units and who have no role in emergency management.⁴⁶

⁴⁴ Ontario (2008) Employment Standards Act

⁴⁵ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p. 2-13.

⁴⁶ Ministry of Health and Long-Term Care (2007) Ministry Emergency Response Plan p.35

A parallel process for personal preparedness

Canada’s emergency management program used to have as its first fundamental principle “It is up to the individual to know what to do in an emergency.”⁴⁷ The flaws in the principle are enormous, from considerations of individuals who are unable ever to know such a thing, to the huge schism between knowing what to do and being able to implement it, to the fact that most authority decisions are appropriately made during an emergency, not in advance. The statement no longer appears in official Canadian documents (it still does at the provincial level)⁴⁸, but the message of individual preparedness remains consistent.

The campaign of encouraging individuals and families to develop a 72-hour stockpile is coordinated among federal⁴⁹, provincial⁵⁰ and municipal⁵¹ emergency management programs. This is a worthwhile but insufficient campaign. Groenewold examined levels of food insecurity in the

⁴⁷ Chagarlamundi, P. (1998) Geomatics in emergency planning and management: Canadian forest fire management experience. Retrieved from www.gisdevelopment.net/aars/acrs/1998/ts5/ts5004.asp

⁴⁸ Emergency Management BC (n.d.) Emergency Management in B.C. Retrieved from www.pep.gov.bc.ca/management/Emergency_Management_in_BC.pdf

⁴⁹ Public Safety Canada (2008) Your emergency preparedness guide: 72 hours: Is your family prepared? Retrieved from www.getprepared.gc.ca/_fl/guide/national-eng.pdf

⁵⁰ Emergency Management Ontario (2009) At home. Retrieved from www.emergencymanagementontario.ca/english/prepare/athome/athome.html

⁵¹ Toronto (n.d.) Preparing your emergency kit. Retrieved from www.toronto.ca/wes/techservices/oem/news/preparing_esk/preparing_esk.htm

light of a comparable American 72-hour stockpile campaign, noting such campaigns are unrealistic, unfair and unequitable.⁵² Further, he suggested that such campaigns foster mistrust of public authorities among those who are most vulnerable. Similarly, Waugh concluded that the response to Katrina failed in part because the affected population was more vulnerable than responders assumed.⁵³

This critique is consistent with Gardner's finding that "There is some evidence that general or universal health promotion programs can widen inequities as their messages tend to be taken up more by the more affluent and educated."⁵⁴ In this case, the disparity is the Preparedness Divide.

A health equity approach to planning will consider access to food during a large health emergency as a public resources priority. Statements such as the following will no longer be included in the Ontario Health Plan for an Influenza Pandemic:

"When [community mental health and addictions] agencies are serving clients who are dependent on food banks, they should work with the food banks to ensure that

*clients will be able to get food during a pandemic."*⁵⁵

Similarly, the health sector can provide leadership in demonstrating that statements such as the following in Emergency Management Ontario's Emergency Preparedness Guide for People with Disabilities / Special Needs require a parallel process: "Request that an emergency evacuation chair be installed on the floor you live or work on preferably close to the stairwell."⁵⁶ An appropriate parallel process could be contributing such chairs to identified buildings, or incenting / requiring building owners to have them available under certain circumstances.

A parallel process can be put into place for these types of campaigns for people who will not be able to implement recommendations. Regarding food security, this could include identifying food-insecure neighbourhoods and prioritizing them for response in food distribution. For campaigns encouraging people to have flashlights, radios, batteries and smoke alarms, it could mean partnering with local community service providers to distribute these items to community members. A similar model could be put into place for first-aid training for community members in areas of concentrated poverty.

An active and well-resourced role for primary care

Gardner identified primary care as a critical site for the reduction of health inequities.⁵⁷

⁵² Groenewold, M., Guernsey, J. & Weitzel, J. (2008) Incorporating social justice principles & addressing health equity through public health preparedness. Webinar retrieved from <http://webcasts.naccho.org/session-archived.php?id=1398>

⁵³ Waugh, W. (2006) The political costs of failure in the Katrina and Rita disasters. Annals of the American Academy of Political and Social Science, 604 p.20

⁵⁴ Gardner, B. (2008) Health equity discussion paper. Retrieved from <http://wellesleyinstitute.com/health-equity-strategy-toronto-central-lhin> p.33

⁵⁵ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic p.16-10

⁵⁶ Emergency Management Ontario (2007) Emergency Preparedness Guide for People with Disabilities / Special Needs. p.18

⁵⁷ Gardner (2008) Gardner, B. (2008) Health equity discussion paper. Retrieved from

Lalonde identified the features of successful primary care organizations in the Quebec Ice Storm of 1998: highly qualified staff (including training in disaster response), quick mobilization, priority to the protection of highly vulnerable persons, a rich vision of the mandate, an expansion of the tasks normally assumed by professionals, and the strategic positioning of home care services.⁵⁸

The Ontario Health Plan for an Influenza Pandemic was updated in 2008 with a significantly expanded role for primary care, suggesting that public authorities are aware of the potential of the sector to make a great contribution.⁵⁹ However, there are currently significant concerns about primary care's ability to perform these tasks. Based on the attributes identified by Lalonde, it is large, multidisciplinary community-based primary care models that are undoubtedly most capable of providing effective response and most able to assist the public and vulnerable populations with preparedness. With the proper resources, these primary care organizations could also provide leadership in local coordination.

Currently, however, primary care and home care may be the major health sectors least likely to have adequate personal equipment, access to prophylactic antiviral medications and access to information. A health equity approach among planners will include supporting the primary care sector as a

http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf p.26

⁵⁸ Lalonde, C. (2007) Primary healthcare organizations facing a disaster: The Quebec experience. *Disaster Prevention and Management*, 16 1 p.47-48

⁵⁹ Ministry of Health and Long-Term Care (2008) Ontario Health Plan for an Influenza Pandemic

partner in the reduction of health disparity.

Conclusion

The concurrent focus on health equity and emergency management provides an opportunity to bring these fields together in a way that has not yet occurred in Ontario. Considering difference in vulnerability based on exposure to risks, likelihood of harm based on exposure and likelihood of receiving adequate care for harms would be very useful for the health sector. Preliminary priorities for action are:

- A clear expectation and modeling from public authorities that emergency management programming needs to include health equity considerations.
- A multi-sectoral approach to emergency management
- A parallel process for personal preparedness campaigns
- An active and well-resourced role for the primary health care system

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