

VIII. Postscript: “Filling in the Gaps”

In this report, we have described selected public health issues and services and begun to demonstrate the relationship between health status indicators and public health programs. Accordingly, it is our intent to continue to use this information for program planning and priority setting over the next year.

Yet, our work in this regard is truly a “work-in-progress”. Preparing this report has been a co-operative effort between epidemiological and other research staff working with program staff to identify the indicators and services to be included in the report. In the process of doing so, we have also identified areas where there are important gaps in data (see Appendix D).

Therefore, it is our intention over the next three years, to develop mechanisms to address some of these gaps. By doing so, we hope to further strengthen our program planning and priority setting in the coming years.

Our plans to “fill in the gaps” are part of a long history of change in the continuum of information/data gathering, analysis, interpretation and follow-up use. Traditionally, public health has used data on births, deaths, hospitalization and communicable diseases to describe the health of the population. These data were readily available and described the important health issues of the day. As our understanding of public health issues expanded, the need for broader data became apparent. Targeted surveys were then added to collect data about specific health problems in the community and related health risk factors and behaviours. Surveys, however, have their shortcomings: for example, reaching only part of the population, addressing only some issues, too costly to repeat, etc. Over the last part of the 20th century, our understanding of public health has expanded to include the importance of looking at social determinants of health. Health indicators now need to be looked at relative to social determinants and disparities.

The indicators we have used in this report are based on all of the above methods of information gathering and analysis, each contributing important information to priority setting and program planning in public health. It is through this complementary process of information gathering that gaps in data were identified in the following areas.

Disparities in Health: In general, most data sets do not include socio-economic information about the individual or geographic information at the census tract level. This prevents an analysis of these data according to income, education and other determinants of health. When health data are available at the census tract level we are able to compare health status for census tracts with different levels of socio-economic status. Increasingly, data are

being captured with census tract or postal code information allowing for more of this type of analysis in the future.

Incidence Data: The burden of illness (as measured by incidence or prevalence) for most diseases in the population is unknown. Currently, the most consistent measures of burden of illness come from mortality data, hospitalization data and specific disease registries, of which there are only a few. Not all diseases, however, result in hospitalization or death and for those that do, not all cases of the disease will show up in these statistics.

In addition, there is currently no trustworthy data for prevalence of diseases such as mental illness, diabetes and asthma. The exception to this is Cancer Care Ontario’s registry of cancer cases, which provides an ongoing, consistent source of data for these diseases (see Appendix E for data limitations). In the area of communicable disease, only those that are legally reportable are captured in public health data sets. And, of these, reporting is usually less than complete (e.g. not all victims of food-borne illness report their condition to a doctor or to public health).

Fortunately, the Canadian Community Health Survey (CCHS) will provide us with some additional up-to-date data; however these may be limited in their usefulness.

Health Behaviours and Risk Factors: An important area of missing or old data is related to issues such as food consumption patterns, physical activity, use of safety equipment (e.g. helmets), physical environment factors, misuse of over-the-counter drugs, breast feeding, etc. The CCHS mentioned above will address only some of these data gaps.

TPH is planning on joining the new Rapid Risk Factor Surveillance System project in Ontario, which started implementation in January 2001. This will provide us with data on issues of immediate interest to public health program planning, including sun safety, heart disease, cancer risks, food security, etc.

While TPH will continue to use the currently available data for our program planning, we are also committed to enhancing it. We base our programs on evidence, and more timely and comprehensive data will help to provide broader evidence for future endeavours. Clearly, research and program evaluation findings help us to identify effective and efficient means by which to address population health needs. TPH will continue, as ever, to underscore our commitment and develop our capacity to practice evidence-based decision-making.

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