Canadian Population Health Initiative/
Canadian Institute for Health Information

The INSPQ Deprivation Index for Health in
Canada: Applications For Research, Policy and
Practice

WORKSHOP PROCEEDINGS REPORT

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Context
In 2007, a collaboration was established between the Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI), and the Urban Public Health Network (UPHN) that led to a project exploring the links between socio-economic status (SES) and health in Canada’s urban areas. Analyses were conducted using a Deprivation Index developed by researchers at the Institut national de santé publique du Québec (INSPQ). As a result of this collaborative project, the 2008 CPHI flagship report *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada* was published.

CPHI hosts an invitational workshop following the release of each of its major reports. These workshops are designed to facilitate dialogue and collaboration among stakeholders, increase knowledge exchange and provide a platform where participants can begin to explore the implications of the report findings within the arenas of policy, research and practice.

On September 23, 2009, CPHI hosted a one-day workshop titled “The INSPQ Deprivation Index for Health in Canada: Applications for Research, Policy and Practice” in Montréal, Quebec. The workshop brought together 85 representatives from government and non-government organizations, encompassing multiple sectors and disciplines (see Appendix A for List of Participants). A collaborative undertaking of CPHI and INSPQ, the workshop was shaped by the following six objectives:

- To provide background on the historical context and recent developments surrounding the INSPQ Deprivation Index;
- To share some examples of current research that has made use of the Deprivation Index, including CPHI’s *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada* report;
- To explore how deprivation indices can be used for health surveillance and needs evaluation, service evaluation and resource allocation at provincial and local levels;
- To provide practical, usable examples of how the INSPQ Deprivation Index and other indices can be incorporated into strategic policy and planning;
- To share promising practices and experiences in measuring socio-economic inequalities and health; and
- To provide a new networking opportunity for a diverse set of stakeholders working in a variety of areas, including research, policy and practice.

This report provides a summary of the presentations and the discussions that took place during the workshop.
Opening Comments
Both Jean Harvey, Director, Canadian Population Health Initiative (CPHI), and Luc Boileau, President, Institut National de santé publique du Québec (INSPQ), welcomed and thanked participants for taking the time to contribute to the workshop. Ms. Harvey provided a brief overview of the vision and goals of CPHI and Dr. Boileau shared insights into the work of INSPQ.

With shared enthusiasm, they recognized this workshop as an excellent opportunity for CPHI and INSPQ to glean insights into the perspectives and expertise from a diverse range of stakeholders. In addition to exploring the practical application of the INSPQ Deprivation Index, it was anticipated that participants would learn from the presentations and group discussion and that increased dialogue and new, collaborative relationships might be forged as a result.

A Deprivation Index for Health Planning in Canada

Presenters:

Robert Pampalon, Chercheur, Institut national de santé publique du Québec (INSPQ)  
Phillipe Gamache, Agent de recherché sociosanitaire (INSPQ)  
Denis Hamel, Agent de planification, de programmation et de recherché (INSPQ)

Dr. Pampalon began with a brief history of deprivation indices (DI) in Canada and selected industrialized countries. He set out the three main reasons for the development of deprivation indices:

- Social determinants of health are numerous and cannot be captured in a single measure such as income or education.
- There is a need to measure/monitor health inequalities to promote initiatives to reduce such inequalities.
- Health databases tend to lack socio-economic information on individuals.

The origins of deprivation indices were traced back to work done by Townsend, Carstairs and Jarman in the U.K. in the late 1980s. These efforts featured three different approaches in terms of using census data to develop variables, such as overcrowding and unemployment that were applied to small geographic areas. Further work on indices of multiple derivation was undertaken early in the new millennium in England, Wales and Scotland. These indices incorporated multiple domains and more than 30 indicators drawn from census and administrative databases. Work in this area was also undertaken in other countries such as Sweden and France, to name a few. In Canada, work on deprivation
indicators was first carried out in Manitoba in the 1990s, with subsequent work carried out in Vancouver and Quebec.

According to Mr. Pampalon, the development of deprivation indices, while utilizing robust statistical methods and data, still tends to involve significant subjective judgment in terms of what comprises deprivation. While indices generally take the form of an overall deprivation score, the diversity of methods precludes comparison among jurisdictions. In response, the Quebec index of material and social deprivation, in use since 1999, was expanded for use on a national scale. The index was originally developed to enable regional resource allocation to be based on population “needs.”

In making determinations about the appropriate spatial unit, socio-economic indicators and method of indicator integration for the Canadian Deprivation Index, the INSPQ took into account the work undertaken internationally. With Townsend’s work being based on two dimensions—material and social aspects of life—the original concept of deprivation was a “state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs.”

The spatial unit on which the Deprivation Index is based must be as small as possible in order to ensure a high degree of homogeneity in the socio-economic conditions attributed to each resident therein. The dissemination area (DA), which comprises one or more neighbouring blocks of houses with a population of 400 to 700 persons, was selected as the basic spatial unit. The postal codes that correspond to each DA were then used to link to administrative databases. Socio-economic indicators were selected based on several factors: relevance to the two dimensions of deprivation; correlation with health issues; previous use as ecological proxies for socio-economic conditions; and availability by dissemination area.

The integration of indicators into a Deprivation Index was achieved using principal component analysis. This reduces the number of indicators to a few components under which indicators are grouped and whose variations by dissemination area are relatively similar. The index was constructed in two stages: the first stage, which included dissemination areas that covered 93% of the population, generated deprivation values that were then projected onto a further set of dissemination areas to achieve 97% population coverage. The factorial structure for the material component included the proportion of persons without a high school degree, the ratio of employment to population, and average personal income. For the social component, the structure included three cohorts: persons living alone, post-marriage persons and single-parent families.

The analysis generated factor scores that represent the value of each component in each dissemination area. To ensure statistical accuracy, the distribution areas were grouped together for each component, first by ranking them according to their factor score, and then breaking the distribution into quintiles. In order to capture the essence of
“deprivation”—the comparison of disadvantage relative to an individual’s community—different versions of the index were generated (by modifying the reference territory) to produce a national version, as well as versions by major census metropolitan area (CMA), geographic area and region.

The results were then cross-tabulated, and the cross-tabulation values were assigned colour codes that were used to generate a visual depiction of how deprivation manifests itself in the jurisdiction of interest. The analyses revealed that inequalities in material and social deprivation are most prevalent in and around major and mid-sized cities.

The index, Mr. Pampalon noted, provides insight into numerous aspects of health and health outcomes. Using Quebec as an example, life and health expectancy data were matched with the Deprivation Index. Among males, the results suggest a positive correlation between deprivation and both life and health expectancy for the material, as well as the social, component. The results among females are less well-defined, although life and health expectancies are lower for both men and women within the most deprived quintiles (combined material and social components) than for men and women in the least deprived quintiles. Life and health expectancies are also lower for men and women in the most deprived quintiles than the indicator averages for Quebec as a whole.

In Quebec, health and social services funding is allocated on a regional basis, while taking into account different parameters, including population needs. The Deprivation Index is now used as an indicator of needs for three health and social services programs: youth with difficulties, general health and social services and short-term hospitalization. It is also used for regional and local planning of medical resources and in urban renewal planning in Montréal.

Since its development, the Deprivation Index has expanded in usage, particularly among a growing number of data sources, such as administrative databases and health-related surveys. Its uses now include health monitoring, service evaluation, resource allocation, and health policy development at national, regional and local levels. In terms of validation, Mr. Pampalon suggested that the use of the Deprivation Index has stood up well to scrutiny on three levels: validity, reliability and responsiveness. As for policy development, the Deprivation Index is considered transparent and comprehensible to non-specialists. It generates plausible results regarding deprivation variations across Canada and is considered durable and practical, as it is updated regularly every census year.

Mr. Pampalon acknowledged that the index does not account for some socio-economic conditions such as ethnicity or immigration and native status, which can also impact health outcomes. Nor can it differentiate the role of socio-economic conditions that are linked to the same material or social component, such as income and education. It is also prone to assignment errors, since postal codes and dissemination areas sometimes do not match perfectly, as is the case in rural areas, and it is not an individual measure of deprivation.
The Deprivation Index is a geographic marker that tracks inequalities related to the characteristics of people (composition) and their living environment (context). It identifies inequalities that need to be scrutinized further using both individual and geographic perspectives on social determinants of health.

**Question and Answer Period**

Following the presentation, Mr. Pampalon and participants explored some of the methodological limitations associated with the index. During the discussion, Mr. Pampalon acknowledged the absence of a theoretical background and the difficulty this presents in terms of interpreting results. In response to a question about whether the population size for the dissemination areas was small enough for targeted policy intervention, Mr. Pampalon offered that population size is a sensitive matter that may result in stigmatization of the population in a particular area. When asked about the inclusion of immigration status, Mr. Pampalon acknowledged that the index does not incorporate this kind of information and that other measures would need to be developed in order to address the issue.

**The Deprivation Index in Action: Examining Premature Mortality Across Canada (Group Exercise)**

As a means of exploring the application of the Deprivation Index, participants engaged in a small group activity. Within their respective groups, and referring to data and analyses from the CPHI report *Reducing Gaps in Health*, participants addressed the following questions:

1. What may be some of the underlying factors that contribute to variations in premature mortality among geographic areas and regions in Canada?

2. What may be the limitations that are inherent in this type of analysis, for example, due to methodological and data issues?

3. What opportunities can we explore that may increase our understanding of social inequalities in health across Canada?

What follows is a brief summary and synthesis of the outcomes of these small group discussions:

1. What may be some of the underlying factors that contribute to variations in premature mortality among geographic areas and regions in Canada?

The groups considered numerous possible contributions to variations in premature mortality or, in other words, the reasons why life expectancy may be different in different areas.
Consideration was given to differences in these factors: distribution of ethnic/cultural groups and Aboriginal populations, gender, cultural/philosophical characteristics, conditions of social isolation across areas and differences in predominant occupations/industry.

Differences in health care—namely inverse care law (people with the greatest need getting the least care)—was also identified as a contributing factor to differences in premature mortality between regions, although it was pointed out that these factors did not adequately explain the gaps among regions.

Another contributing factor was thought to be the potential impact of migration of healthier people to areas that are better off or that have better climates. Other groups pointed to differences in jurisdictional policy (some have proactive poverty reduction strategies), differences in housing and prevalence of student enclaves (low income but high “wealth” status).

2. What may be the limitations that are inherent in this type of analysis, for example, due to methodological and data issues?

One group shared what they referred to as the “key dimensions of social life”: the experiences of people, the characteristics of place, and the practices of institutions. They suggested that these dimensions and various sub-dimensions need to be better understood in order to accurately explain variations among geographic areas and regions. It was suggested that the index is not capable of providing the kind of information that would make such analyses possible.

Other stated limitations reiterated the index’s inability to capture regional differences in Aboriginal populations and populations of new immigrants. Some described the index as a “snapshot in time” and suggested that, as such, it may be limited in its ability to account for mobile populations, including homeless and “hidden” homeless persons. A further limitation of the area-based index was identified as “slippage” in terms of how well area-characteristics matched individual characteristics.

In addition to comments on the index itself, it was suggested that insufficient investment in data infrastructure may limit the potential for the geographic coding of smaller areas. Data consistency issues were also noted, such as geographic variations in response rates for self-reported data, potential variations within postal code areas in rural regions, as well as data timeliness within a five-year collection cycle.

Another methodological challenge noted for this type of analysis was the need to consider measurement of relative versus absolute deprivation. Looking at quintiles developed nationally and applied across regions was mentioned as another consideration. Finally, issues around missing data, in particular for Aboriginal populations, were noted.
3. What opportunities can we explore that may increase our understanding of social inequalities in health across Canada?

In response to this question, two main themes emerged: possibilities for future analyses and links to policy.

Suggested options for future analyses included

- analyses focused on communities with large proportions of Aboriginal Peoples or immigrants;
- age and sex-based analyses;
- examining changes in the Deprivation Index over time across neighbourhoods;
- closer examination of high- and low-performing areas to better characterize the factors associated with their performance; and
- inclusion of more health variables/indicators.

Examination of practices, indicators and standards at the international level was also encouraged. Recent work undertaken by the Organisation for Economic Co-operation and Development, for example, was identified as meriting further analysis, as was the population health framework introduced by the World Health Organization’s Commission on Social Determinants of Health.

A policy-related suggestion involved reconfiguring the maps according to constituency boundaries to highlight inequities in terms of voting patterns, while maps based on real estate markets may be useful for municipal planners—particularly if trends over time can be identified. Finally, a number of groups suggested that, overall, more could be done to ensure that the data effects meaningful policy change.

Groups also noted the importance for consensus around an appropriate measure(s) that is widely endorsed to consistently measure impact of policies on disparities in health.

CPHI Report—Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada

Presenter: Jason Disano, Program Lead, CPHI

Presentation Summary

The objective of the CPHI report Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada was to provide a broad overview of the links between socio-economic status (SES) and health in 15 Canadian census metropolitan areas (CMAs), while exploring socio-economic patterns and gradients within those CMAs and across urban Canada.
The 15 CMAs selected for the analyses provide a broad geographic representation of Canada’s urban areas and actually correspond to the 18 member cities in the Urban Public Health Network (UPHN). The selected CMAs are as follows: Victoria, Vancouver, Calgary, Edmonton, Saskatoon, Regina, Winnipeg, London, Hamilton, Toronto, Ottawa–Gatineau, Montréal, Quebec City, Halifax and St. John’s.

Using the INSPQ’s Deprivation Index, the report presents analyses of a broad range of health-related indicators from CIHI’s Discharge Abstract Database (DAD) and National Trauma Registry (NTR), as well as cycles 2.1(2003) and 3.1(2005) of the Canadian Community Health Survey (CCHS).

Application of the index involved identifying the urban dissemination areas (DAs) in each of the selected CMAs (rural DAs were excluded from the analyses). A total of 30,294 urban DAs were included in the analyses—which represented approximately 66% of all DAs that CPHI classified as “urban.”

Each urban DA was assigned, relative to its region, a deprivation score of low SES if the population was in the lowest quintile for both the social and material components of the Deprivation Index, high SES if it was in the highest quintile for both components, and average SES for populations that fell into all the remaining quintile combinations. Age-standardized hospitalization rates and self-reported health indicator percentages were calculated within the three SES groups for each CMA, and for all 15 CMAs collectively.

Twenty-one indicators were presented for each CMA by SES group. CIHI provided age-standardized hospitalization rates per 100,000 people for 12 different medical conditions, as well as the percentage of low birth weight babies per 100 live births. The CCHS provided data on self-reported health and certain health-related behaviour on eight indicators. The analyses enabled comparisons between SES groups within each CMA for each indicator, as well as between CMAs and the overall pan-Canadian rate for each indicator within each SES group.

In terms of the pan-Canadian, age-standardized hospitalization rates by SES group, the analyses revealed that hospitalization rates were generally higher for the low-SES group than for the average-SES group and generally higher among the average-SES group than the highest SES-group.

The pan-Canadian ratio of age-standardized hospitalization rates between low- and high-SES showed substance-related disorders bearing the steepest gradient: hospitalization rates in the low-SES group were about 3.4 times those of the high-SES group. Other notable examples include mental health-related hospitalization rates, which were about 2.3 times higher in the low-SES group compared with the other two SES groups; ambulatory care sensitive conditions rates, which were more than 2.3 times higher; and diabetes rates, which were about 2.4 times higher.
For the self-reported health indicators, the differences across the three SES groups were statistically significant except in the case of self-reported overweight or obesity, where there was no significant difference observed between the average- and high-SES groups.

Mr. Disano acknowledged the complex relationship between SES and health in urban Canada. He underscored the value of examining gaps in health across an SES gradient, as well as addressing dichotomous differences—high versus low SES—and suggested that subsequent work will divide the populations into five quintiles of SES, rather than three, which will yield a greater level of detail.

**Question and Answer Period**

Following the presentation, a short question and answer period ensued where Mr. Disano and the participants briefly explored a number of issues including reverse causation and the use of dynamic modelling in analytical work. While Mr. Disano addressed the report’s methodological limitations, he acknowledged the value of the analyses presented and underscored the research opportunities that need to be further explored.

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**University of Ottawa Report—The Ottawa Neighbourhood Study**

*Presenter: Dr. Elizabeth (Betsey) Kristjansson, Associate Professor, University of Ottawa*

**Presentation Summary**

The Ottawa Neighbourhood Study (ONS) is a detailed study that defines neighbourhoods in terms of measuring and mapping a number of social determinants of health, including socio-economic status (SES) and health outcomes. While initial funding was provided by the Canadian Institute for Health Research (CIHR), a 2006 Census Update was funded by three local community organizations: the Coalition of Community and Health Resource Centres of Ottawa, the Champlain Local Health Integration Network (LHIN), and United Way Ottawa. The work was supported by a steering group that included representatives not only from the funding agencies but from academia, the City of Ottawa—Ottawa Public Health and the Success by Six initiative.

Dr. Kristjansson began her presentation by acknowledging that the ONS was consistent with the findings of the work covered in the preceding presentations: people in lower-SES neighbourhoods tend to have poorer health outcomes. As well, strong social ties with communities were found to be related to better child outcomes and better mental health, while perceived neighbourhood disorder generates poorer outcomes. The report, she noted, is based on the premise that poor neighbourhoods have fewer resources for health and provide fewer basic needs. A small project called Photovoice was undertaken with
neighbourhood youth, who provided compelling visual evidence to support this theory. The photos they captured highlighted the challenges: the risk of injury from massive chunks of falling roof-ice; the perception of squalor created by an insufficient frequency of garbage removal; and the proliferation of abandoned shopping carts as residents struggle to transport food to their homes from distant supermarkets.

The key to the ONS methodology was the appropriate definition of individual neighbourhoods, which took into account physical barriers and similarity in demographics. The process also incorporated city and community team member knowledge, as well as factors used in the development of real estate maps. After several iterations, the boundaries were also consistent with city planning needs, which resulted in 96 neighbourhoods, of which 91 had enough data to be included in the study.

Sources for the ONS included data from the 2006 Census, the National Capital Commission, the City of Ottawa, local school boards, DMTI Spatial (a provider of digital mapping data), the Canadian Community Health Survey (CCHS), the Rapid Risk Factor Surveillance System (RRFSS), hospital discharge abstracts, and the National Institute on Drug Abuse. The study also included a web search, as well as primary research in the form of phone interviews and on-location work. While the outcomes used for the study were health and school readiness, it included a wide array of indicators based on theoretical frameworks or empirical evidence of their relationship with health outcomes:

- The natural environment (prevalence of parks and other green space);
- The characteristics of access to goods, services and amenities in terms of food and recreation;
- Access to education in terms of neighbourhood schools and libraries;
- The social environment in terms of voting rates, crime, mobility, and sense of belonging;
- The built environment in terms of deterioration of housing, crowding, affordability, dwelling type and age, as well as home ownership rates;
- Socio-demographics;
- The nature of available financial services; and
- Health services.

Compared with the Deprivation Index, the ONS focused more on the material advantage, which included the proportion of people below the low-income cut-off (LICO), average income, the local unemployment rate, the proportion of adults with less than high school education and the proportion of lone-parent families. A principal component analysis indicated a very good fit for these components, which were combined into a single index that was used to divide neighbourhood population into quintiles. The quintiles were then colour-coded and mapped onto the neighbourhoods defined for the study.
Index mapping for Ottawa indicates that the most advantaged quintiles are located in suburban and rural neighbourhoods. The study does not, however, adequately capture known pockets of rural poverty, as some areas have a concentration of wealth along a riverfront, while people below the LICO live just across the street.

Dr. Kristjannson presented a number of findings from the study:

- The “recreation index,” which incorporates the prevalence of facilities, as well as bike paths and park space per person, demonstrates significantly greater availability for persons in the higher income quintile neighbourhoods; facility usage, however, is more evenly distributed, although significantly lower for the lowest quintile neighbourhoods.

- The rates for persons who are physically inactive during leisure time are generally higher in the more disadvantaged quintiles; the more disadvantaged the quintile, the higher the rate.

- There was no significant difference among neighbourhoods in terms of grocery/specialty store prevalence, although there was a significantly higher prevalence of fast-food outlets in third income quintile neighbourhoods, as well as higher convenience store prevalence in the lowest-quintile neighbourhoods.

- The percentage of homes needing major repairs was significantly higher among the lowest income quintiles, which also had a significantly higher rate of persons per room. The proportion of smoke-free homes was smaller for the lowest income quintile neighbourhoods.

- Low birth weight babies and births from teen pregnancy were higher among the lower income quintile neighbourhoods.

- Scores for self-rated health and access to health services in terms of regular doctor and dentist visits were higher among the higher income quintiles.

- Hospitalization rates for ambulatory care sensitive conditions (ACSCs) were more than 30% higher for the most disadvantaged quintiles than the neighbourhood average.

After the ONS was released, city planners adopted the study’s neighbourhood definitions. As well, a new Community Development Framework was based on ONS data, which was used to identify four high-priority neighbourhoods in terms of health, school readiness, poverty and crime. Reports were generated and delivered to CHC/CHRC and the LHIN. They contained overall Ottawa results by SES; catchment profiles; profiles for all neighbourhoods in each catchment; and a set of recommendations.

In terms of next steps, a number of knowledge transfer actions are underway (with CIHR funding): enhancements to the project website; strategic deployment of a knowledge
broker to improve data; and application of the data and findings to the planning process by
the city and the project’s supporting agencies.

**Question and Answer Period**

During a brief question and answer period, participants explored the differences between
what this study provides beyond that provided by other tools, such as the Deprivation
Index. While Dr. Kristjannson acknowledged the commonalities, she also noted that the
ONS is somewhat different because it includes the low-income cut-off but focuses less on
social impacts.

**The Deprivation Index in Action: Focus on Health of
Populations and the Determinants of Health (Group Exercise)**

**Summary**

For this exercise, each small working group was assigned one CMA and three health
indicators that were covered in *Reducing Gaps in Health*. The working scenario positioned
participants as members of a planning committee called upon to develop a health action
plan that addresses the health outcomes relevant to their respective CMA.

During the report-back session, some participants suggested that the development of an
action plan was preliminary and that the exercise inspired more reflection on what “all of
this means” across socio-economic strata than on action-oriented thinking. The most
prominent theme that emerged during the discussion was the overall need to conduct more
research. On the one hand, this will lead to a more extensive exploration of international
work; on the other, there is a great need for community consultation as a means of helping
to frame the issues and increase our understanding of the contextual factors at play in
smaller areas of geography.

**World Café-Style Discussion**

Sadiq Raji, Senior Analyst, CPHI, facilitated an open microphone group discussion inspired
by the following questions:

**What are your experiences as an individual or as an organization with measuring socio-
economic inequalities and health?**

**What are some of the best practices that have been implemented and applied in your
organization or broader community to address socio-economic inequalities and health?**
He also encouraged participants to bring forward “burning questions” or issues that might be important to consider moving forward.

Summary

This workshop convened a diverse range of individuals whose expertise spans the fields of research, policy and practice. Within that arena, there was expressed interest in having more dialogue with, and input from, those who contribute to the policy development process. Workshops and other similar fora were identified as important mechanisms for increasing policy-based input and for promoting multidisciplinary and cross-sector collaboration. International work continued to inspire discussion among participants. The public health observatories in the United Kingdom and other international best practice models were cited as opportunities to gain a more fulsome understanding of what can be accomplished in the field of population health.

Newfoundland Community Accounts was brought forward as an innovative Canadian information system worthy of recognition. The system has been in place in Newfoundland and Labrador for approximately 15 years and has been exported to Atlantic Canada. An important feature of the system is its accessibility to many audiences. It provides users with community, regional and provincial data that is free of charge and negates any retrieval and/or compilation challenges. The system was presented as an excellent means of increasing the opportunity for more people to address the issue of health inequalities.

At the community level, best practice initiatives were also discussed, including a community health centre that has adopted a “group approach” to health services. This integrated practice employs what was termed “open access”—the insurance that each patient will receive care within a 24-hour period. This community health centre also provides dental care/hygiene, which was identified as a potential indicator of other health issues and one that warrants greater attention.

The Cancer Care System Quality Index, an initiative of Cancer Care Ontario, was introduced as a system that monitors progress against cancer in Ontario and helps to inform service providers’ efforts to understand where quality and performance improvements can be made. To build on the index, it was noted that an effort has been launched to begin incorporating socio-economic disparities into measures of quality care. The work is ongoing.

Less of a burning question and more of a burning curiosity was the interest in whether or not there should be an increased focus on qualitative indicators. Quantitative indicators, it was noted, are largely pattern providers, and while they draw attention, ultimately, they have limited explanatory power. Qualitative indicators, it was suggested, might provide more insight into the “why” in addition to the “what this might look like.” While the level
of commitment required would be great, there was some interest in engaging in a broader
discussion to further explore the potential opportunities and implications.
APPENDIX A

List of Participants
The INSPQ Deprivation Index for Health in Canada: Applications for Research, Policy and Practice
September 23, 2009 - Montréal, Québec

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