Race-based COVID-19 data: What it is and how it works

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Do you know what race and income-based health data are and how they're used?

Ontario's chief medical officer of health, Dr. David Williams, said on May 6 that the province would soon begin collecting race- and income-based COVID-19 data.

While health units in Toronto, Peel, Ottawa, Middlesex-London, and Sudbury have begun collecting their own race- and income-based data, Ontario has yet to mandate or standardize it.

"We are in the process of working with public health and privacy experts to determine how best to collect this data across all public health units," Hayley Chazan, spokesperson for Health Minister Christine Elliott, told Torstar in a statement on June 2.

On June 3, Andrea Horwath, leader of Ontario's Opposition NDP, called on Premier Doug Ford to issue an emergency order to collect race-based health-care data.

At a time when COVID-19 and racial justice are commanding attention across Ontario, the concept of race- and income-based health data has fresh pertinence. For anyone unsure of what these data are, and what they mean in the context of COVID-19, here is a basic primer.

What is race-based health data?

Race- and income-based data can offer insight into whether Black people, Indigenous people, people of colour and low-income earners are harder hit by certain diseases.

In the case of COVID-19, health-care professionals may gather information about a patient's race or socioeconomic status by asking questions like the ones the province is considering for use in standardized data collection:

Which race category best describes you?

What was your total household income before taxes in 2019?

Including yourself, how many family members live in your household on a regular basis?

With this information, public health agencies can tell whether racialized or low-income communities have a higher share of Ontario's COVID-19 cases or worse outcomes than other communities.

How does race- and income-based data impact health-care delivery?

When policymakers and health-care providers know certain people are more likely to

experience worse outcomes from a disease, they can deliver health care that is tailored to that group, to help close the gap.

Angela Robertson is executive director of Parkdale Queen West Community Health Centre. She and other Black leaders in health are concerned about pre-existing disparities for Black people that COVID-19 will amplify. – Torstar file photo

Angela Robertson, executive director of Toronto's Parkdale Queen West Community Health Centre, cites research by Cancer Care Ontario on cancer rates and mortality in women as an example of this type of problem solving.

"What their data reveals is that immigrants, racialized women, low-income women and individuals who are trans-identifying had a lower (cancer) screening rate," she said.

"And one of the things we know about a lower screening rate and the impact on these populations, is that we — I include myself in this — were more likely to be diagnosed with cancer in a later stages, which then could mean a higher mortality rate."

Robertson said the data allowed health-care providers to create targeted strategies to increase screening rates in these populations and improve their health outcomes.

"Collecting race-based data can be instructive in health planning and improving the health outcomes of racialized populations because we can introduce early intervention," she said.

What role can it play in the COVID-19 pandemic?

Data can help inform how health-care providers allocate resources to help at-risk populations in the short term, as well as informing future public health policy and resource allocation, said Neethan Shan, executive director for the Urban Alliance on Race Relations in Toronto.

“The quicker these data can be gathered ... the faster we can save lives within racialized communities and within all communities,” he said.

Solutions might include making personal protective equipment and COVID-19 testing more readily accessible to people in racialized or low-income communities, sharing information about COVID-19 that is culturally and linguistically sensitive, increasing the number of sick days people can take off of work and making public transit safer for people who still rely on it to get to their jobs.

“We know anecdotally that racialized communities are over-represented in the number of people who have come into contact with COVID-19,” Shan said. “So you can look at it from the point of view of who has precarious employment? Who is in the essential workers category? Who is over-represented on the front lines?”