Association of Ontario Health Centres
Community-governed primary health care

Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

Towards Equity in Access to Community-based Primary Health Care: A Population Needs-Based Approach

Project Summary

CHCs and AHACs have an explicit mandate to comprehensively serve the health needs of population groups with barriers to access to care including disadvantaged groups in urban settings and geographically dispersed populations in northern, rural and under-serviced areas. The question the study sought to answer was:

> "If we identify the distribution of the 2-3 million people who most need CHC or AHAC services (according to population needs-based models), how could resources to support an additional 250,000 Ontarians be distributed so that the Priority Populations could have equitable access to community-based primary health care wherever they live Ontario?"

The results would need to support Five Strategies (Aboriginal, Francophone, Urban, Southern-rural and Northern-remote) and ideally achieve equity among them and across Ontario.

We created a priority population that included many of the groups that are identified priority populations of CHCs and AHACs. These include: low income people, Aboriginal Peoples, Francophones, people with a disability or activity limitation due to a long term physical or mental health problem, recent Immigrants and non-permanent residents (e.g. refugees, migrant workers), racialized groups, and people living in areas with geographic access barriers. The population groups are the main groups other than age and sex for which detailed data is available that can be used to estimate the number of people with multiple potential barriers to access. The study used multi-way cross tabs of the 2006 census (purchased for the 141 secondary subLHIN geographies) supplemented by: rurality scores at the census subdivision level that were rolled up into subLHINs; updated poverty rates (after-tax LIMs, 2008); and updated Aboriginal data (Indian Register, 2009). All the data was standardized up to the 2009 population estimates obtained from MOHLTC for the 141 subLHIN community planning areas.

A priority population was produced that was a subset of the above groups that totalled 2.7 million excluding all the overlaps. This included all low income people, all Aboriginal peoples (to the extent possible given data limitations), Francophones with multiple potential access barriers, and people living in high RIO areas with multiple potential access barriers. Additional larger priority populations were also created but not used in the results prepared in this study.

Minimum service equity targets were set (ranging from 25% to 50%) for each population group and geographic area type (six geographic area types were created). Targets were set higher for Aboriginal peoples and in remote areas. The number of people being served by CHCs and AHACs was tabulated by geocoding client records with postal codes to the 141 subLHINs and distributing clients without postal codes according to a set of guidelines and the individual expansion status of each CHC or AHAC. Subtracting existing clients from the service equity targets results in calculated service gaps for each population and subLHIN. These results provide one input to a priority setting process that would also consider the accessibility of services provided by other primary health care models and community preferences, etc.

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1. Introduction

1.1 Purpose

The purpose of this study is to identify and describe an equitable distribution of community-based primary health care services provided by Community Health Centres (CHCs) and Aboriginal Health Access Centers (AHACs) in Ontario. This information is needed to plan service expansion towards achieving equity in access to CHC and AHAC services. The Association of Ontario Health Centres (AOHC) initiated this study in order to determine where the greatest gaps were between the greatest need for CHC and AHAC primary health care services and existing access to these services. AOHC has set a target of doubling the number served to reach one million by 2020.[1] This study supports an initial service expansion planning target of 250,000 persons. This is approximately a 50% increase in primary health care clients served by CHCs and AHACs.

The number of people receiving individual and group primary health care from CHCs and AHACs has grown significantly over the past five years. During 2004 and 2005 the provincial government announced expansion of funding that would increase the number of CHCs by 22, and add 27 new satellites. This would potentially increase the number of people served by CHCs and AHACs from approximately 300,000 to 500,000. As of March 2011, CHCs and AHACs were providing individual and group primary health care to more than 425,000 people across Ontario (3.3% of Ontario's 13 million population). When the 2004-2005 expansion has been fully implemented, a total of 75 CHCs and 10 AHACs will be providing individual or group primary health care to well over half a million people in Ontario. The estimate that emerged from CHC and AHAC data compiled as of June 2011 based on actual current clients and projections is 517,950 persons which is 4% of the Ontario population. This is the number used as the baseline for the existing CHC/AHAC service level for primary health care clients in this study.

The geographic areas for the analysis in this study are the 141 community planning areas (secondary subLHINs, Version 9, 2010). We use the best available data for these geographic levels to describe the distribution of population groups with greater health needs and potential barriers to access. Our planning assumptions guide the identification of the priority populations for access to CHC and AHAC services and the choice of service levels that are used as measures of equity. In a nutshell, subtracting the number of people served by CHCs and AHACs in each area from each area's service equity target (share of the priority population) provides a measure of the size of the potential service gap in equitable access to CHC and AHAC services across Ontario.

This study was conducted by Steps to Equity, an independent research service with experience in needs-based resource allocation and equity-focused health planning. The study was supported by funding from Echo – Improving Women's Health in Ontario, an Agency of the Ministry of Health and Long Term Care. This study was also supported by funding and resources provided by Steps to Equity and AOHC. This report does not necessarily reflect the views of Echo or the Ministry.

[1] AOHC. (2010). Ontario's Community Health Centres. Addressing Ontario's Great Health Divide.

1.2 Overview of the Approach

Equity is a judgment about fairness (in this case distribution of CHC and AHAC services according to the need for these services). This judgment needs to be based on all of the above principles as well as transparency regarding the values, assumptions, quality and limitations of the evidence; and leadership and accountability for the choices that are made. The challenges faced by this study included identifying methods, good quality data and a decision making process that takes into account the different health needs and the multiple barriers to access to health care often experienced by diverse population groups across geographic regions of Ontario.

AOHC identified the need for five separate strategies for equity in Aboriginal, Francophone, Urban, Southern-Rural, and Northern-remote service planning. Aboriginal peoples include all First Nations, Métis and Inuit, registered and non-status, on and off reserve). In order to be useful (strategy-based) the results need to be easy-to-use.

The approach used by this study is population needs-based resource allocation which is an equity-focused approach being used in Ontario and elsewhere. This approach typically uses indicators of the relative need for health services of all the geographic areas to be included in conjunction with resource information (budget, FTEs, etc.,) to match the distribution of resources to the distribution of population needs across these geographic areas. Decision makers use the results of the analysis as one source of evidence in their decision making about how to allocate resources equitably across these areas. The primary method we use is based on the distribution of counts of distinct segments of the population that are considered priority groups for the CHC and AHAC services.

1.3 Reports and Results

This report describes the context for a targeted expansion of CHC and AHAC services to support heath equity in Ontario as well as detailed information about the population needs-based approach and methods used in the study. This report has been adapted from the full report (available) and some of the more detailed information is included in numbered Technical Notes which are included in a supplementary document. All of the final results produced by this study are included in the tables attached to this report.

2. Community-Based Primary Health Care and CHCs/AHACs

2.1 Primary Health Care

Community-based primary health care (PHC) provided by CHCs and AHACs exemplifies the original vision of PHC when it was proposed in 1977 as a key strategy for reducing health and social inequalities. In 1977, the World Health Assembly, the central authority of the WHO resolved to work towards reducing existing health inequalities that were seen as "politically, socially and economically unacceptable." "Primary health care (PHC) in the spirit of equity, social justice and participation" was identified as the key strategy for reducing these health inequalities.[2] Universal access to primary health care is an essential strategy for achieving health equity and an effective and efficient health care system.[3]

While it is recognized that the structural determinants of health account for the majority of health inequities,[4] primary health care is an important way that health systems can reduce health and social inequities. Primary health care is often narrowly understood as a 'sector' in the health care system (competing with other sectors for resources) rather than as a 'strategy' for organizing health systems. Underinvestment in PHC relative to other sectors is one way that health systems contribute to health inequalities.[5] A "one-size fits all" approach has meant that the potential for PHC has not been fully realized.[6] A passive "response-to-demand" in health care fails to help large groups of people who are or feel excluded from access to services, or are left out from screening, prevention, treatment or outreach. When PHC services are not planned and delivered to reach all the population including those with barriers to access, health inequities are widened and preventable illness and costs are increased. Many Canadian researchers have concluded that treating the population as if everyone could benefit equally from a service or program intervention or investment has created unjust health and social disparities that could have been avoided by treating groups equitably (taking differences into account).[7]

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[2] WHO. (2008) World Health report 2008. Primary Health Care – Now more than ever (see p 11); Gilson L, Doherty J, Loewenson R & Francis V. (2007). Challenging inequity through health systems. Final report of the Knowledge Network on Health Systems. WHO Commission on the Social Determinants of Health; WHO Regional Office for Europe, Health for All 2000.

[3] WHO, (2008); PAHO, (2007); Institute of Alternative Futures, (2012).

[4] An often quoted graph by CIAR shows a pie chart that suggests health care contributes 25% to population health. Canadian Institute for Advanced Research, Conference Board of Canada, in Public Health Agency of Canada http://www.phacaspc.gc.ca/canada/regions/ab-nwt/resources/present/ppt_02-10-02_s47.htm
See also WHO/Wilkinson, (2006). The Solid Facts; WHO Commission on the Social Determinants of Health, (2008).

[5] Mador, R. (2010). Health System Approaches to Promoting Health Equity: A Discussion Paper Submitted to the "Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention" Project Steering Committee, BC Provincial Health Services Authority

[6] WHO (2008)

[7] Frohlich K & Potvin L. (2008). The Inequality Paradox: The Population Approach and Vulnerable Populations. *Am J of Public Health,* 98 (2); Culyer A, & Bombard Y. (2011). An equity checklist: a framework for health technology assessments. Centre for Health Economics. University of York, UK; Edwards E. & Ruggiero E. (2011). Exploring which context matters in the study of health inequities and their mitigation. *Scand J Public Health* 39(Suppl 6): 43-49; Patychuk & Seskar Hencic, 2008 Patychuk D & Seskar-Hencic D. (2008). First Steps to Equity

2.2 Dimensions of Access

Access is multidimensional (see box 1). Multiple dimensions of access identified over thirty years ago include: affordability, availability, accessibility, accommodation, and acceptability.[8] It was suggested that these "form a chain that is no stronger than its weakest link" and that access is only achieved if all its components are ensured.[9]

Box 1. Dimensions of Access

Affordability	Availability	Accessibility
Acceptability	Appropriateness	
Cultural Safety	People-Centered	Quality
Continuity	Comprehensiveness	Integrated

The terms population-based, people-centered, patient-centered occur in descriptions of primary health care (see also the "medical home" concept (in the US).[10] Ontario's *Excellent Care for All Act 2010* states a vision of "a high quality health care system…that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focused, and safe." In this study we use the term 'people-centered' rather than patient-centered, to be consistent with the broader concept of primary health care in which communities are more than patients or clients, but also involved in the design and delivery of services and strategies to meet community health needs.

Barriers to access are experienced differently by different population groups. There is substantial evidence concerning barriers to access to primary health care beyond sex, gender and income[11] that includes immigration status, disability, Aboriginal identity and status, Francophones, official language ability, housing/homelessness, sexual orientation, racialization, transportation, health insurance coverage/benefits and geographic barriers/living in remote or underserved areas. Individual experiences vary.

2.3 CHCs and AHACs

CHCs and AHACs are community-governed primary health care organizations that provide comprehensive services and strategies relevant to the needs of their communities. Most have geographic service areas. Many focus, prioritize or only serve identified priority populations facing barriers to access to services. Most CHCs were established based on community-driven needs assessments that demonstrated their communities had greater health needs and faced access barriers that could be addressed through CHC programs and strategies.

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[8] Penchansky, R., & Thomas, J W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care,* 19(2):127-40. in McLaughlin, C., & Wyszewianski. (2002). Access to Care: Remembering old lessons. *HSR: Health Services Research,* 37(6):1441-1443; Jackson, V. (2010,). A look at disparities by availability, accessibility, affordability, appropriateness, acceptability. Georgetown Technical Assistance Call Ser.; Mador (2010)

[9] McLaughlin & Wyszewianski (2002).

[10] Rosser et al. (2011). Progress of Ontario's Family Health Team Model: A patent-centered medical home. Annals of Family Medicine, 9(2):165-171.

[11] Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D.. (2006). Low-income Canadians' experiences with health-related services: implications for health care reform. *Healthy Policy,* 76:106-121

Although the term 'community-based primary health care' has been used in other contexts,[12] CHCs and AHACs are the primary health care model that in practice best fits this label.[13] Among models of primary care, only the practice, governance and community participation of CHCs and AHACs are consistent with the multiple broader definitions of primary care. This includes taking action on the social and community level determinants of health, community governance as well as outreach and support activities (translation, transportation, counseling/education, peer support and navigation, etc.) that reduce barriers to access to care. Adequate investment in these non-clinical or "enabling services" [14] can play a crucial role in health equity (access and outcomes) especially for marginalized populations. CHCs and AHACs also integrate alternative, culturally appropriate approaches and address local conditions and determinants of health.

Priority groups for CHC and AHAC services are populations that have demographic characteristics that are often associated with barriers to access or greater health needs. Research shows that populations may encounter barriers in access to primary health care services for many reasons such discrimination, Eurocentrism, heterosexism, gender bias, social exclusion, where they live in Ontario or when available services are not well adapted to population characteristics such as complex heath needs or disability, or social conditions (income, housing, legal status, etc.). Barriers to access to care are one of the explanations for health inequalities among population groups in Ontario. As noted by researchers on measures of access to primary health care, a population with greater health needs requires relatively more services to maintain an equivalent level of access compared to a similarly sized population with lower health needs.[15] Low income populations require greater access to care because of their higher rates of illness, disability and premature death.[16] Equitable access to community-based primary health care is a function of multiple dimensions of access including how well the level and type of services match the health and social needs of all the diverse groups that make up the population.

3. Current Status: Service Capacity of CHCs and AHACs

3.1 Steps and Assumptions Used in Producing Client Distributions

An essential component of the analysis was to determine the distribution of existing CHC and AHAC resources (primary health care clients served by CHCs and AHACs). This section describes the steps in analysis and the assumptions that decided how missing information was addressed.

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[12] Lavis JN, Boyko JA. Evidence Brief: Strengthening Primary Healthcare in Canada. Hamilton, Canada: McMaster Health Forum, 11 May 2009. http://healthcouncilcanada.ca

[13] Muldoon L, Dahrouge S, Hogg W, Geneau R, Russell G & Shortt M. (2009). Community orientation in primary care practices. *Can Fam Physician (56)*:676-83.

[14] AAAPCHO and NACHCs. 2010. Highlighting the role of enabling services at Community Health Centes. The enabling services accountability pproject.http://enablingservcies.aapcho.org

[15] McGrail & Humphreys. (2009). The index of rural access: an innovative integrated approach for measuring primary care access. BMC Health Services Research, 9(124).

[16] Mador, (2010).

Each CHC received a letter requesting that client data be tabulated (common query provided) that included CHC and satellite ID#, Age, Gender Code and Postal code for each active registered client (users of primary health care services or personal development groups with encounters between April 1, 2008 and March 31, 2011). The data was to be sent by a password protected file (the password was obtained separately and not included in any communications accompanying the data file). The uses identified for the data included showing the number of clients served in primary health care and to "prioritize regions that demonstrate the most need for expanded access to CHCs." The data was to be used in aggregated form.

The data base compiled included 70 CHCs with actual counts (363,924) plus 2 with estimates (6,400), plus 10 AHACs with 55,638 clients totaling 425,962. In addition there were 3 new CHCs (that will serve an estimated 10,700 persons) for a total of 436,662 current clients. Estimates were also obtained from each of the 75 CHCs that reflected the number they expected to be serving at full expansion. The estimates from growing CHCs and the new CHCs resulted in a total of 517,953 clients (projected total at full expansion) based on 75 CHCs and 10 AHACs.

Client postal code was used to identify the subLHIN that each client resides in using the Statistics Canada postal code conversion software (PCCF+).In the geocoding of client data for this study, of the 363,924 records included, 356,026 (97.8%) were successfully allocated to a subLHIN area. The remaining 11,120 (3.1%) did not geocode to a subLHIN for a variety of reasons (postal code new or not recognized by the geocoding file, out of province client, homeless clients, etc.). Out of province clients numbered 1,857 (0.5% of records) and 1357 (0.4% of records) had been or had been assigned a dummy postal code (HOHOHO) typically used for clients who are homeless/no fixed address. The remainder of clients with records that did not geocode included 7,898 (2.2% of records). In addition there are 154,026 estimated clients (projections, AHAC clients, new or existing CHCs not yet in operation/not able to produce client data) that need to be included. This includes 98,388 projected and estimated clients for new centres or growing centres.

Because existing clients are used as a measure of service capacity, it was important that all clients be included in the analysis or the gap analysis would overestimate the gap. For most CHCs, clients without geocodable postal codes were allocated across subLHINs according to the CHC's distribution of clients with postal codes across the subLHINs. The exception was all CHCs under expansion, those with more than 5% missing postal code, and AHACs. In these cases individual information from each CHC and AHAC was used to determine how these clients would be distributed.

For this study, Francophone clients are defined as all those served by Francophone CHCs as well as the Francophone population share of the clients served in each area served by bilingual CHCs.

AOHC was the primary contact with AHACs and Aboriginal organizations regarding the assumptions and guidelines concerning Aboriginal client distributions. The guideline that was used was that each AHAC had an equal share of the total AHAC clients. Information that described the geographic area served and population served by each

AHAC was obtained from each AHAC via the AHAC website or the website of the tribal authority sponsoring the AHAC. No estimates were developed for the age, sex and income profile of AHAC clients. Some Aboriginal communities are served by other CHCs but this information is not available in the CHC client data available for this study. Where available from CHCs, this is included in the analysis in the Aboriginal report.

We have created a category called Other Clients (total minus those that are counted as Aboriginal or Francophone). A change in the distribution of clients from that used in the analysis conducted for this study by population group would result in a change in the calculated gap. In the published tables, we have suppressed data for any cells with clients counts <5 (i.e. 1-4 clients) as is standard epidemiological practice for the protection of privacy.

The postal code of each client was also linked to the Dissemination Area (DA) (the smallest census geographic unit) in order to obtain the income quintile that Statistics Canada assigns to each DA.

3.2 Limitations of the Client Distributions Produced by this Study

The "active clients receiving primary health care over a three year period" is the standard way that CHCs and AOHC compile and analyze active client data. This may not be comparable to the way that other primary care models count their clients.

The completeness and quality of this data is dependent on the consistency of data collection, technology, and each CHC having a Data Management Coordinator (DMC) on staff to prepare the data. Three did not and several new centres, had only limited clients to report as yet, or were not yet operational.

The potential overlap between clients (people who may have received services from more than one CHC or AHAC) was not possible to identify. Given the higher than average mobility of some groups (young people, Aboriginal populations), there may be variations in the amount of overlap among different CHCs and AHAC clients.

The population data in this study used to create the priority population counts, is standardized to be consistent with 2009 population estimates, while the estimate of active clients as of March 31, 2011 (includes April 1, 2008 to March 31, 2011).
The geographic units for this analysis are the 141 subLHIN community health planning areas (Secondary subLHINs Version 9, 2010). These areas are combined adjacent census subdivisions (CSDs) such as counties, towns, etc., or dissemination areas (in urban areas). These may not resonate with CHCs, AHACs and the communities they serve. CHC service populations have not to date been planned according to the boundaries of LHINs or subLHINs. The subLHINs are however more practical for province-wide service equity than using CSDs or FSAs which each total more than 500 geographic units and would result in numbers too small in many cases to work with.

It cannot be assumed that all existing clients are in the identified priority population (estimates for the priority population for CHC and AHAC services that was prepared for this study.) Some CHC have strict eligibility criteria such as being a member of one of

the CHC specific priority populations, living in the service area and not receiving care from another provide. However, other CHCs have existing clients and/or accept new clients that may not be in one of the priority groups, or the status of clients (e.g. income status) may have changed over time. A detailed profile of the existing clients of CHC and AHACs was outside the scope of this study.

3.3. Summary of CHC/AHAC Distributions

Table 1 shows that more CHC and AHAC clients live in low income communities or remote communities and are Francophone or Aboriginal (Column C) than in the population overall (Column A). The priority population that resulted from the sum of counts of priority population segments (Column B) is very similar to the current percent share that each group makes up of the current CHC and AHAC clients (Column C). Both of these findings suggest that while CHCs and AHACs are only meeting a part of the estimated service needs, existing services may be fairly distributed across the five strategies: 1) Aboriginal, 2) Francophone, 3) Urban, 4) Southern Rural & Remote, and 5) Northern Rural & Remote.

Table 1: Summary of Client Distributions and Comparisons

Examples of population groups	A. Percent of Ontario Total Population	B. Priority Population (Segment One)	C. %of CHC/AHAC Clients, 2011 (*CHC only)
% age 65+	12.6%		13.8%*
Sex: % Females	50.7% Females		59.8%% Females*
% Low Income (LIMs) % in 2 Lowest Income Quintiles	15.8% 40%	76% N/A	N/A 57%*
Aboriginal	304,390 (2.3%)	11.2%	11.8%
Francophone	608,852 (4.7%)	11.6%	9.1%
Other	Not applicable	77.2%	79.1%
Total	100%	100%	100%
Urban (Cities)	69.2%	64.0%	64.0%
Urban Extended (Mixed)	13.6%	10.9%	15.4%
Southern Rural/Southern	8.4%	7.6%	7.6%
Southern Remote	3.5%	7.7%	6.2%
Northern Rural	4.2%	6.5%	4.2%
Northern Remote	1.1%	3.3%	2.6%
Total	100%	100%	100%

* Client characteristics area not available for AHACs so this only includes CHC clients. Income quintiles are based on the Income per person measure in the Statistics Canada Postal Code Conversion file (on the Dissemination Area variable) that was used to assign an income quintile to each client record. This income variable was not used for any other purpose in this study (other than preparing this table).

Although AOHC identified the need for three geographic area strategies Urban, Southern Rural and Remote and Northern Rural & Remote, for this study we have

created two subcategories for each of these three geographic area types. 'Urban extended' includes urban southern subLHINs that have rural communities within them (Windsor Essex) and northern urban areas where the majority of the population live in urban areas (e.g. Manitoulin-Sudbury and Thunder Bay City). Other southern and northern subLHINs have been categorized as rural or remote based on a combination of population weighted Rurality Index of Ontario (RIO scores) (a variable developed for this study) and % of the population living in rural areas (% Rural).

Table 2 shows the % of total population (unadjusted for needs) that is served as well as the number and percent of clients in each population group and geographic area type. Table 2 shows that the percent served by CHC sand AHACs is highest in remote areas (Southern Remote and Northern Remote) (Column B) where geographic barriers to access is highest and where alternate primary health care service opportunities are less than other geographic communities.

Table 2. CHC and AHAC Client Summary

	Total Served		Distribution of CHC Clients			
	A. Total Population 2009 Estimates	B. % served by CHC AHACs	C. Total CHC and AHAC Clients	D. #(%) of clients are Aboriginal	E. #(%) of clients are Francophone	F. #(%) are Other Clients
Urban	9,066,839	3.7%	331,545	21,330 (34.8%)	21,672 (46.0%)	288,543 (70.5%)
Urban Extended	178,732	4.5%	79,542	16,404 (26.7%)	9,617 (20.4%)	53,521 (13.1%)
Rural Southern	1,096,938	3.6%	39,468	296 (0.5%)	1,742 (3.7%)	37,430 (9.1%)
Remote Southern	461,733	7.0%	32,112	5,025 (8.2%)	4,514 (9.6%)	22,572 (5.5%)
Northern Rural	547,806	4.0%	21,694	12,104 (19.7%)	9,413 (20.0%)	177 (0%)
Northern Remote	142,952	9.5%	13,592	6,183 (10.1%)	134 (0.3%)	7,275 (1.8%)
Total	13,095,000	4.0%	517,952	61,341 (100%)	47,092 (100%)	409,519 (100%)

Table 2 shows the distribution of CHC and AHAC clients across geographic areas. We will return to this information in conjunction with results of the priority population segment distributions in Section 5 when we look at the defining and closing the equity gap. The majority of Aboriginal clients are in northern rural and remote areas or northern urban areas. Although there are a small number of Francophone clients in northern remote areas, a large proportion of Francophone clients live in northern rural areas, (20%) and southern rural and remote areas (13%). Table's 1A-1E shows the information above for each subLHIN.

4. Estimating Relative Needs for CHC & AHAC Services

4.1 Overview

The previous section (Section 3) describes the distribution of the populations receiving individual or group-based primary care from CHCs or AHACs. This represents the distribution of **existing *service capacity***. Subtracting the number served in each area from each area's share of the ***priority population*** provides a measure of the size of the potential full service gap in access to CHC and AHAC services across Ontario. This study supports an ***initial service expansion target*** that would expand access to an additional 250,000 CHC and AHAC primary health care clients. To do this equitably and

expand access in areas where there is the greatest gap between needs and access requires operationalizing "***equitable access.***" This is done in the context of the CHC and AHAC model of care, the diverse priority populations that CHC and AHACs serve the geographic vastness and variation in service access issues among the urban, rural and remote regions all across the province, and the size of this initial targeted expansion. The next section (Section 5) describes how the ***service equity targets*** were set. This section (Section 4) describes the methodology for developing the priority population for CHC and AHAC services in each subLHIN. These priority populations will be used for setting "percent to be served" targets for each population group and geographic area. These targets may support planning and priority setting for this initial service expansion. The results include an initial narrowly defined ***priority population*** (under 3 million) as well as a ***larger priority population*** (more than 3 million) that includes additional population segments that also face potential access barriers.

4.2 Population Needs-Based Resource Allocation

4.2.1 Introduction to Equity-focuses Population Needs-based Resource Allocation

Population needs-based planning and resource allocation is a method of identifying goals and assumptions, compiling best available data and preparing scenarios that decision makers and stakeholders can use. Equity-oriented population needs-based resource allocation can be defined as using evidence of differences in need to guide service planning and resource allocation to: achieve equity in health outcomes, remove barriers to access to opportunities for health, improve overall heath in the population, maximize efficiency in the delivery of health services and reduce rather than widen health inequities.[17] 'Evidence' would include predictors of health/health inequities and 'need' would include relative differences in risk factors and exposure to conditions/vulnerability/barriers to access, potential to benefit from services, etc. This study uses an equity-oriented population needs-based resource allocation method using explicit goals, assumptions, criteria, targets, testing of scenarios and revisions to produce the results described here.

Equity is a judgment about fairness: in this case the fairness in the distribution of CHC and AHAC services in relation to the greatest need for these services. All resource allocation models have embedded values. The process, evidence and results can be judged by the same criteria as other policies. Since the evidence needed for equitable resource allocation is incomplete and controversial and fairness is a judgement, what is needed is a 'fair process' for decision making such as participatory, multi-perspective consensus-based processes and the use of accountability criteria.[18]
This study uses estimates of specific priority population group segments to create priority population counts for each geographic community (the 141 subLHIN community health planning areas). The priority population segments are created to be consistent

[17] Patychuk D. (2011). Identifying Population Health Needs to Guide the Expansion of Access to Primary Health Care Services: Focus on Vulnerable Populations and Population Groups with Socially &/or Medically Complex Needs. Slides

[18] Examples include deliberative processes and Accountability for Reasonableness criteria. For examples see: http://www.ncchpp.ca/docs/DeliberativeDoc1_EN_pdf.pdf, U of T centre for Bioethics

with the main priority populations identified by CHCs and AHACs as well as the research and data available to support this. Overlaps between groups are estimated and excluded so that people with intersecting barriers to access are counted only once.

4.3 Indicators of Health Needs and Access Barriers

We have identified the priority populations for expanding access to CHCs and AHACs as those that have greater health needs or potentially greater access barriers. Indicators used or created for this analysis were selected for their relevance, quality and availability in determining relative health needs and barriers to access.

Potential barriers to access are often intersectional and interrelated. A report on the impacts of alternative methods of hospital funding notes that "Declines in geographic access are also directly linked to equity of access, as socio-economic status has been inversely correlated to the distance travelled to receive care – poorer patients make fewer longer journeys and have a higher incidence of chronic disease prevalence."[19]

There are no indicators for the 141 subLHIN community health planning areas that are publicly available. Several LHINs shared the data they had for previous subLHINs with AOHC and Steps to Equity to support this study. These were used as a reference and to provide comparison data for this study's quality assurance procedures. This study would not have been possible without access to additional data that was obtained from the Ministry of Health and Long-term care (population estimates for 2009 by age and gender) and additional data that we requested, developed or purchased.

Methods used in this study are supported by 2006 census data acquired for this study that was cross-tabulated by multiple dimensions (age, sex, disability, Aboriginal, Francophone, recent immigration, racialized group, income and geography). The 2006 census data was supplemented by Aboriginal estimates provided by Indian Affairs and Northern Development and other sources, 2008 poverty rates using the after-tax low income measures,[20] and 2009 population estimates.[21] Because our source data was from different years (2006, 2008 and 2009), we had to use a series of adjustors to standardize all data to 2009. Although population counts from the 2011 census came out during the course of this study, 2009 population estimates remain the best source of population data for health planning because these are based on census data that has been adjusted for the census undercount.

[19] Sutherland (2011). Hospital Payment Mechanisms: An overview and options for Canada. http://www.chsrf.ca/Libraries/Hospital_Funding_docs/CHSRF-Sutherland-HospitalFundingENG.sflb.ashx

[20] The Statistics Canada After-tax LIM is the poverty measure used by Ontario Poverty Reduction Strategy, Ontario (2010). Second Progress Report .

[21] Provided by the Ministry of Health and Long Term Care, developed by the Health Analytics Branch using the Ontario Ministry of Finance population projections methodology.

Francophone Estimates

We use the Inclusive Definition of Francophone (IDF-DIF) developed by the Office of Francophone Affairs.[22] The IDF-DIF is more inclusive of immigrants from French-speaking countries who may not have French as their mother tongue i.e. "first language learned" and would therefore not be included when Francophone is defined that way. Growth trends (by geographic areas) from the Office of Francophone Affairs were used to estimate the Francophone share of the total estimate 2009 population. People who are both Aboriginal and Francophone are counted as Aboriginal in the segments model.

Aboriginal Estimates

The estimates for the Aboriginal populations (First Nations, Métis & Inuit) use information that became available in 2011 for preparing Aboriginal estimates and projections as well as updated data from Indian Affairs and Northern Development, plus Chiefs of Ontario website and maps, tribal authority websites other surveys (e.g. Homeless) and studies on Aboriginal peoples. This includes the only "official estimate" from Statistics Canada for the Aboriginal population that adjusts for the undercount was published in a report on Aboriginal projections to 2031.[23] The Office of Aboriginal Affairs, using data from Indian and Northern Affairs used an estimate for the Aboriginal population of 296,495 which was 54,000 higher than the census estimate of 242,495 in 2006.[24] With our adjustments and 2009 data from Indian and Northern Affairs, we used an estimate for this study of 304,390 Aboriginal peoples in 2009 that primarily addressed the Aboriginal communities that did not participate in the census where it was clear that the subLHIN population estimates did not adequately account for these missing populations.[25] The base data for the categorization of 'Aboriginal' is 'Aboriginal Identity' from the census and 'Registered Indian' from the Indian Register (the latter accounts for communities not participating in/boycotting the census).

These "official" categories do not capture all population groups served by Aboriginal service organizations who are missed by the data collection or who do not self-identify with these categories. Aboriginal peoples are under-represented in census estimates, and a census snapshot (who lived where on census day) does not reflect the "Aboriginal populations to be served" over a one year or several year period given mobility or service areas that may extend far beyond service site locations. The principles of Aboriginal self-determination include Aboriginal community ownership, control, access

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[22] Office of Francophone Affairs. (2009). The New Inclusive Definition of Francophone. Questions and Answers.

[23] Caron Malenfant et al, 2011

[24] See http://www.aboriginalaffairs.gov.on.ca/english/services/datasheets/Aboriginal.pdf for how Ontario Office of Aboriginal Affairs uses IAND data.

[25] Data from the 2006 census was adjusted for the Aboriginal undercount using data from the Indian Register provided by Indian Affairs and Northern Development Canada (data for on-reserve and off-reserve populations was checked by Steps to Equity for all the reserves for individual years 2006-2010) and other data sources including Statistics Canada estimates and projections for Aboriginal peoples, plus Chiefs of Ontario website and, maps and tribal authority websites other studies on Aboriginal homeless. The more current data is available for First Nations obtained during the second phase of this study enabled the Aboriginal estimates to be revised and added, which improves on the existing data used for population estimates (census-based). For details see Technical Note 8.

and possession of information (OCAP) including collection, storage, use, and interpretation of health data (which was not part of this demonstration project).

There are various ways that the lack of data for Aboriginal population can be addressed. Some of the ways that organizations produce an estimate or count of the Aboriginal populations for planning purposes are as follows:
1) report census counts with a caveat noting that this underestimates Aboriginal peoples[26]
2) use Aboriginal 'ancestry' counts (which are larger especially in urban areas) instead of Aboriginal "identity" counts and/or use a larger geographic are to include a larger population[27]
3) use Aboriginal-community estimates to create a "planning estimate"[28]
4) supplement census estimates with alternate sources[29]
5) use community-based research methods to produce alternate estimates and rates[30]

This study used option 4 above and supplemented census Aboriginal Identity estimates with data from the Indian Register for communities that did not participate in the census, plus estimates for greater Aboriginal population growth, mobility and representation in populations not captured by the census (homeless, institutionalized, etc.). This does not fully account for the non-participation of the off-reserve populations, and others who do not identify with census categories. Information generated through the Our Health Counts project[31] suggests that Aboriginal people with close ties to the First Nations groups not participating in the census may also be more likely to not participate. Also this does not address the service population of any organization that may extend beyond that which can be defined by "place of residence" on census day or the overlaps in Aboriginal populations served.

For example, Anishnawbe Health Centre is an Aboriginal CHC located in the City of Toronto. Approximately one-third of clients served by this CHC live in Toronto Central LHIN. Mapping of client addresses using a methodology that produces footprint maps and analysis of the distribution of clients across subLHINs shows that this CHC serves Aboriginal peoples all across Ontario. For service hubs and service organizations such as this, the Aboriginal estimates based on geography snapshots (census or population estimates of Indian register on and off reserve etc.) will not be useful for service planning. The Aboriginal estimates present a relative distribution of Aboriginal peoples so that they are not lost in population wide planning, but Aboriginal service planning

[26] CW LHIN (2010: p17), McCaskill et al (2011), Health Quality Ontario (2007: p34), Smylie J, Firestone M, Cochran L, Prince C, Maracle S, Morley M, Mayo S, Spiller T & McPherson B. (2011: p16,21). "Our Health Counts" Urban Aboriginal Health Database Research Project. Community Report: First Nations Adults and Children.
[27] Johnston Research Inc. (2010); McCaskill et al (2011) (Se Aboriginal Report in this series)
[28] Anishnawbe Health Toronto (2005), Patychuk estimates produced for City of Toronto (1990-91), Toronto Public Health (1991-2005) and Toronto Central LHIN (2006-2007) as 'planning estimates of 2% of the total population' were approximately double the Aboriginal ancestry number based on estimates used by Aboriginal community organizations.
[29] Schnarch, (2010), Caron Malefant (2011), NW LHIN (2008), (See Aboriginal report in this series)
[30] Smylie et al (2011).
[31] Smylie et al (2011:21)

itself requires a different process with community validated data not possible to construct from official data sources.

Health Needs and Access Barriers

Where available, health measures of choice for predicting health status or the need for health care include, premature mortality (under age 75), mortality rates, functional health status (self-reported health, disability rates, health utilities index, or prevalence of chronic diseases).[32] In health service resource allocation, without a valid measure of health status that predicts health need or care requirements, low income has been used as a predictor for poorer health/greater health needs.[33]

In health equity research, attempts to measure access include comparing rates of screening, diagnostic or treatment procedures where guidelines or standards exist (e.g. immunization, post-natal rubella, Hepatitis B titers, diabetes care, stroke care or post MI protocol, etc.) among population groups with the same health conditions (same need). Differences in these cases among people who differ in their potential access barriers suggest health inequities related to these access barriers. A 1996 discussion paper "Toward an Equitable Planning and Allocation Process for the MTDHC," was an early attempt to outline indicators and determinants of equity and access. A subsequent process involving Ontario DHCs produced a list of access, equity and integration indicators rated by a technical working group. One of the benefits of the POWER study is the identification of feasible measures of access to primary health care, some of which could be produced for smaller geographic areas and population groups. There is growing interest in developing and integrating measures of equity in health planning, funding and accountability (e.g. health service equity plans, health equity impact assessments, health equity research – MAGIC (Measuring and Managing Access Gaps in Care http://www.equitymagic.ca/), etc., uses decision tree analysis to segment populations and uses the difference in rates of outcomes to generate a measurement of the inequity gap for policy and decision making). These all provide an opportunity to ensure the inclusion of measures of access in the future health planning and resource allocation. With their experience in tackling barriers to access faced by the communities they serve, CHCs and AHACs can contribute to the further development and inclusion of access measures in health planning, funding and performance management.

Non-urgent emergency room visits (ER visits) that could have been managed elsewhere (i.e. in primary health care), and what have been called avoidable hospitalizations or hospitalizations for ambulatory care sensitive conditions (ACSC), as well as avoidable deaths have been used as indicators of barriers to access to primary health care. However, these are also indicators of populations that have poorer health and require greater levels of health care. There are also surveys and qualitative studies (including

[32] Minore et al, (2008)

[33] Basrur et al, (1996); Fitzgerald , (2006); Minore et al, (2008)

many done by CHCs) that identify access barriers and experiences from a client or population basis.[34]

In this study, we can use low income as an indicator of health needs. We acquired an updated indicator of % Low Income After Tax, using the Low Income Measures (LIMs) for 2008 from Statistics Canada that was prepared for the study geographies. This is the measure used by the Ontario Poverty Reduction Strategy. In our analysis of income variables, this is the variable of choice, more current and complete than census-based variables. It better captures poverty in rural and northern areas than the Low Income Cut-off (LICO) which has cut-offs set higher in smaller compared to larger communities. This contributes to relatively higher poverty rates in large urban areas (where housing costs are often higher) and it masks some of the poverty (even deep poverty) in small communities especially among groups more undercounted in the census (Aboriginal, youth, homeless, people without status, people that don't speak English or French).

We can also use the percent with activity difficulty or limitation due to a disability or long term physical or mental health problem as an indicator of health needs. This indicator is a collected by the census to obtain a sample for the post census disability survey. While this variable is not usually reported in census tabulations, it is available in census cross tabs that were special ordered for this study. It is also available in the cross tables produced for the Canadian Community Social Data Strategy for some geographies (e.g. CSDs, neighbourhoods, and some census tract and dissemination areas). When we use this as a health indicator, we use the population between age 20 and 64. We exclude seniors who have higher rates due to mobility issues and because the indicator would be an indicator of a higher percent seniors in a population rather than a health indicator. When we use disability rates as an indicator of a population with potential access barriers we use all ages (including seniors).

We produced age standardized hospitalization rates for ambulatory care sensitive conditions (ACSC) our geographies and acquired non urgent ER visits rates and percents (produced at ICES and CRICH by M. Agha for our geographies.[35] However, our primary indicators of potential access barriers are being in a population group with greater potential barriers to access, e.g. being low income, being a recent immigrant, non-permanent resident or being in a racialized group, being Aboriginal, being Francophone, or living in a community with a high score for geographic access barriers based on modified Rurality Index of Ontario (RIO) scores.

[34] WHIWH (2003, 2011); Planned Parenthood of Toronto. (2005). "It's a guy thing not to go to the doctor" The Young Men's Health Consultation Report http://www.ppt.on.ca/pdf/reports/youngmenreport.pdf

[35] The Centre for Research on Inner City Health at St Michaels Hospital is a partner in the Toronto Health Profiles Partnership and produces data for the LHIN and subLHIN geographies in partnership with the Institute for Clinical Evaluative Sciences (ICES).

Geographic Access Barriers

The Rurality Index of Ontario (RIO) for 2008[36] used to identify underserviced areas for incentives to attract providers, is available for CSDs except those with populations under 500 and for Indian reserves and settlements. The exclusion of these areas is an important limitation which we addressed by assigning RIO scores to these otherwise excluded communities. We also supplemented the RIO scores with OECD methodology for categorizing urban, rural and remote areas (data available for Ontario census subdivisions)[37]. Indicators were assigned at the CSD level and then the CSD data was rolled up into subLHINs using a CSD to subLHIN crosswalk (MOHLTC) plus GIS analysis was done to assign shares of several CSDs that cross subLHIN boundaries.

Assumptions
AOHC provided the following assumptions that guided the steps used to create the priority population for this study:

- make low income a significant component of each model
- ensure the population experiencing geographic barriers to access in rural and northern communities (even with small populations) is adequately reflected
- include the total Aboriginal population is prioritized in each model: include all Aboriginal peoples (to the extent possible given data limitations)
- identify Francophone populations with greatest needs and access barriers especially those residing in Francophone priority areas
- capture the diversity in urban populations potentially facing lack of access to linguistically and cultural appropriate services
- identify the overlaps to avoid double counting/unintended overweighting

4.4 Priority Population Segments

Index- or formula-based methods such as those above and others[38] (i.e. deprivation indices, marginalization indices, etc.) identify the relative needs of areas compared to others. It is difficult to translate the results of these composite indices into practical information for resource allocation regarding ***who*** and ***how much***. It is more challenging to produce mutually distinct population segments than the needs-adjusted population that results from index- or formula-based methods. However, a priority population made of counts of distinct population segments identifying overlaps, provides an easier to use and understand target population for service planning and resource allocation.

[36] Kralj B. (2008). Measuring Rurality –RIO2008 BASIC: Methodology and Results. Toronto: Ontario Medical Association

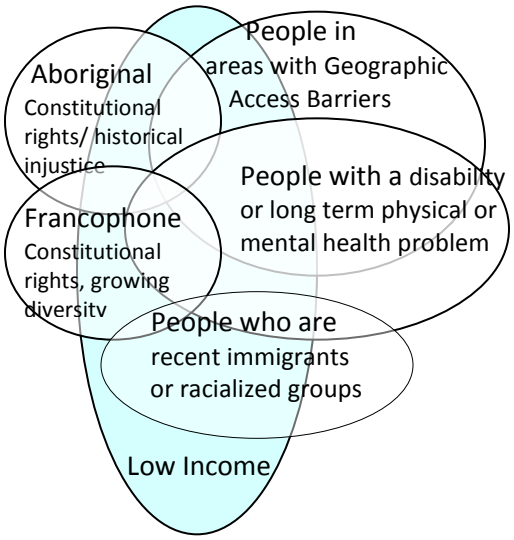
[37] OECD scores for CSDs (Slaunwhite, 2009), were retained when CSDs were rolled up into their subLHINs. CSDs were split between subLHINs and these had their populations proportionately assigned to multiple subLHINs where necessary. If CSDS making up subLHINs had different OECD scores, the OECD definition was applied to the subLHIN. In most cases, all the CSDs in the subLHIN had the same OECD score.

[38] Bell et al (2007); Pampalon, R., Hamel, D., Gamache, P., & Raymond, G. (2009). A deprivation index for health planning in Canada. *Chronic Diseases in Canada*, 29(4):178-190; Ontario Index of Marginalization, at: http://www.crunch.mcmaster.ca/ontario-marginalization-index

AOHC obtained access to a unique data set that made it possible to create a Priority Population that included groups with different barriers to access. The data was cross-tabulated in a way that it was possible to exclude double counting. Our core segment is all people who are low income (approximately two million Ontarians according to the after-tax low income measure (LIMs- the poverty measure used by the Ontario Poverty Reduction Strategy). There is significant overlap between low income persons, Francophones, recent immigrants, racialized groups, people with disabilities or chronic health problems, etc. This unique data set includes 8-way cross tabs of the 2006 census. The variables were: income, sex, age, disability, recent immigrants and non-permanent residents (e.g. refugee claimants and migrant workers), people in racialized groups, Francophones and Aboriginal peoples - First Nations, Métis, and Inuit.

Figure 1 shows the population groups with potential access barriers for which data was available that was used to create distinct population segments (excluding overlaps) for this study. Although this does not include all the priority populations of CHCs, these are the main groups for which census information is available.

Figure 1



Supplementary data and analysis was used to update the population segments to 2009. Using this data, a Priority Population was constructed that included specific counts of people with multiple potential barriers to access in each of the 141 subLHINs. The population segments included:

1) all people who were low income;
2) all Aboriginal peoples (to the extent possible given data limitations);
3) all low income Francophones and all other (not low income) Francophones that were recent immigrants, non-permanent residents (refugee claimants, people or work or student visas or minister's permits and their families), racialized groups, had a disability or limitation due a long term health problem, or lived in areas with geographic access barriers; and
4) all people with a disability, recent immigrants, non-permanent residents (refugee claimants, people on work or student visas or minister's permits and their families) or racialized groups n areas with geographic access barriers.

The Priority Population that resulted totalled 2.7 million (Segment One) which is about 19% of Ontario's population (estimated at 13,373,000 in 2011).[39] Additional priority population segments (Segments Two, Three & Four) that include other people with potential access barriers in one or more of the above categories were also created. These include:

5) other people living in areas with geographic access barriers, and
6) other recent immigrants and racialized groups with disability or long term health problems.

Table 3 presents the size of each of these four Priority Population Segments (excluding overlaps) as well as the proportion of each that live in the six geographic areas. The results from the population segments method also supports planning for population groups as well as geographic areas. Table 3, shows how the Aboriginal, Francophone and Other priority population segments are distributed across the geographic areas.

Table 3. Target Populations Method One

	Segment One	Expanded Segment Two	Expanded Segment Three	Expanded Segment Four
	1-4 above excluding overlaps	1-4 + 5 above excluding overlaps	1-4 + 6 above excluding overlaps	1-6 above excluding overlaps
Urban	1,739,657 (64.0%)	2,072,660 (67.4%)	1,745,009 (52.9%)	2,082,942 (57.0%)
Urban Extended	295,696 (10.9%)	307,014 (10.0%)	345,119 (10.5%)	356,437 (9.8%)
Rural/Southern	207,695 (7.6%)	215,840 (7.0%)	327,188 (9.9%)	330,403 (9.0%)
Remote Southern	208,386 (7.7%)	209,915 (6.8%)	460,595 (14.0%)	462,124 (12.6%)
Northern Rural	177,963 (6.5%)	178,714 (5.8%)	281,264 (8.5%)	282,016 (7.7%)
Northern/Remote	90,326 (3.3%)	90,528 (2.9%)	139,328 (4.2%)	139,530 (3.8%)
Total	2,719,723 (100%)	3,074,672 (100%)	3,298,504 (100%)	3,653,453 (100%)

Reviewers and users will note that except for Aboriginal which are all included, the population that is not low income is only included in the priority population if it has two or more of the other access barriers. This includes not low income persons other than Aboriginal (already included) who are Francophones that are recent immigrants or in a racialized group, or have a disability, or live in an area with Geographic Access Barriers; or recent immigrants or people in racialized groups with a disability or long term physical or mental health problem that live in areas with Geographic Access Barriers; or people with a disability or long term physical or mental health problem that live in areas with Geographic Access Barriers (excluding overlaps in all the listed groups). There isn't enough available information to identify the frail and socially isolated seniors with multiple chronic health problems that would be considered a priority. However, disability rates increase with age so by including this as a priority group, includes progressively a higher proportion of seniors in older age groups (i.e. >60% of those age 75+).

Since the purpose of the study was to identify areas with the greatest need for CHC and AHAC services for an initial targeted expansion, the focus is on people with multiple

[39] This is the Statistics Canada preliminary post census estimate for 2011 (last modified September 2011). This number is the same as the Ontario Ministry of Finance population projection for 2011 (last modified, Spring, 2010.

potential access barriers with low income and Aboriginal people as a priority. Not all the specific priority populations of all CHCs are included in the priority population identified in this study.

The steps in creating the population segment that had greater geographic access barriers were the most complicated part of this study. The Rurality Index of Ontario (RIO) for 2008[40] was complemented by assigning RIO scores to otherwise excluded communities (reserves and communities with populations under 500) and supplemented with OECD methodology for categorizing urban, rural and northern areas (data available for Ontario census subdivisions was rolled up into subLHINs).[41] Identifying all the low income people as well as all the Aboriginal, Francophone, Recent Immigrants, Non-permanent residents, Racialized Groups and people with a disability that were low income as well as not low income and that lived in these areas and excluding all the overlaps between them was especially difficult because the census cross tabs that could be sued to do this were by subLHIN not by CSD. Additional population-specific census cross tabs (at the CSD level) were used as well as "% overlap" calculations at the subLHIN level to enable all the overlaps to be calculated.

Older adults and seniors in the above groups are preferentially captured because of the disability variables (over 40% of those 65 and over are included in this variable and over 60% of those over 75 have a disability). Separate data sets were created with segments for males and females and for seniors (age 65 and over) and for non-seniors that were not used in the distribution for the analysis but that could be useful during specific expansion planning.

Sex differentiated analysis, tables and maps were also developed to support local planning. The census cross table file included data by gender but this was supplemented by multiple sources which were not available by sex and gender. To prepare segments by sex therefore have required major additional estimating steps potentially decreasing the accuracy of the estimates produced. Given the observed differences between males and females in the data that was by sex looking at males and females separately is important for fully considering equity. For some service organizations that serve females primarily of solely, the information produced by this study may have limited use in service planning. However, producing priority population segments by sex was far beyond the budget and time frame for this study.

5. Defining and Closing the Equity Gap

5.1 Setting Service Equity Targets

Because this study is to support initial targeted service expansion to areas with the greatest gaps between need and access. In order to identify the service gaps and priority areas for service expansion, decisions need to be made about what would be

[40] Krali,(2009)

[41] OECD scores for CSDs (Slaunwhite, 2009), were retained when CSDs were rolled up into their subLHINs. CSDs were split between subLHINs and these had their populations proportionately assigned to multiple subLHINs where necessary. If CSDS making up subLHINs had different OECD scores, the OECD definitions were applied to the subLHIN. In most cases, all the CSDs in the subLHIN had the same OECD score.

considered an equitable level of service using existing service capacity (518,000) plus the targeted service expansion (+ 250,000). The objective is to level up services where gaps exist, not to redistribute existing resources (not fair or feasible) or totally close the gap (not feasible with a 250,000 expansion). Existing service levels were calculated for all LHINs, subLHINs, six geographic clusters and three priority population groups: Aboriginal, Priority Francophone and Other (other priority population segments excluding Aboriginal and priority Francophone). Given that in over 50 subLHINs, CHCs and AHACs were serving populations at least the size of 25% of the total priority population in these areas, and given that overall existing CHC and AHACs were serving a population equivalent to 19% of the total Ontario priority population (identified in this study), we set 25% as the minimum service target for leveling up towards equity.

The complementary report on Expanding Aboriginal Access to Community-based Primary Health Care argues that primary health care for Aboriginal people can only be considered 'Aboriginal people-centered' and 'accessible' if it meets the core criteria of Aboriginal self-determination (Aboriginal led/designed/governed); community ownership, control, access and possession of information (OCAP) including collection, storage, use, and interpretation of health data; a wholistic understanding of health and healing; actions supporting community health/community continuity; addressing local priorities; congruency with Aboriginal values (culturally safe); and addressing historic trauma and contemporary discrimination (racism, classism, colonialism). For the above reasons, to achieve equity for Aboriginal populations, all of our scenarios include a higher relative share of resources for Aboriginal populations than for other segments. Service equity targets are set higher for Aboriginal populations than for other population segments in the priority population. Service equity targets are also set higher for remote areas (rural remote, northern rural and northern remote) with geographic access barriers, than for urban and other rural areas because of the additional geographic access barriers (fewer services, greater distances, etc.).

For Aboriginal populations, service equity targets are to achieve the capacity for 33.3% of the Aboriginal population in urban areas and most rural areas and to have access to Aboriginal community-based primary health care; and for 50% of Aboriginal populations in rural remote, northern rural and northern remote to have access to Aboriginal community-based primary health care.

For the other population groups the initial service equity targets are 25% and 33.3% respectively. Once underserved areas are leveled up to these levels (or determined not to need CHC or AHAC services) leveling up to higher service levels can be undertaken. The estimated gap is calculated by subtracting existing service capacity from the each Target population group in each community planning area (subLHIN). Table 4 shows the current status of CHC and AOHC service capacity including the percent of the total population served as well as capacity to serve the identified Target Population. Table 1A at the end of the report has this information for all Ontario LHINs and subLHINs.

Table 4. Estimated Current PHC Service Capacity of CHCs and AHACs by Geo Clusters					
	Total Population 2009 Estimates (Not Needs-Adj.)	Total CHC and AHAC	% of Total Population Served	Target Population	% of Target Pop. served by CHCs & AHACs
Urban	9066839	331545	3.7%	1,739,657	19.1%
Urban Extended	178732	79542	4.5%	295,696	26.9%
Rural/Southern	1096938	39468	3.6%	207,695	19.0%
Remote Southern	460733	32112	7.0%	208,386	15.4%
Northern Rural	547806	21694	4.0%	177,963	12.2%
Northern/Remote	142952	13592	9.5%	90,326	15.0%
Total	1309400	517952	4.0%	2,719,723	19.0%

5.2 Calculating Service Gaps

Table 5 shows the summary of the calculated total service gap and the targeted equity service gap that emerged from this study and the service equity targets set to act as a guide for initial expansion.

Table 5 Summary of Service Gaps†

	A. Priority Population	B. Clients	C. Total % Served B/A)	D.* ***Service Equity Targets*** *(Based on Geo Types)*	E.** ***Calculated Service Gap*** *(sum of subLHINs)*	F. Total % Served After Levelling up (D/B)
Aboriginal	304,390	61,340	20.1%	***121,014***	***73,280***	39.8%
Francophone	316,555	47,092	14.9%	***87,384***	***49,700***	27.6%
Other	2,098,777	409,519	19.5%	***546,236***	***246,556***	26.0%
Total	2,719,723	517,953	19.0%	***754,634***	***369,536***	27.7%

† Table 5 includes information summarized in previous tables. The sums are calculated for each subLHIN and population groups separately. This is because the expansion is about levelling up towards equity not shifting resources from subLHINs that have already achieved the minimum service equity targets to those below these targets.

* The service equity targets are set individually for each population group and each subLHIN based on geographic type (i.e. higher for remote areas where other service options are more limited). Column D represents the sum of all populations groups in all subLHINs.

** The calculated service gap (Column E) is the calculated target population for each population group in each subLHIN minus the calculated number of clients served in that population group in the subLHIN.

The calculated service gap based on sum of subLHINs is different than a simple subtraction of the clients (A) from the total Priority Population (B) because existing service levels vary widely with some subLHINs already having service levels above 25%, 33.3% or 50% served. Our study is based on levelling up to meet a minimum service level for the priority populations, not redistributing existing CHC and AHAC resources so the sum of each subLHIN provides the accurate summary of the service gap.

Table 6 which shows the service equity targets and the calculated total service gap that emerged from this study summarized according to population groups and geographic area type. The sums are calculated for each subLHIN and population groups separately. No resources are shifted from a subLHIN that has achieved the service

equity target to any other has not. The last column (% served after expansion) assumes that areas that have already serving 25%, 33.3% or 50% of the priority population stay at that level and services are expanded in all other areas. As noted before, the service targets are set high enough to identify a gap greater than 250,000 in order to provide some flexibility so that areas with the greatest gaps can be met first and to provide for consideration of other service that may be adequately providing community-based primary health care services according to community needs and preferences.

Table 6		Population Segments	Clients	% Now Served	Total Gap	Equity Targets	Initial Gap	% Served after Exp
	Target Level	**Ab Priority Pop**	Aboriginal Clients	% Now Served	Total Gap	Service Target	Initial gap	% Served aft. Exp.
Urban	33.3%	96,909	21,330	22.0%	75580	32271	14621	37.1%
Urban Extended	33.3%	60,083	16,404	27.3%	43678	20007	9988	43.9%
Sth Rural	33.3%	29,725	296	1.0%	29429	9898	9602	33.3%
Sth Remote	50%	34,354	5,025	14.6%	29329	17177	12702	51.6%
Northern Rural	50%	37,809	12,104	32.0%	25706	18905	9796	57.9%
Northern/Remote	50%	45,511	6,183	13.6%	39328	22755	16573	50.0%
Total		304,390	61,341	20.2%	243050	121014	73282	44.2%
		Fr Priority Pop	Franco-phone	% Now Served	Total Gap	Service Target	Initial gap	% Served aft. Exp.
Urban	25%	148,591	21,672	14.6%	126919	37148	19039	27.4%
Urban Extended	25%	34,107	9,617	28.2%	24490	8527	2721	36.2%
Sth Rural	25%	34,394	1,742	5.1%	32652	8598	7344	26.4%
Sth Remote	33.3%	33,447	4,514	13.5%	28933	11127	6901	34.1%
Northern Rural	33.3%	60,137	9,413	15.7%	50724	20026	11871	35.4%
Northern/Remote	33.3%	5,880	134	2.3%	5746	1958	1824	33.3%
Total		316,555	47,092	14.9%	269463	87384	49700	30.6%
Table 15 cont'd		**Other Priority Pop**	Other	% Now Served	Total Gap	Service Target	Initial gap	% Served aft. Exp.
Urban	25%	1,494,157	288,543	19.3%	1206096	373539	145289	29.0%
Urban Extended	25%	201,506	53,521	26.6%	148374	50377	22779	37.9%
Sth Rural	25%	143,577	37,430	26.1%	109852	35894	13450	35.4%
Sth Remote	33.3%	140,586	22,572	16.1%	120966	46815	31500	38.5%
Northern Rural	33.3%	80,017	177	0.2%	79840	266646	26469	33.3%
Northern/Remote	33.3%	38,935	7,275	18.7%	31660	12965	7069	36.8%
Total		2,098,777	409,519	19.5%	1696788	546236	246556	31.3%
			Total	% Now Served	Total Gap	Service Target	Initial gap	% Served aft. Exp.
Urban		1,739,657	331,545	19.1%	1408595	442958	178949	29.3%
Urban Extended		295,696	79,542	26.9%	216542	78911	35488	38.9%
Sth Rural		207,695	39,468	19.0%	171933	54390	30396	33.6%
Sth Remote		208,386	32,112	15.4%	179227	75119	51103	39.9%
Northern Rural		177,963	21,694	12.2%	156269	65577	48136	39.2%
Northern/Remote		90,326	13,592	15.0%	76734	37678	25466	43.2%
Total		2,719,723	517,952	19.0%	220930	754634	369538	32.6%

The calculated service gap in Table 6 is based on sum of subLHINs which is different than a simple subtraction of the clients from the priority population segments because existing service levels vary with some subLHINs already having service levels above 25%, 33.3% or 50% served. Our study is based on leveling up to meet a minimum service level for the priority populations, not redistributing existing CHC and AHAC resources so the sum of each subLHIN provides the accurate summary of the service gap.

Tables 7A to 7E (at the end of Section 6) provide the data that may guide priority setting for expanding access according to subLHIN, organized by LHINs with sums for each LHIN. These are the main data tables provided to support planning process to identify where an expansion of 250,000 CHC and AHAC clients may be most needed.

As shown in Table 7A, a few LHINs have a total of at least 25% of the target population overall being served by CHCs and AHACs (Column E). Most LHINs have at least one subLHIN within them where less than 25% are served. We've highlighted with dark shading the subLHINs (and LHIN totals) where less than 15% of the Priority Population (Segments, Method One) are being served. Table 1E shows which of the segments in the priority population account for the gap. Tables 7B-1D are specific to the three population groups (Aboriginal, Francophone and Other). Except in areas categorized as rural remote, northern rural or northern remote (which includes not low income people with additional access barriers living in areas with a high RIO score), the 'Other' population is primarily low income people who are not counted in the Francophone or Aboriginal priority population segments. In large urban centres where the number of low income people is very high, unless CHC service levels are relatively high, there will be large numbers of low income people not being served by CHCs.

We illustrate below how the results tables can be used, with examples of three subLHINs (selected to represent different geographic types from different parts of Ontario) where the calculated service gap for this targeted expansion is the highest for the geographic type and where the service level is the lowest for the geographic type.

Example: Bruce (subLHIN 201, South West LHIN). Geo Type: Rural (Rural Remote)
In this area 87 people are receiving primary health care services from CHCs and AHACs (less than 1% of the priority population of the estimated 23,459 priority population). The area is categorized as ***rural remote*** because it has a population weighted RIO score of 52.2 and a % Rural rate of 53.4%. The calculated service gap of 8,120 is made up of the need for services for 1,173 Aboriginal people (to reach a target of 50% served), 184 Francophone people (to reach a target of 33.3% served) and 6,763 other people (to reach a target of 33.3% served). The area does not include a community designated as a French Language Service Area by the Office of Francophone Affairs. Other similar rural remote areas with very large service gaps (>5,000) are: Grey and Muskoka.

Example: Northwest Mississauga (subLHIN 604, Mississauga Halton). Geo Type: Urban
In this area currently 549 people are receiving primary health care services from CHCs and AHACs which is less than 1% of the priority population of 262,684 estimated for this area for study. The calculated service gap of 15,201 is made up of the need for services for 307 Aboriginal people (to reach a service target of 33.3% served), 1,015 Francophone people (to reach a service target of 25% served) and 13,879 other people (to reach as service target of 25% served). The area does include a community that is designated as a French Language Service Area by the Office of Francophone Affairs. Other similar urban areas with very large service gaps (>13,000) are all in the GTA: Brampton, Southeast Mississauga, Markham, Scarborough-Agincourt Rouge.

Example: Cochrane (subLHIN 1307, North East LHIN). Geo Type: Northern Rural

In this area, currently, 3,015 people are receiving primary health care services from CHCs and AHACs which is 7% of the priority population of 43,902 estimated for this area for study. The calculated service gap of 12,707 is made up of the need for services for 2,310 Aboriginal people (to reach a service target of 50% served), 7,635 Francophone people (to reach a service target of 33.3% served) and 2,762 other people (to reach a service target of 33.3% served). The area does include a community that is designated as a French Language Service Area by the Office of Francophone Affairs. Other northern-rural or northern-remote areas with very large service gaps (>10,000) are: Algoma, Nipissing, and Kenora).

Beginning steps in assessing whether these are priority areas for expansion would be to: confirm the data used to calculate the gap with stakeholders (e.g. AHAC and Francophone services counts and distributions in the area, Aboriginal estimates); agree on the service equity targets; identify potential other local community-based primary care service options; and engagement with stakeholders on service references.

4. Using the Data

As shown by Tables 5, 6 and 7A, if the service gap, calculated using the data and assumptions in this study was met through expanding access to AHACs and CHCs to 369,536 more persons in the priority populations, the proportion of the priority population served would increase from 19% to 27.7% overall and each priority population segment and each subLHIN would achieve the minimum service equity targets used in this study.

AOHC set an initial service expansion target of 250,000 persons. The assumptions used in this study intentionally creates a total service target that is larger than 250,000 (i.e. 369,536). The calculated service gaps include many areas with a large population and no or few services. These would be a priority for expansion. The calculated service gaps identify potential priority areas for expansion that upon further assessment, collaborative planning, stakeholder input, etc., may be determined to be adequately served by other models or other services (e.g. Aboriginal services provided by Tribal Authorities), or other models of primary health care (e.g. Nurse Practitioners, Family Health Teams, etc.). Also some subLHINs would achieve the service equity targets by a minor expansion of access to existing services (e.g. <500 persons) whereas areas with gaps over 5,000 may require new service sites or satellites.

The Decision Support Tables (7A-1E) provides the expansion targets and calculated service gaps for each of the three summary segments of the Priority Population for each subLHIN. The results of this analysis only provide one input to the decision process. Many other considerations not included here are required. Some of these include:

- the distribution of other primary care services that may also be targeted to low income, underserved diverse population groups that are providing linguistically and culturally appropriate care
- more specific details about the demographic social and health characteristics of clients of CHCs and AHACs not included in the current client data set available for this study and preferably the same information for other primary care service models

- the interest, community engagement and capacity of local communities to organize for and contribute to the development, planning and governance of new CHC or AHAC services
- the participation of local communities, priority populations and other system planners and service providers in developing appropriate strategies to expand access to community-based primary health care
- the framework for funding, organization and governance of primary care services that includes expansion of CHC and AHAC services as a component of the overall health equity strategy
- other information that would improve the identification of priority communities and priority populations including quantitative and qualitative information not available for this study and the methods used here (service preferences of all groups experiencing access barriers, age and gender-specific needs and preferences of all priority population groups also including lesbian, gay, bisexual, and transgender population, people who are homeless, etc.).

The results presenting here provide a starting point for identifying potentially underserved communities that can be used in distributing new resources towards closing the gap in access to community-based primary health care services. The information included here is not meant to take the place of more in-depth comprehensive knowledge and experience that stakeholder communities bring to the decision making process. Accountability and leadership for use of these results is the responsibility of the users.

5. Limitations

Each of the considerations noted above also describes the key limitations of this analysis for supporting decision making. These include:

- data limitations and data quality issues that require many adjustments and estimates to standardize all the data to a common point in time (2009)
- the limited ability of available data to reflect the complexity of access as a multidimensional concept
- the impact of assumptions on the results (the results could be different under different assumptions)
- the subjective nature of equity (fairness) judgments, that could be decided differently by others or under other circumstances
- the lack of comprehensive community/user input to the choice of methods and assumptions including the lack of Aboriginal governance of the development of the methods and data used to include Aboriginal estimates in this study
- the lack of information about other service models, community preferences, populations served, etc. in each subLHIN that need to be included in a gap assessment
- the client distributions across subLHINs and the geographic areas served may actually differ from the distributions used in this study
- as a geographic unit, subLHINs may not resonate with many community service organizations.
- organizations serving communities that cross multiple subLHINs and LHINs (e.g. service hubs) would need to include a geographic scope that included all the

multiple areas served and this may require service planning with other organizations also serving these areas.

The indicators available for this analysis were limited to what was available or could be produced during the project time frame (March to June 2011), supplemented by data obtained in 2011/2012. A variety of geographic levels were used to test and drill down below the LHIN level including Census Subdivisions (CSDs), and Postal Code Forward Sortation Areas (FSAs). The main geographic levels of analysis are the 141 secondary subLHIN planning areas (as recommended by the Health Analytics Branch, MOHLTC, 2010). Health indicators specific to Francophone and Aboriginal populations are not available at the subLHIN level.

The ability of the model to equitably predict the need for CHC or AHAC services could be improved with updated and additional indicators, stakeholder input to provide relevant contextual information, data at multiple geographic levels to serve the specific needs of local organizations, and information about the distribution of access to and capacity of other service models to meet the identified needs.

This project provides baseline tools and estimates for planning and decision making. It does not include analysis of the distribution of other service models, or alternative options for expansion (new CHCs or AHACs or the capacity for existing CHCs or AHACS to expand their geographic scope or population served, etc.). Other important contextual information including existing CHC client complexity (a separate study underway), local stakeholder knowledge and other needs-based local planning (e.g. Aboriginal community planning, French language Services planning, other CHC, LHIN and MOHLTC initiatives, etc.) would be part of the decision making process for best allocating expanding resources for CHC/AHAC services.

There is no gold standard 'objective' definition of health. Premature mortality rates and a health utilities index emerge most often as health status indicators of choice. These are not available for all subLHIN planning areas. Population needs-based planning is an ethical and policy activity over and above the technical tools it uses. The results of the analysis (this demonstration project) should be considered as an input to the decision making not as the de-facto decisions.

The "results" emerging from this analysis represent one way to use indicators to pose an answer to the question of how to potentially distribute community primary health care services for 250,000 new clients to addresses the most significant gaps in need for the services provided by CHCs and AHACs. Ideally the decision making process would meet a number of criteria such as stakeholder involvement in the decision making process that were not possible for this demonstration project.

6. Results and Recommendations

CHC and AHACs are serving a higher proportion of low income persons than the proportion of the total population considered to be low income. In this study, 57% of total CHC clients live in the lowest income areas (bottom two quintiles or 40% of the population, using Statistics Canada's Income Per Person Equivalent measure).

Aboriginal and Francophone population groups make up a greater share of CHC and AHAC clients than their percent share of the total Ontario population. This demonstrates the success of CHCs and AHACs in serving these population groups. Specific communities with no services or limited access to community-based PHC services for Francophone and/or Aboriginal communities were identified.

When geographic areas in this study (subLHINs categorized as urban/urban extended, rural/rural remote or northern/remote) are weighted according to indicators of potential barriers to access and health needs, or summed according to priority population segments, the percent of the priority population in each geographic area is very similar to the current percent share that each geographic type makes up of the current CHC and AHAC clients. However this study uncovered many service gaps and inequities across geographic regions of Ontario that could be addressed by targeted expansion.

6.1 Service gaps and inequities

Many communities with large populations with multiple barriers to access to primary health care have little or no access to CHC and AHAC services. The percent of the total population served by CHCs and AHACs ranges from less than 1% to more than 30% across Ontario's 141 community health planning areas. In 35 subLHINs less than 1% of the population is served by CHCs and AHACs. When priority populations for access to CHC and AHAC services are identified according to the assumptions guiding this study (see Tables 1A to 1E), and modest service equity targets are set (i.e. that 25%, 33.3% or 50% of the priority population would be able to access CHC or AHAC services), every LHIN has at least one or more subLHIN areas that are under target for one or more population group. In eleven LHINs the service gap is more than 10,000 persons. In eight of these the service gap is more than 25,000. In two of these (Central LHIN and North East LHIN) the total service gap is more than 50,000 persons. When considering the 141 subLHINs, the largest calculated service gaps of more than 10,000 occur in 11 subLHINs (Middlesex, Brampton, Northwest Mississauga, Southeast Mississauga, North York Central, Markham, Scarborough/Agincourt Rouge, Scarborough Cliffs/Scarborough Centre, Algoma, Nipissing and Kenora).

Expanded access to community based primary health care provided CHCs and AHACs is necessary and essential to Ontario's health future. As population diversity and social disparities increase, CHCs and AHACs are uniquely designed, mandated and governed to play an effective role in reducing health inequities and improving the health of their local communities**.**

Recommendation One
Expanded access is needed to reach populations who can most benefit from the comprehensive PHC that CHCs and AHACs provide, especially those with barriers to access to care in urban settings and geographically dispersed populations in northern, rural and under-serviced areas.

6.2 Health Inequities Across LHINs and SubLHINs

Health needs and potential barriers to access to primary health care vary dramatically across population groups within and between Ontario communities. At the level of Ontario's 14 LHINs there is a two fold range in the poverty rates based on the 2008 After Tax Low Income Measures (the poverty indicator used by the Ontario Poverty Reduction Strategy). The range is from 11% to 22% with the Ontario rate at 15.8%. The variation in LIM rates across the 141 subLHINs is 5% to 50%. The low income rate among females averages about 10-20% higher than males across the 14 LHINs,[42] with the rate among Lone Parent Families (26%-43%) averaging at three to four times higher than that of couple families with children (7% to 13%). Poverty and disability rates also vary dramatically among population groups (according to census data). The highest poverty rates occur among recent immigrants and non-permanent residents. The highest disability rates are among Aboriginal populations. Differences in hospitalizations for Ambulatory Care Sensitive Conditions and for emergency room (ER) visits for conditions rated as low triage or less urgent also vary widely by gender, age, and geography. Published studies also show variations by Aboriginal, and income group and geographic community.[43] These health inequities demonstrate the need for disaggregated reporting of health-related variables and targeted resource allocation.

Health data bases in Ontario do not routinely collect information on client characteristics known to be relevant to health inequalities and barriers to access to care. While age and sex are routinely collected, reported health measures are often age and sex-standardized. This masks some of the differences between males and females that are relevant to community health planning.

Recommendation Two
Enhanced data collection and reporting of health measures by sex, gender, income, and other variables relevant to social position, social conditions and circumstances would enhance the capacity for equity-focused planning and resource allocation. The data and methodology exists now to report all health measures by sex, income quintile and small geographic area. Doing so can facilitate decision making that can reduce health equities. Not doing so risks perpetuating or widening existing inequities.

6.3 Benefits of Using Needs-based Models to Identify Underserved Communities

Existing measures of access to primary health care include counts or ratios such as "% served" or "population per physician ratios" or "distance to services." These are drawn from surveys (Primary Care Access Survey or the Canadian Community Health Survey that include questions about having a family doctor or having unmet needs for care),

[42] These male female comparisons are based on the Low Income Cut-Off rather than LIMs because LIMs are household measures not available for individuals or by sex.

[43] Shah, B., Gunraj, N., & Hux, J. E.(2003). Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. *American Journal of Public Health*, 93(5):798-802; Cloutier-Fisher et al. (20060. The devil is in the details: trends in avoidable hospitalization rates by geography in British Columbia, 1999-2000. BMC Health Services Research, 6:104 (12 pgs); CIHI. (2012). Disparities in primary health care experiences among Canadians with Ambulatory care sensitive conditions. (see *Tech Nt. 12*)

utilization data, human resource data (where physicians practice or service located), and GIS mapping methods.[44] There is also the Rurality Index of Ontario which is used to identify underserved areas for incentives to attract providers. These measures do not capture the differences in health needs or multiple access barriers that are relevant to determining "equitable access." These are poor indicators of access because they do not take into account the relevance, quality, cultural safety, accountability to community, the governance structure of services or the heterogeneity of communities. Age, sex and population growth measures do not adequately capture health needs and access barriers necessary to achieving the goals of a publicly funded health system and the legislation which defines health rights (provincial, national & international) and which governs health care (provincially and federally). Resource allocation models which select and weight indicators based on their ability to predict use of services, do not address the unmet needs and barriers to access which are core to the work of CHCs and AHACs. To allocate resources in a way that is equitable, efficient and effective in reducing health inequities across Ontario requires greater inclusion and weighting of indicators of disparities in barriers to access and health needs. A combination of models and approaches are needed. Our analysis suggests there may be limitations to existing and new methods of 'population-based' 'patient-based budgeting' and provides suggestions for how these issues can be addressed.

Recommendation Three

Use an equity-focused, population-needs based planning and resource allocation method and consider the following in developing the model to better achieve equity for population groups across geographic communities:

- adequate weighting for geographic dispersion/remoteness
- adequate representation of socio-economic disparities, given the limitations of census data which has more missing income data for small rural and northern areas and diverse and missing population groups (Aboriginal, homeless)
- inclusion of measures that address unmet needs, funding for strategies for dismantling barriers to access and disaggregating results data to identify where privileged access exists for some while inadequate access according to needs exists for others so that this can be corrected
- correcting or adjusting for the missing Aboriginal populations and the growth rate among missed populations
- stakeholder participation in the decision making process

6.4 Impact of Absence of CHC/AHAC Client Data on Accuracy of Ontario Health Data

While the clients of CHCs and AHACs are currently less than 4% of the Ontario total population, in 21 subLHINs more than 10% of the total population is accessing primary health care from CHCs and AHACs. The profile of the population served by CHCs and AHACs suggests clients on average have greater health needs and access barriers in many cases related to poverty and other circumstances. Therefore the measurement of health status in Ontario overall and especially in these communities is compromised by the exclusion of CHC/AHAC administrative data from Ontario health planning data bases such as disease registries.

[44] Glazier RH, Gozdyra P, Yeritsyan N. (2011).

Measures of health status and chronic disease that are based on physician visits (based on OHIP claims) and or diseases registries (such as the Ontario Diabetes Database) may under-represent the actual disease prevalence in the province because visits to CHC are not included in the measures (e.g. algorithms for disease prevalence based on # of visits to a physician for the condition in a two year period). While the clients of CHCs and AHACs are currently less than 4% of the Ontario total population, this study shows that in some subLHIN areas, CHCs and AHACs serve more than 10% of the population. This compromises the accuracy and completeness of data used to calculate prevalence and incidence rates (e.g. diabetes) and other health indicators.

Recommendation Four
Include CHC/AHAC administrative data in Ontario health planning data bases such as disease registries. Given the profile of the population served by CHCs and AHACs and the proportion of the population served by CHCs and AHACs in many communities, the measurement of health status in Ontario would be more complete with the inclusion of CHC/AHAC data.

6.5 Impact of the Undercount of Aboriginal Populations

All the available information from various data sources on Aboriginal populations groups was assessed for the Aboriginal component of this study. This included: tribal authority websites; Indian and Northern Affairs Canada; Statistics Canada modeling, estimating and projections methodologies and reports; and specific studies (e.g. Aboriginal homeless counts, community studies, theoretical papers explaining the undercount).

Population estimates (such as those produced by Statistics Canada and the Ontario Ministry of Finance) represent the best available published data for health planning and the denominators for calculating area-based health and social indicators. The Ministry of Health and Long-term Care produces subLHIN versions of these estimates that can be used in local planning, reporting and resource allocation. The assessment conducted for this study concluded that although these areas are based on population counts that have been adjusted by Statistics Canada for the census undercount, some of these areas are still missing large numbers of undercounted Aboriginal populations. This can result in invalid rates when Aboriginal populations are included in the numerator but inadequately reflected in the denominator. Population estimates represent a snapshot of the distribution of the population at a specific point in time. The actual population served by an organization such as an Aboriginal CHC or an AHAC, etc., includes a population that may vary in residence over any given time period. Mobility rates are generally higher for Aboriginal populations and census mobility measures may not adequately capture on- and off-reserve movement over any given time period.

Recommendation Five
It is recommended that targets, gaps and leveling up recommendations produced by this study be seen as minimums and that this be noted n all communications. In general, it is recommended that whenever census-based counts or population estimates are used that the underrepresentation of Aboriginal peoples in the data be noted. It is further recommended that planning estimates for Aboriginal population groups and

communities (including geographic planning areas) be developed with Aboriginal communities and include alternate sets of data such as the Indian Registrar and Aboriginal community studies in order to define more "realistic service population estimates" than the census or census-based population snapshot estimates.

6.6 Lack of Access to Relevant Health Planning Data

Access to Ontario's health planning database which includes demographics, vital statistics and visits to physicians, hospitals, ER and other health services through the IntelliHEALTH Ontario data system is available only to the staff of LHINs, public health units and hospitals. Data support in the form of indicators and measures for small planning areas such as subLHINs is prepared by the Ministry of Health and Long-term Care but not publicly available. The Ministry of Health and Long-term Care and Public Health Ontario, also provide access to additional data and indicators directly to LHINs and public health units. CHCs individually regionally and provincially are engaged in strategic planning, performance measurement and resource allocation and evaluation activities that require access to this same data. Despite their mandate for community health planning, CHC planners, researchers, decision support staff and decision makers lack access to data and tools for health planning and resource allocation that several other health system organizations have.

Recommendation Six
To fully achieve their potential to plan with and advocate for the changes needed to protect and maintain the health of the populations and communities they serve, CHCs and AHACs needs better access to relevant local health planning data that is available to other health planners.
Tables that Follow:

1A. Estimated Current PHC Service Capacity and % of Priority Population Served
1B. Aboriginal Population Served by Existing AHACs and Aboriginal CHCs, Equity Targets by Geo Type and Calculated Service Gap for Initial Expansion
1C. Francophone Population Service Equity Targets and Service Gap for Initial Expansion
1D. Other Priority Populations: Service Equity Targets and Equity Gap; includes all other low income people and people with potential access barriers living in geographically underserved areas (excluding Aboriginal and Francophone populations already counted)
1E. Priority Population Segments: Sum of Calculated Gaps for First Stage Targeted Expansion

Technical Notes with reference tables, Maps and Gender Tables/Maps are in separate documents.

Equity Gap for First Stage Targeted Expansion of Access to Community-Based Primary Health Care Services, Results Tables 7A to 7E by SubLHIN and LHIN

LHIN total follows SubLHINs. Footnotes are provided at the end of each table.

Table 7A: Estimated Current PHC Service Capacity and % of Priority Population Served

	A. Community Planning Areas (SubLHINs V9, 2010) and LHIN Totals	B. Total Population 2009 Estimates (Not Adjusted for Needs)[i]	C. Priority 'Target' Pop (Sum of Segments Model)[ii]	D. Total CHC and AHAC clients, 2011[iii]	E. % of Target Pop. that can be served by existing CHCs and AHACs (F/E) **(Very Low <15%) shaded)**[iv]	F. *Calculated Equity Gap for First Stage Targeted Expansion –Sum of Segments and Geo Areas (subLHIN sums)*[v]
Ontario Total		13095000	2,719,723	517,953	19%	369536
SubLHINs & LHINs						
101	Essex	403707	86519	22380	26%	3235
102	Chatham-Kent	110283	20541	7691	37%	1283
103	Lambton	132142	23596	10907	46%	2423
LHIN 1	**Erie St Clair**	**646132**	**130656**	**40978**	**31%**	**6940**
201	Bruce	66896	23459	87	**<1%**	8120
202	Grey	82401	23961	2810	**12%**	5399
203	Huron	60639	19448	3282	17%	3252
204	Perth	76774	10164	395	**4%**	2189
205	Middlesex	452222	83289	11786	**14%**	11923
206	Oxford-Norfolk	120656	14974	4466	30%	509
207	Elgin	90007	15187	4077	27%	431
LHIN 2	**South West**	**949595**	**190483**	**26903**	**14%**	**31823**
301	Urb. Waterloo & Rur. Sth.	467881	63272	12097	19%	4131
302	Urban Guelph	130289	16179	6185	38%	654
303	Rural Waterloo	50322	4250	7399	100%	116
304	Rural - S. Grey and N. Wellington	29203	9822	51	**<1%**	3277
305	Rural Wellington	63014	4897	562	**12%**	692
LHIN 3	**Waterloo Wellington**	**740709**	**98420**	**26293**	**27%**	**8869**
401.1	Brant	36259	3637	989	27%	28
401.2	Brantford	96285	18136	6168	34%	113
402	New Credit and Six Nations	13600	12012	-	**0%**	6003
403.1	Norfolk	50751	7446	100	**1%**	1854
403.2	Haldimand	46387	6328	167	**3%**	1490
404	Burlington	184538	16456	381	**2%**	3828
405.1	Niagara Falls	85031	14480	1867	**13%**	1878
405.2	Fort Erie	30958	5755	2693	47%	339
406.1	Niagara on the Lake	15192	1853	23	**1%**	448
406.2	St. Catharines	137102	23582	5663	24%	676
406.3	Thorold	18869	2800	664	24%	124
407.1	Pelham	16747	1082	75	**7%**	221
407.2	Wainfleet	6823	841	156	19%	79
407.3	Welland	52199	9818	1657	17%	1913
407.4	Port Colborne	19299	3238	998	31%	142
408.1	Grimsby	24751	1782	42	**2%**	420
408.2	West Lincoln	13525	1173	41	**4%**	260

Table 7A (Continued). Estimated Current PHC Service Capacity & % of Priority Pop. Served A. SubLHINs, V9 and LHIN Totals		B. Total Population 2009 Estimates[i]	C. Priority 'Target' Pop[ii]	D. Total CHC and AHAC clients, 2011[iii]	E. % of Target Pop. by existing CHCs and AHACs (<15% shaded)[iv]	F. *Equity Gap for 1st Stage Targeted Exp. Sum of Segments)*[v]
408.3	Lincoln	22412	2493	31	1%	605
409	Stoney Creek	65485	6963	631	9%	1167
410	Glanbrook	16077	1212	110	9%	201
411	Ancaster	34935	2826	162	6%	557
412	Flamborough	41249	3064	153	5%	637
413	Dundas	25950	2384	136	6%	472
414	Hamilton Urban Core	104570	37825	11096	29%	0
415	Hamilton Outer Core	244154	42482	6276	15%	5032
LHIN 4	**Hamilton Niagara HB**	**1403148**	**229670**	**40280**	**18%**	**28486**
501	Dufferin County	58014	10620	46	<1%	3586
502	Malton (Mississauga)	40094	10601	3966	37%	114
503	Caledon	64406	5348	49	<1%	1320
504	Brampton	490695	89188	6193	7%	16343
505	Rexdale (Toronto)	129017	32470	9447	29%	356
506	Woodbridge (Vaughan)	31790	3005	330	11%	427
LHIN 5	**Central West**	**814016**	**151233**	**20032**	**13%**	**22144**
601	Milton	60335	5812	99	2%	1393
602	Halton Hills	61799	5321	40	<1%	1332
603	Oakville	185632	19367	178	<1%	4723
604	Northwest Mississauga	357881	62684	549	<1%	15201
605	Southeast Mississauga	360671	71832	3340	5%	14749
606	South Etobicoke – Tor.	109499	18466	6658	36%	368
LHIN 6	**Mississauga Halton**	**1135817**	**183482**	**10865**	**6%**	**37767**
701	West	147891	22625	13389	59%	439
702	North West	209944	49262	13886	28%	349
703	South West	141753	41674	8490	20%	2035
704	North Toronto	286861	43866	8335	19%	2749
705	South East	130588	46269	13884	30%	11
706	East	106624	17640	4565	26%	188
707	North East	119677	40318	12362	31%	0
LHIN 7	**Toronto Central**	**1143338**	**261656**	**74912**	**29%**	**5770**
801	Sth Simcoe/N. York Rg.	116183	14343	169	1%	3582
802	Central York Region	212268	21875	293	1%	5299
803	Richmond Hill	185059	34959	376	1%	8392
804	SW York Region	239422	31018	3646	12%	4131
805	Nth York West	241829	63837	14165	22%	1872
806	Nth York Central	296934	78665	7988	10%	11734
807	Nth York East	124101	31739	1964	6%	5994
808	Markham	299418	58767	793	1%	13934
LHIN 8	**Central**	**1715214**	**335202**	**29394**	**9%**	**54941**
901.1	Haliburton Highlands	16904	7116	20	<1%	2432
901.2	Kawartha Lakes	76592	11169	5406	48%	522
901.3	Peterborough City & County	133742	26437	186	<1%	6784
901.4	Northumberland-Havelock	78155	18248	2836	16%	1861
902.1	Durham North/Central	57885	9045	3255	36%	329
902.2	Durham West	315234	37451	6817	18%	2770
902.3	Durham East	240536	33931	6032	18%	2773

Table 7A (Continued). Estimated Current PHC Service Capacity & % of Priority Pop. Served A. SubLHINs, V9 and LHIN Totals		B. Total Population 2009 Estimates[i]	C. Priority 'Target' Pop[ii]	D. Total CHC and AHAC clients, 2011[iii]	E. % of Target Pop. served by existing CHCs and AHACs (<15% shaded)[iv]	*F. Equity Gap for 1st Stage Target-ed Expan. Sum of Segments*[v]
903.1	Scarborough Agincourt-Rouge	332754	82894	7480	**9%**	13306
903.2	Scarborough Cliffs /Sc. Ctr.	300236	78076	8299	**11%**	11388
LHIN 9	**Central East**	**1552038**	**304367**	**40331**	**13%**	**42164**
1001	Addington, N&C Frontenac	9621	5038	231	**5%**	1563
1002	Belleville	50764	8872	4281	48%	656
1003	Brockville	39654	5788	748	**13%**	747
1004	Central Hastings	22329	7995	4012	50%	428
1005	Gananoque, Leeds	15291	1837	260	**14%**	395
1006	Kingston & Islands	126900	22674	4287	19%	1676
1007	North Hastings	11954	6411	21	**<1%**	2359
1008	Prince Edward County	26251	4386	39	**<1%**	1112
1009	Quinte West, Brighton	54559	8502	4214	50%	736
1010	Rideau Lakes	11501	1812	3771	100%	223
1011	SE Leeds & Grenville	19034	2824	129	**5%**	607
1012	Smiths Falls, Perth, Lan.	34855	6590	5413	82%	482
1013	South Frontenac	19093	2204	314	**14%**	286
1014	Stone Mills, Loyalist	23525	3154	322	**10%**	534
1015	Tyendinaga, Napanee	25625	4848	794	16%	1395
LHIN 10	**South East**	**490956**	**92936**	**28838**	**31%**	**13197**
1101.1	Central Area	69129	20560	15779	77%	0
1101.2	Glebe, Old Ottawa S&E	29759	4451	2864	64%	33
1101.3	South Central	23960	5978	2340	39%	118
1101.4	Playfair Park Guildwood	24879	5964	1863	31%	178
1101.5	Hunt Club, Leitrim, Riverside	74343	16433	5122	32%	663
1101.6	Rural Southeast	27560	2911	900	32%	156
1102.1	Rural Northeast	12113	1882	574	31%	25
1102.2	Orleans and area	114197	17049	4497	27%	1167
1102.3	Industrial E, Pineview, Elm.	27966	8872	2217	25%	442
1102.4	Beacon Hill, Carson, Rocklf.	32556	7662	1660	22%	634
1102.5	Overbrook, Vanier, Beechwd.	45054	17746	4860	22%	984
1103.1	West Central	43693	7312	5334	74%	136
1103.2	Merivale	73566	13751	7088	52%	240
1103.3	South Nepean	50627	5423	2628	49%	182
1103.4	Rural Southwest	32644	2429	1355	58%	62
1103.5	Cedarview	50921	7712	2810	37%	259
1103.6	Kanata-Stittsville	87757	9148	2934	32%	367
1103.7	Bayshore	38301	10955	5764	53%	62
1103.8	Rural Northwest	23452	2113	659	33%	43
1104.1	Arnprior, McNab, Braeside	14933	2139	105	**5%**	467
1104.2	South Renfrew Cnty	32740	11669	1743	15%	2453
1104.3	North Renfrew Cnty	53738	22186	3254	15%	2578
1105.1	North Grenville	14591	1718	787	46%	144
1105.2	Carleton Place and Beckwith	16099	1997	477	24%	176
1105.3	Mississippi Mills & Lanark Hlds	17299	2706	2435	90%	313
1106.1	Akwesasne	9055	8900	5003	56%	0
1106.2	Glengarry	23978	14445	2078	**14%**	2793
1106.3	Hawkesbury, Champlain	24494	21929	128	**<1%**	5378

Table 7A (Continued). Estimated Current PHC Service Capacity & % of Priority Pop. Served A. SubLHINs, V9 and LHIN Totals		B. Total Population 2009 Estimates[i]	C. Priority 'Target' Pop[ii]	D. Total CHC and AHAC clients, 2011[iii]	E. % of Target Pop. served by existing CHCs and AHACs (<15% shaded)[iv]	F. *Equity Gap for First Stage Targeted Expansion, Sum of Segments*[v]
1106.4	Nation, Alfred-Plantagenet	23912	18816	1645	**9%**	4708
1106.5	Stormont	19573	5086	1185	23%	835
1106.6	Cornwall	48028	14958	5408	36%	217
1106.7	Dundas	21978	8188	176	**2%**	2636
1106.8	Russell Twp	14583	1760	1313	75%	97
1106.9	Clarence-Rockland	21960	4178	1441	35%	160
LHIN 11	**Champlain**	**1239438**	**309025**	**98427**	**32%**	**28707**
1201	Collingwood and Area	55967	9215	5142	56%	280
1202	Barrie and Area	228305	31589	5624	18%	2638
1203	Orillia and Area	56872	16144	132	**<1%**	4140
1204	Midland & Penetanguishene	50652	20002	3118	16%	2341
1205	Muskoka	60176	23023	49	**<1%**	7943
LHIN 12	**Nth Simcoe Muskoka**	**451972**	**99973**	**14065**	**14%**	**17344**
1301	Algoma	120168	43348	5646	**13%**	11119
1302	James & Hudson Bay Coasts	8689	9553	36	**<1%**	4599
1303	Nipissing	86226	36772	3301	**9%**	10340
1304	Parry Sound	42642	19219	635	**3%**	6164
1305	Manitoulin-Sudbury	200228	61384	18826	31%	5347
1306	Timiskaming	33651	20042	4151	21%	4106
1307	Cochrane	82778	43902	3015	**7%**	12707
LHIN 13	**North East**	**574382**	**234220**	**35610**	**15%**	**54382**
1401	Kenora	65117	46639	9383	20%	10914
1402	Rainy River	21767	10875	5534	51%	1921
1403	Thunder Bay District	26504	14915	3538	24%	3789
1404	Thunder Bay City	124857	25971	12571	48%	380
LHIN 14	**North West**		**98400**	**31025**	**32%**	**17003**

Totals may be slightly different than sums when data is based on percents which are rounded from decimal points.

i. Column B. Total Population Estimates, 2009 were obtained from Health Analytics Branch, MOHLTC and supplemented with Aboriginal additions of 25,000 based on 2009 data Indian Affairs and Northern Development Canada.

ii. Column C. Priority 'Target' Population. Sum of priority population segments (All Aboriginal peoples, Francophones with multiple access barriers, other low income persons and other persons in geographic underserved areas with additional potential access barriers, excluding overlaps.

iii. Column D. Total CHC and AHAC clients, 2011 (once 2004-05 expansion is fully implemented), CHC clients were geocoded from postal code to subLHINs. Distribution of AHAC clients is based on AHAC & AOHC information. Francophone clients include the Francophone share of the population among the clients served by bilingual CHCs. Client numbers 1-4 were not included for privacy reasons.

iv. Column E. % of Target Population that can be served by existing CHCs and AHACs (Column D divided by Column C)

v. Equity Gap for First Stage Targeted Expansion, Sum of Segments. This is the difference between the equity service level target for each population segment (according to geographic areas type (e.g. higher for remote areas, see Tables 1B, 1C, 1D for details) and the current capacity to serve these numbers. (Column C minus Column D). Blank cell means the service equity target for this first stage of expansion (i.e. 25%, 33.3% or 50% of the target population served) is being met with existing service levels and the area is less of an initial priority for target service expansion.

The equity service gap is larger than the initial AOHC expansion target of 250,000 recognizing that some of this gap may be addresses by means other than CHC and AHAC expansion (e.g. other services providing primary health care, other expansion of existing services not accounted for, community service priorities and preferences, etc.).

Table 7B. Aboriginal Population minimum estimates (based on Aboriginal Identity and Indian Register to reflect distribution of Aboriginal Identity share of total 2009 population, may not reflect service population planning estimates or total Aboriginal peoples), % served by existing AHACs & Aboriginal CHCs (F), Equity Targets at 33.3% or 50% by Geo Type (G), and calculated service gap for initial expansion (H).

A. Community Planning Areas (SubLHINs, V9) and LHIN Totals		B. Geo Type[i]	C. Aborig. Service Target Level[ii]	D. Aboriginal Estimate Minimum see note[iii]	E. AHAC/ AbCHC clients[iv]	F. % Ab. now served, 2011[v]	G. Service Equity Target[vi]	H. Gap to equity target[vii]
101	Essex	1	33.3	6889	-	0.0%	2294	2292
102	Chatham-Kent	2	33.3	2936	-	0.1%	978	975
103	Lambton	2	33.3	6267	15	0.2%	2087	2072
Erie St Clair (LHIN 1 Total)				**16093**	**20**	**0.1%**	**5359**	**5339**
201	Bruce	4	50	2363	9	0.4%	1182	1173
202	Grey	4	50	1374	-	0.2%	687	684
203	Huron	4	50	346	5	1.4%	173	168
204	Perth	3	33.3	535	-	0.2%	178	177
205	Middlesex	1	33.3	10769	5579	51.8%	3586	
206	Oxford-Norfolk	3	33.3	1163	-	0.1%	387	386
207	Elgin	2	33.3	984	-	0.3%	328	325
South West (LHIN 2 Total)				**17534**	**5601**	**31.9%**	**6521**	**2912**
301	Urb. Waterloo & Rural S.	1	33.3	4937	-	0.0%	1644	1642
302	Urban Guelph	1	33.3	1422	-	0.3%	474	470
303	Rural Waterloo	3	33.3	249	-	0.4%	83	82
304	Rural - S. Grey and N. Wellington	4	50	341	-	0.3%	170	169
305	Rural Wellington	3	33.3	368	0	0.0%	122	122
Waterloo Wellington (LHIN 3 Total)				**7316**	**8**	**0.1%**	**2493**	**2485**
401.1	Brant	3	33.3	660	220	33.4%	220	
401.2	Brantford	1	33.3	5320	1853	34.8%	1772	
402	New Credit and Six Nations	4	50	12000	0	0.0%	6000	6000
403.1	Norfolk	3	33.3	1114	-	0.1%	371	370
403.2	Haldimand	3	33.3	898	18	2.0%	299	281
404	Burlington	1	33.3	1157	-	0.2%	385	383
405.1	Niagara Falls	1	33.3	1503	-	0.3%	501	497
405.2	Fort Erie	2	33.3	1017	-	0.4%	339	335
406.1	Niagara on the Lake	3	33.3	87	0	0.0%	29	29
406.2	St. Catharines	1	33.3	2066	12	0.6%	688	676
406.3	Thorold	1	33.3	373	0	0.0%	124	124
407.1	Pelham	2	33.3	81	0	0.0%	27	27
407.2	Wainfleet	3	33.3	205	-	0.5%	68	67
407.3	Welland	1	33.3	1260	-	0.2%	420	417
407.4	Port Colborne	2	33.3	427	0	0.0%	142	142
408.1	Grimsby	1	33.3	205	-	1.5%	68	65
408.2	West Lincoln	3	33.3	97	0	0.0%	32	32
408.3	Lincoln	2	33.3	141	-	0.7%	47	46
409	Stoney Creek	1	33.3	541	0	0.0%	180	180
410	Glanbrook	1	33.3	92	0	0.0%	31	31
411	Ancaster	1	33.3	157	0	0.0%	52	52
412	Flamborough	1	33.3	281	-	0.7%	94	92
413	Dundas	1	33.3	151	0	0.0%	50	50
414	Hamilton Urban Core	1	33.3	5576	2009	36.0%	1857	

Table 7B (continued). Aboriginal Service Targets and Equity Gaps A. Community Planning Areas (SubLHINs, V9) and LHIN Totals		B. Geo Type[i]	C. Ab. Service Target Level[ii]	D. Aboriginal Estimate Minimum see note[iii]	E. Ab Clients AHACs &CHCs[iv]	F. % Ab. served, 2011[v]	G. Service Equity Target[vi]	H. Gap to initial target[vii]
415	Hamilton Outer Core	1	33.3	5466	1510	27.6%	1820	310
Hamilton Niagara Haldimand Brant LHIN 4				**40875**	**5643**	**13.8%**	**15616**	**10206**
501	Dufferin County	4	50	568	-	0.4%	284	282
502	Malton (Mississauga)	1	33.3	146	5	3.5%	49	43
503	Caledon	2	33.3	389	-	0.3%	130	129
504	Brampton	1	33.3	2877	35	1.2%	958	923
505	Rexdale (Toronto)	1	33.3	373	30	7.9%	124	95
506	Woodbridge (Vaughan)	1	33.3	65	0	0.3%	21	21
Central West (LHIN 5 Total)				**4418**	**73**	**1.7%**	**1566**	**1493**
601	Milton	2	33.3	460	5	1.1%	153	148
602	Halton Hills	2	33.3	514	-	0.4%	171	169
603	Oakville	1	33.3	719	5	0.7%	239	234
604	Northwest Mississauga	1	33.3	963	13	1.4%	321	307
605	Southeast Mississauga	1	33.3	1568	20	1.3%	522	502
606	South Etobicoke – Tor.	1	33.3	525	52	9.9%	175	123
Mississauga Halton (LHIN 6 Total)				**4748**	**97**	**2.0%**	**1581**	**1484**
701	West	1	33.3	968	124	12.8%	322	199
702	North West	1	33.3	1774	693	39.1%	591	
703	South West	1	33.3	1082	298	27.5%	360	62
704	North Toronto	1	33.3	1341	408	30.4%	447	39
705	South East	1	33.3	2767	1155	41.8%	921	
706	East	1	33.3	1179	279	23.7%	393	113
707	North East	1	33.3	660	229	34.8%	220	
Toronto Central (LHIN 7 Total)				**9770**	**3186**	**32.6%**	**3253**	**413**
801	Sth Simcoe/N. York Region	2	33.3	1990	10	0.5%	663	652
802	Central York Region	2	33.3	1492	14	0.9%	497	483
803	Richmond Hill	1	33.3	335	7	2.2%	112	104
804	SW York Region	1	33.3	281	7	2.4%	94	87
805	Nth York West	1	33.3	1136	196	17.2%	378	182
806	Nth York Central	1	33.3	606	136	22.5%	202	65
807	Nth York East	1	33.3	281	51	18.2%	94	43
808	Markham	1	33.3	433	9	2.0%	144	135
Central (LHIN 8 Total)				**6554**	**431**	**6.6%**	**2182**	**1752**
901.1	Haliburton Highlands	4	50	492	-	0.4%	246	244
901.2	Kawartha Lakes	3	33.3	1357	-	0.2%	452	449
901.3	Peterborough City & County	2	33.3	4337	16	0.4%	1444	1428
901.4	Northumberland-Havelock	3	33.3	1633	8	0.5%	544	536
902.1	Durham North/Central	4	50	519	-	0.2%	260	259
902.2	Durham West	1	33.3	2682	33	1.2%	893	860
902.3	Durham East	1	33.3	3899	22	0.6%	1298	1276
903.1	Scarborough Aginc.-Rouge	1	33.3	757	88	11.7%	252	164
903.2	Scarborough Cliffs/Scarb. Ctr	1	33.3	2033	316	15.5%	677	362
Central East (LHIN 9 Total)				**17710**	**489**	**2.8%**	**6066**	**5577**
1001	Addington, N&C Frontenac	4	50	698	0	0.0%	349	349
1002	Belleville	2	33.3	1692	0	0.0%	564	564
1003	Brockville	3	33.3	579	0	0.0%	193	193
1004	Central Hastings	4	50	708	-	0.1%	354	353

Table 7B. (continued) Aboriginal A. Community Planning Areas (subLHINs, V9) & LHIN Totals		B. Geo Type[i]	C. Ab. Service Target Level[ii]	D. Aborig. Estimate Minimum see note,[iii]	E. Ab Clients AHACs & CHCs[iv]	F. % Ab. served, 2011[v]	G. Service Equity Target[vi]	H. Gap to initial target[vii]
1005	Gananoque, Leeds	4	50	260	0	0.0%	130	130
1006	Kingston & Islands	1	33.3	3552	0	0.0%	1183	1183
1007	North Hastings	4	50	1465	-	0.1%	733	732
1008	Prince Edward County	3	33.3	660	0	0.0%	220	220
1009	Quinte West, Brighton	2	33.3	1765	-	0.1%	588	586
1010	Rideau Lakes	4	50	346	0	0.0%	173	173
1011	SE Leeds & Grenville	3	33.3	368	0	0.0%	122	122
1012	Smiths Falls, Perth, Lanark	2	33.3	1117	0	0.0%	372	372
1013	South Frontenac	3	33.3	595	0	0.0%	198	198
1014	Stone Mills, Loyalist	3	33.3	787	0	0.0%	262	262
1015	Tyendinaga, Napanee	3	33.3	4113	-	0.1%	1370	1366
South East (LHIN 10 Total)				**18705**	**8**	**0.0%**	**6809**	**6801**
1101.1	Central Area	1	33.3	1276	563	44.1%	425	
1101.2	Glebe, Old Ottawa S. & E.	1	33.3	319	136	42.7%	106	
1101.3	South Central	1	33.3	379	161	42.6%	126	
1101.4	Playfair Park, Lynda Park, Guild	1	33.3	211	88	41.6%	70	
1101.5	Hunt Club, Leitrim, Riverside	1	33.3	1033	431	41.7%	344	
1101.6	Rural Southeast	1	33.3	373	157	42.0%	124	
1102.1	Rural Northeast	1	33.3	254	107	42.2%	85	
1102.2	Orleans and area	1	33.3	1649	693	42.0%	549	
1102.3	Industrial E., Riverview, Pine.	1	33.3	443	188	42.3%	148	
1102.4	Beacon Hill, Rothwell, Cardinal,	1	33.3	541	230	42.6%	180	
1102.5	Overbrook, Vanier, Beechwd.	1	33.3	1710	613	36%	569	
1103.1	West Central	1	33.3	622	268	43.1%	207	
1103.2	Merivale	1	33.3	963	406	42.2%	321	
1103.3	South Nepean	1	33.3	481	202	41.9%	160	
1103.4	Rural Southwest	1	33.3	465	196	42.1%	155	
1103.5	Cedarview	1	33.3	692	298	43.1%	230	
1103.6	Kanata-Stittsville	1	33.3	871	366	42.0%	290	
1103.7	Bayshore	1	33.3	573	242	42.1%	191	
1103.8	Rural Northwest	1	33.3	541	225	41.6%	180	
1104.1	Arnprior, McNab, Braeside	3	33.3	460	0	0.0%	153	153
1104.2	South Renfrew Cty	4	50	1860	0	0.0%	930	930
1104.3	North Renfrew Cty	3	33.3	3445	0	0.0%	1147	1147
1105.1	North Grenville	3	33.3	287	0	0.0%	95	95
1105.2	Carleton Place and Beckwith	3	33.3	335	0	0.0%	112	112
1105.3	Mississippi Mills & Lanark Hild	4	50	406	0	0.0%	203	203
1106.1	Akwesasne	4	50	8900	5000	56.2%	4450	
1106.2	Glengarry	4	50	362	0	0.0%	181	181
1106.3	Hawkesbury, E. Champlain	3	33.3	287	0	0.0%	95	95
1106.4	Nation, Alfred-Plantagenet,	4	50	525	0	0.0%	262	262
1106.5	Stormont	4	50	314	0	0.0%	157	157
1106.6	Cornwall	1	33.3	2346	564	24.0%	781	217
1106.7	Dundas	4	50	508	0	0.0%	254	254
1106.8	Russell Twp	2	33.3	292	0	0.0%	97	97
1106.9	Clarence-Rockland	3	33.3	481	0	0.0%	160	160
Champlain (LHIN 11 Total)				**34203**	**11132**	**32.5%**	**13539**	**4065**

Table 7B. (continued) Aboriginal A. Community Planning Areas (subLHINs, V9) and LHIN Totals		B. Geo Type[i]	C. Ab. Service Target Level[ii]	D. Ab. Estimate Minimum see note[iii]	E. Ab Clients AHAC& CHCs[iv]	F. % Ab. served, 2011[v]	G. Service Equity Target[vi]	H. Gap to initial target[vii]
1201	Collingwood Area	3	33.3	606	-	0.7%	202	198
1202	Barrie and Area	2	33.3	4391	23	0.5%	1462	1439
1203	Orillia and Area	3	33.3	2839	23	0.8%	945	922
1204	Midland & Penetanguishene	3	33.3	5520	11	0.2%	1838	1827
1205	Muskoka	5	50	1945	-	0.2%	972	968
North Simcoe Muskoka				**15300**	**65**	**0.4%**	**5420**	**5355**
1301	Algoma	5	50	13950	5586	40.0%	6975	1389
1302	James and Hudson Bay Coasts	6	50	8710	9	0.1%	4355	4346
1303	Nipissing	5	50	8355	14	0.2%	4177	4163
1304	Parry Sound	6	50	2390	520	21.8%	1195	675
1305	Manitoulin-Sudbury	2	33.3	18960	10729	56.6%	6314	
1306	Timiskaming	5	50	1952	10	0.5%	976	966
1307	Cochrane	5	50	6597	989	15.0%	3299	2310
North East (LHIN 13 Total)				**60914**	**17857**	**29.3%**	**27291**	**13849**
1401	Kenora	6	50	28544	5569	19.5%	14272	8703
1402	Rainy River	5	50	5010	5500	100%	2505	
1403	Thunder Bay District	6	50	5867	85	1.4%	2934	2849
1404	Thunder Bay City	2	33.3	10830	5576	51.5%	3606	
North West (LHIN 14 Total)				**50251**	**16730**	**33.3%**	**23317**	**11551**
Ontario Total				**304,380**	**61,340**	**20.1%**	**121,014**	**73,280**

Totals may be slightly different than sums where data is based on percents rounded from decimal points.

i. Geographic area types (Column B) created this study were: 1–Urban, 2-Urban Extended (mostly urban but with some rural communities); 3-Rural South (mostly rural without high RIO scores); 4–Rural with higher RIO scores; 5-Northern rural; 6-Northern Remote: High % rural and High RIO scores (60+).

ii. For the purpose of leveling up service access to achieve equity with the preliminary expansion, remote southern, and rural and remote northern areas have a service level target (Column C) of 50% for Aboriginal peoples, while the target for other areas would be access for 33.3% of Aboriginal peoples.

iii. Minimum Aboriginal Estimates, 2009 (Column D) were prepared by Step to Equity using the 2006 census and 2009 population estimates (MOHLTC) and adding-in missing Aboriginal populations based on existing growth rates, undercount estimates from the Statistics Canada report on Aboriginal Projections (Caron Malenfant et al, 2011); 2009 data from the Indian Register (Indian Affairs & Northern Development Canada) and the Toronto Street Needs Assessment (2009).

iv. Column E includes only clients of Aboriginal CHCs and AHACs (information from AHACs , AOHC and a web-search). Aboriginal CHCs clients were geocoded to subLHINs from client postal codes. Client numbers 1-4 were not included for privacy reasons. Other CHCs and other services providing primary health care for Aboriginal populations are not included. These need to be considered in identifying service gaps according to individual Aboriginal communities' priorities and preferences. The total estimated Aboriginal population is included in the Priority Population because of greater health needs, the lack of culturally safe mainstream services, census undercounts and data limitations do not support prioritizing selected groups of Aboriginal people and because the "service population" is not well captured by a census "snapshot."

vi. Column F. % of Aboriginal Population being served by existing CHCs and AHACs (Col. D divided by C).

v. Equity Gap for First Stage Targeted Expansion, (Column H) is the difference between the service target and the number of Aboriginal people being served by Aboriginal CHCs and AHACs (G minus E =H). The cell is blank if the target for leveling up is met. The total gap for leveling up to provide equitable access to Aboriginal community-based primary health care provided by AHACs and Aboriginal CHCs is 73,280. These calculations are a starting point for identifying potential priority areas for expansion.

Table 7C. Francophone Population Service Equity Targets and Service Gap for Initial Expansion										
A. Community Planning Areas (SubLHINs, V9) and LHIN Totals (LHIN total follows subLHINs)		B. Geo Typ[i]	C. Service Targ. Level (%)[ii]	D. Franco-phone Pop[iii]	E. Franco-phone Priority Pop.[iv]	F. Franco-phone clients[v]	G. % Franco-PP served (2011)[vi]	H. Franco Prio. Pop. Service Target[vii]	I. Gap to Equity Target[viii]	J. Gap if Fr. Prio areas[ix]
101	Essex	1	25	15743	7264	873	12.0%	1816	943	943
102	Chatham-Kent	2	25	3394	1255	6	0.5%	314	308	
103	Lambton	2	25	3348	1413	-	0.2%	353	351	
LHIN 1	**Erie St Clair**			**22485**	**9932**	**882**	**8.9%**	**2483**	**1601**	**943**
201	Bruce	4	33.3	633	555		0.2%	185	184	
202	Grey	4	33.3	864	613	0	0.0%	204	204	
203	Huron	4	33.3	499	387		0.3%	129	128	
204	Perth	3	25	504	278	0	0.0%	69	69	
205	Middlesex	1	25	7781	3632	87	2.4%	908	821	821
206	Oxford-Norfolk	3	25	1507	506		0.6%	127	123	
207	Elgin	2	25	941	434		0.6%	108	106	
LHIN 2	**South West**			**12729**	**6405**	**95**	**1.5%**	**1703**	**1636**	**821**
301	Urban Waterloo & Rur.S.	1	25	8147	3293	17	0.5%	823	806	
302	Urban Guelph	1	25	2232	744	-	0.3%	186	184	
303	Rural Waterloo	3	25	345	138	-	0.8%	35	34	
304	Rural - S. Grey/N. Well.	4	33.3	252	235	5	2.2%	78	73	
305	Rural Wellington	3	25	633	202	-	0.5%	50	49	
LHIN 3	**Waterloo Wellington**			**11608**	**4612**	**26**	**0.6%**	**1173**	**1146**	
401.1	Brant	3	25	260	127	-	3.2%	32	28	
401.2	Brantford	1	25	1361	472	5	1.1%	118	113	
402	New Credit - Six Nations	4	33.3	0	0	0		0	0	
403.1	Norfolk	3	25	561	293	0	0.0%	73	73	
403.2	Haldimand	3	25	545	178	11	6.4%	44	33	
404	Burlington	1	25	3875	1349	70	5.2%	337	268	
405.1	Niagara Falls	1	25	2540	1223	157	12.8%	306	149	
405.2	Fort Erie	2	25	675	356	85	23.9%	89	4	
406.1	Niagara on the Lake	3	25	332	129	6	4.9%	32	26	
406.2	St. Catharines	1	25	3611	1533	387	25.3%	383		
406.3	Thorold	1	25	447	176	50	28.5%	44		
407.1	Pelham	2	25	364	113	47	41.6%	28		
407.2	Wainfleet	3	25	187	74	26	34.8%	18		
407.3	Welland	1	25	6363	2119	1540	72.7%	530		
407.4	Port Colborne	2	25	1097	432	120	27.7%	108		
408.1	Grimsby	1	25	390	72	4	5.7%	18	14	
408.2	West Lincoln	3	25	135	81	6	7.6%	20	14	
408.3	Lincoln	2	25	307	160	13	8.4%	40	27	
409	Stoney Creek	1	25	1101	428	120	27.9%	107		
410	Glanbrook	1	25	229	73	14	19.5%	18	4	
411	Ancaster	1	25	395	119	25	20.6%	30	5	
412	Flamborough	1	25	525	127	15	12.1%	32	16	
413	Dundas	1	25	327	130	29	22.1%	32	4	
414	Hamilton Urban Core	1	25	2530	1588	924	58.2%	397		
415	Hamilton Outer Core	1	25	4218	2202	785	35.6%	550		
LHIN 4	**Hamilton Niagara HB**			**32375**	**13552**	**4444**	**32.8%**	**3388**	**777**	

Table 7C (continued) Francophone A. Community Planning Areas (SubLHINs, V9) and LHIN Totals		B. Geo Typ[i]	C. Ser-vice Targ Level (%)[ii]	D. Tot. Franco -phone Pop.[iii]	E. Franco -phone Priority Pop[iv]	F. Franco -phone clients[v]	G Fran. co Pri. Pop served[vi]	H. Franco Pop. Service Target[vii]	I. Gap to Initial Target[viii]	J. Gap if Fr. Prio areas[ix]
501	Dufferin County	4	33.3	738	294	0	0.0%	98	98	
502	Malton (Mississauga)	1	25	514	381	25	6.5%	95	71	
503	Caledon	2	25	681	190	3	1.6%	48	44	
504	Brampton	1	25	6421	3776	96	2.5%	944	848	848
505	Rexdale (Toronto)	1	25	1943	1507	116	7.7%	377	261	261
506	Woodbridge (Vaughan)	1	25	332	130	-	0.8%	33	32	
LHIN 5	**Central West**			**10629**	**6278**	**241**	**3.8%**	**1594**	**1353**	**1109**
601	Milton	2	25	1164	356	19	5.2%	89	70	
602	Halton Hills	2	25	1184	290	-	0.4%	72	71	
603	Oakville	1	25	4192	1439	25	1.7%	360	335	
604	Northwest Mississauga	1	25	6794	4254	48	1.1%	1064	1015	1015
605	Southeast Mississauga	1	25	7157	3964	76	1.9%	991	915	915
606	South Etobicoke - Tor	1	25	2421	1211	58	4.8%	303	245	245
LHIN 6	**Mississauga Halton**			**22912**	**11513**	**227**	**2.0%**	**2878**	**2652**	**2175**
701	West	1	25	3849	1746	196	11.2%	436	240	240
702	North West	1	25	4255	2502	277	11.1%	625	349	349
703	South West	1	25	4011	2229	371	16.6%	557	186	186
704	North Toronto	1	25	7860	3336	250	7.5%	834	584	584
705	South East	1	25	4421	2704	665	24.6%	676	11	11
706	East	1	25	2353	913	153	16.7%	228	75	75
707	North East	1	25	2068	1344	348	25.9%	336		
LHIN 7	**Toronto Central**			**28817**	**14774**	**2260**	**15.3%**	**3694**	**1445**	**1445**
801	Sth Simcoe/N. York Rg	2	25	1740	637	8	1.3%	159	151	
802	Central York Region	2	25	3392	1242	13	1.1%	311	297	
803	Richmond Hill	1	25	3236	2084	41	2.0%	521	480	
804	SW York Region	1	25	3429	1737	34	2.0%	434	400	
805	Nth York West	1	25	2992	2054	224	10.9%	513	289	289
806	Nth York Central	1	25	6218	3923	202	5.2%	981	778	778
807	Nth York East	1	25	3361	2269	350	15.4%	567	217	217
808	Markham	1	25	3709	2573	68	2.6%	643	575	
LHIN 8	**Central**			**28079**	**16519**	**942**	**5.7%**	**4130**	**3188**	**1285**
901.1	Haliburton Highlands	4	33.3	275	280	0	0.0%	93	93	
901.2	Kawartha Lakes	3	25	935	306	-	1.0%	76	73	
901.3	Peterborough City/Cnty	2	25	1823	851	-	0.2%	213	211	
901.4	Northumberland-Havk	3	25	925	540	-	0.6%	135	132	
902.1	Durham North/Central	4	33.3	597	217	-	0.9%	72	70	
902.2	Durham West	1	25	6250	2308	216	9.3%	577	361	
902.3	Durham East	1	25	5413	1810	33	1.8%	452	419	
903.1	Scarborough Agin-Rge	1	25	4057	3228	223	6.9%	807	584	584
903.2	Scarborough Cliffs/ Ctr.	1	25	4987	3427	604	17.6%	857	253	253
LHIN 9	**Central East**			**25263**	**12968**	**1087**	**8.4%**	**3283**	**2196**	**837**
1001	Addington N &C Frontn	4	33.3	145	138	-	0.8%	46	45	
1002	Belleville	2	25	857	369	0	0.0%	92	92	
1003	Brockville	3	25	1060	353	-	1.0%	88	85	
1004	Central Hastings	4	33.3	286	227	-	0.5%	76	75	
1005	Gananoque, Leeds	4	33.3	265	95	-	1.1%	32	30	
1006	Kingston & Islands	1	25	4634	1769	-	0.1%	442	440	440

Table 7C (continued) Francophone A. Community Planning Areas (SubLHINs, V9) and LHIN Totals		B. Geo Typ[i]	C. Ser-vice Targ. Level (%)[ii]	D. Total Franco -phone Pop. Est)[iii]	E. Franco -phone Priority Popu-lation[iv]	F. Franco -phone clients (2011) Ex <5[v]	G. Franco Prio. Pop served (%)[vi]	H. Franco Prii. Pop. Equity Service Target [vii]	I. Gap to Initial Equity Target [viii]	J. Gap if Fr. Prio areas [ix]
1007	North Hastings	4	33.3	119	129	-	0.8%	32	42	
1008	Prince Edward County	3	25	457	152	0	0.0%	38	38	
1009	Quinte West, Brighton	2	25	2317	600	0	0.0%	150	150	
1010	Rideau Lakes	4	33.3	301	154	-	0.8%	51	50	
1011	SE Leeds & Grenville	3	25	732	263	8	3.0%	66	58	
1012	Smiths Falls/Perth/Lnk	2	25	1138	451	-	0.7%	113	110	
1013	South Frontenac	3	25	327	51	-	2.0%	13	12	
1014	Stone Mills, Loyalist	3	25	447	125	0	0.1%	31	31	
1015	Tyendinaga, Napanee	3	25	338	119	-	0.9%	30	29	
LHIN 10	**South East**		**25**	**13424**	**4994**	**24**	**0.5%**	**1299**	**1286**	**440**
1101.1	Central Area	1	25	13541	6377	1890	29.6%	1594		
1101.2	Glebe, Old Ottawa S/E	1	25	3124	996	216	21.7%	249	33	33
1101.3	South Central	1	25	2753	1379	227	16.5%	345	118	118
1101.4	Playfair Pk. Lynda Pk.	1	25	4337	1906	299	15.7%	476	178	178
1101.5	Hunt Club, Leitrim, Rivsd.	1	25	10938	5223	643	12.3%	1306	663	663
1101.6	Rural Southeast	1	25	3311	1165	135	11.6%	291	156	156
1102.1	Rural Northeast	1	25	5786	1166	266	22.8%	292	25	25
1102.2	Orleans and area	1	25	38847	9829	1290	13.1%	2457	1167	1167
1102.3	Industrial E., Riverview, P	1	25	7074	3660	473	12.9%	915	442	442
1102.4	Beacon Hill, Rothwell	1	25	10160	4241	426	10.0%	1060	634	634
1102.5	Overbrook, Vanier, Beech	1	25	18345	8831	1224	13.9%	2208	984	984
1103.1	West Central	1	25	4261	1749	301	17.2%	437	136	136
1103.2	Merivale	1	25	6607	3127	542	17.3%	782	240	240
1103.3	South Nepean	1	25	3601	1373	161	11.8%	343	182	182
1103.4	Rural Southwest	1	25	2002	498	63	12.6%	125	62	62
1103.5	Cedarview	1	25	3864	1737	175	10.1%	434	259	259
1103.6	Kanata-Stittsville	1	25	6703	2161	174	8.0%	540	367	367
1103.7	Bayshore	1	25	4197	2526	570	22.6%	631	62	62
1103.8	Rural Northwest	1	25	1342	314	36	11.3%	79	43	43
1104.1	Arnprior, McNab, Brae.	3	25	612	276	-	1.4%	69	65	
1104.2	South Renfrew Cty	4	33.3	971	680	-	0.6%	226	222	
1104.3	North Renfrew Cty	3	25	4074	3709	7	0.2%	927	921	921
1105.1	North Grenville	3	25	1004	238	10	4.2%	60	49	49
1105.2	Carleton Place/ Beck.	3	25	993	285	7	2.6%	71	64	64
1105.3	Mississippi Mills, Lnk Hld.	4	33.3	843	373	14	3.8%	124	110	
1106.1	Akwesasne	4	33.3	0	0	-		0		
1106.2	Glengarry	4	33.3	8711	8938	1807	20.2%	2976	1170	1170
1106.3	Hawkesbury, Champl.	3	25	17513	19256	122	0.6%	4814	4692	4692
1106.4	Nation, Alfred, Plant.,	4	33.3	18130	16877	1595	9.5%	5620	4025	4025
1106.5	Stormont	4	33.3	3623	2128	983	46.2%	709		
1106.6	Cornwall	1	25	14110	5169	2753	53.3%	1292		
1106.7	Dundas	4	33.3	1288	1128	94	8.3%	376	282	282
1106.8	Russell Twp	2	25	6843	1129	1229	108.9%	282		
1106.9	Clarence-Rockland	3	25	14867	3211	1283	39.9%	803		
LHIN 11	**Champlain**			**244374**	**121656**	**19026**	**15.6%**	**32914**	**17349**	**16952**

Table 7C (continued) Francophone A. Community Planning Areas (SubLHINs, V9) and LHIN Totals		B. Geo Typ[i]	C. Ser-vice Targ et Level (%)[ii]	D. Total Franco -phone Pop. Est)[iii]	E. Franco -phone Priority Popu-lation[iv]	F. Franco -phone clients (2011) Ex <5[v]	G. Franco Prio. Pop served (%)[vi]	H. Franco Prii. Pop. Equity Service Target [vii]	I. Gap to Initial Equity Target [viii]	J. Gap if Fr. Prio areas [ix]
1201	Collingwood & Area	3	25	795	329	0	0.0%	82	82	
1202	Barrie and Area	2	25	6047	1418	5	0.4%	355	349	
1203	Orillia and Area	3	25	909	554	-	0.4%	139	136	
1204	Midland & Penetang.	3	25	3829	2624	228	8.7%	656	428	428
1205	Muskoka	5	33.3	888	818	-	0.2%	273	271	
LHIN 12	**Nth Simcoe Muskoka**			**12468**	**5743**	**237**	**4.1%**	**1504**	**1267**	**428**
1301	Algoma	5	33.3	8977	6138	22	0.4%	2044	2022	2022
1302	James & Hudson Bay	6	33.3	1107	300	23	7.6%	100	77	77
1303	Nipissing	5	33.3	22261	15318	3258	21.3%	5101	1843	1843
1304	Parry Sound	6	33.3	1309	1239	94	7.6%	413	319	319
1305	Manitoulin-Sudbury	2	25	53134	20889	8057	38.6%	5222		
1306	Timiskaming	5	33.3	8785	8627	4130	47.9%	2873		
1307	Cochrane	5	33.3	39674	28927	1998	6.9%	9633	7635	7635
LHIN 13	**North East**			**135247**	**81437**	**17581**	**21.6%**	**25385**	**11896**	**11896**
1401	Kenora	6	33.3	1621	1506	13	0.9%	502	488	488
1402	Rainy River	5	33.3	369	309	-	1.0%	103	100	
1403	Thunder Bay District	6	33.3	2935	2835	-	0.1%	944	940	940
1404	Thunder Bay City	2	25	3517	1522	0	0.0%	380	380	
LHIN 14	**North West**			**8442**	**6172**	**21**	**0.3%**	**1929**	**1908**	**1428**
	Ontario Total			**608852**	**316555**	**47092**	**14.9%**	**87384**	**49700**	**39758**

Totals may be slightly different than sums where data is based on percents rounded from decimal points.

i. Geographic area types (Column B) created this study were: 1 – Urban, 2-Urban Extended (mostly urban but some rural communities); 3-Rural South (mostly rural without high RIO scores); 4 – Rural with higher RIO scores; 5- Northern rural; 6-Northern Remote: High % rural and High RIO scores (60+).

ii. For this phase of expanding access, remote southern and rural and remote northern areas are given a target of 33.3% of the priority population to be served, and the target for other areas us 25%.

iii Francophone Estimates, 2009 (Column D). These estimates were prepared by Step to Equity using the Inclusive Definition of Francophones developed by the Office of Francophone Affairs (OFA), % share in the 2006 census, 2009 population estimates (MOHLTC), and regional trends and projections (OFA, 2010).

iv. Column E. The Francophone priority population is all low income Francophones, plus other (not low income) Francophones that have other potential access barriers (are recent immigrants, racialized groups, have a disability, and/or live in geographically underserved areas

v. Francophone clients (Column F) were geocoded to subLHINs from client postal codes of all Francophone CHCs and the Francophones are in the population served by bilingual CHCs. Client numbers 1-4 were not included for privacy reasons. Other CHCs and other organizations providing services to Francophone populations are not included and need to be considered in identifying service gaps.

vi. Column G. % of estimated Francophone priority being served by existing CHCs (Col. E divided by F)

v. Equity Gap for First Stage Targeted Expansion, (Column I) is the difference between the service target and the number of Francophones being served by CHCs (H minus F = I). It is blank if the target for leveling up is met. Col J, is only Francophone priority areas (include designated Fr. Lang Service Areas (OFA), or Francophones are 5% of total subLHIN Population or 5000+ persons). These calculations provide one starting point for identifying potential priority areas for expanding access.
Table 1D ad

Table 7D. Other Priority Populations: Equity Service Targets and Equity Gap:
Includes all other low income people and people with potential access barriers living in geographically underserved areas (excluding Aboriginal and Francophone populations already counted in Priority Pop).

A. Community Planning Areas (subLHINs, V9) and LHIN Totals (LHIN total follows subLHINs)		B. Geo Type[i]	C. Service Target Level[ii]	D. Other Priority Groups, 2009[iii]	E. Other clients (ex. <5)[iv]	F. % Other now served, 2011[v]	G Service Equity Target (based on Geo Type)[vi]	H. Gap to equity target 1st stage expan-sion)[vii]
101	Essex	1	25	72366	21504	29.7%	18091	
102	Chatham-Kent	2	25	16349	7682	47.0%	4087	
103	Lambton	2	25	15916	10889	68.4%	3979	
LHIN 1	**Erie St Clair**			**104631**	**40075**	**38.3%**	**26158**	
201	Bruce	4	33.3	20541	77	0.4%	6840	6763
202	Grey	4	33.3	21975	2807	12.8%	7318	4511
203	Huron	4	33.3	18715	3276	17.5%	6232	2956
204	Perth	3	25	9351	394	4.2%	2338	1943
205	Middlesex	1	25	68888	6120	8.9%	17222	11102
206	Oxford-Norfolk	3	25	13305	4461	33.5%	3326	
207	Elgin	2	25	13769	4072	29.6%	3442	
LHIN 2	**South West**			**166544**	**21207**	**12.7%**	**46718**	**27275**
301	Urban Waterloo & Rural S.	1	25	55042	12078	21.9%	13761	1683
302	Urban Guelph	1	25	14012	6178	44.1%	3503	
303	Rural Waterloo	3	25	3863	7397	191.5%	966	
304	Rural - S. Grey/N. Wellington	4	33.3	9246	44	0.5%	3079	3035
305	Rural Wellington	3	25	4328	561	13.0%	1082	521
LHIN 3	**Waterloo Wellington**			**86491**	**26259**	**30.4%**	**22390**	**5238**
401.1	Brant	3	25	2851	765	26.8%	713	
401.2	Brantford	1	25	12344	4310	34.9%	3086	
402	New Credit-Six Nations	4	33.3	12	-	8.2%	-	-
403.1	Norfolk	3	25	6039	99	1.6%	1510	1411
403.2	Haldimand	3	25	5253	137	2.6%	1313	1176
404	Burlington	1	25	13949	310	2.2%	3487	3177
405.1	Niagara Falls	1	25	11753	1706	14.5%	2938	1232
405.2	Fort Erie	2	25	4383	2604	59.4%	1096	
406.1	Niagara on the Lake	3	25	1638	16	1.0%	409	393
406.2	St. Catharines	1	25	19984	5264	26.3%	4996	
406.3	Thorold	1	25	2251	614	27.3%	563	
407.1	Pelham	2	25	888	28	3.2%	222	194
407.2	Wainfleet	3	25	562	129	23.0%	141	12
407.3	Welland	1	25	6439	114	1.8%	1610	1496
407.4	Port Colborne	2	25	2379	878	36.9%	595	
408.1	Grimsby	1	25	1505	35	2.3%	376	341
408.2	West Lincoln	3	25	995	34	3.5%	249	214
408.3	Lincoln	2	25	2193	16	0.7%	548	532
409	Stoney Creek	1	25	5994	512	8.5%	1499	987
410	Glanbrook	1	25	1047	96	9.2%	262	166
411	Ancaster	1	25	2550	137	5.4%	638	500
412	Flamborough	1	25	2656	136	5.1%	664	529
413	Dundas	1	25	2103	107	5.1%	526	418
414	Hamilton Urban Core	1	25	30661	8163	26.6%	7665	

Table 7D. Other Priority Populations A. Community Planning Areas (subLHINs, V9) and LHIN Total (LHIN total follows subLHINs)		B. Geo Type[i]	C. Service Target Level[ii]	D. Other Priority Pop.[iii]	E. Other clients [iv]	F. % Other served, [v]	G Service Equity Target [vi]	H Equity Gap - 1st stage expan.[vii]
415	Hamilton Outer Core	1	25	34813	3981	11.4%	8703	4722
LHIN 4	**Hamilton Niagara HB**			**175243**	**30193**	**17.2%**	**43812**	**17503**
501	Dufferin County	4	33.3	9759	43	0.4%	3250	3206
502	Malton (Mississauga)	1	25	10074	3936	39.1%	2518	
503	Caledon	2	25	4769	45	0.9%	1192	1147
504	Brampton	1	25	82536	6062	7.3%	20634	14572
505	Rexdale (Toronto)	1	25	30590	9303	30.4%	7647	
506	Woodbridge (Vaughan)	1	25	2810	329	11.7%	702	374
LHIN 5	**Central West**			**140536**	**19719**	**14.0%**	**35944**	**19298**
601	Milton	2	25	4997	74	1.5%	1249	1175
602	Halton Hills	2	25	4517	37	0.8%	1129	1092
603	Oakville	1	25	17209	149	0.9%	4302	4154
604	Northwest Mississauga	1	25	57467	488	0.8%	14367	13879
605	Southeast Mississauga	1	25	66300	3243	4.9%	16575	13332
606	Sth Etobicoke - Toronto	1	25	16731	6548	39.1%	4183	
LHIN 6	**Mississauga Halton**			**167221**	**10540**	**6.3%**	**41805**	**33631**
701	West	1	25	19911	13069	65.6%	4978	
702	North West	1	25	44987	12937	28.8%	11247	
703	South West	1	25	38363	7804	20.3%	9591	1787
704	North Toronto	1	25	39189	7672	19.6%	9797	2126
705	South East	1	25	40798	12039	29.5%	10200	
706	East	1	25	15548	4133	26.6%	3887	
707	North East	1	25	38315	11814	30.8%	9579	
LHIN 7	**Toronto Central**			**237111**	**69467**	**29.3%**	**59278**	**3912**
801	Sth Simcoe/N. York Reg.	2	25	11716	150	1.3%	2929	2779
802	Central York Region	2	25	19141	266	1.4%	4785	4519
803	Richmond Hill	1	25	32540	327	1.0%	8135	7808
804	SW York Region	1	25	29000	3606	12.4%	7250	3644
805	Nth York West	1	25	60648	13761	22.7%	15162	1401
806	Nth York Central	1	25	74136	7643	10.3%	18534	10891
807	Nth York East	1	25	29189	1563	5.4%	7297	5734
808	Markham	1	25	55762	716	1.3%	13940	13224
LHIN 8	**Central**			**312130**	**28031**	**9.0%**	**78032**	**50001**
901.1	Haliburton Highlands	4	33.3	6345	18	0.3%	2113	2095
901.2	Kawartha Lakes	3	25	9506	5400	56.8%	2376	
901.3	Peterborough City/County	2	25	21249	168	0.8%	5312	5145
901.4	Northumberland-Havelock	3	25	16075	2825	17.6%	4019	1193
902.1	Durham North/Central	4	33.3	8309	3252	39.1%	2767	
902.2	Durham West	1	25	32461	6566	20.2%	8115	1549
902.3	Durham East	1	25	28222	5977	21.2%	7056	1078
903.1	Scarborough Agin-Rouge	1	25	78908	7169	9.1%	19727	12558
903.2	Scarborough Cliffs- Ctre	1	25	72615	7381	10.2%	18154	10773
LHIN 9	**Central East**			**273690**	**38756**	**14.2%**	**69639**	**34391**
1001	Addington, N&C Frontenac	4	33.3	4202	230	5.5%	1399	1169
1002	Belleville	2	25	6811	4280	62.8%	1703	
1003	Brockville	3	25	4857	745	15.3%	1214	469
1004	Central Hastings	4	33.3	7059	4010	56.8%	2351	

Table 7D. Other Priority Populations A. Community Planning Areas (subLHINs, V9) and LHIN Total (LHIN total follows subLHINs)		B. Geo Type[i]	C. Service Target Level[ii]	D. Other Priority Groups, 2009[iii]	E. Other clients[iv]	F. % Other served, 2011[v]	G Service Equity Target[vi]	H. Equity Gap-first stage expan-sion)[vii]
1005	Gananoque, Leeds	4	33.3	1483	259	17.5%	494	235
1006	Kingston & Islands	1	25	17353	4285	24.7%	4338	53
1007	North Hastings	4	33.3	4817	19	0.4%	1604	1585
1008	Prince Edward County	3	25	3575	39	1.1%	894	854
1009	Quinte West, Brighton	2	25	6136	4212	68.6%	1534	
1010	Rideau Lakes	4	33.3	1312	3770	287.4%	437	
1011	SE Leeds & Grenville	3	25	2194	121	5.5%	548	427
1012	Smiths Falls, Perth, Lank.	2	25	5022	5410	107.7%	1255	
1013	South Frontenac	3	25	1558	313	20.1%	390	76
1014	Stone Mills, Loyalist	3	25	2243	320	14.3%	561	241
1015	Tyendinaga, Napanee	3	25	616	789	128.1%	154	
LHIN 10	**South East**			**69237**	**28804**	**41.6%**	**18876**	**5110**
1101.1	Central Area	1	25	12907	13389	103.7%	3227	
1101.2	Glebe, Old Ottawa S/E	1	25	3136	2528	80.6%	784	
1101.3	South Central	1	25	4221	1973	46.7%	1055	
1101.4	Playfair Park, Lynda Park, Guildwood Est.	1	25	3848	1494	38.8%	962	
1101.5	Hunt Club, Leitrim, Riverside	1	25	10177	4139	40.7%	2544	
1101.6	Rural Southeast	1	25	1373	639	46.5%	343	
1102.1	Rural Northeast	1	25	462	218	47.2%	115	
1102.2	Orleans and area	1	25	5570	2632	47.3%	1393	
1102.3	Industrial East, Riverview	1	25	4769	1594	33.4%	1192	
1102.4	Beacon Hill, Rothwell Cardin.	1	25	2880	1053	36.6%	720	
1102.5	Overbrook, Vanier, Beech	1	25	7204	2085	28.9%	1801	
1103.1	West Central	1	25	4942	4820	97.5%	1235	
1103.2	Merivale	1	25	9661	6225	64.4%	2415	
1103.3	South Nepean	1	25	3569	2312	64.8%	892	
1103.4	Rural Southwest	1	25	1466	1142	77.9%	366	
1103.5	Cedarview	1	25	5283	2405	45.5%	1321	
1103.6	Kanata-Stittsville	1	25	6116	2476	40.5%	1529	
1103.7	Bayshore	1	25	7856	5004	63.7%	1964	
1103.8	Rural Northwest	1	25	1258	438	34.8%	315	
1104.1	Arnprior, McNab, Braeside	3	25	1404	101	7.2%	351	249
1104.2	South Renfrew Cnty	4	33.3	9129	1739	19.0%	3040	1301
1104.3	North Renfrew Cnty	3	25	15032	3248	21.6%	3758	510
1105.1	North Grenville	3	25	1193	777	65.2%	298	
1105.2	Carleton Place/Beckwith	3	25	1377	470	34.1%	344	
1105.3	Mississippi Mills/Lanark Hlds	4	33.3	1927	2421	100%	642	
1106.1	Akwesasne	4	33.3	0	0		0	
1106.2	Glengarry	4	33.3	5145	272	5.3%	1713	1442
1106.3	Hawkesbury, E. Hawk, Ch.	3	25	2387	6	0.3%	597	591
1106.4	Nation, Alfred-Plantagenet	4	33.3	1414	50	3.5%	471	421
1106.5	Stormont	4	33.3	2644	202	7.7%	881	678
1106.6	Cornwall	1	25	7443	2091	28.1%	1861	
1106.7	Dundas	4	33.3	6551	82	1.2%	2182	2100

Table 7D. Other Priority Populations A. Community Planning Areas (subLHINs, V9) and LHIN Total (LHIN total follows subLHINs)		B. Geo Type[i]	C. Service Target Level[ii]	D. Other Priority Groups, 2009[iii]	E. Other clients (ex. <5)[iv]	F. % Other served, 2011[v]	G Service Equity Target [vi]	H. Equity Gap, 1st stage expan-sion)[vii]
1106.8	Russell Twp	2	25	338	84	24.7%	85	
1106.9	Clarence-Rockland	3	25	486	159	32.7%	121	
LHIN 11	**Champlain**			**153167**	**68269**	**44.6%**	**40517**	**7293**
1201	Collingwood and Area	3	25	8280	5138	62.0%	2070	
1202	Barrie and Area	2	25	25780	5595	21.7%	6445	850
1203	Orillia and Area	3	25	12751	106	0.8%	3188	3082
1204	Midland & Penetanguishene	3	25	11858	2879	24.3%	2965	86
1205	Muskoka	**5**	33.3	20260	43	0.2%	6747	6704
LHIN 12	**N. Simcoe Muskoka**			**78930**	**13760**	**17.4%**	**21444**	**10722**
1301	Algoma	5	33.3	23261	38	0.2%	7746	7708
1302	James & Hudson Bay Coasts	6	33.3	544	5	1.0%	181	176
1303	Nipissing	5	33.3	13099	29	0.2%	4362	4334
1304	Parry Sound	6	33.3	15589	21	0.1%	5191	5170
1305	Manitoulin-Sudbury	2	25	21535	37	0.2%	5384	5347
1306	Timiskaming	5	33.3	9463	11	0.1%	3151	3140
1307	Cochrane	5	33.3	8378	27	0.3%	2790	2762
LHIN 13	**North East**			**91869**	**168**	**0.2%**	**28805**	**28637**
1401	Kenora	6	33.3	16589	3801	22.9%	5524	1723
1402	Rainy River	5	33.3	5556	30	0.5%	1850	1821
1403	Thunder Bay District	6	33.3	6212	3447	55.5%	2069	
1404	Thunder Bay City	2	25	13620	6992	51.3%	3405	
LHIN 14	**North West**			**41977**	**14270**	**34.0%**	**12848**	**3544**
	Ontario Total			**2098777**	**409519**	**19.5%**	**546236**	**246556**

Totals may be slightly different than sums where data is based on percents rounded from decimal points

i. Geographic area types (Column B) created this study were: 1–Urban, 2-Urban Extended (mostly urban but some rural communities); 3-Rural South (mostly rural without high RIO scores); 4 –Rural with higher RIO scores; 5-Northern rural; 6-Northern Remote: High % rural and High RIO scores (60+).

ii. For this phase of expanding access remote southern and rural and remote northern areas have a service level target of 33.3% of the priority population to be served; the target for other areas is 25%.

iii. Other priority population (Column D) is all low income people (After Tax LIMs, 2008), people with other access barriers living in geographically underserved areas (recent immigrants, racialized groups, disability) not already included (Aboriginal and Francophone), % share in the 2006 census and 2009 population estimates (MOHLTC). This does not include people with other access barriers (LGBTT, homeless, youth etc.) not captured by one or more of the other identified segments that were included.

iv. Column E. Other CHC clients are all CHC clients not included in Aboriginal and Francophone counts, geocoded to subLHINs from client postal codes. Cells with 1-4 clients suppressed for privacy reasons.

v. Column F. % of estimated other priority being served by existing CHCs (Column D divided by Column E)

vi. The service equity target (Col. G) for other priority populations for this phase, is set according to geographic area type, i.e. that 33.3% of the other priority populations have access to CHCs if they live in remote rural or northern rural or remote areas (where other service options are more limited) and a minimum of 25% have access in other rural and urban areas (where additional service options exist).

v. Equity Gap for First Stage Targeted Expansion, (Column H) is the difference between the service target and the number of other priority populations being served by CHCs. (G minus E = H) blank if the target is met. These calculations provide one starting point for identifying potential priority areas.

Table 7E. Priority Population Segments: Sum of Calculated Gaps for First Stage Targeted Expansion. Community Planning Areas (subLHINs V9) and LHIN Totals		Aborigin-al Gap Table 1B	Franco-phone Gap Table 1C	Gap in Fr. Prio areas only	Other Population Gap Table 1D	Sum of Gaps to reach Equity Targets for First Stage Targeted Expansion
101	Essex	2292	943	943		3235
102	Chatham-Kent	975	308			1283
103	Lambton	2072	351			2423
LHIN 1	**Erie St Clair**	**5339**	**1601**	**943**		**6940**
201	Bruce	1173	184		6763	8120
202	Grey	684	204		4511	5399
203	Huron	168	128		2956	3252
204	Perth	177	69		1943	2189
205	Middlesex		821	821	11102	11923
206	Oxford-Norfolk	386	123			509
207	Elgin	325	106			431
LHIN 2	**South West**	**2912**	**1636**	**821**	**27275**	**31823**
301	Urban Waterloo & Rural S.	1642	806		1683	4131
302	Urban Guelph	470	184			654
303	Rural Waterloo	82	34			116
304	Rural - S. Grey & N. Wellin.	169	73		3035	3277
305	Rural Wellington	122	49		521	692
LHIN 3	**Waterloo Wellington**	**2485**	**1146**		**5238**	**8869**
401.1	Brant		28			28
401.2	Brantford		113			113
402	New Credit and Six Nations	6000	0		3	6003
403.1	Norfolk	370	73		1411	1854
403.2	Haldimand	281	33		1176	1490
404	Burlington	383	268		3177	3828
405.1	Niagara Falls	497	149		1232	1878
405.2	Fort Erie	335	4			339
406.1	Niagara on the Lake	29	26		393	448
406.2	St. Catharines	676				676
406.3	Thorold	124				124
407.1	Pelham	27			194	221
407.2	Wainfleet	67			12	79
407.3	Welland	417			1496	1913
407.4	Port Colborne	142				142
408.1	Grimsby	65	14		341	420
408.2	West Lincoln	32	14		214	260
408.3	Lincoln	46	27		532	605
409	Stoney Creek	180			987	1167
410	Glanbrook	31	4		166	201
411	Ancaster	52	5		500	557
412	Flamborough	92	16		529	637
413	Dundas	50	4		418	472
414	Hamilton Urban Core					0
415	Hamilton Outer Core	310			4722	5032
LHIN 4	**Hamilton Niagara HB**	**10206**	**777**		**17503**	**28486**
501	Dufferin County	282	98		3206	3586
502	Malton (Mississauga)	43	71			114

Table 7E Priority Population Segments: Sum of Calculated Gaps Community Planning Areas (subLHINs V 9) and LHIN Totals		Aborigin-al Gap Table 1B	Franco-phone Gap Tb. 1C	Gap in Fr. Prio areas only	Other Population Gap Table 1D	Sum of Gaps to reach Equity Targets-1st Stage Targeted Expan.
503	Caledon	129	44		1147	1320
504	Brampton	923	848	848	14572	16343
505	Rexdale (Toronto)	95	261	261		356
506	Woodbridge (Vaughan)	21	32		374	427
LHIN 5	**Central West**	**1493**	**1353**	**1109**	**19298**	**22144**
601	Milton	148	70		1175	1393
602	Halton Hills	169	71		1092	1332
603	Oakville	234	335		4154	4723
604	Northwest Mississauga	307	1015	1015	13879	15201
605	Southeast Mississauga	502	915	915	13332	14749
606	South Etobicoke - Toronto	123	245	245		368
LHIN 6	**Mississauga Halton**	**1484**	**2652**	**2175**	**33631**	**37767**
701	West	199	240	240		439
702	North West		349	349		349
703	South West	62	186	186	1787	2035
704	North Toronto	39	584	584	2126	2749
705	South East		11	11		11
706	East	113	75	75		188
707	North East					0
LHIN 7	**Toronto Central**	**413**	**1445**	**1445**	**3912**	**5770**
801	Sth Simcoe/N. York Region	652	151		2779	3582
802	Central York Region	483	297		4519	5299
803	Richmond Hill	104	480		7808	8392
804	SW York Region	87	400		3644	4131
805	Nth York West	182	289	289	1401	1872
806	Nth York Central	65	778	778	10891	11734
807	Nth York East	43	217	217	5734	5994
808	Markham	135	575		13224	13934
LHIN 8	**Central**	**1752**	**3188**	**1285**	**50001**	**54941**
901.1	Haliburton Highlands	244	93		2095	2432
901.2	Kawartha Lakes	449	73			522
901.3	Peterborough City/County	1428	211		5145	6784
901.4	Northumberland-Havelock	536	132		1193	1861
902.1	Durham North/Central	259	70			329
902.2	Durham West	860	361		1549	2770
902.3	Durham East	1276	419		1078	2773
903.1	Scarborough Aginct-Rouge	164	584	584	12558	13306
903.2	Scarborough Cliffs-Sc. Ctre	362	253	253	10773	11388
LHIN 9	**Central East**	**5577**	**2196**	**837**	**34391**	**42164**
1001	Addington, N&C Frontenac	349	45		1169	1563
1002	Belleville	564	92			656
1003	Brockville	193	85		469	747
1004	Central Hastings	353	75			428
1005	Gananoque, Leeds	130	30		235	395
1006	Kingston & Islands	1183	440	440	53	1676
1007	North Hastings	732	42		1585	2359
1008	Prince Edward County	220	38		854	1112
1009	Quinte West, Brighton	586	150			736

Table 7E Priority Population Segments: Sum of Calculated Gaps Community Planning Areas (subLHINs V 9) and LHIN Totals		Aborigin-al Gap Table 1B	Franco-phone Gap Table 1C	Gap in Fr. Prio areas only	Other Population Gap Table 1D	Sum of Gaps to reach Equity Targets for First Stage Targeted Expansion
1010	Rideau Lakes	173	50			223
1011	SE Leeds & Grenville	122	58		427	607
1012	Smiths Falls, Perth, Lanark	372	110			482
1013	South Frontenac	198	12		76	286
1014	Stone Mills, Loyalist	262	31		241	534
1015	Tyendinaga, Napanee	1366	29			1395
LHIN 10	**South East**	**6801**	**1286**	**440**	**5110**	**13197**
1101.1	Central Area					0
1101.2	Glebe, Old Ottawa S/E		33	33		33
1101.3	South Central		118	118		118
1101.4	Playfair Park, Lynda Park		178	178		178
1101.5	Hunt Club, Leitrim, Riverside		663	663		663
1101.6	Rural Southeast		156	156		156
1102.1	Rural Northeast		25	25		25
1102.2	Orleans and area		1167	1167		1167
1102.3	Industrial E., Riverview, Pineview, Elmvale		442	442		442
1102.4	Beacon Hill, Rothwell. Cardinal, Carson, CFB		634	634		634
1102.5	Overbrook, Vanier, Beechwood		984	984		984
1103.1	West Central		136	136		136
1103.2	Merivale		240	240		240
1103.3	South Nepean		182	182		182
1103.4	Rural Southwest		62	62		62
1103.5	Cedarview		259	259		259
1103.6	Kanata-Stittsville		367	367		367
1103.7	Bayshore		62	62		62
1103.8	Rural Northwest		43	43		43
1104.1	Arnprior, McNab, Braeside	153	65		249	467
1104.2	South Renfrew Cty	930	222		1301	2453
1104.3	North Renfrew Cty	1147	921	921	510	2578
1105.1	North Grenville	95	49	49		144
1105.2	Carleton Place /Beckwith	112	64	64		176
1105.3	Mississippi Mills & Lanark Highlands	203	110			313
1106.1	Akwesasne					0
1106.2	Glengarry	181	1170	1170	1442	2793
1106.3	Hawkesbury, E. Hawk, Champlain TWP	95	4692	4692	591	5378
1106.4	Nation, Alfred-Plantagenet, Casselman	262	4025	4025	421	4708
1106.5	Stormont	157			678	835
1106.6	Cornwall	217				217
1106.7	Dundas	254	282	282	2100	2636
1106.8	Russell Twp	97				97
1106.9	Clarence-Rockland	160				160
LHIN 11	**Champlain**	**4065**	**17349**	**16952**	**7293**	**28707**

Table 7E Priority Population Segments: Sum of Calculated Gaps Community Planning Areas (subLHINs V 9) and LHIN Totals		Aborigin-al Gap Table 1B	Franco-phone Gap Table 1C	Gap in Fr. Prio areas only	Other Population Gap Table 1D	Sum of Gaps to reach Equity Targets for First Stage Targeted Expansion
1201	Collingwood and Area	198	82			280
1202	Barrie and Area	1439	349		850	2638
1203	Orillia and Area	922	136		3082	4140
1204	Midland & Penetanguishene	1827	428	428	86	2341
1205	Muskoka	968	271		6704	7943
LHIN 12	**Nth Simcoe Muskoka**	**5355**	**1267**	**428**	**10722**	**17344**
1301	Algoma	1389	2022	2022	7708	11119
1302	James & Hudson Bay Coasts	4346	77	77	176	4599
1303	Nipissing	4163	1843	1843	4334	10340
1304	Parry Sound	675	319	319	5170	6164
1305	Manitoulin-Sudbury				5347	5347
1306	Timiskaming	966			3140	4106
1307	Cochrane	2310	7635	7635	2762	12707
LHIN 13	**North East**	**13849**	**11896**	**11896**	**28637**	**54382**
1401	Kenora	8703	488	488	1723	10914
1402	Rainy River		100		1821	1921
1403	Thunder Bay District	2849	940	940		3789
1404	Thunder Bay City		380			380
LHIN 14	**North West**	**11551**	**1908**	**1428**	**3544**	**17003**
	Ontario Total	**73,280**	**49700**	**39758**	**246556**	**369536**