Health Equity Impact Assessment Workshop
Healthy Connections
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The Wellesley Institute and St. Michael's Hospital

Outline

- Icebreaker
- Health equity 101
- Why we do planning on HE?
- HEIA Tool
- Small group assignment
- Report back

Getting on the bus…

WHO Definition of Health (1948)

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Equality vs. Equity

Equality = Sameness

Treating everyone the same, removing difference

Ignores power differentials

Equity = Fairness

Acknowledging and respecting our differences

Treating people accordingly

Health Equity

- Health disparities or inequities are differences in health outcomes that are ***avoidable, unfair and systematically related to social inequality and disadvantage***

- **The goal of a health equity strategy** is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes

Understanding discrimination…

Systemic Discrimination

- "The way we do things around here"
- How our multiple identities "intersect" with each other to compound discrimination
- A social institution that uses it's **power** to discriminate

Discrimination

An action resulting from prejudice and stereotype, of an individual or small group of people of treating someone differently.

Prejudice

Making a decision about a person without getting all the facts, usually based on a stereotype.

Stereotypes

A negative generalization applied to all members of an identified social/cultural group.

What about other isms?

- Racism
- Sexism
- Homophobia
- Ableism
- Class bias
- Anti-Semitism
- Islamophobia
- Ageism
- Transphobia
- Faith affiliation
- Political affiliation
- Country of origin
- Language
- Health status
- Housing status
- Family status
- Gender expression
- Dress/Appearance

Health Disparities in Ontario

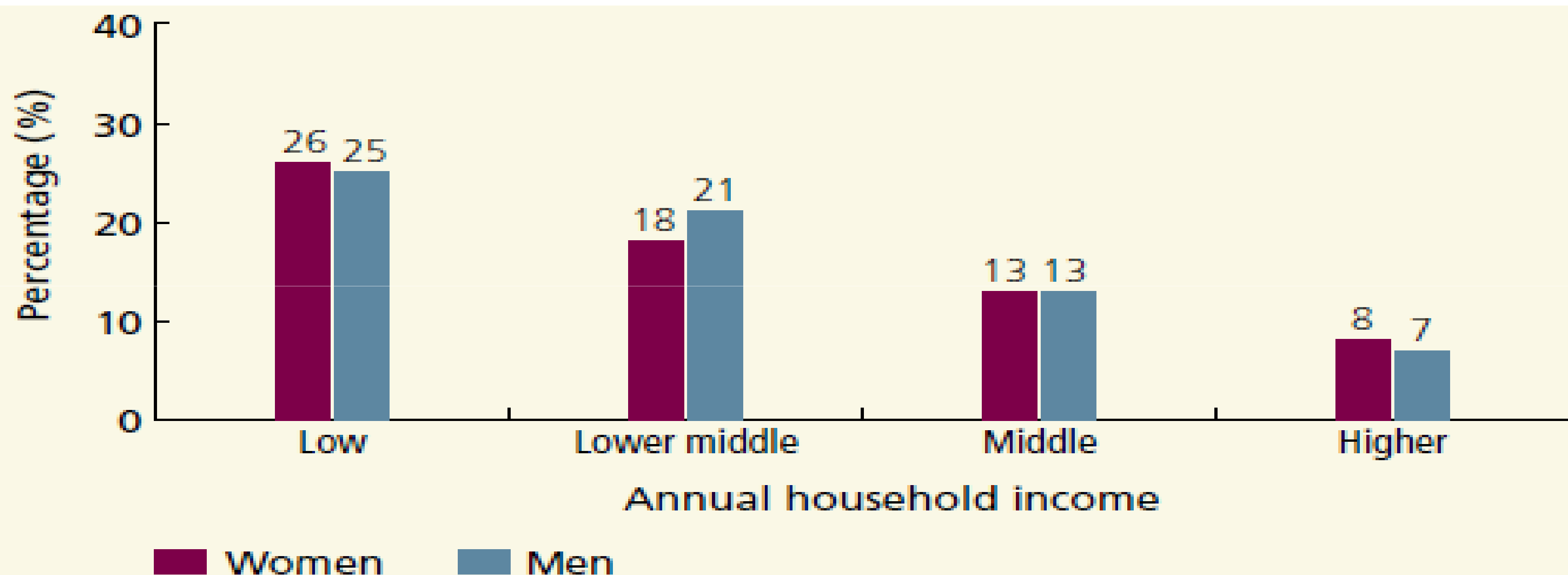
- there is a clear gradient in health in which people with lower income, education or other indicators of social inequality and exclusion tend to have poorer health + major differences between women and men

- in addition, there are systemic disparities in access to and quality of care within the healthcare system

- that's why enhancing health equity has become a clear priority – from the Province to LHINs to many providers

- and that's why we need tools and approaches to build equity into effective system and service planning

Age-standardized percentage of adults aged 25 and older who reported their health as fair or poor, by sex and annual household income, in Ontario, 2005

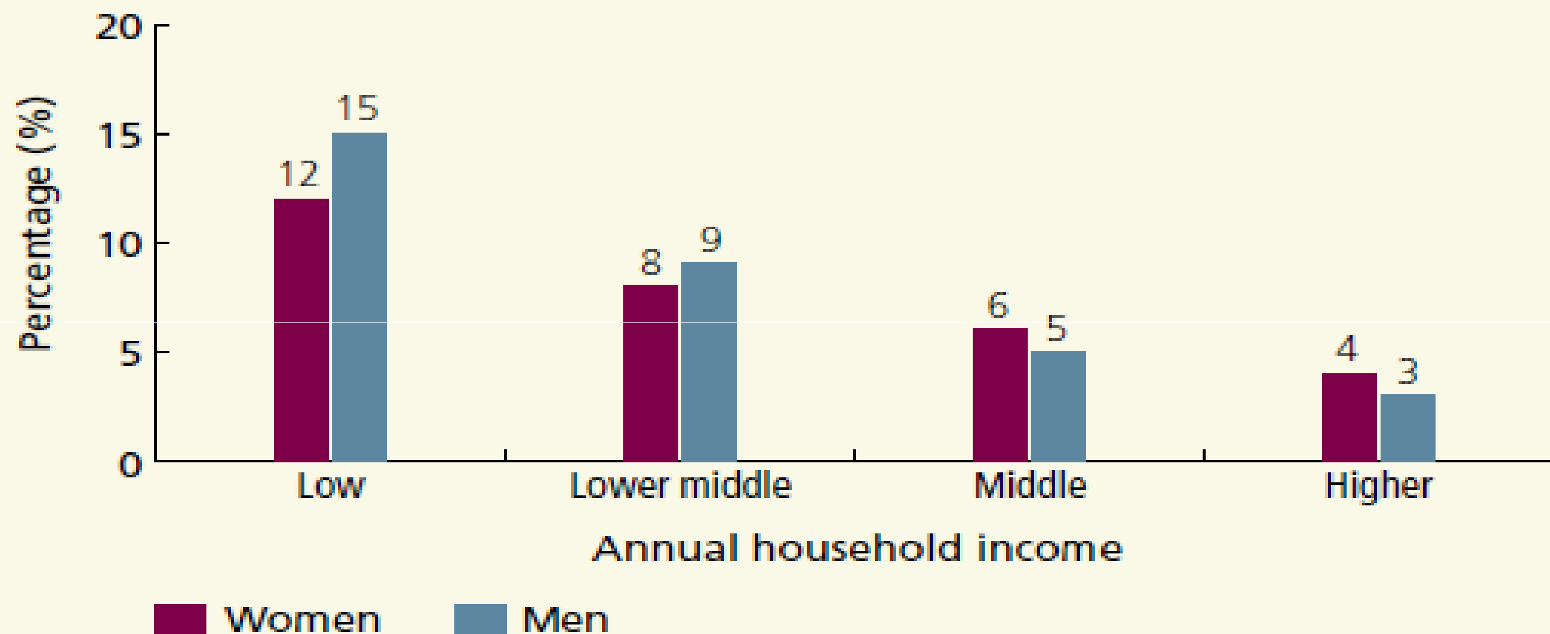


DATA SOURCE: Canadian Community Health Survey (CCHS), Cycle 3.1

NOTE: See Appendix 3.3 for definitions of annual household income categories

POWER Study

Age-standardized percentage of adults aged 25 and older who reported their mental health as fair or poor, by sex and annual household income, in Ontario, 2005



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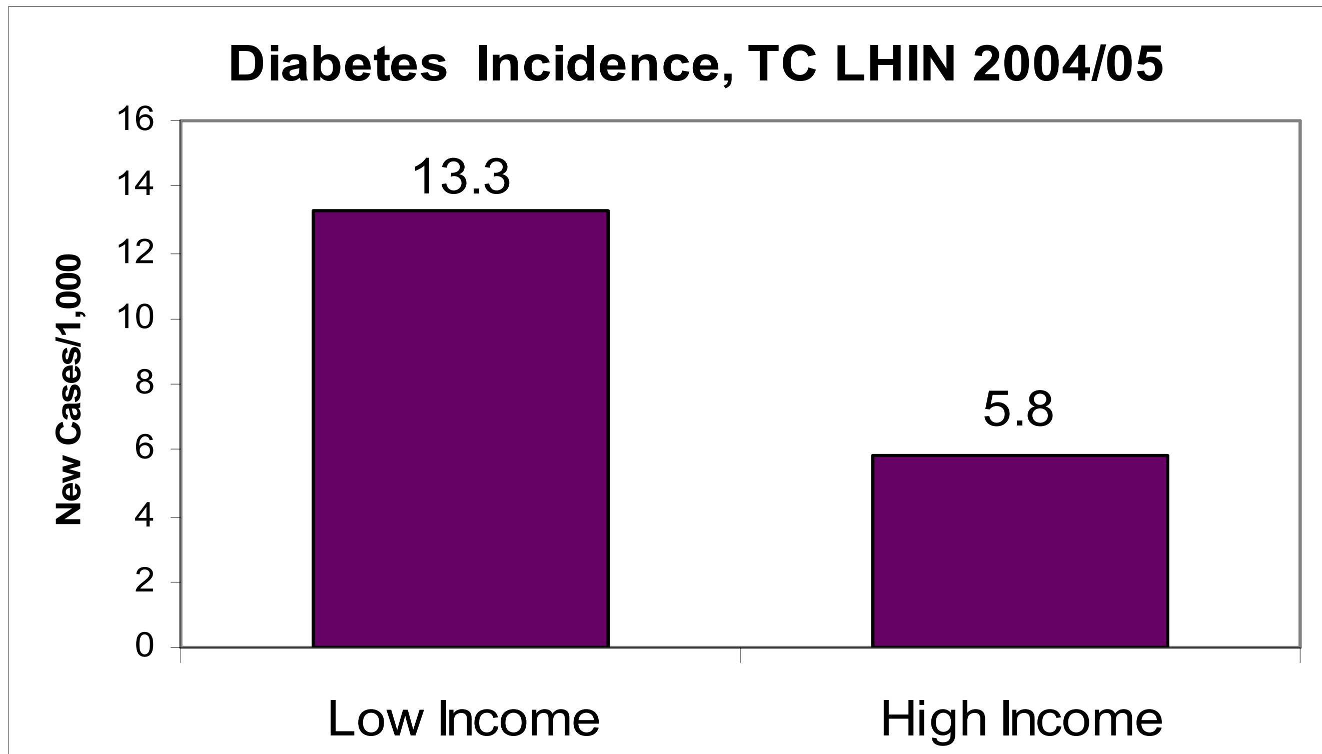
POWER Study

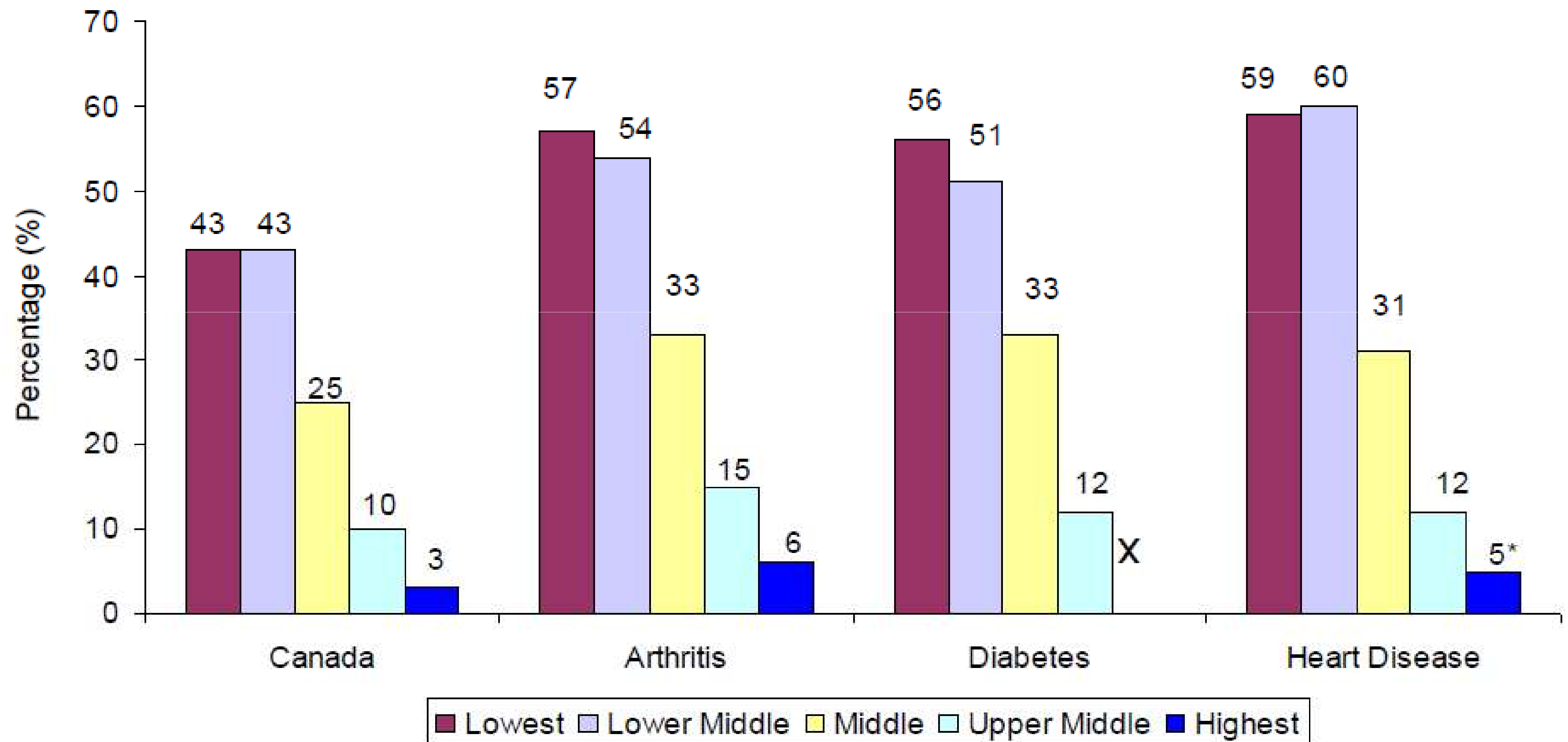
Lower Income: Higher Diabetes Rate



Two fold difference in Diabetes Incidence among lowest and highest neighbourhoods.

Age Standardized Rates. Data Source: Ontario Diabetes Database, 2004/05
www.ices.on.ca/intool

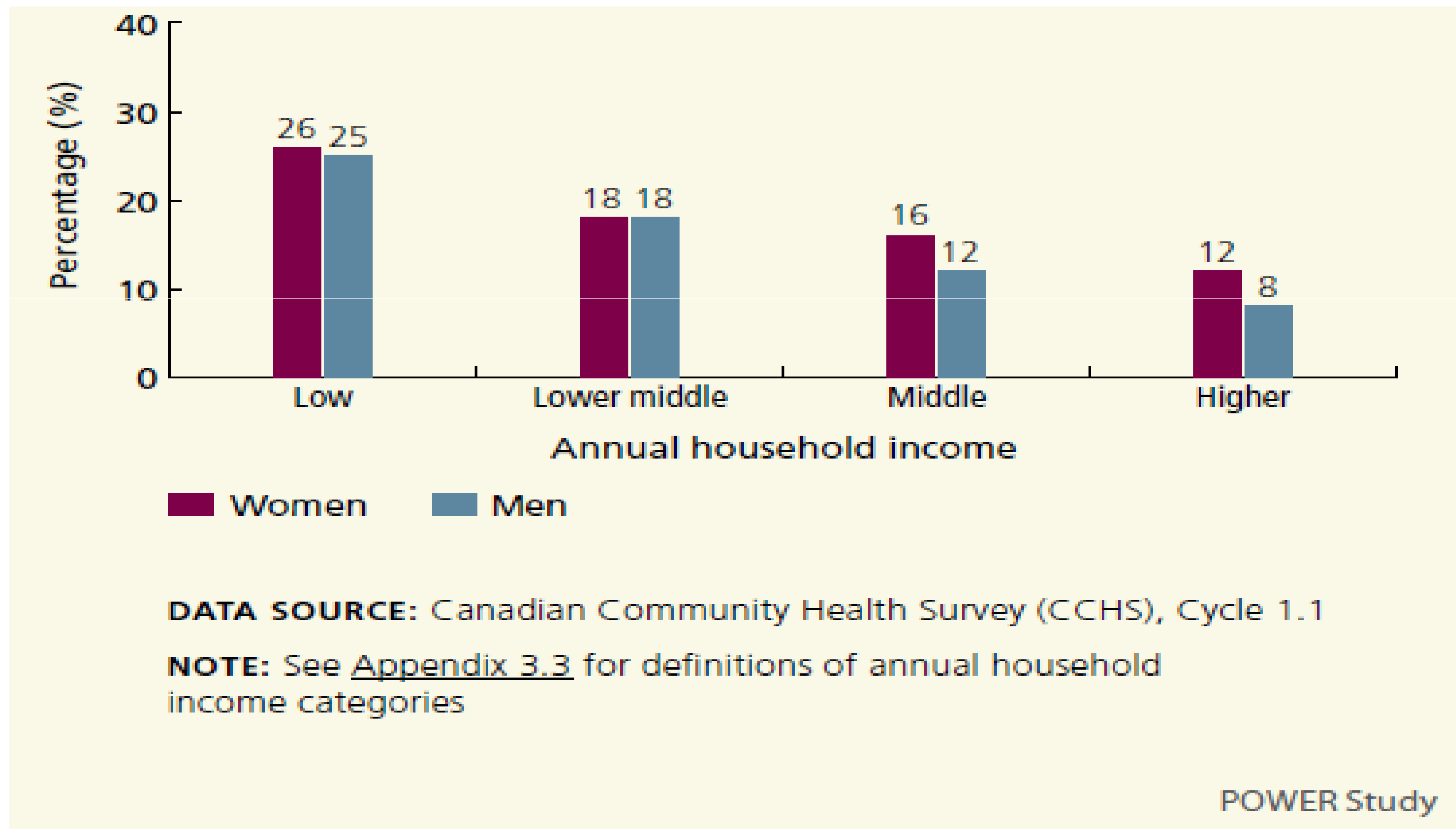
Canadians With Chronic Conditions Who Also Report Food Insecurity



Data source: Canadian Community Health Survey (CCHS) Cycle 3.1
*Interpret with caution due to high sampling variability (CV 16.6-33.3)
X Data suppressed due to small sample size

power
www.powerstudy.ca

Age-standardized percentage of adults aged 25 and older who reported that their activities were prevented due to pain or discomfort, by sex and annual household income, in Ontario, 2000/01



Damaging Impact

- Gap between the health status of the best off and most disadvantaged can be huge – and damaging
  - difference btwn life expectancy of top and bottom income decile = 7.4 years for men and 4.5 for women
  - more sophisticated analyses add the pronounced gradient in morbidity to mortality → taking account of quality of life and developing data on health adjusted life expectancy
  - even higher disparities btwn top and bottom = 11.4 years for men and 9.7 for women (Statistics Canada *Health Reports* Dec 09)
- these systemic and pervasive health inequalities are the problem we are trying to solve

Think Big, But Get Going

- the point of all this analysis is to be able to identify policy and program changes needed to reduce health disparities
- but health disparities can seem so overwhelming and their underlying social determinants so intractable → can be paralyzing
- think big and think strategically, but get going
- need to start somewhere – and we're in health systems

Need Equity-Focused Planning

- **addressing health disparities in service delivery and planning requires a solid understanding of:**
  - key barriers to equitable access to high quality care
  - the specific needs of health-disadvantaged populations
  - gaps in available services for these populations

- **and this requires an array of effective and practical equity-focused planning tools**

Equity-Focused Planning Tools

1. quick check to ensure equity is considered in all service delivery/planning	1. simple equity lens
2. take account of disadvantaged populations, access barriers and related equity issues in program planning and service delivery	2. Health Equity Impact Assessment
3. assess current state of provider organization	3. equity audits and/or HEIA
4. determine needs of communities facing health disparities	4. equity-focused needs assessment
5. assess impact of programs/interventions on health disparities and disadvantaged populations	5. equity-focused evaluation

Health Equity Impact Assessment

- **HEIA is one part of this repertoire of equity-focused planning tools**
- **arose out of broader health impact assessments, which have been increasingly used in many jurisdictions in last 15 years**
  - HIA is commonly understood in municipal and community planning circles
  - one reason for HEIA was increasing policy attention to SDoH and health disparities → need explicit equity focus
  - at same time, need for shorter and more focused processes – sometimes called Rapid HIA -- had been recognized
  - HEIA is seen to be relatively easy-to-use tool
- **planning tool that analyzes potential impact of program or policy change on health disparities and/or health disadvantaged populations**

Components of HEIA

1. screening – identifying projects where HEIA would be useful
2. scoping – which pop'n and health effects to consider
3. assessing potential equity risks and benefits – specifying particular pop'n
4. developing recommendations – to promote positive or mitigate negative effects
5. reporting results to decision makers
6. monitoring and evaluation – of effectiveness of recommendations

Piloted In Toronto and Ontario

- **Ontario surveyed best practice jurisdictions**:
  - Wales and New Zealand were furthest advanced
  - Ontario model was adapted from them
  - but increasing interest in other jurisdictions
  - including from PHAC here in Canada

- MOHLTC equity unit developed **a one page tool** and accompanying 'how-to' guide – first used in *Aging at Home* initiatives in 2008
- **MOHLTC** partnered with the **Toronto Central LHIN**
- the **Wellesley Institute** was engaged to consult, refine and pilot test the tool in spring-summer 09

Revised Ontario HEIA Tool

- **in response to consultations:**
  - template was revised
  - a new workbook was developed to support easy and consistent use

- **the workbook:**
  - provides definitions, examples, prompts and possible questions
  - is set up to help users work through the HEIA process in a step-by-step way
  - users simply fill out the appropriate tables in workbook itself to complete their HEIA
  - the workbook was designed so it can be adapted to become a Web-based interactive resource

- **further changes were made in response to the pilot phase, but this basic structure has been retained**

Current Situation

- HEIA is being used in Toronto Central LHIN:
  - Aging at Home applications are encouraged to use HEIA in developing their proposal
  - those short-listed will be required to do HEIA
- MOHLTC is working with several LHINs to further implement and develop HEIA
- HEIA is being incorporated into a "health in all policies' framework by MOHLTC

Workshopping HEIA

- **each table will actually go thorough the HEIA for a concrete specific example**
- **we will see if participants have examples they want to pursue**

- **and/or some tables will work up this hypothetical case:**

  - You are planning to develop diabetes outreach in a specific neighborhood. You want to improve people's ability to monitor and manage their own care, and to get residents hooked into primary care for ongoing support and monitoring. Use the tool to help plan this programme.

- **we will then report back and collectively discuss lessons learned**

HEIA Template

Using this HEIA Tool: The numbered steps in this tool correspond with sections in the accompanying Workbook. The Workbook is designed to lead assessors through conducting an HEIA step-by-step.

1. How does your program/service affect health equity for these vulnerable or disadvantaged populations? [1]	2. Potential Impacts			3. Mitigation Strategy	4. Monitoring
	Positive Impacts	Negative Impacts	More information needed		
Aboriginal					
Age-related groups, e.g., children, youth, seniors					
Disability, e.g., physical, deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use					
Ethno-racial, e.g., racial/racialized or cultural minorities, some immigrants and refugees					
Francophone					
Homeless, marginally or under housed people					
Linguistic communities, e.g., people not comfortable receiving care in English or French or whose literacy affects communication					
Low income, underemployed, or unemployed people					
Religious/faith communities					
Rural/remote, inner-urban populations, e.g., geographic isolation, social isolation, under serviced areas					
Sex/gender, e.g., women, men, transsexual, transgendered					
Sexual orientation, e.g., lesbian, gay, bisexual, two-spirit					
Other [2]					
Impacts on Social Determinants of Health, e.g., Income/Social Status; Social Support Networks; Employment; Education; Social Environments; Physical Environments etc. [3]					

[1] This list is not exhaustive and uses terminology that may or may not be preferred by members of the communities in question. It is important to consider the range of populations an individual could be a part of.
[2] This list is not definitive. There may be other populations you wish to add, such as people without health insurance or a family doctor.
[3] For more information on SDOH please refer to the Definitions section and Step 2 of the Workbook.

Ontario HEIA: 4 Step Process

1. template asks **how the planned program or initiative affects health equity** for particular populations
   - list of health disadvantaged populations – not exhaustive
   - potential impact on social determinants of health

2. planners **assess potential positive and negative impacts** of the initiative on the population(s) (and indicate where more information is needed)

3. **develop strategies** to build on positive and mitigate negative impacts

4. planners indicate how implementation of the initiative will be **monitored to assess its impact**

Report Back / Q&A

Further Resources on HEIA

Wellesley has developed a page on HEIA resources at http://www.wellesleyinstitute.com/health-equity-impact-assessment-heia-resources

Other Health Equity Resources:

- The Wellesley Institute http://wellesleyinstitute.com
- Health Equity Council http://healthequitycouncil.ca
- Rainbow Health Network http://www.rainbowhealthnetwork.ca
- Ontario Women's Health Network http://www.owhn.on.ca
- Ethno-Racial People with Disabilities http://erdco.ca
- Health Equity Toolkit – blog is at http://www.smallstepsbigdifference.blogspot.com