HEIA

Health Equity Impact Assessment

Health Equity Impact Assessment (HEIA) Workbook

Ontario

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HEIA Version 2.0 (Spring 2012)

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HEIA Workbook: How to Conduct an HEIA

For the latest resources, please visit: www.ontario.ca/healthequity
For further information, please contact: HEIA@ontario.ca

Introduction

Health Equity Impact Assessment (HEIA) has broad application and is intended for use by organizations and health service providers who have an impact on the health of Ontarians. Thus, HEIA is not only intended for use by organizations across the Ontario health care system, such as the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs), Public Health Units (PHUs), and health service providers; but also by organizations outside the health care system whose work can have an impact on health outcomes. Examples include other Ontario social policy ministries such as the Ministry of Education, Ministry of Transportation, and Ministry of Children and Youth Services, and various non-profit organizations and community service providers. The HEIA tool also has the intention of being a bridging tool across relevant sectors to encourage creative thinking, collaboration, and practical, actionable solutions on current policies, programs, or initiatives impacting health outcomes.

Getting Started

The HEIA Workbook provides general information on how to conduct a health equity impact assessment, and how to use the HEIA Template in your everyday practice. The workbook:

- Explains what HEIA is, when to use it, and who should use it;
- Leads users through the 5 steps of conducting an HEIA;
- Provides examples and prompts users to illustrate how each section of the HEIA Template is designed to be completed;
- Provides information you should have available while completing an HEIA (Appendix C); and
- Refers users to additional complementary resources to access when conducting an HEIA. These will be noted throughout the workbook as **Supplementary Resources.**

Supplementary Resources

In addition to the HEIA Template and HEIA Workbook, users may access various complementary resources to assist completing the tool. These resources are available on the MOHLTC's HEIA website at www.ontario.ca/healthequity. Visit this webpage for the most up-to-date information.

Currently Available Resources

- **French Language Services (FLS) Supplement** – outlining specific legislation and requirements regarding the *French Language Services Act.*
- **Public Health Unit (PHU) Supplement** – outlining special considerations for the public health sector in applying HEIA, including how the HEIA tool can assist local PHUs with meeting Ontario Public Health Standards (OPHS) requirements.
- Various **web links** to external resources and data sources to inform the user when using the tool.

Resources Under Development

- **Evidence summaries** of useful data and information on vulnerable population groups;
- **Case studies** illustrating the application of HEIA; and
- **Web links** to external resources and data sources.

What is the HEIA tool?

HEIA[1] is a flexible and practical assessment tool that can be used to identify *unintended* potential health impacts (positive or negative) of a policy, program, or initiative on vulnerable or marginalized groups within the general population. In identifying those impacts, the user can then make recommendations to decision-makers as to what adjustments might mitigate negative impacts and maximize positive impacts on the population groups identified.

It is important to emphasize that HEIA is focused on the identification of **unintended** positive and negative impacts – not the **intended** benefits of the planned policy, program, or initiative.

What do we mean by *unintended* impacts versus *intended* impacts?

Consider, for example, the *intended* goal of a province-wide diabetes prevention and management program. Imagine the intended goal of the program is to reduce the incidence rate of diabetes and improve care and health management for those with diabetes. The *unintended* consequence of an operational decision to only provide this program online may be that it excludes those who have no Internet access, having a potential inequitable impact on the health of those groups. A further impact is that those who may already be vulnerable and at risk of poorer health will be disproportionately affected and thus further marginalized – an unintended consequence contravening the intended goals of the program, which is province-wide improvements in diabetes incidence rates and care. Mitigation strategies to improve access should then be considered to avoid increased marginalization of those identified vulnerable groups.

The primary focus of this tool is to reduce inequities that result from barriers in access to quality health services and programming and to increase positive health outcomes by identifying and mitigating *unintended* impacts of an initiative prior to implementation.

Broader corporate initiatives such as strategic and business planning, budget or resource allocation, accreditation, governance, accountability, legislative and regulatory, and community engagement processes can also benefit from HEIA, as it supports integration of health equity across an organization.

Although intended primarily for application during the design phase of an initiative (pre-implementation), the tool can also be applied retrospectively to reviews, evaluations, or decisions related to expansion, realignment, or closure of existing programs or services.

At a macro level, the tool can be used on broad strategies or to assess the "mix" of programs or services to determine whether that mix will result in equal benefit across the population or whether it will exacerbate existing health inequities. HEIA may also be useful in identifying equity-based indicators of success.

[1] Health Equity Impact Assessment (HEIA) arose out of Health Impact Assessment (HIA) methodology which has gathered considerable momentum internationally over the past decade as a decision support tool to enable "healthy public policy." While HIA often addresses health inequities, its structure did not lend itself to a more targeted and systematic focus on health inequities. As a result, a model of equity-focused Health Impact Assessment evolved and is currently in use in the U.K. (Wales), New Zealand, Australia and other jurisdictions.

Why use the HEIA tool?

Addressing health equity can make a critical contribution to health system sustainability by reducing the incidence of costly and preventable illnesses and related treatments. Addressing disparities in health program and service delivery and planning requires a solid understanding of key barriers that inhibit equitable access to high quality care, and an understanding of the specific needs of health-disadvantaged populations. This requires an array of effective and practical planning tools.

HEIA is often seen as a "first-pass" screening tool that can assist decision-makers in integrating equity considerations into new initiatives and more detailed planning. In this way, HEIA supports the achievement of the long term strategic priority of improved access and responding to the needs of diverse communities identified as an important priority by the Ontario Ministry of Health and Long-Term Care and the health sector.

HEIA has five primary purposes for users:

1. Help identify potential unintended health impacts (positive or negative) of a planned policy, program, or initiative on vulnerable or marginalized groups within the general population;
2. Help develop recommendations as to what adjustments to the plan may mitigate negative impacts as well as maximize positive impacts on the health of vulnerable and marginalized groups;
3. Embed equity across an organization's existing and prospective decision-making models, so that it becomes a core value and one criterion to be weighed in all decisions;
4. Support equity-based improvements in program or service design, i.e., through considerations such as "How must this program be adjusted to meet the needs of specific populations?";
5. Raise awareness about health equity as a catalyst for change throughout the organization, so decision-makers develop 'stretch goals' through considerations, such as "How can we include more people in this program, especially those often missed?" or "What barriers should we look for?" and "Are we as effective as we could be, especially those with the greatest health needs?"

HEIA provides a strong framework for examining whether an organization's policies, programs, and initiatives are on the whole taking advantage of available opportunities to improve equity, or whether they may potentially result in widening the health disparities between vulnerable and marginalized populations and the general population.

While users may apply HEIA at the **micro level** to assess individual policies, programs, or initiatives, they may also apply HEIA at a **macro level** to assess their mix of current or planned offerings, to determine whether they potentially widen health disparities or improve health equity.

Finally, the aim is that after an HEIA is conducted and the chosen mitigations are implemented, there should be an assessment of whether the anticipated positive impacts on health and equity were maximized, and the negative impacts minimized. If not, then why not, and how can future plans be further adapted to promote health equity?[2]

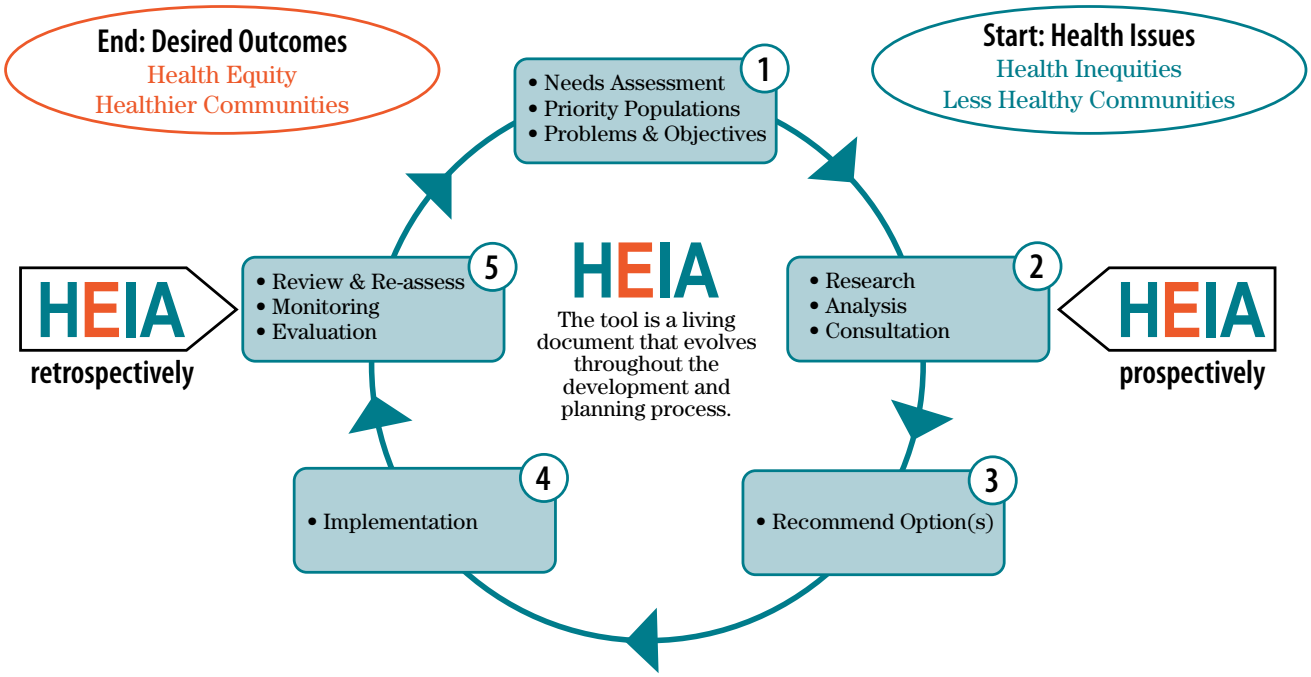
[2] UCLA Health Impact Assessment Clearinghouse. "Phases of HIA." Available at http://www.hiaguide.org/methods-resources/methods/phases-hia-4-reportingevaluation

When should the HEIA tool be used?

HEIA should be conducted **as early as possible** in the development and planning stages in order to enable adjustments to the policy, program, or initiative before opportunities for change become more limited (e.g., such as during implementation).

Figure 1 depicts a simplified development and planning process, indicating the stages at which the HEIA tool can be applied, as part of either a prospective or retrospective analysis.

Figure 1 – When to use HEIA



While early assessment is ideal, HEIA can be introduced at later points in the development and planning process, such as during post-implementation reviews or evaluations. For example, HEIA could be used to assess program or service expansion, re-alignment, or discontinuation. However, recommendations resulting from a late-stage HEIA may be constrained by factors such as prior decisions, previous investments, available resources, and time commitments. Nonetheless, these considerations should not limit or preclude HEIA analysis.

HEIA is only one part of a collection of equity-driven planning tools, and may not be appropriate for all purposes. For example, HEIA is not as well suited as other equity tools for needs assessment, measuring and tracking action on equity, program and service evaluation, or strategic planning.

Who should use the HEIA tool?

HEIA is typically conducted by the development and planning staff working on the policy, program, or initiative. The results of HEIA should then be considered by decision-makers in the organization. HEIA is not intended to be conducted by third parties to policy-making (e.g., consultants), as they are further removed from the process and the cost can be prohibitive.

What is the scope of the HEIA tool?

Among impact assessment methodologies there are usually three broad categories of assessment:[3,4]

- **Desktop Assessment**
  - Information is gathered by the user from existing data and resources.
  - Generally completed within a few days.
- **Rapid Assessment**
  - More detailed and involves more outreach and sourcing of information.
  - Generally completed in a few weeks.
- **Comprehensive Assessment**
  - Involves more extensive research such as community and sector consultation.
  - Complete assessment can take months.
  - Typically used for large scale, very complex projects.

Generally, HEIA falls between the desktop and rapid assessment categories. These types of assessments can be completed in a shorter timeframe, and generally use existing information, data, and resources. The level and intensity of the HEIA application is decided by the user, often determined by the available time and resources.

HEIA Definitions and Concepts

Supplementary Resources: For an extended glossary of terminology and the different meanings throughout different sectors, please see the HEIA website for an up-to-date list, available at: www.ontario.ca/healthequity/

For simplicity, we have chosen the most commonly accepted terms and used them throughout the HEIA Workbook and Template.

Health Equity

Within the health system, equity means reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations. Equity planning acknowledges that health services must be provided and organized in ways that contribute to reducing overall health disparities.

Health inequities or disparities are differences in health outcomes that are avoidable, unfair and systemically related to social inequality and marginalization. Research shows that the roots of health disparities lie in broader social and economic inequality and exclusion, and that there are clear social gradients in which people's health tends to be worse the lower they are on the scales of income, education and overall privilege.

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[3] Centers for Disease Control and Prevention. "Health Impact Assessment." Available at http://www.cdc.gov/healthyplaces/hia.htm

[4] Centers for Disease Control and Prevention. "Health Impact Assessment Fact Sheet." Available at http://www.cdc.gov/healthyplaces/factsheets/Health_Impact_Assessment_factsheet_Final.pdf

Health equity, then, works to reduce or eliminate socially structured differentials in health outcomes. Health equity builds on broader ideas about fairness, social justice, and civil society.

Determinants of Health

The Public Health Agency of Canada defines the determinants of health (DOH) as:

> *"…the range of personal, social, economic and environmental factors that determine the health status of individuals or populations.*[5] *The determinants of health can be grouped into seven broad categories:*[6] *socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services."*

While the list continues to evolve, the Public Health Agency of Canada currently identifies the following determinants of health,[7] which is the list referred to throughout the HEIA Workbook and Template:

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

For a definition of each determinant of health see Appendix A.

Why focus on the Determinants of Health?

The most effective way to address health disparities is grounded in a framework that includes consideration of the determinants of health – the factors impacting health beyond the traditional confines of the health care system. It is important to focus "upstream" of the health sector, on a broad range of socio-economic influences and outcomes that affect individual, community, and population health.

The *Commission on Social Determinants of Health* established by the World Health Organization (WHO) states that "health care is an important determinant of health (and) lifestyles are important determinants of health, but it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."[8]

Although many of the determinants that produce health disparities lie beyond the health care system itself, analysis of the broader determinants of health has the potential to clarify important pathways to health outcomes and may suggest powerful approaches to address identified health inequities.

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[5] World Health Organization (WHO), Health Promotion Glossary, 1998.
Available at http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

[6] Source: Public Health Agency of Canada. "Canada's Response to WHO Commission on Social Determinants of Health."
Available at http://www.phac-aspc.gc.ca/sdh-dss/glos-eng.php

[7] Public Health Agency of Canada (PHAC), "What Determines Health?"
Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#key_determinants

[8] Work Health Organization (WHO), "*Closing the gap in a generation: Health equity through action on the social determinants of health.*" Available at http://ww.who.int/social_determinants. The Commission identifies 9 key themes: early child development, employment conditions, globalization, social exclusion, health systems, priority health conditions, women and equity, urbanization, measurement and evidence.

Determinants of Health or Social Determinants of Health?

Terminologies to describe the factors impacting on health include the 'determinants of health' (DOH) and the 'social determinants of health' (SDoH). The terms have slightly different meanings, although many of the same concepts are encompassed within both terms.

SDoH can be understood as the social conditions in which people live and work.[9] They are "the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. These resources include but are not limited to: conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and income distribution; social exclusion; the social safety net; and unemployment and job security."[10]

In the HEIA Workbook and Template, the broader umbrella term DOH will be used to refer to the concept of determinants of an individual or group's health that looks beyond the traditional medical concept of health. DOH is a broader term that encompasses the spectrum of influences on health, and it has been designated by Ontario's Chief Medical Officer of Health as the preferred terminology.

As the importance of the social environment in determining health outcomes becomes clearer, research into the particular social factors that are most critical is intensifying. Other lists of these social factors impacting health can be referenced as needed when applying the HEIA.

For example, researchers at York University[11] have recently defined fourteen key social factors impacting health, including: income and income distribution; education; unemployment and job security; employment and working conditions; early childhood development; food insecurity; housing; social exclusion; social safety networks; health services; Aboriginal status; gender; race; and disability. Other determinants of health identified by various individuals and organizations include wealth distribution and poverty, gender, race and ethnicity, citizenship and immigration status, language, ability, sexual orientation, age, racism and discrimination, social exclusion, and natural and built environments. These lists vary depending on the focus or emphasis of the work of that individual or organization.

When completing the HEIA tool, users are welcome to use any list of SDoH or DOH most relevant to their organization or project, and that they are most comfortable or familiar with. In the HEIA Workbook and Template, the Public Health Agency of Canada's DOH list is used.

[9] World Health Organization (WHO) Commission on SDH discussion paper, "Towards a Conceptual Framework for Analysis and Action on SDH." Available at http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

[10] Raphael, Dennis (Ed) 2004. Social Determinants of Health: Canadian Perspective.

[11] Mikkonen, J. and Raphael, D. *Social Determinants of Health: The Canadian Facts.* Toronto: York University School of Health Policy and Management, 2010.

Gathering the Evidence

HEIA provides a framework of analysis, while the user inputs evidence that is appropriate for the effective consideration of potential equity impacts. The HEIA analysis is as robust as the quality of evidence fed into the tool.

However, mainstream research (i.e., quantitative and qualitative research studies) has tended to not equally reflect the realities and issues faced by marginalized or vulnerable population groups. As a result, users can sometimes experience difficulties in accessing mainstream evidence that relates specifically to the populations under consideration.

For best results, when undertaking an HEIA analysis, consider using a 'realist' approach – integrating mainstream research evidence with broader streams of evidence, including:

- Grey literature (e.g., policy, program, or project reports, informal practice guidelines, recommended or promising practices, etc.);
- Inter-jurisdictional evidence;
- Online resources;
- Consultation and community engagement findings;
- Key informant interviews (e.g., with local experts or staff from relevant organizations);
- Program evaluation results;
- Client surveys; and
- Field evidence, staff evidence, organizational data, tacit evidence, etc.

A broad consideration of evidence will facilitate a robust analysis and will ensure that the needs of populations that may experience exclusion from mainstream research are adequately considered in completing the HEIA. All evidence sources should be weighed based on their strength and quality.

Supplementary Resources: Appendix B and C of this HEIA Workbook has a comprehensive list of resources to assist you in gathering the relevant information for conducting a HEIA. Please refer to this before completing the HEIA Template.

HEIA in Five Steps

If the policy, program, or initiative has the potential to impact the health of vulnerable or marginalized groups, HEIA is applicable. It is desirable that **all potential decisions or plans** be considered, and a recommendation made whether to proceed further to complete an HEIA, and with what scope of analysis.

1. Scoping

Identify affected populations or groups and potential unintended health impacts (positive or negative) on those groups of the planned policy, program, or initiative. Consider a wide range of vulnerable or marginalized groups to avoid overlooking unintended consequences of an initiative.

2. Potential Impacts

Use available data or evidence to prospectively assess the *unintended* impacts of the planned policy, program, or initiative on vulnerable or marginalized groups in relation to the broader population. It is both useful and important to consider a broader range of evidence, including consultation findings, grey literature, or field evidence. These sources of evidence should be weighed based on their strength and quality. Where there is very limited data or no evidence available, note this in the HEIA tool or, where possible, implement

strategies to gather required evidence. Strategies could include conducting surveys, focus groups, or consultation with experts or members of the affected groups where time permits.

3. Mitigation

Develop evidence-based recommendations to minimize or eliminate negative impacts and maximize positive impacts on vulnerable or marginalized groups. These recommendations comprise your mitigation strategy. Uptake of these recommendations in the rollout of the initiative will help to ensure that the initiative contributes to equity and does not perpetuate or widen existing health disparities. Where possible, recommendations should be informed by a diversity of members of the affected communities.

4. Monitoring

Determine how the rollout of the initiative will be monitored to determine its impacts on vulnerable or marginalized groups in comparison to other subpopulations or the broader target population. The resulting data will enhance the overall evidence base for equity-based interventions and can be fed back into the development and planning process. After the HEIA is completed, conduct a short process and impact evaluation to determine whether the tool was practical and appropriate (process), and whether there was uptake of the recommendations for adjustments made as part of the mitigation strategy (impact).

5. Dissemination

This step involves sharing results and recommendations for addressing equity. Dissemination is a cyclical process, interacting with step four (monitoring). By sharing the results of your HEIA, you are raising awareness of the gaps in equity and service provision that need to be filled, and sharing lessons learned which are important to reduce inequities in the long run.

It is important to document and share the results of the HEIA with relevant groups and stakeholders who would be interested in learning from the information you have collected. By sharing the results of your application of the HEIA, you are contributing to the growing body of knowledge on the reduction of health inequities. By sharing results of new indicators and evaluation you are also increasing access to evidence and evaluation data for the future. It is especially important to share your results and recommendations with stakeholders from non-health sectors, such as housing, transportation and childcare, as their initiatives and policies can have a substantive impact on health inequities.

After the HEIA process has been completed, it is useful to consider your results, particularly those from the monitoring strategy and how these can be incorporated into broader planning instruments such as corporate and regional strategies, annual planning and reports and other similar documents.

Supplementary Resources: For all steps of the HEIA, access the following complementary resources for assistance in completing the HEIA Template:

- If your work is in the public health sector or falls under the Ontario Public Health Standards (OPHS), please refer to the **Public Health Unit (PHU) Supplement** for additional information.
- Please refer to the **French Language Services (FLS) Supplement** to confirm whether your organization or project falls under the parameters of the *French Language Services* Act. This legislation defines where individuals are guaranteed to receive services in French. Crown agencies, Government of Ontario ministries (including all Local Health Integration Networks) as well as third-party designated agencies are covered by this legislation.

Completing the HEIA Template

This section of the HEIA Workbook guides users through each part of the HEIA Template, with prompts and examples. The examples are not meant to be comprehensive, but are for illustrative purposes only.

Please Note: Each numbered step in the Workbook corresponds to the appropriate step in the HEIA Template. A graphic at the beginning of each section highlights where in the template you are located.

Step 1: Scoping

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

While it is difficult to identify all groups that are vulnerable or marginalized with respect to a specific health policy, program, or initiative, disparities in access and quality of care have been repeatedly associated with particular populations and sub-populations. Marginalized groups, however, may vary from one project to another. In completing the HEIA tool, the populations of concern will be identified by the user based on knowledge of the project to anticipate groups that would likely be impacted.

Supplementary Resources: Although not directly applicable to all organizations, such as the PHUs, the "Key FLS Considerations for both MOHLTC and LHIN Staff" section of the **French Language Services (FLS) Supplement** provides key questions for consideration in the incorporation of French Language at the beginning of a project. Please refer to this supplement at the beginning of the development and planning process to support meaningful FLS integration.

Questions

Determine if your initiative could have a positive or negative impact on the health of vulnerable or marginalized communities by asking questions such as:

- How does your policy, program, or initiative affect health equity for identified vulnerable or marginalized populations in your area?
- Will it have a differential impact on people or communities that you serve? Will some clients have different access to care, or overall health outcomes, than others?
- Are there other vulnerable or marginalized communities which may experience unintended results of this program?

Potential Vulnerable or Marginalized Populations (Step 1a)

The following list of populations is not exhaustive, and the terminology used may or may not be preferred by members of the communities in question, as preferences vary both within and across communities. If preferences are not known, it is helpful to seek guidance with respect to preferred terminology from local experts and representatives of the communities themselves. Examples are provided under each population outlined below, in an effort to clarify populations listed.

When completing Step 1a of the HEIA, vulnerable and marginalized subpopulations may include, but are not limited to, the following:

- **Aboriginal peoples:** The Aboriginal peoples of Canada comprise the First Nations, Inuit and Métis (FNIM) peoples. These distinct groups have unique heritages, languages and cultures.[12]
- **Age-related groups:** Refers to populations whose health or equity could be specifically impacted by factors related to their age (such as the ability to vote) or developmental factors (early childhood) or physical changes (such as frail elderly). Potential groups within this category include infants, children, youth, seniors, the elderly, etc.
- **Disability:** Refers to people with physical or mental disability, infirmity, malformation or disfigurement such as blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, mental impairment (developmental or learning disability), a mental disorder, or a workplace injury or disability.[13] This could also refer to people with a mental illness, addiction, or substance use problem.
- **Ethno-racial Communities:** An ethnic group (or ethnicity)[14] is a group of people whose members identify with each other, through a common heritage, often consisting of a common language, a common culture (often including a shared religion) and/or an ideology that stresses common ancestry or endogamy. Potential communities include racial or racialized groups, cultural minorities, immigrants, refugees, etc.
- **Francophone:** People who communicate in French as their primary official or preferred language, including new immigrant francophones, deaf communities using French or Quebec sign language (la langue des signes québécoise) (LSQ)/la langue des signes francaise (LSF), etc.
- **Homeless:** Includes marginally or under-housed people, those without a permanent address, and those without stable housing or high-quality housing, including transient people.
- **Linguistic Communities:** People uncomfortable receiving care in either English or French or who prefer a first language other than English or French, or those whose literacy level affects communication in any language.

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[12] Statistics Canada. "Aboriginal peoples." Available at http://www5.statcan.gc.ca/subject-sujet/theme-theme.action?pid=10000&lang=eng
[13] Ontario Human Rights Code, R.S.O. 1990, Available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h19_e.htm
[14] Ornstein, M. "Ethno-Racial Groups in Toronto, 1971-2001," Institute for Social Research. Available at http://www.isr.yorku.ca/download/Ornstein--Ethno-Racial_Groups_in_Toronto_1971-2001.pdf

- **Low income:** includes economically vulnerable people who are underemployed, unemployed, living on a fixed income, receiving social assistance, etc.
- **Religious/Faith Communities:** Refers to systems of religious beliefs or faith that may also include specific dietary or cultural practices.
- **Rural/remote or inner-urban populations:** Includes people facing geographic or social isolation, or living in under-serviced areas, or living in densely populated areas.
- **Sex/gender:** Sex refers to the biological and physiological characteristics that define male and female, while gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.[15] Potential groups include female, male, women, men, transsexual, transgendered, two-spirited, etc.
- **Sexual orientation:** Sexual orientation is a personal characteristic that covers the range of human sexuality from lesbian and gay, to bisexual and heterosexual.[16]
- **Other:** Includes any other relevant population group not captured in the HEIA Template. For example, uninsured people (people without legal status in Canada and no government health insurance), people without a family doctor, etc.

Intersecting Populations (Step 1a)

One of the most important considerations in assessing health disparities is that these various lines of inequality and identity can **intersect and often reinforce** each other in individuals and communities.

For example, health disadvantages faced by homeless people with disabilities and limited literacy or English fluency will be even worse, and low-income older immigrant women may face specific multiple barriers. Disadvantage is almost always multi-dimensional. Similarly, research on the DOH indicates these different lines of inequality can themselves contribute to poorer prospects and positions within the labour market, which contributes to higher levels of poverty, poorer housing, and other DOH.

Supplementary Resources: For more in-depth explanations and descriptions of the DOH, refer to Appendix A of this Workbook. In addition, refer to the HEIA website for more information and evidence on selected population groups. The website is available at: www.ontario.ca/healthequity/

Examples

When identifying vulnerable or marginalized populations, look for these kinds of health disparities as they relate to your project:

- For a project designed to address a chronic condition such as arthritis, diabetes or depression, it is important to consider how it will impact on women. While Ontario women live longer than men, a majority are more likely to suffer from disability and chronic conditions. It is also important to consider low-income women as a vulnerable and marginalized population as they have more chronic conditions, greater disability, and a shorter life expectancy than high-income women.[17]
- For a project designed to improve early years' health it would be important to take into account the often poorer infant and child health of certain populations. For example, the death rate from injury for Aboriginal infants is four times the rate of that for infants in the broader Canadian population, while Aboriginal preschoolers experience five times the rate, and teenagers experience three times the rate of death from injury versus the broader Canadian population.[18]

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[15] World Health Organization. "What do we mean by 'sex' and 'gender'?" Available at http://www.who.int/gender/whatisgender/en/
[16] Ontario Human Rights Commission. "Sexual orientation and human rights." Available at http://www.ohrc.on.ca/en/issues/sexual_orientation
[17] Bierman, A. et al. POWER Study, 2009.
[18] Bierman, A. et al. POWER Study, 2009.

- For a project designed to assist under-housed individuals obtain stable housing it would be important to keep in mind that homeless people often suffer from poorer health. In 2006, homeless people in Toronto were 20 times as likely to have epilepsy, five times as likely to have heart disease, four times as likely to have cancer, three times as likely to have arthritis or rheumatism, and twice as likely to have diabetes.[19] Acknowledging and developing methods to address these disparities could help make your program or initiative more effective.
- For a project developing a service that requires people to come into a hospital or clinic it will be important to identify populations that experience transportation barriers, such as persons with physical disabilities, those with low incomes, or those who are more geographically isolated. Additionally, if your initiative requires that individuals have access to a primary care physician or specialist, those who reside in rural areas may experience barriers. In 2004, 21.4 per cent of the Canadian population lived in rural areas, where only 9.4 per cent of physicians (15.7 per cent of family physicians and 2.4 per cent of specialists) practised.[20]

- For a project developing a service that suggests people purchase items, such as mosquito repellent and/or sun block for a public health initiative, it is important to consider those who may not be able to follow the recommendations due to barriers such as low income, or the item not being readily available in their geographic area. Acknowledging these barriers and being able to suggest mitigations, such as staying in the shade or remaining indoors when mosquitoes are most active will assist in making your program or initiative more effective, inclusive and practical.

Identified Vulnerable Populations

Based on your research and analysis, have you identified vulnerable or marginalized groups who may be affected by your planned policy, program, or initiative? If so, highlight them in the HEIA Template, or add them to the "Other" section as needed.

Determinants of Health (Step 1b)

In this step, identify the relevant DOH and health inequities facing the vulnerable or marginalized population group identified in Step 1a.

A project could have an effect beyond its formal objectives and targets on client social connectedness, skills building and labour market opportunities, or individual or family living conditions; all of which can have a major impact on health. It could unintentionally also broaden the inequities commonly faced by a certain vulnerable population. Therefore, examining the project through a DOH 'lens' may help identify additional potential adjustments that will reduce the disparate impact on these groups.

Applicable determinants of health can be noted in column 1b adjacent to the corresponding population groups. Once recorded, impacts related to these determinants of health will be examined in Step 2.

Examples

- A health service for seniors was delivered in a community health setting, but is now redesigned to provide in-home service. This could result in a negative impact on social supports and connectedness by removing an opportunity for social interaction for isolated elderly individuals.
  - **Population:** seniors
  - **DOH:** Social Support Networks/Social Environments

[19] Khandor E & Mason K. *The Street Health Report 2007*. www.streethealth.ca
[20] Pong RW, Pitblado JR. *Geographic Distribution of Physicians in Canada: Beyond How Many and Where*. Ottawa: Canadian Institute for Health Information, 2006.

- A community kitchen program is designed to strengthen healthy eating behaviours for members of a specific ethno-cultural community at high risk for diabetes. The program has additional positive impacts relating to social connectedness for members of this community by bringing together members who might otherwise be isolated by both cultural and linguistic barriers. The positive impacts on social connectedness might be further enhanced in the program design by providing participants with additional social supports such as child care.
  - **Population:** specific ethno-cultural communities
  - **DOH:** Social Support Networks/Social Environments/Healthy Child Development
- A network of health system navigators or "health ambassadors" is created to assist members of a community of recent immigrants who require assistance to overcome cultural and linguistic barriers to their health care. Navigators with medical or health system skills or expertise from their country of origin are hired from within the community to fill this role. Experience on this project is leveraged to overcome barriers to employment experienced by the health ambassadors themselves and to assist them to advance their careers in the health system in Ontario.
  - **Population:** recent immigrants/communities experiencing linguistic barriers
  - **DOH:** Social Support Networks/Employment and Literacy/Income and Social Status

Step 2: Potential Impacts

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Once you have identified populations that could be affected by the initiative, the next step is to analyze the potential *unintended* impact (both positive and negative) on the health of these populations.

Assessment of Potential *Unintended* Impacts on Identified Populations

Thinking back to the vulnerable or marginalized groups and relevant determinants of health that you identified in Step 1a and Step 1b, what are the positive and negative impacts you have identified for each of the groups? It may be necessary to rely on research and analysis to determine these impacts.

Questions

Determine whether your initiative will have a positive or negative impact on vulnerable or marginalized communities by asking questions such as:

- How will the policy, program, or initiative affect access to care for this population?
- Is it likely to have positive impacts or effects that enhance health equity?
- Is it likely to have negative effects that contribute to, maintain or strengthen health disparities?
- How will it affect the quality and responsiveness of care for this community?
- Will providing this program, or improving access to it, help to narrow the gap between the best and worst off in terms of health outcomes?
- If you don't know, what more do you need to know and how will you find out?
- Will some people or communities benefit more from the program than others, and why?

Your appraisal should also consider:

- The nature and quality of the evidence you are using to assess impact;
- The probability of the predicted impact(s);
- The severity and scale of the impact(s); and
- Whether the impact(s) will be immediate or latent.

Examples

- Imagine that a program is designed to increase access to pre-natal care for lower income women and is being rolled out in designated neighbourhoods, with a facility that will be open from 10:00 a.m. to 6:00 p.m. Many people with a low income work more than one job, or have a job that falls outside of traditional 9 to 5 hours. Taking this into consideration might mean that the hours of service for this facility would have to be altered to ensure access.
- You are planning to roll out a heart health awareness campaign. People with higher education and income levels typically use health promotion programs more, with the unintended consequence that these programs can serve to increase health disparities. Could this be the case here? Will the program be understandable and relevant for people from diverse cultural backgrounds? Not all groups communicate and access information in the same manner, and understanding how to best access your intended audience can contribute to your program's success.

More Information Needed

In some instances, you will identify the fact that you require further data or evidence in order to more accurately identify the impacts of your initiative on a specific population. In this instance, you may identify this information in the "More Information Needed" column of the HEIA Template. If information cannot be located within the necessary timelines, the missing information should be noted in the template as a possible missing component of the analysis.

Step 3: Mitigation

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Once you have identified the impacts of your project, the next step is to plan how to minimize the negative impacts that create or contribute to existing health disparities, and to maximize positive impacts that create or contribute to health equity. Although you can be creative, the point is to be feasible and practical – consider what can be mitigated now, and what can perhaps be mitigated later.

Questions

Analyze how the impact of your initiative will be mitigated by asking questions such as:

- How can you reduce or remove barriers and other inequitable effects?
- How you can you maximize the positive effects or benefits that enhance health equity?
- What specific changes do you need to make to the initiative so it meets the needs of each vulnerable or marginalized community you have identified? How does it need to be customized or targeted?
- Could you engage the population in designing and planning these changes or consult with key stakeholders?
- How will the program address systemic barriers to equitable access to care created by the health care and other systems?
- Will you be making recommendations to decision-makers?

Examples

- If a cancer screening program is being designed to reach women in low-income neighbourhoods, its strategies might include extending opening hours to accommodate a range of work schedules, ensuring it is located in a building easily accessible by public transit, and providing free child care services for those women who require it. If a particular low-income neighbourhood has one or more significant ethno-racial populations, strategies should also address potential barriers to these groups, such as linguistic accessibility, cultural competence, or system navigation.

- Community Health Centres and others have employed strategies that include training and supporting community-based peer workers in outreach and system navigation services to overcome language and cultural barriers. For example, volunteers from particular ethno-cultural communities provide health promotion to particular communities, in a language and culture they understand.
- Language can be a significant barrier to accessing care and can affect care quality as it may lead to poor communication between patients and providers (i.e., possible misdiagnoses or inappropriate prescriptions or treatment). Common directions have included enhanced interpretation services, engaging directly with affected language and other communities, and training in culturally competent care.
- Some populations have complex needs and can be particularly difficult to reach. Psychiatric services have been delivered to homeless people in shelters and other non-medical sites, rather than assuming homeless people will come into hospitals or clinics to receive psychiatric care. These services can be combined with multi-disciplinary care and support to address the underlying reasons individuals are homeless (i.e., the "upstream" social factors).
- Some Community Health Centres directly provide or partner with other agencies to offer employment, literacy and other social services that help to address the underlying causes of ill health such as poverty and broader determinants of health to support their clients.

Mitigation Strategies

For each of the *unintended* negative and positive impacts identified in Step 2, outline the recommended adjustments to the initiative you will make in order to:

- Minimize unintended negative impacts on the populations identified, in Step 1; and
- Maximize unintended positive impacts on the populations identified in Step 1.

Please use these additional prompt questions to help identify mitigation strategies to either minimize negative impacts or maximize positive impacts:

Additional Questions

Consider how your policy, program, or initiative can be changed to bring about a reduction in health inequities. Here are some prompt questions:

- Reducing or eliminating barriers to access (e.g., translation, transportation, childcare, etc.);
- Ensuring appropriate reading or comprehension level for communications materials;
- Ensuring cultural appropriateness of communications and service delivery;
- Increasing priority group participation in the development and planning process;
- Changing the way in which a program, policy, or initiative is implemented;
- Changing the way in which a program, policy, or initiative is promoted;
- Changing internal policies and procedures;
- Ensuring greater alignment and collaboration with complementary projects or partners (i.e., local, regional, provincial, or federal organizations) both inside and outside of the health sector; and
- Offering staff education, training, or professional development opportunities.

Supplementary Resources: If your work is in the public health sector or falls under the Ontario Public Health Standards (OPHS), please refer to the **Public Health Unit (PHU) Supplement** for additional mitigation strategy considerations.

Step 4: Monitoring

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

The next step of the HEIA is to determine, if possible, if your planned mitigation strategy has been effective. You will want to monitor:

- Whether or not your mitigation strategy was implemented;
- Whether or not your mitigation strategy was effective;
- Since the HEIA is a living document, go back to determine and record your results, comparing them back to your original HEIA objectives; and
- How roll-out of the initiative will be monitored to determine its impacts on vulnerable or marginalized populations identified in Step 1 of the analysis.

Once finalized, the monitoring strategy should be integrated within the overall evaluation or performance measurement plan for the project. The resulting data will enhance the evidence base and feed back into the planning and development process.

Questions

Analyze how the impact of your initiative will be monitored by asking questions such as:

- How will you know if your program has enhanced equity?
- How will you know when the program is successful?
- What equity indicators and objectives will you measure, and how?

Monitoring Impact of Mitigation Strategies

Additional Questions (same as Step 3)

Consider whether your mitigation strategy addressed the following issues, and will be measured effectively by your monitoring strategy:

- Reducing or eliminating barriers to access (e.g., translation, transportation, childcare, etc.);
- Ensuring appropriate reading or comprehension level for communications materials;
- Ensuring cultural appropriateness of communications and service delivery;
- Increasing priority group participation in the development and planning process;
- Changing the way in which a program, policy, or initiative is implemented;
- Changing the way in which a program, policy, or initiative is promoted;
- Changing internal policies and procedures;
- Ensuring greater alignment and collaboration with complementary projects or partners (i.e., local, regional, provincial, or federal organizations) both inside and outside of the health sector; and
- Offering staff education, training, or professional development opportunities.

Examples

There are many ways you can monitor the impacts on equity as your initiative is implemented, including:

- Client satisfaction surveys – questionnaires could be provided to members of identified vulnerable or marginalized populations to monitor quality of care issues; or the broader population could be surveyed with results stratified by gender, ethno-cultural background or socio-economic status.
- Monitoring the organization's broader community engagement activities for information and feedback from particular marginalized populations.
- Program evaluation that disaggregates and tracks measures of program success by vulnerable or marginalized groups (e.g., tracking hospital re-admission or cancer screening rates).
- Process evaluation to ensure that developers, planners, and decision-makers are integrating equity considerations into their processes.
- Consultation with key providers and other stakeholders on how they are seeing the equity impact of the initiative. For example, run focus groups with affected populations.

Step 5: Dissemination

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
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Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Step 5 involves sharing results and recommendations for addressing equity, a process which is closely linked to the monitoring strategy you put in place in Step 4. Now that you have a process for collecting data and evaluating the effectiveness of your mitigations, it is only logical to:

- Embed this information into your organization's planning and operational structures (such as corporate and regional strategies, annual/operational planning and reports, etc.); and
- Share the results of your evaluation with relevant groups and stakeholders who may be interested in learning from the information you have collected. By sharing the results of your application of the HEIA, you are contributing to the growing body of knowledge and information on marginalized and vulnerable groups. It is particularly important to share your results and recommendations with stakeholders from non-health sectors, such as housing, transportation and childcare, as their initiatives and policies can have a substantive impact on health inequities.

Sharing the results of your HEIA through knowledge exchange activities helps to ensure that other health planners benefit from your experience. Here are some suggested knowledge exchange activities:

- Sharing the assessment as a case study through a conference presentation, webinar or other vehicle for knowledge exchange;
- Publication of literature review or evidence summary;
- Submission of an abstract at a scientific meeting;
- Development of a workshop or professional development activity based on your experience; and
- Formation of a community of practice focused on the reduction of health inequities.

Also:

- Document your changed policies and revised decision-making (including relevant corporate documents such as briefing notes, decision papers, etc.);
- This is useful for corporate memory, and to reflect on when reviewing a program and its impact on populations; and
- Document your suggested frequency of future follow-up or assessments (i.e., program re-design at a later date), and if there are any statutory requirements for program review.

Questions

- Where would be a logical place in your organization to document the results of your HEIA?
- What would be a good forum and/or strategy to disseminate the results of your HEIA?

Sharing your evaluation results is an important contribution to the growing body of knowledge on the reduction of health inequities. This step helps you to link impacts to mitigation strategies your organization may have implemented to reduce health inequities among vulnerable or marginalized groups. These results should be reviewed to identify any additional modifications to your project.

Appendix A: Determinants of Health

You are welcome to use any determinants of health or social determinants of health list – this list is provided here for your reference.

Source: The Public Health Agency of Canada website:
www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php

What Makes Canadians Healthy or Unhealthy?

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian:

> "Why is Jason in the hospital?
> Because he has a bad infection in his leg.
>
> But why does he have an infection?
> Because he has a cut on his leg and it got infected.
>
> But why does he have a cut on his leg?
> Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.
>
> But why was he playing in a junkyard?
> Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.
>
> But why does he live in that neighborhood?
> Because his parents can't afford a nicer place to live.
>
> But why can't his parents afford a nicer place to live?
> Because his dad is unemployed and his mom is sick.
>
> But why is his dad unemployed?
> Because he doesn't have much education and he can't find a job.
>
> But why ...?"
>
> – *from Toward a Healthy Future: Second Report on the Health of Canadians*[21]

There is a growing body of evidence about what makes people healthy. The Lalonde Report[22] set the stage in 1974, by establishing a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology and health services. Since then, much has been learned that supports, and at the same time, refines and expands this basic framework. In particular, there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. On the other hand, there are strong and

[21] Public Health Agency of Canada. "Toward a Healthy Future: Second Report on the Health of Canadians." Available at http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/pdf/toward_a_healthy_english.PDF

[22] Lalonde, M. "A new perspective on the health of Canadians. A working document." Ottawa: Government of Canada, 1974. Available at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/1974-lalonde/lalonde-eng.pdf

growing indications that other factors such as living and working conditions are crucially important for a healthy population.

The evidence indicates that the key factors which influence population health are:[23]

- Income and social status;
- Social support networks;
- Education;
- Employment and working conditions;
- Social environments;
- Physical environments;
- Personal health practices and coping skills;
- Healthy child development;
- Biology and genetic endowment;
- Health services;
- Gender; and
- Culture.

Each of these factors is important in its own right. At the same time, the factors are **interrelated**.

> *For example: a low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and a sense of control and mastery over life circumstances also come into play.*

The following Underlying Premises and Evidence Table provides an overview of what we know about the ways the determinants influence health. The source documents are:

- *Toward a Healthy Future: Second Report on the Health of Canadians*[24]
- *Strategies for Population Health: Investing in the Health of Canadians*[25]

[23] Public Health Agency of Canada. "What Determines Health."
Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants
[24] Public Health Agency of Canada. "Toward a Healthy Future: Second Report on the Health of Canadians."
Available at http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/pdf/toward_a_healthy_english.PDF
[25] Public Health Agency of Canada. "Strategies for Population Health: Investing in the Health of Canadians."
Available at http://www.phac-aspc.gc.ca/ph-sp/pdf/strateg-eng.pdf

Key Determinant 1 – Income and Social Status	
Underlying Premises	**Evidence**
Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems	There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health. **Evidence from the Second Report on the Health of Canadians** • Only 47 per cent of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73 per cent of Canadians in the highest income group. • Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of residence. • At each rung up the income ladder, Canadians have less sickness, longer life expectancies and improved health. • Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole. **Evidence from Investing in the Health of Canadians:** • Social status is also linked to health. A major British study of civil service employees found that, for most major categories of disease (cancer, coronary heart disease, stroke, etc.), health increased with job rank. This was true even when risk factors such as smoking, which are known to vary with social class, were taken into account. All the people in the study worked in desk jobs, and all had a good standard of living and job security, so this was not an effect that could be explained by physical risk, poverty or material deprivation. Health increased at each step up the job hierarchy. For example, those one step down from the top (doctors, lawyers, etc.) had heart disease rates four times higher than those at the top (those at levels comparable to deputy ministers). So we must conclude that something related to higher income, social position and hierarchy provides a buffer or defence against disease, or that something about lower income and status undermines defences. • See also evidence from the report Social Disparities and Involvement in Physical Activity.[26] • See also evidence from the report Improving the Health of Canadians.[27] • See also **The Social Determinants of Health**: income inequality[28] and food security:[29] • Are poor people less likely to be healthy than rich people?[30] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[26] Gauvin, L and the Interdisciplinary Research Group on Health. Social Disparities and Involvement in Physical Activities, Montreal (2003). http://www.gris.umontreal.ca/rapportpdf/R03-02.pdf
[27] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367
[28] Scott, K and Lessard, R. Income Inequality as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/02_income_e.pdf
[29] McIntyre, L and Tarasuk, V. Food Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/08_food-eng.php
[30] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr1-eng.php

Key Determinant 2 – Social Support Networks	
Underlying Premises	**Evidence**
Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems. In the 1996-97 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for. Similarly, in the 1994-95 National Longitudinal Survey of Children and Youth, children aged 10 and 11 reported a strong tendency toward positive social behaviour and caring for others.	**Evidence from Investing in the Health of Canadians:** Some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure. • An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates. • Another U.S. study found that low availability of emotional support and low social participation were associated with all-cause mortality. • The risk of angina pectoris decreased with increasing levels of emotional support in a study of male Israeli civil servants. • See also **The Social Determinants of Health**: social inclusion and exclusion[31] and social economy.[32] • How do relationships with others affect people's health?[33] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[31] Galabuzi, G-E and Labonte, R. Social Inclusion as a Determinant of Health. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php

[32] Vaillancourt, Y and Armstrong, P. Social Policy as a Determinant of Health: The Contribution of the Social Economy. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php

[33] Public Health Agency of Canada. "How do relationships with others affect people's health?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr2-eng.php

Key Determinant 3 – Education and Literacy	
Underlying Premises	**Evidence**
Health status improves with level of education. Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.	**Evidence from the Second Report on the Health of Canadians:** • Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy. • People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods. • In the 1996-97 National Population Health Survey (NPHS), only 19 per cent of respondents with less than a high school education rated their health as "excellent" compared with 30 per cent of university graduates. **Evidence from Investing in the Health of Canadians:** • The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven workdays per year due to illness, injury or disability, while those with university education lose fewer than four days per year. • See also evidence from the report: How Does Literacy Affect the Health of Canadians?[34] • See also **The Social Determinants of Health**: education.[35] • How does education affect health?[36] This question was prepared by the Canadian Council on Social Development.

[34] Public Health Agency of Canada. "How Literacy Affects the Health of Canadians." Available at http://www.phac-aspc.gc.ca/ph-sp/literacy-alphabetisme/index-eng.php

[35] Public Health Agency of Canada. "The Social Determinants of Health: Education as a Determinant of Health." Available at http://www.phac-aspc.gc.ca/ph-sp/oi-ar/10_education-eng.php

[36] Public Health Agency of Canada. "How does education affect health?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr3-eng.php

Key Determinant 4 – Employment and Working Conditions	
Underlying Premises	**Evidence**
Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.	**Evidence from the Second Report on the Health of Canadians:** • Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job. • Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being. • Participation in the wage economy, however, is only part of the picture. Many Canadians (especially women) spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is bound to suffer. Between 1991 and 1995, the proportion of Canadian workers who were "very satisfied" with their work declined, and was more pronounced among female workers, dropping from 58 to 49 per cent. Reported levels of work stress followed the same pattern. In the 1996-97 NPHS, more women reported high work stress levels than men in every age category. Women aged 20 to 24 were almost three times as likely to report high work stress than the average Canadian worker. **Evidence from Investing in the Health of Canadians:** • A major review done for the World Health Organization found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities. • See also **The Social Determinants of Health**: employment and job security[37] and working conditions.[38]

[37] Tremblay, D-G. Employment Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/04_employment_e.pdf

[38] Andrew Jackson, A. and Polanyi, M. Working Conditions as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/05_working_e.pdf

Key Determinant 5 – Social Environments	
Underlying Premises	**Evidence**
The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. A healthy lifestyle[39] can be thought of as a broad description of people's behaviour in three inter-related dimensions: individuals; individuals within their social environments (e.g., family, peers, community, workplace); the relation between individuals and their social environment. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community (i.e., shared) issue. Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health. In 1996-97: • Thirty-one per cent of adult Canadians reported volunteering with not-for-profit organizations in 1996-97, a 40 per cent increase in the number of volunteers since 1987. • One in two Canadians reported being involved in a community organization. • Eighty-eight per cent of Canadians made donations, either financial or in-kind, to charitable and not-for-profit organizations.	**Evidence from the Second Report on the Health of Canadians** • In the U.S., high levels of trust and group membership were found to be associated with reduced mortality rates. • Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24 per cent of all assaults against children; among very young children, the proportion was much higher. • Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80 per cent of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend. • Since peaking in 1991, the national crime rate declined 19 per cent by 1997. However, this national rate is still more than double what it was three decades ago.

[39] Lyons, R. and Langille L. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Prepared for Health Canada (2002). http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf

Key Determinant 6 – Physical Environments	
Underlying Premises	**Evidence**
The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being	**Evidence from the Second Report on the Health of Canadians** • The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13 per cent of boys and 11 per cent of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 1996-97. • Children and outdoor workers may be especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts. **Evidence from Investing in the Health of Canadians:** • Air pollution, including exposure to second-hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second-hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined. • See also **The Social Determinants of Health**: housing.[40] • What affects health more: germs and viruses, or the environment?[41] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[40] Bryant, T., Chisholm, S. and Crowe, C. Housing as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/09_housing_e.pdf

[41] Public Health Agency of Canada. "What affects health more: germs and viruses, or the environment?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr4-eng.php.

Key Determinant 7 – Personal Health Practices and Coping Skills	
Underlying Premises	**Evidence**
Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health. Definitions of lifestyle[42] include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events. However, there is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.	**Evidence from the Second Report on the Health of Canadians** • In Canada, smoking is estimated to be responsible for at least ¼ of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole. • Multiple risk-taking behaviours, including such hazardous combinations as alcohol, drug use and driving, and alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men. • Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 1996-97, from 22 to 34 per cent among men and from 14 to 23 per cent among women. **Evidence from Investing in the Health of Canadians:** • Coping skills, which seem to be acquired primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day-to-day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles. • See also evidence from the report Social Disparities and Involvement in Physical Activity.[43] • See also evidence from the report Improving the Health of Canadians.[44]

[42] Lyons, R. and Langille L. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Prepared for Health Canada (2002). Available at http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf

[43] Gauvin, L and the Interdisciplinary Research Group on Health. Social Disparities and Involvement in Physical Activities, Montreal (2003). http://www.gris.umontreal.ca/rapportpdf/R03-02.pdf

[44] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367

Key Determinant 8 – Healthy Child Development	
Underlying Premises	**Evidence**
New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.	**Evidence from the Second Report on the Health of Canadians** • Experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health into adulthood. • Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 1996-97 National Population Health Survey, about 36 per cent of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy. • A loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life. • Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death. **Evidence from Investing in the Health of Canadians:** • A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play. • See also evidence from the report Improving the Health of Canadians.[45] • See also **The Social Determinants of Health**: early childhood education and care.[46]

[45] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367.

[46] Friendly, M. and Browne, G. Early Childhood Education and Care as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/07_ecec_e.pdf

Key Determinant 9 – Biology and Genetic Endowment	
Underlying Premises	**Evidence**
The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.	**Evidence from the Second Report on the Health of Canadians** • Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime. • Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.

Key Determinant 10 – Health Services	
Underlying Premises	**Evidence**
Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention	**Evidence from the Second Report on the Health of Canadians** • Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained. • There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services. • Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs.

Key Determinant 11 – Gender	
Underlying Premises	**Evidence**
Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.	**Evidence from the Second Report on the Health of Canadians** • Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34. • While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence. • While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb. See also articles: *Rural, remote and northern women – where you live matters to your health* and *How being Black and female affects your health.*

Key Determinant 12 – Culture	
Underlying Premises	**Evidence**
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.	**Evidence from the Second Report on the Health of Canadians** • Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole and the prevalence of major chronic diseases, including diabetes, heart problems, cancer hypertension and arthritis/rheumatism, is significantly higher in Aboriginal communities and appears to be increasing. • In a comparison of ethnic groups, the highest rate of suicide occurred among the Inuit, at 70 per 100,000, compared with 29 per 100,000 for the Dene and 15 per 100,000 for all other ethnic groups, comprised primarily of non-Aboriginal persons. • The 1996-97 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian born peers, even though far more of the former lived in low-income households. The study suggests that "poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty's blows; the hopelessness of majority-culture poverty accentuates its potency." See also evidence from the report Improving the Health of Canadians.[47]

[47] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367.

Appendix B: Supplementary Resources

In addition to the HEIA Template and HEIA Workbook, users may access various complementary resources to assist completing the tool. These resources are available on the MOHLTC's HEIA website at www.ontario.ca/healthequity. Visit this webpage for the most up-to-date information.

Other General Health Equity Resources

- Project for an Ontario Women's Health Evidence-Based Report, *the POWER Study*: www.powerstudy.ca/
- Echo: Improving Women's Health in Ontario: www.echo-ontario.ca./echo/en.html
- Public Health Agency of Canada: www.phac-aspc.gc.ca
- Ontario Health Quality Council: www.ohqc.ca
- Toronto-based Health Equity Council: www.healthequitycouncil.ca
- National Institute of Public Health in Quebec: www.ncchpp.ca/en/
- World Health Organization: www.who.int/social_determinants
- HIA gateway (UK): www.apho.org.uk/default.aspx?QN=P_HEIA
- HIA connect (NSW Australia): www.HEIAconnect.edu.au/
- World Health Organization HIA: www.who.int/hia/en/
- Health Quality Ontario: www.hqontario.ca
- Better Outcomes Registry Network (BORN): www.bornontario.ca
- Wellesley Institute: www.wellesleyinstitute.com

Health Equity Terminology

- Public Health Agency of Canada Glossary: www.phac-aspc.gc.ca/sdh-dss/glos-eng.php
- World Health Organization Glossary: www.who.int/hia/about/glos/en/index.html

Appendix C: Methodology

Useful resources and methods for gathering information and evidence for the HEIA

The following sources of data are listed according to the degree of time and effort that need to be expended in obtaining this information:

Your common knowledge and working experiences related to the project:

Your planning to date may already have involved some background research or needs assessment that enabled you to easily identify potentially vulnerable groups. You may be able to go through the "populations" column of the HEIA Template and highlight or eliminate some groups simply based on your current understanding of the issue at hand. Similarly, you may already be aware of some interventions that are used in this area, or of significant data, research or other knowledge gaps that may need to be filled in order to effectively reduce related inequities. Furthermore, your team or manager may be able to share important observations, such as attendance levels in certain programs, the effectiveness of certain outreach methods and perceived barriers to participation among certain priority populations.

Literature review

A literature review will naturally be informed by the above information. It is important to consider a literature review for any areas of uncertainty regarding populations affected or interventions that may be effective. A rapid review focused on synthesized evidence sources will be appropriate in most cases. If your area is particularly new or the profile of your program/policy is very high, then a primary literature search may be appropriate. Some key documents addressing the link between health inequities and the determinants of health are listed below.

Environmental scan

An environmental scan can help to raise your awareness of the policy landscape surrounding an issue, identifying community groups and government organizations already working on this issue. An environmental scan can also increase your knowledge of priority groups affected by your program or equity issues that you may not have perceived in your original conceptualization of the project.

Analysis of existing data

- Lack of existing or sufficient data related to the determinants of health and other drivers of inequalities is a key challenge in Ontario and other jurisdictions. However, available data should be disaggregated in order to highlight inequities that may be related to the issue under consideration. Examples of data sources are listed below.
- If data are unavailable, and you believe such an analysis is of significant importance to your work, this should be noted in Step 2 of the HEIA Template under "More Information Needed." This assists you in recording the gaps in the information from your analysis, and gives you a platform from where to start looking (i.e., expert consultation, grey literature, etc.).

Stakeholder/Expert consultation

If the preceding steps do not provide adequate information regarding health inequities related to your program or policy, formal or informal stakeholder or expert consultation may be considered.

Community consultation

Community consultation is unlikely to be an early step in an HEIA of your project. However, as you progress you may find that it becomes increasingly important to consult with priority group members in order to better understand the impact of your work on their perceived health status, quality of life, access to programs/services, etc.

Collection of new data

For some questions, particularly those related to evaluation, developing a protocol for the collection, analysis and dissemination of new data may be necessary. This may also go under the "More Information Needed" section of the HEIA Template, to ensure that the need for new data is recorded.

Data Sources Containing Socio-demographic and Economic Variables for Scoping Analysis

- The Rapid Risk Factor Surveillance System (RRFSS)
- Integrated Public Health Information System (iPHIS)
- Canadian Community Health Survey (CCHS)
- Census data (typically obtained via data requests)
- Administrative databases
- Data and reports from other local, regional, provincial and national sources

Useful Resources on Health Inequities and the Determinants of Health

Ontario

Gardner, B. (2008). *Health Equity Discussion Paper*. Toronto Central Health Integration Network. Retrieved May 25, 2010, from http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf

Region of Waterloo Public Health. (2009). Evidence and Practice-based Planning Framework with a focus on health inequities. Retrieved May 28, 2010, from http://chd.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?open

Sudbury and District Health Unit. (2010). Implementing Local Public Health Practices to Reduce Social Inequities in Health. Retrieved June 1, 2010, from http://www.sdhu.com/uploads/content/listings/EXTRAInterventionProjectDraftFinalReportSDHUJanuary2010_External.pdf

Toronto Public Health. (2008). *The Unequal City: Income and Health Inequalities in Toronto.* Retrieved May 25, 2010, from: www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf.

Canada

Bell, B. (2009). *Actions to Reduce Health Inequalities in Canada: A description of strategic efforts led or supported by public health organizations.* Working Document prepared for the Public Health Agency of Canada Strategic Initiatives and Innovations Directorate. Retrieved May 21, 2010, from http://www.opha.on.ca/resources/docs/StrategicInitiatives-PHAC-6Mar09.pdf

Canadian Institute for Health Information. (2008). *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada*, Ottawa, ON. Retrieved May 25, 2010, from: http://secure.cihi.ca/cihiweb/products/Reducing_Gaps_in_Health_Report_EN_081009.pdf.

Keon, W.J., and Pepin, L. (2009). *A Healthy, Productive Canada: A Determinant of Health Approach. Final Report of the Senate Subcommittee on Population Health.* Retrieved May 21, 2010, from: www.parl.gc.ca/40/2/parlbus/commbus/senate/Com-e/popu-e/rep-e/rephealthjun09-e.pdf

Public Health Agency of Canada. (2008). *The Chief Public Health Officer's Report on the State of Public Health in Canada.* Retrieved May 21, 2010, from http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/index-eng.php.

International

Commission on Social Determinants. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization. Retrieved, May 20, 2010, from: www.who.int/social_determinants/thecommission/finalreport/en/index.html.

Ontario

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