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Seeing the Unseen: An introduction to Health Equity Impact Assessment

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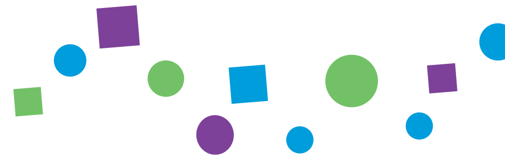
Introduction

Many community groups and networks working to build healthy communities have long been concerned with addressing the growing inequities in their communities. Recently, the Ministry of Health and Long-Term Care (MOHLTC) in, partnership with Local Health Integration Networks (LHINs), developed the Health Equity Impact Assessment (HEIA) Tool. Derived from widely-practiced impact assessments such as Environmental Impact Assessment and Health Impact Assessment, the HEIA tool can be used by anyone whose work impacts the health and wellbeing of marginalized populations, with health defined in a holistic sense as incorporating physical, mental and social aspects.

This issue of @ *a glance* is a follow-up to an introductory webinar delivered by HC Link on HEIA. The resource is designed to help readers gain familiarity in using the HEIA tool to address health inequities in their work with marginalized populations. In the sections below, you will find discussion of key concepts and definitions used in the HEIA and an overview of steps to carry out the assessment.



Key Concepts

WHAT IS HEALTH EQUITY?

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided” (WHO, 1986, cited in Whitehead, 1991). Health inequities are differences in health that are considered unfair and unjust by our society’s standards. Health equities are avoidable because they result from social and economic conditions, policies and practices which can be changed.

How is INEQUITY different from INEQUALITY?

Inequality and equality are dimensional concepts, referring to measurable quantities, whereas inequity and equity are political concepts, expressing a moral commitment to social justice (Kawachi et al, 2002).

EXAMPLES OF HEALTH INEQUITIES IN ONTARIO

- In Hamilton, life expectancy varies from neighbourhood to neighbourhood. In one lower income neighbourhood, life expectancy is 67 while in another higher income neighbourhood it is 87 (The Social Planning and Research Council of Hamilton, 2011).
- In Toronto, the lung cancer incidence was 1.5 times higher for males in the lowest income quintile, compared to residents of higher-income neighbourhoods (Toronto Public Health, 2008).
- Nearly one in five adults from First Nations communities has been diagnosed with diabetes, while for the general population it is 1 in 19 (Heart and Stroke Foundation, 2013).
- Vulnerable populations experience more difficulty with accessing employment, nutritious food, higher education, transportation, adequate housing, primary health care, and social support. These are the social determinants of health that are mainly responsible for health inequity in Ontario.

WHY HEALTH EQUITY MATTERS

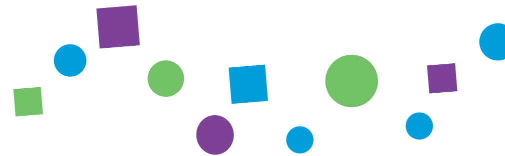
Ethical Reasons

“The unequal distribution of resources and power leading to certain groups having limited access to health care, schools and education, living in unsafe neighbourhoods and in inadequate housing is not a natural phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics” (WHO, 2008). Frequently health equity is seen as an issue of social justice.

Studies have shown that about 10% of health outcomes are attributed to access to health care and about 20% to genetic predispositions. The remaining 70% are due to social and environmental factors as well as behavioural variables, which are often socially and environmentally determined (Schroeder, 2007).

Legislative Requirements

The preamble of the Excellent Care for All Act (2010) defines equity as a critical component of quality health care. The Local Health System Integration Act (2006) states that the health system should “be guided by a commitment to equity and respect for diversity in communities in serving the people in Ontario.”



Economic Reasons

Income disparity alone is associated with about 20% increased health care spending. In Ontario, marginalized populations and those in the lowest income quintile use approximately twice the volume of health care services as those in the highest quintile (Toronto Public Health, 2008).

Estimate: If all people in Ontario had the same health as Ontarians with higher income:

- about 318,000 fewer people would be in fair or poor health,
- 231,000 fewer people would be disabled, and
- 16,000 hospitalizations a year would be avoided (POWER, 2012).

The following sections will take a closer look at the HEIA and how to conduct it step by step. You can find more information on all the topics discussed below from the HEIA Workbook, published by the MOHLTC in 2012.

Health Equity Impact Assessment

The HEIA helps service providers consider marginalized or vulnerable groups who are part of their client population, to understand how their health could be impacted by the service, and to develop creative mitigation strategies addressing problems uncovered. This assessment is designed to identify unintended health impacts, and such impacts can be either positive or negative. Service providers can think of ways to minimize negative impacts such as addressing discrimination or programmatic barriers to access, and to maximize positive impacts such as unplanned social bonding that can happen between program participants.

WHO SHOULD USE IT?

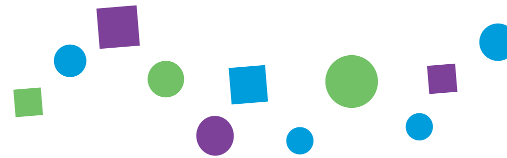
The HEIA is designed to be conducted by internal staff or management; someone with intimate knowledge of the organization's history, work and culture. It is not necessary to hire an external consultant for the task. This tool is useful for organizations working in the traditional health sector as well as those working outside of it, such as education, children and youth services or community non-profits.

HOW LONG AND WHAT RESOURCES DOES IT TAKE?

The HEIA is scalable depending on your need. As a desktop assessment, it can be completed in a few days with information already available in your organization, such as program statistics, reports and other data sources. Rapid assessment, the next level up, takes up to a few weeks where staff conduct a more detailed program review and literature scan. Finally, the comprehensive assessment, which could last a few months, is where staff conduct extensive literature reviews, interviews and broader community consultation. For more information on the types of resources that staff could use to conduct the HEIA, please see page 14 of the HEIA workbook.

WHEN SHOULD AN HEIA BE CONDUCTED?

The HEIA should preferably be done at the beginning of program or service development, during the planning stage. It can also be useful at the end of a project as part of the review or evaluation process to assess service expansion, re-alignment or termination. For more information, see page 10 of the HEIA workbook.



Steps in Conducting the HEIA

STEP 1 - SCOPING: Identify the priority groups or marginalized populations who use your service or could benefit from your service. Consider the intersectionality in people's identities: a client can both enjoy privilege as a Caucasian but also experience oppression as a woman living with a disability. Wherever possible, use the best evidence that's available to you. You can gather information by speaking with fellow staff or managers, conducting a more structured environmental scan, or conducting a review of the grey and academic literature on your population or issue, through using free search engines such as Google Scholar. *For more information on ways to "scope", please see pages 14-19 in the HEIA workbook.*

STEP 2 - POTENTIAL IMPACTS: Once you have identified populations that could be affected by the initiative, analyze the potential unintended impacts (both positive and negative) on the health of these populations. For many of us, thinking of the negative consequences is much easier than thinking about the positive ones. However, knowing your strengths is just as important as knowing your weaknesses. If you do not know how your program will impact a population, what do you need to do to find out? *See pages 20-21 in the HEIA workbook.*

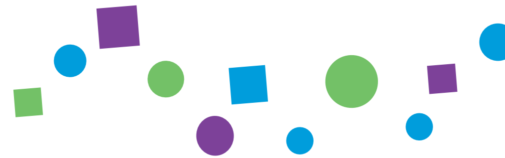
STEP 3 - MITIGATION: Once you have identified the different impacts your service or program may have on a population, the next step is to think how to minimize the negative effects and maximize the positive effects. In this step, keep in mind these four good reminders:

- **Think practical:** Try to find strategies that are feasible given your limitations.
- **Think timeline:** Not everything has to change at once. Try to focus on what needs to be done now versus what can be done later on.
- **Think deep:** How will the program address systemic barriers to equitable access to care?
- **Think ahead:** Will you be making recommendations to decision-makers? What will these recommendations look like?

See pages 22-23 in the HEIA workbook for more information.

STEP 4 - MONITORING: The next step is to determine whether your planned mitigation strategies have been effective. Some ways of using the HEIA tool to monitor results can be through client satisfaction surveys and collecting community engagement/outreach statistics. The HEIA is meant to produce a living document. You can record your results then go back and compare them to your original objectives. *See pages 24-25 in the HEIA workbook for more information.*

STEP 5 - DISSEMINATION: Once you have collected a set of data on your mitigation strategies and perhaps distilled "lessons learned" from your implementation experience, think about embedding this information in your organization's planning or operational processes. You can also share your findings and recommendations with other people in your network or field, in order to help them address health inequity in their own work. The Ministry of Health and Long-Term Care especially welcomes feedback from the organizations who have implemented this tool. *For more information, see pages 26-27 in the HEIA workbook.*



Conclusion

Many of you have already thought deeply about health inequity and have actively taken steps in your work to reduce barriers and mitigate harmful impacts on vulnerable populations. This tool, far from being redundant, can be a useful way to capture the work you are doing and amplify your efforts. Those in leadership positions, such as managers, directors and members of the board, can use the HEIA tool to help with planning and development of policies and protocols, ensuring that health equity is embedded in all stages of the organization. Frontline staff can also use the HEIA to capture evidence of a health inequity that they see in their everyday practice, such as gaps in service or barriers to access. With such information documented, staff can more effectively bring their concerns to management, and facilitate quicker mitigation strategies. Finally, we need to remember that the HEIA, like any other tool, has limitations. Simply completing this assessment does not mean we have effectively addressed health inequity or social injustice in our work. It is, however, a great first step in addressing health inequities.

Further Resources

Health Equity Impact Assessment (HEIA) Template and Workbook, Ministry of Health and Long-term Care
http://www.health.gov.on.ca/en/pro/programs/heia/tool.aspx

HEIA Resources, Health Nexus http://en.healthnexus.ca/topics-tools/health-equity-topics/heia

HEIA Resources, The Wellesley Institute
http://www.wellesleyinstitute.com/our-work/healthcare/healthequity/heath-equity-impact-assessment/

HEIA Online Course, Public Health Ontario https://www.publichealthontario.ca/en/LearningAndDevelopment/OnlineLearning/HealthPromotion/HEIA/Pages/default.aspx

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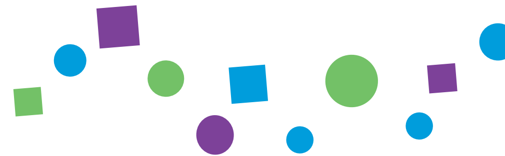

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HC Link works with community groups, organizations, and partnerships to build healthy, vibrant communities across Ontario. We offer consultations, learning and networking events, and resources in both English and French. Our services are funded by the Government of Ontario and are provided free of charge where possible.

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