Reducing Childhood Obesity in Ontario through a Health Equity Lens

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Introduction

Childhood obesity is increasing in Ontario and has significant health implications. Childhood obesity, defined by the World Health Organization as a body mass index greater than or equal to 30, can lead to a lifetime of poor health, negatively affects the broader well-being of individuals and communities, and, as a result, increases demands on the health care system.[1]

Not all children are affected equally by the burden of obesity and poor health. Children in families that do not have adequate resources are more likely to be obese and face a greater burden of ill health than children who grow up in families that are better off. Contributors to poor health include poverty, a lack of safe and affordable housing, inadequate access to good food, being socially marginalized, and faring poorly in a range of other determinants of health. While these determinants affect everybody, children are particularly negatively impacted.

This paper sets out strategies to reduce childhood obesity in Ontario and its associated health problems by taking a health equity and social determinants of health approach.

Childhood obesity and health

The burden of childhood obesity is significant. In 2004, 26 percent of Canadian children and adolescents aged 2-17 were overweight or obese.[2] This has been an increasing trend across Canada in recent decades: over the past 25 years the rate of young people aged 12-17 who are overweight doubled, while the obesity rate tripled.[3] Adolescent boys are more likely to be overweight or obese (34 percent) compared with girls (23 percent).[4] In 2005, Canada was the third most overweight or obese G-7 nation, trailing only the United States and the United Kingdom.[5]

Children who are obese during adolescence are more likely to have risk factors associated with cardiovascular disease, such as high blood pressure and cholesterol, and have higher rates of type 2 diabetes, stress, and asthma. These risks and health conditions continue into adulthood: obese adolescents are more likely to be obese as adults and face greater risks for heart disease, stroke, osteoarthritis, some cancers, and depression.[6] It is estimated that if the current childhood obesity rates persist, children will live three to four years less than today's adults due to obesity.[7]

Being overweight has significant social implications for children and young people. Research shows that obese youth are at greater relative risk of being bullied. Overweight and obese children are at higher risk of experiencing relational victimization (for example, spreading of rumours or withdrawal of friendship) and overt victimization (for example, teasing, name-calling, or physical abuse). Older youth who are obese are also more likely to perpetrate bullying[8] and obese boys are more likely to be bullied and be bullies than girls.[9] Obese children have lower levels of self-esteem by early adolescence, especially girls, and are more likely to smoke and drink alcohol than non-obese children.[10]

The risks of childhood obesity are not shared evenly across the population. In Canada, 24 percent of children growing up in the most well-off neighbourhoods are obese, compared with 35 percent of children in the poorest neighbourhoods. There is a clear gradient in which rates of overweight children decrease at each step up the

1 World Health Organization, *Obesity and Overweight*. http://www.who.int/mediacentre/factsheets/fs311/en/
2 Ontario Ministry of Health Promotion, *Child Health Guidance Document*, May 2010, p.23.
3 Ontario Ministry of Health Promotion, *Child Health Guidance Document*, pp.23-26.
4 Human Resources and Skills Development Canada, 'Health – Obesity', *Indicators of Well-Being in Canada*. http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=6#M_4
5 Human Resources and Skills Development Canada, 'Health – Obesity'
6 Ontario Ministry of Health Promotion, *Child Health Guidance Document*, pp. 20-21; Public Health Agency of Canada, Obesity in Canada: Snapshot, 2009, p. 5.
7 Ontario Ministry of Health Promotion, *Child Health Guidance Document*, p.22.
8 Ian Janssen, Wendy M. Craig, William F. Boyce, & William Pickett, 'Associations Between Overweight and Obesity With Bullying Behaviors in School-Aged Children', *Pediatrics*, Vol. 113, No. 5, May 2004.
9 L.J. Griffiths, D. Wolke, A.S. Page and J.P. Horwood, 'Obesity and bullying: different effects for boys and girls', *Archives of Disease in Childhood*, Vol. 91, 2005.
10 Richard S. Strauss, 'Childhood Obesity and Self-Esteem', *Pediatrics*, Vol. 105, No. 1, January 2000.

income ladder.[11] While obesity rates are high in all income groups, the increasing rates of obesity at the bottom end of the gradient demonstrate that faring poorly in the determinants of health have significant health impacts for children.

It is these structural contributions to obesity that we wish to address. We set out how addressing the social determinants of childhood obesity can improve the health of children in Ontario.

Pervasive health inequities are rooted in social determinants of health

There is a gradient of health in which people with lower income, who are unemployed or in precarious or low-paid work, or who face other forms of social inequality and exclusion have poorer health. This gradient of health means that the risk and burden of many chronic conditions and poor health is far higher for marginalized populations.

Health inequities – differences in health outcomes that are avoidable, unfair, and systematically related to social inequality and disadvantage – are rooted in structural features of our society and are beyond individuals' control. These inequities are not because of lifestyle, genetics or bad luck, but are rooted in structural features of contemporary Canadian society.

The foundations of these health inequities lie in the effects of poverty and income inequality, precarious work and unemployment, inadequate housing and homelessness, racism and other lines of social exclusion, inequitable access to social, health and other services and support, and other social determinants of health. These determinants interact and reinforce each other. Thus people who are at the disadvantaged end of the gradient of health are more likely to lack access to the services and supports that enable good health.

Chronic conditions that are connected to obesity, like diabetes, illustrate the kinds of barriers people face in maintaining good health. Research shows that obesity rates are lower in neighbourhoods that have good access to a range of shops that sell food that is nutritious and affordable.[12] It is well-known that to prevent and manage diabetes it is crucial to eat a healthy diet with plenty of fresh fruits and vegetables. However, poorer communities tend to have more fast food restaurants and fewer grocery stores where fresh foods can be purchased.[13] Moreover, lower incomes mean that community members may not be able to afford healthy foods or transportation to grocery stores. On top of this, poorer people tend to have worse primary health care access, which further compounds the impact of diabetes. This means that people who face higher risks and prevalence of diabetes also have less access to nutritious foods and other resources to manage their condition and maintain good health. Thus faring poorly in the social determinants of health is an ongoing – and compounding – challenge.

Inequities are worse for children

One of the greatest challenges in addressing health inequities is that children are particularly negatively impacted. Children who grow up in poorer families and in poorer neighbourhoods not only have poorer health as children, but these negative health outcomes continue throughout their lives.

Children are particularly sensitive to environmental factors associated with poverty. Inadequate housing is directly linked to higher morbidity and mortality, and children are particularly at risk. For example, children who live in homes that are damp or moldy have a greater risk of chronic conditions such as asthma, and these

11 Lisa N. Oliver & Michael V. Hayes, 'Neighbourhood socio-economic status and the prevalence of overweight Canadian children and youth', *Canadian Journal of Public Health,* Vol. 96, No. 6, pp. 415-420.

12 K.B Morland & K.R Evenson, 'Obesity prevalence and the local food environment', *Health and Place*. Vol. 15, No. 2, June 2009, 491-495.

13 Shiriki Kumanyika & Sonya Grier, 'Targeting Interventions for Ethnic Minorities and Low-Income Populations', *The Future of Children*, Vol. 16, No. 1, Spring 2006.

conditions can last a lifetime.[14] Children also suffer disproportionately when low income families are forced to pay unaffordable housing costs at the expense of other essential items like food or heating.[15]

Compounding this challenge is that children's needs vary with their circumstances. Even children in similarly disadvantaged situations require different types of support. For example, a child whose parents are recent immigrants and do not speak English or French requires different support than a child living in a single-parent household where the mother works two part-time jobs that do not offer health benefits.

Addressing childhood obesity by tackling social determinants

Childhood obesity does not occur because of a single factor – there is a complex chain of factors that lead to it.[16] Therefore, policy interventions are required at various stages along the chain to address its underlying causes. Living conditions and the options and opportunities that are available to people have significant impacts on obesity. Thus high levels of childhood obesity are an important indicator of underlying social and economic challenges.

We set out four areas that are informed by the evidence above on which the province should act in addressing childhood obesity: reducing childhood obesity through poverty reduction, focusing on early development, addressing neighbourhood factors, and enhancing coordination with a health promotion and whole-of-government focus.

Reducing childhood obesity through poverty reduction

Children who grow up in poverty are at higher risk of a lifetime of poor health. Poverty affects the ability of families to provide basic necessities such as healthy food, quality housing, child care, recreational opportunities, and early childhood education that contribute to positive child health. Research shows that even if children who grow up in poverty are able to move up the socioeconomic ladder during their adulthood they are more likely to experience physical and mental health problems that are influenced by their childhood, such as asthma, diabetes, and heart disease.[17]

The inability of families to afford sufficient healthy and nutritious food is a significant contributor to childhood obesity.[18] In Ontario, one in four people with low income report that they do not have enough to eat, are worried about there not being enough to eat, or do not eat the quality or variety of foods they require due to a lack of money.[19] Financial barriers are often exacerbated by the existence of food deserts in poorer neighbourhoods. The need to take transit – if transit connections exist – to access a grocery store can be a

14 Jonathan I Levy, LK Welker-Hood, Jane E Clougherty, Robin E Dodson, Suzanne Steinbach, & HP Hynes, 'Lung function, asthma symptoms, and quality of life for children in public housing in Boston: a case-series analysis', *Environmental Health: A Global Access Science Source*, Vol. 13, No. 3, 2004.

15 There is evidence that low income mothers in Canada may sacrifice their own nutritional intake in order to ensure that their children are able to eat. See Kim D. Raine, *Overweight and Obese in Canada: A Population Health Perspective, Canada Institute for Health Information*, 2004, p. 34.

16 See Raine, *Overweight and Obese in Canada*, for a comprehensive assessment of the individual/behavioural, environmental, and social determinants of obesity.

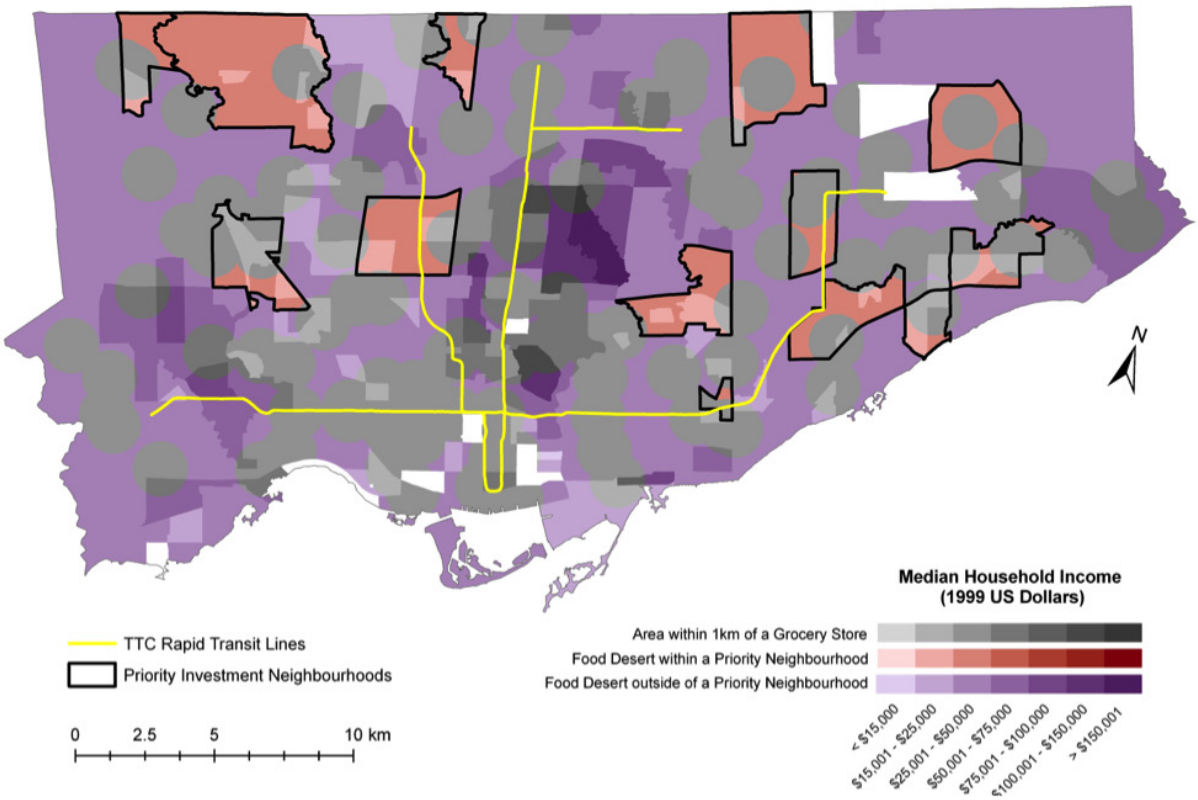
17 Ontario Ministry of Health Promotion, *Child Health Guidance Document*, p. 21; Katherine Magnuson & Elizabeth Votruba-Drzal, 'Early Influences of Childhood Poverty', Focus, Vol. 26, No. 2, Fall 2009, p. 34.

18 Morland & Evenson, 'Obesity prevalence and the local food environment'.

19 A.S. Bierman, A. Johns, B. Hyndman, C. Mitchell, N. Degani, A.R. Shack, M.I. Creatore, A.K. Lofters, M.L. Urquia, F. Ahmad, N. Khanlou & V. Parlette, 'Social Determinants of Health and Populations at Risk', in A.S. Bierman (editor), P*roject for an Ontario Women's Health Evidence-Based Report: Volume 2*: Toronto, 2012, p. 5.

major barrier to accessing healthy food for people with low income. Food banks, upon which some of the poorest families rely, tend to offer foods of sub-optimal nutritional quality.[20]

In Toronto, many of the poorest neighbourhoods have the worst access to sources of healthy and nutritious foods, as demonstrated by the map below.



Source: Martin Prosperity Institute, http://www.martinprosperity.org/media/images/Toronto_Updated.jpg

In Ontario, family poverty is an increasing concern. In 2009, the child poverty rate in Ontario was 14.6 percent. In the same year one-third of children growing up in lone-parent families and one-third of racialized children lived in poverty.[21]

Social assistance rates are set so low that children growing up in households that depend on social assistance live in poverty and are amongst the poorest people in Ontario. While social assistance provides some health benefits, these are modest and few supports are available to address the causes of poor health, like a lack of access to affordable food that is healthy and nutritious.

Being in the workforce does not guarantee that families can avoid living in poverty. In 2009, 35.8 percent of children living in poverty had at least one parent who worked the equivalent of a full-time, full year job.[22] Entry-level and minimum wage jobs do not provide sufficient income to ensure good health for families and usually do not include health benefits. Thus many low income families cycle between periods in employment and periods on social assistance. This uncertainty can damage health. People who are exposed to stress for prolonged periods

20 Raine, *Overweight and Obese in Canada: A Population Health Perspective*, p. 34.

21 Ontario Campaign 2000, *Campaign 2000 Report Card of Child and Family Poverty in Ontario 2011*, 2011, pp. 2-4. http://www.campaign2000.ca/Ontario/reportcards/2011Ont.%20Report%20Card_Feb2012.pdf.

22 Ontario Campaign 2000, *Campaign 2000 Report Card of Child and Family Poverty in Ontario 2011*, p. 4.

– including the stress of growing up in poverty – are at greater risk of obesity and other health-compromising conditions.[23]

In addition to facing increased risk of poor health, people with low incomes can also be less likely to participate in health promotion programs. Research shows that these programs are more likely to be utilized by people with middle and upper level incomes and people with low income who are healthy. This means that people who could benefit the most from health promotion efforts – low income individuals and families who have poor health – are often not reached by these programs.[24] This highlights the need to target programs to populations that have the greatest needs and to address the specific barriers to participation that they face.

Based on this evidence and the growing trends in childhood obesity in Ontario, we present the first of our five key recommendations to the Healthy Kids Panel.

Recommendation 1

The Healthy Kids Panel should recommend that the provincial government build on its commitments in Ontario's Poverty Reduction Strategy in its legislated five-year review that will be completed in 2013. This should include ensuring that:

a) Children growing up in families on social assistance have adequate income and other essential supports, such allowances for healthy food, transportation, and child care, that enable good health.

b) Minimum wages and minimum employment standards are raised to levels that support good health for families and children. Options for expanding health benefits to all low income Ontarians should be considered.

Focus on early development

It is important to children's health that they get a good start in life. Children who have a good start in life do better at school, get better paid jobs, and have better physical and mental health in adulthood. According to the World Health Organization, a good start is characterized by:

- Having a mother who:
    - Was in a position to make reproductive health choices;
    - Is healthy during pregnancy;
    - Gives birth to a baby of healthy weight.
- The baby:
    - Experiences warm and responsive relationships in infancy;
    - Has access to high-quality child care and early education;
    - Lives in a stimulating environment that allows safe access to outdoor play.[25]

Providing high-quality prenatal and early childhood services can help to compensate for the effects of social and economic disadvantage on early childhood development.[26] This means ensuring that pregnant women and young children have access to essential supports like safe housing, nutritious food, clean air, affordable child care, accessible and affordable recreation services, and access to high quality health care.

23 Bierman et al, 'Social Determinants of Health and Populations at Risk', p. 30.

24 Ray Pawson & Sanjeev Sridharan, 'Theory-driven evaluation of public health programmes', in Amanda Killoran & Michael P. Kelly (eds.), *Evidence-Based Public Health: Effectiveness and Efficiency* (New York: Oxford University Press, 2010), pp. 43-62.

25 World Health Organization Regional Office for Europe, *Health 2020: Policy and Research Strategy*, p.42. http://www.euro.who.int/__data/assets/pdf_file/0020/170093/RC62wd08-Eng.pdf.

26 World Health Organization Regional Office for Europe, *Health 2020: Policy and Research Strategy*, p.42.

Recommendation 2

Establish a basket of supports that facilitate healthy early childhood development. The basket should include:

c) Prenatal supports, such as affordable folic acid and vitamin D supplements, appropriate subsidies to allow good nutrition and access to physical recreation, and connections to primary care providers.

d) Early childhood supports, such as breastfeeding support, healthy food allowances, subsidized child care, housing supports, and regular well-child visits.

Address neighbourhood factors

The built environment is comprised of numerous elements that affect our health, both individually and collectively. The built environment:

> "includes our homes, schools, workplaces, parks/recreation areas business areas and roads. It extends overhead in the form of electric transmission lines, underground in the form of waste disposal sites and subway trains, and across the country in the form of highways. The built environment encompasses all buildings, spaces and products that are created or modified by people. It impacts indoor and outdoor physical environments (e.g. climatic conditions and indoor/outdoor air quality), as well as social environments (e.g. civic participation, community capacity and investment) and subsequently our health and quality of life."[27]

How neighbourhoods are designed have direct impacts on childhood obesity. The presence of amenities such as parks, recreational centres, and places at which healthy food can be purchased reduces the risk of children being obese and developing diabetes.[28] Research shows that children tend to be less physically active in newer neighbourhoods that are designed primarily for vehicles and often lack sidewalks, thereby reducing walkability. These neighbourhoods also tend to lack safe outdoor spaces for children to play.[29]

The existence of and access to health-promoting aspects of the built environment tend to reflect neighbourhood income. Neighbourhoods with higher socioeconomic status tend to have more features that encourage physical activity than poorer neighbourhoods.[30] Barriers such as user fees at recreation centres can also reduce access to physical activity for children from poorer families; lower income families in Canada are less likely to participate in recreational sports.[31]

27 Shobha Srinivasan, Liam R. O'Fallon & Allen Dearry, 'Creating Healthy Communities, Healthy Homes, Healthy People: Initiating a Research Agenda on the Built Environment and Public Health', *American Journal of Public Health*, Vol. 93, No. 9, September 2003, p. 1446.

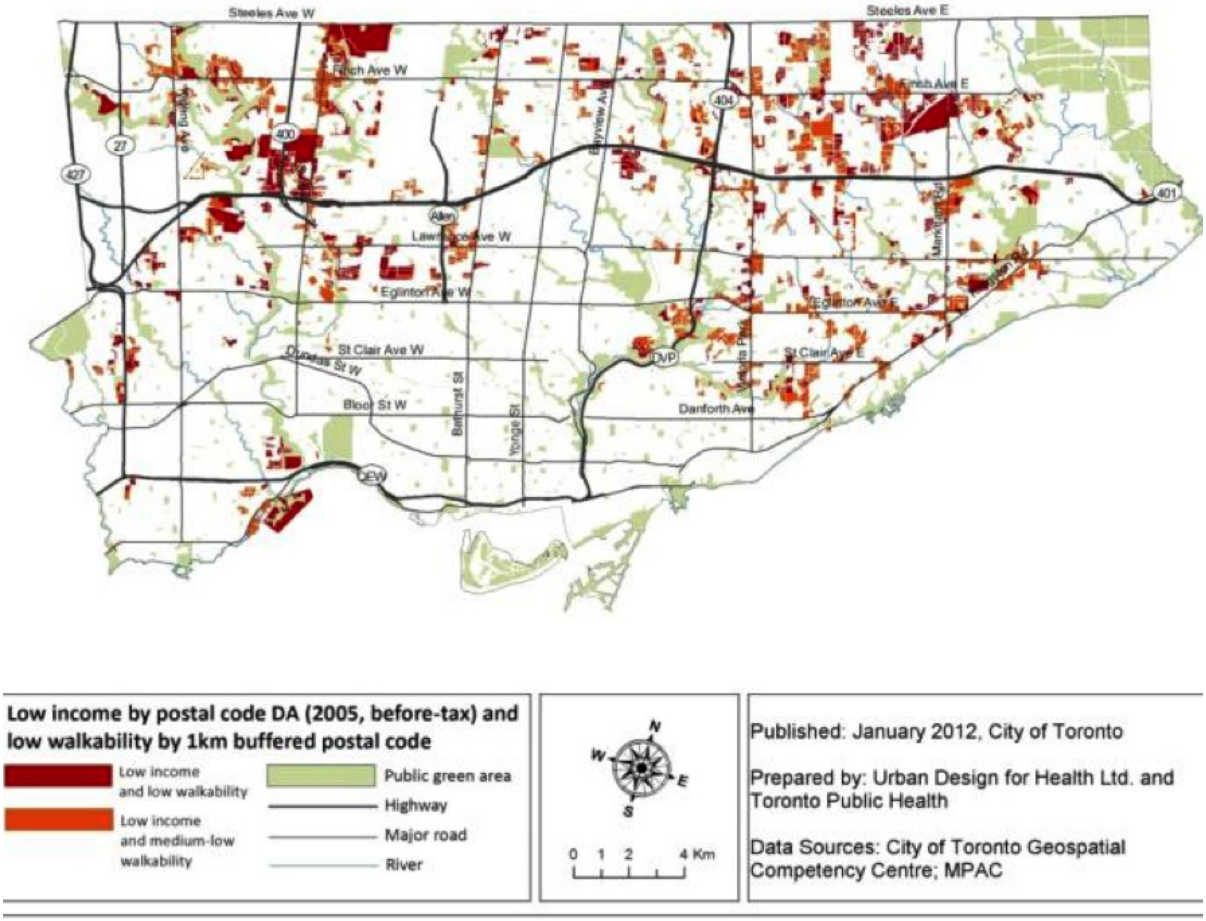
28 Bierman et al, 'Social Determinants of Health and Populations at Risk', p. 29.

29 Bierman et al, 'Social Determinants of Health and Populations at Risk', p. 29.

30 Raine, Overweight and Obese in Canada: A Population Health Perspective, pp. 35-36.

31 Raine, Overweight and Obese in Canada: A Population Health Perspective, p. 35.

In Toronto, the areas of the city in which people with low income disproportionately live are typically less walkable than other areas of the city, as shown by the map below.



Source: Toronto Public Health, *The Walkable City: Neighbourhood Design and Preferences, Travel Choices and Health*, April 2012.

In addressing childhood obesity, it is important to address elements of the built environment that hinder good health and to enhance health promoting aspects.

Recommendation 3

Ontario should support municipalities to incorporate health as a foundation of their planning activities. This should include support for working with communities to create land development, urban planning, and transportation plans that promote good health. These plans should encourage physical activity and walkability by incorporating green spaces, community recreation centres, and sidewalks. Inequitable access barriers, such as user fees, must also be addressed. Further, the province must ensure that it provides adequate financial support for these activities.

Enhance coordination

Childhood obesity is a complex problem for which there is no one solution. Obesity should be addressed as part of well-coordinated and integrated chronic disease prevention programs and governments must align policies across ministries and jurisdictions.[32]

Health Promotion

Health promotion strategies are a critical method to enable good health and to delay or prevent illness. Emphasizing health promotion is particularly important for vulnerable populations, like children, but also for populations that experience greater risks of poor health, such as those with low income. Conditions like obesity and other chronic conditions such as asthma, hypertension, diabetes, and depression are particularly sensitive to social circumstances. Poorer people are at greater risk, yet also tend to have less access to health promotion services.

Health promotion ranges from ensuring all populations have understandable information on risks and enablers of health, through access to exercise and recreational activities, to, most fundamentally, adequate living conditions.

Children and young people should have equitable access to health promoting activities and support. This may include subsidizing user fees and removing other barriers that may prevent children from families with low income or who face other barriers from being able to participate in health-promoting activities. This highlights the need to connect efforts to reduce childhood obesity to other spheres; for example, ensuring there are adequate parks and activity opportunities in poorer neighbourhoods, and working with healthy community partnerships to ensure the needs of the poorest and most marginalized are met.

There are already examples of community-led health promotion initiatives in Ontario that could be expanded and replicated, including HC Link, which is supported by the Ministry of Health and Long-Term Care. HC Link members work with a range of community organizations and resource centres to build on existing capacities and resources to improve the health of communities. This allows communities to create or adapt health promotion programs to address specific community needs.[33]

Setting clear goals and implementing measurement and evaluation are important to making progress in addressing childhood obesity. To promote health and manage childhood obesity, objectives could be to:

- Increase the proportion of children from populations that are at high risk of obesity or related chronic conditions who participate in health promotion programs
- Decrease the differential for participation in health promotion programs and appropriate screening between children from high risk populations and other children.

Recommendation 4

Improve access to primary care and health promotion services for children and their families that are at high risk of obesity or related chronic conditions.

Establish concrete targets and a comprehensive monitoring system to track and report on health outcomes of children who are at high risk of obesity or related chronic conditions.

Policy Alignment across Government

There is growing understanding that complex social and economic problems require integrated and comprehensive policy solutions. This means getting beyond the current disjointed structure of Ministries,

32 This section has been adapted from Bob Gardner, Steve Barnes and the Social Assistance Review Health Working Group, *Towards a Social Assistance System that Enables Health and Health Equity: Submission to the Commission for the Review of Social Assistance in Ontario*, Wellesley Institute, 2011.

33 See the Ontario Healthy Communities Coalition for more information. http://www.ohcc-ccso.ca/en/hc-link.

agencies and programs, and the rigid jurisdictional boundaries between different levels of government.[34] In Canada, poverty reduction strategies from several provinces emphasize coordinated planning across departments and levels of government, concentrated investments in disadvantaged neighbourhoods or regions, and cross-sectoral collaborations of government, business and community organizations. Comprehensive strategies to reduce health inequities from other leading countries are also based on cross-sectoral collaboration across government and with community organizations.

In addressing complex challenges, like childhood obesity, it is important to understand how policy decisions interact with one another; uncoordinated policies can have negative impacts on vulnerable populations.[35] The World Health Organization notes that the effects of interventions are typically small if they are too narrowly focused on individuals or single determinants of health. Combined approaches that address multiple determinants are more effective and efficient.[36]

Many policy areas intersect with childhood obesity: education, food security, transportation, housing, land-use planning, and others. These policy domains have significant impacts on children's health.[37] Addressing childhood obesity cannot be pursued in isolation; it must be considered within the context of other changes in public policy that are needed to reduce health inequities, poverty, and inequality. Integrated policy development is crucial to addressing complex social problems such as childhood obesity and reducing systemic health inequities – and seeing how they are inter-connected.

A policy tool that is recommended by international agencies and is being developed in a number of jurisdictions, including within Canada, to drive more integrated and aligned policy is Health in All Policies. The idea is that all policy development should consider possible health impacts and implications.[38] A recent Senate Sub-committee report on population health emphasized the need for integrated policy approaches to address the determinants of health.[39]

There have been exploratory efforts within Ontario to develop a Health in All Policies framework in recent years: a major cross-Ministry research and policy project was completed on how to address health equity and the social determinants of health in an integrated way across the provincial government, and a Health in All Policies model has been developed within Ministry of Health and Long-Term Care.

The intersecting policy areas that affect childhood obesity make it an ideal demonstration of how a Health in All Policies approach could work in Ontario. Children's health is a key lever to improving population health more generally, and setting out clear pathways for all government ministries to reduce childhood obesity and to improve children's health would have benefits for society as a whole.

Recommendation 5

The Healthy Kids Panel should recommend that childhood obesity be selected as a demonstration of how a Health in All Policies framework could work in Ontario in partnership with other levels of government. The demonstration project should develop systematic approaches to improving children's health through action on the social determinants of health.

34 World Health Organization, *Population-Based Prevention Strategies for Childhood Obesity*, 2009. http://www.who.int/dietphysicalactivity/childhood/child-obesity-eng.pdf.

35 For an analysis of population health approaches that prioritize creating policy coherence and collective efficacy to address youth obesity, see Kathryn M. Clinton, 'Preventing Youth Overweight and Obesity: A Population Health Perspective', *Transdisciplinary Studies in Population Health Series*, Vol. 1, No. 1, pp. 7-21.

36 World Health Organization, *Population-Based Prevention Strategies for Childhood Obesity*, p. 12.

37 The World Health Organization sets out the connections between childhood obesity and urban planning, education, sport, transport, food supply and standards, commerce, agriculture, trade, and finance. World Health Organization, *Population-Based Prevention Strategies for Childhood Obesity*.

38 In Quebec, any legislation or regulation with possible health implications must be reviewed with the Ministry of Health and signed off by the Minister.

39 The Standing Senate Committee on Social Affairs, Science and Technology, *A Healthy, Productive Canada: A Determinant of Health Approach: Final Report of The Subcommittee on Population Health*, June 2009. http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/rephealth1jun09-e.pdf

Conclusions

The causes of childhood obesity and its attendant impacts on health are complex and can only be fully addressed through a range of coordinated responses at the government, community, and family levels. It is imperative that children are not saddled with a lifetime of poor health owing to inequities that can, and must, be addressed. The Healthy Kids Panel must be innovative and look for new solutions that transcend the view that childhood obesity is a problem for the health care system.

The burden of childhood obesity is not evenly distributed across the population and this has differential and inequitable health impacts. Children are amongst the most vulnerable people in our society and they are particularly impacted by the conditions in which they grow up. It is therefore important to consider children's health and health equity when making policy decisions and to account for the different needs of different communities.

One tool that assists in doing so is the Health Equity Impact Assessment (HEIA). This tool analyzes a program or policy's potential impact on health disparities and/or on health disadvantaged populations. If there could be a health impact, HEIA helps policy-makers to make changes to the planned policy to mitigate adverse effects on the most vulnerable and to enhance equity objectives. The HEIA tool assists in setting targets and measurements to determine the policy's success.[40]

The Healthy Kids Panel should conduct a HEIA of its recommendations to determine whether they could have an inequitable impact on some groups, and, if so, what actions should be taken to mitigate these inequities. The Wellesley Institute has experience providing workshops and other resources for HEIAs, and we are happy to assist the Panel in this task.

The Healthy Kids Panel must set out a clear strategy to reduce childhood obesity in Ontario and addressing social determinants of health and health inequities must be the key driver. Whether the inequitable health outcomes that many children face are reduced will be the ultimate test of the Panel's success.

40 See Rebecca Haber, *Health Equity Impact Assessment: A Primer*, (Toronto: The Wellesley Institute, 2010) for a summary of HEIA. The Wellesley Institute has a range of Health Equity Impact Assessment tools and resources, which are available at http://www.wellesley-institute.com/policy-fields/healthcare-reform/roadmap-for-health-equity/heath-equity-impact-assessment/. The Ontario government has developed a HEIA tool: http://www.health.gov.on.ca/en/pro/programs/heia/.