

TOOLS

Towards a Health Inequalities Audit Process

Process and learning



EQUITYACTION

TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •



This work is part of EQUITY ACTION which has received funding from the European Union, in the framework of the Health Programme. The sole responsibility for this work lies with the author



TOWARDS A HEALTH INEQUALITIES AUDIT PROCESS – LEARNING AND REFLECTIONS

About this document

This document arises from the work done as part of Equity Action. It draws on work with the European Commission to carry out two Health Inequalities Audits, and:

1. Identifies why and when to use a Health Inequalities Audit
2. Describes the process of conducting the primary and secondary screening and the subsequent scoping and review work
3. Identifies learning from the process
4. Presents the Health Inequalities Audit screening tool
- 5.

Definition of HI Audit

Health Inequalities Audit is defined here as:

‘A combination of procedures, methods and tools by which a policy and its implementation may be judged as to its effects on the health of a population, and the distribution of those effects within the population’;

with **health inequalities** taken to mean:

‘Differences in health, either between parts of the EU, or between social groups within the EU, which may be amenable to policy intervention’.

What is the process of a HI Audit?

HI Audit involves the following five steps:

1. Screening (to ascertain if it is appropriate for an HEA to be undertaken on a specific policy area)
2. Scoping (to agree the key issues to be considered)
3. Appraisal (to assess the current equity impact of the policy and its implementation)
4. Recommendations (for how the policy and its implementation could be altered to improve health equity)
5. Monitoring and evaluation (to assess the impact of the HEA process on the policy and health equity)

Why use a Health Inequalities Audit

A Health Inequalities Audit is a useful process that can be used by professionals with a good grasp of the health inequalities agenda and of public health. It can be used to facilitate a discussion on policies and programmes both within and outside the health sector, by those with an interest in promoting action on health inequalities across populations. It helps give an entry point!



It is a non-legislative process which is used in agreement with other policy areas to assist in reviewing the impacts of policies and their implementation on health impacts and their distribution. Equity Action undertook Health Inequalities Audits on two policy areas, air quality and nutrition and obesity, although the initial process identified 5 potential areas: Air quality, child poverty, nutrition, Patient rights – cross border health care, and tobacco control - which were then screened to identify the final two.

We pre-screened five policy areas by a desk review of policies, evidence, and the potential impact of the policy on health inequalities, and then undertook a further screening of the remaining three policy areas by face-to-face dialogue with both the EC health inequalities leads, and the air quality, nutrition and tobacco policy leads.

While it is helpful to use the skills associated with health impact assessment, it is within the competency of public health professionals to manage the process at least up the scoping phase. Beyond that phase we found it useful to have specialist research commissioned on air-quality by geographic area, and on health inequalities in relation to several areas relevant to EU nutrition and obesity.

We were invited by the European Commission to explore which policies would be best suited to a fuller audit. We tested against:

1. Evidence: What evidence is there that this topic area is relevant to health inequalities and the social determinants of health?
2. Impact: What will conducting a Health Inequalities Audit achieve?
3. Practical Implications: Given the time and resource constraints within both the Commission and Equity Action which topic area might lend itself best to a Health Inequalities Audit.

Most importantly we found that having a process to engage with policy makers gave a valuable entry point to discuss health inequalities in a structured fashion. The skills needed were as much about negotiating , seeking common understanding and developing relationships as about research and analysis.

An Health Inequalities Audit assumes a willingness of both parties to at least start a process of exploring the inequalities dimension and how it might impact on the policy under review, and how the policy might impact on health inequalities.

When to use Health Inequalities Audit

Health inequalities audits can be used to take stock of the impact of current policies and their implementation, in relation to their potential impact on the distribution of health outcomes across the population. It can be used where a more formal Health Impact Assessment is not possible, for example because the policy has already been agreed and is being implemented, or because a more formal Health Impact Assessment is seen as being over bureaucratic, and requiring a more formal mandate and response. It is a soft mechanism that operates by negotiation and not by obligation. The Health Inequalities audit follows the



basic methodology of the health impact assessment, however it is more concerned with identifying with the policy makers areas where a more thorough review might be useful.

We found it helpful to frame the work as a process we were undertaking with a range of policies and that we were testing out the methodologies. This made the process more engaging and less ‘threatening’.

What can a Health Inequalities Audit do?

HI Audit can be used to add value to existing work by facilitating the development of better, more equitable policy, highlighting the ways in which policy outcomes impact on the distribution of health within society, whether intentionally or unintentionally. This in turn should enable policy to be revised, in order to maximise positive and minimise negative health impacts on vulnerable groups, and consider measures which will mitigate negative health impacts, thereby achieving a more equitable distribution of health within the population.

THE HEALTH INEQUALITIES AUDIT PROCESS

The preliminary screening process.

In our case we considered the likely candidate policy areas which the EC had responsibility for, and where we initially thought it would be useful to do some more research on potential impact of the policies and their implementation on the distribution of health outcomes, the available evidence, and the opportunities to influence the policy or its implementation. We then undertook an initial scoping based on the documentation publicly available, supplemented by discussion with experts in the policy area.

Preliminary screening of potential topics was conducted in Summer 2012. Five policy areas – access to healthcare; air quality; child poverty; nutrition, physical activity and obesity; and tobacco – were put forward by the Commission as being potential topics for an HEA. Desk-based research was then conducted, reviewing each potential topic against the criteria of relevance to health inequalities; potential impact of conducting an HEA; and practical considerations for conducting an HEA. The desk-based screening process including reviewing relevant policy documents and the evidence base for impact on health inequalities, in relation to each potential topic area. Of the five policy areas initially screened, three – air quality; nutrition, physical activity and obesity; and tobacco – were deemed to be potentially suitable for HEA.

Following the preliminary screening process, it was decided that more in-depth screening of the three short-listed policy topics was required. This involved the development of a screening tool, which was used to guide face-to-face discussion with the EU policy leads for each of the three potential policy topics.

Secondary screening process

The secondary screening process involved face to face discussions with policy leads. It was found that even where we chose not to pursue further audit work (tobacco control) that the



process itself of screening was useful as it helped to build understanding of the health inequalities agenda with the policy area, and helped to high-light particular areas for the policy makers to consider in future policy and implementation. The screening process itself should therefore be considered as useful in its own right for advancing work on health inequalities.

The most important aspects of the secondary screening were that this enable a negotiated discussion with the policy leads to identify areas where further analysis would be useful to inform future policy or implementation.

The key learning was:

1. It is essential to prepare as much as possible by developing an understanding of the policy and how it is implemented.
2. The credibility of the people involved in the process to the policy lead is crucially important
3. It is helpful to have a structured set of questions and also be ready to be led by the discussions (see HIA screening tool below)
4. Identifying a preliminary list of potential areas for further review is particularly helpful.

Scoping

The scoping phase aims to break down the policy and its implementation into smaller sub-sections, so for example within nutrition policy we considered among other areas the role of the European platform for action on diet, physical activity and health and the extent to which commitments had a health equity focus, and the extent to which health inequalities were included in diet and nutrition strategies at member state level and visa versa. Scoping also aims to unpack the particular inequalities dimensions which merit further analysis such as between country inequalities, to regions as defined by the EC (NUTs 2 and 3), to socio-economic status, to excluded group.

The aim is then to clarify any questions to be answered by the audit and how the assessment will be carried out. So, we for example, developed an analysis to explore whether there is a correlation between poor air quality and deprivation, and what thresholds and definitions might one use to explore those?

In summary one is aiming to:

1. Identify dimensions of the policy and its implementation which may have an impact on the inequitable distribution of health outcomes
2. Identify data and information sources for exploring the differential impacts
3. Identify possible deliverables as a result of the scoping
4. Assess the timescale and cost of the various options proposed for review.
5. Agree with policy makers which are the most beneficial to pursue

We used public health specialists to carry out the initial screening, however we found that it was helpful to have topic specialists to be able to further develop the scoping of the work and deliver the studies. There are several reasons for this:

1. It is easier to identify potential areas of work and assess their scope and costs



2. Expert knowledge in the policy area allows a more rapid understanding and development of trust in the discussion
3. Information and data sources are known in more detail and can be assessed more readily can be readily assessed
4. Creative opportunities for exploring inequalities dimensions are more readily identified again because of greater knowledge of what is possible.

Appraisal

The appraisal stage is really the delivery of the work identified in the scoping stage. Typically this might:

1. Carry out a data analysis on the relevant areas identified in the appraisal, and seek to quantify health impacts and their distribution.
2. Identify if there is a socio-economic patterning to health which may be caused by the policy area under review.
3. Identify if the policy itself and its implementation has improved or worsened health inequalities, and the current direction of travel.
4. Consider the scale of the policies impact on health inequalities and the degree of certainty to which the impacts can be ascribed to the policy and its implementation.

Recommendations

Once the appraisal has been carried out, it is useful to have a face-to-face meeting to further flesh out the findings and test them with the policy makers. The anticipation is that the results are presented in a neutral fashion 'what does the evidence say'. The results and their interpretation are likely to be rigorously tested by the policy makers, and in particular it is likely that they will push for an assessment of the certainty with which a claim is made.

Our learning was:

- The credibility of the research and the presenter is paramount
- The interface between 'research' and policy is tricky. Policy makers are keen to know as precisely as possible the implications of the research for policymaking.
- Using statistical means to indicate the degree of certainty attached to a statement or correlation is helpful.
- Further studies may well be called for to help test hypothesis of correlations between health inequalities and the policy area.
- Building a rapport so that findings are more easily received is crucial in the meeting, and it is better to 'show' than to 'tell' as far as possible – so that decisions can be derived by the policy lead.

The meeting should aim In consultation with topic experts and policy makers make recommendations for i) current implementation and enforcement, ii)future policy identifying



how good health consequences could be enhanced and bad health consequences avoided or minimised and how health inequities can be reduced, while not worsening the overall health outcomes of the policy.

Monitoring and Evaluation

Health Inequalities Audits are relatively new area of work for health inequalities, though using a fairly standard set of public health skills. It is therefore particularly useful to reflect on and draw lessons from the work, and evaluate the quality of the audit process highlighting lessons for future Health Inequalities Audits.

As with Health Impact Assessment the key question is ultimately to what extent the recommendations were taken up, what helped them to be taken up, and is there any evidence that the recommendations have made an impact on health inequalities.

While in this paper we have reflected on some of the learning, we will not be in a position to consider the longer term impact as the Equity Action project is currently completing, and funds cannot be spent outside the contract period. However we found this to be a very interesting 'soft' approach to enabling health inequalities to be considered across a range of policies, and to facilitate dialogue and discussion.



Health Inequalities Audit Screening Tool

How to use this tool

This screening tool is intended to help practitioners identify areas of policy where conducting a Health Inequalities Audit (HEA) may be beneficial, and to enable prioritisation of policy areas, if it is identified that there are several areas which may benefit from an HI Audit, but insufficient resources to allow HEAs to be conducted in all areas. It also helps identify whether a Health Inequalities Audit can plausibly be carried out.

Depending on the number of policy areas being considered for a HI Audit, a preliminary round of desk-based screening may need to be conducted, in order to identify a small number of policy areas where a face-to-face discussion can be had between HEA practitioners and policy leads.

The tool should be used as a discussion guide during a face-to-face discussion with policy leads. It is helpful to share the tool in advance of the meeting, so that policy leads have an understanding of HI Audit, and the topics that will be discussed during the screening meeting.

It should be emphasised that the tool is a discussion guide, and is not prescriptive, nor should it prevent additional issues being raised during the discussion.

Practitioners should prepare for the screening meetings with policy leads by familiarising themselves with the key policy document; policy renewal timeline; equity issues relating to the policy area; and available data and evidence base on inequalities related to the policy area.

Following the screening discussion, practitioners should write up their notes from the meeting and share these with the policy leads to check for accuracy. A report should then be produced outlining the practitioners' recommendations as a result of the screening process.

The tool

There are a wide range of social groups for which inequalities can be explored, however we recognise that the primary focus is likely to be on health inequities between groups living in different regions, groups with different socio-economic status, and vulnerable or excluded groups, for example people with mental health problems; people with disabilities; Roma communities; undocumented migrants etc.

Screening questions

These questions will serve as a guide to a face-to-face screening discussion, however they are not prescriptive and do not preclude additional issues being raised. The three broad areas that we want to explore are listed below. We have also composed a list of more detailed questions that you may wish to consider, in the boxes below.



1. Intended effects of the policy on health inequalities
2. Implementation of the policy and potential impact on health inequalities
3. Availability of evidence on differential health impacts of the policy and its implementation
4. Availability of opportunities to influence policy and implementation , and level of interest in / concern about health equity within your policy area

Intended effects of the policy on health inequalities

- Does the policy make explicit reference to the need to address health inequalities, and if so, which social groups does it refer to?
- If not, does the policy document contain other explicit aims relating to reducing inequalities – or increasing equality?
- If not does the policy contain implicit aims or objectives which relate to reducing inequalities?
- Were health inequalities, or related issues, a concern in the drafting of the policy? For example is there mention of health inequalities in the impact assessment or results of the consultation?

Implementation of the policy

- Please comment on progress in relation to implementing any explicit objectives of the policy that relate to health inequalities identified above.
- How is progress being measured?
- Please comment on progress in relation to any implicit objectives of the policy that relate to health inequalities identified above.
- To what extent have additional aspects related to health inequalities, or related issues been an issue which has arisen in the implementation of the policy? Which were not foreseen in the original policy document? Please give examples
- To what extent is addressing health inequalities aspects of this policy a priority for the team responsible for the policy?
- Are you aware of any external stakeholders who are concerned about health inequalities in relation to this policy area? How has their interest been expressed? What has been the response of the Commission? Please give examples.



Availability of evidence of Impact of the policy on health inequalities

- Have any studies, evaluations or background work been carried out since the policy was agreed, which provide information on impact of the policy on health inequalities – directly or indirectly?
- Has any other information arisen during the implementation of the policy regarding possible concerns about some areas of the EU or some population groups being more affected (positively or negatively) by impacts from the policy area?
- Is there any information or data that you are aware of that could be used to carry out additional work on the impacts of the policy in relation to health inequalities? Please give details and preliminary suggestions of the kind of analysis that might be helpful.

Opportunities to influence policy and implementation, and interest in participating in HIA

- Is there interest in undertaking a HI Audit, and if so on which aspect of the policy?
- Is there a timely review of policy or other opportunity, which recommendations from an HI Audit could feed into?
- Do you think the equity issue is largely about the formulation of the policy at EU level, or the implementation at either EU or member state level?
- Are there resources and capacity to put potential recommendations from an HI Audit into action?
- Where do you think recommendations could make the most impact (EU, member state, or regional level?)

Key points:

1. Initial screening can be conducted based on a broad understanding of the policy areas under review. These help to brief the policy team
2. The screening process is useful in itself, giving an entry point for discussions with policy colleagues on the impact of their policy on health inequalities. It helps to make explicit the potential intended and unintended consequences both in the development of the policy and in its implementation and/or enforcement.



3. It is useful to separate out the technical discussions from the political discussions. The screening exercise is best conducted by a health inequalities audit expert rather than in either policy area, and will therefore need to work closely with subject experts from the respective policy areas. They should be seen as impartial by both policy teams.
4. The first stage of the process is to identify the potential to impact on health inequalities, and the availability of studies or data which can be used to identify potential differential impacts. The need for studies and data to help quantify health inequalities impact may be a key recommendation arising from the screening
5. The political process is a negotiation between the policy teams over the plausibility, desirability, and the resources to undertake specific reviews in the light of the screening.
6. Further scoping work will need to be conducted within the chosen policy area(s), to identify a focus that is of interest to the policy teams, and for which there is sufficient evidence and data available to make a Health Inequalities Audit feasible.
7. The Health Inequalities Audit(s) will need to be conducted in line with the policy cycle timings for the chosen policy area(s), to ensure findings and recommendations from the HI Audit(s) feed in at a time when they will be able to affect future policy decisions.
8. Consideration must be given to the limited capacity within many policy teams, to ensure the Health Inequalities Audit process does not create excessive additional workload, and that the Health Inequalities Audit adds to rather than duplicates work that is already being carried out within the policy area.
9. The learning from the screening process at EU level included the value of the screening team having a basic understanding of the policy documents and key equity issues within each policy area; the value of using a standard but flexible screening tool to guide the screening discussions; and the fact that the discussion in itself could offer policy leads an opportunity to reflect on how health inequalities are being addressed within their policy area, even if that policy area was not selected for an HEA.