Health Impact Assessment:

Pre meeting questionnaire summary Report

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Equity Action – Joint Action on Health Inequalities Agreement No 2010 22 03

Contents

Introduction 3
Methods 3
Results: General overview 3
Level of development of HIA, ... 3
Experts in the country 3
Networks 5
About the organisation and HIA 6
Extent of knowledge 6
Current guidance used 6
Support available 6
HIA Framework 7
Definition of HIA and equity 7
Example of a framework that assesses equity 8
How is equity currently being considered 9
Sources of data 9
Where do they find evidence of different impacts 10
Quality standards used by MS 11
Undertaking and implementing recommendations of HIA 11
Who are the leads in the country going to a undertake HIA 11
What policy area/theme are you considering for the HIA 13
How will you identify mechanisms to help HIA 14
Supporting other partners and twining 14
Mechanisms for adopting Health in All Polices approach 14
Further comments 14
Discussion 16
Next steps 17
Contact details for leads in WP4. 18
Appendix 1. EU Joint Action: Pre 7-8th April meeting questionnaire on Health Impact Assessment 19
Appendix 2. Suggested HIA frameworks 23

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Introduction

This summary report brings together responses from Member States (MS) and partners that are part of the Joint Action (JA) to present a picture of the use and impact of Health Impact Assessment (HIA) process within the countries. The summary report provides an overview of where different MS are with the HIA method, information on different expertise and resources available to MS in relation to HIA and the consideration of equity in the HIA process.

Methods

MS part of the Equity Action programme were asked to complete a questionnaire (appendix 1) before the Kick-off Equity Action meeting in April 2011. The report summarises the responses received from MS.

Results: General overview

This first section provides a general overview of the use of HIA previously in MS and the expertise available within each MS on HIA.

Level of development of HIA,

There is a mixed picture of the importance and use of HIAs across different countries. For example in France, Belgium, Latvia, and Greece there is little known or action happening at a national level on HIAs, whereas for Italy and Hungary it is known by experts in public health, yet there it is not common practice in public sector policy making (although a legal requirement in Hungary). There is an emerging use of HIAs in Basque Country, Portugal, and Spain particularly in regional settings, yet in the Netherlands, there appears to be a loss of focus in recent years.

Those with established processes (Scotland, Wales, England, Ireland, Wales, Norway and Sweden) have undertaken many HIAs, in different public policy areas outside health, although there is still a concern the use of HIAs is not well established or somewhat patchy outside the field of healthcare.

There was a concern in Norway that although there is a legal requirement for municipal authorities to consider health impacts and equity in local planning, there are little methodological or process requirements on how assessment should be done. Therefore, the degree to which HIAs area carried out varies considerably. Countries in the UK also have equality impact assessment (required by legislation), which covers some, but not all, of the issues, that a HIA considers.

Experts in the country

For those countries where there has been a little use of HIAs, there are a limited number of people involved in the HIA field and currently not seen as “experts” as such. France have a partnership with the International Union for Health Promotion and Education (IUHPE) which are developing understanding of HIA and aim to develop guidelines in French.

In the Netherlands, key organisations include the National Institute for Public Health and the Environment (RIVM) and University Medical Centre Rotterdam (Erasmus Mc), Municipal Health Services Netherlands (GGD NL), Netherlands Institute for Health Promotion (NIGZ), and University Amsterdam (VU Amsterdam).

In Portugal, there are links with some academic institutions like the Institute of Hygiene and Tropical Medicine, the Lisbon Faculty of Medicine and the National Health Institute Doutor Ricardo Jorge (INSA) and the Directorate-General for Health (DGH), which are under the Ministry of Health´s direct responsibility. The expertise in the Basque Country lay with the Department of Health of the Basque Government and Department of Health of the city council of Vitoria-Gasteiz. Vitoria-Gasteiz is included in the WHO "Healthy Cities" project.

The Scottish Health Impact Assessment Network leads on promoting and supporting HIA. It is chaired by Dr Margaret Douglas, who was recently seconded into Scottish Government to work on integrated impact assessment. Other key organisations include; Glasgow city council planning department and corporate policy team, Glasgow centre for population health and the Institute for Occupational Medicine, which have been involved for many years in quantitative HIAs.

In Spain, the Ministry of Health, Social Policy and Equality, Public Health Directorate are key organisations. In Sweden it is mostly the organisations/authorities sat the local and regional level that are the experts on HIA, although the Swedish National Institute of Public Health (SNIPH) is helping develop HIA methods within strategically important areas and supporting the application of HIA at the central, regional and local level.

In Greece the University of Athens, University of Thessaloniki, and the University of Pelloponissos lead on HIA. In Italy epidemiologists and public health professionals in the area of environmental risks and policies are well aware of HIA and have tried to introduce it within the frame and regulation of Environmental Impact Assessment and Strategic Impact Assessment. Moreover a recent project on the Health in All Policies (HiAP) Strategy has put together experts from different fields (social sciences, economic sciences, technical engineering sciences and epidemiology and public health) to scrutinize the impact on health of different categories of policies.

In Wales, The Wales Health Impact Assessment Support Unit (WHIASU) supports the development of HIA in Wales. WHIASU is a partnership between Cardiff University and Public Health Wales. Further expertise in Wales has been built through training and support in conducting HIAs.

In Norway, the Norwegian Government Agency for Financial Management is the governmental authority responsible for impact assessment guidelines and advice. A number of organisations, academic and other, conduct studies and analyses and the Directorate have a department that is responsible for economic analyses. Health impact has been integrated in other sectors, particularly the transport sector.

In Ireland Institute Public Health (IPH) is an all-island body working to build capacity for HIA. A specific HIA team has been established which includes two Public Health Development Officers and an Associate Director who leads the work programme. The IPH carries out HIA and provides support to others undertaking HIA. Belfast Healthy Cities has also developed an extensive work programme in HIA.

In Hungary the School of Public Health, Debrecen University, WHO Healthy Cities Network and Mediconsult Kft (a private company, previously carried out HIA commissioned by OEFI) have developed HIAs and in England, the Department of Health, HIAgateway hosted by the Public Health Observatory West Midlands and IMPACT Liverpool provide key expertise on HIA. The HIAgateway brings together key experts on HIA.

Networks

There are varying degrees of formal and non-formal networks across different countries. In Belgium there is a working group on "Health inequalities" with representatives from different ministers of public health in Belgium, with members are interested in HIA. There are no formalised networks in France, Latvia, Norway, Portugal and Hungary, however in Hungary the Association of Public Health Research and Training institutes carried out scientific HIA-related work and Portugal is involved in another JA (High Commissioner for Health and INSA).

In the Netherlands, there is a national network of HiAP with the main objective to disseminate knowledge and best practices with regard to HiAP. There are many groups (e.g. organisations) and individuals (e.g. policymakers) interested in HIA, but there is no formal network for HIA (e.g. support, training).

In the Basque Country, there is a working group in the Department of Health to carry out a plan to develop HIA, with the creation of a HIA network, one of the elements included in the plan. The Scottish Health Impact Assessment Network has about 50 active members who have been working on HIA.

There are a number of networks in Spain, the Ministry of Health, Social Policy and Equality Expert Group on HIA, the National Healthy Cities Network and the Spanish Association of HIA. In Sweden, the Swedish National Institute of Public Health (SNIPH) has a formalised network/reference group in relation to HIA and it consists of 8-10 representatives from different authorities /organisations. The representatives are experts on HIA within their organisation and SNIPH provides information and publications on HIA on their website.

In Greece the University of Athens is interested in HIA and Italy has two networks; the regional and national environmental agencies, focussed on waste, nuclear, traffic policies and HiAP focussed on cities, mobility, labour, income, education policies. In Wales, the WHIASU has a well-used website, an email distribution list with regular updates on HIA activity. They also hold an annual best practice workshop. In Ireland, the IPH supports a HIA Forum, which provides an opportunity for those with an interest in HIA to meet, share experiences, hear about new developments and consider how to progress HIA.

In England, the HIAgateway provides access to resources and information on HIA for those new to HIA, practitioners of HIA and those wishing to commission HIAs or some other Impact Assessment process.

About the organisation and HIA

This section covers the current skills and knowledge available within each MS organisation, what guidance is currently used and if the ministry is able to obtain support to undertake a HIA.

Extent of knowledge

There is a wide range of skills and knowledge across organisations relating to HIA. Partners with little (some theoretical knowledge and no practical application) or no experience, include Belgium, France, Latvia, Portugal, and Spain. Hungary have had some experience although bring in external support to support their process. The Basque Country are gaining experience in HIAs and the Netherlands and Italy, have some theoretical and practical experience in undertaking HIA, with Norway having had some experience in the past, and feeling that there is now a need to rebuild competence. Within Wales, there is a range of knowledge and a number of HIA have been undertaken. However, they would seek further support and training from WHIASU in the future.

Scotland has recently piloted an integrated impact assessment, assessing the impact on health, equalities and human rights with participants feeling confident to undertake similar assessments. Sweden has undertaken a number of HIAs and has been part of the project "*the effectiveness of health impact assessment. Scope and limitations of supporting decision-making in Europe*". Ireland has an extensive range of expertise in HIA, have annual training, produced a number of publications and support and undertake a number of HIAs. Within England, there is a range of expertise and a number of HIAs have been undertaken, however some expertise have been lost within the Department with recent changes.

Current guidance used

There is a varied picture from respondents on the use of their own HIA framework. Some countries do not have their own framework (Belgium, France, Latvia, Portugal, Basque Country, Spain, and Greece) use other guidelines including WHO, Swiss, Merseyside, and British guidance to undertake HIAs within their countries. Others have little previous experience of undertaking a HIA.

Those that have their own guidelines, (the Netherlands, Scotland, Wales, England, Ireland, Sweden, Italy, Norway and Hungary) some are regulated by law, with others not. These guidelines have been used and tested in a number of different settings (national, regional and local), have checklists of evidenced-based determinants (Sweden) or been integrated with other impact assessments (Scotland).

Support available

There is a range of support available within countries. Those countries with no support inside the ministry include, Belgium, France, Basque Country, Portugal, Spain, Norway and Hungary although some can access a range of support from within their country from other organisations i.e. in Wales WHIASU, Portugal the National Health Institute Doutor Ricardo Jorge and Directorate-General for Health, and Latvia externally from WHO.

There is limited support in the Netherlands, and Latvia, with Greece having support from other countries and other institutions for the provision of training courses. Scotland and England have a HIA network, and e-learning is available, Scotland provides face-to-face training on an ad hoc basis. In Sweden the SNIPH provides support for HIAs, they have a reference group and there are expert lectures from universities than can offer support. In Ireland, they deliver a wide range of training and provide support for HIAs.

HIA Framework

This section focuses on MS own frameworks, definitions used to define HIA and equity, how equity assessed within the framework and what sources of data are used to assess equity.

Definition of HIA and equity

A definition for HIA and equity was proposed in the questionnaire. HIAs were defined as;

> *A combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. European Centre for Health Policy, WHO Regional Office for Europe. Gothenburg Consensus Paper (1999)*

and equity defined as;

> *Differences in health that are not only unnecessary and avoidable, but in addition are unfair and unjust. (Whitehead, 1992).*

Spain, Latvia, Portugal Basque Country, Scotland, Sweden, England and Hungary use the same definition for HIA and equity, however Hungary have difficulties with translating the terminology of equity issues into Hungarian. Ireland use the same definition of HIA, although define equity as *"to differences in health which are unnecessary and avoidable and considered unfair and unjust*". In Norway, there is no agreed definition of HIA, but the definition of equity is basically in line with the one proposed.

Belgium and Greece have no definition within their country at present and would be happy to agree a consensus with others. In Italy, the HIA definition is agreed among epidemiologists, and starting to be agreed by public health professionals. Equity is different and has not been agreed. France sometimes use the following definition proposed by Louise Saint Pierre (from Canada);

> *"The assessment of impact on health is a structured and collaborative approach that, using different tools and methods, mobilizes the knowledge of public health and other types of relevant knowledge, to estimate the potential effects of a project or a policy on the health of the population"", and the distribution of those effects within it, to provide information useful to policy makers."*

In the Netherlands, they define HIA as;

> *"A combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. The HIA is a flexible method, which is well suited to study, and examine broad policy objectives as well as concrete policy intentions. The application of the method is multi-level: local, national and international."*

With the definition of health inequalities:

> *"The health of people with a low socioeconomic status is generally worse than that of individuals with a high socioeconomic status. It is closely related to inequalities in other aspects, such as low income, unemployment, low educational level, poor living and working conditions and an unhealthy life style".*

Wales use the Gothenburg Consensus; however, WHIASU also recognises that it is a process, which tries to address a variety of perspectives and concerns and is a more dynamic process than the Gothenburg consensus suggests. In recognition of this, Wales have a working definition:

> *"Health impact assessment is a process through which evidence (of different kinds), interests, values and meanings are brought into dialogue between relevant stakeholders (politicians, professionals and citizens) in order imaginatively to understand and anticipate the effects of change on health and health inequalities in a given population"*[1].

Example of a framework that assesses equity

The use of a specific framework also varies. Belgium, France, Latvia, Portugal, Spain have no framework. Greece use the DG Sanco and British frameworks, and Italy have some examples of HIAs with equity focus. In the Netherlands, they have developed a theoretical model for reducing health inequalities and use the model to investigate the potential impact of policy on health inequalities.

The Basque Country use the Merseyside guidelines,[2] and suggest the Equity-focused HIA framework[3] as a good approach to addressing equity within the HIA process. Scotland use a integrated impact

[1] Elliott E, Harrop E and Williams GH (2010) '*Contesting the science: public health knowledge and action in controversial land developments*' Bennett P, Calman K, Curtis S, and Smith D (eds) *Risk Communication in Public Health, 2nd edition.* Oxford: Oxford University Press.

[2] Scott-Samuel, A., Birley, M., Ardern, K., (2001). The Merseyside Guidelines for Health Impact Assessment. Second Edition, 2001. International Health Impact Assessment Consortium. [http://www.liv.ac.uk/ihia/IMPACT%20Reports/2001_merseyside_guidelines_31.pdf]

assessment and Sweden uses the SNIPH guidance. England has produced HIA guidance which was recently updated (2010) that has some equity focus and Wales have their own guidance, which assesses vulnerable groups rather than equity.

Norway use the Ministry of Finance guidance, recommending that distributional effects are considered. Irelands HIA process has equity and reducing health inequalities at its core and the Hungary guidelines include an equity focus in the concept of impact assessment, although there is no established practice to implement HIAs with an equity focus.

How is equity currently being considered

Norway, Greece, Spain, Portugal, the Netherlands, Belgium, France, Latvia do not a specific method for addressing equity within the HIA process. The Netherlands have focused on analysing broader social determinants of health inequalities and Latvia use data surveys to assess general impact of different groups in society. Italy have focused on vulnerable groups, as well as Wales, including, gender, ethnicity, age, socioeconomic status, and geographically marginalised groups. Hungary also assesses the impact on disadvantaged groups.

The Basque Country have addressed equity within their HIA process in the screening, scoping and impact stage, analysing the distribution of impacts on different social groups by age, gender, place of residence, socioeconomic status and disability. Scotland and England systematically identify affected population and identify differential impacts on these, with particular attention paid to impacts of vulnerable groups in the Scottish process.

In the Swedish HIA process, assessing equity is the cornerstone of the process and age, ethnicity, socioeconomic status, sexual orientation, and disability are assessed. The results are presented using “health matrices”, which show both the determinants studied and how different prioritised populations are affected. The Irish framework provides a structure to consider equity, and screening enables users to identify vulnerable groups. Stakeholder engagement considers health impacts in terms of different sub-sections of the population that may be affected.

Sources of data

Countries use a range of data sources to assess equity. Belgium use population surveys making links between education level and different indicators of health. France have been bringing together data from varied sources to produce a yearly report on the evolution of population health with respect to a series of indicators, at the national and to some extent at the regional or sub-regional levels, although there is limited scope to link data to produce differential indicators according to socioeconomic characteristics.

[3] Mahoney M, Simpson S, Harris E., Aldrich R., Stewart Williams J. (2004). Equity Focused Health Impact Assessment Framework, the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). [http://www.hiaconnect.edu.au/files/EFHIA_Framework.pdf]

In the Netherlands, the effects of policy inside and outside the domain of public health on (determinants of) health inequalities are still inadequately understood. Latvia use routine statistics as well as data from regular and ad-hoc surveys, yet there is lack of data for analysing the impact of socio-economic factors on health (e.g. education and incomes). The Portuguese new National Health Plan, have monitoring systems, which consist in a health indicators group collected regularly. In the Basque Country, the impact identification has been based both on the published evidence, and on qualitative information. The Spanish population census, health interview survey of the Basque Country, atlas of mortality and mortality by socioeconomic position has been used.

Norway, Scotland and England have a wide range of data sources and depending the on the policy area have varying degrees of data available, with efforts being made to improve ethnicity reporting in health service data in Scotland.

In Sweden, most of the HIAs that have had a qualitative approach. Swedish authorities on national, regional and local level have good data that can be used to some extent, yet it is common that there can be constraints to the access of data due to personal privacy, making it harder to conduct quantitative HIAs. Spain did not provide any information on data sources.

Greece has conducted Health Interview Surveys in order to quantify the impact of health and equity, with analysis conducted with European databases. The University of Athens have studied measuring health inequalities. Italy have some good record linkage longitudinal systems, mortality and hospital discharge data, national health interview surveys, and private workforce followed up until death, hospital discharges and work accidents data. They also monitor health inequalities through health indicators classified by aggregated deprivation (at the municipality level). Hungary use data of the Central Statistical Office of the National Health Surveys (morbidity and mortality data, secondary data analysis) and of the National Health Insurance Fund.

Wales (through WHIASU) use community-profiling data as appropriate, and recognise that techniques in using data to predict impact quantitatively are inadequate at present. Ireland utilises evidence from a wide range of data sources, which includes census data, local health information and surveys. Northern Ireland has developed extensive data collection methods and reporting structures for small, localised data sets, although, in the Republic of Ireland such low level data does not exist. A tool has recently developed to provide easy access to information for the research community and supports HIA process.

Where do they find evidence of different impacts

A range of sources of evidence are used across different countries. Belgium use the health population survey, France use the varied sources to produce a yearly report, the Netherlands use national and international scientific literature and health reports, and Latvia look for a good examples and best practices from across Europe. In Portugal the National Health Plan (2004-2010) had programmes in each region with some of these plans producing useable data. The Basque Country has no resource where we could find (local or other) evidence to characterise the differential impacts on health. They have previously used the standard sources of evidence (i.e.,

published HIA reports, HIA web resources, and bibliographic data sources). In Spain they conduct a bibliographic research for scientific evidence using the common tools for research (Medline, Embase, PsycINFO, etc).

Scotland and England use a wide variety of data sources depending on the specific HIA. Sweden use different authorities on national, regional and local level that have good collected data, registries, scientific databases and scientific articles for evidence. Greece looks at the European experience and attempts to customise to the Greek experience. In Italy, literature evidence comes from the HiAP project and local data would come from the epidemiologic studies.

The Welsh guidance provides a wide range of evidence based resources and is currently being updated. Norway has no central resource, and would use a range of data sources dependent of the HIA and experts in the field. There are a range of data sources and good registries on health and socioeconomic factors.

Ireland have various sources of information in relation to specific areas including, the built environment, active travel and education. There are resources to undertake literature reviews, although no central database for this information. Hungary uses relevant data sources dependent on the HIA, and can *purchase existing databases, or organise focus group meetings with experts for a specific HIA.*

Quality standards used by MS

Many countries are not using quality standards to assess the HIA process they currently undertake, if they were undertaking HIAs, or were looking to develop standards through the JA. Nevertheless some countries were using some standards as part of the HIA process. For example, in Scotland the NHS Lothian Board have criteria and regularly quality assures impact assessments, Wales use the HIA Review Tool developed by Ben Cave Associates to assess whether a HIA had been conducted to a sufficient standard, Italy have used several standards used in WHO and EU projects and developed their own HiAP framework, Sweden suggest that any HIA should be conducted on a scientific base and evidence on how health is affected should be presented based on the Gothenburg Consensus paper (1999), using evidence in an ethical way, therefore with no need to quality standards.

Undertaking and implementing recommendations of HIA

This section covers those who will be leading on the HIA within the JA, the potential theme/policy area that are being considered within the JA, mechanisms that could be used to initiate a HIA, the sharing of experience and willingness to twin within another country, to help each other with the HIA.

Who are the leads in the country going to a undertake HIA

Country	Name	Organisation	Contact Details

Belgium	To be confirmed		
France	To be confirmed		
The Netherlands	Ilse Storm, senior researcher and project manager Health in All Policies Mariel Droomers, senior researcher Health Inequalities Nicoline Tamsma, senior adviser International Affairs	National Institute for Public Health and the Environment (RIVM)	
Latvia	To be confirmed		
Portugal	Maria João Heitor	INSA	
Basque Country	Elena Aldasoro, Santiago Esnaola, Amaia Bacigalupe, Unai Martín	Department of Health of the Basque Government and University of the Basque Country	
Scotland	Margaret Douglas	NHS Lothian	Margaret.j.douglas@nhslothian.scot.nhs.uk +44131 465 5437
Spain	Begoña Merino Merino, Pilar Campos Esteban, María Santaolaya Cesteros, Ana Gil Luciano	Ministry of Health, Social Policy and Equality	
Sweden	Ida Knutsson (Public health planning officer) Chatrine Höckertin (Public health planning officer) and Anita Linell (Expert).	Swedish National Institute of Public Health (SNIPH)	ida.knutsson@fhi.se +46 63 19 97 50
Greece	John Yfantopoulos University of Athens Mary Geitona University of Pelloponissos Persofoni Kritikou University of Athens	In collaboration with the Secretary General Dr. Dimopoulos A Ministry of Health	
Italy	To be confirmed		
Wales	To be confirmed		
Norway	Stig Erik Sørheim	The Norwegian Directorate of Health	ses@helsedir.no
Ireland	Owen Metcalfe	Institute of Public Health in Ireland	
Hungary	To be confirmed	National Institute for Health Development,	

		together with external experts	
Finland	To be confirmed		
England	To be confirmed		

What policy area/theme are you considering for the HIA

Country	Policy/theme
Belgium	To be decided and discussed at the cross sector and cross government group within Belgium.
France	To be identified, possibly through our "Comité national de santé publique" (Public Health National Committee) that brings together representatives from different Ministries.
The Netherlands	Two possible areas, Ministry of Social Affairs and Employment (Poverty and Equity) and the Ministry of Infrastructure and Environment (Healthy environment and Equity).
Latvia	To be decided.
Portugal	There are a couple of possibilities; a new airport which has been built to assess the overall health impact and analysis of the change in traffic law on potential years of life lost due to traffic accidents.
Basque Country	Initial thoughts are policies at the local level: urban planning and healthcare policies (population screening programs; introduction of information and communication technologies in health care).
Scotland	No specific polices, although it would be useful to look at a major cross-Government priority such as climate change. Otherwise to target a "non-Health" policy.
Spain	Policies that affect population health, i.e. environmental policies and those related to childhood.
Sweden	Regional development, applications for EU social funds.
Greece	Regional inequalities due to current implementation of the legislation on regionalisation, socio-economic inequalities and marginalised groups due to economic crisis.
Italy	Analysis of healthcare policies that try to move resources from hospitals to home care, the impact on equity in the processes of care and non-healthcare polices; occupations during recession, specific labour polices i.e. control of asbestos and prevention of work accidents in constructions.
Wales	Actions from "*Fairer Health Outcomes For All: Moving the Agenda Forward*". Area 1 "Building Health into All Policies and all Policies into Health".
Norway	The transport sector.
Ireland	In the Republic of Ireland, planning strategies (spatial and transport), Climate Change Bill, the new Programme for Government, the increased liberalisation of the energy market, and the increasing privatisation of the social housing. In Northern Ireland, the Regional Development Strategy, Regional Transportation Strategy, Review of Public Administration amongst local government, and gambling policy.

Hungary	To be decided.
Finland	To be decided.
England	To be decided.

How will you identify mechanisms to help HIA

A range of different mechanisms were identified to support the HIA process, within each MS. Examples included, simple fact-sheets with examples of concrete interventions to tackle HI, creating a win for the policy sector, and simplistic HIA process to convince other areas. National committees or cross-sector working groups and national process/law to conduct HIAs, putting the HIA on the agenda of national plans, integrating into other assessments i.e. equality, planning, and environmental which are required of policy makers, dissemination of the EU communication, national HI reviews, and engaging decision makers at the earliest stage through networking and advocacy would help implement HIA. Some mentioned that, it is not obligatory and therefore difficult to get other sectors to undertake a HIA, others had not identified specific mechanisms.

Supporting other partners and twining

All respondents were happy to offer support if they felt they could offer their learning to others and all respondents were happy to be twinned with another partners where synergies were possible. This would support the sharing and dissemination of knowledge on HIA.

Mechanisms for adopting Health in All Polices approach

Identifying mechanisms to embed HiAP varied from legislation to examples of good practice, however many thought a range of mechanisms is probably most effective for HiAP. The use of national committees, additional financial resources, improving health intelligence, training, networking, gaining political leadership, providing tools, creating networks, resources devoted to HiAP, linkages with sustainable development, and developing advocates across different policy areas to champion HiAP approach were all suggested.

Further comments

Respondents felt it was important that HIA is built into existing processes rather than trying to develop something new. This might mean that slightly different processes are used in different MS and slightly different language is used to describe HIA, as a new HIA framework would be unlikely to be institutionalised in the longer term.

As there are so many different definitions and different terms used in relation to HI it was suggested that a primary goal for this WP must be to reach a common understanding on the terms used, for example the term Health Equity Audit is completely unknown to some countries. Additionally it was felt that there is a need to properly define the difference between HiAP and HIA so there is no confusion between the two areas. It was suggested that HiAP focuses on influencing the health of the population and its determinants, whereas HIA analyses actions and makes recommendations to reduce the impact of those actions on health.

There was agreement that HIA and the focus on equity are relevant issues and only with inter-sector action and a focus on HIA, sustainable health gains can be obtained. Therefore, it is important that those working on this WP need to integrate with others ministries at the planning steps. Suggested mechanisms include, interdepartmental communities, steering committees and networks.

It was noted that for the success of the HIA part of the WP, answers to important questions should be agreed. Such questions as, who are the final user groups (e.g. policymakers) that are (potentially) applying HIA, what are the indications (that are considered) to apply HIA or not, what are 'lessons learned' applying the HIA instrument in other fields, what are functional needs of the final user groups with regard to the instrument and what is needed to endorse application of the instrument (e.g. content, usefulness).

Finally, there is still some way to go before HIA becomes routine in all sectors and cross sector decision making. There are still questions about who is responsible for leading HIAs, at a local level the relative responsibilities of the local authority (municipality) and broader public health partnerships are not clear. It would be helpful if this WP helped identify these.

Discussion

The responses to the questionnaire have provided a good understanding of the current use, skills, knowledge and expertise of HIA across different MS involved in the JA. Some countries have a broad range of knowledge and expertise, whereas others are just starting to look at HIA for polices. There are a range of networks that exist, some formal and others not.

Within ministries, some have a core expertise to support HIA with resources, while others have no expertise, or support. A variety of different HIA guidance is used, with many countries having here own. Those countries that do not have their own guidance use other well-recognised guidance when conducting a HIA, or are looking to the JA to offer guidance.

The majority of MS agree with the definitions used for HIA and equity, with some having there own or that terms are not well translated into the native language. There were many different frameworks suggested that could be used to assess equity within a HIA, with many MS having their own preferred framework. A variety of different methods are used to assess equity, including analysis of vulnerable groups, distribution of impacts on different social groups and using "health matrices" to show both determinants and how different populations are affected.

Many countries had data to support the analysis of equity within a HIA, ranging from one off surveys, to cohort studies and qualitative interviews. MS also used literature searches and evidence databases to support analysis of equity. Scotland had some quality standards for HIA, Wales use the HIA review tool and Italy has used standards developed by WHO. However, Sweden suggests that a HIA should be conducted based on the Gothenburg Consensus and therefore does not need to have quality standards.

The majority of countries have identified the lead for undertaking the HIA within the JA and the policy/theme that is being considered. A range of mechanisms/levers have been identified to ensure a HIA will be undertaken, which include simple fact-sheets to national groups who would lead on the process. All respondents were happy to support others where they could and be twinned to share knowledge, experience and assist each other to complete a HIA. To achieve HiAP a range of mechanisms were thought to be the most effective.

It was suggested that those countries who already have a HIA framework should continue to use that, supported within this JA by questions that will effectively assess equity within the HIA process. As there were many different terms used by countries for HI, and differences were noted between HiAP and HIA, a common understanding is needed and should be agreed between MS. Those undertaking a HIA would need to work with other sectors to ensure sustainable health gains are made within the JA, understand how and when a HIA has been successful and ensure that the WP helped to identify roles and responsibilities when undertaking a HIA.

Next steps

After reviewing the responses to the questionnaire, the following recommendations are made for agreement by members in WP4 and for completion by August 2011.

1. Agree to use the Gothenburg definition of HIA and the Whitehead (1992) definition of equity within the WP.
2. Decide whether you will use your own HIA framework (if you have one), or choose a contextual HIA framework for the policy/theme area being considered for an HIA (a number of suggested HIA frameworks with equity focus are included in appendix 2, although you do not have to choose those suggested).
3. Work to agree to use a supplementary questions tool that will address equity (to be developed) to ensure equity is fully considered within the HIA.
4. Identify a lead for the HIA, HiAP and HEA and provide contact details (if not already done so).
5. Identify a policy/theme for an HIA and mechanisms for initiating a HIA (if not already done so), if you are undertaking a HIA as part of this WP.
6. Offer suggestions for an individual/company to deliver HIA training in September/October, once the tender document has been drafted.
7. DH to tender for training to be tailored to meet the needs of participants.
8. DH and EuroHealthNet to agree date for the next meeting and training in London and circulate to all.
9. Identify any particular learning needs for HIA for the training to be tailored and sign up to training in October (if required) and send through to Stephen.gunther@nhs.net
10. Keep a reflective journal (template to be provided) throughout the WP to capture learning and provide learning reports annually for monitoring and evaluation of the JA.
11. Work to agree a process for HEA and HiAP which will enable the analysis of the extent a policy is orientated and contributes towards reducing HI (to be developed further).

Contact details for leads in WP4.

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Appendix 1. EU Joint Action: Pre 7-8th April meeting questionnaire on Health Impact Assessment

This questionnaire is designed to help us start thinking about the present Health Impact Assessment (HIA) process within our countries, the consideration of equity and collectively provide an overview of where different Member States (MS) are with the HIA method.

HIA's have been defined as;

> *A combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.* *European Centre for Health Policy, WHO Regional Office for Europe. Gothenburg Consensus Paper (1999)*

A definition of Equity is;

> *Differences in health that are not only unnecessary and avoidable, but in addition are unfair and unjust. (Whitehead, 1992).*

This questionnaire collects information on different expertise and resources available to MS in relation to HIA and the consideration of equity in the HIA process.

Information from the questionnaire will be used to help discussions at our first meeting on the 7-8th April 2011.

Please fill the questionnaire to the best of your ability. If you are unable to answer a question, please state so and the reason why, as it will help us gather a picture of where different MS are on HIA and what support could be offered between MS in the future.

The questionnaire should take no longer than 10-15 minutes to complete.

Please send your response back to Stephen.gunther@nhs.net by Monday 4th April and bring your response to the Joint Action meeting on the 7-8th April 2011.

Thank you for completing the questionnaire.

General overview of HIA in your country

1. What is the current level of development of HIA in your country? (e.g. established process with many being undertaken, to little known about them and little happening).

2. Who (individuals/organisations) are the experts in your country on HIA, and what relationship do you have with them? (List of organisations/people that carry out HIA's, how well to you know these organisations/individuals).

3. Is there a network of groups or individuals in your country that are interested in HIA? (e.g. HIAgateway (www.hiagateway.org.uk) in the UK is a group of individuals interested in HIA, do you have something similar in your country).

About your organisation and HIA

4. To what extent do you know the methods of undertaking a HIA? (e.g. confident and understand how to undertake one, to do not know anything about them).

5. Do you have your own guidance on conducting an HIA, or where would you look for guidance on conducting an HIA? (e.g. have you developed your own guidance or use another organisations guidance).

6. Can you access support (i.e. training) for HIA within your country and if so, who would provide that support? (e.g. do you have internal support within your ministry, or within government, and/or external organisations that can provide support when undertaking a HIA).

HIA framework

7. What is your working definition of HIA (is it different from the above definition) and what terms do you use for equity? (e.g. is there an agreed HIA and equity definition in your country).

8. Do you have an example of an HIA framework, which has a good consideration of equity? (e.g. is there a well recognised HIA framework that you use that considers equity within the process, and are there any good examples of this framework being used. Please provide links/references).

9. How is equity considered in your HIA methods at the moment? (e.g. do you have specific questions on equity, how do you consider the different impacts of policy on different groups i.e. geographic, socio-economic, any specific marginalised groups).

10. What measures/sources of data do you use to quantify the impact of health and equity? (e.g. do you have access to different data sources and if so what are they and are there any gaps in data).

11. Where would you look for evidence of differential impacts on health from a proposed policy? (e.g. is there a central resource you would go to, to assess the evidence of differential impact).

12. Are there any quality standards you use associated with doing an HIA? (e.g. is there a specific minimum standard that should be met when conducting an HIA).

Undertaking and implementing recommendations of HIA within your country

13. If you are part of the workstream on "tools to improve the health equity focus for cross government policy making" - who will undertake the HIA within your country (name of individuals and organisation, please include contact details i.e. email/tel.).

Name(s):

Organisation(s):

14. Do you have any ideas on policy areas/themes for an HIA within your country? (e.g. policies that will be emerging that you could develop an HIA to support in the near future, or past policy that will be changed in the future, that the HIA could inform).

15. Have you, or how will you identify mechanisms to help your HIA to inform the relevant policy (e.g. are there any requirements for policy makers to undertake a HIA, who would be the lead on the identified theme, are there any linkages with others areas of work currently happening).

16. Would you be willing to support another Member State with the application of the HIA process? (e.g. share your expertise/learning, support other Member States, share evidence/resources).

17. Would you find it helpful to be twinned with one or two other countries who are seeking to develop an equity focused HIA? (e.g. this could be either similar demographics and/or policy area).

18. Have you identified any effective mechanisms to getting a Health in all policies approach adopted in your country and if so what are they? (e.g. legislation, training, resources, networking).

19. Do you have any further comments you would like to add?

Thank you for filling out the questionnaire. Please send your response back to Stephen.gunther@nhs.net and bring your response to the JA meeting on the 7-8th April 2011.

Appendix 2. Suggested HIA frameworks

Department of Health (DH) (2010b) Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process. [Online] Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_120110.pdf Accessed on 25th February 2011.

Mahoney M., Simpson S., Harris E., Aldrich R., Stewart Williams J. (2004) *Equity Focused Health Impact Assessment Framework*, the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA) [Online] Available at: http://www.hiaconnect.edu.au/files/EFHIA_Framework.pdf Accessed on 25th March 2011.