



EQUITY ACTION

TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •

Learning from Equity Action Health Impact Assessment (Processing and Training)

“EU projects like the Equity Action project are very helpful to get HIA on the agenda of policymakers”

(Comment from a participant)



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Summary

The programme enabled and assisted 16 MS undertake an equity focus Health Impact Assessment (HIA), which ensured a good balance between consistency of practice and local relevance.

Integrating equity into the impact assessment process is challenging because equity is a difficult concept to define, not mutually agreed across Member States (MS), with different meanings in different cultures. Many MS have no materials on HIA in their own language, *e.g.* guidance documents or case studies and many MS are still developing their HIA skills and capacity.

This programme has started to develop skills and capacity for HIA across Europe, with a particular focus on assessing equity. If an HIA is undertaken well, it can have a significant impact on policy and health inequalities. To have this impact, the process needs to be flexible and meaningful for policymakers. Implementing this and further developing capacity across MS in Europe should be encouraged, with specific support tools for MS, use of [existing resources](#) and evidence to support MS. For example Public Health research grants could be used to further develop the agenda and show specific impacts on HI from changes in policy.

For those who want to address equity in policy making, the set of questions we developed provide a helpful check list to enhance policy making.

Joint training programmes such as this help MS who have no experience feel confident about engaging and also help those with experience perform better.

Background

Equity Action Work Package 4 supported Member States (MS) to undertake a Health Impact Assessment (HIA) with an equity focus. After a rapid review of the [evidence](#) and having a strong steer from MS, it was decided to develop a series of questions (developed in collaboration with HIA experts) to focus current MS HIA processes on equity. These questions were discussed and tested with the MS participants during three HIA training sessions provided by [Ben Cave Associates](#).

This report is based on the evaluation and reflection reports from Ben Cave Associates, feedback from MS participants, their [case studies](#) and learning from peer to peer presentations in [training session 3](#). We shared findings with HIA experts (annex 1) to produce the final summary report.

The report addresses two areas –

1. learning from conducting the Health Impact Assessment with an Equity Focus and
2. learning from delivering the training itself.

Analysing Equity in HIA

The *series of questions to address equity in the HIA process* was discussed at the first training session and subsequently updated (see Annex 2). There were a wide range of [topics](#) that were addressed by the various HIAs undertaken by the MSs, and a broad range of skills and expertise of participants in the training. This created a challenge for the trainers with regard to both pitching the content of the training and discussing the concept of equity, as this varied from MS to MS.



MS participants noted that it was important to be:

- explicit about equity in the planning stages of HIA,
- transparent and creative about the choices/scope of how this was delivered.

Many MS used both qualitative and quantitative approaches to analyse equity, although quantitative processes were preferred by most.

The series of questions were predominately used as a checklist or menu of options to supplement existing or emerging MS guidance.

Simply using all of the questions was not feasible either because they required extensive experience of HIA or needed more data and skills than were available. It was felt that the broader range of questions could help provide further opportunities for learning. On the other hand it highlights the importance of being able to confidently reduce the questions to reflect local skills and availability of data.

It was clear that a major barrier to analysis of equity was the lack of available data, and even when it did exist, the complex policies under investigation meant that it was hard to evidence causality given the multi-factoral influences on outcomes.

Integrating equity into the impact assessment process was the most challenging aspect of the project, as equity is a difficult concept and does not translate easily from one language or culture to the next (a range of definitions produced by MS are shown in annex 3).

- not all MS see a difference between equity and equality
- many of the MS have no materials on HIA in their own language, *e.g.* guidance documents or case studies.

An additional common difficulty in undertaking the HIA on a policy was how to strike a balance between looking at the policy document in its entirety and the need to focus the assessment on particular issues (predominately driven by available data).

Many participants (particularly those who had little experience in HIA) wanted a simpler, flexible, pragmatic and clear way of addressing equity in their HIA. For those MS that were in their initial stages of using HIA in practice, a pragmatic two-step process of analysis equity was developed:

1. First, identify any quantitative differences and
2. Secondly, decide whether those differences are fair and/or avoidable (at reasonable cost).

The first step is technical: the impact assessor identifies the quantitative differences in, and relationships between, any given factors/indicators.

The second step requires engagement and deliberation about what is fair and/or avoidable. This judgement is difficult to make without the policy maker, with the concept of 'what is fair?' important to define as part of the discussion. This is difficult as it is often hard to define the constituent parts of fairness, and that the concept is relatively subjective. "Operationalising" an equity focus frequently



meant bringing new concepts to policy makers. Equity varies both depending on policy, MS language and culture, therefore understanding this was crucially important for implementation of the HIA and for its consideration by the policy maker. These softer skills of engagement were the biggest areas of learning and development for many.

Through the implementation of the HIA training it became clear that as an HIA informs decision-making, the responsibilities should be clear in the process:

- the technicians must show the politicians/policy-makers the potential effects of the policy upon different population groups;
- the politicians have a responsibility to take the information from the impact assessment (and other sources) into account and to make the decision.

Participants reported that the following helped their HIA inform and shape policy:

- having legislation,
- data,
- the degree of democracy in country,
- political commitment,
- advocacy (*“PH getting out of the office”*),
- previous positive experiences by policy makers,
- speaking the same language as other departments,
- willingness of policy makers to react to results,
- budgets,
- showing cost-effectiveness (the economic argument)
- capacity and skills to undertake the HIA in the MS.

The group of trainees felt it was important to build relationships with policy-makers and in many cases these were outside the health department. This takes time and energy, yet can help others across government departments to understand the concept of equity and inequalities.

Key elements for the delivery of future HIA training which focuses on equity

The ‘learning by doing’ approach was helpful and allowed participants to focus on softer skills (art of negotiation, agenda alignment and relationship building) rather than just the technical skills of analysing the data.

Walking people through the process and using a peer review process (sharing what had been done) was not only important for other MS to hear the challenges; it inspired others.

The majority of respondents found the following areas most useful in training:

- meeting face-to-face to share experiences and build personal networks for future support or collaboration
- discussing challenges with those from other MS - these were often the same



- having practical as well as theoretical step-by-step guidance including how to use quantitative and qualitative data
- having a general framework (for those without one) to begin the HIA process, and
- support to build capacity within their MS as there had often been no recent experience of HIA.

Many respondents felt that they had enough support to complete their HIA; however suggestions for further support included:

- access to expert guidance in specific moments of the process i.e. help develop solutions
- comments/reviews on final reports i.e. a quality assurance process
- more practical HIA case reports/guidance i.e. how to undertake a HIA at national level and the practical steps required
- a process of reflective analysis at each step of the HIA, and
- access to an international helpdesk e.g. at EU-level to support MS in HIA.



Annex 1.

HIA experts present 6th November 2013 teleconference

Alex Scott-Samuel	International Health Impact Assessment Consortium
Ben Cave	Ben Cave Associates
Chris Brookes	Health Action Partnership International
Colleen Williams	Independent consultant
Eva Elliot	Cardiff Institute of Society and Health
Margaret Douglas	NHS Lothian
Mark Gamsu	Health Action Partnership International
Mary Mahoney	University of Gloucestershire
Peter Goldblatt	University College London
Ray Earwicker	Department of Health
Salim Vohra	IOM Centre for Health Impact Assessment
Stephen Gunther	Department of Health
Sue Atkinson	Public Health Action Support Team



Annex 2.

A series of questions to analyse equity in the policy Health Impact Assessment process (Revised draft following HIA training Nov 2011)

S. Gunther

Updated Dec. 2011



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Background

Action to tackle health inequalities (HI) is required at EU, national, regional and local level, with a wide range of stakeholders across a range of policy areas (EC, 2009). The challenge for Equity Action is to assist the Member States (MS) involved to develop tools to better enable HI to be addressed in cross-government policy making, to assess the evidence, and to engage with key stakeholders, especially regions.

One mechanism that can be used by policy makers to address HI is Health Impact Assessment (HIA) with an equity focus. HIA is increasingly being used as a policy support tool in many MS. A rapid review and expert opinion on policy HIA with equity focus, and MS use and process of HIA with equity focus was undertaken (Gunther 2011a, Gunther 2011b). The headline findings were;

- there are already many different HIA frameworks that exist and developing a new one would not be beneficial
- there are a range of different approaches across Europe to HIA and the analysis of equity
- the most important analyses and also most challenging is of the HI gradient
- a method to enable the analysis of equity within any HIA process is needed
- HIA training should run alongside the policy making process and
- an assurance process is required to analyse the outcomes of any HIA.

The systematic lack of an equity focus in the policy HIA process is a key issue for the Equity Action programme. The purpose of this set of questions is to provide a mechanism that places equity at the centre of HIAs, ensuring that every HIA is an HIA with an equity focus. We recognise that to be effective, it must demonstrate the impact of policy on health and HI, and it must fit within the policy making process if it is to be accepted in the mainstream of policy development.

Aims

The list of questions is to help policy makers better undertake the analysis of equity within policy HIA framework to be used as an addition to current questions within the HIA framework that is being used. To consider the extent to which a policy's impacts are potentially inequitable and avoidable, which are relevant and that can be used systematically as an adjunct to policymaking. The list of questions aims to be;

- practical – usable across the EU and in different MS
- applicable – easy to use and understood by policymakers
- flexible – accommodates cultural, political and other differences
- sustainable – as part of the HIA process and other impact measures
- evidence-based – building on best evidence and good practice of what works to increase equity.

It should be noted that this process has started to be piloted through an iterative approach through the Joint Action HIA training being led by Ben Cave associates. This is the second working draft, building on the first draft following comments and review from the first HIA equity action training in November 2011. This will build capacity, improve skills and develop understanding across Europe to enable these questions to be addressed in the policy making process, having people with the capabilities to undertake this in the future. Another output from this work will be examples and



illustrations that highlight the benefits of this approach and these will be gleaned from a range of case studies that will come out of the Joint Action.

Introduction to the questions

This list has been devised to aid a systematic consideration and analysis of equity in the policy HIA process, to be an addition to a HIA framework that is currently being used in MS. It aims to identify potential differential impacts, positive and negative, to determine those negative impacts that are inequitable and avoidable, and make recommendations on policy to reduce the impact of the policy on HI or to enhance potential for positive impact on equity.

A HIA should aim to reduce inequalities by making clear if a policy will differentially impact on different groups, and by assessing the potential differential distribution of health impact across the population. The process has been developed by reviewing the evidence (Gunther 2011a) and through discussion with HIA experts.

There are many different HIA frameworks, with differing analysis of equity, yet all contain at least five common stages (figure 1). Analysis of equity should be considered in each of these stages. Some of this list of questions below may already be within MS HIA framework. Therefore the list is intended to add to the analysis of equity in addition to what is already being done, so use the questions that are relevant to your HIA framework.

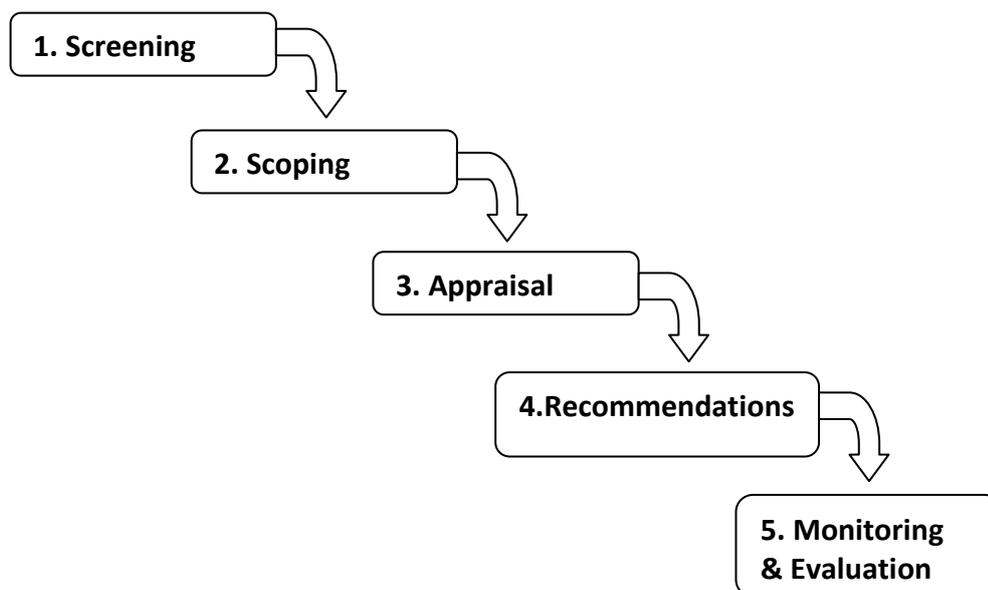


Figure 1. Five key stages of a Health Impact Assessment.

Definition of terms

For the purpose of this list of questions, the following definitions of HI, health equity and HIA that were used. Following the initial HIA training with participants, a new definition of equity was developed and is show below. Additionally, there is a full glossary of terms in Appendix 1.

Health Inequalities can be defined as systematic differences in health status. For example, differences in mobility between elderly people and younger populations or in the distribution of health



determinants between different population groups, or differences in death rates between people from different social classes (WHO 2011). What we are interested in are differences in health that arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables (e.g. living and working conditions, education, occupation, income, access to quality health care, disease prevention and health promotion services) that are largely beyond individual control and that can be addressed by public policy. Therefore, HI here refer to avoidable differences in health that are strongly influenced by the actions of governments, stakeholders and communities, and that can be addressed by public policy (European Commission, 2009).

Health equity (and equity in health) Equity is the absence of avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically (WHO, 2007). “Health equity” or “equity in health” implies that ideally everyone should have an opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential (WHO, 2011). Therefore, health equity is the absence of health inequalities (applying the aforementioned definition) (Madrid Ministry of Health and Social Policy, 2010).

Health Impact Assessment (HIA) is 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, 1999).

Health equity as defined in the HIA workshop: The purpose of the HIA with equity focus is that the policy should enable the: (Opportunity*) *to achieve the best possible health outcome to reduce existing health inequalities.*

*Opportunity is in brackets as this was not agreed by all of the participants.

The questions

The questions are set out in each stage of the HIA process to aid the analysis of equity and **should be used in addition to the questions that are set out in the HIA framework that you are using.** Answering the questions will determine the action required. There is a core (minimum) set of questions and an enhanced set of questions for analysing equity. The core set of questions are for MS who have limited data or expertise in HIA, whereas the enhanced set of questions are for those MS who have a higher level of expertise for a more comprehensive assessment of equity in HIA. The questions provide a systematic process to consider if the policy being analysed will potentially impact on HI, the parameters for analysis, analysis to be undertaken, provision of recommendations and the impact of the HIA.

Screening

Screening is the stage in which seeks to ascertain whether there are potential health equity impacts from the proposed policy and will determine if a HIA is undertaken or not. **The HIA framework that is being used will determine whether a HIA is undertaken or not. The goal of these questions is to help determine whether there might be potential for differential impacts (the health equity aspect)** i.e. if the policy could affect different groups of people in different ways and the series of questions should be used once a decision has been made to take a HIA or not. At this stage, the consideration that some groups will experience greater adverse effects than others because of existing poor health will



need to be taken. The consideration of equity is important as it sets the context for the rest of the HIA and will ultimately determine the outcome from the HIA i.e. if it is going to have an impact on HI and health equity outcomes.

Some **core** questions you may want to ask as the policy is currently described/intended:

- Which populations are currently relatively disadvantaged in the context of the policy?
- Does the policy affect health equity issues in these populations?
- Are the health equity issues affected directly or indirectly?
- Does the policy enhance equity or increase inequity e.g. by affecting different population sub-groups differently because of what the policy targets, how the policy is implemented or how it works with/against existing policy?
- What might the unintended consequences be (positive and negative)?
- What might consequences be of the policy be on the determinants of health?

Some **enhanced** questions you may want to ask as the policy is currently described/intended:

- Could there be public concern about the equity of the policy?
- Could there be an equity concern by other key stakeholders and/or those affected by the policy?

Action: If it is identified that the policy may have an impact affecting health equity, then the rest of the questions should then be used during the HIA. If it is identified that the policy does not have an impact on health equity, then it is advised that the rest of the questions are not needed.

Scoping

The scoping section of a HIA covers key issues to be considered when conducting the HIA including; setting parameters/focus and decisions on method, nature and type of evidence to be assessed. These should be addressed in the HIA framework you are using. Importantly it should identify;

- the relevant populations,
- relevant determinants of health,
- the questions that need to be answered during the appraisal stage,
- the decisions about the nature and type of evidence to be gathered to identify the health equity issues,
- how the evidence will be judged when it is gathered and
- what to do if there is no evidence.

The goal of this section is to help scope the potential differential impacts and affected populations¹ as well as the potential impact on the determinants of health which in turn may affect health equity.

The conception of health equity needs to be understood by all those scoping the HIA. Others who know the policy may be able to identify possible populations affected (target groups) and/or stakeholders. Additionally a decision will need to be made about whether to use both qualitative and

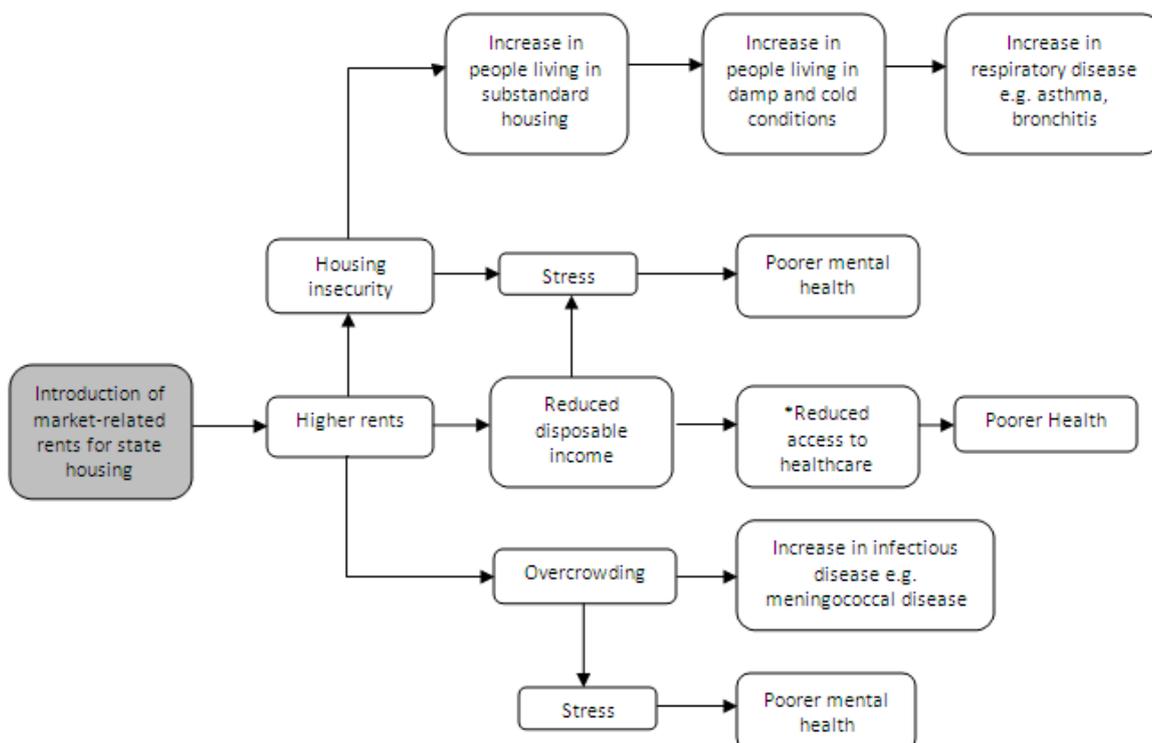
¹ To note: the populations identified will depend on the schema used. For example if list of existing “target” groups based on ethnicity and migration is used, some groups of people may get missed (i.e. the homeless, low income families). An alternative is to use key social and economic factors. However it is important to be systematic and be able to demonstrate the basis for identifying potential populations who may be differentially affected.



quantitative data in order to understand the impact of the policy. This should be identified in the HIA framework you are using. Policy makers should note that the absence of evidence does not mean an absence of effect, therefore obtaining data or identifying its absence on the impact is crucial.

Most policies will not impact directly on health, but may impact by changing the factors that determine health i.e. the determinants, or can be a determinant themselves, as the determinants of health inequality are inequalities in health determinants. Broad categories of the determinants of health include socioeconomic (e.g. income, or employment and other material resources), social and cultural factors (e.g. social support/discrimination, human rights, parenting), environmental (e.g. living and working conditions), services (e.g. childcare, early years education, healthcare), individual/behavioural factors (e.g. life skills, diet, physical activity) and biological factors (e.g. sex, age). Appendix 2 provides examples of some of the health determinants. Therefore decisions about evidence gathering need to link to the determinants of health, and the list in appendix 2 provides indicators to the sources that might be able to be used to indicate how they will affect health equity.

Causal connections need to be established to show how the policy has the potential to impact on the determinants indirectly. For example, this simplified diagram gives some possible causal pathways between a change in policy (introduction of market-related rents) and health outcomes (figure 2). When assessing the possible impacts assess those that are key and those that are potentially inequitable.



**Reduced access to healthcare will only affect those who have to pay for healthcare and may not apply to your country.*



Figure 2. Possible causal pathways between a housing policy change and adverse health outcomes. Adapted from: PHAC (2005) *A Guide to Health Impact Assessment: A policy tool to New Zealand*.

Generally in the scoping section, consideration of how to monitor the impact of the policy and evaluate the HIA should be undertaken, as well as who will need to be involved in analysing the impact. Ensure that there is data available to answer the questions proposed, as these will be used as the basis for ensuring that the questions can be answered. If data is not available, highlight these potential gaps in the recommendations. You may also need to undertake some data collection if necessary. In addition to the scoping in your HIA framework, the questions below will help scope the health equity issues of the proposed policy.

Some **core** questions you may want to ask:

- Which determinants of health that effect health equity will be assessed in the context of the policy?
- What information is needed to understand health equity impacts of the policy and inform recommendations/suggestions?
- What evidence² (quantitative and/or qualitative) will be used that will show how the health equity impact is identified?
- Which populations are relevant to the policy? (see appendix 4 for some groups)
- What information is needed about the relevant populations to determine if there is an health equity issue?
- Who will be involved in the assessment i.e. will key stakeholders or those effected by the policy (target groups) have an opportunity to feed into the HIA to help determine health equity dimensions?
- How will health equity impacts be presented e.g. number of people affected, types of health/wellbeing impacts, and the degree of change in equity/inequity?
- How will uncertainty in health equity impacts be handled e.g. unknown effects, absence of evidence, how public views and professional judgement can be used alongside scientific knowledge, etc.?

Some **enhanced** questions you may want to ask:

- Consider long-term/trans-generational timescale of the health equity impacts, e.g. some equity impacts may be trans-generational, or occur over the life-course
- What existing policies and new policy developments are likely to affect/interact with the equity aspects of the policy under consideration and how will this information be assessed?

Action: Once the questions have been answered, this should provide you with the scope to be able to identify the potential impacts and affected populations with regard to health equity.

Appraisal

The appraisal stage of any HIA framework should systematically assess the potential impact of the policy, collating different information about the effected populations identified in the scoping stage.

² Evidence: one or more reasons for believing that something is or is not true



The goal of this section is to ensure that explicit identification of any gaps and/or gradients in health equity are assessed. Different ways of analysing distribution of differences are outlined in appendix 3. Detailed evidence relating to the proposed policy is crucial in assessing its potential health equity impacts. During the appraisal phase, impact on different groups should be considered, if not already done so in the HIA framework you are using. State the positive impact as well as negative impacts and the impact between and within groups, the gradient and gap of difference.

Good data will be able to provide meaningful answers. This can be quantitative (i.e. one or more measures of health status, and social position and a statistical method of summarising the differences between groups) and qualitative (gather views from stakeholders on the likely impact, experiences and views of the policy). Aim for a comprehensive analysis of the impact on the policy on health equity and make it useful and usable for policy makers. Appendix 4 has a list of documents that have EU level data and tools that could be used as a starting point for analysis. The questions below build on those within the HIA framework you are using, although may already be within that framework.

*Building on the scoping answers, now consider some **core** questions you may want to ask:*

- What health equity impacts have been identified as likely to arise from the policy?
- How will the identified health equity impacts be distributed?
- Does it introduce new health equity impacts?
- Considering the range of health equity impacts identified, what can be done to reduce the negatives and enhance the positives so that the health equity gradient is more equal/equity gap is narrower? (Consider direct and indirect impacts of the policy and the evidence to support such actions).
- Has the causal pathway and key factors in the causal links, been considered in the impact of health?

*Some **enhanced** questions you may want to ask:*

- Can the type, degree and likelihood of positive and negative health equity impacts be mapped against the different population groups' e.g. socio-economic, vulnerable/non-vulnerable?
- Does it make the existing health equity gradient steeper/shallower or the gap bigger/smaller?
- Do the benefits of changing the policy, for moderating or removing these differential impacts outweigh the social, economic and environmental costs or disadvantages of doing so? (Consider the health equity impacts in the short-term, medium and long-term).

Action: Answering the questions, you should be able to explicitly identify any gaps and/or gradients in health equity.

Recommendations/suggestions

In all HIA frameworks recommendations/suggestions should be developed from the evidence collected and analysed and presented to mitigate risks and increase potential benefits of the policy. These should be communicated in a way that is clearly understood and different options should be given to the policy maker to enable them to make an informed judgement and be practical to maximise health gains and minimise harmful effects on health of the policy. **The goal of this stage is to provide the**



policy maker with options that describe the potential health equity impact of the policy and provide options to mitigate the impacts.

Generally recommendations/suggestions should state if there were gaps in the evidence, how they could be rectified, include how to monitor outcomes from the policy, and set out how the HIA will be evaluated. State any lessons learnt and focus on the elements of the proposed policy that will happen if the policy remains the same versus the rationale (linked to evidence) of making changes to it from an equity perspective. In addition to the guidance in the HIA framework you are using, recommendations/suggestions specifically on health equity should be made.

*Some **core** topic areas in the recommendations/suggestions you may want to cover:*

- The impact of the policy on existing health equity issues – gradient and/or gap
- The policy's likely intended and unintended health equity impacts
- The evidenced based measures that would reduce the negative and enhance the positive health equity impacts of the policy
- The health equity indicators to be used to monitor the policy
- The changes required to reduce the health equity impact of the policy.

*Some **enhanced** topic areas in the recommendations/suggestions you may want to cover:*

- The existing health equity issues in the policy area
- The policy's likely interactions/influence/effects on existing and emerging policies that could increase health inequity
- The measures required to align the policy with existing or newly emerging policy to enhance health equity
- The cost-benefits of the measures recommended (data and expertise dependent).

Action: Provide the policy maker with information that describes the health equity impact of the policy and options to mitigate them.

Monitoring and evaluation

With all HIA frameworks monitoring and evaluation should be part of the HIA. Monitoring refers to tracking the relevant health equity indicators to the policy and evaluation refers to the HIA itself i.e. did the HIA achieve its aims. Monitoring and evaluating the HIA and its impact ensures that lessons can be learnt and assessment of whether the HIA had an impact in reducing health inequity can be made. Monitoring depends on the outcomes of the previous steps, with outcomes needing to be meaningful and usable, demonstrating the power of evidence and the potential for modifying HI. The evaluation of the effect of HIA can be carried out straight after the policy is completed. A review package for HIA reports by Ben Cave Associates may aid evaluation³. **The goal of this stage of the questions is to ensure that within the monitoring and evaluation stage, it captures the impact of the HIA on health equity and if and how the health equity was considered in the policy making process.**

³ Freedsgaard MW., Cave B., and Bond A. (2009) *A review package for Health Impact Assessment reports of development projects*. [Online] Available at: http://www.bcahealth.co.uk/pdf/hia_review_package.pdf Accessed on: 24th October 2011.



The questions are in addition to the ones to be found in the HIA framework you are using and explicitly focus on the health equity aspect.

Some questions you may want to ask regarding monitoring and evaluation specifically for equity:

Monitoring

- How will you know if health inequities have been reduced? (What health equity data/outcomes are being collected on the impact of the policy on the identified groups in the assessment stage, compared to the whole population)
- Have the stakeholders (including target groups) been asked what the health impact of the policy has been to them?
- How will increased inequity be dealt with?

Evaluation

- Was the HIA carried out as defined in the in the scoping stage coving the health equity issues? If not why not?
- Were the recommendations of the health equity parts of the HIA adopted?
- Did the health equity focus of the policy change in relation to the HIA and if so how?
- What was the process to enable changes in the policy in relation to health equity?
- Did the stakeholders and target groups have access to the policy making process and if so, were their views considered?
- If so, did this help in the analysis of health equity?

Action: Answering the questions in this stage will help ensure that the impact of the HIA on health equity is captured and consequences monitored.

Table of questions

Stage of HIA	The Questions	Action
<p>Screening</p>	<p>Some core questions you may want to ask as the policy is currently described/intended:</p> <ul style="list-style-type: none"> • Which populations are currently relatively disadvantaged in the context of the policy? • Does the policy affect health equity issues in these populations? • Are the health equity issues affected directly or indirectly? • Does the policy enhance equity or increase inequity e.g. by affecting different population sub-groups differently because of what the policy targets, how the policy is implemented or how it works with/against existing policy? • What might the unintended consequences be (positive and negative)? • What might consequences be of the policy be on the determinants of health? <p>Some enhanced questions you may want to ask as the policy is currently described/intended:</p> <ul style="list-style-type: none"> • Could there be public concern about the equity of the policy? • Could there be an equity concern by other key stakeholders and/or those affected by the policy? 	<p><i>If it is identified that the policy may have an impact affecting health equity, then the rest of the questions should then be used during the HIA. If it is identified that the policy does not have an impact on health equity, then it is advised that the rest of the questions are not needed.</i></p>
<p>Scoping</p>	<p><i>Some core questions you may want to ask:</i></p> <ul style="list-style-type: none"> • Which determinants of health that effect health equity will be assessed in the context of the policy? • What information is needed to understand health equity impacts of the 	<p><i>Once the questions have been answered, this should provide you with the scope to be able to identify the potential impacts and affected populations with</i></p>





regard to health equity.

	<p>policy and inform recommendations/suggestions?</p> <ul style="list-style-type: none"> • What evidence (quantitative and/or qualitative) will be used that will show how the health equity impact is identified? • Which populations are relevant to the policy? (see appendix 4 for some groups) • What information is needed about the relevant populations to determine if there is an health equity issue? • Who will be involved in the assessment i.e. will key stakeholders or those effected by the policy (target groups) have an opportunity to feed into the HIA to help determine health equity dimensions? • How will health equity impacts be presented e.g. number of people affected, types of health/wellbeing impacts, and the degree of change in equity/inequity? • How will uncertainty in health equity impacts be handled e.g. unknown effects, absence of evidence, how public views and professional judgement can be used alongside scientific knowledge, etc.? <p><i>Some enhanced questions you may want to ask:</i></p> <ul style="list-style-type: none"> • Consider long-term/trans-generational timescale of the health equity impacts, e.g. some equity impacts may be trans-generational, or occur over the life-course • What existing policies and new policy developments are likely to affect/interact with the equity aspects of the policy under consideration and how will this information be assessed? 	
<p>Appraisal</p>	<p><i>Building on the scoping answers, now consider some core questions you may want to ask:</i></p> <ul style="list-style-type: none"> • What health equity impacts have been identified as likely to arise from the policy? 	<p><i>Answering the questions, you should be able to explicitly identify any gaps and/or gradients in health equity.</i></p>



	<ul style="list-style-type: none"> • How will the identified health equity impacts be distributed? • Does it introduce new health equity impacts? • Considering the range of health equity impacts identified, what can be done to reduce the negatives and enhance the positives so that the health equity gradient is more equal/equity gap is narrower? (Consider direct and indirect impacts of the policy and the evidence to support such actions). • Has the causal pathway and key factors in the causal links, been considered in the impact of health? <p><i>Some enhanced questions you may want to ask:</i></p> <ul style="list-style-type: none"> • Can the type, degree and likelihood of positive and negative health equity impacts be mapped against the different population groups' e.g. socio-economic, vulnerable/non-vulnerable? • Does it make the existing health equity gradient steeper/shallower or the gap bigger/smaller? • Do the benefits of changing the policy, for moderating or removing these differential impacts outweigh the social, economic and environmental costs or disadvantages of doing so? (Consider the health equity impacts in the short-term, medium and long-term). 	
<p>Recommendations/ Suggestions</p>	<p><i>Some core topic areas in the recommendations/suggestions you may want to cover:</i></p> <ul style="list-style-type: none"> • The impact of the policy on existing health equity issues – gradient and/or gap • The policy's likely intended and unintended health equity impacts • The evidenced based measures that would reduce the negative and enhance the positive health equity impacts of the policy • The health equity indicators to be used to monitor the policy 	<p><i>Provide the policy maker with information that describes the health equity impact of the policy and options to mitigate them.</i></p>



	<ul style="list-style-type: none"> • The changes required to reduce the health equity impact of the policy. <p><i>Some enhanced topic areas in the recommendations/suggestions you may want to cover:</i></p> <ul style="list-style-type: none"> • The existing health equity issues in the policy area • The policy’s likely interactions/influence/effects on existing and emerging policies that could increase health inequity • The measures required to align the policy with existing or newly emerging policy to enhance health equity • The cost-benefits of the measures recommended (data and expertise dependent). 	
<p>Monitoring and Evaluation</p>	<p><i>Some questions you may want to ask regarding monitoring and evaluation specifically for equity:</i></p> <p>Monitoring</p> <ul style="list-style-type: none"> • How will you know if health inequities have been reduced? (What health equity data/outcomes are being collected on the impact of the policy on the identified groups in the assessment stage, compared to the whole population) • Have the stakeholders (including target groups) been asked what the health impact of the policy has been to them? • How will increased inequity be dealt with? <p>Evaluation</p> <ul style="list-style-type: none"> • Was the HIA carried out as defined in the in the scoping stage coving the health equity issues? If not why not? • Were the recommendations of the health equity parts of the HIA adopted? • Did the health equity focus of the policy change in relation to the HIA and if 	<p><i>Answering the questions in this stage will help ensure that the impact of the HIA on health equity is captured and consequences monitored.</i></p>



	<p>so how?</p> <ul style="list-style-type: none">• What was the process to enable changes in the policy in relation to health equity?• Did the stakeholders and target groups have access to the policy making process and if so, were their views considered?• If so, did this help in the analysis of health equity?	
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http://www.health-inequalities.eu/health-inequalities/Equity_Action_WP4Tools.html Accessed on: 10th August 2011.

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October 2011.

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http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

Accessed on: 20th October 2011.

WHO (2011) *Health Impact assessment: Glossary of terms*. [Online] Available at:

<http://www.who.int/hia/about/glos/en/index1.html> Accessed on: 10th August 2011.

Further Reading

These two documents provide a detailed analysis of the social determinants of health and possible policy solutions.

Commission on Social Determinants of Health (CSDH) (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*.

http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Marmot M. et al. (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*.

<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

Other HIA Frameworks with equity focus

Additionally these HIA frameworks include some analysis of health and equity within them which will enable a view of a complete HIA framework.

Abrahams D, den Broeder L, Doyle C, Fehr R, Haigh F, Mekel O, Metcalfe O, Pennington A, Scott-Samuel A. (2004) *EPHIA - European Policy Health Impact Assessment: A Guide*. Liverpool.

International Health Impact Assessment Consortium, University of Liverpool. Available at:

http://www.liv.ac.uk/ihia/IMPACT%20Reports/EPHIA_A_Guide.pdf

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). Available at: http://www.hiaconnect.edu.au/files/EFHIA_Framework.pdf

Ministry of Health, New Zealand (2007) *Whanau Ora Health Impact Assessment*. Available at:

[http://www.moh.govt.nz/moh.nsf/pagesmh/6022/\\$File/whanau-ora-hia-2007.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6022/$File/whanau-ora-hia-2007.pdf)

Public Health Advisory Committee (2005) *A Guide to Health Impact Assessment: A Policy for*

New Zealand. Available at: <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-guide-hia-2nd>

Public Health Institute of Scotland (2006) *Health Impact Assessment: a guide for local authorities*.

Available at: <http://www.healthscotland.com/documents/1283.aspx>

Welsh Health Impact Assessment Support Unit (2004). *Improving Health and Reducing Inequalities: A practical guide to health impact assessment*. Available at:

<http://www.apho.org.uk/resource/item.aspx?RID=44257>

Appendix 1: Glossary of terms

Determinants of health (WHO⁴)

Determinants of health are factors which influence health status and determine health differentials or health inequalities. They are many and varied and include, for example, · natural, biological factors, such as age, sex and ethnicity; behaviour and lifestyles, such as smoking, alcohol consumption, diet and physical exercise; the physical and social environment, including housing quality, the workplace and the wider urban and rural environment; and access to health care (Lalonde, 1974; Labonté, 1993). All of these are closely interlinked and differentials in their distribution lead to health inequalities.

Differential health impacts (ACHEIA⁵)

Are those changes (positive or negative) that may occur as a result of the proposed initiative **and** are *differentially* distributed among population groups. For example, a new home visiting initiative for families where first contact is made through telephoning the family at home. A potential impact of this proposal is that those families without telephones at home won't be contacted and therefore the health impact is distributed differentially among the target population.

Evidence Base (WHO³)

The evidence base refers to a body of information, drawn from routine statistical analyses, published studies and “grey” literature, which tells us something about what is already known about factors affecting health. For example, in the field of housing and health there are a number of studies which demonstrate the links between damp and cold housing and respiratory disease and, increasingly, the links between high quality housing and quality of life.

Health impact (WHO³)

A health impact can be positive or negative. A positive health impact is an effect which contributes to good health or to improving health. For example, having a sense of control over one's life and having choices is known to have a beneficial effect on mental health and wellbeing, making people feel “healthier” (Wilkinson, 1996). A negative health impact has the opposite effect, causing or contributing to ill health. For example, working in unhygienic or unsafe conditions or spending a lot of time in an area with poor air quality is likely to have an adverse effect on physical health status.

Health inequality Gap (HDA⁶)

Health inequality is the gap between the health of the best-off and worst-off groups. Narrowing health gaps means ‘raising the health of the poorest, fastest’. It requires both improving the health of the poorest and doing so at a rate which outstrips that of the wider population.

Health inequality gradient (HDA⁵)

The penalties of inequalities in health affect the whole social hierarchy and usually increase from the bottom to the top. Thus, if policies only address those at the bottom of the social hierarchy, inequalities in health will still exist (Acheson, 1998). Health improves at each step up the socioeconomic ladder. There are gradients in disability and chronic illness, self-rated health and psychological wellbeing, and life expectancy and premature mortality – as well as in most major causes of death, such as coronary

⁴ WHO (2011) *Health Impact assessment: Glossary of terms*. [Online] Available at: <http://www.who.int/hia/about/glos/en/index1.html> Accessed on: 10th August 2011.

⁵ 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: 24th October 2011.

⁶ Health Development Agency (2004) *Health Inequalities: concepts, frameworks and policy*. [Online] Available at: http://www.nice.org.uk/niceMedia/pdf/health_inequalities_policy_graham.pdf Accessed on: 24th October 2011.

heart disease and lung cancer. There are also marked gradients with increasing levels of area deprivation in mortality from these major causes. Tackling health gradients is in line with international health policy. The founding principle of the World Health Organization is that the enjoyment of the highest attainable standard of health is a fundamental human right, and should be within reach of all 'without distinction for race, religion, political belief, economic or social condition'. As this implies, the standards of health enjoyed by the best-off should be attainable by all.

Stakeholder Group (ACHEIA⁴)

A stakeholder refers to someone who has a stake in the policy, either through its development or implementation, or in the outcomes of it. The term 'stakeholder' might refer to either a member of a marginalised group who is likely to be affected by the policy or to a person whose interest it is to have the policy developed. As all stakeholders have a stake in the policy, they have a valuable role in any consultation processes conducted within the EFHIA processes.

Target group (ACHEIA⁴)

Is used to describe the group or section of the population to whom the policy is directed.

Appendix 2: Examples of some health determinants

Categories of determinants of health	Examples of specific health determinants	
Social and cultural factors	Social status Social support, social cohesion Social isolation Participation in community and public affairs family connections Cultural and spiritual participation Expression of cultural values and practices Racism	Perceived control Discrimination Attitudes to disability Fear of prejudice Level of fear of crime Reputation of the community/area Perception of safety
Economic factors	Creation and distribution of wealth Income level Affordability of adequate housing	Availability and quality of employment/education/training Skills development opportunities
Environmental factors (including living and working conditions)	Housing conditions and location Working conditions Quality of air Quality of water (surface, groundwater, drinking water) Quality of soil Waste disposal Energy Urban design	Land use Biodiversity Sites of cultural significance A change in the emission of greenhouse gases Public transport and communications networks Noise Exposure to pathogens
Population-based services	Access to and quality of: Employment and education opportunities Workplaces Housing Public transport Healthcare	Disability services Social services Child care Leisure services Basic amenities Policing
Individual and behavioural factors	Personal behaviours (e.g. diet, physical activity, smoking, alcohol intake, drug use) Life skills Personal safety Peoples belief in the future and sense of control in their lives	Employment status Educational attainment Level of income and disposable income Stress levels Self-esteem and confidence Access to employment
Biological factors	Sex	Ethnicity

	Biological age	Disability
Equity factors	Distribution of health impacts based on existing health status, environmental quality, capacity to cope with health pressures, early years development, schooling, training, employment and retirement etc.	

Adapted from: *A Guide to Health Impact Assessment: A policy for New Zealand* (PHAC, 2005)⁷

⁷ Public Health Advisory Committee (2005) *A Guide to Health Impact Assessment: A Policy for New Zealand*. [Online] Available at: <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-guide-hia-2nd> Accessed on: 17th October 2011.

Appendix 3. Different ways of analysing the distribution of differences

There are three ways to report the distribution of differences in potential health impacts. For example you can measure:

- The health impacts in a specific population such as people living in poverty, Roma community, migrants, women or men, different ethnic groups, unemployed etc. = *remedying health disadvantage*; or
- The difference in the potential health impact(s) between two groups in the population, e.g. between those in the highest socioeconomic quintile and those in the lowest socioeconomic quintile = *closing the gap*; or
- the difference in the potential health impact(s) between more than two groups in the population, e.g. differences between socioeconomic quintiles = *the social gradient*.

For example the table below shows the absolute and relative changes in age-standardized death rates (per 100 000 population) for circulatory diseases in people less than 75 years of age, by deprivation area, in England, 1995–1997 and 2001–2003.

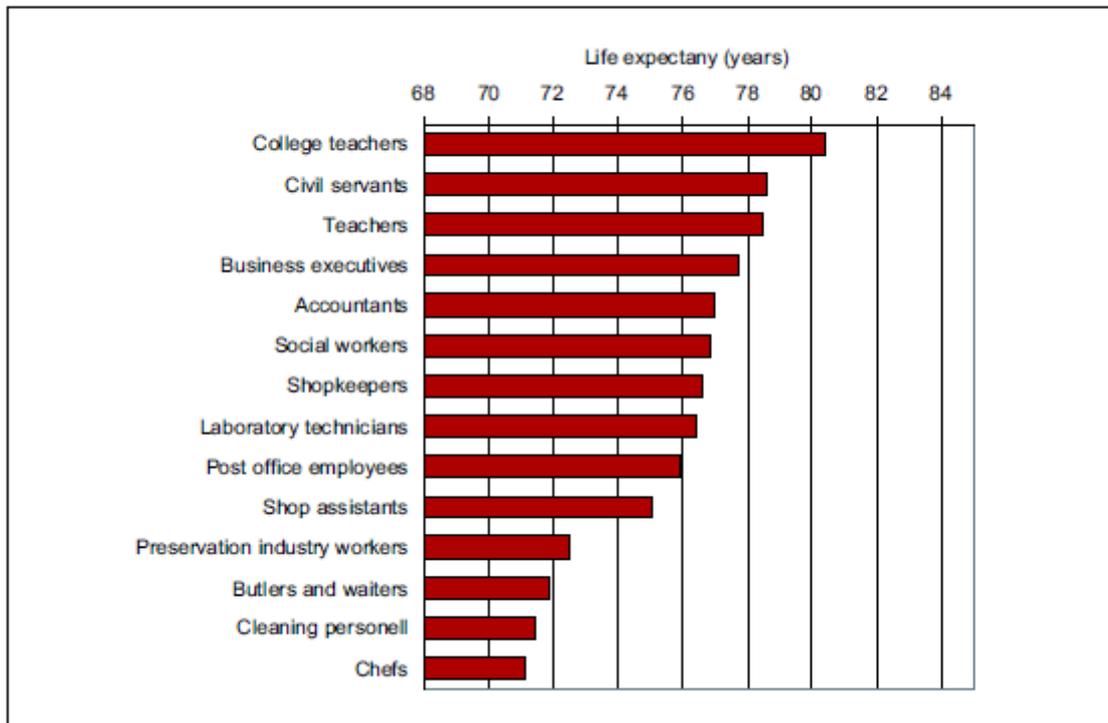
Rates and gaps	1995-1997	2001-2003	Change in inequality
Death rate for the 20% most deprived local authorities (in deaths per 100 000 population)	173	129	-
Death rate for England as a whole (in deaths per 100 000 population)	141	103	-
Absolute gap (difference) between disadvantaged and England as a whole (in deaths per 100 000 population)	173-141 = 32	129-103 = 26	Reduction
Relative gap (ratio) between disadvantaged and England as a whole	173/141=1.22	129/103 = 1.25	Increase

Adapted from: *Concepts and principles for tackling social inequalities in health: Levelling up Part 1*. (WHO, 2007)⁸.

An example of gradient can be shown in occupation and life expectancy. Factors at work have an impact on health, these factors may be physical (ergonomic, chemical and biological), psychosocial or organisational. The figure below highlights the gradient in life expectancy by occupation.

⁸ WHO (2007) *Concepts and principles for tackling social inequalities in health: Levelling up Part 1*. [Online] Available at: http://www.euro.who.int/_data/assets/pdf_file/0010/74737/E89383.pdf Accessed on: 17th October 2011.





Life expectancy for a sample of occupations, men (based on occupation at the 1980 census and deaths recorded 1996-2000). Adapted from: *National strategy to reduce social inequalities in health (Norwegian Ministry of Health and Care Services)*⁹.

⁹ Norwegian Ministry of Health and Care Services (2006) *National strategy to reduce social inequalities in health*. [Online] Available at: http://ec.europa.eu/health/ph_determinants/socio_economics/documents/norway_rd01_en.pdf Accessed on: 24th October 2011.



Appendix 4. Data examples

The list below provides examples of data sets and analysis tools at the EU level that could be used as a starting point for analysis. The www.hiagateway.org.uk also provides a range of guides, tools and information on HIAs.

Dynamic Model for Health Impact Assessment <http://www.dynamo-hia.eu/root/o14.html>

Eurothine – A platform to facilitate information exchange <http://survey.erasmusmc.nl/eurothine/>

EU Statistics - Eurostat <http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/>

Health – EU Public Health Portal for the European Union http://ec.europa.eu/health-eu/health_in_the_eu/statistics/index_en.htm

Organisation of Economic Co-operation and Development statistics- OECD Statistics Portal <http://stats.oecd.org/Index.aspx>

United Nations Statistics Division - National level statistics <http://unstats.un.org/unsd/default.htm>

World Health Organisation Statistics – Global Health observatory <http://www.who.int/gho/en/>

The commission on the social determinates of health¹⁰ suggested a minimum health equity surveillance system which would provide basic data on death and morbidity by socioeconomic and regional groups within countries. The suggested health outcomes included;

- **Mortality:** infant mortality and/or under 5 mortality, maternal mortality, adult mortality and life expectancy at birth
- **Morbidity:** at least three nationally relevant morbidity indicators, which will vary between countries and might include prevalence of obesity, diabetes, under-nutrition and HIA, self-rated mental and physical health.
- **Measures of inequality:** In addition to population averages, data on health outcomes should be provided in a stratified manner including stratification by;
 - Sex
 - At least two social markers (e.g. education, income/wealth, occupational class, ethnicity)
 - At least one regional marker (e.g. urban/rural, province)
 - Include at least one summary measure of absolute HI between social groups and one summary measure of relative HI between groups
 - Good quality data on the health of indigenous peoples should be available where applicable.

¹⁰ Commission on Social Determinants of Health (CSDH) (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. [Online] Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf Accessed on: 24th October 2011.



To frame the difference in different groups you may want to consider difference by;

- Ethnic groupings
- Sex
- Age
- Socioeconomic status
- Geographical
- Sexual orientation
- Religion or belief
- Those with disabilities and their carers
- Other particularly vulnerable groups e.g. homeless people, Roma
- Other groups who may be affected by the policy



Appendix 5. Method of development of this series of questions

An expert workshop was held on 8 September 2011 at the Department of Health as part of the EC Equity Action programme on HI Work Package 4 (“tools”). The aim of the day had been stated as “to develop a tool for use across the EU member states to address equity in the policy HIA process”, the workshop would - in practice be a key part of a process to develop such a tool, initially for use in the November 2011 HIA training workshop.

Notes from the expert workshop were used to develop a draft series of questions. This draft was sent back around to the experts for refinement three times, before the final working draft to be used in the HIA training for MS in November 2011 was used.

Attendees of the workshop

Alex Scott-Samuel	International Health Impact Assessment Consortium
Ben Cave	Ben Cave Associates
Chris Brookes	Health Action Partnership International
Colleen Williams	Independent consultant
Erica Ison	Ben Cave Associates
Eva Elliot	Cardiff Institute of Society and Health
Margaret Douglas	NHS Lothian
Marco Martuzzi	WHO European Office
Mark Gamsu	Health Action Partnership International
Mary Mahoney	University of Gloucestershire
Nerys Cross	Department of Health
Peter Goldblatt	University College London
Ray Earwicker	Department of Health
Sabrina Diffang	Health Action Partnership International
Salim Vohra	IOM Centre for Health Impact Assessment
Sarah Simpson	WHO European Office
Stephen Gunther	Department of Health
Sue Atkinson	Public Health Action support Team

The first draft of the series of questions was presented at the Equity Action work Package 4 HIA training delivered by Ben cave Associates on the 14/15 November 2011. Attendees of the training critiqued the first draft and made suggestions to develop the series of questions further. This version represents the changes suggested by participants.



Attendees of the HIA training 14/15 November 2011

Ben Cave	Ben cave Associates – Training provider
Erica Ison	Ben cave Associates – Training Provider
Stephen Gunther	Department of health UK
Ida Knutsson	Swedish National Institute of Public Health
Simona Olivadoti	Agenzia Nazionale per I servizi Sanitaria Regionali
Giuseppe Costa	Azienda Sanitaria Locale T03 - Piemonte Regione
Michele Marra	
Ilze Straume	Veselibas ekonomikas centrs
Eszter Lőrík	Országos Egészségfejlesztési Intézet
	Federal Public Service Health, Food Chain Safety and Environment
Pol Gerits	
Michel Lambrechts	
Mariel Droomers	National Institute of Public Health and the Environment
Ellen Uiters	
Mirjam Busch	
Stig Erik Sørheim	Norwegian Directorate of Health
Mali Strand	
María Santaolaya	Ministry of Health, Social Policy and Equality
Ana Gil Luciano	
Mario Saugo	Regione del Veneto
Manuele Falcone	
Luska Jerdin	
Gila Gingell	Welsh Government
	Direction generale de la sante, Ministere de la sante et des sports
Nicolas Prisse	
Geraldine Tonnaire	
Amaia Baciglupe	Fundación Vasca de innovación e Investigación Sanitarias
Elena Aldasoro	



Annex 3: Different components of equity/equality & inequity/inequality noted by participants

Components of equity/equality & inequity/inequality

- Health improvement/health promotion
- Access to healthcare
- Ethical component – Human Rights, equal rights, justice social justice
- Fairness/Fairness in the distribution of resources
- Social gradient/stratification/
- Pre-existing health inequalities and pre-existing social inequalities
- Avoidable/modifiable aspect to inequalities
 - Differences in need across population
 - Differences in opportunity across population
 - Differences in access to services/resources
 - Differences in availability of services/resources
 - Differences in quality of services/resources
 - Differences in use of services/resources or barriers to access to services/resources
 - Differences in organisation of services
 - Potential differences in effects/distribution of effects across population
 - Potential differences in outcomes of proposal implementation
 - Importance of targeting certain groups in population (disadvantaged/vulnerable/people experiencing health or other inequalities)

Personal factors

Age	Religion or beliefs	Place of residence
Gender	Sexual orientation	Gender reassignment
Disability	Family status/marriage & civil partnership	Skin colour
Ethnic group/identity/background or race	Civil status/social background or status/socio-economic status	Language
Physical environment	Political and other views	