

ACHEIA
Australasian Collaboration for Health Equity Impact
Assessment

*Equity-focused Health Impact Assessment - working collaboratively to
develop a strategic framework*

POSITION PAPER

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This document has been developed by Jenny Stewart Williams in conjunction with Rosemary Aldrich, Mary Mahoney, Elizabeth Harris, Sarah Simpson and other members of ACHEIA.

Abstract

In September 2002, the University of Newcastle, Australia, in partnership with Deakin University and the University of New South Wales, was funded under the Australian Government's Public Health Education Research Program (PHERP) to undertake a two year project entitled 'Equity-focused Health Impact Assessment - working collaboratively to develop a strategic framework'. The project brings together an international collaboration known as the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). The project aims to: develop an Equity-focused Health Impact Assessment (EFHIA) framework; test the framework in five case studies located across Australia and New Zealand; disseminate the results, and promote the implementation of EFHIA in the Australian health sector workforce.

The project is underpinned by the social model of health, which attributes the causes of illness beyond biological and genetic factors, to include a range of social, geographic and economic determinants such as income, education, area of residence, employment and levels of social and workplace support and cohesion, as well as the health care system. In many societies, the evidence points to better health for those who have higher incomes, are more highly educated, and have greater social and material support and power.

Social, cultural and economic factors determine health, and the unequal distribution of the determinants of health produces health inequalities. Achieving equity in health, or health equity, is not about eliminating all health inequalities, but instead about reducing or eliminating unnecessary and avoidable differences that are also considered to be unfair and unjust.

Health inequity is commonly measured in terms of socioeconomic health inequalities. Building upon and extending the practices of policy-linked Health Impact Assessment, EFHIA will identify health inequalities that are associated with relative levels of socioeconomic disadvantage, and articulate a transparent process for equity-focused decision-making in public policy.

1 Introduction

The aim of this project is to demonstrate the application of Equity-focused Health Impact Assessment (EFHIA) in a range of health settings in Australia and New Zealand (NZ). This position paper provides a context and rationale for the project, and its conceptual and methodological underpinnings, as well as a review of the relevant literature. The paper comprises three main sections, of which this introduction is the first. The second section clarifies the terminology around health equity and EFHIA, and the third section frames EFHIA within a policy context.

1.1 Project background

In September 2002, the University of Newcastle, Australia, in partnership with Deakin University and the University of New South Wales, was funded under the Australian Government's Public Health Education Research Program (PHERP) to undertake a project entitled 'Equity-focused Health Impact Assessment - working collaboratively to develop a strategic framework'. This project, which runs from September 2002 to August 2004, brings together an international collaboration of multi-disciplinary investigators, clinicians, academics, public health experts, and key senior health managers working in national, state and local settings.

The project is the responsibility of the Project Management Committee that comprises a management team (to oversee the implementation and evaluation of the framework and ensure the professional integrity of the project), the Case Study Partners, an International Reference Group (to provide expert advice and support for the project) and additional Australian advisers. These groups together comprise the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA) to guide the strategic direction of the project.

Although all areas of public policy have potential impacts on the health of populations, this project is grounded in the health sector. In this first iteration of EFHIA, we will demonstrate an explicit approach for decision-makers working in a range of health settings, to identify and assess the unanticipated and embedded socioeconomic health inequalities and inequities, that exist, actually, and/or potentially, in policies, plans, strategies, decisions, guidelines, programs or services. These activities are referred to here as 'policy and practice'.

There are three phases within the project. In addition to ongoing operational matters, phase 1 comprises the development of a draft Equity-focused Health Impact Assessment framework, phase 2 encompasses the testing of the framework across five case studies at local, state and national levels, and phase 3 comprises the dissemination of the results, as well as workforce capacity building.

1.2 Project aims

In line with these three phases, the project aims to:

1. develop a draft EFHIA framework and accompanying draft manual (with a suite of analytical tools, methods and procedures) to identify and assess the impact of policy and practice on health inequalities and inequities.
2. examine, monitor and appraise the application of the draft EFHIA framework to determine the prospective, concurrent, and retrospective impacts that policy and practice activities have on socioeconomic health inequalities.
3. modify and refine the draft EFHIA framework and manual in the light of the lessons learnt, disseminate the results of the case studies, and support capacity building for EFHIA in the Australian health workforce.

1.3 Case studies

Policy making within the health care sector leads to decisions that influence the costs, distribution and delivery of health care resources. The case study focus here is on health policies and practices aimed at improving the health of population groups, rather than the financing and organisation of health care infrastructure. The five case studies have been selected to illustrate a variety of health policy and practice issues, and a range of methodological approaches.

The decision to adopt a health focus in this first iteration of EFHIA in Australia and NZ, was made for a number of pragmatic reasons, including the collective professional skills, knowledge, experience and networks of the principal collaborators, in addition to the fact that funding was provided by the Department of Health and Ageing in Australia, for research into public health innovation and workforce development.

The Case Study Partners are the NZ Ministry of Health, the Royal Australasian College of Physicians (RACP), the ACT Health Promotion Board, Australian Capital Territory (ACT) Health Department, the National Health and Medical Research Council (NHMRC) in Australia, and the Division of Medicine, John Hunter Hospital, in Newcastle, Australia. The NZ case study will involve collaboration with the NZ Ministry of Health to assess the equity impact of the “Healthy Eating: Healthy Action” policy which was written with specific reference to Maori health. The RACP case study will apply EFHIA to components of the College’s Support Scheme for Rural Specialists; the ACT case study will undertake a retrospective EFHIA on projects funded by the ACT Health

Promotion Board (known as Healthpact), the NHMRC case study will apply EFHIA to the NHMRC guideline “Dietary Guidelines for Older Australians”, and the John Hunter Hospital case study will focus on investigating the health impacts of the hospital’s outpatient Cardiac Rehabilitation Program. While these first four case studies have a population health focus, the Cardiac Rehabilitation case study has a clinical service focus.

Through its case studies, the project will demonstrate EFHIA as a transparent and structured process, in which values and assumptions are explicitly stated. While the findings of the case studies will be of interest, their purpose is to provide a vehicle for the development and testing of the draft EFHIA framework, with recommendations for improvement. It is not possible, in this first iteration comprising only five case studies, to explore every possible variation of EFHIA. Each application of the framework will be a function of setting, resource availability and other contextual factors, which will describe when, how, why and by whom, the activity in question is being assessed for its impact on health inequities.

The case studies will provide feedback to ACHEIA on the application of the draft EFHIA framework. Data will be gathered through process evaluation, and where feasible, impact evaluation, to monitor acceptance of the EFHIA recommendations. The evaluation will highlight both anticipated and unanticipated implementation issues, and recommend ways in which EFHIA processes can be improved. Outcome evaluation will not be possible due to the time frame required for completion of the project. Ongoing investment and commitment is required to evaluate whether such initiatives contribute to equity in health over the longer term.

1.4 Definitions of health

In 1946 the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease”.¹ Health is also “the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs, and on the other hand, to change and cope with the environment. Health is a resource for everyday life; it is a positive concept emphasising social and personal resources as well as physical capacities”^{2,3}

The meaning of health is culturally dependent, and there are many diversities within societies and cultures that result in different interpretations of health. For indigenous peoples, the concept of health differs within tribes and nations, and some researchers and indigenous groups have developed their own definitions of health.^{4,5} In general, indigenous peoples view health and well-being from a comprehensive holistic perspective which includes the natural, geographical, social and spiritual dimensions of life, and relates them to each other in a network of dependencies.⁶

In recognition of the fact that many earlier definitions of health did not specifically apply to indigenous peoples, in 1999, the WHO proposed a definition of indigenous health as “both a collective and an inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life....the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present, and future co-exist simultaneously”.^{4 5 7-9}

This project encompasses a broad definition of health, taking into account biological and genetic determinants, the physical, social, cultural and economic environments, as well as emotional, psychological and spiritual dimensions.

1.5 Social model of health

Equity-focused HIA is underpinned by the broad social model of health, under which the causes of illness are extended beyond biomedical factors to include a range of ‘social determinants’ such as income, education, area of residence, employment, and levels of social and workplace support and cohesion, as well as the health care system, which includes the delivery and utilisation of health services, the allocation of health care resources, the public/private financing of health care, and the availability, accessibility, affordability and quality of health care services.^{3 10-13}

A main tenet underlying the social model of health is the belief that health is a basic human right, with health development being essential for social and economic development.¹⁴ Under the social model, there are profound links between the concepts of poverty, social justice, human rights, fairness, and equal opportunities for the health of sub-groups who endure discrimination and social marginalisation.^{13 15} In many countries in which the attainment of the maximum possible level of health is viewed as a key responsibility of governments, there is increasing recognition that this requires action by sectors other than health, to address and lessen the patterns of health disadvantage.^{2 10 16}

The Ottawa Charter emphasised the need for broad health promotion strategies to improve the physical, social and economic environment.¹⁷ Health promotion is a process of enabling people to increase control over, and improve their health. Through investment and action, health promotion can impact upon the social determinants of health, and contribute to gains in health status, defined as the degree to which a person is able to function physically, emotionally and socially, with or without aid from the health care system.^{14 17 18}

2 Equity and Policy-linked EFHIA

Health equity is a multi-dimensional concept. While there is a degree of overlap, the term 'health inequalities' is often incorrectly used as a synonym for 'health inequities'. This section first clarifies the terminology, before outlining Health Impact Assessment and Equity-focused Health Impact Assessment.^{13 19 20}

2.1 Equity and equality

Regardless of the health care system, some degree of difference in health outcomes is inevitable and unavoidable. There are many observed and measurable differences in health status between individuals or groups. These differences include natural, *unavoidable* variations due to biological or genetic factors that cannot be changed (e.g. age, sex, disability), as well as *avoidable* variations due to social and economic factors. It is these avoidable and reversible differences that may be considered, in a given societal context, to be unnecessary, unfair and unjust.

Inequities are differences that are also considered to be unnecessary and avoidable, as well as unfair and unjust.^{12 21 22} The continuum of equity/inequity has a moral and ethical dimension premised upon 1) one's theory of social justice; 2) one's theories of society and 3) one's reasoning underlying the genesis of inequities.²³ Judgments as to which health differences are unnecessary and avoidable, and unfair and unjust, are often controversial, and views on what is equitable vary socially, culturally and historically.^{12 21} Equity is a normative concept, implying fairness and justice.¹⁹

On the other hand 'equality' and its corollary 'inequality' are descriptive terms, referring to observed measurable differences that may or may not be considered inequitable. While the terms 'equity' and 'equality' are related, they are different concepts. The key differences are that equality can be assessed with respect to measurable outcomes, whereas equity is underpinned by value judgments and not all inequalities are inequities.¹³ There is a need for conceptual clarity when using terms like *inequalities* and *inequities*. Paula Braveman claims that inequity does not refer generically to just any inequalities between any population groups, but very specifically to disparities between groups categorised *a priori* according to some important features of their underlying social position.¹⁹ Our approach supports this view which requires identification of socioeconomic inequalities in health according to factors that reflect relative social advantage and disadvantage.

The term 'health equity' is used synonymously with 'equity in health'. However inequity in health is not only due to the health care system. The need for health services is influenced by social as well as medical factors.²⁴

In 2003 Braveman and Gruskin published a definition of equity in health as “the absence of systematic disparities in health (or the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage - that is wealth, power or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged...at further disadvantage with respect to their health”.¹³

Achieving equity in health is not about eliminating all health differences so that everyone has the same level of health, but rather about reducing or eliminating those differences which result from factors considered to be unfair and also avoidable or amenable to change.¹² In operational terms, the pursuit of health equity can lead to the reduction or elimination of health inequalities that are systematically associated with underlying social disadvantage and/or marginalisation.^{13 15} The extent of positive discrimination made in favour of the less advantaged reflects how ‘caring’ a society is.²⁴

2.2 Health Impact Assessment (HIA)

One of the most commonly cited definitions of HIA was developed by the European Centre of Health Policy as part of the WHO Gothenburg consensus paper.²⁵⁻²⁷ The ‘Gothenburg definition’ states that HIA “is a combination of procedures, methods and tools by which a policy, program 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”.^{25 26 28-31}

Under HIA, health impacts encompass direct and indirect, intended and unintended, and potential and actual effects on the health of a population. Such impacts may be felt immediately, in the short term, or after a longer period of time.²⁵ However the task of quantifying and qualifying these impacts, and their distribution within and between populations, can be complex, and resource constraints dictate the depth and extent to which this is feasible.

The broad definition of HIA refers to an approach for decision-makers to ensure that policies, practices, and also discrete projects, can be properly assessed in terms of how they impact upon health. Health Impact Assessment can therefore be used to inform policy and decision-making to maximise health benefits and minimise negative impacts on health.^{27 32} The linkage to projects can, in part, be attributed to the fact that HIA originated in Environmental Impact Assessment (EIA), which grew into prominence in many western market driven economies (such as the United States, Canada and Australia) in the 1980s.²⁸ Environmental Impact Assessment carries legislative requirements for projects and developments that impact upon the physical and social environment. Critics of EIA argue that because it is carried out by the proponents of the project being assessed, it leads to conflicts of interest.

In many countries including Australia, NZ and Canada, HIA has developed as an essential component of EIA.²⁶ The Health Impact Assessment Guidelines produced by Enhealth in Australia in 2001, specifically address the use of HIA when conducting EIA.³³ Despite the overlaps, applications of HIA within EIA and HIA, have fundamental differences; EIA is driven by environmental regulation, whereas HIA is underpinned by the social model of health, and when used as a public health policy tool, is often positioned within a health promotion agenda.³⁴

Although there is debate in the HIA literature about the types and levels of evidence required for HIA, both qualitative and quantitative tools and methods are necessary to assess the nature and extent of health impacts.³⁵ The choice of tools and methods also depends upon the resources available. Critics of HIA claim that it is insufficiently rigorous to establish the magnitude, or even direction, of the health impacts of policy interventions.²⁷ This view can result from a lack of understanding of HIA as a broad multi-disciplinary activity, straddling the traditional boundaries between public health, epidemiology, health services planning, and environmental and social sciences.³⁶ (See also section 2.7).

2.3 HIA values

In the Gothenburg Consensus Paper, the WHO proposes values which are particularly important for HIA democracy, equity, sustainability, and the ethical use evidence.^{25 31} There is broad agreement that HIA should also be based on a number of key principles which include the social model of health, an explicit focus on equity and social justice, a multi-disciplinary approach, and the use of both qualitative and quantitative evidence.³⁷ The equity-focused approach also supports the need for participatory methods, and for openness to public scrutiny at all stages of the evaluation process.³⁸

2.4 Equity-focused HIA

The 1997 Jakarta Declaration on Health Promotion into the 21st Century placed a high responsibility on governments in promoting social responsibility for health, and further identified equity-focused HIA as a high priority for action.^{14 39} In 1998 the UK *Independent Inquiry into Inequality and Health*, which was chaired by Sir Donald Acheson, and known as the Acheson Report, had 39 recommendations. The first recommendation was that “*as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities*”.⁴⁰ The Acheson Report led the debate in the UK about perceived differences between HIA and what is termed ‘Health Inequalities Impact Assessment’.⁴⁰

We recognise the ongoing international debate about whether HIA already has an integral equity focus, or whether a separate process of policy-linked HIA, with an explicit equity focus, is required.²⁶
⁴¹⁻⁴⁴ However in Australia and NZ, the linking of HIA to policy and practice outside EIA is in its infancy, and this project adopts the term 'Equity-focused Health Impact Assessment'. While EFHIA involves identifying health inequalities, it is concerned with assessing socioeconomic inequalities in health according to factors that reflect relative social advantage and disadvantage.¹⁹ The EFHIA framework reinforces equity as a core and explicit value across all policy-linked applications of HIA in Australia and NZ.

2.5 Policy-linked HIA

In Europe during the 1990s, the application of HIA shifted from projects under the EIA umbrella, to the public policy arena. Policy-linked HIA is the application of HIA tools to policies, strategies, decisions, programs or services, (i.e. policy and practice as defined here), as distinct from discrete developments and projects, which often carry legislative requirements under EIA.³²

Although it has been argued that HIA can be carried out retrospectively, concurrently and prospectively, one of the main strengths of HIA lies in prospective applications.⁴⁵ The application of prospective HIA in policy settings injects health awareness to policy-making at all levels.^{46 47} If prospective HIA is implemented early during the planning phase, recommendations can inform the decision-making and planning processes.^{25 48}

In addition to the legislative requirements, one of the fundamental differences between HIA within EIA, and the newer policy-linked HIA, is that under the former, health is one of multiple components for consideration, whereas under policy-linked HIA, impacts on human health are the primary focus of attention.²⁶ Some argue that when compared with EIA, policy-linked HIA is not an accurate title, and that it has stronger parallels with Strategic Environmental Assessment which is the policy dimension of EIA.³¹ The central goal of HIA in the policy context is to ensure that governments' (or other bodies') policies and programs do not diminish individual and population health, while also assisting with the prevention of health inequalities.²⁶

Attempts to integrate health and sustainable development have placed policy-linked HIA on the agendas of some governments in Europe, and also on the agendas of international agencies such as the World Bank, WHO and the European Union.^{25 49} Within the European Union (EU) there is a growing commitment to the institutionalisation of HIA into mainstream policy development and implementation, as evidenced by the EU legislative requirements.²⁶ While the UK government has not yet legislated for policy-linked HIA to occur, all four of the UK nations' consultative documents

on public health strategy have referred to the requirement for HIA to be undertaken on both national and local policies and projects.⁴⁵

2.6 Policy-linked Equity-focused HIA

Through its case studies, this project will demonstrate the first applications of policy-linked EFHIA in the health sectors in Australia and NZ. Equity-focused HIA is specifically concerned with the potential and actual unequal distribution of health impacts that are inequitable. Equity-focused HIA is not a separate sub-specialty of HIA, but rather policy-linked HIA with an embedded equity focus. Building upon and extending the practices of policy-linked Health Impact Assessment, EFHIA will identify health inequalities associated with levels of socioeconomic disadvantage, and articulate a transparent process for equity-focused decision-making in public policy.

2.7 Disciplines which inform EFHIA

While there are overlaps, the methodological approach adopted by EFHIA is broader than any single discipline. Epidemiologists, for example, analyse risk factors, exposures or determinants, and distinguish between risk factors that are alterable, (e.g. behaviours) and those that are fixed, such as age, gender and genetic inheritance. Under EFHIA, the underlying socioeconomic determinants of health, or the “determinants of determinants” are examined. Socioeconomic, as well as environmental, behavioural, biological and genetic factors are all relevant in assessing the chain of causation between policy and health outcomes.⁵⁰

Under policy-linked EFHIA, health impacts that are judged unfair and unjust are assessed. While it is difficult, if not impossible, in the short run to change the structural, social, and economic determinants of equity, EFHIA identifies ways in which health impacts can be modified to reduce unfair socioeconomic health inequalities. A range of disciplines (including epidemiology, health economics and sociology) employing both quantitative and qualitative methods, inform the process of gathering evidence for EFHIA. An emphasis on quantitative versus qualitative methods qualifies HIA/EFHIA as “tight perspective” or “broad perspective” respectively.³¹

2.8 The core steps

We have identified six sequential steps for EFHIA. These are *Screening, Scoping, Profiling, Mapping, Recommendations* and *Monitoring and Evaluation*.^{31 50 51} The *Profiling* and *Mapping* steps are also described in the literature as ‘identifying the impacts’ and ‘appraising the impacts’ respectively.^{26 32} Under EFHIA, an explicit equity focus is embedded within each step. The EFHIA steps are outlined in the draft ACHEIA project manual, which also provides a user-friendly guide to EFHIA, for those both familiar, and unfamiliar, with HIA and health equity.

Screening

As the first step in EFHIA, screening is a process of systematically deciding whether the EFHIA should be undertaken, i.e. whether it will add value to the decision-making process, and whether there are sufficient resources to undertake the proposed impact assessment.³¹ Stating what is judged to be unfair, unjust, avoidable and unnecessary, occurs at this first step in the EFHIA process. Screening includes the identification of the actual or potential health impacts of the activity in question on population sub-groups, and also an assessment of whether the differential impacts are inequitable. Screening is undertaken through consultation with stakeholders, and also relies on informed opinion and available evidence. Screening leads to a decision to either undertake, or not undertake, an EFHIA.²⁹

Scoping

Scoping involves defining the scope and setting the boundaries for the EFHIA.⁵⁰ The key tasks include setting the boundaries (or terms of reference) for the appraisal of health impacts, and their distribution, identifying the key informants, stakeholders, populations to be studied, resource availability and time frame, agreeing on the way in which the appraisal will be managed, allocating responsibility for decision-making, including establishing a steering committee, and agreeing on how to monitor and evaluate the processes.³² Specific to EFHIA is the need to establish the way in which equity is to be defined, measured and assessed. By the end of scoping, the foundations for the EFHIA should be clearly established, with agreement on the aims and objectives, as well as the values underpinning the EFHIA.

There is a balance to be struck between undertaking EFHIAs or HIAs that require specialist expertise and are resource intensive, and those that can be carried out easily in line with capacity constraints.⁴⁸ Scoping involves judging which potential direct and indirect health effects of the policy or practice need to be considered in terms of their equity impacts, the methods and resources to be employed, who should participate, and the time frame for undertaking the processes.²⁵ Decisions about the level of the EFHIA to be undertaken, help define the levels of evidence needed to inform the profiling step.⁵²

Profiling

Profiling uses published literature and consultations with colleagues, experts and stakeholders to collect data and information needed to identify the ways that the proposal or activity will potentially, or has already, impacted on health, and how these impacts have been distributed on population sub-groups. Both quantitative and qualitative methods may be employed to collect new data, although the methods will vary according to the level of EFHIA.²⁶

At its simplest level, and when resources are limited, EFHIA can be undertaken fairly quickly as an “expert driven process” informed by previously obtained or accessible evidence. This usually results in limited quantification or qualification of evidence when appraising impacts and their distribution. This is also described as “desk top appraisal” and can take one or two days, or part thereof.⁵⁰

At the intermediate level, EFHIA involves consultation with key stakeholders or experts. A limited literature review is usually undertaken. At the intermediate level, there is reliance on routinely available local data and limited community consultation. This is also described as “rapid appraisal”.⁵⁰ Intermediate level EFHIA can take up to four or five months.

Comprehensive EFHIA involves considerable investment of resources, specialist expertise and stakeholder evidence. This typically includes review of the literature, analysis of secondary data, collection of new data, high levels of stakeholder participation, and extensive analyses of the qualitative and quantitative data.⁵² A full EFHIA can take six months or more.

The human resources input varies with the level of EFHIA. It is advisable to have designated staff responsible for the EFHIA. Their time commitment will vary with the level and time frame under which the EFHIA is conducted.

Mapping

The mapping step in EFHIA involves systematically identifying the health impacts, their distribution, and the equity issues associated with the unequal impacts. In some applications, impacts are ranked according to their nature, size and measurability and the risk of impact is ranked according to whether it is definitely likely to occur, probably likely, or speculative.⁵²

Recommendations

Recommendations include suggestions for strategies to maximise positive health gains, ameliorate negative impacts, and achieve a level of health equity. It may be possible to define a clear ‘solution’, but more often there will be a number of alternatives presented for consideration by the decision-makers. The *recommendations* step can include the preparation of a report with recommendations, and submission (of the report) to decision-makers.³¹ Equity-focused HIA provides a framework to explore the equity impacts of alternative options, and also to examine ways in which equity and efficiency can co-exist.^{53 54}

Monitoring and evaluation

There is a view that if common quality assurance criteria were developed, then this would facilitate ease of monitoring and evaluation, although such criteria would need to be evaluated independently for precision, rigor, feasibility and influence.^{36 52 55 56} In the absence of such criteria, process

evaluation is an important source of learning for quality improvement, and a mechanism for quality assurance. Process evaluation should be conducted throughout the EFHIA.³¹

In order for EFHIAs to inform and influence policy, the processes must be seen as adding value, and also being worthwhile in terms of the resource requirements.⁵⁷ Monitoring is an ongoing process which provides insights into ways in which it is possible to improve EFHIA processes, modify future or existing proposals so as to promote health equity and health gains, and assess the accuracy of predictions made during appraisal.³² Monitoring may include process, impact and outcome evaluation depending upon time and other resource constraints.

3 Equity in health

This section begins with the rationale for achieving health equity, outlines policy based responses and approaches, and frames EFHIA in relation to evidence and health equity.

3.1 Rationale for achieving health equity

In the 1970s, the WHO's 'Health for All' policy gave precedence above all other objectives, to the promotion of equity in health within and between countries. This was supported by the 1978 International Conference on Primary Health Care at Alma-Ata, which strongly reaffirmed that health is a fundamental human right and that the attainment of the highest possible level of health is an important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to health.²

Despite the explicit commitment made by world governments at Alma-Ata, the goal of 'Health for All' is now as distant as it was in 1978.⁵⁸ Of all the WHO's 'Health for All' targets, reducing inequities is the one where there is greatest concern for lack of progress.⁵⁹ Across and within countries there are major gaps in the standards of living, and health status is strongly correlated with levels of affluence and wealth. These differences in health are an important international social injustice.⁶⁰ In its 2002 report, WHO identified the extent of disease, disability and death in the world, quantifying their impact from region to region, and providing cost-effective ways to reduce those risks in both wealthy and less wealthy countries.⁶¹

3.2 Tackling health inequalities

For many societies, the scientific evidence points to better health outcomes for those who earn more, know more, and have more power.^{59 62} This has been observed in a range of societies, and in developing and developed countries.⁶³ There is now a large body of evidence describing the substantial and increasing inequalities in life expectancy, and general levels of health between the richer and poorer members of societies within most countries.

The tackling of (what are considered to be) unfair health inequalities, or inequities, is a major challenge for health policy developers world-wide, and several countries in Europe and Australasia are struggling with realistic ways to reduce these inequalities.⁶⁴⁻⁶⁸ Over the past decade health inequalities have been placed on the policy agendas of a number of countries including the UK^{40 69}, Australia¹¹, NZ⁶⁸, Sweden⁷⁰ the Netherlands⁶⁵ and Canada.⁷¹ Health inequalities in this context refer to measured social and economic differences, which are associated with levels of relative disadvantage across populations.

Developing strategies and programs to address health inequities is challenging because the underlying causes are embedded in social and economic structures at all levels of society.²² Access to health services, the ability to act on health advice, and the capacity to modify health risk factors, are all strongly influenced by the circumstances in which people live and work, and such circumstances are influenced by local, as well as broader systemic factors.¹¹ While the pursuit of equity of access to health care is a core objective of many health care systems, there is evidence from the UK in the 21st century that female patients of ethnic minority descent and in lower socioeconomic position, are less likely than more affluent white males, to access secondary and tertiary medical care, and further that these systematic differences are not related to patients in these sub-groups failing to self refer.⁷²

It cannot be assumed that the general application of interventions which are shown to be effective in one area or sub-group will reduce health inequalities overall.⁷³ Examples include situations in which there are barriers to the uptake of an intervention (e.g. immunisation), or where a policy such as transport, which has a positive local impact, displaces the problem to another area or population group.^{10 28} Targeted interventions alone can further marginalise and stigmatise the already disadvantaged, and deal with only one aspect of the problem. People who are socially and economically disadvantaged often have multiple needs to be met through various sectors, including the health, welfare, education and criminal justice systems.

Different approaches are relevant under different circumstances, and multiple approaches can be used as part of overall strategies aimed at reducing health inequalities. Contextual factors such as the availability of resources and the roles, responsibilities, and relationships between decision-makers and their organisations, will influence the choice of approach.²² The importance of health promotion in tackling health inequalities, is also being increasingly recognised.^{14 34}

In the past, advocates of approaches that focus on the re-distribution of health benefits between population sub-groups, as a way of improving the health of the poor, reducing rich-poor health

inequalities, or redressing health inequities, have been viewed as being at odds with those primarily concerned with the efficiency of health systems to bring about health improvements in society at large.⁷⁴ During the 1990s, there was a concern that the efficiency-driven health reforms implemented in many countries, in which there are huge health inequities, might lead to further inequities, and also slow down economic growth. At the World Bank, David Gwatkin called for a “new wave of major equity-orientated health sector reforms”, the objectives of which were to “increase efficiency and effectiveness with which health systems reach the poor and disadvantaged, thereby alleviating current inequities in health service use and contributing to lessened differences in health status”.⁷⁵ At the global level, the WHO showed that investments which target the reduction of health inequities can also lead to economic growth.⁷⁶

A discussion is also emerging in the literature about the need to re-define health goals, now expressed primarily in terms of population averages, to refer to improving conditions among the poorer groups and reducing differences between these groups and others in society. There is a view that national averages hide the differences that need to be tackled in order to reduce inequities, and equity targets should supplement, rather than replace average targets.^{10 74} It is essential that there is adequate public discussion to inform the setting of equity targets and the formulating of actions to achieve them.^{10 77 78}

Internationally, there is a lack of reporting and evaluation on multi-sector approaches for addressing health inequalities, or of the health impact of actions taken by the non-health sectors.²² In 1996 Gepkens and Gunning-Schepers reviewed information on evaluated interventions to reduce socioeconomic health differences, from both published and unpublished sources, and concluded that the lack of standardised measures and a common methodology, hamper our ability to integrate and compare results.⁷⁹ One view is that our imperfect understanding of the mechanisms of socioeconomic gradients limits our ability to formally evaluate the cost-effectiveness of interventions designed to reduce such disparities.⁸⁰

Mackenbach and Gunning-Schepers⁸¹ argued that the effectiveness of interventions to reduce health inequities, is largely unknown, and recommended the development and establishment of a systematic knowledge base for evaluating these interventions, as well as an international exchange of experience in developing and implementing interventions and policies.^{65 81} In a paper published in 2003, Mackenbach and Bakker analysed policy developments on health inequalities in European countries between 1990 and 2001. The authors concluded that policy making in this area is still largely intuitive and would benefit from the “incorporation of more rigorous evidence-based approaches”.⁸²

In response to the imperatives of equity-focused evidence, members of the Cochrane and Campbell Collaborations recently formed a Methods Group to advance the methodology surrounding the incorporation of equity into systematic reviews and also promote the synthesis of data exploring the effectiveness of interventions on all groups within society. See websites www.campbellcollaboration.org and www.cochrane.org.

3.3 EFHIA, evidence and health equity

Whether they are aiming to reduce inequities or not, decision-makers in the health care sector frequently draw upon evidence of effectiveness to determine whether interventions are meeting specified objectives.³⁰ However while health and social researchers are generally good at describing and measuring health inequalities and inequities, the development of tools for testing the effectiveness of interventions, particularly those at multiple levels and across different settings, remains a major challenge.²²

There is an ongoing debate in the literature about the applicability and use of epidemiology-based research evidence to inform public health policy and practice.⁸³⁻⁸⁸ For example there are claims that public health interventions are complex, heterogeneous and context-dependent, and that evidence of effectiveness has limited applicability to real world settings.⁸³⁻⁸⁶ Existing rules of evidence are often based on interventions with simple, easily identifiable chains of causation. Interventions in public health include many variables with degrees of measurement difficulty.⁸⁵

There is a view that randomised controlled trials (RCTs) and also systematic reviews of RCTs, are the “gold standard” for assessing the effectiveness of interventions.⁸⁹ However, the appropriate “gold standard” to use depends upon the questions that are asked. It is well documented that RCTs for health promotion and health service interventions can be subjected to bias, which limits their external generalisability. Patient consent is important in these trials, however factors associated with consent are never randomly distributed.⁹⁰ While all study designs can incur selection bias, there is evidence that for trials of preventive or health promotion interventions, the excluded subjects are generally less affluent, less highly educated, and have worse health outcomes than those who consent to participate.⁹⁰

Disadvantaged sub-groups not represented in trials may require different interventions to achieve the same health gains as more advantaged groups, yet frequently this evidence is not used to inform health policy and practice. Systematic bias in evidence used to plan health policies and services has equity implications. Policy and practice decisions based on poorly generalisable evidence can exacerbate health inequalities, by perpetuating policies and practices which are

relevant to advantaged sub-groups, and less relevant, or even not applicable, to less advantaged sub-groups in the population.⁹¹

“The Inverse Care Law”, developed in 1971 by Dr Julian Tudor Hart, is a major statement on socioeconomic health inequalities. The Law states that the availability of good medical care varies inversely with need, or that the more good medical care is needed, the less of it is available.^{92 93} Originally as it was formulated, the Inverse Care Law attributed health inequalities to market forces operating within the health system. However in 2002, Watt refuted the profit motive aspect of the Law and argued that although commercial drivers are still a threat to health equity, evidence-based medicine has the “perverse effect” of increasing health inequalities.⁹⁴

Rather than focusing on what constitutes evidence in all its complexities, we need ways of using evidence of socioeconomic health inequalities to inform the development, appraisal and costing of health policies and practices. In addition to research evidence, there is a need for routine qualitative and quantitative data describing health impacts on less advantaged groups, as well as data describing the effectiveness of interventions which specifically target health inequalities. The failure of policy makers to incorporate explicit consideration of the differential population health impacts of their options may partly explain why little progress has been made in addressing health inequalities or inequities.⁸⁰ Policy-linked EFHIA provides a timely way of injecting equity into policy development and service planning and assessment processes.

By demonstrating the application of an approach (encompassing a suite of analytical tools, methods and procedures) to assess the impact of policy and practice on health inequities, policy-linked EFHIA will promote a level of health equity consistent with the resources and context of the policy or practice being assessed, as well as the values of the stakeholders. This will mean focusing on the distributional impacts of policy and practice activities that are associated with systematic inequalities in health, for sub-groups described by their relative socioeconomic position. Evidence identified through policy-linked EFHIA will comprise a range of qualitative and quantitative information inputs to assess systematic inequalities in health outcomes, for socioeconomic sub-groups within and between populations.

While each demonstration of policy-linked EFHIA will be specific to the setting, context and values of the stakeholders, there will be core lessons learnt in all applications. Many HIA proponents have recommended the establishment of a sound evidence-base for the long-term reputation of HIA. While the draft EFHIA framework may undergo future modifications and refinements, through its case studies, our project will, very importantly, initiate the development of an evidence-base for EFHIA.³⁵

3.4 Conclusions

The European Commission recognises policy-linked HIA as an important policy tool for addressing public health inequalities.³⁴ Policy-linked EFHIA is a tool for systematically identifying the intended and unintended health impacts of policy and practice activities, as well as the distribution of health inequalities associated with social disadvantage and marginalisation.

The application of policy-linked EFHIA will encompass feedback to prompt and encourage policy responses that promote equity in health. This will be particularly relevant for prospective policy-linked applications of EFHIA. Our project will demonstrate how policy-linked EFHIA will ensure that equity of health impacts can be explicitly addressed as part of health policy development, assessment and appraisal. Accordingly EFHIA has the potential to become an important mainstream policy tool for reducing the unanticipated health inequities that are embedded in policy and practice.

The project's major contribution will be to demonstrate (through its case studies) how policy-linked EFHIA can embed an equity focus into the development and appraisal of policy and practice. By identifying and assessing impacts that are judged inequitable, EFHIA will promote a level of health equity consistent with the resources and context of the policy or practice being assessed, as well as stakeholders' values. While our project is being demonstrated in the health sector, we anticipate that the results may have international resonance across multiple sectors.

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