The Liverpool Statement

Equity in health impact assessment

A summary of the key messages from the
Health Equity Impact Assessment Pilot Project

Closing the Gap
The publication of Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health (WHO, 2008) - the final report of the Commission on Social Determinants of Health - created a new momentum for the application of what the report termed health equity impact assessment throughout the world and in all areas of public policy which affect health equity. The Health Equity Impact Assessment Pilot Project comprised a scoping review of published reports, a series of interviews with global stakeholders and an international workshop in Liverpool, including participants from five continents. A detailed reading of the project's immensely rich findings is strongly recommended.

Equity and HIA
There is no need for a new form of health impact assessment (HIA) to address policy impacts on health equity. Equity can be assessed within HIA as it currently exists - but the equity focus needs strengthening to engage with the multiple and complex influences on health equity. There is a multidimensional web of causal interactions affecting health equity, at all geographic levels from global to local and at all causal levels from root causes to immediate causes. Within each of these interactions there is a moral and ethical dimension – the right to health. Accordingly, distributional impacts should be identified and emphasised in all HIAs, equity should be considered at all stages of HIA, and fairness and social justice should underpin all HIAs.

Equity is contextual: its material, social and cultural patterning varies in different parts of the world. Public policies and HIA recommendations must be sensitive to these patterns and to the social and the policy dynamics that create them, if they are to be effective in remedying inequities. And while the basic concept of HIA is universal, its interpretation is similarly context dependent.

Adequately addressing equity in HIA will require time; resources; effective communication; commitment from political and other key decision makers; inter-sectoral collaboration; widespread involvement of civil society; and a meaningful commitment to effective implementation, monitoring and evaluation of equity recommendations.

Making it happen
There needs to be recognition that policy at all levels impacts on people's lives and that inequities that are not addressed now will cause or compound further inequities in the future. The HIA community needs to advocate actively for equity, in order that people in other sectors will understand the need to include it in policy and in impact assessment. This must include learning to use available evidence to distribute health benefits of policy more equally.
Existing HIA methodology is appropriate in principle but requires strengthening to address more effectively the full range of equity influences and policy impacts. These must include root causes of health inequities like unequal distributions of power, money and status, and protective factors like resilience and other community assets. Historical analysis will often be helpful in illuminating current inequities.

Other key research areas to enhance consideration of equity in HIA include mapping of causal networks relating to policy impacts and of key actors in the generation of (in)equitable public policies. Sources of funding for such research will also be a key issue.

Pilot studies to strengthen and test strengthened HIA methods and processes will be essential. These should focus on urgent and important inequities that have not received adequate consideration from HIA, such as climate change, health care charges, trade policies, armed conflict and lending conditionalities. Bearing in mind the universal nature of the 'new' determinants needing to be addressed (like unequal power distributions, which cause health inequities within villages as well as across continents), studies should focus on all relevant levels from local to global. Action is required worldwide – in the Global South where the burden of avoidable inequity is greatest and in the Global North where avoidable inequity so often originates.

Research will also be needed on relationships between HIA and the equity policy process. This should include consideration of what facilitates and constrains action on equity at key points in the causal web; how decision makers at such points understand and use the language around equity; ethnographic studies of local processes of equity policy implementation, including engagement with civil society.

Don’t wait – just do it!
Take global action: Promote a global conversation about equity in HIA – including civil society and the media
Create a global network: Use the conversation to create a global network on equity and HIA
Develop and fund a global strategy: Develop a global strategy within the network to take action forward. Seek collaborative funding for methodological developments, research and capacity building.
Spread the word: These messages should be disseminated by WHO and other key players globally and regionally.

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Acknowledgements

This report is the work of IMPACT, the International Health Impact Assessment Consortium, University of Liverpool.

This scoping study has been funded by Liverpool Health Inequalities Research Institute, a collaboration between The University of Liverpool and Liverpool Primary Care Trust, working to reduce health inequalities in the Liverpool city region.

In total, 29 people took part in our interviews and the Liverpool workshop. A further 20 took part in the HIA09 workshop in Rotterdam. We would very much like to thank each of these key informants for giving their time and sharing their knowledge and experience with us, especially those in different time zones who made time early or late in their days to speak with us.

We would also like to thank the members of our Advisory Group whose input was invaluable in the management and design of this scoping study: Ruth Barnes, Carlos Dora, Mark Exworthy, Paula Grey, Mary Mahoney and Sarah Simpson.

Thank you to Fran Bailey, Anne Dawson and Chris McLoughlin for their administrative support.

Thank you too to Hilary Dreaves for sharing her notes from the Rotterdam workshop.

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**1: Introduction**

In August 2008 the WHO Commission on Social Determinants of Health (CSDH) published its final report *Closing the gap in a generation: Health equity through action on the social determinants of health* (CSDH, 2008). The report made the institutionalisation of what it called health equity impact assessment (HEIA) one of its main recommendations, calling for HEIA of “all government policies including finance”. In addition, the commission specifically recommended:

- investment in HEIA training, tools and resources;
- the creation of national and regional support centres;
- ensuring budgeting for HEIA across departments.

Earlier, in June 2009, the UK Government had called for health impact assessment (HIA) to be used “more systematically and consistently to reduce health inequalities” and for the health inequalities element of HIA to be strengthened (DH, 2008b). This requirement has recently been further emphasised by the report of Sir Michael Marmot’s Strategic Review of Health Inequalities Post-2010 (Marmot, 2010) in February 2010.

HIA is “based on a broad model of health, which proposes that economic, political, social, psychological, and environmental factors determine population health” (O’Keefe and Scott-Samuel, 2006). By identifying potential health impacts and providing evidence-based recommendations to maximise positive impacts as well as minimise and / or mitigate negative health impacts, HIA enables decision makers to create healthier public policies, programmes and projects. Although the most commonly applied HIA definition has an explicit focus on differential impacts, the extent to which equity is incorporated into HIA methodology is variable and evidence suggests that a majority of HIAs do not move beyond this to identify whether these differential impacts are inequitable (avoidable and unfair) (Simpson et al, 2005).

There has previously been action to strengthen the equity component of HIA. For example, in 2000, following the recommendations of the Independent Inquiry into Inequalities in Health (Acheson) Report emphasising the importance of ‘health inequalities impact assessment’ (Acheson, 1998), one of the authors (ASS) obtained Department of Health (DH) funding for an international seminar to bring together key thinkers in the areas of HIA and inequalities in order to explore some of the issues around the relationship between equity and HIA (Douglas and Scott-Samuel, 2001). More recently, an Australian / New Zealand collaboration developed an equity focused HIA framework which concentrated on developing the HIA process to help practitioners to consider equity (Simpson et al, 2005). However further work is required, especially in the context of the CSDH report which is generating international demand for HEIA methods focusing on equity in the context of global public policy.

In addition, standard HIA tools tend to focus on project level assessment and fail to acknowledge the importance of the macro policy environment (‘the causes of the causes’). There is currently no impact assessment methodology available that systematically addresses macro / structural impacts on health inequalities (e.g. impacts of macroeconomic policy). Nor does most current HIA methodology consider impacts beyond national borders. Adequate HEIA methodology will capture such influences on health equity, including those of the political and policy context. A core component of HEIA is thus the consideration of such ‘upstream’ determinants of health. For
example, HEIA should involve moving beyond identifying how a policy, programme or project impacts on people living in sub-standard housing to examining how public policies are causing people to live in sub-standard housing, i.e. moving beyond identifying vulnerable groups to identifying why those groups are vulnerable and formulating appropriate policy responses.

Health Equity Impact Assessment Pilot Project

One of the authors (ASS) obtained funding from the Liverpool Health Inequalities Research Institute (LivHIR) for a 12 month study to scope the requirements for Health Equity Impact Assessment. LivHIR is a collaboration between The University of Liverpool and Liverpool Primary Care Trust, working to reduce health inequalities in the Liverpool city region. The pilot project ran from 1 January 2009 to 31 December 2009.

The core components of the project were a scoping literature review looking at peer-reviewed and grey literature to examine the ways in which equity is currently incorporated into impact assessment; interviews with key stakeholders in the fields of HIA, health equity and global public policy; a stakeholder workshop in Liverpool to further develop the findings from the literature review and the interviews. In addition, we were fortunate to also have the opportunity to run a short workshop at the HIA09 conference in Rotterdam, which enabled us to explore our findings with a different group of people with varied HIA experience.

Aims and objectives

The overarching aim of this 12 month research project was to carry out a pilot study to define and test key concepts underpinning Health Equity Impact Assessment (HEIA). Specifically, we wanted to understand the extent to which equity is already incorporated into HIA and how the impacts on equity of macro policy can be considered within HIA. In particular we wanted to examine whether a new HEIA methodology was needed or whether existing HIA methodologies are sufficient to assess policy impacts on health equity.

The project’s objectives were to:

- Examine the extent, range and nature of research activity related to HEIA;
- Critically appraise existing research on equity appraisal to identify gaps in evidence and methodology;
- Identify and clarify key concepts underpinning HEIA;
- Develop theoretical and conceptual frameworks relating to HEIA;
- Contribute to theoretical debate about equity in health impact assessment (HIA);
- Demonstrate the value / feasibility of undertaking a project to develop HEIA further;
- Identify and develop links with experts, stakeholders and potential project partners;
- Identify funders to target a bid to secure funding to develop HEIA based on the outcomes of this project.

Project outputs

There are three sets of outputs from this project:

1. Project reports: project report; short report and checklist for Liverpool Primary Care Trust.
2. Publications in peer reviewed journals: Literature review; HEIA project findings.
3. Competitive bid for substantive funding to conduct research identified in the pilot project.
The findings from the research are presented in Sections 3 to 5 of this report. Section 2 describes the methodology used. Section 6 discusses the findings and Section 7 offers some final conclusions and recommendations from the pilot project.
2: Methodology

The aim of the HEIA pilot was to test out key concepts underpinning health equity impact assessment. In order to achieve this we undertook three pieces of inter-related research: a scoping literature review, interviews with key informants and two international workshops to explore and add to the issues arising from the interviews and literature.

The original intention was for these pieces of research to be undertaken sequentially, with the results from earlier steps informing the development of the later ones. Unfortunately real world research does not always go to plan. Our project was delayed in three ways. Firstly, the main researcher (SP) was bought out of part of the early stages of the project to work on the Marmot Review (Marmot, 2010). This funded the involvement of Fiona Haigh (FH) and Debbie Abrahams (DA). Their input has been invaluable, but did not fully cover SP’s absence from the project. Secondly, we lost time chasing requirements for ethical approval. Thirdly, we lost time at the end of the project due to illness. As a result of these complications it was decided to focus on the critical path of the project – the interviews and workshops – and the Scoping Review was simplified and conducted throughout the project, although early findings were fed into the workshops.

It was always an intention that this project would develop iteratively, with constant reflection on and development of the process based on learning achieved at stages throughout the project. With hindsight we recognise that the scope of the project was too large for the time and resources we had available. For these reasons, and because the project team members have now moved on to new projects, this report has been delayed beyond the end of the funding period.

This section considers the overarching methodology employed on this project. The specific methods used for the scoping review, interviews and workshops will be described in the relevant sections.

Project management

The HEIA pilot project team consisted of Alex Scott-Samuel (PI), Sue Povall, Debbie Abrahams and Fiona Haigh. We had project team meetings approximately once every two weeks. SP was the primary researcher for the project; ASS and DA were the project managers, conducted some of the interviews, were fully involved in both workshops, and made contributions to this report. DA also contributed to the scoping review. On either side of her maternity leave, FH contributed to early management processes, drafted the NHS ethical approval application, assisted with the scoping review, and contributed to this report.

An early task in the project was to identify and recruit an Advisory Group. The members of this group were: Ruth Barnes, Carlos Dora, Mark Exworthy, Paula Grey, Mary Mahoney and Sarah Simpson. The Advisory Group have expertise in HIA, equity focussed HIA and health equity. FH drafted the Terms of Reference for the Advisory Group, which were agreed at the first AG Meeting. At the time of writing, there have been three Advisory Group meetings, two via teleconference and one face-to-face.

We have also submitted project reports to the funders, LivHIR, and have had two face-to-face meetings with them.
HEIA scoping project

Methodology

Project scope

FH wrote the bid for this project and that document became the draft project outline. Some Advisory Group members felt that we were pre-empting the outcomes of this research by aiming to test the requirements for new HEIA methodology and to have as an outcome of the pilot project to seek funding to develop such a methodology. There was a feeling amongst the AG that HIA methodologies already exist that can be used to assess equity impacts of policies, and that one possible outcome of this project might, for example, be to build capacity to use these existing methodologies. The project aims were altered to make them more open, in line with these recommendations.

Project milestones

Table 1 shows the project milestones, when they were planned and when they were actually completed.

Table 1: Project Milestones

<table>
<thead>
<tr>
<th>HEIA Project Milestones</th>
<th>Planned Date</th>
<th>Actual Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEIA Advisory Group meeting 1</td>
<td>03 Mar 2009</td>
<td>03 Mar 2009</td>
</tr>
<tr>
<td>HEIA Advisory Group meeting 2</td>
<td>Jun 2009</td>
<td>29 Jun 2009</td>
</tr>
<tr>
<td>NHS ethical approval, obtained by</td>
<td>15 Jun 2009</td>
<td>N/A</td>
</tr>
<tr>
<td>Scoping review, completed by</td>
<td>30 Jun 2009</td>
<td>30 April 2010</td>
</tr>
<tr>
<td>Mapping of key informants and stakeholders, completed by</td>
<td>30 Jun 2009</td>
<td>09 Jul 2009</td>
</tr>
<tr>
<td>Telephone interviews, completed by</td>
<td>28 Aug 2009</td>
<td>08 Sep 2009</td>
</tr>
<tr>
<td>HEIA Advisory Group meeting 3</td>
<td>Sep/Oct 2009</td>
<td>5 Oct 2009</td>
</tr>
<tr>
<td>HEIA stakeholder workshop in Liverpool, completed by</td>
<td>30 Sep 2009</td>
<td>5 &amp; 6 Oct 2009</td>
</tr>
<tr>
<td>Project reports: Full report, short report and HEIA checklist for Liverpool PCT, completed by</td>
<td>27 Nov 2009</td>
<td>31 May 2010</td>
</tr>
<tr>
<td>HEIA Steering Group meeting 4</td>
<td>Dec 2009</td>
<td>N/A</td>
</tr>
<tr>
<td>Final HEIA reports delivered to Liverpool PCT by</td>
<td>31 Dec 2009</td>
<td>30 July 2010</td>
</tr>
<tr>
<td>Identify partners and funders for next phase; submit bid by</td>
<td>31 Dec 2009</td>
<td>ASAP</td>
</tr>
<tr>
<td>Papers for peer-reviewed journal: scoping review &amp; full project, completed</td>
<td>31 Dec 2009</td>
<td>ASAP</td>
</tr>
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</table>

Definitions of key terms

Our AG recommended that we have clear definitions for key terminology used in the project, specifically health equity. SP summarised definitions from the literature for health inequalities, health inequities, health equity and HIA and produced some draft definitions. These were then
considered by the project team and Advisory Group, resulting in the following working definitions for the project.

Health inequalities / inequities are:
“Systematic, socially produced (and, therefore, avoidable or modifiable), unfair or unjust differences in health determinants or health outcomes between groups with different levels of underlying social advantage / disadvantage.”

Health equity:
“The absence of health inequalities / inequities.”

Health Equity Impact Assessment:
“A combination of procedures, methods and tools that systematically assesses the potential, and sometimes unintended, impacts of a local / regional / national / global policy on the distribution of health or health determinants within a defined population. HEIA can be used as part of the policy development process to identify and minimise that policy’s potential negative impacts and enhance its potential positive impacts on health equity.”

Ethical approval
The project did not fall under the remit of the University of Liverpool ethical review committee because it had National Health Service (NHS) involvement; the project, therefore, needed to be reviewed by the local NHS National Research Ethics Service (NRES) committee. The Liverpool NRES team considered the project proposal and judged the project to be service evaluation, therefore not needing NHS ethical approval.

Participant recruitment
Participants in the interviews and Liverpool workshop were identified through a process of Stakeholder Mapping. FH developed a framework for the Stakeholder mapping. Here, key categories of people we would want to interview were tabulated (see Appendix A) and then the Advisory Group were asked to recommend individuals within those groups. The project team then augmented these suggestions with suggestions of their own. This final list was discussed amongst the project team and a list of preferred participants, with reserves, was agreed upon. The people identified were then contacted in order of preference to see if they would be willing to participate in the project. Attempts were made to balance the participants by gender, occupation, area of expertise and region within which they work. In this way the sampling was purposive (a non-random sampling method which aims to sample a group of people with a particular characteristic, e.g. older people). Some of the people invited to participate were identified through other participants (snowball sampling - a non-random sample method which involves an initial group, e.g. community workers, identifying people they know with a particular characteristic, e.g. older people). This approach aimed to ensure both systematic and widespread coverage.

The development of a final list of preferred participants was done separately for the interviews and Liverpool workshop. This enabled us to include some of the interview participants in the Liverpool workshop, but also to broaden the range of people we could involve in the project through the workshop. 14 people took part in the interviews, and 19 people (some of whom were interviewees) took part in the Liverpool workshop; there were 29 people in total.
Participants in the Rotterdam workshop were self-selected. There was one person whom we had interviewed; otherwise all participants were new to the project.

**Inclusion / exclusion**

Participants were included based on their expertise in equity and HIA, global public policy and health. They were potential HEIA users, commissioners and practitioners. Participants were limited to those who can speak English. With limited time and funds the project team would not have been able to employ translators or interviewers nor have interview transcripts translated into English.

**Informed consent**

Participants to both the interviews and Liverpool workshop were contacted through email with a letter informing them of the study, of its aims and the ways in which we would like them to take part. The participants were assured that they would be free to withdraw at any time, if they wished to do so. All participants were asked to, and did, return a form agreeing to take part, giving their consent to conversations being digitally recorded and their consent to the use of anonymous extracts from project transcripts being used in documents relating to the HEIA Pilot Project.

**Confidentiality**

Identifiable data from the project will be kept confidential unless agreed otherwise. Where the likelihood is that data may be shared with other researchers, the potential uses to which the data might be put may need to be discussed with research participants. In the presentation of findings, details will be changed where necessary to ensure that anonymity is maintained (for example when using quotes). All identifiable written and tape recorded data will be kept in a locked cupboard in a locked room and computer-based data will be kept password protected and secure.

**Risks, burdens and benefits**

There are not expected to be any risks or burdens associated with being involved in the study. The interviews and workshops did not cover sensitive, embarrassing, upsetting or personal issues. Participants were informed of their rights to stop interviews at any time and the interviews were carried out at a time convenient to them. Travel and accommodation costs were covered for the majority of the participants who attended the Liverpool workshop. This was an important opportunity for participants, including potential users and commissioners of HEIA, to share their views and shape HEIA methodology.
3: Scoping Review

Introduction
The scoping review explored how equity is being addressed within HIA and related impact assessment methodologies and how this is being applied in actual assessments. The purpose of this was to:
1. Identify whether equity is currently being adequately addressed within HIA;
2. Establish whether there is a need for a specific HEIA methodology;
3. Identify issues that will influence addressing equity in HIA.

The scoping review builds on the literature review carried out by Harris-Roxas et al. (2004) as part of the equity focused HIA (EFHIA) project (Mahoney et al., 2004; Simpson et al., 2005). Our scoping review revisited literature gathered by the EFHIA review and identified additional literature that has been published since then (2004-2009).

In general, the findings of the EFHIA review are still applicable in 2010. There have, however, been some developments:
- EFHIA has provided a framework for considering equity within HIA and there are now examples of EFHIAs;
- New Zealand’s Health Equity Tool (HEAT) (Signal et al., 2007) also provides questions designed to assist in identifying and addressing health equity impacts, and there are a number of new HIA guidelines with an explicit focus on reducing health inequalities;
- The growing calls for HEIA from the CSDH and the Marmot review in the UK (The Strategic Review of Health Inequalities in England Post 2010);
- WHO interest in HEIA.

Equity focused HIA (EFHIA) review
The EFHIA review involved a search of published literature, compiling a grey literature citation index and web searching. The searches covered a period from 2003 to 2004. A total of 42 references were identified. The main findings were:
- The bulk of the literature identified in this review takes the form of commentary and originates from the United Kingdom. This reflects not only HIA’s growth in the UK, but also the status of HIA as an emerging field and the impediments to disseminating HIA findings that exist.
- The literature review found that equity is not effectively addressed in other forms of impact assessment, with issues of avoidability and fairness rarely examined.
- A key mechanism to ensure the consideration of equity, cited in the HIA and general impact assessment literature, is increased community participation. This approach is based on a number of assumptions that may not exist in real-world situations.
- HIA has greater scope to consider equity due to the explicit and implicit mechanisms utilised to address health equity. The extent to which these mechanisms lead to the consideration of health equity in practice is still very much open to question. This is largely due to the unexplained leap that is required to move from identifying differential impacts to making a determination about avoidability, fairness and avenues to address inequities.
• A specific form of HIA that addresses equity had not been developed, practitioners favouring an “equity in every HIA” approach. There is however a lack of structured guidance or tools that may be drawn upon to achieve this goal in practice.

• A gap in the literature was identified for an approach that:
  o moves beyond looking at differential impacts to explicitly addressing issues of avoidability and fairness, and
  o clarifies how equity issues can be considered at every step of a HIA.

• Existing approaches are limited from an EFHIA perspective because they either provide guidance on HIA or address equity issues - none comprehensively integrate both elements.

• Many of those behind the increased international interest in HIA are also promoting a health equity agenda, and there is increasing interest in how the two may be combined. Despite suggestions that equity should be considered in every HIA there is little enabling guidance available.

• There is a need, particularly in contexts where an explicit commitment to reducing health inequalities does not exist, for clearly structured, practical guidance on how to incorporate equity in HIA.

**Methods**

A scoping review is a form of literature review that aims to map the literature relating to a specific topic, and can be used to identify gaps in existing research (Arskey and O’Malley, 2005). The aim of this scoping review was to understand how equity is currently considered in HIA and to see where gaps in the research, and innovative practice, are. It builds upon and expands the literature review done for the EFHIA project (Harris-Roxas et al, 2004).

Scoping reviews are usually a rapid appraisal of the literature in a specific area; they look at a broad range of literature and as such may compromise on the depth to which they examine that literature. Scoping reviews are not systematic reviews, and differ from systematic reviews in two main ways: they typically answer broad research questions that are not limited to specific study designs; because of this, scoping reviews tend not to be concerned with the quality of studies, rather they are concerned with mapping the nature and scope of the research in a particular topic area (Arskey and O’Malley, 2005).

Although a scoping review does not employ some of the methods used in a systematic review, the process still needs to be rigorous and transparent. Arskey and O’Malley (2005) suggest the following five steps to ensure this rigour: identifying the research question; identifying relevant studies; study selection; charting the data; collating, summarising and reporting the results. They also recommend consultation with key stakeholders in order to inform and validate the findings. Early results from this scoping review were presented at the Liverpool workshop. Feedback on that presentation identified HIA guidelines that had not been included and provided valuable reflection of the scope of the review at that stage.

**Review questions**

The purpose of this scoping review is to understand the extent and ways in which equity is considered within impact assessment. The main focus is on equity within HIA; however, we were
also interested in understanding how other impact assessment methodologies approached issues of equity. In summary:

- How is equity addressed within methodologies for impact assessment?
  (Including: IA methodologies and reviews of IA methodologies.)
- How is equity addressed within reports of impact assessments: screening / scoping; assessment; reporting; recommendations; evaluation?
  (Including: reports of IAs and reviews of reports of IAs.)

**Review scope**

There are a growing number of methodologies and tools for considering equity impacts, prospectively and retrospectively. This is a scoping study to look at the requirements for a Health Equity Impact Assessment based on HIA; therefore the literature has been limited to those tools and methodologies that are similar in scope or structure to HIA.

In particular we searched peer-reviewed and grey literature for:

- HIA methodologies with an explicit equity dimension;
- Reviews of HIA methodologies;
- Reports of HIAs that have explicitly considered equity in the process and / or recommendations;
- Reviews of HIAs where equity is considered;
- Other health assessment tools and methodologies with an explicit equity dimension.

Time constraints meant that we were not able to do an extensive search of the literature for impact assessments other than HIA. The search terms for the peer-reviewed literature were set so that they would include other impact assessments, but the grey literature searches were restricted to HIA.

In the UK there is a legal requirement for public sector organisations to assess the impact of their policies and programmes on race, disability and gender equalities (IDeA, 2008; DH, 2008a; DH, 2009). It has become common to do this through a single Equalities Impact Assessment (EqIA) (DH, 2008a). These EqIAs may also include other categories of people that are protected from discrimination by law. Collectively known as equality strands, the most common categories are: age, disability, gender, transgender, sexual orientation, race and ethnicity, religion or belief (IDeA, 2008; DH, 2009). As of October 2009, the National Health Service EqIA includes the aim of reducing health inequalities in England between people from different socio-economic groups (DH, 2009).

EqIA have a similar methodology to HIA, but they are primarily concerned with reducing discrimination. As these impact assessments are statutory requirements, there are a large number of them. There is no overall EqIA methodology that we can consider here as each public sector organisation has developed guidelines of their own. We do feel it is important to include EqIA in the review, so we have limited our consideration to the guidelines developed by the NHS North West, and to reports of EqIAs that have been done as a combined Health Inequalities and Equality Impact Assessment.

**Identifying and selecting relevant studies**

The literature included in this scoping review has been identified from various sources:
1. FH sent out requests for information to 14 impact assessment websites and listservs. This generated 16 responses and brought to our attention four reports not identified from other sources.

2. Searches for peer-reviewed literature through the database engines Web of Knowledge (WoK), Cambridge Scientific Abstracts (CSA) and PubMed. The following databases were selected for searching on CSA: ASSIA: *Applied Social Sciences Index and Abstracts*; BHI: *British Humanities Index*; Biological Sciences; EconLit; EIS: *Digests of Environmental Impact Statements*; Environmental Sciences and Pollution Management; MEDLINE; CSA Social Services Abstracts; CSA Sociological Abstracts; CSA Worldwide Political Science Abstracts. The searches on PubMed proved to be redundant as both WoK and CSA searches included MEDLINE. Searches were also done through Google Scholar.

**Search criteria:**
- a) health impact assessment AND (equit* OR inequalit* OR disparit*)
- b) "impact assessment" AND (equit* OR inequit* OR inequalit* OR disparit* OR differential*)
- c) (checklist OR gauge OR audit) AND (health AND (inequalit* OR differential* OR disparit* OR equit*))
- d) “health equity impact assessment”
- e) “health inequalities impact assessment”
- f) “equity gauge” OR “equity audit”

**Records retrieved:**
These searches retrieved 988 records, 798 after duplicates had been removed. These records were then scanned by SP and, based on the title and abstract only, those that met the following basic exclusion criteria were rejected: before 1990; not in English; no relevance to health equity (e.g. screening for autism, hospital audit); inequalities in service provision; no abstract. This left 88 records. Two reviewers (SP and DA) then assessed these 88 records for relevance to the review, based on title and abstract only. Records were selected for inclusion in the review (24) where both reviewers had chosen it for inclusion. FH then screened and summarised these remaining 24 records based on the full-text article; 12 articles were included in the review.

3. HIA Guidelines were identified from reviews of guidelines and through personal recommendations and responses to the RsFI; 10 are included in the review.

4. Reports of HIAs in the grey literature were sourced through searches on: the grey literature DB, Open Sigle; HIA websites: Ben Cave Associates, HIA Community Wiki, HIA Connect, HIA Gateway, HIA Network, Human Rights Impact Resource Centre, IAIA, IMPACT, London Health Commission, NICE, NZ HIA Support Unit, Scottish HIA Network, Welsh HIA Support Unit, WHO HIA page; reference lists in reviews of HIA guidelines; personal recommendations.

**Search criteria:**
- a) Open Sigle:
  - i. (("impact assessment" OR "health impact assessment") AND (equity OR inequity OR inequities OR inequality OR inequalities OR equality));

b) HIA Gateway:
   i. Level = policy or type=inequalities, not Mental Well-being Impact Assessment, with an active web link.

c) Welsh HIA Support Unit:
   i. Policy level / strategies (not projects or programmes); text contains “equal” or “equit” with some discussion of equity considerations; HIIA; HIA and HIIA guidelines.

d) All other websites:
   i. Full documents – no summaries; web link works; text contains “equal” or “equit” or “disparit” with some discussion of equity considerations.

Records retrieved:
SP hand searched the websites noted above using the search criteria as an initial selection process. These searches retrieved too many papers to include in the scoping review. For practical reasons only, the 39 reports retrieved through searches on HIA Connect and HIA Gateway were included in the data extraction stage of the review. SP then assessed each document to ensure that it fitted the overall inclusion criteria (see Appendix B) and that health equity was considered explicitly within the document, either as health equity, health inequalities, health disparities or as differential impacts on identified subgroups. The HIAs were limited to those that were looking at impacts at the policy level. Some basic quality criteria were also applied to the reports of HIAs:

- Is this a report of an impact assessment?
  If ‘No’ then exclude from the review.
- Is equity or reducing inequity / inequalities a primary aim of the impact assessment?
  If ‘No’ then exclude from the review.
- Are the methods clearly described and appropriate to the stated equity aims?
  If ‘No’ then exclude from the review.
- Are the findings relating to equity clearly presented and discussed in the report?
  If ‘No’ then exclude from the review.

16 reports of HIAs were included in the review from these sources.

Structure of the findings
The findings from this review are presented in the following sections:
- Equity in HIA guidelines: reviews from the literature and a review of selected guidelines;
- Equity in HIA practice: reviews from the literature and a review of selected HIA reports and HIA evaluations;
- Equity in other related areas.

Equity in HIA guidelines
The standard definition of HIA includes the specific consideration of differential health impacts and equity is a core principle of HIA. However experience has shown that the consideration of equity within HIA is difficult to achieve. Guidelines on addressing inequalities in HIA produced by the National Institute for Health and Clinical Excellence (NICE, 2005) concludes that
there is a consensus that practitioners have a difficult task ahead of them to successfully address inequalities within HIA, and that without a sufficient focus on inequalities they may well not achieve such an outcome (NICE, 2005, p.16).

However, they also conclude that it is feasible.

Reviews of HIA Methodologies

Three reviews of HIA methodologies are included in this review: Harris-Roxas et al (2004), Mindell et al (2008) and Orenstein and Rondeau (unpublished). Two of these reviews (Harris-Roxas et al, 2004; Orenstein and Rondeau, unpublished) define health inequities and health inequalities, and make the distinction that health inequities are differences in health status that are avoidable and unfair.

A summary of the findings from the Harris-Roxas et al (2004) review, conducted for the EFHIA project, are presented at the beginning of this chapter and are the starting point for this review. The EFHIA review was a scan of the literature and as such is not comprehensive or done in depth. It does give an indication of the extent to which equity has been considered in HIA and other methodologies and tools. Harris-Roxas et al (2004) conclude that HIA is an important mechanism for including a consideration of equity in planning processes, but the issues are not systematically addressed. They found that often equity is inferred through the model of health used in the HIA and that even where differential impacts on health are considered explicitly these are not discussed in terms of whether or not these differences are avoidable and unfair (Harris-Roxas et al, 2004).

Harris-Roxas et al (2004) also examined whether or not equity was considered in other impact assessment methodologies. They found that differential impacts of policies and programmes were considered in a patchy way, mostly through considering differences by gender, ethnicity and area disadvantage. Again, issues of whether or not these differences are avoidable or unfair were rarely considered (Harris-Roxas et al, 2004).

Mindell et al (2008) conducted a comprehensive review of guidelines and toolkits that gave adequate advice for someone to carry out an HIA. Although the authors discuss the inclusion of equity and inequalities in HIA, they do not offer definitions for either of these terms. It is clear from one of their data tables, however, that considerations of equity within the HIA guidelines reviewed can vary from nothing, through the consideration of the differential impacts on specific groups, to a commitment to reducing inequalities. Mindell et al (2008) found that all but five of the 27 frameworks reviewed referred to the consideration of differential health impacts, and in most cases these were to be assessed by considering specific vulnerable groups. They found that there was no consensus on whether these vulnerable groups should be identified at the start of the HIA or during the HIA process. They found five frameworks offering guidance on the consideration of differential exposures to issues raised and / or vulnerability to their impacts (European EPHIA; Australia’s EFHIA; Australia’s CHETRE HIA guidelines; New Zealand’s Whānau Ora HIA; Welsh Health Inequalities Impact Assessment tool), with the Australian frameworks having a particularly strong equity focus; six frameworks provided a structured way to assess potential impacts on equity (Queensland Health HIA guidance; Institute of Public Health in Ireland’s HIA guidance; Birmingham’s HIA Research Unit’s HIA training manual; European EPHIA; Australia’s EFHIA; New Zealand’s Whānau Ora HIA), giving a total of eight with an explicit approach to equity, inequalities or differential outcomes (Mindell et al, 2008).
Orenstein and Rondeau (unpublished) conducted a scan in 2009 of HIA tools for a Canadian project to clarify the requirements for HEIA in Canada. Theirs is a comprehensive consideration of HIA tools and frameworks and other frameworks that might guide the inclusion of equity in public policy development processes and projects. Like Harris-Roxas et al. (2004), they conclude that HIA offers a promising methodology for including a consideration of equity in policy development processes. Most of the tools they identified were for use in the screening and scoping phases of HIA, however, and they observe that HIAs with an equity focus have not been evaluated to determine their impact on health inequalities. Determining what is inequitable – avoidable and unfair – requires a value judgement and Orenstein and Rondeau (unpublished) conclude that there are no tools to help judge fairness. They recommend EFHIA from Australia, Whānau Ora HIA from New Zealand and the approach proposed by Quigley et al. (2005).

Review of selected HIA guidelines

We identified 10 impact assessment methodologies for inclusion in this review (see Table 3.1). These were selected on the basis that they had been recognised in the literature, or from personal recommendation, as having the explicit aim of reducing health inequalities or improving health equity.

Table 3.1 Impact Assessment guidelines included in the HEIA scoping review

<table>
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<tr>
<th>Guideline</th>
<th>Origin</th>
<th>Reference</th>
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Three of these guidelines are specifically for policy level HIA (EPHIA Project Group, 2004; PHAC, 2005; Ministry of Health, 2007), the rest are for use at the policy, programme or project levels. All but the EqIA (NHS NW, 2008) follow the basic steps of screening, scoping, impact identification, assessment / appraisal, reporting / recommendations, monitoring / evaluation, although the Merseyside Guidelines (Scott-Samuel et al, 2001) and EPHIA guidelines (EPHIA Project Group, 2004) follow a different model within the assessment phase. EqIA has a slightly different purpose in that it is designed to assess the impact on equalities groups – those population groups protected from discrimination by law in the UK. As such the target populations are clearly articulated throughout.
the framework, which includes the stages of preparation, information gathering, assessment, report writing, consultation on a draft report, publishing and monitoring. The majority of these guidelines provide detailed instructions, prompts and toolkits to guide the user through the HIA process.

Two of the guidelines (Taylor et al, 2003; NHS NW, 2008) do not discuss which model of health they are using; all of the others use a broad model of health, encompassing social, economic and environmental determinants. Similarly, three guidelines (Taylor et al, 2003; Mahoney et al, 2004; NHS NW, 2008) do not define HIA or IA; Scott-Samuel et al (2001) define HIA as “the estimation of the effects of a specified action on the health of a defined population” (p.4), the remaining guidelines all use a version of the Gothenburg Consensus (1999, p.4) definition:

**Health Impact Assessment 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.**

Although consideration of equity or inequalities is central to all these frameworks, the equity terminology used is inconsistent. Only four of the guidelines define the equity terminology used (Taylor et al, 2003; Mahoney et al, 2004; EPHIA Project Group, 2004; Metcalfe et al, 2009). Of these, the EPHIA Project Group (2004) and Metcalfe et al (2009) use the term “health inequalities” and define it as “avoidable and unjust” differences in health. Mahoney et al (2004) and Taylor et al (2003) make a distinction between health inequalities and health inequities, both stating that there is a moral and ethical dimension to health inequities – these are health inequalities that are both avoidable and unfair or unjust (Taylor et al, 2003; Mahoney et al, 2004). Taylor et al (2003) make health inequalities the focus of their framework; Mahoney et al (2004) make health equity the focus of theirs. Of the six guidelines that do not offer a definition of their chosen equity terminology, four use the term health inequalities (PHAC, 2005; MWIA, 2007; Ministry of Health, 2007; NHS NW, 2008). The Merseyside Guidelines (Scott-Samuel et al, 2001) uses the term ‘equity’ and the Welsh guidelines (WHIASU, 2004) uses the terms health inequalities and equity interchangeably.

Given the contested nature of the term “health inequalities”, it is disappointing that so few of these guidelines are clear about the definition they are using and whether or not they mean to include the moral and ethical dimension of assessing potential health differences in terms of whether or not they are avoidable and unfair / unjust. In fact, only the EFHIA framework (Mahoney et al, 2004) offers explicit guidance on including issues of avoidability and fairness in the HIA process.

Within these guidelines, equity or inequalities is generally addressed through the inclusion of stakeholders, especially those from affected communities, and the assessment of potential differential impacts on population subgroups, often referred to as vulnerable or disadvantaged groups:

- Seven frameworks (Taylor et al, 2003; WHIASU, 2004; Mahoney et al, 2004; EPHIA Project Group, 2004; PHAC, 2005; Ministry of Health, 2007; Metcalfe et al, 2009) suggest these groups should be identified during the HIA process. Of these, four (Mahoney et al, 2004; EPHIA Project Group, 2004; PHAC, 2005; Ministry of Health, 2007) identify subgroups that should be included as a minimum;

- Five frameworks (Scott-Samuel et al, 2001; WHIASU, 2004; PHAC, 2005; Ministry of Health, 2007; Metcalfe et al, 2009) offer guidance on the sorts of groups to consider. In the case of the New Zealand guidelines, these groups are either in addition to the essential inclusion of
Māori populations (PHAC, 2005) or as particular subgroups of the Māori populations that are the focus of the HIA (Ministry of Health, 2007);

- These suggested subgroups may include characteristics such as age, gender, race, geography, socio-economic status.

- Two frameworks (Coggins et al, 2007; NHS NW, 2008) have fixed groups that should be considered in the IA. In the case of the EqIA framework (NHS NW, 2008), these groups are defined by legislation and are known as the seven equalities strands - age, gender, race, disability, religion, sexual orientation, trans-gender – and are the groups protected from discrimination by law.

- Two frameworks (WHIASU, 2004; Coggins et al, 2007) argue that there should be a balance between the recommendations concerned with the impact on subgroups and those concerned with the impact on the population as a whole.

- The EqIA (NHS NW, 2008) states that identified differential impacts should be assessed as to whether or not they are “unjustifiable” in relation to the policy’s aims, and whether or not they are missing an opportunity to promote equality.

Within the HIA process, five frameworks (Taylor et al, 2003; Mahoney et al, 2004; EPHIA Project Group, 2004; PHAC, 2005; Ministry of Health, 2007) state explicitly that equity and / or inequalities should be considered at all stages of the HIA. Otherwise, the guidance in the frameworks is weighted towards the inclusion of equity in the screening, scoping and appraisal stages. Only two frameworks (NHS NW, 2008; Metcalfe et al, 2009) do not explicitly state that equity should be a factor in the recommendations. Mahoney et al (2004) observe that the inclusion of equity and inequalities considerations in HIA recommendations is difficult and is likely to be met with resistance.

Three frameworks (Mahoney et al, 2004; EPHIA Project Group, 2004; PHAC, 2005) explicitly state the values that underpin the process. Two guidelines (Mahoney et al, 2005; EPHIA Project Group, 2004) explicitly recommend the consideration of the processes by which a policy has an impact on health, health determinants or population groups.

**From the peer-reviewed literature**

Lester et al (2001) describe the Health Inequality Impact Assessment (HIIA) rapid appraisal methodology developed by Bro Taf Health Authority. HIIA is described as a refinement of HIA which ensures a focus of the needs of the most disadvantaged. This paper focuses on using HIIA for prioritising actions to tackle health inequalities. In this example rather than assessing the impacts on health inequalities the focus of the assessment is actions to tackle inequalities. Five steps are described which relate quite closely to traditional HIA: brainstorming to identify impacts on health determinants; the local context in which identified health determinants operate is discussed; evidence collection; identifying opportunities for action, prioritisation considering strength of evidence, magnitude of impact, probability of achieving change locally and time scale. It’s interesting that the prioritisation criteria do not appear to be actually aimed towards addressing inequalities.

**Equity in HIA practice**

**Published reviews and reflection of HIA practice**

Most HIAs include a consideration of equity or inequalities (Quigley et al, 2005), and most often through assessing differential impacts for particular population subgroups (Parry and Scully, 2003; Simpson et al, 2005; Harris-Roxas and Harris, 2007; Wismar et al, 2007; Dannenberg et al, 2008). The intentions for assessing equity often do not manifest in practice, however (Parry and Scully, 2003; Wismar et al, 2007), and issues of avoidability and fairness are rarely examined (Simpson et al, 2005). There is often an uncritical assumption that increased community participation will in itself ensure an equity perspective (Simpson et al, 2005). Although generally HIAs use models capable of addressing health equity, most do not use a structured approach to doing so (Aldrich et al, 2005; Quigley et al; 2005). Harris-Roxas and Harris (2007) note that, in the HIA case studies they considered, subgroup analysis was often limited to the consideration of the impacts on indigenous groups. Parry and Scully (2003) and Harris-Roxas and Harris (2007) suggest that HIAs should include a minimum set of subgroups (such as age, gender, ethnicity, socio-economic status), with other groups defined as part of the HIA process.

Even where an assessment of differential impacts of a policy or programme has been done, the HIAs often do not present their findings in a way that demonstrates that the impact on health equity / inequalities has been assessed (Parry and Scully, 2003; Kemm, 2005; Quigley et al, 2005). Wismar et al (2007) found that identifying and reporting equity considerations within the HIA process rarely led to changes in the decisions made.

Measuring equity in HIA is difficult. It is complex and resource intensive (Quigley et al, 2005; Simpson et al, 2005; Wismar et al, 2007), it is challenging methodologically and is time consuming (Quigley et al, 2005; Simpson et al, 2005; Harris-Roxas and Harris, 2007; Wismar et al, 2007). In addition it can be limited by the lack of synthesised or summarised evidence (Harris-Roxas and Harris, 2007). Through two case studies, Quigley et al (2005) find that including inequalities in HIA is feasible, and they provide a structure for doing so. Simpson et al (2005) argue that just carrying out screening with an equity focus (with explicit considerations of avoidability and fairness) would be useful.

Harris et al (2007) identify reasons why incorporating equity into HIA has proven to be difficult:

- Lack of definitions concerning which potential impacts are unfair and whether proponents of a proposal are in a position to influence their elimination,
- Lack of awareness of which population groups to consider in an HIA, and
- Lack of available data to assess whether these groups experience differential impacts.

In addition to this the authors also identify the risk that HIAs tend to focus on one or two health determinants and ‘forget’ to consider the differential distribution of impacts (Harris et al, 2007).
Approaches to dealing with these challenges are also identified (Harris et al, 2007):

- Lack of definition on what is unfair and avoidable requires thinking through who is responsible for what actions on what impacts.
- Concerning population groups, at a minimum it is recommended that age, socio-economic position, ethnicity and culture, location disadvantage, and disability or other health status are considered.
- Where data are lacking, the potential for inequity should nonetheless be reported (along with the lack of data).

Five EFHIA case studies are reported by Aldrich et al (2005) and Simpson et al (2005). These case studies demonstrated that EFHIA enabled the identification of potential unintended anti-equity consequences and generate recommendations that potentially enhance equity / reduce inequality (Aldrich et al, 2005). They do this by incorporating specific questions or processes to each HIA step. These questions and processes are intended to prompt the exploration of equity considerations within the HIA (Aldrich et al, 2005), assessing whether identified potential differential health impacts are avoidable and unfair (Simpson et al, 2005). As such, EFHIA has the capability to prevent health inequities by using the findings from the EFHIA to amend, ameliorate and improve the proposed policy, program or project (ideally before it is implemented) (Simpson et al, 2005).

Harris-Roxas and Harris (2007) identify ways in which the HIA process can enhance equity within the policy process: HIA can broaden the range of potential health impacts that are assessed; HIA can introduce evidence into the decision making process that would not otherwise have been considered; engaging stakeholders with the process can make the recommendations from an HIA more acceptable and identify issues that would not otherwise have been included in the policy making process; HIA may act as a catalyst for collaborative working either during the HIA process or as a spin-off from the process.

HIA evaluations

Mathias and Harris-Roxas (2009) observe that evaluations of HIAs are rarely done and even more rarely published. There are few evaluations included in this study for that reason. In addition to the Mathias and Harris-Roxas process and impact evaluations of the Greater Christchurch Urban Development Strategy HIA in New Zealand (2009), three of the 16 HIAs included in the review have reported the findings of process evaluations (Queensland Health, 2003; CDHB, 2006; Tugwell et al, 2007). Collectively, these evaluations demonstrate that HIA can be successful in including representatives of disadvantaged communities, it can provide a forum for sharing understanding and learning the equity language of participating organisations, and it can lead to a shift in understanding about health, health inequalities and social determinants of health.

Mathias and Harris-Roxas (2009) found that the HIA did influence the development of the Urban Development Strategy, but that not all of the recommendations were taken up, and not all of those that were taken up translated into action points. They also found that the HIA process had an influence beyond the development of that particular policy in terms of improved cross-sectoral working and the greater participation of Māori in local bodies. One key informant in this evaluation felt that health inequalities had not been adequately considered in the HIA, however (Mathias and Harris-Roxas, 2009).
Although Harris et al (2006) did not include a formal evaluation in their report of an HIA of components of the Australia Better Health Initiative in New South Wales, they did include reflections on the process. They reported that the HIA process was clear and there was good collaboration and commitment between participants and policy makers. In terms of limitations, they found that there was a lack of time to properly consider the evidence base and that some participants had difficulties in stepping away from their own strategies in order to identify potential positive and negative consequences (Harris et al, 2006).

**Review of selected HIA reports and evaluations**

16 HIAs have been included in this scoping review (see Table 3.2). They were chosen because they are policy level HIAs and have an explicit aim of reducing health inequalities or improving health equity.


Most of the HIAs used the WHO definition of health or a socio-environmental definition. Only two offered no definition at all (Quigley, 2005; LHC, 2008), although it was clear that Quigley (2005) employed a socio-environmental model and LHC (2008) acknowledges broad determinants of health. Two HIAs incorporate indigenous definitions of health: Australian Aboriginal (Trindall and Bell, 2008) and Māori (Quigley et al, 2006). Bhatia et al (2008) define health in terms of illness, but this HIA is assessing the impacts of a policy to introduce paid sick leave in California; broader determinants are considered throughout the HIA.

The terms equity, inequities or inequalities are not always defined. Where they are defined, three HIAs used the term “health inequalities” in the value-neutral sense of differences in health status between population groups (Abrahams et al, 2008; LHC, 2008; PHDU, 2009), four used the term “health inequalities” in the sense that these differences may be judged to be avoidable and unfair / unjust (Chilaka, 2005; CDHB, 2006; Quigley et al, 2006; Tugwell et al, 2007), and three defined “health inequities” in this way (Queensland Health, 2003; Harris et al, 2006; WSROC and Gethin, 2007).

Considerations of equity or inequalities are usually assessed through differential impacts on vulnerable / disadvantaged groups, specific population subgroups (such as Australian Aborigines, Māori, or the UK equalities groups), or subgroups identified during the HIA as being particularly sensitive to the impacts of the policy being assessed. The Coffs Harbour HIA (Tugwell et al, 2007) includes an assessment matrix with columns to assess whether or not identified differential impacts are avoidable and / or unfair. Neither this HIA nor any of the others that define inequalities or inequities as potential differences in health impacts that are avoidable and unfair / unjust explicitly discuss these judgements within the text of the reports. That is not to say that these assessments have not been made; it is clear that some of these HIAs have considered the equity of identified differences very thoroughly (Harris et al, 2006; Quigley et al, 2006; Tugwell et al, 2007; WSROC and Gethin, 2007). What are missing are explicit discussions of the value judgements made to determine
whether or not potential impacts are inequitable. Similarly, even where there is a clear consideration of equity issues throughout the HIA process, recommendations are not always explicitly framed in this way.

**Table 3.2 Health Impact Assessments included in the HEIA scoping review**

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<th>Reference</th>
<th>Source</th>
<th>Type of HIA</th>
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The HIAs included here demonstrate two further aspects of equity impacts. The first is the consideration of social determinants of health (SDH). As already noted, most of the HIAs employ a
social model of health and as such are looking at social determinants. WSROC and Gethin (2007) recognise that inequities result from barriers to achieving full health potential and that, as the determinants are social, the solutions need to be joined-up. Harris et al (2006) note the interconnections between policies and two HIAs (Abrahams et al, 2004; Abrahams et al, 2008) consider the “causes of the causes” of health inequities, which can be limited by a lack of evidence (Abrahams et al, 2008). Winters (2006) discusses the equity implications of consumerism and competition within English health care organisations.

The Goodna HIA (Queensland Health, 2003) was a pilot to test the efficacy of HIA in considering multi-departmental service integration to address SDH. It has two facets: an HIA of human service integration and the assessment of HIA as an appropriate methodology for public health practitioners to assess the impacts of human service integration. Equity - ensuring the multiple and complex needs of disadvantaged communities were met - was a key component of this HIA. The findings indicated the importance of communication and relationship building between services and communities. They also revealed the need to address the underlying causes of health inequalities. The unexpected findings, both positive and negative, can be used to inform future HIAs of service integration. The report concludes that: "... [HIA] has the capacity of changing the culture of whole-of-government service delivery so that policy makers always take health into consideration” Queensland Health (2003, p.56).

The value of stakeholder involvement in HIA is demonstrated by the Good for Kids. Good for Life. Equity-Focused Health Impact Assessment (Trindall and Bell, 2008). The whole HIA is aimed at ensuring adequate consideration of Aboriginal needs and cultural requirements. There is no explicit definition of equity or of what would be considered inequitable. Nonetheless there is evidence throughout the HIA that Aboriginal representatives were able to shape the HIA process to be responsive to their culture and population needs, i.e. challenging the dominant culture represented in the HIA process. In this sense this HIA considers differentials in power (to shape social norms) within the HIA process, and makes appropriate adjustments. Similarly, the recommendations include many that are culturally sensitive to Aboriginal communities.

Examples from the peer-reviewed literature

Jobin (2003) and Utzinger et al (2005) both describe an HIA of a large oil project in Africa where there were potentially significant inequitable health impacts resulting from the project but these were not able to be adequately addressed within the HIA. Some factors that are also likely to be relevant to the successful development of HEIA on a global scale are identified:

- public consultations being held in presence of armed security forces;
- NGOs being focused on human rights, environment (not specifically on public health);
- potential important role that civil society organisations can play in monitoring;
- importance of support from those with power (for example, the World Bank);
- success should not rely on the ‘internal motivation’ of project proponents.

Equity in other related areas

The Health Equity Assessment Tool (HEAT), New Zealand

HEAT (Signal et al, 2008) is designed for use by the health sector to help them understand their role in improving health equity. It is not a full HIA, rather a tool than can be used with an HIA or as a
standalone process. The tool is a set of 10 questions that can be used to assess the impact on health inequalities of policy, programme or service interventions (Signal et al, 2008, p.6):

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where / how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

The 10 questions can be used quickly to give an overview of the health equity impact of a policy, programme or service, or it can be used to consider equity impacts in more depth. A subset of the questions can be used if that is deemed appropriate. The guidance includes tables and checklists designed to facilitate the process. HEAT can be used alongside other strategic planning tools such as HIA.

The model of health employed is a socio-economic-environmental one; health equity is defined as “Absence of unnecessary, avoidable and unjust differences in health” (Signal et al, 2008, p.28). No distinction is made between health inequalities and health inequities, both describe health differences that are “unnecessary, avoidable and unjust”. Māori, Pacific, low-income groups should be represented when using the tool. Subgroups identified are ethnicity, gender, socio-economic, geographical, people with disabilities.

**Equity gauge**

The Global Equity Gauge Alliance (GEGA) is an international network of groups in developing countries that facilitate processes designed to confront and mitigate inequities in health. In 1999 and 2000, a series of meetings involving researchers and activist NGOs noted that, despite the 1978 Alma-Ata Declaration, which emphasizes the importance of equity for the attainment of good health, inequities still prevailed and continued to grow worldwide.

GEGA has three ‘pillars’ (GEGA, 2003). Measuring and tracking the inequalities and interpreting their ethical import are pursued through the Assessment and Monitoring pillar. This information provides an evidence base that can be used in strategic ways for influencing policy-makers through actions in the Advocacy pillar and for supporting grassroots groups and civil society through actions in the Community Empowerment pillar. Actions are interconnected.

GEGA is similar to HIA in that in addition to identifying equity issues it incorporates concrete actions to reduce unfair disparities.

Inherent within the Equity Gauge concept is an understanding that the determinants of health inequities are largely socio-political in nature, and often relate to unfair distributions of power,
influence and wealth. Therefore, achieving a more just distribution of resources needed for health requires some degree of social and political mobilization (GEGA, 2003).

Examples from Equity Gauges could provide valuable information, tools and guidance that could be incorporated into a HEIA approach. For example Scott et al (2008) describe:

- A list of questions that guide the assessment. These include questions related to general state of inequity, government, other decision making and power broking institutions, civil society environment, macro-economic and public policy environment, health care system.
- Monitoring is similar to profiling in HIA and includes qualitative as well as quantitative indicators (for example case studies, narrative approach to reporting.
- A framework for identifying social groups to compare.
- Advocacy involves a set of organised actions to support pro-equity policy and its implementation.
- Development of stakeholder maps which include the identification of stakeholders that may resist or support actions and goals.
- Community empowerment pillar separate from advocacy pillar. This involves actions that support community empowerment and help communities to speak more effectively for themselves.
- Bottom up development.

Environmental Justice and Human Rights

With an increase in interest in HIA in the US we are also starting to see stronger links being made between environmental justice and HIA. Environmental Justice developed from the publication of evidence (from studies but also local protest movements) that showed that policies, programmes and projects that have environmental impacts tend to negatively impact more on already vulnerable groups- these groups bear an unfair burden (Bass, 1998).

It is interesting to note that the link between environmental justice and the concept of equity is often not made explicit (Bhatia and Wernham, 2008, for example). However in a paper based on the experience of HIA in urban contexts in Australia, Harris et al (2007) do identify the link between equity and the concept of environmental justice. This is seen to provide an opportunity for HIA to build on the environmental justice movement and strengthen its focus on health inequality. Assessing differential health impacts of urban regeneration programmes across age, gender, culture, socio-economic status and disability is given as an example.

Right to Health Impact Assessment is a developing field. Several human rights monitoring bodies, including the UN Committee on the Rights of the Child, the UN Committee on Economic, Social and Cultural Rights, as well as the UN Special Rapporteur on the right to health, have called on governments to perform human rights-based impact assessments. Members of the HIA community have also endorsed this development. For example, Scott-Samuel and O’Keefe identified human rights-based HIA “as central to the development of healthy foreign policy on a global scale and to the development of globalization as if health mattered” (Scott-Samuel & O’Keefe, 2007, p.215). New methodologies are being developed and existing methodologies adapted to assess impacts on the right to health (RTHIA) (for example: Asher, 2004; People’s Health Movement, 2006). The immediate purposes for RTHIA methodology are (a) identification of impacts that particular state actions, in particular in relation to policies, are likely to have on people’s right to health, and (b) identification
of modifications to policies that may be necessary to minimize negative and enhance positive impacts.

There are obvious links between RTHIA and HEIA. From a human rights perspective, integrating human rights into policy-making processes, through impact assessment and other evidence-based tools for policy analysis, is necessary for governments to abide by their human rights legal obligations. From the perspective of HIA and HEIA, human rights provide a legally binding and morally compelling framework for evaluating the evidence and options. Linking HIA to rights and concepts of justice could be one useful way of conceptualising and also strengthening HEIA.

**Complexity and evidence**

Complexity is a theme that is developing in more recent HIA related literature (for example: Simpson et al, 2005; Utzinger, 2005; Curtis, 2008; Patz et al, 2008). Complexity science, or theory, responds to the view that

*linear relations and correlations, linear trajectories, linear report formats and linear narratives make for very poor representation of complex phenomena. Whether embedded in quantitative analyses or qualitative descriptions, such Euclidean forms are of limited interpretive value and have virtually no predictive value, as is proven daily in stock markets, classrooms and personal lives* (Davis and Sumara, 2005, p.313).


Curtis (2008), in a paper identifying some of the potential limitations around using HIA of public policies in addressing health inequalities within a European context, argues that there is a shift from linear to non-linear theories of knowledge. The challenges around participation are highlighted and Curtis (2008) concludes that

*meaningful participation in HIA consultation, rather than producing an orderly consensus, often appears to involve a multiple field of competing knowledges and contradictory certainties among different actors, which are features of non-linear knowledge* (Curtis, 2008, p.299).

Curtis (2008) calls for a wider range of types of knowledge to be used. For example, the use of social and geographical theories and evidence should be used to inform healthy public policy alongside the traditional use of epidemiological and medical theories and evidence. She believes that this could lead us to challenge traditional research on the geography of health inequalities in various ways.

**Context and values**

The importance of local and global contexts has also been identified (Curtis, 2008). This leads to discussion about how health inequalities can be ‘delineated and localized’. There are challenges identified in potential non-transferability of settings. ‘Cultural’ and situational difference in health protection can also be a potential source of inequalities. Curtis (2008) is suggesting that we need to look beyond the immediate area and that “notions of scale may be the product of social power relations” (Curtis, 2008, p.296). Curtis (2008) goes on to discuss the phenomenon of ‘post-national
communities of risk’ with processes that produce effects operating not just at local level. For example:

- European Union level (e.g. SEA protocol, Art 152 ),
- International statutory agencies such as WHO and also less formal coalitions such as NGOs, consumer protection groups, professional networks such as IAIA.

Connelly and Richardson (2005) argue that we cannot debate Strategic Environmental Assessment (SEA) procedures separately from questions of value. The issue of conflicting values has relevance to HEIA. There appears to be a debate in SEA literature similar to that in HIA about participation and expert driven assessment. Authors suggest that underlying values might be a cause of some of the disagreement.

Because fundamental questions of value difference are not being explicitly addressed in procedural debates, certain interpretations, or ways of thinking, may come to dominate SEA practice, without the SEA community being able to consciously identify the values which it believes should drive assessment (Connelly and Richardson, 2005, p.393).

Connelly and Richardson (2005) argue that decisions about the aims and design of policy are essentially questions of value because they are based on who should benefit from the policy and who should not; this “creates a series of conceptual, practical, and political difficulties for any proposed mechanism for implementing sustainable development” (Connelly and Richardson, 2005, p.394).

Summary

Our review indicates that equity is still not being addressed adequately within HIA with the exception of EFHIA. In line with the EFHIA review, the scoping review found that in general even when HIAs were described as having a specific focus on consideration of equity they did not generally move beyond identifying vulnerable population groups and differential impacts.

The reviews of HIA guidelines show that a number of new guidelines have been developed that include a more explicit focus on inequities / inequalities, often with tools and guidance for how to include equity or health inequalities in the various stages of HIA. Disappointingly, there is still no consistency in the definitions of equity / inequity or inequality used. If these terms are defined at all; often they are inferred through the model of health employed in the guidance. Without a consistency in this terminology it is difficult to see how an equity focus can be consistently applied within HIA. The concept of equity as the absence of avoidable and unfair differences in health status across population subgroups, necessarily leads to the need to make value judgements within the HIA process. The importance of values is rarely acknowledged and there are no tools to help judge fairness. EFHIA addresses this through the guidance that such values need to be explicitly negotiated in the scoping phase of the HIA, and decisions on equity negotiated as part of the assessment and recommendations steps.

A few of the guidelines argue for the inclusion of considerations of equity / inequalities in all steps of the HIA; most tools focus on the screening, scoping and assessment phases. There is little help in including equity within the results and recommendations. Equity is most frequently addressed through the assessment of potential differential impacts on vulnerable or other population subgroups. These groups may be defined ahead of the impact assessment, or may be identified as
part of the scoping and screening phases. Some guidelines argue for a minimum set of subgroups, usually race, gender, income, and so forth, with others identified as part of the process. This begs the question as to whether attempting to ‘level up’ the potential impacts of policies is the same as improving equity. Is the focus on vulnerability sufficient?

The reviews of HIAs mirror the findings of the guidelines, perhaps not surprisingly so. Again, there is inconsistency in the definition and use of the equity / inequalities terminology. Most HIAs discuss health inequalities or, perhaps, equity, but do not then employ a structured approach to assessing impacts on equity or inequalities. Where this is done, it is done through subgroup analyses and the inclusion of representatives of community groups in the Steering Group or through consultation in the assessment phase. It does not necessarily follow that such participation will lead to greater equity. Often, even where the assessment has included consideration of differential impacts, these analyses are not easy to trace through to the results and recommendations of HIA. The Queensland Health HIA of service integration highlighted the lack of assessment of the ‘causes of the causes’ of health inequalities / inequities as a limitation of the HIA. Such assessments of distal determinants of health are very rare.

The inclusion of equity within HIA is complex, difficult and time consuming.

Process evaluations of HIAs demonstrate that they can have value beyond their recommendations and potential impact on policy development and implementation. The process itself provides an opportunity for inclusion – different sectors and different social groups – and fora for learning the language of equity and of other organisations, fostering a shared understanding and greater collaboration. Some of these benefits may extend beyond the life of the HIA and have been shown to lead to greater inter-sectoral working and improved inclusion of Māori in local government decision making processes.

Linking HIA to the environmental justice and right to health movements provides opportunities to strengthen the equity component of HIA. Environmental justice has an explicit focus on vulnerability, and linking to the human rights agenda could provide a legally binding and morally compelling framework for evaluating evidence and options within HIA. Complexity theory emphasises the need to incorporate a broad spectrum of evidence within HIA, to ensure that multiple perspectives and ‘knowledges’ are included. This would, of course, require that the different value systems of different participants be made explicit, as should the values underpinning the HIA. And we should expect conflict and difficulty in negotiating results and recommendations.
4: Interviews

Introduction

The interviews were conducted with 14 people with expertise in health equity and/or health impact assessment. The participants had been identified through a process of stakeholder mapping. The interviews took place during August and September 2009 and were mainly one-to-one interviews conducted over the telephone.

The interviews aimed to explore the participants' views on the effective incorporation of equity within the HIA process. We discussed the nature of health equity itself, the influences on health equity at the global, regional, national and local levels, the strengths and limitations of HIA in considering health equity, and finally whether or not there is the need for a new HEIA methodology.

Methods

Interview participants:
The interview participants had expertise in one or more of the areas of Health Impact Assessment, health equity, policy impact on health equity at the global, national and/or local levels, health equity measurement and the WHO Commission on Social Determinants of Health. They were representative of the following groups:

- Gender: 7 women, 7 men;
- Occupation: 5 practitioners, 5 academics, 4 academic practitioners;
- Region: 5 from the UK, 1 from Europe, 2 from Canada/US, 3 from Australia/New Zealand, and one each from Chile, South Africa, Thailand;
- Expertise: 7 with practical knowledge of health (equity) impact assessment methodologies or health equity tools, and 7 with other health equity knowledge and experience.

Interviews:

14 out of the 16 people invited to take part in the project agreed to be interviewed. Two people were interviewed together, so there were 13 interviews in total. The interviews took place between 18th August 2009 and 8th September 2009. Each participant was sent written information about the project and a consent form, which they were asked to return via fax or email before their interview took place. The joint interview was conducted face-to-face, the rest were over the telephone. The mean interview time was 60 minutes. All interviews were digitally recorded and then transcribed. A thematic analysis of the interview transcripts was undertaken using NVivo8.

Interview questions (the full interview schedule is given in Appendix C):
The interview schedule was designed to explore the participants’ knowledge and opinions in the following areas:

- Health equity: definition, factors that alter health equity, actions to increase health equity
- The barriers and facilitators for policy change to maximise health equity
- The different factors for and impacts on health equity in the global, regional, national and local geographical regions, and the methodologies required to assess these factors and impacts.
- For those participants with experience in health impact assessment we were interested in:
HEIA scoping project

Interviews

- The strengths and weaknesses of current impact assessment methodologies and tools;
- The barriers and facilitators for assessing health equity impacts within those methodologies and tools;
- The barriers and facilitators for implementing recommendations aimed at increasing health equity;
- How to increase the uptake of recommendations aimed at increasing health equity;
- Whether or not they thought a health equity impact assessment would differ from HIA as it is now used.

Key findings

The analysis is presented in the same categories as set out in the interview questions section above.

Health Equity

a) Definition: It is perhaps not surprising that the participants had similar definitions for health equity. There was a clear moral aspect to the definitions, although this was expressed differently; four key aspects of health equity emerged from the interview data:

i. Health equity is the distribution of health in a just society, so that individuals should have the opportunity to live a decent life and achieve their full health potential regardless of their gender, religion, income, where they live, what job they do, etc. They should have access to healthy living and working environments, affordable and reliable health services and education.

ii. Social justice can be characterised as the fair distribution of: power; ownership and control of basic resources; resources for health and healthy living; goods and services.

iii. Health inequity is the avoidable and unfair differential distribution of the impacts of policies, programmes and life chances on different sections of society (based on age, gender, socio-economic status, disability, ethnicity / culture, and so on). These differences are avoidable because they are modifiable through public policy or other interventions. The underlying influences on these distributional differences relate to power divisions and social hierarchy within society.

iv. Health equity needs to be a focus within policy development and organisational goals, and also needs to be visible in planning and impact assessment. Public organisations need to be accountable to the populations they serve and those populations need to be empowered to demand high quality services.

In addition, there were some caveats about defining health equity. It should be noted that the definition of health equity and how it is put into operation will be culturally specific and may, therefore, vary by country. Even within the same organisation different definitions of health equity may be being used, and this may create confusion in policy decisions. As specific language becomes more embedded, definitions can eventually become short-hand for the phenomenon they represent, and it is possible that eventually we lose sight of what was originally meant by that term.

b) Factors: The participants identified the following as the main factors contributing to health equity:
i. **Structural factors** such as poverty, including poverty of expectation. Those conditions collectively acknowledged as social determinants of health, such as education, income, a healthy living environment, and so forth. The way such social determinants interact to influence the opportunities that people have to live a reasonable life, and the way these influences interact across the life-course. Inequalities have their roots in historical social and political developments.

ii. **Politics and policy.** The influence of public policies on the material and social conditions within which people live, and the lack of evaluation of the impact of policy on health equity. The level of political commitment to improving health equity, reflected in levels of social democracy and the provision of social safety nets. The lack of democracy at all levels of decision making.

iii. **Access to affordable and reliable health services.** This is generally accepted as a contributory factor to health inequity in the Global South and less of a factor in the Global North. There was an example from Australia, however, that showed how increased co-payments within the health services had led to reduced access to health services within that country.

iv. **Power and control.** Not feeling in control of one’s own life and opportunities. The distribution of power within and between societies and between countries and global or multinational organisations was seen as a key factor underpinning the distribution of health outcomes. Associated, but slightly different factors are: the control over authority – who makes the decisions, and how; the control over information – how and what information is presented, how issues are described and explained and the role of the media in this; control over regulation – especially at the global level.

v. **Injustices:** one participant felt strongly that underlying these factors are fundamental injustices in society around discrimination against people because of their race, gender, income level, and so on.

vi. **Differences in language and culture.**

c) Actions to improve health equity would address the factors affecting health equity set out above, but the participants also identified other actions that could be taken.

i. **Policy and politics:** Promote social democracy and the introduction of social safety nets; promote decision making for health equity; strengthen global regulatory structures; address the underlying influences on and strengthen the positive social determinants of health; recognise life-course influences; move away from behaviour change models and invest in these long-term approaches; promote inter-sectoral action; strengthen the influence of the health sector; improve access to health care. Such changes will take time; in the short-term target action where there is evidence that it will make a difference.

ii. **Communities and civil society:** A number of participants felt that community development and community empowerment were key to improving health equity. It would help people to feel more in control of their circumstances and through this process people could be educated about their civil rights. HIA could be used as an advocacy tool to raise awareness amongst policy makers of social determinants of health and health equity and the impact that a policy may have.
iii. **Pressure for change**: Empowering communities in this way will help to create grass roots pressure for better health equity; engage with the media to raise awareness of social determinants of health and health equity, and to promote the message that health inequities are not just an issue for poorer communities but that they affect the whole of society. At the global level, civil society can also create pressure for global health equity. As Global South (e.g. Brazil, India, China) economies become stronger and gain more power in the global economy it creates an opportunity for them to press for change in global financial regulatory structures and to introduce a different set of values more sympathetic to the issue of equity.

iv. **Champions** are important in generating change.

Some of the participants expressed their concern that focusing on actions to improve health equity might mask what can be done to reduce health inequities. The evidence base is not necessarily there to support action to address health equity, but there is strong evidence to show what can be done to reduce health inequities. It is possible that working to improve health equity may be seen as too big a task, and so nothing will be done.

**Global to local factors, issues and methodological requirements**

There are four areas of interest: Firstly, issues relevant to both levels; secondly, issues specific to the national / local context; thirdly, issues specific to the global / regional context; fourthly, the interaction between these two levels.

a) **Issues relevant to both levels:**

   i. **Research** is needed: to understand the processes of change at each level; to understand the structures of decision making at each level; to understand the relationship between democracy and health;

   ii. At each level policies should be informed by the priorities the next level down, facilitated by a bottom-up pressure for health equity;

   iii. Recognise the context within which the impact assessment is being conducted: time constraints; transparency of the policy being assessed; place and culture; political context – how supportive is the political environment?

   iv. **Methods and tools**: Specific tools would need to be developed for specific issues. In-depth policy analysis would be able to explore the complexity of the global policy process and the influence of global policies in local settings. This policy analysis would include an historical analysis of the development of that policy as well as the interactions with other policy. It would take time and so would not be suitable for all policies. It would help to expose the distribution of power in the policy process. Such analyses would be much more complex at the global level, with many more influences on the policy development and implementation. There may not be the capacity to do such detailed analyses at the local level.

b) **Issues specific to the national / local context:**

   i. There are different social contexts within a country. Some areas will have small pockets of deprivation and others will have small pockets of affluence. The actions to increase
health equity or minimise health inequities compared to the national average will be
different in each of these areas.

ii. The political context and level of public awareness of the issues will affect action to
address health equity in the national or local context. As will the level of organisational
capacity to do so.

iii. Making health equity assessment a legal requirement could focus attention on health
equity, although this then runs into the danger of becoming burdensome and so
reduced to a tick-box exercise.

c) Issues specific to the global / regional context:

i. The dominance of global financial institutions such as the World Bank, the International
Monetary Fund and the World Trade Organization are factors at the global and regional
levels. For example, Structural Adjustment has had a negative impact on health equity
within and between countries. There are concerns about the accountability of these
institutions and powerful individuals, such as Bill Gates. This lack of accountability
allows their values and priorities to dominate global processes, even when their
intentions are good. Trade agreements and water rights were both factors highlighted at
regional levels.

ii. Methodologically, the context for policy development and implementation becomes
more complex as one moves from the local to the global arena. The complexity of policy
development at the international level means that different tools and indicators may be
needed for assessing the health equity impacts of policies. One participant suggested
that countries with a greater knowledge of the global and regional influences on health
(such as trade agreements) could develop tools for assessing their local impacts that
could be shared globally.

d) The interaction between these two levels:

i. The local impact of global policies and processes: Actors at the global level are not
generally concerned about the local consequences of their actions. Aside from the
activities of the global financial institutions outlined above, other global processes that
have an impact locally include the global spread of technology and the global diffusion
of culture. For example, different employment and safety regulations in different countries
aid the movement of production around the globe so that harmful processes or products
can continue to be used in the manufacture of goods to be sold globally. Long term food
security is an increasing concern. Global pressures on land in the Global South
undermine these countries’ ability to ensure their own long-term food security: growing
flowers instead of food in Kenya; rich countries buying land for food production in
poorer countries. The global spread of culture can have negative effects locally in terms
of undermining local identities and influencing personal choices; such as changes in diet
to less healthy foodstuffs (such as sugar rich cereals replacing traditional breakfasts,
drinking sugar dense drinks like Coca Cola instead of fruit juice, and eating fast foods
such as MacDonal). These multinational corporations may adapt their products to
local palates and food regulations in order to secure a place in those markets. Global
pricing policies may also affect what foods are available and affordable locally – for
example, despite producing a surplus in milk nationally the price of milk in New Zealand means that there are some who cannot afford it. These local impacts are differentiated by class.

ii. Assessing the local impact of global processes: local practitioners do not necessarily have sufficient knowledge of global processes; lack of access to processes at the global level forces a focus at the local level; local practitioners need help with tools to assess local impacts of international policies and agreements – these could be developed globally for local use; there is also the need to assess the global footprint of national policies, for example international recruitment of health service personnel.

iii. HIA is still a relatively new methodology. The Global North dominates in the development and undertaking of HIA. However, there is still a lack of capacity for conducting HIA in the Global North and more so in the Global South. There were concerns expressed about the potential impacts of HIAs done in the Global South by practitioners from the Global North. These practitioners may lack understanding of local cultures and contexts. Where these practitioners work outside the health equity field they may not be familiar with the concepts of equity or social determinants of health.

**Barriers to and facilitators for policy change to improve health equity**

**Barriers**

Key barriers to policy change to improve health equity centre around perceptions of health, health equity and inequity, the political context and the distribution of power.

There are many definitions of health and the biomedical model is dominant amongst them. This has implications for how interventions are planned and implemented (such as vertical programmes to address specific diseases), but also for our ability to engage people around social determinants of health. For many “health” still means “health care”; this makes it difficult to discuss social determinants. The concept of “well-being” is not linked to health care and the broader influences on well-being are more readily accepted and understood. It might, therefore, be better when engaging with people on the broader influences on health to focus on well-being and to talk about those influences that fall within their remit.

Just as health from a socio-environmental perspective can be difficult to understand, health equity is also a difficult concept to grasp. There is a general lack of awareness that health is distributed unevenly throughout society and the contribution that social determinants make to this. The way that health is represented in the media affects public opinion; the over-representation of the impact of unhealthy behaviours and medical interventions occludes the discussion, and therefore understanding, of social and political influences on the distribution of health. This lack of awareness reinforces the dominance of the biomedical model and effectively reduces support for broader, upstream changes that would improve health equity. These upstream changes to promote health equity may also be seen as too big to tackle, which in turn can lead to inertia and the focus remaining on medical interventions and behaviour change models. Some participants warned that focusing on promoting health equity may distract attention from the existing evidence of what can be done to tackle health inequities.
Within organisations there may be a lack of capacity to work towards promoting health equity. For some organisations, such as the health care services, there may be a need to redistribute existing resources away from the better-off areas, which tend to be better served, to the less well-off areas, which tend to be underserved. This imbalance in the distribution of resources may go unrecognised, or may not be addressed. In addition, there may be a lack of sufficient data at the local level to describe the extent of health inequities, and a lack of people with the necessary skills to understand health equity and to work across boundaries to address health inequities. For public sector organisations priorities from central government, in terms of performance management and funding allocations, may favour addressing disease-based (such as cancer and diabetes) and behavioural (such as smoking and obesity) outcomes, rather than addressing upstream causes of health inequity through collaborative working.

The extent to which organisations embrace the challenge of promoting health equity and / or reducing health inequities will, in some part, be determined by the prevailing political culture; that is to say, the extent to which the dominant politics values promoting health equity and is prepared to make the necessary structural changes to do so. It has already been mentioned that pressures and priorities from central government can conflict with the ability of organisations to work together to improve health equity locally. In addition, the dominant political culture may act as a barrier to promoting health equity through: prioritising economic concerns over social and health concerns; being unwilling to give up power – health equity requires a more even distribution of power; a lack of support for the values underpinning health equity, often associated with right-wing governments; lack of evidence-based policy making – policies are made to fit political priorities rather than based on the evidence of what is needed. One participant gave examples of where NGOs working in a rich country had their funding withdrawn because of their advocacy for social justice.

Several of the participants identified the imbalances in the distribution of power mentioned earlier as key barriers to action to improve health equity. These power differentials are manifest in the dominance of global organisations with the power to promote and protect the primacy of trade and economic priorities over social and health concerns; in the globalisation of culture and values associated with these processes; nationally and internationally the dominance of the ideology of individualism and market fundamentalism makes it difficult to connect these processes to health outcomes. This power over knowledge and ideas extends to the ways in which evidence can be distorted to lead to false understandings of issues in order to promote political priorities or vested interests. Political corruption is an extreme imbalance in power that works against the promotion of health equity. But even in more benign forms power imbalances can lead governments to fail to recognise that people at the grassroots are actors in the implementation of policies and programmes, and that these grassroots activists may not use the policies and programmes in the way that was intended or anticipated.

All of the above can be considered countervailing forces – even where policies are introduced to improve health equity or reduce health inequities, these barriers will limit the success of those policies.

Facilitators

Participants suggested several facilitators for policy change to promote health equity. These are essentially different mechanisms for raising awareness of health equity issues.
The first is to do with making the arguments and values associated with health equity visible and palatable. Such bottom-up pressure may take the form of grassroots collective action and pressure from local governments. Tools such as Health Impact Assessments also serve to raise awareness of social determinants of health within broad partnerships of individuals and organisations.

Secondly, opportunities to put these issues on political agendas come with changing political cycles, changes that cause re-evaluation of the status quo – such as the current economic crisis, legislation in related areas – such as public health, human rights and social inclusion, and shifts in the focus of research – for example the re-emergence of social epidemiology in the United States, which affords the opportunity to examine links between social policy and health.

Lastly, these “policy windows” (Kingdon, 1995) are best capitalised upon when there are champions in place to bring issues and opportunities together. These champions may be sympathetic politicians, activists, key workers or international agencies.

Equity in IA methodologies and tools

The participants were asked to consider how equity is included within impact assessment tools and methodologies. The participants felt that equity is often missed in the HIA process. Considering equity in terms of differential health impacts adds a layer of complexity to HIA that becomes time consuming. HIA is often required within short time frames and so such explicit considerations of equity can be lost.

It was felt that equity should be embedded throughout the HIA methodology, however. Tools such as the Dahlgren and Whitehead “Rainbow Model”\(^1\) of social determinants of health and the PROGRESS-Plus\(^2\) could be used as an equity lens to aid discussions. The specific population groups that would be affected by the policy should be identified. Too often socio-economic groups are left out of such analyses. Gender audit could also be part of HIA.

Some participants recommended in-depth health equity analyses of specific issues. These analyses may follow the usual HIA methodology or may encompass research strategies examining the health equity impacts of a policy from different perspectives and over time. Either way they are likely to be in greater depth, offer more insight into the health equity impacts but may take too long to be useful in the policy development process.

There are strengths and weaknesses to the HIA methodologies generally. Like other such tools, HIA can be ignored or the findings misused, especially if it becomes too ‘tick-box’. On the other hand, HIA can raise awareness of social determinants of health and health equity and can be used for advocacy. Some felt that there is a need for a standardised methodology; others that the existing methodologies are sufficient but that there is a need for more tools. Some requested more guidance on what tools to use when.

Barriers to and facilitators for assessing health equity impacts

Barriers

\(^1\) A conceptual model of the main determinants of health portrayed as layers of influence (Whitehead, 1995, p.23).

\(^2\) PROGRESS-Plus (Place of residence, Ethnicity, Occupation, Gender, Religion, Education, Socio-economic status and Social Capital + age, disability, sexual orientation, and other specific vulnerable or excluded groups): Kavanagh et al (2008).
A number of barriers to assessing health equity impacts were identified. One clear barrier is the lack of available local data. There is better data at the city, state and regional levels, but at the local level this has not necessarily been collected in sufficient depth to be useful in assessing equity impacts within HIA. One participant commented that the data might be suitable for those conducting academic research, but it is not meaningful or accessible to those working at a practical level, for example within local government. Another participant observed that gathering this local data in their locality requires contacting multiple local agencies, not all of which are prepared to share their information. It was observed that where local data is available the way it is examined will determine which equity issues emerge. The quality of the available data was also a concern.

There is a lack of capacity to conduct HIA. This is true in terms of the lack of people able to do HIA, lack of people able do HIA to sufficient depth and quality, and because in some countries people with the skills to do HIA have too much other work to do. It is of particular concern that those contracted to do HIA may not understand the process of research, and so will not conduct HIA with sufficient rigour. In addition they may not have backgrounds in public health nor understand equity, and so social determinants of health and equity impacts may be missed in the HIAs they conduct. Special concerns were raised about conducting HIA in the Global South where contractors brought in from the Global North to conduct HIA might not understand specific local contextual factors, such as cultural influences, that impact on the implementation of policies and programmes.

The political context can constrain the assessment of health equity impacts; if health equity is seen as a lesser priority than reducing chronic diseases or managing health care costs, for instance. There was some concern that health equity assessments instigated by the organisations whose policies are being assessed, or other vested interests, may receive the assessment they want rather than an accurate one. In some circumstances they may be done to reduce political opposition.3

Again, concerns were raised that if HIA or health equity impact assessment is recommended to be done on everything it will become burdensome, and will become tick-box. It was felt that if HIA is done too lightly it could be ignored or would reinforce existing inequalities.

Facilitators

The following were suggested as ways of facilitating the assessment of health equity:

- A minimum set of standards for HIA to ensure the quality of the final assessment;
- Having an explicit values base, underpinned by human rights and specifically the right to health;
- Ensuring that health equity research is of high quality – that it is robust and rigorous;
- International academic collaboration – to train people in HIA, to help raise awareness of the issues;
- Evaluations of policy impacts on health equity:
  - Not just prospective HIA or HEIA;
  - Concurrent and retrospective evaluations – there is little control over how a policy is implemented in practice;

3 See Smith et al (2010) for a description of how British American Tobacco sought to influence the design of the European Union integrated Impact Assessment to their benefit.
o Such evaluations would need to look at the impact on the whole system, not just the policy area being assessed.

Barriers to implementing HIA recommendations

The barriers to implementing equity recommendations from HIA reflect the barriers already described. There needs to be political will to act on the recommendations because recommendations for social change may be threatening to those in power. This could be damaged by not emphasising the health equity benefits of a policy, and focusing on the potential negative consequences of the policy.

The policy making context is also important. The person or group responsible for implementing the recommendations may not have time to do so. There may not be a culture of evidence-based policy making. If the HIA practitioners are consultants, they may not have understood the cultural or national differences in the commissioning country: the extent of the development of public health; the level of understanding of social determinants of health; local priorities – e.g. environmental impacts on health, rural communities’ access to health care.

Facilitators for the uptake of HIA recommendations

Several clear facilitators to the uptake of health equity recommendations were identified:

• **Involve key stakeholders throughout the HIA process.**
  It is important to engage with key stakeholders early in the HIA process and throughout. These stakeholders should include decision makers from all sectors involved and community members. A valuable tool is to hold a stakeholder workshop at the beginning of the HIA to explore the issues. Steps should be taken to maintain relationships with key stakeholders, especially during any organisational changes that may occur. This approach creates an opportunity to raise awareness and train policy makers about health equity.

• **Offer different policy options**
  Use HIA to offer and assess more than one policy option, to give stakeholders and policy makers a choice. This is done routinely in Thailand. Frame the policy options to fit government policy statements. Use government think-tanks and use the language of the agencies commissioning the HIAs. In this way HIA can give politicians tools to back up the moral argument for working to improve health equity.

• **Recommendations**
  Use the recommendations to offer criticism to participating agencies; this can be well received. Tie recommendations to the underlying influences on health equity. Having recommendations for equity can influence the order in which policy tasks will take place. Recommendations should be aimed at different levels – for individual and organisational change. Set targets for the recommendations, where possible. This will aid in the evaluation of the HIA.

• **Pressure**
  Similar to facilitators for policy change to address health equity, pressure from below can help create opportunities for the implementation of HIA recommendations. Pressure for greater equity can come from civil society movements, and it would be valuable to link different social movements working towards greater social justice. In order to facilitate this, health should be seen as just one of the issues of concern, and not the priority. There is a need to raise awareness that improving health equity has benefits for all of society. Champions and the media
can be used as advocates for health equity by raising awareness of the level of inequality and to push for the implementation of recommendations. HIA can also be used as an advocacy tool for health equity, if the reports are in the public domain.

**Is HEIA different from HIA?**

Finally, participants were asked whether they felt there was a need for something new to assess health equity impacts; whether or not HEIA would differ from HIA.

Two participants felt that there was a need for something different, either an HEIA methodology or another way of evaluating the health equity impacts of policy. They felt that there was a need for a methodology with an explicit equity focus in order to draw attention to the equity aspect of the assessment. It was felt that equity has an explicit values base that is not necessarily included within HIA as it currently stands.

One participant argued for an Equity Impact Assessment, where health is just one facet of the equity assessment. An example of this sort of methodology can be found in the Right to Health impact assessment (see Hunt and MacNaughton, 2006).

Most participants felt that the current HIA methodologies are sufficient, however. There were concerns about having too many different impact assessments. These could become burdensome, and there is the danger that a separate HEIA would mean that equity is perceived as an option rather than integral to the process. These participants felt that HIA has enough capacity to consider equity as it stands. A common opinion, however, was that equity is not currently used widely within HIA and that there is a need to build capacity for HIA and equity within HIA in both the Global North and Global South.

Although the current methodology is considered sufficient, it was felt that there was scope for new tools:

- In-depth policy analysis that would set a policy in its political and social context, identify the key actors in its development, particularly vested interests, conduct cross-country comparisons, and include an historical analysis of the policy development. Such analyses would be time consuming and would therefore not be suitable for all policy assessments but, if the policies assessed are chosen carefully, would provide in-depth knowledge of the policy development process and its impact on health equity;
- Sociological assessments to understand the processes of change at different levels of the policy implementation process and people as actors in policy delivery;
- Develop new indicators for democracy and power distribution;
- Include a framework for thinking about equity in policy development – e.g. PROGRESS-Plus or the Rainbow Model.

A number of participants argued against institutionalising HIA; this could slow down the policy development / implementation process and might lead to HIA / HEIA becoming a tick-box exercise that loses visibility and value.

There was also a call for HIA to be values based rather than a technocratic exercise; and a request for HEIA to be piloted in the Global South.
Summary

In summary, the majority of the interview participants felt there was no need for a new HEIA methodology. Rather there is a need to strengthen the equity focus of HIA through capacity building and new assessment tools.

Several areas of research and methodological development were identified: in-depth policy analyses including historical analyses of policy development; concurrent or retrospective evaluations of policy impacts on health equity, taking a whole system approach; sociological research to understand the processes of change; explorations of the distribution of power and its impact on health; cross-country comparisons to assess the impact of democracy on health.

The participants argued that we use HIA to expose and challenge differentials in power and the lack of democracy and accountability in decision making, especially at the global level; and use HIA as an advocacy tool at the local level.

Finally, we need to raise awareness of health equity by engaging with the global civil society, the media and policy makers – it affects us all.
5: Workshops

Introduction

The findings presented in this section are based on the discussions from two workshops. The first, and main workshop, took place on 5 and 6 October, 2009, in Liverpool. This was the workshop planned as part of the empirical work of the project. The second was more opportunistic in that Dr Alex Scott-Samuel had a workshop application accepted for the HIA09 conference in Rotterdam. We used this workshop to present the project and explore some of the questions with participants interested in HIA, but with differing levels of experience in HIA, and from a broader range of countries.

Methods

Liverpool Workshop

Participants:

The Liverpool workshop participants were identified through the stakeholder mapping process outlined in Section 2. The participants had expertise in one or more of the areas of Health Impact Assessment, health equity, policy impact on health equity at the global, national and / or local levels, health equity measurement, health economics, health rights and the WHO Commission on Social Determinants of Health. The majority had practical experience of HIA, and some had developed HIA methodologies with an explicit consideration of equity or health inequalities. They were representative of the following groups:

- Gender: 12 women, 7 men;
- Occupation: 1 was an HIA consultant, 2 worked for the English Department of Health, 1 worked for the European Union, 3 worked within the UK National Health Service, 1 worked for a national Public Health organisation, 2 worked within local or regional government, 7 were academics, and 2 worked for the World Health Organisation;
- Region, one or more of: England, Wales, Scotland, Ireland, continental Europe, Canada, Australia, Chile, South Africa;

Workshop:

The Liverpool workshop took place on 5 & 6 October, 2009, at the Foresight Centre. Three members of the project team (ASS, DA and SP) led the workshop through presentations, facilitating group work and chairing feedback sessions. 19 out of the 44 people invited were able to attend, including three members of the Advisory Group. The low response rate reflects the fact that invitations to the workshop were sent out at relatively short notice, four weeks before it took place. Also, we received additional funding to enable us to invite more overseas participants most of whom were unable to attend. Three of those who came could only attend on the Monday and six others had to miss one or both of the final sessions on the Tuesday.

Workshop programme (see Appendix D):

Central to the workshop programme were four group work sessions designed to explore the participants’ knowledge and opinions in the following areas:
- **Group work 1**: Strengthening equity in Health Impact Assessment – the local context;
- **Group work 2**: Strengthening equity in Health Impact Assessment – the global context;
- **Group work 3**: Equity recommendations within HIA / HEIA;
- **Group work 4**: Making HEIA happen and maximising its impact.

The participants were split into 3 groups, with a different mix for the Monday and Tuesday sessions. ASS pre-planned the groups so that there would be an equitable division of people by gender and experience. The three groups met in separate rooms and each was facilitated by a member of the project team. For Group work 4, however, the number of participants was sufficiently reduced for it to be more practical for everyone to meet as one group.

A final session, “Health Equity Impact Assessment: towards a consensus”, had been intended to be a group discussion to draw some conclusions from the workshop. The number of participants remaining (10) at this stage meant that the discussion would not have been representative of all participants. It was decided, therefore, for the participants and members of the project team to work together and break into five groups to answer the following questions:

“What would you like to say to the world about:
1. Equity in HIA?
2. What you think should happen next?”

Key messages from the feedback and discussion from this session have been incorporated into the findings below.

**Recording:**

All the group work and feedback sessions were digitally recorded. Unfortunately one of the digital recorders had been set to record only when people were speaking and we discovered afterwards that this is not suitable for a conference environment as the recorder tends not to record the beginning and end of sentences as people speak loudest in the middle of sentences. Consequently the group sessions where this recorder had been used have not recorded completely. There are enough of the conversations to identify the key points from these sessions, but not enough to extract accurate quotes.

All the recorded sessions were transcribed.

**Rotterdam Workshop**

The Rotterdam workshop took place at the HIA09 conference in Rotterdam, The Netherlands, 14-16 October. It was titled “Health Equity Impact Assessment Pilot Project” and lasted for two hours. The participants were self selected; as they were at an HIA conference, they all had an interest in HIA, but had differing levels of experience of HIA. Most had an interest in health equity.

Following a brief presentation by ASS and SP, the 20 participants were asked to break into three groups. Each group was facilitated by a member of the project team (ASS, DA and SP). The groups were asked to reflect on the following questions:

- How do we strengthen equity in HIA locally?
- How do we strengthen equity in HIA globally?
- Equity recommendations within HIA?
- How to make it happen, including whether or not we need something new?
The groups elected someone to feedback. The facilitators took notes of the group discussions and the feedback to the whole group.

**Analysis**

The workshop transcriptions, together with notes from project team members from both workshops, were subjected to a thematic analysis. Because of time constraints the analysis was not done using NVivo8, rather one author (SP) read the notes and transcripts and extracted key themes.

**Key findings**

The following themes emerged from the discussions at both the Liverpool and Rotterdam workshops.

**Equity**

The workshop participants were asked to reflect on the influences on equity at the local / national levels and at the regional / global levels. As well as influences and actions specific to these levels, which are reported below, the participants identified areas of action and concerns that apply to all levels.

The pursuit of equity is essentially a statement of values; a belief in the importance of social justice. Policy makers are not necessarily motivated by equitable, utilitarian values. Their priorities might not fit the equity agenda; their priority, for example, might be economic growth rather than health and wellbeing of the many.

Wealthy countries and wealthy people endeavour to protect their own interests. It is difficult to visualise inequity in areas physically and culturally removed from where we are. To counteract this it is necessary to build a consensus that equity is an important value. To do this we need to make equity personal to those not considered to be at risk, such as the middle classes and wealthy nations. It is important that we highlight the benefits of equity to the whole society, national and global. In order to build such a consensus we need to identify the actors we want to engage with, what their power base is, what their influences are. These actors will vary according to the local and national contexts. When working with sectors unaccustomed to considering health and equity it is important that we work with their priorities and use language that they can engage with. ‘Equity’ might be too specific; more progress might be made if we use the term ‘fairness’.

We need a social movement and charismatic champions to raise awareness of equity issues and create pressure for change at local, national and global levels. Champions at the local and national levels could be politicians, policy makers, service providers, and community leaders. At the global level we would need to engage with people in positions of high authority, or with high visibility – in the same way that Bob Geldof and Bono have been champions for the fight against extreme poverty, especially in Africa.

The fundamental determinant of inequities is the distribution of power. Powerful elites control resources and make policies. We need to identify and engage with those with the greatest power and influence in order to advocate for health equity. In order to do this we need to recognise that different groups operate in different ways, use different language, and have different values.
The participants emphasised the contextual nature of equity. There are different patterns of equity within countries and in different parts of the world; the European stepwise gradient in health determinants and outcomes does not apply in all countries. Equally the determinants of health vary by country; gender inequalities, for example, have a much greater influence in some areas. Policies and recommendations have to be sensitive to these patterns and to the policy and social dynamics that create and re-create them. The distribution of power will vary by country, and this will limit the transferability of research findings on improving health equity.

The workshop participants raised concerns about accountability and the constraints that accompany aid to poorer countries. Although these issues have been expressed as international concerns, there are also parallels at the local / national levels.

Even though philanthropists, such as Bill Gates, are providing much needed funds to tackle serious challenges to health, they are not accountable to anyone for their actions. At the local level, powerful groups and organisations may engage with communities in order to promote their own agendas, rather than for the benefit of those communities. Conditions attached to aid may promote the donor country's products. Vertical health programmes can undermine the development of health systems. And multiple programmes from multiple donors may be uncoordinated, not accountable to a single organisation, and time spent reporting back to multiple donors can drastically reduce the amount of time that can be spent on delivering the policies and programmes locally. Together, these limit a country’s capacity to cope and be autonomous.

At the local level, many participants expressed concern at the unintended consequences of area regeneration programmes where the original inhabitants are displaced as areas are improved: for example:

...there was a project to clean up an informal settlement, because it would flood regularly there, and [there were] high rates of infectious disease, etc. And the people there said, what are you doing? You clean this up, we're not going to be able to afford the rent ... it's right next to where we live, we can tell when it's going to flood, we just move our stuff. It's fine for us, don't muck it about, please. And then, sure enough, it was improved and everybody had to move out. And it's now much more expensive to live there.

Sheffield has rebuilt itself in terms of housing and that sort of thing. But what tends to happen is that you then get better qualified and richer people coming in. And what you don’t get is the actual people, who were the third generation unemployed, doing any better out of the deal at all.

It would be useful to have examples of where the original inhabitants have benefitted from area improvements. Equally, it would be useful to understand which people end up in poor housing, for example, and why.

There was also concern about the unintended consequences of national health protection and improvement programmes. The example given was that of reducing smoking rates. The reduction of smoking in richer countries can have economic implications for communities in poorer countries where tobacco is grown as a cash crop. These communities could lose their livelihoods. As tobacco consumption is reduced, these communities will need help to identify and produce alternative crops.
There are opportunities for promoting an equity perspective. Currently, the CSDH and the Marmot Review on health inequalities policy in England have raised awareness of the social determinants of health and health equity. These create an opportunity to raise the profile of health equity within the UK. Policy opportunities can come from responses to both natural and man-made crises, such as extreme weather and the banking crisis, respectively. At the global level, trade negotiations and climate change talks create opportunities to raise health equity as an issue to be considered.

Rather than “Health in all Policies”, we need to promote “Equity in all Policies”.

The next sections consider influences on equity in the local / national and regional / global contexts. Workshop participants stressed that local–national–global interactions are not linear and are complex, and they are characterised by power imbalances.

**Equity in the local / national context**

At the local / national level, action is constrained by personal and political values. Individuals and governments need to be sympathetic to the ideals of social justice for there to be the right context within which equity impacts can be assessed. The political context is further defined by short-term priorities, which can lead to considerations such as economic growth being given higher priority than equity. The degree of democracy and freedom within a country will determine the extent to which civil society will be willing to create pressure for change; if they are fearful of retribution they are unlikely to speak out. In a different way, communities in countries with higher levels of democracy, such as the UK, that have felt excluded for generations may feel disenfranchised and not engage with democratic processes. In such circumstances, and in emerging democracies, it is important to encourage and support people to vote, especially the young.

One participant commented that emphasis is usually placed on engaging with decision makers and communities in terms of generating top-down and bottom-up pressure for change. There can be top and bottom level commitment to change but policies get interpreted inconsistently in the middle, however. This may reflect the different historical characteristics of diverse areas, organisations and groups. To challenge this we need champions for equity in key positions, and to support the middle layer by the provision of skills and the creation of local networks.

Workshop participants identified the following positive influences on health equity at the local / national level:

- Social democracy – including the redistribution of money and services for social justice;
- Strong universal programmes;
- Progressive tax systems and social protection;
- Strong civil society organisations:
  - We need people empowered to demand their rights and / or to ask the right questions of policy makers and implementers;
  - We need people – civil society groups AND professional groups – empowered to engage with each other and find common ground;
  - We need to recognise and support community resilience and personal resilience.

Participants also identified the following negative influences on health equity:

- Market fundamentalism;
- Power and resource inequalities:
- Distribution of power, money, and resources,
- Inequalities in structural determinants of health and health inequalities,
- The personal choice agenda in the UK may exacerbate inequalities;
  - The rise in neo-conservatism;
  - Economic reductionism;
  - A health discourse dominated by biomedicine and behaviour change approaches,
    - State control of the media limits debates and the provision of information.

Local levers/drivers of action to improve health equity include transport policy, land use planning, housing policy, local taxation, environmental regulations, business zoning, local government procurement policies. The ways in which public services are delivered may have a positive effect on health equity. Equity could be enhanced if the different sectors are able to co-operate with each other and engage effectively with communities. This could be supported by local flexibility in managing resources, although this can be limited by the political context and global pressures. There would have to be effective accountability systems, and monitoring and evaluation of services to assess their health equity impacts.

**Equity in the regional/global context**

The workshop participants observed that the regional/global context is more sophisticated, more structured and hierarchical, uncontrolled and uncontrollable, covert in its operations and characterised by complex interactions.

Workshop participants identified the following negative influences on health equity at the regional/global level:

- A lack of common values and/or goals.
- Power inequalities, including gender inequalities;
- The influence of national governments through foreign policy and military spending. Also, because national regulatory systems are at different stages of development, and because there are different degrees of political commitment to social justice, there are different degrees of social protection and regulation of employment conditions.
- Changes in local identities through the spread of the culture of countries and organisations that dominate global political and economic power, for example replacing traditional diets with fast foods such as MacDonald’s and high sugar drinks like Coca-Cola;
- The global capitalist movement, represented by:
  - Financial systems: Unregulated financial markets; the existence of derivatives; the activity of investment banks and private equity firms; off-shore financial centres – “tax havens”; the elimination of moral hazards – for example, the tax payer bailout of failed banks removes the incentive for those organisations to behave in a more responsible and equitable way;
  - Liberalisation of trade – trade is seen as an end in itself, rather than a means to an end. This is particularly damaging for health equity in the trade of: food, tobacco, alcohol, the disposal of hazardous waste;
  - The activity of drug companies that place profit over the health and wellbeing of the people in need of their products – especially those in poorer communities and poor countries;
The growth of public / private partnerships and the role of transnational organisations in the formulation of global policy, leading to the increased privatisation of health care and the movement of health care workers from poorer countries to richer ones;
- The inequitable distribution of the gains from and exploitation of natural resources, such as water, oil and minerals.
- Climate change; the growing of crops for biofuel – rather than for food - and the destruction of natural habitats to do so.
- Population growth – longer life spans need greater numbers of younger, working age people to support ageing populations through taxation. This is unsustainable. It is leading to the leasing of land in the global South by countries in the global North in order to grow food to feed their populations. This may limit the ability of countries in the global South to be self-sufficient in food production.

Participants also identified the following positive influences on health equity at the regional / global level:
- Regional agreements between middle income countries to pool resources and support through local financial organisations similar to the IMF;
- The G8 has been expanded to include more countries with developing economies, creating the G20;
- Global health diplomacy – “multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health” (WHO).
- NGOs raising awareness of health equity in their activities and partnerships;
- Some foreign investment can lead to better working conditions in poorer countries;
- The activities and leadership of WHO and the UN.

HIA or HEIA?
The workshop participants were clear that there is no need for a new HEIA methodology. HIA, in theory, includes the consideration of inequalities / inequities, although the participants felt this is often more rhetorical than completed in practice. The challenge, therefore, is to improve the equity focus of existing HIA methodologies. Challenges to this come from the multiple and complex influences on health equity, described above, and the fact that interpretation of HIA is context dependent; we need to take account of the 3Cs: context, culture and capacity.

How do we improve the equity focus of HIA?
Firstly, the workshop participants noted that equity is most often addressed in HIA through the assessment of potential differential impacts on vulnerable groups or other population subgroups. However, equity within HIA is not just differential analysis; there is also the need to understand the gap between policy development and implementation, and the ways in which this generates inequity. These processes will be context dependent.

It is good practice in HIA to involve stakeholders in the process, including those from affected communities. There was some discussion of how we characterise and interact with communities. The participants observed that, as practitioners, we might characterise a community in a negative way but that local residents may not experience it as a bad place to live. It is important that we recognise that different communities have different capacities:
to be heard and have influence, with different time frames for change;
- to manage devolved funding, and these differences in capacity could contribute to the widening of the inequalities gap.

We, therefore, need to develop ways of engaging with all communities regardless of their capabilities.

The workshop participants stressed that equity in HIA is difficult to do. Experience from the use of EFHIA demonstrates that policy makers find it difficult to understand the social determinants of health inequity.

**Opportunities for strengthening the equity focus of HIA**

**Acknowledge the Context**

The participants noted that HIA practitioners need to acknowledge the different contexts within which HIA is being implemented. The priorities in the UK, Africa and China, for example, will be different. There will be different levels of capacity to HIA, and different cultural understandings of health and its determinants. English equity language may not translate into other languages, and the equity terminology itself may not be understood in different contexts. HIA may not be the most appropriate methodology to assess equity impacts in some countries, like China where the priority is to understand policy drivers. HIA practitioners can then be advocates of assessing equity, but assist in identifying the most appropriate tool for those circumstances.

**Advocate**

HIA practitioners can advocate for the inclusion of equity in HIA through promoting examples of good HIAs with an equity focus that have already been done, and through the inclusion of equity in their own work. There is a need to promote the inclusion of equity in the practices of powerful global institutions, and make them accountable for their actions that affect equity, and promote the inclusion of equity considerations in both HIAs commissioned by developers and in other impact assessment methodologies, such as the International Finance Corporation guidelines. Generate / facilitate global conversations about health equity, using existing networks and publications; include organisations such as the IAIA, WHO and PAHO. Advocate for health equity amongst political leaders and stakeholders; use stories to highlight the issues and help them to learn the equity language. Promote the role of the health sector as an advocate for health equity and HIA. Most HIA activity is in the global North, so listen to the global South.

**Process**

Participants felt that there was no need for new HIA tools. Instead different aspects of HIA could be emphasised for different foci (equalities, mental wellbeing, and so forth); so it is important that the HIA practitioner is clear about what the HIA is intended to achieve – including the equity focus. Use different tools for different audiences. Promote the use of equity within HIA by choosing topics with good news outcomes. Include the policy context in the HIA – it is possible to critique the context without being negative about the policy, and this will help to reduce resistance to the process. Emphasise the positive outcomes of the policy. Negotiation is an important part of the HIA process because it can reduce the potential for conflict and help to build understanding. HIA should be introduced at the start of the policy process and equity should be included in the beginning of the
HIA process – to act as a hook for the whole HIA. Involve stakeholders from the start. HIA needs to have recommendations with an explicit equity focus.

HIA is often talked about as if it is the assessment itself that changes policies; we need to remember that HIA is a path towards policy change. HIA can make a difference to how people consider health equity but it needs to be recognised as part of a bigger process to evaluate the impact of policies on health equity. It can help to identify the causal chain of influences on health equity from the local context upwards.

Quality

Workshop participants argued for the need to develop quality standards for HIA at all geographical levels. There should be a minimum set of standards that would have to be signed off, along the same lines as Environmental Impact Assessment. We need a lever to make HIA mandatory.

There is a need for capacity building to assess and address health equity impacts; not just through HIA, although HIA has a role to highlight the need to assess health equity, and look for ways of doing so, in regions where there is currently little capacity to do HIA. HIA training should focus on how to take equity into account in HIA. There is scope to build global collaborations to develop capacity for HIA training in regions where there is still little capacity to do HIA; and generate learning networks for HIA.

It is crucial that more monitoring of the outputs from HIA takes place; in terms of the uptake of recommendations from HIA, the impact of HIA on policy development and implementation, and the monitoring of the impacts of policy on health equity.

Limitations on the inclusion of equity in HIA

Context

The lack of political commitment and legislative backup will limit the consideration of equity within HIA. The inclusion of equity can be perceived as a criticism by non-health sectors, so it can be easier to engage them in an HIA that focuses on population health outcomes alone. A few participants observed that HIA reports can be left in limbo or reduced in scope due to changes in the public sector staff participating in the research (through restructuring or individual leave of absence).

Workshop participants wondered who would conduct global HIAs: the World Bank? WHO? IMF? UN? All these organisations are constrained by their funders and partners, so who would be able to independently assess the impact of global policies and systems on health equity?

Process

HIAs of global policies will need to assess their impact on power imbalances – power imbalances are not widely understood as a determinant of health inequities; HIA is currently weak in addressing issues of power and power inequalities. Local HIA practitioners are not as good as they could be in raising difficult questions and challenging policy makers. The HIA process represents white, middle class systems and values and as such can be alienating to local population groups, especially indigenous groups. Community engagement is key to the success of HIA and as such local HIA practitioners need to be conscious of the ways in which they engage with communities.
Recommendations

The workshop participants note that HIA is often just the appraisal process and does not include the mapping of the local context, nor does it make efforts to gain ownership of the recommendations. Political time frames, finances and other resources determine which recommendations get taken up; the more difficult ones might be dropped.

Evidence

A recurring theme throughout the workshops was the importance of available, accurate and different types of evidence.

The participants indicated that there is a need for more detailed data at the local level, and better national level indicators. The availability of data is country specific with generally good access to data in high and upper-middle income countries and poor availability of data in lower-middle and low income countries, which might not have the structures in place to gather robust local level data. Different countries also have different population structures and different priorities, which will affect the types of data needed for HIA.

There is generally a lack of robust evidence for HIA practitioners to draw upon. And there is a poor evidence base for the impact of upstream determinants on health equity, especially at the global level. This forces a focus on downstream determinants, and a retreat to the biomedical model of health.

Evidence can be discounted where it does not fit with the political aims of policy makers or the value systems of different sectors. These value systems will lead to one sort of evidence being prioritised over others; quantitative evidence usually dominates. There is an assumption that economic evidence cannot be challenged, but it can be flawed. Although there are economists that argue against dominant macroeconomic practices their voices are not heard because what they are saying does not fit with the interests of elite powerful groups. HIA practitioners are generally not good at breaking down such barriers and championing other sorts of ‘soft’ evidence.

Impact assessment models that are based on reductionist, cost-benefit analyses are likely to produce simplistic assessments that do not account for local needs, contexts and impacts. A breadth of evidence is required, including social science research and narratives from those most likely to be affected. These stories can be powerful ways of engaging with policy makers who, research has shown, often make their decisions based on passion rather than logic. There is a need, therefore, for both hard evidence (quantitative and qualitative) and stories.

Often evidence from different sources is blended together in HIA reports. This is problematic because this evidence will have originated from sources with very different value systems. The evidence in HIA should be presented in such a way as to make these value systems transparent and enable particular interests and issues to be highlighted. The relative weighting of evidence relating to vulnerable populations and the area characteristics of where they live will be determined by the objectives of the policy being assessed.

It is important that HIA is seen to be robust and that the value systems underpinning it are made explicit. It would enhance the reputation of HIA if it were peer-reviewed by potential critics with knowledge of research rigour, especially those ideologically opposed to it.
Research

Different areas of potential future research were identified by the workshop participants throughout the workshop discussions. These suggestions are summarised below.

Pilot studies:

- Take an equity issue and map all the current and historical influences on that policy from the bottom to the top – map the network, identify the key players, and identify the key policy influences.
- To address root causes of health inequalities, including immigration, trade policy and climate change, in national and transnational contexts.
- International collaborations to pilot, test and produce high quality HIAs with an equity focus that can be used as examples of what can be done – taken to different country settings, not to criticise, but to demonstrate the added value of considering health equity.
- In the Global South.

Case studies:

- To understand the processes, behaviours, cultures and opportunities of working with multinationals.
- To see how else we might judge long term health inequalities impacts, beyond the use of mortality figures.

Process research:

- How and when is HIA used in the policy process; to what extent does HIA promote a lasting understanding of health (equity) influences and policy impacts on health (equity).
- Identify the enablers and barriers to the implementation of HIA recommendations;
- Identify key points on the equity causal web and examine what facilitates and constrains action on equity at those points and how the people at those points understand the language around equity.
- Policy ethnography (ethnographic methods to explore the local processes of policy implementation) to understand the local commitment to equity and the facilitators and constraints that people experience in acting on their commitment to equity.
- Policy ethnography to explore the language that policy makers, practitioners and community members in an area use to talk about equity. This knowledge will help to facilitate a broader engagement around equity within HIA.
- Equity language can be a barrier to collaboration – get funding to create a language about inequities that works across all sectors – businesses, countries, IAs, health sector, etc - recognising that equity / inequity, equality / inequality, deprivation, vulnerability are all contested concepts

Mapping:

- Map the causal networks, and upstream processes.
  The workshop participants highlighted the need for evidence to understand and to map the causal pathways linking activity at the global level (such as trade agreements) with health outcomes at the local level. Although some felt this could be daunting for people at the local
level because the complexity of the global context and its interaction with national and local processes make its influences difficult to unpick at the local level – it can seem too far removed from local action.

- This could result in a generic methodology that could be adapted for different countries. Some of this is being developed from the work of the CSDH knowledge networks.
- For low- and middle-income countries, where data is scarce, it would be possible to extrapolate from what is known in the EU. This could be achieved by bringing together people with good inside knowledge of a country to debate how those conditions might work in that context.

- Map the key actors: Who are they? What businesses do they do? What are their processes?
- How do they interact with communities? What pressures are they under?
- Map potential funders for future research.

Summary

The workshop discussions stressed the importance of raising awareness of equity and health equity at the local and global levels. There were a number of common concerns and observations at these different levels. Firstly, that a concern about equity reflects a particular set of values that prioritise social justice, but these values are not shared universally. So, there is a need to raise awareness about the importance of equity through international collaboration, social movements and the identification of champions with influence in their particular arena (global, national, local or community).

Power imbalances are at the root of social inequalities, these power differentials need to be acknowledged, explored and accounted for within HIA. There is a need for greater accountability of activity and actions that affect equity at all levels. Thought needs to be given to the unintended consequences of policies – there may be global consequences of national action, such as the migration of health care workers and the damage to the livelihoods of people in poorer countries; there may also be consequences locally where poorer residents may be displaced due to area improvements.

Currently there are opportunities to raise awareness of equity in local, national and global spheres.

At the global level equity can be damaged by things such as: a lack of common goals and values, the distribution of power, the impact of national governments, the spread of unhealthy cultural identities, climate change, and the inequitable access to and exploitation of natural resources. There are indications that there is a growth in awareness of equity globally, however. More countries have been invited to join the G8 (making the G20). There is growing regional collaboration. The leadership of global organisations such as WHO and UN create an opportunity for raising awareness of the issues.

The participants were clear that there is no need for a new HEIA methodology. They also felt that there are sufficient tools available within HIA to assess equity. These could be better applied, however, and there is a real need to strengthen the consideration of equity within the HIA process. Equity is rarely considered within HIA, and where it is done equity is equated with assessing the potential differential impacts of policies on vulnerable groups. We need to move beyond this to
consider what the causes of inequalities are and the ways in which policy affects social determinants, perpetuating inequalities in access to resources, including power.

Opportunities for strengthening the equity focus of HIA come through acknowledging that HIA and health equity are context specific; advocacy and building collaborations to assess and promote health equity; recognising that HIA is part of a bigger process to assess the equity impacts of policy; and taking steps to improve the quality of HIA. With regards to the latter, there is a need to build capacity to do HIA and to incorporate equity within HIA training; HIA would benefit from having a minimum set of standards that can be applied in all contexts; and it is essential that HIA and policy impacts are monitored and evaluated for their effects on health equity.

Limitations to including equity within HIA come from a lack of political will, and powerful groups protecting their own interests. It is not clear who would be sufficiently independent to do equity based HIAs of global processes and policies. Inadequate methods for dealing with power imbalances is another limiting issue. Locally, time and resource pressures will constrain the use of equity within HIA and will inform which recommendations will be acted upon.

A clear common thread throughout these discussions was the need for available, accurate and diverse evidence to support HIA. The prioritisation of evidence is value laden, and it is necessary for HIA practitioners to promote the use of a broad range of evidence, in the face of opposition from groups with disparate value systems and different priorities.

Finally, several opportunities for research have been identified to further the understanding of influences on health equity, identify key actors and processes in the distribution of power and determinants of health, understand the constraints on action to improve equity, and to map the complex causal webs that are the ‘causes of the causes’ of inequity.

Participants considered that this project constitutes a wake-up call that equity and equality need to be considered better in HIA. It was argued that we need a strategy for incorporating equity better in HIA. This project could map that strategy, and develop a route map or plan for what to do next.
6: Discussion

Margaret Whitehead has identified four categories of action to tackle social inequalities in health: strengthening individuals, strengthening communities, improving living and working conditions, and promoting healthy macro-policies (Whitehead, 2005). HIA currently has the capacity to contribute to the first three of these categories. HIA can be a tool for empowerment for both individuals and communities, where individuals and groups are actively involved in the HIA process. HIA can help to improve living and working conditions by identifying potential negative impacts and enhancing potential positive impacts of policies and programmes, and differential assessment of potential impacts on vulnerable or other population subgroups makes a contribution to the reduction of inequalities between groups. However, the fourth category of promoting healthy macro-policies is largely lacking from HIA as it stands. But it is this that this project chiefly aimed to address.

This project set out to assess the extent to which equity is currently incorporated into HIA, to explore ways of assessing the impacts of macro policy (upstream determinants) on health equity, and to determine whether or not there is a need for a new HEIA methodology.

It was clear from both the interviews and workshops that participants felt that there is no need for a new HEIA methodology. There are existing methodologies and tools that are capable of considering equity within HIA. All three research phases of this project concluded that equity is not currently assessed adequately within HIA, and so discussions turned to how this could be strengthened.

The scoping review demonstrates that there are now more guidelines with an explicit equity or inequalities focus. Of the HIAs that assess equity impacts, most do so through examining potential differential impacts for vulnerable/disadvantaged groups or other population subgroups. In truth most of these assessments are not assessing equity as defined here – as avoidable and unfair or unjust differences. Only the EFHIA guidelines and assessments made any attempt to include this qualification, and practitioners using these guidelines observed that the assessment of avoidability and fairness adds a layer of complexity to the HIA and so may not be done.

In addition, many HIAs talk about equity or inequalities in their complexity but then focus on the ‘do-able’, assessing differential impacts. Even those HIAs with a strong focus on differential impacts often do not discuss their findings and recommendations in terms of their impact on equity or inequalities – even though the recommendations may come out of a deep consideration of the impacts on equity, they are frequently not presented in this light.

There are two concerns here. One is the lack of definitions of equity terminology within HIAs. Without defining this essential terminology it is difficult to assess whether or not the practitioners intend to apply the values of avoidability and fairness to the results. The other is the basic question of whether or not assessing equity is the same as assessing the potential impacts on vulnerable or disadvantaged groups. Hilary Graham has identified three strategies to reduce health inequalities: focusing policies and programmes on the disadvantage; attempting to narrow the gap between the poorest groups and either the richest or the national average; attempting to reduce the social gradient in health outcomes (Graham, 2004). Although addressing the gradient is the hardest option, it is also the optimal one (Graham, 2004). There is evidence from this research that some HIA practitioners agree that equity is more than addressing the health consequences of policy for
vulnerable and disadvantaged groups. A consideration of equity also needs to consider the ‘causes of the causes’ of differences in health status, which echoes the aims of this research.

Findings from all three research phases emphasise that the inclusion of equity within HIA is complex, resource intensive, challenging methodologically and time consuming. For these reasons it was argued against institutionalising HIA with an equity focus. Rather, the suggestion is that HEIA should be done on carefully chosen topics, offered as examples of what can be done.

There were several recurring themes across the data collected. Firstly, the inclusion of equity considerations in HIA reflects a particular values base; one that prioritises social justice and fairness. These values are not universal and may not be shared by the institutions and organisations whose policy and practice we would wish to assess for its impact on health equity. This has implications for how HIA practitioners would engage with these institutions and organisations, for the need to be explicit about the values underpinning HEIA, for the need to work carefully to find common language or to find ways to translate health equity language into terminology that can be understood by different audiences, and for the types of evidence that would be acceptable in these contexts. HIA practitioners need to be advocates for different types of evidence and for equity itself.

Secondly, the determinants of health equity, the patterns of equity, and the social and policy influences on health equity are context specific. These will vary within and between countries. HEIA needs to take account of these differences. Also, the English equity language may not translate in a meaningful way into other languages, and this may limit the translation of the concepts and values underpinning HIA into other cultures.

Thirdly, the ‘causes of the causes’ of health equity were clearly identified at all levels, global to local, as including the influence of financial regulation and practices, and inequalities in power. HIA cannot currently incorporate consideration of the impacts of differentials in power; participants in this research identified a number of research approaches that could help map power distributions. Participants argued for the need for accountability systems for actions at the global level that impact on equity. O’Keefe and Scott-Samuel (2010) suggest that HIA can be part of such an accountability framework, using the operations of the International Monetary Fund as an example.

Fourthly, we can strengthen the consideration of equity within HIA through:

- capacity building to do HIA and emphasising equity within HIA training;
- learning networks to build and sustain the capacity for HIA and HIA training globally;
- introducing a minimum set of standards to be applied to all HIAs and for those standards to be enforced;
- ensuring that HIA is robust and of high quality;
- evaluation and monitoring of the uptake of HIA recommendations, and of the impact of policy on health equity.

Some participants stressed that the assessment of equity impacts does not have to be limited to HIA. In fact, HIA practitioners could help identify other tools and methodologies for use in contexts where HIA may not be appropriate.

Finally, there are several mechanisms by which health equity could achieve a higher profile: use HIA to raise awareness; encourage the health sector to raise awareness of and support interventions to
improve health equity; action by civil society and high profile champions could create pressure for change; take advantage of opportunities, or policy windows, to introduce equity and health equity into the consciousness of the organisations and institutions that have an influence on equity.

The hourglass effect

The interplay between the historical development of policy, the policy impacts on health equity and social pressures for change can be conceptualised in terms of an hourglass.

In one rotation, the hourglass shows how multiple factors and developments, including dominant culture and ideology, over time lead to the development of a specific policy or policy perspective; this then has impacts that spread out over different populations. The policy implementation occurs at the waist of the hourglass, with the historical developments above and the impacts below. HIA typically occurs at the point of implementation and does not take the history of the policy development into account. Findings from this research highlight the need to understand the influences represented by the top bowl of the hourglass in order to fully understand the equity impacts represented by the bottom bowl. The impacts will be more than the differential impacts on identified vulnerable groups. They may include reinforcing social norms and value systems, which help to limit action on the upstream determinants on health equity.

Inverted, the hourglass represents the pressure for change brought about by civil society action and champions advocating for health equity perspectives. Now, the waist of the hourglass represents that point in time when this social pressure coalesces with a policy window or opportunity, such as the report of the Commission on Social Determinants of Health, the banking crisis or Hurricane Katrina, to generate change. At this time new perspectives and values can be introduced into the policy making process. Examples of this are the growth in concern about the impacts of climate change; and social pressure to cancel the debts of some of the poorest countries in the world, such as happened recently for Haiti in the wake of the devastation caused by the earthquake there.

Developing a strategy

*The economic evaluation of interventions aimed at changing systems requires new ways of thinking: one sensitive to ecological theory, interactions between microlevel and macrolevel variables, non-linearities, multiplier effects, and the fact that individual values are shaped by the interventions we seek to evaluate and the contexts we seek to change.* (Shiell et al, 2008, p.1283)

Participants at the Liverpool workshop suggested that this project could develop a strategy for including equity within HIA. That is perhaps ambitious for a scoping study; nonetheless the project has identified several ways in which things can be moved forward.

There is a need for multiple conversations to raise awareness and build consensus:
• conversations within the global health equity community to identify shared values, concerns and activity;
• conversations with different actors to raise awareness of health equity, such as community representatives, politicians and global actors;
• conversations with complementary areas that can enhance the equity component of HIA, such as social justice, environmental justice, and human rights;
• conversations across different geographies – the context for health equity action is important and we need to engage with these different contexts to understand the implications for the assessment of equity impacts of policy. Particular attention should be paid to engaging with the Global South.

It is these conversations and collaborations that will lead to the development of a strategy to promote health equity locally and globally and to use HIA as part of that process. One of us (ASS) is already working collaboratively with colleagues in Canada and WHO who are also looking to develop work around HEIA, and also engaging with the network of WHO Collaborating Centres with a focus on health equity.

Alan Shiell and colleagues highlight the need develop ways of identifying and exploring complex systems (Shiell et al, 2008); our scoping review echoes their findings. Although the findings from the workshops and the interviews were contradictory as to whether or not there is a need for new tools within HIA to assess impacts on equity, collectively they identified several areas of research that would deepen our understanding of the mechanisms that generate inequities. Some of this research would be for further methodological development, and others to map the distribution of power and influence in the decision making and implementation processes of policy. In addition there is work to investigate and develop conceptual models that would provide frameworks for understanding the interplay of the complex processes and values that promote or undermine health equity.

Specifically, the following possible research areas have been suggested:

**Process research**

• Sociological assessments to understand the processes of change at different levels of the policy implementation process and people as actors in policy delivery;
• Development of new indicators for democracy and power distribution;
• How and when is HIA used in the policy process? To what extent does HIA promote a lasting understanding of health (equity) influences and policy impacts on health (equity)?
• Identification of the enablers and barriers to the implementation of HIA recommendations;
• Identification of key points on the equity causal web and examination of what facilitates and constrains action on equity at those points and how the people at those points understand the language around equity.
• Policy ethnography (ethnographic methods to explore the local processes of policy implementation) to understand the local commitment to equity and the facilitators and constraints that people experience in acting on their commitment to equity.
• Policy ethnography to explore the language that policy makers, practitioners and community members in an area use to talk about equity. This knowledge will help to facilitate a broader engagement around equity within HIA.
• Equity language can be a barrier to collaboration – identification of funding to create a language about inequities that works across all sectors – businesses, countries, IAs, health sector, and so forth: recognising that equity / inequity, equality / inequality, deprivation and vulnerability are all contested concepts.

Pilot studies
• Take an equity issue and map all the current and historical influences on that policy from the bottom to the top – map the network, identify the key players, and identify the key policy influences. This would provide in-depth knowledge of the policy development process and its impact on health equity.
• Assessment of root causes of health inequalities, including immigration, trade policy and climate change, in national and transnational contexts.
• International collaborations to pilot, test and produce high quality HIAs with an equity focus that can be used as examples of what can be done – applied in different country settings in order to demonstrate the added value of considering health equity.
• Pilot studies are especially required in the Global South.

Case studies
• To understand the processes, behaviours, cultures and opportunities of working with multinationals.
• To see how else we might judge long term health inequalities impacts, beyond the use of mortality figures.

Mapping
• Mapping of the causal networks, and upstream processes of a local policy.
• Mapping of the key actors on that causal network.
• Mapping of potential funders for future research.

Implications for Liverpool Primary Care Trust
This work has been funded by Liverpool Primary Care Trust. A core aim of this research is to provide an output that will benefit the health of the people of Liverpool. Liverpool has long been at the forefront of efforts to improve public health: from the first Medical Officer of Health in the early 19th century, through the first municipal laundry and the first district nursing service, to the city’s founding involvement in the WHO Healthy Cities programme in the late 20th century, and current work combining the efforts of LPCT and Liverpool City Council to reduce health inequalities. This wealth of experience and history makes Liverpool an important site for case studies to further our knowledge about the generation of health equity and inequities in the research areas summarised above.

The HEIA Project Team will work with Liverpool PCT to identify an opportunity to disseminate the findings or this project in such a way as to raise awareness and generate reflection on the health equity impacts of LPCT policies and programmes: for example, a workshop to examine the implications for LPCT of the recommendations from the Marmot Review. LPCT will be a partner in applications for funding to conduct research identified above in the suggested case studies and pilot projects in a Liverpool context.
7: Conclusion

In our view, this project has shed substantial light on the manner in which health impact assessment must develop if it is to respond successfully to the new demands placed on it by the recommendations of the WHO CSDH and in the case of England, by the Marmot Review which followed it. In this section – which builds on the rich and detailed findings summarised in this report – we outline the key lessons learned from the project and where appropriate, make recommendations for future development and action.

The definition of health equity

The range of definitions and concepts of health equity that we found is unfortunate, in that it can and does lead to frequent confusion when putting the concept into practice. This is as true in the context of health impact assessment as it is in more general health equity analysis and research. However, this situation is probably unavoidable, given the historical specificity of the terminology used in different agencies and societies: for example, a single term and concept, 'health equity' throughout the WHO; co-existing concepts of health inequality and health equity in the UK and mainland Europe; and a single concept of health disparities in the US.

What this situation clearly demands is that whenever health equity is discussed or employed, the terms used should be defined and should be used in a consistent manner.

In addition, the global context of what the Commission on Social Determinants of Health called HEIA demands one single, global understanding of the HEIA concept. This could be an expansion of the Gothenburg and IAIA definitions of HIA, to explicitly encompass global public policy determinants of health equity.

The determinants of health equity

Unlike the determinants of health, the determinants of health equity are themselves inequalities – in material, psychosocial and behavioural aspects of the life course and of society. These include inequalities in income and wealth, in power and control over health and life chances, in access to education, information and health care, in social inclusion, in social status and the privileges it brings, in culture and its myriad influences on behaviour and experience. Many inequalities have deep historical and cultural roots; this requires explicit consideration in HIA methodology. In particular, the inequitable nature of much public policy and the non-participative nature of most political processes are important determinants of health inequity.

Equally important are the many different levels – from individual to societal and from local to global – at which health equity is determined. HIA can and should consider potential impacts at and between all of these levels.

In describing the need to acknowledge and address novel determinants and dimensions of health equity in HIA, we are not necessarily arguing for an impossibly complex HIA process. Rather, we are refining and extending the conceptual framework for HIA. Many if not most relatively local HIAs will continue largely as at present – though hopefully with an enhanced acknowledgement of local impacts of global public policies. It is, however, the new context of HIA of global public policies themselves that will be most affected by our recommendations.
In addition to the outputs (evidence based recommendations) of HIAs, aspects of the HIA process itself also contribute to health equity – these include health awareness-raising and advocacy, community participation, validation of popular knowledge, personal and social development. These impacts should be enhanced by the application of the knowledge generated by this project.

**HIA or HEIA?**

We share the majority view of our stakeholders and key informants that new terminology is not required for new variants of HIA capable of addressing global policy impacts on health equity. We believe that the term health impact assessment will suffice to tackle new global challenges.

**Methodological implications for HIA**

At present, little account is taken in HIA of the principles, processes and practices of political science and of policy science. Given their central role in the determination of global health equity, this situation clearly needs to change. New HIA tools are required which address the role of political and policy variables and knowledge in determining health equity outcomes. This will require both the development and the piloting of such tools, using appropriate global public policy programmes and projects as the test-bed.

Although there was agreement at the Liverpool workshop that new methodological developments in HIA were unnecessary, the nature and range of 'new' health equity determinants described above in the review, interview and workshops sections, together with the complexity of their potential interrelationships, leads us to question this conclusion. At the very least, further research is required to elucidate this question.

**Capacity building**

The task of building adequate capacity for HIA, especially in the Global South, is beyond the scope of this project. However, we are impressed that in the wake of the CSDH report, WHO has already made good progress in initiating international discussions aimed at addressing this task. The resource implications in terms of knowledge transfer, human and financial resources are, however, substantial. Their realisation will in turn depend on the political priority given to the realisation of health equity itself.
8: References


WSROC and Gethin A (2007) Greater Western Sydney Urban Development Health Impact Assessment: FINAL REPORT. Sydney (NSW), Australia: Western Sydney Regional Organisation of Councils Ltd (WSROC) and AGA Consulting P/L.
Appendix A: HEIA Stakeholder Mapping

HEIA Pilot Project Stakeholder Map

Please add to / comment on.

<table>
<thead>
<tr>
<th>Stakeholder / Key informant Category</th>
<th>Stakeholders / Key Informants</th>
<th>Contacts (with details if available)</th>
<th>Stakeholder role (interview, workshop, future work)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity / Inequality</td>
<td>e.g. leaders in the field of inequalities and health</td>
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<tr>
<td>HIA</td>
<td>e.g. HIA practitioners with experience in incorporating equity into HIA</td>
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<td>Equity Focused HIA</td>
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<td>Commission on Social Determinants of Health (CSDH)</td>
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<tr>
<td>Potential HEIA users, commissioners, funders</td>
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### Appendix B: HEIA Scoping review – literature searches

#### HEIA scoping review – inclusion / exclusion criteria

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<th>Methodologies and tools</th>
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<th><strong>Exclusion criteria</strong></th>
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<td>Equality Impact Assessment, non-IA methodologies, methods or tools – unless specifically included</td>
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<th>Incomplete or unclear description of methods used</th>
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<th>Project assessments</th>
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<tr>
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<th>Limited to biomedical or health care related determinants</th>
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<table>
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<th>Operation</th>
<th>Local, national, global</th>
<th>No exclusions</th>
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</table>

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<tr>
<th>Data sources</th>
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<th>1989-</th>
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<th>Editorials, commentary, opinion pieces, letters, reviews not of primary research</th>
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<tr>
<th>Abstract</th>
<th>Must include an abstract or summary</th>
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4 ASSIA; BHI; Biological Sciences; EconLit; EIS; Environmental Sciences and Pollution Management; MEDLINE; CSA Social Services Abstracts; CSA Sociological Abstracts; CSA Worldwide Political Science Abstracts

Appendix C: HEIA Interview Schedule

Introduction
1. As a reminder: The purpose of this project is to define and test the key concepts underpinning Health Equity Impact Assessment (HEIA) and to determine the scope for a new HEIA methodology. The project aims to understand how health equity impacts could best be assessed, the way that equity is currently addressed in impact assessments, and how equity assessment could be better included in Health Impact Assessment (HIA).

2. Interviewer introduces themselves.

3. Interviewer to remind the participant that the interview will be recorded.

4. Interviewer asks the participant to introduce themselves and to describe their experience in relation to health equity / HIA.

All informants
5. What does health equity mean to you?

6. What factors alter health equity – positive and negative?
   • For example: increased income inequality has a negative impact
   • Do you have any examples?

7. What actions would increase health equity?
   • For example: policy to redistribute income
   • Do you have any examples?

8. What different impacts and methodological considerations are there when assessing the health equity impact of global policies, such as international trade agreements or macroeconomic policies, than when assessing the health equity impact of local and national policies, such as education or employment?
   • Examples of different impacts: global vs national / local
   • Examples of different methodological considerations: global vs national / local

9. How could we assess this differently to what is already being done?
   • For example: is there a need to adapt HIA?
   • Do you have examples?

10. What specific factors would need to be considered to prospectively assess the impact of policy on health equity?
    • Globally?
    • Regionally?
    • Nationally?
    • Locally?
11. What are the barriers and facilitators for policy change to maximise health equity?
   • For example: presence or absence of political will to address macroeconomic inequalities.

Impact assessment practitioners

12. What are the strengths and weaknesses of current impact assessment methodologies in assessing health equity (e.g. Health Impact Assessment (HIA), Health Inequalities Impact Assessment, Equity Focused HIA)?
   • Strengths – examples
   • Weaknesses - examples

13. To what extent do existing tools enable the effective assessment of the impact of policy on health equity? (E.g. Health Equity Gauge, Equality Impact Assessments)
   • Strengths – examples
   • Weaknesses - examples

14. What are the barriers and limitations to assessing health equity impacts?
   • For example: access to relevant data; the quality of data available; evidence of the impact of specific policies and interventions.

15. What are the barriers and facilitators for implementing recommendations aimed at increasing health equity from HIA or other health equity tools and methodologies?
   • For example: Commitment to implementing the recommendations, even when they are politically difficult.

16. What would need to be done to increase the uptake of recommendations aimed at increasing health equity?
   • Can you give some examples?

17. Taking all this into account, would an HEIA methodology differ from HIA?
   • If so, in what ways?
   • If not, what needs to be done to make HIA more equity focussed?

18. Are you aware of any work currently being done to develop an HEIA tool?
**Appendix D: HEIA Workshop Programme**

**Health Equity Impact Assessment Pilot Project**
Two day international workshop, 5th and 6th October 2009

The Foresight Centre, Liverpool, UK

*Workshop Programme*

**Day 1: Monday, 5th October 2009**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>10:30 – 11:00</td>
<td>Registration; tea and coffee</td>
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<tr>
<td>11:00 – 11:30</td>
<td>Welcome and introductions</td>
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<tr>
<td></td>
<td>Chair: Alex Scott-Samuel</td>
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<tr>
<td>11:30 – 11:50</td>
<td>Background and policy context for HEIA</td>
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<td></td>
<td>Alex Scott-Samuel</td>
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<tr>
<td>11:50 – 12:20</td>
<td>Video clips from “Unnatural Causes: Is inequality making you sick”</td>
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<tr>
<td>12:20 – 13:00</td>
<td>Project introduction and findings from phases I and II</td>
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<td>Sue Povall</td>
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<tr>
<td>13:00 – 13:45</td>
<td>Lunch</td>
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<tr>
<td>13:45 – 14:00</td>
<td>Definitions of key concepts; Introduction to HIA; Introduction to group work</td>
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<tr>
<td></td>
<td>Sue Povall and Debbie Abrahams</td>
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<tr>
<td>14:00 – 15:30</td>
<td>Group work 1:</td>
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<td>Strengthening equity in Health Impact Assessment – the local context</td>
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<td>15:30 – 15:45</td>
<td>Group feedback and discussion</td>
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<td>Chair: Debbie Abrahams</td>
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<tr>
<td>15:45 – 16:00</td>
<td>Break</td>
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<tr>
<td>16:00 – 17:30</td>
<td>Group work 2:</td>
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<td>Strengthening equity in Health Impact Assessment – the global context</td>
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<td>17:30 – 18:00</td>
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<td>Chair: Debbie Abrahams</td>
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<tr>
<td>19:30</td>
<td>Workshop Dinner:</td>
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<td></td>
<td>Ego Mediterranean Restaurant</td>
</tr>
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<td></td>
<td>Hope Street, Liverpool</td>
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<tr>
<td></td>
<td>Phone: 0151 706 0707</td>
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**Day 2: Tuesday, 6th October 2009**

09:00 – 09:15  **Open discussion on emerging themes**  
Chair: Debbie Abrahams

09:15 – 09:30  **Introduction to Group Work 3 and Group Work 4**  
Alex Scott-Samuel

09:30 – 11:00  **Group work 3:**  
**Equity recommendations within HIA / HEIA**

11:00 – 11:15  **Group feedback and discussion**  
Chair: Debbie Abrahams

11:15 – 11:30  **Break**

11:30 – 13:00  **Group Work 4**  
**Making HEIA happen and maximising its impact**

13:00 – 13:15  **Group feedback and discussion**  
Chair: Debbie Abrahams

13:15 – 14:00  **Lunch**

14:00 – 16:00  **Health Equity Impact Assessment: towards a consensus**  
Chair: Alex Scott-Samuel

16:00  **Close**