ACHEIA

Equity-Focused Health Impact Assessment Framework

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Suggested Reference

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1. BACKGROUND

1.1. Background to the Development of the Equity-Focused HIA Framework

The equity focused health impact assessment (EFHIA) framework arises out of a two year research project funded for the most part by the Australian Government's Public Health Education Research Program (PHERP) Innovations Grants (Round 2) scheme. This project had as its primary objective the development of a framework for health inequalities impact assessment, subsequently renamed equity focused health impact assessment. A partnership between the University of Newcastle, Deakin University and the University of New South Wales (the Project Management Steering Committee) received the funding and the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA) was formed to undertake appropriate background research and to develop, pilot test, modify and disseminate the framework. The work commenced in September 2002 and concluded in October 2004. Part of the funding included a capacity building workshop in August 2004. ACT Health and the Division of Medicine at the John Hunter Hospital, Newcastle, also provided financial support for the project. The August 2004 Workshop was supported by NSW Health. All participants and organisations involved in the project gave extensive in-kind support.

The aims of the workshop were to bring together an international collaboration of multi-disciplinary investigators, public health experts, and key senior health managers working in national, state and local settings, to inform the further development of the framework and to provide training in its application.

The initial goals of the project were to work collaboratively to develop a strategic framework to assess the health inequalities of public health-related policies, plans, strategies, decisions, programs and services. The EFHIA framework as presented at the August workshop was developed through:

1. an extensive review of the relevant literature
2. formal and informal consultation with members of ACHEIA (the international reference group), members of the Project Management Steering Committee and other relevant experts; and
3. testing of the draft EFHIA framework with the 5 case study partners – who applied the draft framework in a range of health settings (see Acknowledgements).

The result of this work has been the development of an equity focused health impact assessment framework that can be used to determine the unanticipated and systemic health inequities that may exist within the decision making processes or activities of a range of organisations and sectors. The EFHIA framework provides one approach that can be used to assist decision makers to put equity and health on their agenda in a more obvious and systematic way. The framework represents a 'moment in time' rather than a

definitive statement or 'toolkit' on the best way to proceed. Further practice, refinement and adjustment will be needed over many years to consolidate both HIA and EFHIA.
As well as this guide to the framework, additional outputs from the project team include:

- A literature review
- A position paper
- A report on the five case studies
- An evaluation report.

With the consent of the Australian Government, a monograph will be made available to workshop participants at the end of October which contains the framework and the appropriate background papers.

1.2. Aims of this Document

This document has been designed to provide a concise introduction to EFHIA and an explanation of the factors to be considered at each step in the process. It assumes a basic level of understanding of health impact assessment (HIA) methodology and its applications within the policy development and/or planning cycles. We would encourage readers who are unfamiliar with the concept and steps of HIA to review some of the general references listed at the end of the document. Examples, derived from the application of EFHIA within the 5 pilot projects are included within the framework steps to assist the reader.

For simplicity's sake:

- the abbreviations of HIA (health impact assessment) and EFHIA(equity focused HIA) will be used throughout this document;
- the term 'proposal' or 'proposals' or 'draft proposal' are used to refer to all policies, programs, projects, activities or actions that may be the subject of the EFHIA,
- the terms socioeconomic determinants of health, socioeconomic status (SES) and socioeconomic position (SEP) are used throughout. All pertain to the same concept with subtle differences. Debate around the definition of, and distinction between, SEP and SES is ongoing in the international literature with SEP being increasingly used. SEP and SES are used synonymously to avoid overlooking literature which uses one or other term, and
- a glossary of terms is provided at the back of the document to clarify terms used throughout the framework.

2. EQUITY FOCUSED HEALTH IMPACT ASSESSMENT

2.1. What is Equity-focused HIA?

Equity-focused health impact assessment (EFHIA) uses health impact assessment methodology to produce a complementary and structured way of determining the potential differential and distributional impacts of a policy or practice on the health of the population as well as on specific groups within that population and it assesses whether the differential impacts are inequitable (see glossary for definition of HIA). For example, an equity- focus relates to assessing whether identified differences in health such as higher Aboriginal infant mortality rates are the result of factors that are avoidable and unfair i.e. they are potentially inequitable.

The EFHIA framework in this guide outlines one approach for ensuring that:

1. equity is included in a structured way within HIA; or
2. that a specific EFHIA is undertaken when needed.

Application of the EFHIA framework will allow decision-makers to determine the unanticipated and systemic health inequities that may exist in policies and practice. The framework has been developed for people who are in a position to review an existing or potential policy or practice and can contribute to, or effect, change.

Equity focused health impact assessment seeks to:

- put concern for equity and the reduction of inequalities in health on the planning and policy agendas where it currently is not considered,
- provide a flexible, yet structured approach to routinely and consistently identifying and determining the possible impacts of policies and practices on different population groups, and
- provide a means for adding evidence about inequalities and the consequences of inequity into decision making processes at all levels of government.

2.2. Defining Equity

Equity is about equal access to services for equal need, equal utilisation for equal need and equal quality of care for all, with a focus on health outcomes. These ideas have been summarised by Margaret Whitehead (1991):

> Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or

> eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible.
>
> (Whitehead and Dahlgren 1991)

An equity approach recognises that not everyone has the same level of health nor level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to work towards equal outcomes (NSW Health 2004). While there are many definitions of equity, the key features of relevance to EFHIA are:

1. Health differences resulting from factors which are considered to be both avoidable and unfair: EFHIA is about *both* identifying and assessing differential health impacts *and* making judgments about whether these potential differential health impacts will be, are, or were, inequitable – that is, avoidable and unfair.

2. Reducing the potential for these differential impacts to become health inequities by using the findings from the EFHIA to amend, ameliorate and improve the proposal, ideally before it is implemented.

2.3. Why is there a need for EFHIA?

There are two main reasons why EFHIA is needed.

1. **It will strengthen current HIA processes and approaches**
   Equity has been identified as a core principle and/or goal in the broader application of HIA. There is however currently no routine way for consideration and identification of differential health impacts or for assessment of whether these differential impacts are inequitable. EFHIA seeks to provide such an approach and/or to open up the discussion on how best to achieve this.

2. **In its own right, EFHIA allows policy makers to focus specifically on the differing needs of population groups**
   Frequently, the target groups for a proposal are left intentionally vague, with the express intention that this approach will widen the net and include more people. There is a general acceptance that this is a sensible approach to policy making, planning and/or program development. This generalised approach however can potentially result in the exclusion of those people/population groups who would probably benefit most from the policy or service – resulting in unintended and unanticipated health impacts on certain population groups. For example, when we use the term "equity focus" we do not mean equality for all but that greater resources and more services should be made available to the most vulnerable and disadvantaged groups in society or that issues of redistribution be considered. EFHIA provides a structured approach to consider the potentially differential impacts of the proposal or existing practice and/or the ways in which it might or currently does disadvantage certain groups. Such information can assist decision makers in targeting resources to reduce inequalities.

2.4. In what circumstances would EFHIA be used?

There are many methods by which health impacts can be measured, including:

1. Evaluation
2. Needs Assessment
3. Monitoring during implementation
4. HIA
5. Other tools such as regulatory impact statements (e.g. the NSW Aboriginal HIA process), audits or checklists.

Despite their differing intentions (e.g. needs assessment not being about health impacts), all of these activities have a role in determining health impacts.

Similarly, there is a range of other equity-focused activities which are used that differ in their intention from EFHIA:

- An **equity lens** refers to 'a metaphorical pair of glasses that ensures people ask 'who will benefit?' (Signal 2002). An equity lens would be applied throughout the development cycle to ensure that the proposal was developed, implemented and evaluated taking due account of equity.
- An **equity audit** is used to identify the differential needs of targeted population groups usually in local areas and to set priorities. It would be conducted during the needs assessment and planning stages.

As all of these activities are time and resource intensive, the differential role of each and the added value they provide within the policy and practice planning processes must be clear. EFHIA is no exception.

The principal function of EFHIA is to assess a specific proposal (be it a policy or practice) at an appropriate stage in its development, when there is still an opportunity to modify it, to ascertain:

- How it will (or does) impact differentially on groups within the population?
- What the nature of those impacts might be (or are)?
- Whether the differential impacts will be (or are) inequitable?
- In the light of the findings, what, if any, recommendations or changes should be made to it so that inequities are reduced and positive impacts are enhanced?

Ideally EFHIA is undertaken prospectively so that changes can be made before the proposal is finalised and implemented – hopefully reducing the potential for inequalities in health status to arise or worsen. Despite the potential for confusion with evaluation however EFHIA can also be used retrospectively where it is being used *as a way of looking backwards in order to move forwards*. As we are not yet in the position to consider all policies prospectively, it is critical that retrospective EFHIA be applied as a way of understanding the ways in which policies have had an impact so that alternatives can be considered. The following points provide insights into each of the suggested applications of the EFHIA framework.

1. **Prospective application of EFHIA**: When applied prospectively, EFHIA is solution focused, seeking to remove, or raise awareness of any aspect that might inadvertently be unfair or unjust *prior to* finalisation and implementation of the proposal. Its role, therefore, is to work towards reducing or ameliorating any potential negative health impacts and enhancing any positive impacts across the population or within subgroups of the population. As the actual impacts of a proposal in a given context cannot be known in advance, the role of existing evidence on the likely links between the proposal and factors that have the potential to exacerbate or create inequities, and thus inequalities in health, is crucial. Prospective application of EFHIA is where there is potential for maximising the "added value" of such a process because it provides a means for dealing with problems before they arise. The use of scenarios or extrapolating from existing data may be useful in a prospective EFHIA.

2. **Retrospective application of EFHIA**: When applied retrospectively, EFHIA seeks to strengthen the focus on equity by identifying the unintended impacts of an *existing* policy or practice to inform future action. Essentially, the goal is to look back in order to look forward. By focusing specifically on equity issues in a way that may not have previously been done, the lessons learnt can be used to change existing practice, provide insights on the awareness of equity considerations within the organisation, strengthen considerations of equity within future planning processes or inform implementation strategies. With retrospective application of EFHIA, the existing policy/program/project/plan is considered as 'the proposal' and assessed as if it were a draft proposal for a new policy or practice. As the impacts of the existing policy or practice are known, it is easier to collect evidence on all aspects of the policy/practice including the development process. In order to avoid confusion with evaluation, retrospective application should treat the existing policy or practice as if it is the proposal for future action.

In both of these applications, EFHIA also acts as a mechanism for considering policy or practice in relation to other policies and practices in order to consider the extent to which groups of the population are consistently missing out or being excluded (i.e. cumulative impacts of multiple policies).

2.5. The Principles Underpinning EFHIA

There is general agreement that the four basic values underpinning the use of HIA in the decision-making process are:

- **Democracy:** emphasizing the right of people to participate in a transparent process for the formulation, implementation and evaluation of policies that affect their life, both directly and through the elected political decision makers;
- **Equity:** emphasizing that HIA is not only interested in the aggregate impact of the assessed policy on the health of a population but also on the distribution of the impact within the population, in terms of gender, age, ethnic background and socio-economic status;

- **Sustainable development:** emphasizing that both short term and long term as well as more and less direct impacts are taken into consideration; and
- **Ethical use of evidence:** emphasizing that the use of quantitative and qualitative evidence has to be rigorous, and based on different scientific disciplines and methodologies to get as comprehensive assessment as possible of the expected impacts (Lehto and Ritsatakis 1999)

Additional to these, EFHIA is based on the following broad principles which are important to considerations of equity:

- health and illness are produced by social, environmental, political, economic, as well as biological, conditions, and inequalities arise from the unequal distribution of the determinants of health (see glossary)
- all policies, programs and projects should seek to be socially just and equitable in their aims and outcomes,
- many health inequalities and inequities are largely avoidable,
- decision-makers should be accountable to the communities they serve and actions are required to include public participation in the process, and
- individual experiences serve as valid representations of lived experiences and should be considered as a form of evidence and thus taken into account by decision-makers. (based on Barnes, Cooke et al. 2001)

2.6. The Role of Values and Evidence in EFHIA

As EFHIA is based on equity and this is based on a series of judgments about fairness and justice, it is important to note that the process and the outcomes are value-laden. The values of the decision makers, health or policy practitioners, or the assessor undertaking an EFHIA will impact on the decisions made and the perspective taken. For instance, the decisions made about the type of evidence to be collected and how it is weighted or judged will be important. The tensions between the art and science of both evidence and policy making will be challenging. Similarly judgments about trade –offs between the differing needs of groups of the population are linked to values. Practitioners must be aware of these tensions throughout and articulate them at each step in the process. These tensions will not always be resolved but can be reduced by acknowledging the role of values and working from the principles underpinning equity and HIA *in the given context*.

Additionally, by systematically and intentionally incorporating the views of a broad range of perspectives, practitioners endorse the goals of impact assessment which are to identify the unintended and unanticipated impacts that are otherwise not identified within the formal mechanisms of planning for a new policy, program or project. To move beyond current practices, the application of the EFHIA framework therefore requires practitioners and decision makers to modify existing practices, to be open to alternative ways of thinking, to broaden the usual channels of consultation and to examine the beliefs and priorities of other constituency groups.

3. THE EFHIA FRAMEWORK

3.1. Components of the EFHIA Framework

The following diagram shows the steps and components of the EFHIA framework.

Equity focused HIA follows the six generally accepted steps of HIA. To undertake an EFHIA one needs to: screen, scope, identify impacts and assess these making judgments based on equity considerations, develop recommendations and evaluate *and* actively apply an equity focus at each step.

Figure 1: The EFHIA Framework

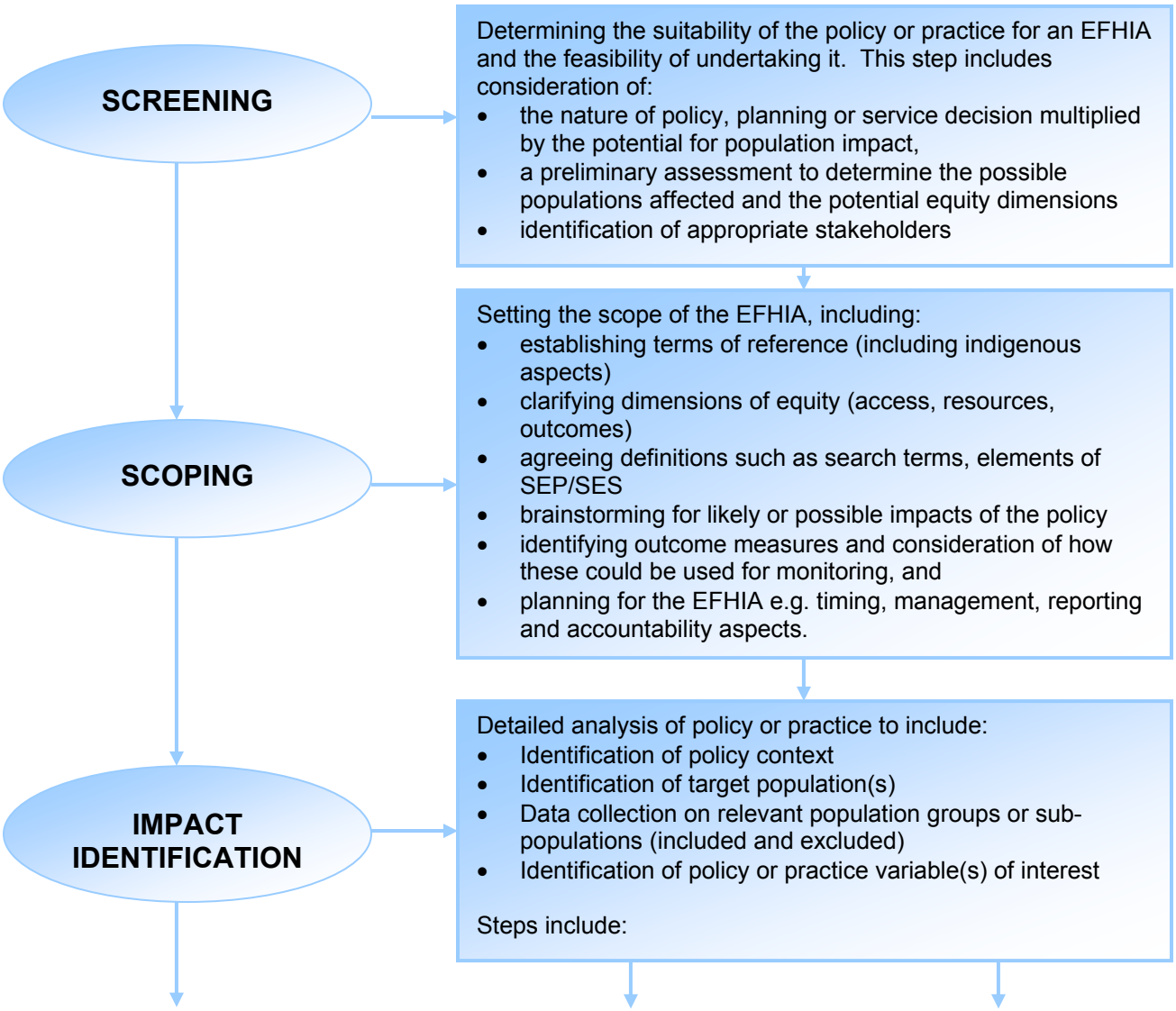
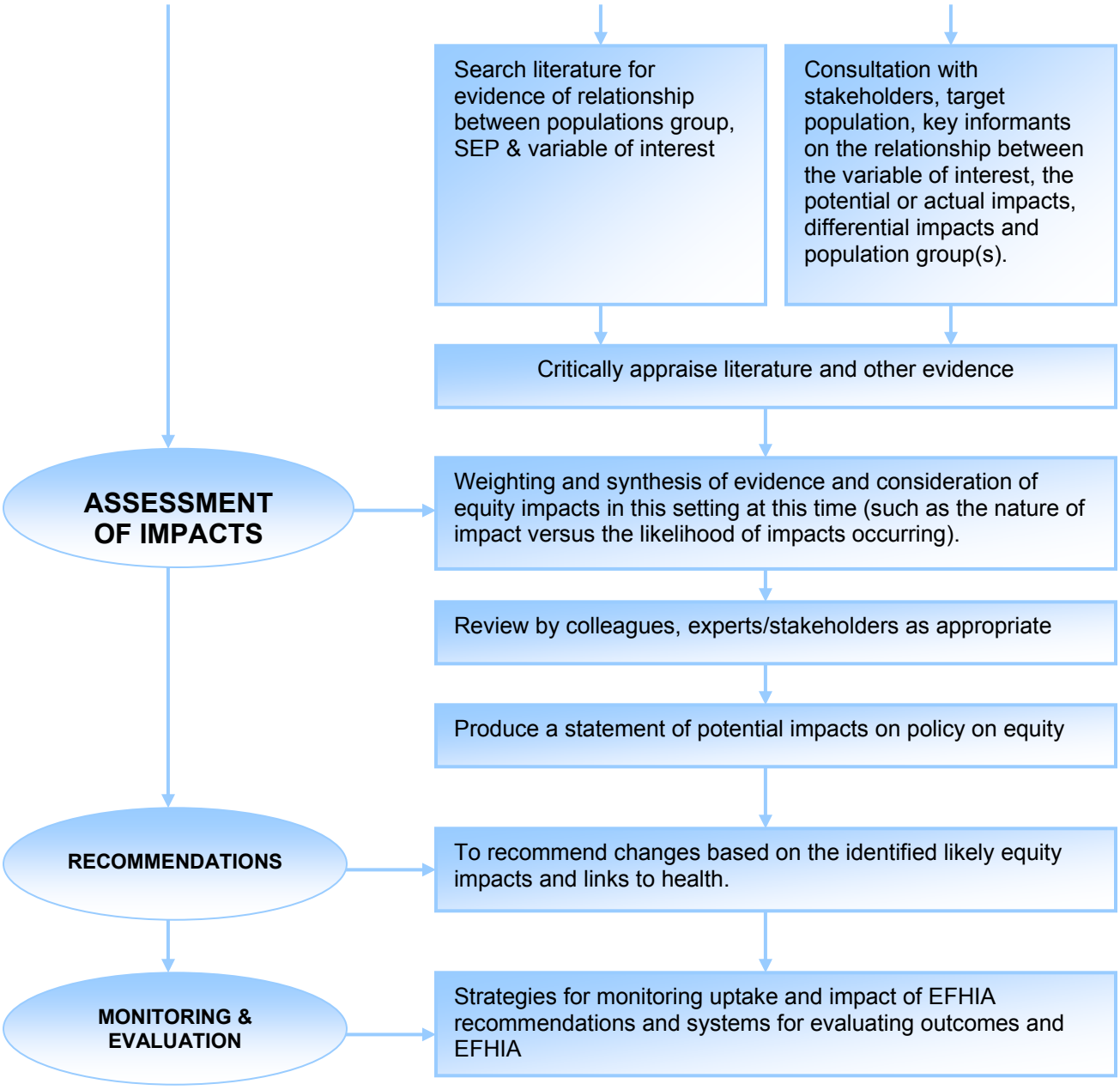


Figure 1: The EFHIA Framework Cont.



3.2. Applying the EFHIA Framework

The following section will outline the components inherent in each step of the framework using a consistent approach. As each application will vary, no attempt has been made to provide instructions on how to undertake each step. Appendix 2 contains examples of some activities that can be used during impact identification. The discussion focuses on broad principles and specific equity dimensions, assuming some knowledge of HIA processes. If the framework is to be applied to an existing policy or practice the EFHIA should be framed as if it is a proposal for future action. For example, the EFHIA of the Health**pact** Community Funding Program used existing processes for the program (e.g. criteria, policy, advertisement calling for applications) as the draft 'proposal' and assessed the potential health inequalities impacts in the ACT of such a 'proposal'.

4. STEP 1 - SCREENING

4.1. Definition and Explanation of the Step

Screening involves:

- identifying the links between the policy or practice and health,
- what links there might be to equity and inequalities in health, and,
- whether, and in what ways, it might impact differentially on groups within the population.

It should usually be a quick process that assumes some basic understanding of health and equity and involves taking a preliminary look at the proposal to determine whether an EFHIA is warranted and if so at what level or depth. However it is worth investing time at this step and during scoping to make sure that you get it right. Spending too little time on screening may result in you not undertaking an EFHIA where it is required, meaning that potentially negative health impacts arise during implementation and/or potentially positive health impacts are not enhanced to maximize the benefits of the proposal. Screening is based on a series of questions or activities that interrogate the proposal and its potential or actual links to equity and to the goals of reducing inequalities in health. As the context in which decisions are being made and the priorities of the organisation making them will vary, the actions taken at screening will differ.

4.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of the screening step you should have:

Table 1: Screening Step Components and Suggested Actions

Component	Suggested Actions
Described the context and content of the proposal e.g. draft policy	Identify important contextual information about why the policy is being developed or was developed and how it fits within the institution's goals. List policy aims and other appropriate parameters e.g. objectives, strategies etc
Described the target population(s) of the policy as precisely as possible	Write a profile of the target population(s) and their attributes in this setting (especially in respect to health inequalities and SES/SEP)
Identified populations included or excluded from the policy and identified any potential links between the policy and health (both direct and indirect).	Produce a table indicating who is included and excluded from the policy or practice
Identified key stakeholders of the policy	Produce a list which shows who the stakeholders are and their role in the policy or practice (e.g. advisor on health, advisor on local issues, specialist expertise in a given field, those directly affected by the proposal)

Table 1: Screening Step Components and Suggested Actions Cont.

Component	Suggested Actions
Articulated the equity dimensions	Describe any of the relevant dimensions of equity plus any potential connections between the policy and practice, specific populations and health. List any potential broad desirable and undesirable equity outcomes of the proposal
Identified opportunities for change to the policy or practice	Describe the opportunities for input into the policy or practice arising from the EFHIA
Identified the new course of action	Justify broadly whether an EFHIA (or any other action is appropriate) and the level it should occur.

4.3. Core Questions to be Addressed within Screening

There are three levels of decision making within screening: making a judgment about the link between the proposal health and equity; determining recommendations; and considering appropriate future action.

4.3.1. What are the links between the policy/practice, health and equity?

It would be helpful to answer the following 6 questions:

1. Is it necessary to consider health within this policy or practice?
2. Does this policy or practice have any (potential) health impacts?
3. Are these health impacts likely to be differentially distributed by socioeconomic status, ethnicity, gender, geography, or some other factor?
4. Are these differential impacts fair?
5. Are these differential impacts avoidable?
6. Do the benefits of changing the policy or practice to moderate or remove these differential impacts outweigh the costs or disadvantages of doing so?

4.3.2. What recommendations should be made?

The decision should be based on the nature of the impact and the requirement for change. There are three possible recommendations:

Recommendation 1

There are likely to be only negligible or differential (potential) health impacts following the implementation of the policy or practice. There is no need to adjust the proposal or to proceed to an EFHIA in this instance.

Recommendation 2

There are non-negligible (potential) health impacts and differential impacts. It is recommended that there is no need to undertake an EFHIA but the following adjustments should be made to minimize the negative and maximise the positive impacts on health and make the policy or practice more equitable.

Recommendation 3

There is considerable uncertainty about

- the (potential) impacts,
- the differential impacts,
- the extent of the non-negligible impacts, or
- the opportunities for adjusting the proposal (select as appropriate).

therefore an EFHIA is recommended for addressing the following aspects:

4.3.3. What level of action is required?

Based on the previous answers, it is important to make a recommendation which is realistic of the workplace and the pressures on resources.

Traditional HIA approaches determine the need for an HIA based on the size and cost of the proposal and the extent of the impacts across the population. The EFHIA can be conducted at three different levels: mini or audit level, rapid or intermediate level or comprehensive level.

Table 2: Levels of EFHIA

Level	Description
A mini EFHIA: a review of existing evidence	Information on impacts is largely known, limited consultation is needed so it is largely desk based: minimum time and cost but good research skills are needed
An intermediate EFHIA	Largely draws on existing evidence but consultation is needed to draw out contextual or local area impacts: limited time frame, scope and budget but requires good research skills
A comprehensive EFHIA	Resource intensive, impacts largely not known, frequently uses commissioned consultants and multidisciplinary research team: time and resource intensive

In EFHIA judgement has to be made on the basis of:

- the importance of the proposal,
- the extent to which considerations of equity are important within the organisation or policy/practice context,
- the extent to which evidence exists on the need for attention to be paid to the health of specific populations, and
- clear instances of the existence of inequities but where little is known about how to reduce or remove them.

4.4. Specific Issues to be Considered

- It is hard to identify the implicit assumptions in a policy or practice, particularly if you were responsible for drafting it and its intentions are benevolent. A range of expertise and differing perspectives should be used to assist in the task.
- As a pragmatic approach to determining the need for an EFHIA, one can adopt the position that the policy *is* equitable (i.e. innocent until proven guilty) in order that a prioritisation process can be built up into the screening stage - EFHIA can be time consuming and/or resource intensive if not used judiciously.
- As a way of framing the scoping, the following factors that might be taken into account: the context in which the policy or practice was developed; the processes used; the target population included or excluded from it; the stakeholders involved; and, the content.
- The potential to influence decision-makers will be vitally important in making the judgment about appropriate future action.
- Be prepared to find that an EFHIA is not needed. Once people are committed to EFHIA or HIA it is sometimes hard to get them to stop at the end of screening if that is all that is needed.
- The recommendations to undertake a comprehensive EFHIA and to commit extensive resources to it must be based on the knowledge that one has a very good chance of making significant changes to long- term policy and practice.

4.5. An Example Drawn from the Pilot EFHIA Projects

Box 1: Healthpact EFHIA Screening

Background

The ACT Health Promotion Board (known in the community as Health**pact**) is a health promotion statutory authority in the ACT and comprises nine people appointed by the ACT Minister for Health for their expertise in areas such as community health, sport, environmental health and business. Through the Community Funding Program (CFP) the Board conducts an annual funding round to provide grants and sponsorships to community, arts, health, cultural and sporting agencies to undertake health promotion activities. The intent of the funding round is to add value to existing activities, build the health promotion capacity of the non-government sector and to encourage new and/or innovative health promotion approaches - not to explicitly address health inequalities. Since the new Board commenced in June 2003, a number of continuous improvement directives have been implemented including administrative changes to the CFP. As part of its commitment to continuous improvement, however, the Board agreed to undertake an EFHIA of the CFP. The EFHIA was undertaken by the Centre for Health Equity Training Research and Evaluation (CHETRE) in collaboration with the Health**pact** secretariat and a Board member. These comprised the Steering Group.

Approach Taken to Screening

A draft screening report was developed for the Steering Group's consideration and to inform the screening step. The draft screening report was based on the seven outcomes from the screening step in EFHIA (listed in Table 1). There are many ways to undertake screening and, in addition to the process outlined in the draft EFHIA manual, the Context, Mechanisms and Outcomes approach developed by Curtis and Cave (2001) was used as a basis for this screening

Box 1: Health*pact* EFHIA Screening Cont.

exercise. The Steering Group focused on addressing the questions outlined in the screening step of the draft EFHIA framework including; what is the policy context; identifying the target population(s) – as precisely as possible; identifying (superficially) the potential health equity impacts (intended & unintended, positive and negative) of the policy; and justifying whether an EFHIA is required and at what level (i.e. proposed scope).

Key policy and program documents were reviewed as part of the screening step and to address the above issues/questions. For example, the following documents were assessed: the ACT Health Promotion Board Strategic Plan 2002-2005; the Guidelines and application form for the 2003/2004 funding round; the ACT Chief Health Officer's Report 2000-2002; and the ACT Health, Health Action Plan 2002

Outcomes

Potential issues identified as part of the screening step include:

- The CFP has a specific focus on addressing the social determinants of health, however, this does not equate with an equity focus. For example, projects funded under the healthy communities banner potentially still only benefit those who are already health advantaged.
- Current measures of the CFP do not contain information about the potential health inequalities impact(s) of the program.
- The priority population groups are groups within the population who may experience health inequalities but not necessarily inequities.
- Four of the seven focus areas of the CFP are focused on behavioural risk factors – increasing the chance that many funded projects will focus on individual behavioural risk factors and therefore potentially widen the health inequalities gap by improving the health of those who are already well/health advantaged.

The EFHIA Steering Group therefore recommended that an intermediate and retrospective EFHIA be undertaken to identify:

- the potential health equity impacts from the Community Funding Program using the outcomes of the 2003/2004 funding round as a focus; and
- how the equity focus of the CFP can be strengthened (if appropriate).

The draft report on screening was then revised and finalized to reflect the key issues considered as part of the screening step.

Lessons Learnt

It is difficult to identify the assumptions that underpin a policy by yourself – having input from several people is essential. For example, identifying that a commitment to addressing the social determinants of health is not the same as addressing equity - one of the Steering Group members read the draft screening report and identified this as an issue where the content analysis of key policy documents had not elicited this issue. Therefore screening should be done by a group i.e. more than one person. You also need to be thorough in the screening step. It should be done by more than one person so that as many of the different understandings and assumptions about "equity", an "equity focus", what's fair and unfair etc can be identified early on.

5. STEP 2 - SCOPING

5.1. Definition and Explanation of the Step

"Scoping is a procedure for bounding the assessment in time and space and consulting all stakeholders about their concerns" (Birley 1999). It consists of three components:

- Establishing the scope and nature of the specific EFHIA and being clear about exactly what is to be done, at what level and in what time frame.
- Identifying individuals to be responsible for each aspect of the work.
- Other project management aspects (timing, budget, planning, reporting).

All of these are established either through the organisation that is commissioning the EFHIA, by a lead individual or by the management committee established specifically for the purpose of undertaking it. Ideally, a Steering Committee to oversee the EFHIA processes and outcomes should be established. Interpretations on how equity is defined and what is to be considered fair, just, avoidable must be debated and agreed.

As for screening, it is worth investing time in scoping properly as it may save time and resources during the profiling and mapping stages, for example, it may avoid the collection of unnecessary information and/or result in identification of existing sources of information thus saving new data collection.

5.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of the scoping step you should have:

Table 3: Scoping Step Components and Suggested Actions

Component	Suggested Actions
Established a Steering Committee and reached agreement on core issues	Prepare a statement outlining the Terms of Reference for the SC, an agreed definition of equity and the dimensions of equity relevant to this proposal that will be used later in the EFHIA.
Articulated values	Prepare an agreed statement of the values underpinning this EFHIA process held by the SC and the researchers.
Agreed on process issues including process evaluation	Produce a brief project plan which outlines the time-plan for each step, a schedule of meetings, grid of tasks with identified personnel, key accountabilities and reporting responsibilities, and details relating to the level of EFHIA being undertaken including process evaluation procedures.
Agreed an approach to obtaining evidence	Prepare a search strategy for literature review, researching evidence and identifying sources of information on health impacts

Table 3: Scoping Step Components and Suggested Actions Cont.

Component	Suggested Actions
Agreed the methods to be used	Identify the methods to be used in the impact identification step and debate their relative merits in respect to the policy or practice.
Agreed the methods to deal with conflicts	Identify, through detailed discussion, where the areas of potential conflict may occur, e.g. how to resolve conflicting information and/or views about information during assessment of impact step. Negotiate how these will be resolved and who is responsible for deciding.

5.3. Core Questions to be Addressed During the Step

The core questions that need to be answered during the scoping step are:

1. At what level will the EFHIA be undertaken?
2. What methods will be used to obtain information?
3. How will differential and unintended impacts be identified?
4. What level of consultation will be sought and from whom?
5. What management structures will be used?
6. How are core terms within the EFHIA defined?

Based on the answers to these questions, a plan is required for the following three aspects. These will obviously be refined as the EFHIA is undertaken but they can be useful as a starting point.

EFHIA processes: for instance, goals, objectives, management, accountabilities and lines of reporting, resources, timelines.
EFHIA methods: for instance, profiling, consultation, data collection, search strategy, analysis of information.
EFHIA 'ideals': for instance, mechanisms for seeking agreement or consensus on values, evidence, weighting systems, judgements on equity issues.

5.4. Specific Issues to be Considered

- The membership of the steering committee is crucial to the outcomes of the EFHIA. Diverse and multidisciplinary expertise is required to get a range of perspectives on how socio-economic status may differentially impact on the health of segments of the population and on equity. People able to contribute in respect to age, gender, culture, ethnicity, education, employment, indigenous health, as well as people who are able to represent competing agendas and priority areas, should be included (wherever possible and feasible).
- Management of the processes and outcomes requires high levels of interest and thus a chairperson should be carefully selected. The committee's practices should reflect an egalitarian and inclusive approach.

- Briefing papers at each step are helpful to keep the EFHIA on track.
- Consultation can be helpful in the scoping step to assist with the framing. It can help to identify any stakeholder concerns; identify any equity issues, classify and prioritise these in this community; identify and acknowledge any restrictions on the EFHIA process; and, identify the desired outcomes for the broader constituency.
- If the EFHIA is inadequately structured and poorly planned at the beginning, the whole EFHIA will be problematic and unhelpful in showing potential impacts.
- Any of the work delegated or assigned to a third party must be detailed and specifications for requirements should be drawn up.

5.5. Examples Drawn from the Pilot EFHIA Projects

Box 2: Dietary Guidelines for Older Australians EFHIA Scoping

Background

This case study was undertaken in partnership with the National Health and Medical Research Council (NHMRC) and considered the Dietary Guidelines for Older Australians. The Guidelines aim to maintain health through nutrition for healthy independent Australians over 65 years of age. It is a public health intervention with GPs and Nutritionists acting as an information conduit. There is a document designed for professionals and a consumer pamphlet and brochure which is given to older people.

Approach Taken to Scoping

After screening was completed a Steering Committee was established with four representatives from the NHMRC and NIPH at Newcastle University (project investigators), two members of the public who were part of the target population of the Guidelines, and five additional members who provided specialist expertise such as policy linked to ageing, community nutrition and general practice.

The Committee identified skills and resources, allocated tasks to the project team and provided "lead" to the work to be undertaken during profiling. Boundary issues including planning of activities, timing, budgeting issues and ethical considerations were clarified, as were accountability and reporting functions.

Outcomes

There were no areas of concern so a clear project plan was able to be established and the EFHIA proceeded to the next step.

Lessons Learnt

Critical project management aspects were considered during this step including broad considerations of contextual factors that had to be taken into account. As the case study was being undertaken as a research project through the University of Newcastle, some aspects of the scoping were predetermined by the Ethics Committee. As project staff were paid to complete the EFHIA, boundary issues such as budget and timeframe, were not a problem. The range and breadth of expertise on the Steering Committee assisted with both formal and informal processes, e.g. contacts with other relevant experts would introductions and access to information and contacts easier during impact identification.

6. STEP 3 –IMPACT IDENTIFICATION

6.1. Definition and Explanation of the Step

Impact identification involves collecting information (data and evidence) to identify the potential and/or actual impacts of the proposal. There are three core activities in this stage:

- Profiling the affected community focusing particularly on SES/SEP aspects and other factors that might impact on subgroups of the population differentially,
- Gathering evidence on the effectiveness of the (proposed) intervention - described here as the (proposed) policy or practice,
- Gathering evidence from the affected stakeholders including residents and target group(s). (based on personal communication with Anthea Cooke, HIA consultant, 2003)

Once the three types of data are compiled it will be necessary in the next step (assessment) to collate, analyse and appraise it with specialist input. As with all subsequent steps, the scoping stage should have planned for how the impact identification step will be conducted.

As stated earlier, all forms of impact assessment and particularly EFHIA, require some form of consultation with stakeholders at some stage in this process (unless a mini level EFHIA is carried out). Joffe and Mindell (2002) state:

> the key feature of HIA that differentiates it from pure epidemiology is that the risk factors, exposures and determinants are not just taken as given, but are considered in the context of their own underlying causes. (p 133)

This cannot necessarily be done unless there is some way in which the specialist, contextual or local knowledge is factored in as needed. This should be done during impact identification.

6.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of this step you will have:

Table 4: Impact Identification Step Components and Suggested Actions

Component	Suggested Actions
Examined the policy or practice, its target population and any groups or populations for whom there is likely to be impacts	List the key population groups (or expand on the list developed during screening.
Profiled the target population(s).	Produce a summary of the relevant local data for the target population including evidence of health inequalities and SES per population group.

Table 4: Impact Identification Step Components and Suggested Actions Cont.

Component	Suggested Actions
Searched the literature for evidence on the link between the policy/practice, SES, health and health inequalities.	Produce a summary of the evidence obtained from published sources and provide it in a format appropriate to a lay audience (if needed).
Consulted with colleagues, stakeholders and target population(s) as appropriate, regarding the potential impacts of the policy/practice on health, and in terms of differential impacts and SES	Tabulate separately the findings from each consultation process in terms of likely health impacts, nature of these impacts (+/-), differential impacts, likelihood of them occurring, and potential severity.
Identified any equity issues	List any likely equity issues which arise from the literature or consultations.

6.3. Core Questions to be Addressed During the Step

There are two core questions to be answered in the impact identification step. The answers will be drawn from a range of different sources as appropriate and include a detailed exploration of the research evidence and the consultation processes undertaken.

1. What are the potential impacts on health, positive and negative, arising from the implementation of this policy in general and on different groups in the population?
2. Are these health impacts likely to be differentially distributed e.g. by socioeconomic status, gender, age etc?

Answering these questions will involve three main activities:

- literature searches for evidence of the relationship(s) between population sub-groups, SEP and/or the variable of interest.
- obtaining evidence from colleagues, experts and stakeholders about these relationships
- critically appraising the evidence gathered

There is a vast amount of literature describing relationships between socioeconomic factors and health. Developing strategies to address health inequalities is challenging because the underlying causes are embedded in social and economic structures at all levels of society. It cannot be assumed that the general application of interventions which are shown to be effective in one area will reduce health inequalities overall. Different approaches are relevant under different circumstances and multiple approaches can be used as part of overall strategies aimed at reducing health inequalities. With EFHIA however the intent is to assess the proposal to identify if there is potentially a differential distribution of health impacts, for whom and then to assess if these health inequalities or differences are also potentially inequitable rather than assuming that an effective intervention in one context will be equally as effective for all population groups in another context.

The depth to which the literature is searched and critically appraised will be determined by the level of the EFHIA (see Appendix 2) and this level will have already been established in the scoping step. There should be heavy reliance on routinely available local data on both the population, SES, the issue and health status. Similarly, depending on the level of EFHIA being undertaken, the amount of consultation will vary (see Appendix 2). The task of any consultation process is to identify as the group sees it, the potential health impacts of the policy/practice and the extent to which they envisage differential impacts potentially occurring (or having occurred) for different groups. The key questions to be asked focus on their perceived views of the relationships between the policy, the population sub-groups and SEP or the variable of interest.

As the assessment stage will appraise the identified impacts, no attempt should be made at this stage to do anything other than collect and collate the information obtained from the various sources. Recording evidence from this systematic search should be done as simply as possible so that it can be understood by a lay audience. The findings of each of the consultation processes should be recorded separately at this stage with no attempt to appraise the findings from the various types of consultations. Depending on the nature of the consultation process, complexity may compound inequity caused through reduced access to information. A summary table will be the most useful way of presenting the research evidence collected. Gaps in research evidence should also be noted.

6.4. Specific Issues to be Considered

- Impact identification will build in the initial work undertaken during screening but will be more detailed.
- A resource that may be helpful in the task of searching the literature for socioeconomic evidence, and applying the evidence in the development of clinical practice is the NH&MRC *Using Socioeconomic Evidence in Clinical Practice Guidelines* (2002). While this handbook specifically targets the developers of clinical practice guidelines, it includes useful strategies for obtaining information on socioeconomic position and health.
- If only one consultation process is undertaken with stakeholders (such as a workshop of expert stakeholders), it may be appropriate to provide a summary of the published evidence in advance. This must be carefully considered as the aim of the workshop may be to draw out as much contextual information as possible.
- In larger EFHIA where impacts are unknown, it is likely that sub-groups who have been omitted or excluded from the policy are already disadvantaged both socially and economically and will thus be hard to access. Involvement of stakeholders such as representatives of groups within the community or community members will provide important insights into the (potential) impacts.

6.5. An Example Drawn from the Pilot EFHIA Projects

Box 3: Support Scheme for Rural Specialists EFHIA Impact Identification

Background

The Royal Australasian College of Physicians (RACP) manages the Support Scheme for Rural Specialists (SSRS) on behalf of the Committee of Presidents of Medical Colleges. The Scheme aims to provide continuing professional development (CPD) opportunities to medical specialists in rural Australia using strategies such as videoconferencing.

It is widely thought that videoconferencing can overcome some impacts that distance has on the ability of rural specialists to participate in CPD activities, and is seen as a cost effective way for delivering education without the need for travel and associated productivity losses. While it is recognised that face-to-face education has other advantages, this medium is neither always available nor accessible to all specialists. As the SSRS program moved into its second year, it was considered important to select videoconferencing as the focus of this EFHIA in order to establish any equity-based implications of programs that offer videoconferencing as a means of delivering education.

Approach Taken to Identify Impacts

We aimed to subject the use of videoconferencing to support rural specialists to an equity-focused health impact assessment to determine whether equity issues between specialists, and by extension the communities they served, were addressed or worsened by the use of videoconferencing. We hypothesised that the EFHIA framework would provide information concerning equity issues between specialists and their access to CPD activities, and other information about the program components that might otherwise have been missed.

Having established that the EFHIA was worth doing, and that information derived by it would be useful to planners and managers of the SSRS, we commenced the profiling step of the EFHIA. We characterised our target population (rural specialists), identified equity issues inherent to that population (rural location meant routinely reduced access to continuing professional development activities in metropolitan centres), and sought to derive evidence about potential equity impacts of the program through a review of the literature and by consultation with experts, colleagues and stakeholders using the question “what are the potential equity impacts of using videoconferencing for continuing professional development for rural specialists?”

Outcomes

Several literature databases were searched for reports about continuing professional development, and/or videoconferencing/ telemedicine in which equity issues were discussed. We found little formal discussion concerning equity issues and telemedicine for CPD, although one trial evaluated videoconferencing clinical meetings from large tertiary institutions to rural centres (with collegial interaction being the most highly valued outcome). The literature in general communicated uncritically the assumption that telemedicine had the ability to alleviate problems associated with geographical isolation.

Importantly, as this EFHIA was conducted as part of the usual activity of the SSRS program manager, consultation was undertaken opportunistically with colleagues, experts and stakeholders using three strategies: an e-mail survey of rural specialists, including our EFHIA question in eight focus groups of rural specialists brought together (some by videoconference) for another reason, and personal interviews with commercial telemedicine providers, CPD program developers from Colleges, and government policy officials. We found that while videoconferencing was widely regarded as having potential to improve professional development for rural specialists and could have flow-on effects for communities served by those specialists,

Box 4: Support Scheme for Rural Specialists EFHIA Scoping Cont.

equity issues arose where access to videoconferencing was limited by technology. Further, we found that where locally available technology failed to keep pace with emerging internet-based programs, a program for continuing professional development based on videoconferencing or internet programs may widen educational disparity between specialists, with flow-on effects to the communities they serve.

Lessons Learnt

In the absence of a developed literature around this question it was clear that the contributions from experts, colleagues and stakeholders were critical to making recommendations as a result of our equity-focused health impact assessment on a program to provide continuing professional development for rural specialists using videoconferencing.

7. STEP 4 – ASSESSMENT OF IMPACTS

7.1. Definition and Explanation of the Step

This is a complex step requiring the appraisal of the identified impacts from an equity perspective. Assessment of impacts seeks to match all the sources of kinds of evidence derived from the previous step to the priorities of the organization and/or stakeholders and considers the trade-offs that will be needed so that the proposal does not unintentionally, unavoidably and unfairly differentiate and/or increase inequalities in health. The step involves a mapping process whereby all the different information/evidence collected during impact identification and making decisions is reviewed based on the following:

- the nature of the health impacts identified and the extent of differential distribution according to SES or other factors,
- the differences, similarities or gaps in evidence collected from the various sources,
- the judgments about dimensions of equity (i.e. whether the impacts are fair, avoidable),
- consideration of the needs of the organization, and the stakeholders.

There is no right answer to the judgments required in this step. The step involves two actions:

1. synthesising the range of evidence collected during consultations against the research evidence; and
2. making decisions about the implications of this evidence from an equity perspective e.g. are the potential health inequalities impacts unfair, avoidable and unjust.

Essentially, what you are seeking is a list of likely impacts which have the potential to be inequitable and then decisions about the best course of action is to ensure that the negative impacts are minimised and the positive impacts are enhanced.

7.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of this step you will have:

Table 5: Assessment of Impacts Step Components and Suggested Actions

Component	Suggested Actions
Reached some form of agreement about the potentially positive and/or negative impacts of the proposal on health and the priorities for each groups differentially impacted upon	Produce a synthesized report of the findings of the impact identification stage which shows likely +/- impacts, and differential impacts for different population groups, areas of disagreement or gaps in evidence. Gain approval from Steering Committee on these findings.
Identified the potential equity dimensions of the policy	Based on the agreed dimensions of equity at Scoping step, produce a brief profile of areas of the policy likely to include equity issues. Gain agreement from Steering Committee.
Searched the literature for evidence on the link between the policy/practice and health inequalities.	Produce a summary of the evidence obtained from published sources and provide it in a format appropriate to a lay audience.

7.3. Core Questions to be Addressed During the Step

Investigators need to be able to answer the following 4 questions, and prepare draft recommendations as appropriate:

1. Given the range, number and severity of potential health impacts identified, how should they be prioritised so that those that impact negatively on health are reduced and those which impact positively are enhanced?
2. Which impacts have the potential to be, or are, unfair?
3. Which are avoidable?
4. On the basis of evidence obtained, what changes should be recommended for which will reduce the potential for inequities?

7.4. Specific Issues to be Considered

- The goal of this step is to develop a set of equity impact priorities:
  - which are ranked in order of importance for each group of stakeholders,
  - which is supported, as appropriate, by the research evidence,
  - which take account of the contextual factors, and
  - which are endorsed by the Steering Committee.
- Once the consultation activities have been completed and the documented evidence has been obtained, it is important to map the findings separately to see the trends that emerge. A simple way to show the different findings, the expected health

outcomes and equity considerations, is to develop a matrix of impacts. Multiple matrices can be used to deal with a large quantity of information from differing sources. Alternatively if different methods have been used to gather data then the findings from each method can be represented separately to indicate differing trends. There is no one right way to deal with the data at this stage but matricies will help to synthesize the evidence and to draw out the equity parameters which were set at scoping. The potential impacts for each of the groups in the target population need be explored from a range of perspectives and judgments about actions which ensure fairness, avoidance or justice are required. Mapping the evidence will also illustrate where the gaps are.

- There are two potential areas of conflict during the impact assessment stage: first, evidence which shows conflicting information and second, differing opinions on the interpretation of that evidence and the subsequent changes required. Equity considerations will must be used for determining the actions to be recommended.
- In cases of conflicting evidence or opinion on likely health impacts or differential impacts, judgment must be made by looking at the main question that the EFHIA is seeking to answer. For instance, if one's goal is to decide whether the policy has the potential to impact negatively on one group then the results of past scientific research will be prioritised. Alternatively, if one is interested in whether the community will find the proposed policy or intervention acceptable for a group of the population, then evidence drawn from the community such as local data and findings of consultations will need to be prioritised. As EFHIA is, by its very nature value laden then the *rationale* for prioritising evidence must be clear. If no resolution can be found, the goals or priorities of the organization commissioning the work will determine the outcome.
- In the case of EFHIA there are two different issues at play in the assessment step and both are interlinked: the *quality* of the evidence and the model or approach which will be used to *make a judgment about actions arising from the evidence.* All evidence needs to be assessed for quality but in the case of EFHIA there will be times when evidence available from target group(s) will not conform to the standards expected in scientific research. From an equity perspective consideration of such issues is crucial and will link to the main question being addressed in the EFHIA. In situations where there is conflicting information and the process is grounded in scientific research it may be possible to use standard means for judging evidence and develop models for weighting based on these. An example of such an approach is provided in the Appendices. When the situation is not clear one should remember that the goal of EFHIA is to make clear the likely trade offs in the decision making process. Some strategies to assist in the resolution of these issues include:
    - clearly articulate the principles of equity underpinning the EFHIA;
    - use mixed methods to draw out the range and scope of potential impacts;
    - share the findings with appropriate key informants or stakeholders so that areas of potential tension can be explored and considered broadly by all constituents;
    - document all processes used to prioritise one aspect over another.

7.5. Examples Drawn from the Pilot EFHIA Projects

Box 4: Health*pact* EFHIA Assessment of Impacts

As part of the mapping step, the Steering Group met twice:

1. First to consider a draft report on the results from the profiling step and discuss how best to map the findings as potential health inequalities impacts; and
2. Second to consider a further draft of the report on the findings, identify areas for recommendation, and how to progress the findings from the EFHIA (e.g. presentation to Board etc).

At the second meeting, specific feedback was provided on the draft Health Inequalities Impact Statement and it was agreed that a postscript detailing the changes that the new Board had made to the CFP subsequent to 2003/2004 should be included with the EFHIA report once it was finalised.

The Steering Group did not use a matrix to map the potential health inequalities impacts as this did not meet their purposes. Instead the Group considered how the potential outcomes of existing CFP processes (as identified through the profiling step) potentially impacted on health inequalities in the ACT. An important lesson is that the mapping step may take a considerable time such as two or three Steering Committee meetings to progress this step. As part of this step it is important to focus on the proponent or organisation's capacity and scope to act on the findings. In addition it is very important to be very clear about how information/evidence from different sources will be valued – will one source be valued more than another; has this happened by accident; and how will recommendations be prioritized.

Box 5: Cardiac Rehabilitation Program EFHIA Assessment of Impacts

Members of the Steering Committee faced heavy demands on their time, and consequently the processes were streamlined as much as possible. The meeting to discuss the mapping step also incorporated aspects of the recommendations step. The meeting was attended by three CRP nurses, one representative from the patient target group and the two researchers.

A report on the impact identification step was circulated by e-mail several weeks before this meeting. The meeting discussed the findings presented in the report. In summary, the Committee concluded that:

a matrix approach to weighting the equity impacts was not an appropriate tool for this particular case study;

members preferred not to "quantify" or rank the importance of various barriers to attendance, as the barriers were not directly comparable;

In this case study the conflicting information was used as the basis for illustrating the range of possible actions needed for different groups. CRP staff did not wish to prioritize the resulting recommendations but instead list them in non rank order. They were concerned about political sensitivities amongst colleagues and managers. The staff had the confidence of other committee members on this issue.

Most of the findings in the impact identification report were of no surprise to the members, but they were pleased to have something other than anecdotal evidence to back up their views. All agreed that some aspects of the CRP could be modified to produce more equitable outcomes for users. The assessment of impacts step allowed for specific consideration of the differing needs of users and rather than being a source of tension, created a range of possible responses for consideration.

Box 6: Cardiac Rehabilitation Program EFHIA Assessment of Impacts Cont.

The meeting drafted EFHIA recommendations and the rationale for each of them. These recommendations were subsequently refined and circulated by e-mail to all Steering Committee members for comment.

STEP 5 - RECOMMENDATIONS

8.1. Definition and Explanation of the Step

Solution focused recommendations are the suggested changes to the proposal or to the existing initiative within the organisation. They are prepared and presented in such a way that the decision makers are aware of the (potential) impacts on health of the population or various sections of the population, the likely consequences and the potential impacts in respect to socioeconomic status and inequalities in health arising out of the (proposed) policy or practice. The recommendations need to be contained within a clear and concise report that outlines clearly the changes or modifications that are needed, priority actions and the evidence to support the claims being made.

8.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of this step you will have:

Table 6: Recommendations Step Components and Suggested Actions

Component	Suggested Actions
Formulated recommendations	Produce a brief statement of recommendations (ideally contained in the front of a concise final report), circulate to key stakeholders and Steering Committee for approval
Provided a report of recommendations to decision makers	Submit the final report to decision makers and offer to present or discuss the findings of the EFHIA and the recommendations suggested.

8.3. Core Questions to be Addressed During the Step

The recommendations are based on the answers to the questions asked so far in the EFHIA steps. Based on the findings in the previous step, produce a set of agreed recommendations which highlight in practical ways the ways in which the policy should be strengthened or changed to maximise (potential) health gains and minimize harmful effects on the health of the population or specific groups within the population. Prioritise these recommendations as appropriate and provide appropriate evidence to support each of them.

8.4. Specific Issues to be Considered

- Until this stage, there has been little acknowledgment of the political reality of the decision making process unless it has been raised during the consultation phase. Equity or inequalities in health may not be high on the agenda of decision makers so the case for change will need to be argued strongly. If the EFHIA is to be productive, the recommendations should not amount to a simple “wish list in an

ideal world". When formulated, political realities will have to be considered because resource implications that arise out of the suggested changes will generally involve some form of trade-off in the ultimate decision making process.

- In the interests of achieving agreement by decision makers that changes are required, a strong case will need to be made. The report that served as a discussion document in the previous step will not necessarily be appropriate at the recommendations stage.
- Recommendations are more likely to be adopted if the decision makers have either: been involved throughout or at least engaged in part of the HIA process; if the report and recommendations are presented in a concise format; and, if they arrive before the key decisions are made (Taylor and Stevens, 2002, p.15)
- Since one of the principles of EFHIA is that it is a transparent and accountable process, the contribution of all people who have been involved in the EFHIA should be acknowledged in the final report. They are also entitled to receive a copy of this document and information on the final outcome.

8.5. A Cautionary Note

It is unrealistic to suggest that the EFHIA process will result in everyone achieving the outcomes that they would prefer. There is a great deal of evidence in project-based HIAs that different constituencies are not satisfied with the outcomes. In a policy development situation or in a retrospective EFHIA little research evidence exists. Not everyone who reads the recommendations will necessarily agree with them or with the arguments used to justify the changes. Equity is also a contested concept. There is no doubt that any proposed change to a policy is likely to cost another group in some way. This is because there will always be 'trade-offs'. Practitioners may well discover that their work and findings are ignored. This does not mean that the work has been useless – it may simply mean that a point of readiness to take the recommendations on board has not yet been reached. Other outcomes such as increased public support may be generated. EFHIA forms part of a long-term incremental strategy to get health and equity onto the broader agenda.

8.6. An Example Drawn from the Pilot EFHIA Projects

Box 7: Healthy Eating: Healthy Action (HEHA) EFHIA Recommendations

Background

Healthy Eating: Healthy Action (HE: HA) is a strategy for action around nutrition, physical activity and obesity developed by the New Zealand Ministry of Health and launched in March 2003. The rationale for its development is that there is a growing problem of obesity and a need to improve nutrition and increase physical activity in New Zealand. The aim of the study was to undertake a retrospective EFHIA to assess the extent to which issues of equity were taken into account during the development of the strategy in order to inform the future implementation strategy. The HE: HA strategy focuses on improving both population and individual health and it takes account of the underlying principles of the Treaty of Waitangi. The main question addressed in this EFHIA

Box 7: Healthy Eating: Healthy Action (HEHA) EFHIA Recommendations Cont.

was 'did the way the policy was developed have the potential to create, maintain or reduce health inequalities?

Developing Recommendations

Documentary analysis of the Ministry of Health files on the strategy development and key informant interviews were conducted. A Steering Committee was formed to oversee the EFHIA comprised people with expertise in the nutrition and physical activity sectors and in HIA, including Maori and Pacific representatives. Comprehensive screening, scoping and profiling steps were undertaken. The five EFHIA questions were posed at the mapping step and the findings indicated that there were some shortcomings to the internal and external consultation processes undertaken in the strategy development processes that had the potential to reduce the equity of input and thus the potential effectiveness of the strategy, particularly for Maori. Based on this and other more specific findings, four recommendations were developed which focus on changing or reviewing broader approaches to policy and strategy development within the Ministry as well as to the implementation strategy for this particular policy area. The recommendations include: reviewing the current Ministry of Health (MOH) Consultation Guidelines from an equity perspective; reviewing these Guidelines from an implementation perspective; reviewing the MOH policy development process and building equity into each step; and building on the strengths and addressing the weaknesses of the HE:HA strategy development in its implementation strategy.

Lessons Learnt

This pilot project has the potential to inform future decision making in respect to equity because it draws out weaknesses or areas of common practice that potentially cut across departments of government. The initial lessons will be applied within the MOH but potentially they could be translated into the practices of other Ministries and into other decision making settings. Additionally, as the EFHIA fitted within a total portfolio of activities linked to reducing inequalities in health so it has enormous potential to be effective as part of a suite of activities within government.

9. STEP 6 - EVALUATION AND MONITORING

9.1. Definition and Explanation of the Step

This step involves the systematic consideration of three different aspects: what added-value did the EFHIA process bring to the decision making processes in terms of equity considerations; what changes should be made to the EFHIA itself; and what changes over time in terms of equity considerations.

9.2. Outcomes to be Achieved by the End of the Step with Suggested Actions

By the end of this step you will have:

Table 7: Evaluation and Monitoring Step Components and Suggested Actions

Component	Suggested Actions
Reflected on the EFHIA process	Complete an evaluation of the EFHIA process and draft a report or integrate the lessons into the EFHIA report. Upload to the HIA Gateway website. Evaluate the extent to which equity considerations are now more clearly noted within the organisation
Developed strategies for monitoring impact and outcome	Develop protocols for monitoring the outcomes of the policy or practice based on the actions/components that were modified as a result of the EFHIA and those which were not. Establish or build into existing structures an ongoing monitoring strategy.

9.3. Core Questions to be Addressed During the Step

1. Was the EFHIA conducted in a rigorous and proficient way taking due account time and resource constraints against principles of good research?
2. How and to what extent did decision makers utilize the outcomes of the EFHIA process?
3. Did considerations of the link between the policy or practice take account of potential health impacts, and differential impacts and equity result in changes to health status, differential health status in that context over time?

9.4. Specific Issues to be Considered

As there was no opportunity to undertake monitoring activities as part of the pilot projects for this EFHIA study, it is suggested that readers refer to the information available on the hiagateway website about evaluating and monitoring HIA activities.

REFERENCES

Barnes, R. Cooke, A. Ellis D. Gee, N. & James, S. (2001). *Health Impact Assessment of Regeneration Programmes Part 3: Toolkit for rapid HIA*. London Borough of Hammersmith and Fulham.

Birley, M. (1999). *Procedures and methods for health impact assessment*. London, UK Department of Health.

Cave, B. Curtis, S. Aviles, M. & Coutts, A. (2001). *Health impact assessment for regeneration projects: Selected Evidence Base Volume II*. East London: East London & The City Health Action Zone, University of London.

Harris-Roxas, B., Simpson, S. and Harris, E. (2004) *Equity-Focused Health Impact Assessment, A literature review*. Australasian Collaboration for Health Equity Impact Assessment

Horton, R. (2000). "The less acceptable face of bias." Lancet **356**: 956-959.

Joffe, M. and J. Mindell J. (2002). "A framework for the evidence base to support Health Impact Assessment." Journal of Epidemiology and Community Health **56**: 132-138.

Lehto, J. & Ritsatakis, A. (1999). *Gothenburg consensus paper: Health Impact Assessment Main concepts and suggested approach*. Brussels: European Centre for Health Policy, World Health Organisation Regional Office for Europe.

Mahoney, M. Simpson, S Stewart-Williams, J. Brooks, J. (2003). *An Introduction to Equity-Focused Health Impact Assessment* Volume 1. Australasian Collaboration for Health Equity Impact Assessment.

NHMRC (2000). *How to use the evidence: assessment and application of scientific evidence*. Canberra, National Health and Medical Research Council**:** 84.

NHMRC (2002). *Using socioeconomic evidence in clinical practice guidelines*. Canberra, Commonwealth of Australia.

NSW Health, (2004) *In all fairness, NSW Health and Equity Statement*. Sydney, NSW Department of Health

Signal, L. (2002) *Tackling inequalities through health promotion action.* Health Promotion Forum of New Zealand Newsletter **56** 10

Taylor, L. and Stevens B. (2002). *Introducing health impact assessment (HIA): informing the decision making process*, Health Development Agency, NHS.

Turrell, G. and Oldenburg, B. et al. (1999). *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*. Canberra, Queensland University of Technology School of Public Health, Ausinfo.

WHO European Centre for Health Policy (1999). *Screening: a preliminary draft*. Brussels, World Health Organisation.

Whitehead M. *The concepts and principles of equity and health*, Copenhagen, World Health Organisation, Regional Office for Europe, 1990

APPENDICES

Appendix 1: Glossary of Terms Used in EFHIA

Differential health impacts

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

Health differentials

are measurable differences, variations and disparities in the health of individuals or groups. Differentials arise in populations due to range of factors including (but not limited to) age, gender, race and socioeconomic status. These observed differences in health are seen in mortality data, morbidity data (including mental health) and health risk behaviours. For example the higher:

- mortality rate among older people than younger people
- Aboriginal mortality rates
- rates of poor to fair self-reported health status among those who are socioeconomically disadvantaged.

Health determinants

It is widely agreed that the causes if illness and good health extend beyond biology and genetics and are determined by factors such as gender, ethnicity, geography, socioeconomic status and socioeconomic position as well as policies and practices inside and outside the health care system. All are determinants of health and can result in health differentials.

Health impacts

are the (intended and unintended) positive and negative changes in the population that may occur as the result of the proposed policy, program or project (Mindell, Ison & Joffe, 2003).

Policy

is any action that is being planned and that has the potential to impact upon people's health and wellbeing. The word 'policy' could mean a strategy, program, project, service, or any equivalent action.

Target group

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

Stakeholder group

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

Socioeconomic determinants of health

the social, economic, cultural and environmental factors which affect a person's circumstance and which may have an impact on their health.

SEP (socioeconomic position)

The term 'socioeconomic position' refers to the components of economic and social well-being in a societal context. It is a concept that included both:

- resource-based measures such as income and educational qualifications; and
- prestige-based measures such as an individual's rank or status in a social hierarchy, for example the prestige associated with certain occupations (NHMRC 2002, p6)

Socioeconomic Status (SES)

a person's circumstance or context in society, which may be expressed and/or measured using criteria such as income, educational level attained, occupation, value of dwelling place. SES is often used as a technical or social construct to measure a person's societal circumstance.

Evidence

'Evidence comprises the interpretation of empirical data derived from formal research or systemic investigations which use any type of scientific or social science methods. It is useful to distinguish between data on the cause or scale of a health problem (aetiologic studies and needs assessments) and evidence on the implementation and outcomes of interventions.' (Rychetnik L. & Frommer M. (2000) *A proposed schema for evaluating evidence in public health interventions*, NPHP, Australia)

Negligible impacts

Are those impacts which, based on evidence available at the time of the EFHIA, are deemed to be insubstantial or lack sufficient justification to warrant further acknowledgement or action.

Variable of interest

That component that is the subject of the proposal e.g. in a draft transport plan for rural health it would be transport.

Appendix 2: Some Suggestions for Undertaking the Impact Identification and Assessment Steps

Box 8: Questions to Assist in Drawing out the Answers to the Two Main Impact Identification Questions

- Who will be impacted upon by the policy/practice?
- What will the nature of the impacts be (good or bad, positive or negative)?
- What will the impacts on their health be and is there a link to SES/SEP?
- How do you know this is likely to happen (do you have any evidence?)?
- Which determinants of health are likely to be impacted upon?
- What are the key health issues of concern in this local population?
- In what ways is the proposal likely to impact on specific groups within the population?
- How likely is it that this will occur?
- How severe is this impact likely to be?

Box 9: Suggestions for Examining the Policy or Practice, Its Target Population and Any Peoples, Populations or Sub-Groups for Whom there is Likely to be an Impact

The policy: understanding the background and context of the policy or practice is crucial. Questions that might need to be asked in relation to the policy or practice being assessed include the following.

- Which institution created the policy?
- Who has been consulted during the development of the policy?
- Why was the policy developed?
- Why is it being developed now?
- What is the stated intent of the policy?
- Is there an 'unstated' agenda? If so, what is it?
- Does the policy relate to any other relevant policies? If so how?

Box 10: Data Collection on Relevant Population Groups or Sub-Groups

As EFHIA examines the intended and unintended impacts across and within population(s), is important to examine health impacts for both the targeted and also the non targeted population groups and sub-groups. Questions to ask in relation to the policy in question might include:

- Who is targeted for inclusion?
- How is the target group described/defined in the policy?
- What is known about the demographic and SES characteristics of the targeted group? Who does the policy or practice exclude?
- What is known about the demographic or SES characteristics of the excluded group? Is there a stated reason for the exclusion?
- Who is responsible for implementing the policy?

Box 10: Data Collection on Relevant Population Groups or Sub-Groups Cont.

- Are there sufficient resources for implementation? (this needs to be considered in the light of possible modifications to reduce any inequalities)
- How will resources influence the way the policy impacts across the relevant population groups or sub-groups (included and excluded)?

Box 11: Identification of Variables of Interest

This component involves gathering and assembling data on the socioeconomic parameters which describe the included and excluded population sub-groups. The information should provide a profile of the population sub-groups. The information may be obtained from census, local government or public health unit demographic reports. The internet also provides valuable resources.

There are standard approaches to appraising the quality of published quantitative evidence. The NHMRC has a guide to the critical appraisal of evidence reporting health interventions. This uses standard levels of evidence for ranking the validity and reliability of reports of intervention studies (please refer to http://www.nhmrc.gov.au/publications/synopses/cp65syn.htm). A framework for appraising public health intervention studies has also been published by the National Public Health Partnership (please refer to http://www.nphp.gov.au/publications/rd/schemaV4.pdf).

Box 12: A Model for Dealing with Conflicting Evidence in Impact Assessment Step Where the Evidence is Deemed to be of Equivalent Quality

One option is to develop a matrix indicating which evidence is valued more highly and by whom. This approach means that the recommendations flow from that hierarchy of evidence (see Box 11) and that the decision maker is able to see the variations and choose which option they will choose to value over the others. In this situation a possible approach is:

1. Set out the evidence from each source showing how it was valued by each source separately from most to least. Examples used here are results of focus groups, published literature and analysis of policies/records
2. Make assessments about the overall meaning of the evidence given the precedence given to each part of the evidence:

Value-Ranking Evidence from Multiple Sources

Most valued	Mid-level	Least valued	→	Impact assessment statements valuing the evidence in this order means
Literature which said that…	Focus groups which said that ….	Document analysis which said that …..	→	1. 2.
Focus groups which said that …	Document analysis …	Literature ….	→	1. 2.
Document analysis which said that ….	Literature …..	Focus groups ….	→	1. 2.

Box 12: A Model for Dealing with Conflicting Evidence in Impact Assessment Step Where the Evidence is Deemed to be of Equivalent Quality Cont.

3. Make impact statements such as:
   If the evidence from the scientific literature is to be valued more highly than other evidence then the EFHIA tells us that:
   This may need to be repeated for each type of evidence. Recommendations will then lead on from the trends evident in that particular type of evidence.

Table 8: Levels of Evidence and Consultation Required

Level of EFHIA	Published Evidence	Suggested Levels of Consultation
Mini	This will require searching at least one relevant database for research evidence of relationships between the policy/practice, a measure of health status and SEP. This level is an expert-driven process informed by previously obtained research evidence (usually derived from the individual or team's expertise). At this level it is clear that the link between the policy/practice and health is clearly understood and research evidence exists. This level of literature searching usually results in limited quantification or qualification of (potential) impacts.	Key informant interviews with a limited number of key stakeholders to inform screening, scoping, impact identification and assessment steps
Intermediate	At this level the literature review is more comprehensive, strengthened by input from consultation with key stakeholders or experts regarding the relationships between SEP and health for this policy. Research evidence is largely known about impacts on health but the process requires additional input from key stakeholders and experts in the field, particularly to add local considerations.	Can involve some or all of the following. *Key informant interviews* with colleagues: selected opportunistically and consulted formally or informally regarding their knowledge about the relationship between SEP and the policy. *A meeting or workshop*(s) with identified experts or stakeholders possessing specialist or appropriate knowledge. *Focus groups* with stakeholders or representatives of the target population(s).
Comprehensive	This level requires considerable investment of resources, specialist expertise and high levels of appropriate stakeholder consultation. Comprehensive HIAs typically include an extensive review of the published literature, analysis of secondary data, and collection of new data. Frequently, little research evidence exists on the connection between the (potential) policy and health. The Cochrane (www.cochrane.org) and Campbell (www.campbellcollaboration.org) Collaborations provide published evidence of the effectiveness of health, social, educational and behavioural interventions. The Collaborations are currently working to address a gap that exists in research evidence relating the effect of interventions to distributional equality and equity.	Full consultation with representatives of target populations, key stakeholders and experts is required.