

*Preliminary version – for discussion*

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health actors<sup>1</sup> about effective strategies for promoting the adoption of healthy public policies. Health Impact Assessment (HIA) is currently the most structured practice available to actors in this field. It is applied to policies developed by sectors other than that of health that can significantly affect health determinants.

This brief document is the second of a series that examines the practice of HIA from various perspectives. The web-based versions of these documents include hyperlinks to other resources that can be accessed through the NCCHPP website.

### Introduction

Health Impact Assessment (HIA) is defined by the World Health Organization as “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” (WHO, 1999).

This definition invites health practitioners to take not only the impacts on the health of the population into consideration, but also how these impacts could have differential effects on some groups of the population.

This brief paper intends to expand more specifically on this aspect of HIA.

### What do we mean by health inequities?

<sup>1</sup> Here, the term ‘actors’ refers to people working in the health field at whatever level (practitioners, health promoters, etc).

Before going further on the topic of health inequities in the HIA process, it is useful to review certain distinctions in the definitions related to the concept.

- The literature on the topic generally distinguishes the notions of inequality and inequity. Inequality refers to unequal distribution in terms of health status within the population. Inequity refers to the fact that in some situations these differences are unnecessary and unjust (Hogstedt, Moberg, Lundgren & Backhans, 2008).
- Some disparities in the health status of individuals can be due to biological or genetic factors, or to chance. In these cases, we refer to the notion of inequality. However, we refer to inequity when these disparities are persistent and systematically affect specific groups of people (for example, ethnic groups, Indigenous peoples, or low-income persons) and because they are often due to structural factors such as unhealthy physical and social environments, poor working conditions, or lack of access to good jobs and education (Butler-Jones, 2008).
- As such, inequalities in health that are systematically associated with underlying social disadvantages and that reflect unequal opportunities for better health are considered to be unjust, unfair and avoidable, and are commonly referred to as ‘health inequities’.
- Equity in health refers to the absence of avoidable health differences among populations or population groups defined socially, economically, demographically, or geographically (WHO, 2009).

The distinction between the terms “inequality” and “inequity” is not always the subject of consensus, and these terms are sometimes



used interchangeably, whether explicitly or not. The World Health Organization (WHO) uses the term “health inequity,” to designate avoidable and, thus, unfair, differences in health among population groups (WHO, 2008). It is this term, understood in this way, which will be used here.

### **The role of HIA in combating health inequities**

Concern among public health actors for health inequities stems from the fact that improvements in health status at the population level usually involve a reduction in health disparities between sub-groups in the population. In order to reduce these disparities, particular attention must thus be paid to the most vulnerable individuals and groups if we wish to improve their health status. At the policy level, three broad types of strategies are used:

- those that call for the allocation of specific resources to these groups (for example, a program that targets the homeless);
- those aimed at making existing resources more accessible (for example, subsidies to extend access to daycare);
- those aimed at reducing the negative effects of programs and policies designed for the general population but which have the potential to create, maintain or widen existing gaps.

HIA acts mainly on the last strategic level by estimating the effects on health as well as the distribution of these effects within the population.

The HIA process has sometimes been adapted so that it would account exclusively for impacts on health inequities, resulting in guides and tools for addressing this issue (For example see, Lester, Griffiths, Smith & Lowe, 2001). It has been observed that HIA practitioners do not always take an equity focus into account in a satisfactory manner (Harris-Roxas, Simpson & Harris, 2004). This was discussed by an international round table of HIA practitioners,

and it was generally agreed that it would be better to strengthen the equity dimension within a generic HIA framework rather than to develop a parallel practice focused solely on how policies affect inequities (Douglas & Scott-Samuel, 2001). This document has been written following this perspective.

### **Considering health inequities in the HIA process**

As its definition implies, HIA aims to make explicit the potentially differential effects of a policy or program on various population groups. Thus, the practice of HIA can help reduce health inequities by informing policy makers of the probable negative effects (increased disparities) or positive effects (decreased disparities) of a proposed policy or program.

For this reason, it has been introduced by many governments (for example, those of Norway and New Zealand) as a means of combating health inequities. Moreover, it is supported by the WHO, which, in a follow-up to the report by the Commission on Social Determinants of Health, urged member states to take health equity into account in all policies aimed at acting on the social determinants of health (WHO, 2009). In Canada, the report of the Senate Subcommittee on Population Health also suggested that this practice be applied to Canadian public policies (Keon & Pépin, 2008).

### **Concern about inequities as a core element of HIA**

The practice of HIA, which is based on health promotion principles, automatically incorporates concern for health inequities. This is done by ensuring that the differential effects of a proposed policy on groups within a population are systematically identified through inquiry into how the policy’s effects disadvantage certain vulnerable groups. It is important, also, to investigate the cumulative effects of these policies. Indeed, a single policy may produce minor effects, but an

accumulation of minor effects can have major repercussions for the continuation or growth of health disparities.

### **Integrating equity considerations into each stage of the HIA process**

The best way to systematically take health inequities into account is to integrate this concern into each stage of the HIA process, and to do this for all proposed policies or programs being analyzed.

#### **At the screening stage**

The screening stage is a systematic process that aims to determine if aspects of a policy or program can potentially affect the health of the population and whether conducting an HIA is appropriate or not for a particular project or policy. Tools developed for carrying out this stage generally incorporate analysis grids listing the determinants of health in relation to which the public policy in question should be examined. Analysis grids that integrate concern for health inequities can simultaneously examine the effects of a proposal on the determinants of health and the distribution of these effects within vulnerable groups, sometimes through the use of two separate columns (see, for example, *An Easy Guide to Health Impact Assessment for Local Authorities* (Egbutah & Churchill, 2002)). Sub-groups may be defined geographically, economically, according to cultural identity, or based on other factors linked to age or to mental or physical condition, for example, that may result in fragility.

#### **At the scoping stage**

The scoping stage serves two main functions: identification of the type of information needed for the impact analysis and of the method to be used to gather that information. Thus, taking health inequities into account means identifying the sub-groups about which specific information is needed as well as the nature of the information needed, if this differs from that which will be relevant to the overall population. Including concern for health

inequities throughout the HIA process also implies considering the feasibility of seeking input from persons in sub-groups that may be negatively affected by the proposed policy under study, to get their perspective on how the policy might affect their health.

#### **At the appraisal stage**

At this stage, health impacts are analyzed on the basis of the results obtained during the previous stages in order to evaluate the scope and scale of these impacts. At the epidemiological level, it may be difficult to clearly establish the potential effects of a policy on specific groups within the population. Faced with this difficulty, it is sometimes suggested that the direction rather than the magnitude of effects be identified (Parry & Scully, 2003). It can also be very difficult to identify all sub-groups and to make appropriate choices between groups considered vulnerable and the general population. It is sometimes necessary to make compromises when choosing between improving the health status of the general population, improving the health of the most vulnerable people and reducing disparities. The formation of a multidisciplinary scientific committee, including partners from a variety of backgrounds, is therefore recommended as a way to resolve the dilemmas associated with these choices (Ison, 2000).

#### **At the reporting stage**

Reporting involves identifying potential health effects and their distribution within the population. Reporting also includes suggesting possible changes. This stage should be guided by transparency. Thus, the report lays out the rationale behind the choice of sub-groups analyzed, as well as any uncertainty surrounding the results reported, if applicable. It is sometimes suggested that results be presented in the form of matrices, which makes it possible to illustrate various trends within sub-groups and within the population in general (Mahoney, Simpson, Harris, Aldrich & Stewart-Williams, 2004). (See, for example, the guide entitled *Improving Health and Reducing*

*Inequalities*, Welsh Health Impact Assessment Support Unit).

### At the evaluation stage

In the literature, this stage is presented in three ways (Ison, 2000). The first stresses the importance of monitoring the effects of implementing the policy whose health impacts were assessed. In this case, it is necessary to identify indicators that will be monitored to assess the real effects on inequities of the policy choice. Alternatively, this stage is conceptualized as a reflective exercise, whose purpose is to review the process as a whole. This involves a critical analysis of the efforts made to take into account the differential effects of the proposed policy. Finally, the third approach advises practitioners to assess the influence the process has had on decision

making. To this end, the question of how decision makers reacted to the information about differential effects and to the proposed changes should be examined.

### For further information

HIA guides that consider health inequities

- Equity-Focused HIA Framework (Australia)
- A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health (New Zealand)
- Whanau Ora Health Impact Assessment (New Zealand)
- Health Inequalities Impact Assessment: Screening; Rapid Appraisal Guidance and Notes (United Kingdom)

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### Further reading

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