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Health Equity Assessment

Facilitators and Barriers to the Application of Health Equity Tools

CASE STUDY ANALYSIS

October 2014

Public Health Ontario

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Abbreviations

ABHI	Australian Better Health Initiative
CHETRE	Centre for Health Equity Training Research and Evaluation
EFHIA	Equity-Focused Health Impact Assessment
GHS	Goodooga Health Services
GWAHS	Greater Western Area Health Service
HEA	Health Equity Audit
HEAT	Health Equity Assessment Tool
HEIA	Health Equity Impact Assessment
HIA	Health Impact Assessment
HiAP	Health in All Policies
MOHLTC	Ministry of Health and Long-Term Care
NDHB	Northland District Health Board
NSW	New South Wales
PHO	Public Health Ontario
NHS	National Health Service
PCT	Primary Care Trusts
WOHIA	Whanau Ora Health Impact Assessment

Introduction

This report presents an analysis of the application of selected health equity assessment tools (HEATs) from Australia, New Zealand, United Kingdom and Canada. The content, current as of June 2012, is organized into two parts:

- **Part 1 - Summary of Facilitators and Barriers:** Summarizing factors that facilitate or hinder the application of HEATs and uptake of resulting recommendations
- **Part 2 - Case Studies:** Summarizing a selection of existing practices in the application and evaluation of health equity-focused tools

WHAT IS HEALTH EQUITY?

Health equity is the absence of systematic, socially-produced (and therefore modifiable) and unfair differences in one or more aspects of health across populations or population groups; defined socially, economically, demographically, or geographically.[1] We can improve health equity by:

- Targeting resources or programs
- Addressing disadvantaged populations or key access barriers
- Looking for investments and interventions that will have the highest impact on reducing health disparities
- Enhancing opportunities for good health of the most vulnerable
- Building health equity into all health planning and delivery[2]

WHY USE HEALTH EQUITY ASSESSMENT TOOLS?

Health equity-focused impact assessment is one of the 10 promising practices used to guide local public health practice to reduce social inequities in health.[3] HEATs provide systematic steps for health policy makers, program planners, and researchers to assess their initiative through the lens of health equity. They can be applied at various stages of program or policy development including the planning phase (prospective application), the early implementation stages of a program, or after the program is completed (retrospective application).[4]

Use of HEATs can:

- Provide a structured method to assess potential impacts of proposed policies or programs
- Assess the impact of proposed policies or programs at the general population level
- Assist decision makers to minimize and/or mitigate negative health outcomes
- Increase awareness of social determinants of health and equity considerations among decision makers
- Influence both immediate and long-term policy decisions[3]

WHAT IS THE PURPOSE OF THIS REPORT?

This analysis was conducted to inform application of HEATs in the Canadian context, specifically the application of the Health Equity Impact Assessment (HEIA) tool in the province of Ontario. There are a growing number of health equity tools available,[5] but research on the application and evaluation of these tools is limited.

This report is intended to help public health practitioners:

- Become familiar with various HEATs
- Appreciate the use of these tools through discussion of selected case studies
- Understand facilitators and barriers to the application of HEATs
- Validate experiences with applying HEATs
- Anticipate issues that may arise when planning to incorporate HEATs into practice

WHAT TOOLS ARE EXAMINED IN THIS REPORT?

In this report, we focus on health equity impact assessment tools, including Equity-Focused Health Impact Assessment (EFHIA),[4,6] Whanau Ora Health Impact Assessment,[7] Health Equity Assessment Tool (HEAT),[8] Health Equity Audit (HEA),[9,10] Health Equity Impact Assessment (HEIA).[2]

Many of these tools take their structure from the Health Impact Assessment (HIA). [11] HIA uses structured procedures and methods to assess policies, programs or projects for their potential and often unanticipated effects on the health of the population.[6]

There are many different variations of HIAs, including health equity impact assessment and integrated impact assessment. These bring together components of environmental, social, health, and other forms of impact assessment. The purpose of these HIAs is to incorporate an exploration of all the different ways in which policies, programs or projects may affect physical, social, and economic environments.[12]

HIA vs. HEIA

Classic HIA addresses health equity explicitly (stating equity as one of the principles) as well as implicitly (using a broad definition of health). Some argued that HIA does not adequately identify differential impacts on vulnerable populations, and so health equity-focused tools were developed.[4] Povall et al. examined whether HEIA methodology was needed or existing HIA methodologies were sufficient to assess policy impacts on health equity.[13] This report concluded that:

- Existing HIA methodology is appropriate to address health equity considerations in principle
- More focused application of the equity components is needed to address the full range of equity influences and policy impacts
- To adequately address equity in HIA, a combination of factors is needed, such as time, resources, effective communication, commitment from political and other key decision makers, inter-sectoral collaboration, widespread involvement of civil society, meaningful commitment to effective implementation, and monitoring and evaluation of equity recommendations.

Although HIA is a tool used to assess the impact of policies on health inequity and health in general,[13] particularly in jurisdictions where the Health in All Policies (HiAP) approach is used when developing policies (i.e. European Union and Quebec),[11,14-18] the scope of this report is exclusive to equity focused assessment tools.

WHAT METHODS WERE USED IN RESEARCHING THIS REPORT?

We used written materials and key informant interviews to abstract concepts related to the practical application and evaluation of HEATs.

1) Literature Review

We scanned published and grey literature to identify applications of HEATs, and detailed existing practices and/or evaluation of these tools, including factors that facilitate or hinder the application of tools and the uptake of recommendations. The search is current as of June 2012. The key words used in our search were: health equity, equity lens, health inequity, HIA, health equity impact assessment, health equity tools, evaluation, and application. We used the following databases: Ovid MEDLINE, EBESCO, and Google Scholar. Our search generated 220 articles. We reviewed titles and abstracts for inclusion based on these criteria: 1) English language, 2) describe research in Canada and in countries comparable to our own (i.e., United States, United Kingdom, Europe), 3) publication after 1996, and 4) use of a structured health equity-focused tool. Case studies applying an "equity lens" as a general term rather than a structured tool were excluded, as were case studies of HEATs from developing countries. In our scan of the grey literature, we initially targeted specific organizations and agencies and accessed documents via site-specific search engines. From these findings, we conducted a snowball search using related terms, sites and links. We then conducted a general web search, scanning only the first three pages of results obtained for each combination of search terms used. Materials were assessed for relevance to public health programs and policies, and their potential to inform facilitators and barriers to the application of HEATs. Case study material was also supplied by key informants.

2) Key Informant Interviews

Ethics approval for the interviews was granted by the Research and Ethics Board at the University of Toronto. Interviews were conducted from May to July 2012. We selected experts from Canada, Australia and New Zealand based on their knowledge and experience designing, implementing, and/or evaluating health equity-focused assessment tools. We invited seven key informants representing Canada (Ontario, British Columbia, and Manitoba), Australia and New Zealand to participate in individual, semi-structured qualitative interviews, all of whom took part in the study. In advance of the interviews, we sent them questions regarding:

1. Factors that encourage the application of HEATs and uptake of recommendations
2. Factors that hinder the application of the tools
3. Questions related to evaluating the use of these tools
4. Key outcomes of applying assessment tools
5. Factors that facilitate/support the evaluation of the tools
6. Any metrics that discussants could propose to evaluate health equity-focused tools

Data was managed in Microsoft Excel. Thematic analysis was used to identify, analyze and report on facilitators and barriers emerging from both sources above.[19,20] Common themes emerged directly from

case studies and key informant interviews. In some cases, similar constructs were merged into themes derived from analysis of the data. Data were organized into categories as these emerged from the analysis.

WHAT ARE THE LIMITATIONS OF THESE METHODS?

Much of the case study material informing this review was gained through searching of the grey literature, the limitations of which include lack of reproducibility, variability in terminology, and search engine limitations.[21] Records of how health equity tools are applied in public health and other program policies are likely kept within institutional files and are not available to the public. This review does not take into account the important equity assessment work done in developing nations.

Key informants were chosen from individuals involved in the application of HEATs. They do not represent all jurisdictions included in this report. Furthermore, as with all qualitative methodology, key informants interviewed might be biased in certain ways.[20] For example, key informants may favour one type of tool over another, or they may over or under-emphasize certain advantages and disadvantages of using particular tools.

Summary of Lessons Learned

Facilitators and Barriers to Application of Health Equity Assessment Tools

Facilitators and barriers to the application of health equity tools derived from the analysis of case studies and key informant interviews are summarized in Tables 1 and 2. Themes that support the application of HEATs were identified as a clear mandate to support health equity assessment, organizational commitment and readiness, attention to team composition and dynamics, and attention to project planning. The themes that hinder the application of HEATs were identified as competing priorities; lack of organizational commitment, readiness and resources; and lack of shared understanding. Facilitators and barriers were categorized according to system, organizational and operational levels as follows.

SYSTEM LEVEL FACILITATORS AND BARRIERS

We identified system level factors as those that affect the application and uptake of the tool arising from the socio-political environment in which the health care system operates. Mandated use of tools and embedding health equity into system performance targets were found to be the main facilitators for use of health equity tools. These facilitators also operate on the organizational level (below). Mandating use of the tools may also result in allocation of funds. This may be helpful as key informants noted that a lack of resources was a common barrier to applying health equity tools.

ORGANIZATIONAL FACILITATORS AND BARRIERS

We identified organizational level factors as those that relate to how responsibilities are assigned and controlled among different levels of management. Support from leaders and policy makers, buy-in from management, and organizational readiness were all found to facilitate use of equity planning tools. Specifically, a lack of discussion about applying the tools at the management level was found to be a barrier.

OPERATIONAL LEVEL FACILITATORS AND BARRIERS

We identified operational level factors as those that emerge during the application of the tools by end users. Project management factors, including a clearly defined approach, detailed information collection strategy and assignment of skilled staff to conduct and analyze data were all found to be important facilitators. The need for trust, common purpose and good working relationships among project group members was also emphasized. Differing views on health equity and difficulty reaching consensus regarding the nature and extent of health equity impacts were noted as barriers to successful

application of the tools. Lack of data to support consensus and reliance of expert opinion exacerbated this issue.

Table 1. Facilitators to applying HEATs

System Level Facilitators	Organizational Level Facilitators	Operational Level Facilitators
CLEAR MANDATE – Mandated use of the health equity tools at a health system level appears to increase uptake and completion* **LINK TO EVALUATION** – Use of health equity tools embedded into performance management incentives that are linked to national and regional inequality targets#	**CLEAR MANDATE** – Mandated use of the health equity tools at an organizational level appears to increase uptake and completion* – Having an organizational health equity plan# **ORGANIZATIONAL COMMITMENT AND READINESS** – Supportive views of public health leaders and key policy makers, including organizational management^ **LINK TO EVALUATION** – Use of health equity tools embedded into performance management incentives that are linked to national and regional inequality targets#	**ATTENTION TO TEAM COMPOSITION AND DYNAMICS** – Manageable size of a highly skilled working team* – Representation of a range of organizations on the working team^ – Generating trust and common purpose within working team# – Developing a team consensus on basic equity definitions early in the assessment process# **WELL CONSIDERED PROJECT PLANNING AND METHODOLOGY** – Highly skilled project management^ – Clearly outlined approach detailing each stage of the application process and information collection strategy# – Specific and well-defined roles for working team participants# **APPROPRIATE SKILLS AND AVAILABLE SUPPORT** – Availability of literature and other sources of information/data* – Availability of technical support from skilled professionals, including national/provincial guidance on application of specific tool(s) used^ – Ability of working team staff to conduct literature reviews and analyze quantitative and qualitative data^

Source: ^directly from case studies, #directly from key informant interviews, *derived from analysis

Table 2. Barriers to applying HEATs

System Level Barriers	Organizational Level Barriers	Operational Level Barriers
– Absence of facilitators* **COMPETING PRIORITIES** – Allocation/re-allocation of resources to acute issues[#] – Conflicting priorities between different health sectors, e.g. local health unit interested in applying the tool to a program but provincial/ national bodies interested in implementing the program [#] – Political pressures to adopt programs or policies without equity consideration[#]	– Absence of facilitators* **LACK OF ORGANIZATIONAL COMMITMENT AND READINESS** – Lack of discussion on applying the tool at management level[#]	– Absence of facilitators* **FINANCIAL AND HUMAN RESOURCES CAPACITY** – Lack of resources (financial/human)[^] – Capacity of the healthcare sector to conduct research, access different types of information and analyze data[^] – Time constraints[^] **LACK OF SHARED UNDERSTANDING** – Differing views on health equity/inequities among working group members[#] – Difficulty in reaching consensus regarding the nature and extent of health inequities, i.e., subjectivity of the tools[#] – Lack of clarity in purpose or process [#] **LACK OF DATA** – Lack of data to support consensus[#] – Reliance only on expert opinion, limited availability of literature, and subjective interpretation[#]

Source: [^]directly from case studies, [#]directly from key informant interviews, *derived from analysis

Facilitators and Barriers to Uptake of Health Equity Assessment Recommendations

We were also able to identify some facilitators and barriers to the uptake of the recommendations generated by HEATs (see Table 3). These were primarily at the system and operational levels.

Timing was the most important theme that emerged. This was in reference not only to the timing of the application of the HEAT in the program planning cycle, but also the timing of the application of the tools with consideration of the political climate.

Some key informants noted that often the political climate is a barrier to the uptake of recommendations. However, having a clear systems mandate to improve the health of vulnerable populations supported not only the application of the tools (above) but also the adoption of any resulting recommendations from the application of the HEAT.

Uptake of recommendations from completed projects was facilitated through involvement of community input during the application phase.

Table 3. Facilitators and barriers to uptake of recommendations arising from HEATs

	System Level	Operational Level
Facilitators	**CLEAR MANDATE** – Constitutional commitment to improve health of vulnerable population such as indigenous people^ **TIMING** – Knowing the right time to apply the tools in order to influence policy#	**PARTICIPATION** – Involving community in the process^ **TIMING** – The timing of applying the tool (planning phase)^
Barriers	**POLITICAL CLIMATE** – The broader political decision-making context#	**TIMING** – The timing of application of the tool (retrospective)^

Source: ^directly from case studies, #directly from key informant interviews, *derived from analysis

Case Studies

We identified examples of HEATs in Australia, New Zealand, United Kingdom and Canada. These studies varied significantly with regard to how the tools were applied and evaluated. Below we highlight examples that illustrate lessons learned, including factors encouraging or hindering the application of health equity-focused tools.

EQUITY-FOCUSED HEALTH IMPACT ASSESSMENT

Country: Australia

Description: Equity-Focused Health Impact Assessment (EFHIA) [4] is used to determine the potential differential and distributional impacts of a policy, program, or project on the health of the population or groups in the population, and assesses whether differential impacts are inequitable.

Application notes: The EFHIA has been described for use in decision support, advocacy, and prospective and retrospective applications.[22] It has been used for a broad range of initiatives including public health, community funding programs, hospital construction planning,[23] and continuing professional development for medical specialists working in rural areas.[24]

1.1 EFHIA: Australian Better Health Initiative Implementation Plan[25]

Brief Summary of Initiative: As outlined in the EFHIA report, the Australian Better Health Initiative (ABHI) aims at achieving better health for all Australians. This initiative provides for the implementation of a range of activities promoting good health and reducing the impact of chronic disease. The New South Wales (NSW) government had committed $20 million, from mid-2006 for a four year period to support the implementation of the ABHI in NSW across these two priority areas. Implementing a range of initiatives within these areas will build on the considerable work already being implemented across the state.

> **“You really need to put equity into all planning. How could you deliver health promotion without taking into account equity in hospital planning or community health centres? ”**
> **– Key informant**

HEAT Application: As part of the consultation process on the ABHI Implementation Plan, the Centre for Health Equity Training, Research and Evaluation (CHETRE) was asked to comment on the proposal. Following discussions with NSW Health it was decided to undertake a rapid EFHIA to improve the equity focus of the ABHI Implementation Plan on eight initiatives in two priority areas: promoting healthy lifestyles and supporting lifestyle and risk modification. It is noted in the EFHIA report that as the potential health impacts of the ABHI initiatives are potentially large and the level of investment is high, normally a minimum of a 6 –12 week period would be recommended to undertake the EFHIA. However, in order to be able to contribute to the policy process within a tight time frame it was decided to undertake a rapid EFHIA which involved a six hour workshop and two teleconferences with the Steering Committee. The work was undertaken over four working days by the equivalent of two full time staff members. Time constraints limited the number and range of people who could be involved in the Steering Committee, and the level of external consultation that could be undertaken, especially with the population groups that had been identified. The process was largely informed by expert opinion and the key documents that were used. As a result, authors report that some of the analysis was somewhat superficial and they were unable to unpack the complexity in looking at each of the population groups. Under these conditions, however, the EFHIA was successfully applied at a total cost of USD$4306. The original ABHI plan was redrafted to include the general and specific equity-related recommendations, without changing the overall funding model.

Lessons Learned: Based on key informant interviews, this application showed that the EFHIA could be applied during the time frames within which policy-makers operate and at minimal cost. The parameters outlined by the health department provided a clear focus and transparency to the working committee in terms of time and scope of the activities to be undertaken. An important facilitator is ensuring the appropriate size, skills and working relationships of the team applying the HEAT. In addition, the application of the EFHIA was facilitated by the small size of the highly skilled working committee which represented a range of organizations (health sector, university, community, non-governmental organizations, expert from another jurisdiction). Both these factors reportedly encouraged broad discussion and appeared to allow for a sense of common purpose, trust and willingness to accept the restrictions under which the EFHIA was being applied.

1.2. EFHIA: Good for Kids for Life Child Obesity Prevention Trial Program[26, 27]

Brief Summary of Initiative: The goals of the Good for Kids program were to reduce the prevalence of child overweight and obesity in the Hunter New England region and to build evidence for policy and practice related to the prevention of child obesity in New South Wales (NSW). The focus of the overarching program was on children aged 2 - 12 years. The Good for Kids program adopted a multi-

setting capacity-building approach, based on the view that for healthy eating and physical activity to become the norm for children, the community settings with which they interact need to foster these behaviours. This capacity-building approach was implemented in seven community settings with interventions targeted at particular age groups.

> **"Have someone at the end of a line to answer questions…or have a virtual community where interested users can drop questions and get answers from those who have skills. These will help those who are applying the tool from getting stuck in the process."**
> **– Key informant**

HEAT Application: An EFHIA was undertaken to ensure the Good for Kids program plan did not exacerbate existing inequalities between Aboriginal and non-Aboriginal communities. A working party was established to conduct the EFHIA, and the EFHIA itself occurred over the period of February to June, 2007. The EFHIA was supported through the NSW EFHIA development site project, which provided training and access to resources from the University of NSW CHETRE. The identification, assessment, decision-making and recommendations steps were conducted by a working party of Aboriginal leaders. Most work conducted by the EFHIA working party took place following scheduled meetings of the Good for Kids Aboriginal Health Stream Advisory Group, which were held roughly every two months. Some additional meetings, such as the Impacts Identification Workshop and follow-up meetings, were also held. The EFHIA identified more than 80 areas within the program plan that required modification to meet equity goals. The recommendations included incorporating additional settings and target areas for the program, for example, focusing on Aboriginal health workers, amending Good for Kids resources to include culturally safe and appropriate material, and highlighting gaps in the program where additional planning and strategies were required. The EFHIA recommendations were endorsed by the Good for Kids Aboriginal Health Advisory Group in late 2007. The program's senior management body agreed to make recommended changes to Good for Kids at a Program Advisory Committee meeting in December 2007.

Lessons Learned: According to the authors of the report, EFHIAs are generally undertaken prior to the commencement or implementation of a policy or program. The Good for Kids EFHIA was conducted after the program plan had been developed and program implementation had already commenced. This situation was unavoidable due to the need for effective consultation with Aboriginal communities and external political pressure to implement the program. However, the working party was able to assess the program in depth due to the quality and extensiveness of the Good for Kids program plan. This enabled practical and direct recommendations to be produced which were then understandable and had relevance for Good for Kids program staff. However, the management of the inclusion of the EFHIA recommendations would have been more efficient if the EFHIA had been conducted prior to program plan confirmation and program commencement.

1.3 EFHIA: Australian Capital Territory (ACT) Health Promotion Board Community Funding Program[28]

Brief Summary of Initiative: The Australian Capital Territory Health Promotion Board (Healthpact) funds community health promotion activities through small targeted community grants. This process is managed by the Healthpact Community Funding Program.

HEAT Application: A working group used various resources to complete the EFHIA, including literature reviews; review and analysis of key ACT policy documents; interviews with key informants within ACT; half-day workshops with the community, government organizations and consumers; and content analysis of funding applications for one budget year. By using the EFHIA tool, they identified ways to strengthen the equity focus, including re-emphasizing the importance of giving funding priority to projects that seek to address health inequality.

Lessons Learned: Challenges in the assessment process resulted from different interpretations of health impact(s), understanding of effective responses to reduce health inequalities, and the role of health promotion in reducing inequities/inequalities. Authors conclude that more information is required about how divergent views/conflicting evidence should be reconciled and how the trade-offs are made. They also discuss the need for greater clarity about how different types of information are managed, for example, whether stakeholder views are prioritized over the literature review. The project team subsequently developed a matrix to illustrate – compare and contrast – the information provided by each source in response to the three questions that the EFHIA sought to address in order to mediate some of these issues.

1.4 EFHIA: Goodooga Aboriginal Community Health Services[29]

Brief Summary of Initiative: A review was commissioned in late 2008 by Greater Western Area Health Services (GWAHS) to inform proposed changes to the Goodooga Health Service (GHS). The Goodooga community is in remote rural New South Wales (NSW); its population is largely indigenous. In February 2009, the review of GHS was presented to the Goodooga community, and at this meeting GWAHS agreed the recommendations from the impact assessment would be considered with the review team to inform the implementation plan being developed concerning GHS.

HEAT Application: The EFHIA was applied by the Goodooga community which agreed that CHETRE would assist in the analysis of evidence from a number of sources to inform the appraisal of impacts. This evidence included a community survey, community case studies developed from interviews, the international literature on provision of health care in indigenous communities, and Australian and NSW policy documents and data in relation to indigenous health. The community agreed that while this evidence was important, the most important voice to inform the appraisal of potential impacts was their own. Therefore, a number of community workshops were conducted during March 2009 to work through the tool. In addition, notes from these discussions were sent to each household in Goodooga

and any responses were collated and incorporated into the final report.

Lessons Learned: This is an example of the "community led" typology of impact assessment application.

THE WHANAU ORA HEALTH IMPACT ASSESSMENT

Country: New Zealand

Description: The Whanau Ora Health Impact Assessment (WOHIA) [7] is specific to its indigenous/Māori population. It includes two appraisal levels: the Health Appraisal Tool (for detailed equity assessment) and the Health Lens (for less detailed policy or program assessments). New Zealand also has a Health Equity Assessment Tool (HEAT)[8] which was not used because no inclusion criteria were found.

Application notes: In New Zealand, although use of the WOHIA tool is not strictly mandated, there exists a constitutional agreement to improve the health of the Māori people. This agreement has been attributed to the development of the tool and its application to a wide range of issues (health care sector and non-health sector) that affect the health of Māori.[30] Many of these studies used a standardized reporting framework developed by the New Zealand Health Ministry's HIA Support Unit. Standardization of case study documentation assists practitioners in report writing and standardizes data elements for future evaluation activities. Refer to the published guide to writing HIA case studies.[31]

WOHIA: Wairarapa District Health Board Regional Alcohol Strategy[32]

Brief Summary of Initiative: Wairarapa is a region of New Zealand on the south-eastern corner of the North Island, east of metropolitan Wellington and south-west of the Hawke's Bay region. The draft Wairarapa Alcohol Strategy was developed by the local Community Alcohol Action Group, which consists of 15 governmental and non-governmental organizations. The draft strategy was developed with a vision to create an environment in which alcohol-related activities could be enjoyed with minimal risk of harm to the community. The overall goal of the strategy was to reduce alcohol-related harm in the Wairarapa.

HEAT Application: The WOHIA was applied by a health promoter in the public health unit who coordinated the project. A literature scan, group facilitation and evaluation appear to have been contracted by the health unit to aid in the completion of the WOHIA.

Lessons Learned: The case study report included detailed descriptions of lessons learned including:

- Getting the right people on board from the beginning and ensuring that a wide voice of the community was involved in the WOHIA.
- Gaining buy-in from key stakeholders (including authors of the draft strategy) and engaging with those stakeholders who were unable to attend, ensuring that they understood the WOHIA process clearly and were comfortable asking questions.
- Ensuring that everyone was informed of each step no matter how involved or uninvolved they were in the WOHIA.
- Having skilled researchers with the ability to complete a rapid scan of relevant literature within a short time frame and still produce useful results.
- Ensuring the participants' voices are heard in the final report while backing up (with evidence) what was said by participants is essential to ensuring a well-rounded argument.

> **"If someone (mid-level decision maker) is involved in the HIA process, they understand what we mean by health equity, and what comes out of doing the assessment… so they don't say at the end, 'Where did this come from?'"**
> **– Key informant**

WOHIA: Northland District Health Board Prioritization Policy [33,34]

Brief Summary of Initiative: District Health Boards are required to carry out principles-based prioritization processes in order to meet the objectives of the New Zealand Public Health and Disability Act 2000. Northland District Health Boards (NDHB) undertook a WOHIA of its existing prioritization policy, with a view to developing a new prioritization policy.

HEAT Application: The WOHIA assessed the whole NDHB Prioritization Policy (2005), including both its content and its implementation. The project team responsible for conducting the WOHIA included NDHB staff with consultant and evaluation support. A steering group comprised of 10 senior NDHB staff was set up to provide governance for the WOHIA. This group was responsible for setting the direction of the WOHIA and overseeing the process. The governance group was also responsible for carrying the recommendations forward once the WOHIA was complete. Methods were selected by the steering group, and consisted of both qualitative and quantitative methods including a rapid literature search, review and analysis; analysis of prioritization policies from other DHBs; development of a NDHB community profile; and four stakeholder workshops.

> **"You can have a great tool, but if the organization is not ready and there is no discussion or buy-in from top management, then it's not going to work."**
> **– Key informant**

Lessons Learned: A major strength of this application was support from senior management at the NDHB, including indicating strong support for the redevelopment of the prioritization policy and for future WOHIAs in Northland. In addition, appraisal workshops were well facilitated, ensuring everyone understood why the WOHIA was being done, the time it would take to go through the process, the concepts, the stages, the policy, the outcomes of scoping and initial appraisal, and the strengths and weaknesses of the policy. According to the WOHIA evaluation report, the strengths far outweighed the constraints, which were resource limitations and the high level and sensitive nature of the prioritization policy. This WOHIA has been particularly valuable for NDHB in relation to increased knowledge and capacity for DHB staff and general buy-in to the WOHIA process, particularly from senior management. It was also valuable for stakeholders and for other DHBs who could use the evidence to inform the revision of their own prioritization policies.

HEALTH EQUITY AUDIT

Country: United Kingdom

Tool description: The Health Equity Audit (HEA)[7] is a national tool used to assess health equity considerations. It consists of six stages including a health equity profile, finding evidence to identify local action, and reviewing progress against local targets.

Application Notes: Common features of HEA reports include: a quantitative nature with the focus on service; need-to-use ratios by gender, age, ward, and population; use of routine data collected from different sources, e.g., health care provider, regional data, national data, and disease-specific registry; and focus on understanding the patients' perspectives on services in order to design a better intervention and generally supplement the quantitative results.[35-39] In a preliminary survey in 2005, the London Health Observatory and Association of Health Observatories identified factors that most influenced the services to which HEA was applied: 1) the views of the director of public health, 2) the manageability of the issue within existing resources, and 3) the existence of a good evidence base for health inequality related to the issue being addressed. The least important influence was the strategic partners' views.[40] This survey also found that the person most frequently leading the HEA process was the director of public health, explaining the director's role as a significant influencing factor.

HEA: Learning from Practice Briefing[41]

Brief Summary of Initiative: Health equity audit (HEA) was being undertaken by Primary Care Trusts (PCTs) across the country to meet the requirement in the National Health Service (NHS) priorities and planning framework prior to the dissolution of PCTs in 2011. All PCTs were expected to conduct at least

one HEA annually.[40] A briefing providing a summary of learning from three workshops on HEA, including examples of completed or near-completed HEAs, summarize a variety of learning points from case studies.

HEAT Application: HEA has been applied to a diverse range of health conditions and related services including diabetes, chronic obstructive pulmonary disease, chronic heart disease, and children's health and dental services. PCTs were required to carry out HEAs to inform the execution of local health plans, community strategies, local neighbourhood renewal strategies and local development plans. Strategic health authorities also had a role in relation to HEAs with their responsibility for performance management of the PCTs. From the HEA case study analysis it was found that the choice of audit topic was influenced by:

- availability of data
- understanding of local inequality gradient and known areas of concern
- opportunity to assess the impact of services on traditionally underserved groups such as travellers
- resources available, including availability of public health analysts, health economists, statisticians and epidemiologists
- time available and requirements for information to feed into the planning process

> **"In order to increase the uptake of tools, you need to attach or align them with the pressures and drivers of organizational changes. You need to either require it or provide incentive to do it."**
> **– Key informant**

Lessons Learned: While discussing several of the challenges and benefits found in other case studies included in this report, such as the importance of gaining support from upper management and the importance of partnerships both within and beyond the NHS, the HEA briefing discusses the use of quantitative data in health equity assessments data. Measurement challenges include the selection of equity dimensions; the choice of measures of need and provision; the choice of comparators; the types and sources of data to use; and identification of resources to analyse and interpret the findings. The availability and format of data is a key development issue in HEA and is often a critical factor in influencing change. The main concerns relate to:

> **"Sometimes it is difficult to find evidence that recommendations are picked up by policy makers as they appear in the document …. By the time they are implemented they often end up looking quite different from what is originally proposed."**
> **– Key informant**

- selecting measures of need

- geographical limits of many data sets
- lack of local baseline prevalence data for a number of public health priorities
- lack of monitoring information of prevention and community-based activities that take account of deprivation and ethnicity
- availability of ward-based data within a reasonable timeframe
- interpretation of profile data

In terms of impact, establishing HEA as a routine audit tool to inform planning and decision making has been of great value in a number of PCTs. The most significant changes appear to be achieved when the audit feeds into the business planning process of all organizations influenced by the audit.

HEALTH EQUITY IMPACT ASSESSMENT

Country: Canada

Description: The Ministry of Health and Long-Term Care (MOHLTC) collaborated with Public Health Ontario (PHO) to develop the Health Equity Impact Assessment (HEIA) tool. HEIA provides a pragmatic and practical five step approach to incorporating equity into health systems.[2]

Application notes: Ontario appears to be the only Canadian province with an established HEAT. It appears that various health equity-focused tools are being investigated and applied within provinces, regional health authorities, public health units, and community agencies. Through key informants we learned of pilot studies that use HEAT (Manitoba) and EFHIA (Manitoba, Ontario), and that other provinces are also investigating the potential use of health equity-focused tools in their ministries. While the province of Quebec has not endorsed a particular HEAT, the province uses HIA for policies and programs that effect the health of Quebecois.[19] British Columbia Core Programsrefers to an equity lens to be incorporated into the public health renewal process,[42] enhancing the identification of health inequities, with a particular emphasis on the social determinants of health. British Columbia has also included a measure that supports the practice of HIA in its new Public Health Act.[43]

HEIA: Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario[44.45]

Brief Summary of Initiative: The "Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario" report provides the Ontario government with evidence to guide actions aimed at reducing chronic diseases through primary prevention at the population level. It proposes 22 recommendations for policies and other interventions to address four major risk factors associated with chronic disease: tobacco use, alcohol consumption, physical inactivity, and unhealthy eating.

To examine how recommendations proposed in "Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario" may unequally impact Ontarians, a secondary assessment was conducted using the Ontario MOHLTC's Health Equity Impact Assessment (HEIA) tool.

HEAT Application: The HEIA was completed in two months by a full-time research assistant and part-time epidemiologist. Literature search and five key informant interviews informed the process.

Lessons Learned: The application of the HEIA tool to the 22 recommendations for policies and other interventions in the "Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario" report found that evidence was not indexed in a standard way, which made it hard to find using standard search strategy. This was in spite of extensive literature searches performed in PubMed, Google Scholar and Google to compile published and grey literature that assessed the unequal impact of similar policy recommendations and potential mitigation strategies. In most cases there was a lack of literature directly related to the recommendations, so where research studies were available for similar initiatives (e.g. healthy food choices in adults as opposed to children), some of these were used to inform the HEIA.

Conclusion

This report presented facilitators and barriers to the application of HEATs based on selected case studies from Australia, New Zealand, United Kingdom, and Canada. Several common themes emerged from the cases examined, including the need for a clear mandate to conduct health equity assessments, organizational commitment and readiness, appropriate skills and available support, and the need for shared understanding and data challenges.

In summarizing these themes as facilitators and barriers to use of HEATs and the adoption of recommendation, this report is intended to help public health practitioners:

- become familiar with various HEATs
- appreciate the use of these tools through discussion of selected case studies
- understand facilitators and barriers to the application of HEATs
- validate experiences with applying HEATs
- anticipate issues that may arise when planning to incorporate HEATs into practice

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