

Making the case: health equity audit

Introduction

This briefing aims to provide guidance to the NHS and local government on undertaking health equity audits (HEA).

It is one of a series of 'Making the case' briefings which aim to increase understanding of the impact of social, economic and environmental influences on health and health inequalities, and to promote effective action. The briefings are targeted at primary care trusts (PCTs) and local authorities working together through local strategic partnerships (LSPs).

Policy framework

- The requirement for PCTs to use HEA to inform service planning and delivery was set out in the NHS *Priorities and planning framework 2003–2006* (DH, 2002). This has since been reinforced in the planning framework issued by the DH for 2005/06–2007/08 (DH, 2004a).

What is HEA?

HEA is a process through which local partners systematically review inequities in the causes of ill health, and in access to effective services and their outcomes, for a defined population. Actions required to make services more equitable (thereby reducing inequalities) are agreed and incorporated into local plans, services and practice. It is now mandatory that PCTs carry out HEAs. (HDA, 2005a)

- The Healthcare Commission's performance indicators for the 2004–05 star ratings include HEA (as a balanced scorecard indicator): the effective use of health equity auditing in service planning, commissioning and delivery to tackle health inequalities (for England).
- The Healthcare Commission's proposals for assessing performance against the national healthcare standards (set by the Department of Health) include HEA as a marker of compliance with the core and developmental public health standards.
- *Tackling health inequalities: a programme for action* (DH, 2003a) provides a focus for activity at national and local levels. Health equity audit is now seen as a vital part of the planning process for tackling health inequalities, and one of the tools in achieving the DH's national public service agreement (PSA) target of reducing inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth, and local health inequalities targets.
- Tackling the determinants of health does not automatically reduce health inequalities; an overall improvement in health outcomes can mask widening local area-based inequalities. It is recognised that policy needs to focus on the unequal distribution of determinants (Graham and Kelly, 2004).

Making the connections locally

- The public health white paper *Choosing health* and its delivery plan (DH, 2004b, 2005) emphasise the importance of PCTs and local authorities working jointly to plan services, and to check on progress in reducing inequalities, through the use of health and wellbeing equity audits.

- The national *Health and social care standards and planning framework 2005/06–2007/08* (DH, 2004a) emphasises the need for a joint approach: ‘PCTs and their partner organisations should demonstrate that they have taken account of different needs and inequalities within the local population, in respect of area, socio-economic group, ethnicity, gender, disability, age, faith, and sexual orientation, on the basis of a systematic programme of health equity audit and equality impact assessment.’
- In developing local plans, PCTs should ensure that they:
 - are in line with population needs
 - address local service gaps
 - deliver equity
 - are evidence-based
 - are developed in partnership with other NHS bodies and local authorities
 - offer value for money.
- Local strategic partnerships are expected to play a key role in overseeing local action to tackle inequalities. Health equity audits can provide a common framework for all LSP partners to assess the contribution their services are making, and help allocate resources across the priorities agreed in the community strategy, the local neighbourhood renewal strategy, the local delivery plan (LDP), and their main themed strategies.
- Guidance on LDPs (DH, 2004c) states that: ‘narrowing health inequalities should be an integral part of the local delivery plans. All PCTs are expected to conduct health equity audits on issues which will have a significant impact on inequalities, to publish the results, and ensure action is reflected in plans of sufficient scale to address service gaps and deliver equity.’
- Health equity audit can help PCTs and local authorities jointly develop local public service agreement targets and local area agreements (in the pilot areas) on health inequalities.
- Health equity audit can be used by local authority health scrutiny committees.

Health inequalities and health equity

The *Independent inquiry into inequalities in health* (Acheson, 1998) summarised the evidence for inequalities in health and life expectancy in England, and made tackling health inequalities a policy priority. The recent public health white paper *Choosing health* (DH, 2004b, chapter 4) states that:

‘...although on average we are living healthier and longer lives, health and life expectancy are not shared equally across the population. Despite overall improvements, there remain big and in some communities increasing differences in health between those at the top and bottom ends of the social

scale. There are unacceptable differences in people’s experience of health between different areas, and between different groups of people within the same area.’

Definitions

- **Health inequality** describes differences in health experience and health outcomes between different population groups according to socio-economic status, geographical area, age, disability, gender or ethnic group.
- **Health inequity** describes the different health outcomes of separate population groups that are the result of the inequitable access and opportunity to access the determinants of good health, such as health services, nutritious food, adequate housing, etc.
- **Equity** is concerned with how fairly resources are distributed throughout a group of people according to the needs of a population and not the individual. Equity can be defined as equal resource (access, use or quality) for equal need (Dahlgren and Whitehead, 1991).

How to use HEA

In the first instance, HEA can be used to assess different types of health inequalities such as:

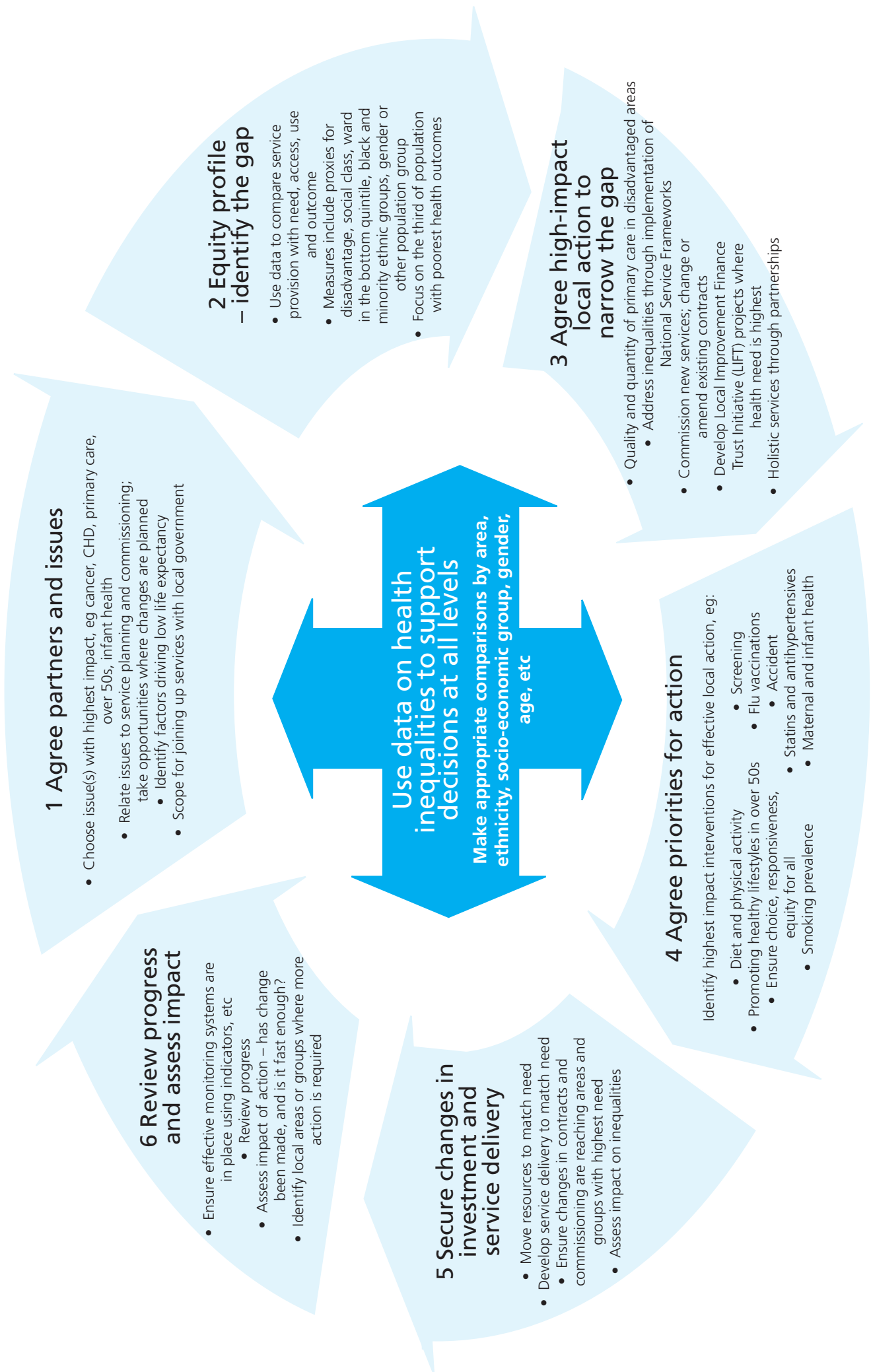
- Socio-economic/environmental circumstances – including employment, housing, education and transport
- Lifestyle and health behaviour – such as diet, smoking, physical activity, social networks
- Access to effective health or social care (eg GP access, hospital waiting times, proximity to services) or other services (such as leisure services).

Why use HEA?

Health equity audit:

- Is a ‘must do’ – and is a powerful process for bringing about change
- Leads to changes in investment and services that can reduce avoidable health inequalities and improve the determinants of good health, access to health and other services
- Can be used to look at particular groups, areas or services in the NHS and outside – eg cross-cutting audits, which look at how equitable or how fairly distributed a range of services are for specific groups or areas, can be very useful
- Can be used to look at the whole care pathway across different provider agencies to identify where the inequities occur that cause poor health outcomes.

The health equity audit cycle. Source: DH (2003b)



1 Agree partners and issues

- Choose issue(s) with highest impact, eg cancer, CHD, primary care, over 50s, infant health
- Relate issues to service planning and commissioning; take opportunities where changes are planned
 - Identify factors driving low life expectancy
- Scope for joining up services with local government

6 Review progress and assess impact

- Ensure effective monitoring systems are in place using indicators, etc
 - Review progress
- Assess impact of action – has change been made, and is it fast enough?
- Identify local areas or groups where more action is required

2 Equity profile – identify the gap

- Use data to compare service provision with need, access, use and outcome
- Measures include proxies for disadvantage, social class, ward in the bottom quintile, black and minority ethnic groups, gender or other population group
- Focus on the third of population with poorest health outcomes

5 Secure changes in investment and service delivery

- Move resources to match need
- Develop service delivery to match need
- Ensure changes in contracts and commissioning are reaching areas and groups with highest need
- Assess impact on inequalities

Use data on health inequalities to support decisions at all levels
 Make appropriate comparisons by area, ethnicity, socio-economic group, gender, age, etc

3 Agree high-impact local action to narrow the gap

- Quality and quantity of primary care in disadvantaged areas
 - Address inequalities through implementation of National Service Frameworks
- Commission new services; change or amend existing contracts
- Develop Local Improvement Finance Trust Initiative (LIFT) projects where health need is highest
- Holistic services through partnerships

4 Agree priorities for action

- Identify highest impact interventions for effective local action, eg:
- Diet and physical activity
 - Promoting healthy lifestyles in over 50s
 - Ensure choice, responsiveness, equity for all
 - Smoking prevalence
 - Screening
 - Flu vaccinations
 - Accident
 - Statins and antihypertensives
 - Maternal and infant health

Each type of inequality can be broken down, eg by age, gender, disability, geography and ethnicity.

An HEA can be used at a strategic level to identify and evaluate particular problem areas. Individual HEAs can then be carried out for specific issues identified by the strategic HEA. Alternatively, an HEA can be carried out for particular priority services only, perhaps as part of a programme covering the main areas seen to have an impact on health inequalities.

The learning so far

This section outlines some of the key learning so far, identified from research with those carrying out HEAs.

Choosing a topic

The choice of topic for HEA will be influenced by national and local priorities, and may be chosen through a process involving the PCT board, professional executive committee, the director of public health, and key partners in the LSP.

A survey of HEAs carried out by PCTs (Aspinall and Jacobson, 2005) provides examples of topics including prevention, community and clinical services, and different population groups. These topics include the following.

Coronary heart disease – revascularisation

Does the need match supply for residents of the most deprived and the least deprived wards?

Smoking cessation – smoking and social class

Using HEA to assess where the greatest prevalence of smokers are, in line with socio-economic data, undertaking baseline assessment of service provision at both specialist and primary care level, and using this information to plan and commission future smoking cessation service provision.

Access issues – access to local health services

How are people from black and minority ethnic communities using primary and secondary care services?

Diabetes – podiatry

Using HEA to look at access to dietetics and podiatry for South Asian communities.

Health visiting and children's services – school nursing

Is school nursing time allocated in relation to need and measured by educational attainment/free school meals?

Area-based planning and development

Using HEA to look at equity of health and service provision in one part of the borough to inform the development of a neighbourhood management pilot.

Other topic areas, identified during the HDA's masterclasses on HEA, are emerging (HDA, 2005c), which are less NHS-focused. An example might be an HEA looking at users of a council's leisure services to assess which population groups could benefit most from physical activity (compared with, for example, the levels of coronary heart disease in particular population groups in the borough) – leisure services would be retargeted as a result.

Factors for success

The following success factors have been identified (Aspinall and Jacobson, 2005; HDA, 2005b):

- Availability of good quality data
- Knowledge and understanding of available data (eg with support from public health observatories)
- Training in HEA
- Capacity/staff and leadership to carry out HEA
- Support at the most senior levels (PCT and strategic health authority)
- Support from stakeholders external to the PCT
- Understanding what implementation will mean at the planning stage (and tying in with commissioning timetable)
- Sharing good practice, resources and support with others carrying out HEA.

Making a difference – examples

The HEA cycle is not complete until something changes to reduce inequalities demonstrably (eg resource allocation, commissioning, service provision or care outcomes). There are examples of HEA leading to a change in service provision or resource allocation and, as a result, inequities being reduced. The following provide good illustrations of how the complete HEA cycle can work.

Example 1: Southwark PCT

An HEA for the population of South Bermondsey/North Livesey Neighbourhood Renewal Area was undertaken by Southwark PCT Public Health. It was developed in partnership with the PCT's Locality Director and Southwark Council's Area Renewal Officer. An equity profile of health and access to services for the community was completed and presented to the Neighbourhood Management Group and the Health and Worklessness subgroup of Southwark Alliance LSP. To date, the equity profile has been used by the Neighbourhood Management Group for priority setting. It has informed the development of a Neighbourhood Health Promotion Team, and has been instrumental in the decision to make the health of travellers a focal point. The next steps include updating the equity profile as more information becomes available, and developing further recommendations and informing the planning-for-action process.

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Example 2: Borough of Poole, Young People's HEA

The Borough of Poole undertook an HEA for vulnerable children and young people to identify priorities and inform investment choices for the Children's Fund, the Local Preventative Strategy, *Every Child Matters* and the Children's Act. Agencies working with children and young people in Poole were involved in the HEA. Jan Sayers, Poole Local Government, states: '... areas where children and young people have the greatest needs were identified very clearly from the HEA of both demographic information and performance indicators.' As a result, cross-agency targets have been agreed and progress is being made towards sharing budgets to carry out work.

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Example 3: Huddersfield Central, South Huddersfield and South West Yorkshire Mental Health Trust – Mental HEA

An HEA was undertaken across both Huddersfield PCTs for adults and older people experiencing mental ill health. The dimensions of inequality against which service provision was audited included age, gender, ethnicity and geography. The services against which these dimensions of inequality were audited included outpatients, post-natal depression, admissions, neurosis, GP prescribing rates and suicides. However, not all dimensions of inequality were reported due to variations in data collection between services. The HEA aimed to provide data in a user-friendly format to assist commissioners and service providers in the areas where equity may be an issue, to help inform decisions regarding resource distribution in relation to needs.

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Where to go for guidance and support

Guidance documents

Health equity audit. A guide for the NHS (DH, 2003b). www.dh.gov.uk/assetRoot/04/08/41/39/04084139.pdf

Health equity audit. A self-assessment tool (DH, 2004d). www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4070715&chk=arvA5D

Health equity audit made simple (Hamer *et al.*, 2003). www.hda-online.org.uk/documents/equityauditfinal.pdf

National and regional support

Public health observatories provide technical support for carrying out HEA: www.pho.org.uk

Other tools

Health impact assessment can also be used to inform resource allocation; see HDA (2005d).

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- HDA (2005c) *Learning from effective practice: report from the 2005 health equity audit masterclasses*. London: Health Development Agency.
- HDA (2005d) *Clarifying health impact assessment, integrated impact assessment, health needs assessment, health equity audit and race equality impact assessment*. London: Health Development Agency.

From 1 April 2005, the functions of the Health Development Agency will transfer to the National Institute for Clinical Excellence.

The new organisation will be the National Institute for Health and Clinical Excellence (to be known as NICE). It will be the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

The web address from 1 April 2005 will be www.nice.org.uk.

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