

Practical lessons for dealing with inequalities in health impact assessment

Introduction

This publication is a companion to *Addressing inequalities through health impact assessment* (Taylor *et al.*, 2003a), which described what a focus on inequalities could achieve, offered case study examples, and outlined promising practice. This bulletin discusses recent publications and presents a further two case studies that attempt to address health inequalities through the use of HIA.

Inequalities and health

A key focus of HIA is to reduce inequalities that result from unnecessary, avoidable and unjust differences in health status between different people (Woodward and Kawachi, 2000; Kawachi *et al.*, 2002). This moral and ethical dimension that underpins HIA stems from the values of the World Health Organization's programme of health in the 21st century, which advocates tackling social injustices globally, nationally and locally. The prime minister expressed the importance of inequalities in the report *Tackling health inequalities: a programme for action* (DH, 2003): 'Our society remains scarred by inequalities. Whole communities remain cut off from the greater wealth and opportunities that others take for granted. This, in turn, fuels avoidable health inequalities. Tackling such entrenched and enduring health inequalities is, of course, a daunting challenge. But nor can we any longer ignore these problems.'

There are four main arguments for tackling inequalities:

- Inequalities are unjust
- Conditions that lead to marked inequalities affect all members of society

- Inequalities are avoidable
- Interventions to reduce health inequalities are effective. (Woodward and Kawachi, 2000)

Kawachi *et al.*'s 2002 glossary for health inequalities is helpful background in the context of HIA.

Why address inequalities in HIA?

The Gothenburg consensus paper (ECHP, 1999) describes equity as one of the four underpinning values of HIA – 'where HIA is not only interested in the aggregate impact of the assessment policy on the health of a population but also on the distribution of the impact within the population, for instance in terms of gender, age, ethnic background and socio-economic status.' This is supported by HIA practitioners, who have described addressing inequalities as 'the heart of HIA' (Opinion Leader Research, 2003) and as central to undertaking HIA (Douglas and Scott-Samuel, 2001).

The government-commissioned Acheson Report (1998) also notes the important role HIA can play in addressing health inequalities, by recommending 'that as part of health impact assessment, all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities, and formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.' The Acheson Report also makes the important point that inequalities will only be reduced if 'all policies' are subject to assessment. This is because 'policies' from nearly all sectors have an impact on the health of people, as described in the social model of health (Dahlgren, 1995). Governments in the Netherlands, Sweden and New Zealand have also proposed HIA as a method of dealing with inequalities

within similar national policy documents (Ostlin and Diderichsen, 2000; Mackenbach and Stronks, 2002; Public Health Advisory Committee, 2004).

A further UK policy link is the *Priorities and planning framework*, where primary care trusts are required to carry out health equity audit (HEA) (DH, 2002, 2004). Partnership work within HEA can support HIA work, and many of the steps in the HEA approach can be usefully informed by an HIA.

As described by Taylor *et al.* (2003a), addressing inequalities within HIA can result in better decision making by supporting decision makers in assessing proposals on the grounds of equity. It may also create better awareness of the political dimensions of health, particularly of how the wider determinants of health (Dahlgren and Whitehead, 1991) could affect health inequalities. Taking an inequalities focus with HIA may also lead to better outcomes for communities – addressing inequalities often requires a participatory approach with the affected population, and this process may contribute to better health for the population. Finally, equity itself is a determinant of health (of all people, not just those most disadvantaged), and without a focus on inequalities HIA may miss an opportunity to improve the health and wellbeing of all people.

Methods

The two case studies identified here (page 5) were selected for use at the former HDA's 2003 Conference, where a workshop was held to discuss how practitioners were attempting to tackle inequalities within HIA. A call for abstracts, asking for examples of HIA practice, was also made to registered users of the HIA Gateway website (www.hiagateway.org.uk) and members of the European Centre for Health Policy's HIA Electronic Discussion Network (www.euro.who.int/eprise/main/WHO/Progs/HPA/HealthImpact/20020320_2%20). A requirement was that the case studies should demonstrate how they had attempted to address inequalities at each stage of the process. The case studies were to be presented at the workshop as examples, and the presenters were available to answer questions about their work.

Submitted abstracts were read by two people, and those displaying the clearest attempts to address inequalities within HIA practice were chosen. It is important to note that this selection was not based on a systematic search of all examples of HIA that attempted to address inequalities – other examples, both better and worse, are likely to exist.

Approaches to addressing inequalities within HIA

HIA is a practical approach that determines how a proposal will affect people's health. Recommendations to 'increase the positive' and 'decrease the negative' aspects of a proposal are produced to inform decision makers. HIA is described as one way to attempt to address inequalities. Within the peer-reviewed literature, four papers provide explicit frameworks (or commentaries on them) for addressing inequalities within HIA.

Lester *et al.* – Lester, C., Griffiths, S., Smith, K. and Lowe, G. (2001) Priority setting with health inequality impact assessment. *Public Health* 115: 272-6.

Mackenbach *et al.* – Mackenbach, J., Lennert Veerman, J., Barendregt, J. and Kunst, A. (2004) Health inequalities in HIA. In: Kemm, J., Parry, J. and Palmer, S. (eds). *Health impact assessment: concepts, theory and applications*. Oxford: Oxford University Press, ch. 3.

Parry and Scully – Parry, J. and Scully, E. (2003) Health impact assessment and the consideration of health inequalities. *Journal of Public Health Medicine* 25(3): 243-5.

Taylor *et al.* – Taylor, L., Gowman, N. and Quigley, R. (2003a) *Learning from practice bulletin: Addressing inequalities through health impact assessment*. London: Health Development Agency.

It is well recognised that to attempt to address inequalities through an HIA, it is important to take a rigorous and structural approach, and action should be taken at each stage of the HIA process (Taylor *et al.*, 2003a; Mackenbach *et al.*, 2004). The majority of HIAs undertaken discuss and consider inequalities and use HIA models that are able to address inequalities. But they do not use a structured approach to address inequalities in their work, or present it in a way that makes it clear that any impact on health inequalities was assessed (Parry and Scully, 2003; Mackenbach *et al.*, 2004). Ideas for more rigorously addressing inequalities in HIA are presented by Parry and Scully (2003) and Mackenbach *et al.* (2004), but both reports note that a lack of available resources and time within most HIAs may make such a rigorous and complex approach difficult, despite it being appropriate in theory.

HIA can attempt to address inequalities in two ways:

- By outlining the distribution of impacts that are likely to be experienced across populations – recommendations can reflect this understanding and minimise harm or maximise benefits to vulnerable people. In this case the **outputs and outcomes** of the HIA are important
- By carrying out the HIA – the process can include the participation of vulnerable groups, and this involvement may be empowering and beneficial in itself. In this case the **process** of the HIA is important.

Four approaches to HIA

Parry and Scully (2003)

As a minimum, these authors believe that HIA should 'explicitly set out the estimation of the differential distribution of effects arising from a policy ... stratified by sex, age, ethnicity and socio-economic status relative to the whole population.' Also, they call for clear exclusion and inclusion criteria for relevant subgroups to be developed. This commentary focuses on what the authors considered the most important first steps required to address inequalities, without outlining a more detailed process for anyone who may have wanted to stretch their practice.

Lester et al. (2001)

In contrast, these authors present a detailed process (and a rapid appraisal toolkit) for attempting to address inequalities when undertaking HIAs. The process was developed by the Bro Taf Health Authority, drawing on *The Merseyside guidelines for health impact assessment* (Scott-Samuel et al., 2001), and has been used for carrying out an HIA on a proposed new road development (Lester and Temple, 2002, 2004). The toolkit focuses on the needs of the most disadvantaged in the community when carrying out planning. The basic steps include:

- Identifying which determinants of health are related to the planning topic
- Discussing the prevalence of these determinants locally, for the whole population and for socio-economic groups
- Gathering evidence to support or refute the initial discussion on local determinants
- Identifying opportunities for action as a result of examining the evidence
- Rating the opportunities for action in terms of strength of evidence, size of possible impact, probability of achieving change locally, and the timescale for achieving such a change.

Mackenbach et al. (2004)

Similarly, these authors outline a four-step process to address inequalities in HIA:

- Identify what health determinants the proposal may have an impact on, then estimate their prevalence
- Look at the socio-economic distribution of these determinants, and what this contributes to current inequalities in health
- Estimate how the policy will affect the prevalence of the health determinants in different socio-economic groups
- Estimate how such changes in the prevalence of the determinants of health may affect health inequalities among the different socio-economic groups.

Taylor et al. (2003a)

These authors present promising practice guidance for attempting to address inequalities, derived from a workshop attended by practitioners, leading academics, policy makers and HIA commissioners. The guidance emphasises the need for action at every stage of the HIA process (from screening to reporting) to maintain the focus on inequalities. The promising practice guidance is grouped around five themes:

- Being clear about purpose and choices
- Screening and scoping
- Using a participatory approach
- Working systematically
- Reporting back.

Discussion of approaches

The frameworks of Lester et al. (2001) and Mackenbach et al. (2004) begin by identifying the determinants of health on which the proposal may have an impact. This demonstrates one of HIA's strengths: that health outcomes affected by the wider determinants of health are considered. The prevalence of the determinants is considered in both frameworks, and each asks questions about how these determinants may be distributed among the population. Mackenbach et al. (2004) stretch the practitioner to consider the impact of this distribution on current inequalities in health. This step is a valuable addition, as it will highlight those determinants that are most important for addressing inequalities in the local population – but whether the data for such an analysis are available is a pertinent question.

Lester et al. (2001) explicitly describe the evidence-gathering step, whereas Mackenbach et al. (2004) describe the need to estimate how the policy will affect

the prevalence of the health determinants. The language used by Mackenbach *et al.* (2004) is quantitative, and exhorts that data should be quantitative where possible (while also acknowledging that qualitative data may be all that is available). The Mackenbach framework makes a major contribution by explicitly setting out a chain of reasoning that informs the appraisal process, which is often missing from other frameworks. So while it calls for a degree of quantification that may prove difficult to deliver, it does provide a structure to the appraisal process that others can follow regardless of the type of data used (dependent on time, skill, financial and data resources available). Lester *et al.* (2001) also add critical steps that were otherwise missing from Mackenbach *et al.* (2004) – identifying options for action, and producing recommendations for change. It is important to note that, while these frameworks present HIA as though it occurs in discrete steps, in practice such steps often overlap and entwine – for example, identifying options for action may occur throughout any of the stages within an HIA.

The work of Taylor *et al.* (2003a) differs from the other frameworks because of its approach – attempting to identify promising practice from and by practitioners. This has produced a practical listing of work attempting to address inequalities. These practical tips reinforce the frameworks of Mackenbach *et al.* (2004) and Lester *et al.* (2001), while echoing the recommendations of Parry and Scully (2003). Taylor *et al.* (2003a) take the consideration of inequalities right back to the screening and scoping steps of HIA – and emphasise that it is critical to ensure that inequalities are on the agenda of all stakeholders and in the objectives of the HIA. Within the appraisal stage of the HIA, Taylor *et al.* (2003a) explicitly emphasise the community participation component of HIA and its role in addressing inequalities – as also described by Lester *et al.* (2001) in their guiding principles for HIA (not discussed here); but unlike

Mackenbach *et al.* (2004) in their ‘systematic, partly quantitative approach’.

Taylor *et al.* (2003a) also emphasise the importance of developing recommendations that address inequalities (similarly to Lester *et al.*, 2001); however, they go further by encouraging practitioners to write up reports that explicitly show how inequalities are addressed in the HIA, and call for practitioners to feed results back to those vulnerable groups (and other stakeholders) who have participated in the HIA. Taylor *et al.* (2003a) continue into the final stage of HIA, unlike the other frameworks, and call for practitioners to evaluate their work by undertaking process and impact evaluation of the HIA. This includes a particular focus on how health inequalities are assessed, and what recommendations with specific inequalities dimensions are accepted and implemented by the decision makers.

Case studies

Each case study has a brief introduction, followed by a proposed idealised structure for addressing inequalities within HIA (derived from the above frameworks), using each case study as an example only. The framework has not been developed with the thought that each component must be addressed in every HIA. Instead it provides prompts, allowing practitioners to match the depth of query and investigation with the resources and skills available to them. This maintains the flexible approach that makes HIA so valuable. Both case studies have attempted to influence inequalities by producing recommendations to support vulnerable people – and have also included these people in ways that may empower and benefit them.

Table 1 outlines criteria that the authors have used to question and guide HIA when considering inequalities; the two case studies provide practical examples of how these may be achieved.

Case study 1: HIA of a strategy for financial investment in primary care services (Elliston, 2003)

Who undertook the HIA?

The Plymouth Teaching Primary Care Trust (PCT)

On what?

A strategy for delivering improvements to primary care and related facilities and services for the population of Plymouth, England. The strategy was developed by a public-private partnership called a local improvement finance trust (LIFT), which was supported nationally by the government. Plymouth LIFT is in the third wave of the national LIFT programme. The prospective value of Plymouth LIFT-funded projects over the next 20–25 years is expected to be greater than £40m. The LIFT was a vehicle for this investment, and was the major component of the PCT's 20-year strategic service delivery plan.

Why was the HIA undertaken?

The PCT believed it had a responsibility to consider how its major projects affected the health of the population, and wanted to lead by example for other decision-making organisations in Plymouth to encourage the uptake of HIA in the city.

Informing the decision-making process

Before embarking on the HIA, assurances were received from the LIFT Board that the HIA would form part of the decision-making process and be integrated into the planning timescales.

Plymouth PCT project team: Kevin Elliston – project lead, Public Health Specialist; Andrew Pratt, HIA Specialist; Neil Boot, Deputy Director of Public Health.

Case study 2: Health inequalities in an integrated HIA and environmental impact assessment (EIA)

Who undertook the HIA?

Westminster City Council commissioned ARUP Environmental and Ben Cave Associates to carry out integrated environmental and health impact assessments. Ben Cave Associates carried out the HIA component of the contract.

On what?

Proposed development of the 3.5 hectare Westbourne Green Triangle site in the City of Westminster, London. The site under consideration was predominantly in leisure

use and included an area for skateboarding, two netball courts, a football pitch, a kick-about area and a play area. These uses are located directly underneath the alignment of Westway (an elevated section of one of the main roads into London from the west) so, while an open space, this part of the site benefits from year-round cover. Offices and residential populations border the site. The appraisal considered two development options and a 'do-nothing' option. The two development options were as follows:

- Construct a purpose-built nine-storey building in the north corner of the site containing sub-basement car parking; underground depot; housing assessment and advice centre; health and social services facility (including doctor's surgery, social and community services); one-stop shop for council services; youth club; multi-purpose community hall; adult education service and teachers' professional development centre; café or restaurant; and 72 residential units on three floors (including 50% affordable housing)
- Construct a new secondary school on the main site. The conceptual design featured a school and associated outdoor facilities that would occupy the entire site. With a total floor space of approximately 11,000 square metres, it would educate approximately 900 pupils aged 11–16 and an additional 200 or more over 16. The existing outdoor courts and pitches would be rationalised and upgraded. The academy would include designated shared areas, allowing community access to rooms and halls for activities and meetings. In addition, the outdoor sports facilities would be available to the public outside school hours. This option also included the redevelopment of smaller sites close to the main site, to accommodate a health centre and other community facilities.

Why was the HIA undertaken?

A statutory internal review process conducted by Westminster City Council recommended the innovative step of commissioning integrated HIA and EIA at an early stage in the design.

Informing the decision-making process

Westminster City Council commissioned the appraisal before the design stage so that recommendations from the integrated appraisal could be taken into account when the local authority decided which development option to pursue.

Project team: Ben Cave, Salim Vohra and Leigh Rampton of Ben Cave Associates Ltd carried out the HIA. Stephanie McGibbon of ARUP coordinated the assessment and the EIA.

(The report is not in the public domain.)

Table 1 Criteria for questioning and guiding HIA when considering inequalities

<p>Screening</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p>
<p>Consider explicitly whether proposals are likely to have an impact on inequalities (Taylor <i>et al.</i>, 2003a; Mackenbach <i>et al.</i>, 2004)</p>	<p>A screening tool was not used to decide whether the project required an HIA. However, due to the size of the potential population affected (Plymouth) and the scale of investment in primary care infrastructure and services (>£40m over 10 years) to address inequalities in health, it was determined relatively quickly that the project was appropriate for an HIA</p>	<p>A screening tool was not used to decide whether the development required a HIA. Instead it was commissioned as part of an EIA – because the Best Value Review of Westminster City Council recommended that an HIA was included, and partly in response to local pressure for an independent review of the proposed development. The council has since developed a screening tool</p>
<p>Apply criteria for assessing proposals to assess which will have the greatest impact on equity and equality (Taylor <i>et al.</i>, 2003a)</p>	<p>No data available</p>	<p>No data available</p>
<p>Scoping</p>		
<p>Set clear aims and objectives for the HIA, and be explicit about the inequalities dimension of your HIA (Taylor <i>et al.</i>, 2003a)</p>	<p>Health inequalities were at the heart of the HIA right from the start. The objectives were to:</p> <ul style="list-style-type: none"> • Assess potential impacts (negative and positive) on health inequalities arising from the implementation of the strategic plan in Plymouth • Inform further development of the strategic plan to reduce negative and enhance positive health impacts 	<p>It was necessary to understand the role that the site played as a social and health resource for users (Cravey <i>et al.</i>, 2001). Key questions for analysis included:</p> <ul style="list-style-type: none"> • How do (local) residents use the site? • How does it function as a social and health resource? • How does it relate to other sites, services and resources in the area (local)? • What formal and informal uses are made of the site? • Who are the main formal and informal users? • What are the health-related effects of current patterns of use? • What are likely to be the initial health effects of potential developments? • Who are potential stakeholders in any future social and health impact work? <p>We also asked about the mechanisms by which people may be affected, eg the effects on different population groups and how they will take shape were also covered.</p>

<p>Scoping <i>continued</i></p> <p>Consider who your stakeholders are, identify the methods needed to involve them, and then involve them (including disadvantaged groups and/or advocates). Use representatives and 'experts' as advocates for 'hard-to-hear' groups where you need to – they are not a perfect substitute, but can still protect against excluding points of view (Taylor <i>et al.</i>, 2003a)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>Key informants were drawn from the Social Inclusion Partnership in Plymouth, an independent partnership comprising over 100 signatory organisations, including representatives of community groups, voluntary sector and statutory service providers</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>Stakeholders were identified by observation: use of advocates, representative groups, local service providers and reports from the grey literature, eg a health needs assessment (HINA) report. Stakeholders were also reached through personal introductions from other individuals.</p> <p>Methods identified to involve stakeholders included:</p> <ul style="list-style-type: none"> • Meetings with residents' association • One-to-one interviews with key informants • Phone interviews • Visits to people's homes • Attending local groups, eg youth club • Structured observation of the site at different times of day and night, on different days, and in different weather conditions
<p>Ensure stakeholders and participants expect to consider inequalities as part of the HIA (Taylor <i>et al.</i>, 2003a)</p>	<p>One of the aims of the Social Inclusion Partnership is to tackle social exclusion, and this was made clear within the HIA</p>	<p>The brief to contractors included discussion of inequalities. The tender documents asked for a range of impacts to be considered, so the bid for the HIA component made it clear that health and other social inequalities would be one of the areas of focus, eg differential impacts for different residents</p>
<p>Provide stakeholders with information that will improve their understanding of inequalities and the determinants of health (Taylor <i>et al.</i>, 2003a)</p>	<p>A review of the relevant literature and a community profile was provided to key informants. This report described the key determinants of health and their contribution to current socio-economic inequalities in health</p>	<p>Information was provided in meetings where the environmental and health impacts were discussed, in special meetings of the consultative group, and during interviews. There was concern about providing people with an evidence base that highlighted the theoretical links between deprivation and health in a predominantly negative way (the nature of the health evidence base). The effects on, and tensions between, different population groups was a constant theme of the consultation. The emerging conclusions of the report were talked through with key informants and developed accordingly</p>

<p>Scoping <i>continued</i></p> <p>Identify subgroups of the population most likely to be affected by the proposal and on which the HIA will focus. These subgroups should be accurately defined by sex, age, ethnicity and socio-economic status – with clear inclusion and exclusion criteria, eg what is ‘ethnic minority’? (Parry and Scully, 2003; Taylor <i>et al.</i>, 2003a)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>Population groups in the community which were most likely to be affected by the proposal were identified from an HIA toolkit, originally developed by the Bro Taf Health Authority, that specifically targets inequalities (National Public Health Service for Wales, 2003) and from Acheson (1998).</p> <p>Population groups most vulnerable to experiences of inequalities in health were selected for assessment (National Public Health Service for Wales, 2003):</p> <ul style="list-style-type: none"> • Families with children, pregnant women, young children and teenagers • Vulnerable people – those who are mentally or physically disabled, frail older people, and those with learning disability and carers • People who may be disadvantaged by reason of their gender or sexuality • Black and minority ethnic communities (including asylum seekers) and those who find communication in English difficult – an undifferentiated group as Plymouth has a very small minority ethnic population (<2% of total population) <p>A mini-health profile of Plymouth was produced using data and reports relevant to inequalities in health. The profile was included as part of the baseline information in the strategy prospectus</p> <p>No data available</p> <p>Key informants were drawn from the Social Inclusion Partnership in Plymouth</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>Population groups were identified during the work that required particular assessment and consideration:</p> <ul style="list-style-type: none"> • Older residents • Parents with young children • Refugees and asylum seekers • Young men • Long-term residents <p>Population groups analysed by the HIA were selected after discussion with key stakeholders, and did not include the office workers bordering the site</p> <p>The effects identified for the different population groups were not compared with controls external to the area. Learning from other areas is used to inform discussion, but local knowledge and understanding is key to identifying what will make the development successful</p> <p>The HIA was part of a wider assessment that was looking at a range of determinants/factors</p> <p>The HNA produced by the local PCT was invaluable in providing access to baseline information. This was complemented by consultation with local groups</p>
<p>The comparator group should also be specified – often the whole population (Parry and Scully, 2003)</p> <p>Identify which determinants of health are related to the proposal (Lester <i>et al.</i>, 2001)</p> <p>Work with partners to ensure good quality community profiles exist, and secure public health and specialist skills support required, such as external facilitation for stakeholder meetings (Taylor <i>et al.</i>, 2003a)</p>		

<p>Scoping <i>continued</i></p> <p>Use an HIA model or method that explicitly identifies inequalities</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>The HIA was framed around the WHO Gothenburg Consensus Statement on HIA (ECHP, 1999) that has equity as one of its core values; the methodology was adapted from the prospective HIA of the Morice Town Home Zone (Maconachie <i>et al.</i>, 2003) which was also conducted in Plymouth and adapted from the <i>Merseyside guidelines</i> (Scott-Samuel <i>et al.</i>, 2001).</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>The EIA/HIA aimed to identify and assess potential unintended (good and bad) effects of each option. The HIA was conducted using a guide for HIA in urban development (Cave <i>et al.</i>, 2001), which recommends working with stakeholders to examine development proposals in greater detail and to tease out information that is not included in development documents. Key questions are: what is the existing context; what are the intended and unintended impacts; and what are the mechanisms affecting those impacts? (see Pawson and Tilley, 1997)</p>
<p>Appraisal</p> <p>Aim to appraise inequalities in a systematic way (Taylor <i>et al.</i>, 2003a)</p> <p>Confirm what health determinants the proposal may have an impact on, then estimate their prevalence (Mackenbach <i>et al.</i>, 2004)</p> <p>In stakeholder workshops, involve disadvantaged groups and/or advocates, working with existing channels where available (Taylor <i>et al.</i>, 2003a)</p>	<p>The methodology adopted allowed for a systematic appraisal of inequalities</p> <p>A report presented a review of the relevant literature and a community profile, and described the key determinants of health that may have been affected by the proposal</p> <p>Participatory, facilitator-led workshops were held. The workshops drew participants from the existing Social Inclusion Partnerships of Plymouth. Informants for the HIA at the workshop represented key members of community groups, the voluntary sector and statutory service providers as well as the business sector in Plymouth</p>	<p>The methodology adopted allowed for a systematic appraisal of inequalities</p> <p>The literature review covered each of the determinants of health under consideration (not published as a stand-alone document). The findings from the literature review were incorporated into the report and placed in the context of the local situation</p> <p>Data were collected from stakeholders by:</p> <ul style="list-style-type: none"> • Visiting and talking to residents in their homes • Meeting regularly with the residents' association • One-to-one interviews with key informants • Phone interviews • Attending local groups, eg youth club <p>Semi-structured interviews were used that focused on the proposed development and how this would affect people, and the mitigation measures that may be appropriate, eg how could each option be improved? Participants described the area, what it was like to live there, and issues they had with housing, street lights, etc</p>

<p>Appraisal continued</p> <p>In stakeholder workshops, ensure the agenda for all workshop topics contains core questions about the likely impact on inequalities, and apply these consistently – you could ask participants to consider the likely positive and negative impacts of proposals on defined vulnerable groups (eg black people, those from minority ethnic groups, people with disabilities, older people, people on low incomes, families with young children) (Taylor <i>et al.</i>, 2003a)</p> <p>In stakeholder workshops, discuss the prevalence of these determinants locally, for the whole population and for socio-economic groups (Lester <i>et al.</i>, 2001)</p> <p>In stakeholder workshops, learn from other areas of practice that use participatory techniques, eg community development (Taylor <i>et al.</i>, 2003a)</p> <p>Gather evidence to support or refute the initial discussion on local determinants. Ensure the evidence review adequately addresses inequalities, makes best use of the evidence available from a range of sources, and avoids bias from selectively choosing evidence (Taylor <i>et al.</i>, 2003a; Lester <i>et al.</i>, 2001)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>HIA workshops were devised using a task book of group work activities based on Maconachie and Elliston (2002). The participants' task book included: a mini-health profile of Plymouth; definitions of inequity, inequality, health and health impact assessment; categories of the influences on health; group work tasks; charts to record health impacts. The HIA task book attempted to maintain a focus on inequalities throughout the workshops</p> <p>As the focus of the HIA was to identify the impacts that might arise for the vulnerable groups, discussions were steered towards these groups. In the process of group discussion it was not feasible to restrict discussions to one group at a time, and there was much debate about the impact on the general population. The group facilitator's task was to record discussions accordingly</p> <p>The HIA drew on extensive community involvement/ participation experience of individuals within the HIA team, and of stakeholders. Members of the HIA team had experience of developing a participatory approach to HIA through the Home Zone project (Maconachie and Elliston, 2002) and through exploring approaches to using HIA as a component of community development</p> <p>A report presented a review of the relevant literature and a community profile. The review focused on key texts or strategies that addressed the links between inequalities in health and the vulnerable groups identified as being potentially most affected by the Strategic Service Development Plan (SSDP) in Plymouth</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>Workshops were not used as stand-alone events in this assessment: People living on this estate had been subject to a lot of consultation and it was decided to work through existing networks and to visit people rather than convene a separate event. The techniques described by Taylor <i>et al.</i> (2003a) were used in all consultations, eg people were asked what they knew about the development options, what the important issues in the area were, and how the developments would affect them and others</p> <p>Issues were usually raised by participants, eg people were happy to talk about housing, air quality, noise, community safety. A strong feeling that emerged from the consultation was that people living closest to the development would bear the heaviest burden</p> <p>The HIA drew on extensive community involvement/ participation experience of individuals within the HIA team, and of stakeholders</p> <p>A structured observation of the site was conducted to determine how the site was used (L'Aoustet and Griffet, 2001). A literature review was conducted using HIA resources (eg Cave <i>et al.</i>, 2001). The data collected from stakeholders included:</p> <ul style="list-style-type: none"> • A structured observation 'walkabout' of the area over two months to determine how people used the area • An assessment of current health and social welfare provision by consultation with local service providers and analysis of HINAs and data compiled by the local health centre • Analysis of existing reports and evidence on health needs • Visiting and talking to residents in their homes • Regular meetings with the residents' association
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<p>Appraisal continued</p>	<p>Look at the socio-economic distribution of these determinants for the specified groups, and what this contributes to current inequalities in health (Mackenbach <i>et al.</i>, 2004; Parry and Scully, 2003)</p>	<p>Estimate how the policy will affect the prevalence of health determinants in different socio-economic groups (Mackenbach <i>et al.</i>, 2004)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>The review of the relevant literature and community profile included the distribution of key determinants of health for the whole population and by socio-economic group, and described its contribution to current socio-economic inequalities in health</p> <p>The health profile highlighted the prevalence of health inequalities across Plymouth, and the HIA identified areas of health concern for vulnerable groups as a consequence of implementing the policy. The analysis of the workshop task books identified eight major impact categories and 28 derived impact categories, as well as the links between the determinants of health, the primary care investment strategy and their impact on particular vulnerable groups</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>Such information was described in local information sources, eg the HNA, other community profiles, and community safety data</p> <p>There were discussions about the potential change in determinants, but they were not quantified. The HIA team examined the differential effects on health of the proposed interventions as a core part of the method</p>
<p>Estimate how such changes in prevalence of the determinants of health may affect health inequalities among the different socio-economic groups (Mackenbach <i>et al.</i>, 2004)</p>	<p>Key informants in the workshops were tasked with identifying the positive and negative, short-term (five years) and long-term (20 years) impacts of the strategy on the population of Plymouth, with particular reference to impacts on the population groups identified previously. The workshop data were recorded in the task books, which were analysed using grounded theory (an approach to qualitative data analysis). This approach allowed issues of inequalities to be considered as they arose from the data. The emergent themes consisted of eight major impact categories (locale, transport, workforce, service provision, holistic health, social capital, sustainability, secondary care). These were described in the full report and broken down into 28 categories of impact. The review and evidence were also used in the analysis phase</p>	<p>An appraisal matrix was used that compared the three options, covering both construction and implementation phases of the site redevelopment, and identified potential pathways of impact</p> <p>The information volunteered by residents was experiential knowledge and evidence. This was placed alongside peer-reviewed information so that each source (typically) supported or (occasionally) questioned the other. The HIA made the power inequalities explicit, and aimed to reduce these by incorporating residents' voices and experiential knowledge into the impact assessment process. Transcripts of interviews were discussed with residents who also commented on drafts of the report</p> <p>Due to the number and breadth of impacts identified they are not presented here; please contact the authors for further details</p>		

<p>Appraisal continued</p> <p>Identify opportunities for action as a result of examining the evidence (Lester <i>et al.</i>, 2001)</p> <p>Rate the opportunities for action in terms of strength of evidence, size of possible impact, probability of achieving change locally, and the timescale for achieving such a change (Lester <i>et al.</i>, 2001)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>Rather than producing a series of HIA recommendations for the LIFT Project Board to respond to, it was felt more appropriate, and more useful for HIA uptake and influence, to pose a series of policy questions for each of the eight health impact areas identified. Sixteen policy review questions were therefore raised (Appendix 1)</p> <p>The action plan that was devised to respond to the HIA policy review questions was determined not by the HIA team, but by the LIFT Project Board. This gave ownership of the HIA project outcomes to a senior executive board to implement the potential for mitigation and enhancement of impacts</p> <p>No data available</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>Opportunities for action were developed through consultation with residents, policy makers, the impact assessment team, review of the evidence base, and discussions with Westminster City Council policy makers</p> <p>Opportunities for action (and discussions about evidence, size of impact, etc) emerged in the consultation and through the cross-checking of draft reports by stakeholders. This was not a discrete stage, but part of a process</p>
<p>Developing recommendations</p> <p>Consider holding a final workshop to agree and develop consensus around final recommendations – highlight areas of common ground and, where agreement cannot be reached, explain what has been decided, and why (Taylor <i>et al.</i>, 2003a)</p>		<p>The recommendations were developed through consultation with residents, policy makers, the impact assessment team and a review of the evidence base. They were discussed with Westminster City Council policy makers, who were keen that the recommendations should be as specific as possible, so the draft recommendations were strengthened for the final report.</p> <p>Residents disagreed with the conclusion of the report, that neither development option would have negative effects which were not amenable to mitigation. Residents approved the text of the HIA report and the way the information had been gathered, assimilated and interpreted. They were opposed to the development, so did not like the conclusions. We discussed this at length with the residents' group and amended our conclusions accordingly. We noted the fact that neither development option was supported by the residents. The recommendations about the management of the reconstruction of the development and its implementation thus acquired extra weight</p>

<p>Developing recommendations <i>continued</i></p> <p>State your recommendations clearly in terms of their likely impact on health inequalities (Lester <i>et al.</i>, 2001; Taylor <i>et al.</i>, 2003a)</p>	<p>The full HIA report pulled together the impacts based on the judgements of the 25 key informants from the workshops. Sixteen policy review questions were raised and presented to the LIFT Project Board meeting (Appendix 1). The policy review questions were endorsed by the Board, which then enabled and empowered them to generate their own response recommendations. A number of these questions had a focus on inequalities, eg:</p> <ul style="list-style-type: none"> • Transport impacts – what proportion of the population, who have transport needs and are therefore potentially vulnerable, will rely on public transport to access the LIFT centres? • Service provision – what governance proposals does the LIFT Project Board have which would ensure coordination and new service development (eg outreach services) across a number of sites in Plymouth so that vulnerable members of the community are not health disadvantaged? 	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p>	<p>The final report to the council concluded that the development options were in line with planning policy guidance, and that development options 1 and 2 (rather than ‘do nothing’) showed clearer potential health benefits and fewer negatives at a strategic level. Both options provided opportunities for improving facilities on the site and providing resources for the local community</p> <p>The report also made clear that the proposals were likely to have both adverse and beneficial health impacts on local residents. The short-term health impacts were dependent on how the construction process was undertaken. The appraisal looked at outline designs and was thus not able to make detailed recommendations about the options. Recommendations were made about the construction process and about ways to lessen the impact of construction on the residents adjacent to the development site – this was where many of the negative health impacts were identified, particularly for the block of residents closest to the development site. The long-term health impacts were found to be determined by the accessibility and appropriateness of any new facilities and services provided by the development, and the subsequent management of the new facilities – it is important that local residents benefit directly from any proposed development. The recommendations in the final report stressed the importance of appropriate management of the development and the inclusion of local people in decisions, as residents had strong objections to the two development options</p> <p>The report described the major focus on inequalities and how they were addressed</p>	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p>	<p>The draft report was circulated to the residents’ association and discussed in detail with the consultants</p>	<p>In any written report, explain fully why and how you addressed health inequalities (Taylor <i>et al.</i>, 2003a)</p> <p>Feedback is especially important when participatory methods have been used – make sure stakeholders, especially community representatives, understand how they contributed to recommendations, and what will happen next (Taylor <i>et al.</i>, 2003a)</p>
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<p>Monitoring and evaluation</p> <p>Undertake process and impact evaluation of the HIA, with a particular focus on how health inequalities were assessed, and what recommendations with specific inequalities dimensions were accepted and implemented by the decision makers (Taylor <i>et al.</i>, 2003c)</p>	<p>Case study 1: HIA of a strategy for financial investment in primary care services (Plymouth Teaching PCT)</p> <p>The LIFT Project Board also used the outcomes of the HIA to judge and select a potential private partner bidder for the LIFT, by posing a question to all prospective bidders: 'HIA is a method of judging the potential effects of initiatives such as LIFT on the health of the local population and, in particular, how it would impact on vulnerable groups such as children, pregnant women, older people, the mentally and physically disabled and black and ethnic minority communities. Please describe how you would evaluate and take account of these areas in arriving at your proposals for the Plymouth LIFT schemes.'</p> <p>Responses from the prospective private sector bidders were instrumental in the decisions of the LIFT Project Board when appointing the private sector partner. This was backed up by the Chief Executive of the PCT, stating that the HIA was very helpful in feeding into the early assessment phase of the LIFT project</p> <p>The LIFT Project Board considered all 16 policy review questions, and in many of the development areas the HIA was instrumental in shaping discussion and affecting changes in healthy public policy. These included:</p> <ul style="list-style-type: none"> • Undertaking several public meetings to consider associated community regeneration issues • Cross-departmental work with the City Council Transport Department, including £50,000 towards public transport service improvements for the local area where one of the local care centres will be built • Development of a joint workforce strategy with Plymouth Hospitals Trust for staffing of the local care centres • Proposals for the first local care centre to include a mix of social and health care, social services, benefits advice and health promotion services 	<p>Case study 2: Health inequalities in an integrated HIA and EIA (Westminster City Council)</p> <p>A section of the HIA report looked at requirements for monitoring and evaluation, and recommended that these be carried out when the development option was chosen</p>
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The case studies as examples of addressing inequalities

These examples are not presented as best practice for addressing inequalities through HIA, but simply as examples of HIA that have attempted to address inequalities. As with all HIAs, these examples were undertaken within limited budgets and timeframes.

The two case studies presented here used quite different approaches for attempting to address inequalities within HIA. The first (in Plymouth) used the HIA successfully to influence public policy, with a particular focus on the most disadvantaged. The second (in Westminster) used the HIA to attempt to address power inequalities between the council, researchers and residents; and to involve local people in the decision-making process (at the time of going to press, the outcome of whether people were involved is still not known). HIAs can help tackle health inequalities *directly* by highlighting and describing the negative (and positive) health effects of any proposed development, project, service, programme or policy. HIAs can help tackle health inequalities *indirectly* by making the power inequalities explicit. Both case studies aimed to reduce power inequalities by incorporating residents' voices and experiential knowledge into the impact assessment process.

Neither case study provided an example of screening. It is rare for HIA to begin with a screening exercise – most begin because of a political process; or because a local champion recommends an HIA; or because funding for an HIA becomes available (Taylor *et al.*, 2003b).

Scoping is a critical stage for an HIA to set the focus on addressing inequalities – both in theory and in practice. The Plymouth case study had explicit aims and objectives that covered the HIA's role in addressing inequalities, and this provided a solid basis for all the following inequalities-based work. In comparison, the Westminster HIA inequalities agenda was listed explicitly in the tender documents, but not in the aims and objectives of the HIA, and was instead driven implicitly by the people working on the HIA. Identifying stakeholders (with a focus on inequalities) during the scoping stage was common, so community groups become particularly important, as shown by the Plymouth case study. Such groups can offer local-level evidence to supplement that provided by others, establish the local context for any information, and suggest local mitigation and improvement strategies. Both HIA case studies identified what population groups the HIA would focus on, but neither provided an example that would satisfy Parry and Scully (2003), who would like more explicit details to be recorded about such decisions,

for example 'families with children' (what age ranges for the parents and children?). Neither case study contained an example of 'identifying which health determinants were related to the proposal' during the proposal stage, as recommended by Lester *et al.* (2001). They specifically separated out early identification of health determinants in the scoping stage, and then confirmation of the health determinants in the appraisal stage. This differentiation did not appear important in the two case studies, where all work on the determinants of health was carried out in the appraisal stage.

The two case studies used quite different stakeholder participation methods. The Plymouth HIA focused on many different stakeholders in the community by identifying key informants via the city-wide Social Inclusion Partnership; the Westminster HIA focused on current users of the proposed development site, and some of the community surrounding the site (but not local office workers, or young women using the site, for example). The Plymouth HIA used the extensive existing social networks to inform the appraisal stage, as also suggested by Taylor *et al.* (2003a).

Both case studies used stakeholder workshops to involve disadvantaged groups, ask core questions that covered inequalities, and discuss the distribution of impacts across the populations as recommended by Taylor *et al.* (2003a) and Lester *et al.* (2001). Although workshops are quick and convenient for the HIA practitioner, they may not always be representative of hard-to-reach communities – it is typical to attract proxy representatives of the community (semi-professionals) rather than actual community members. Capturing and analysing the data from the workshops may also be a problem due to the diverse views expressed in a short time. Alternative methods to capture community views, examples of which are included in the case studies, should be considered.

Both HIAs provide examples of components of the Mackenbach model for appraising impacts – although neither carried out as quantitative an appraisal as that to which Mackenbach aspired, and neither explicitly set out to follow such a structured model. The Mackenbach model provides a framework and a clear chain of reasoning for future HIAs to follow, ensuring that no important stages in inequalities appraisal are missed, and that the focus of the HIA stays on the determinants of health and health inequalities. A key component of all HIA is gathering the best available evidence to inform the HIA's conclusions. Both case studies provide examples of this work, including literature reviews, community profiles, gathering of community evidence, and an innovative structured observation (walkabout), to name a few.

Both case studies offer considerable community-based evidence, a feature that appears critical for addressing inequalities through HIA. The stakeholder workshop approach used in Plymouth appeared to give adequate opportunity for a community voice in providing evidence for a decision-making process.

Both case studies also identified opportunities for action and developed recommendations that were specific to inequalities. Interestingly, the Plymouth HIA developed a set of policy questions for the members of the strategy board to use and consider. This novel approach gave ownership of the HIA project outcomes to the senior executive board, and they were able to see the potential impact on inequalities through subsequent decisions. The Westminster HIA developed recommendations through consultation with residents, policy makers, the impact assessment team, and a consultation of the evidence base – gaining significant buy-in from all stakeholders to the HIA recommendations.

Evaluation of the policies and programmes being assessed was recommended in each case study, but little formal evaluation of the HIA itself was carried out. This is normal among HIAs, although regrettable, and Taylor *et al.* (2003c) have called for more process and impact evaluation of HIA. Plymouth has published a full report of the HIA, which contains much process information, but unfortunately the Westminster HIA is not in the public domain. The Plymouth HIA has also undertaken some informal impact evaluation, and received positive feedback from the CEO of the PCT and the project

manager of the strategy on the HIA undertaken and the results it achieved in addressing inequalities. However, while the evidence base about the efficacy of HIA is growing (Quigley and Taylor, 2003), the HIA community needs formal evaluations to demonstrate that HIA also works to address inequalities.

Conclusions

These two case studies offer examples of how to address inequalities through HIA. Both use a structured process in the assessment of health inequalities within an HIA – a challenging task within an already challenging HIA process. From these examples, and the literature to date, there is a consensus that practitioners have a difficult task ahead of them to successfully address inequalities within HIA, and that without a sufficient focus on inequalities they may well not achieve such an outcome. But it is clear from the examples presented here that attempting to address inequalities through HIA is feasible, and there is now a growing literature to assist practitioners in this (Parry and Scully, 2003; Taylor *et al.*, 2003a; Mackenbach *et al.*, 2004). A structure for attempting to address inequalities within HIA is presented, as derived from the four frameworks and commentaries (Table 1). It is hoped that this drawing together of information will assist practitioners by providing descriptions and examples of how inequalities may be addressed within each stage of the HIA approach. Finally, formal process and impact evaluation of HIA are essential to confirm HIA's often-stated claim that it addresses inequalities.

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Appendix 1 Plymouth Teaching PCT (case study 1) – 16 policy review questions presented to the LIFT Project Board meeting

Questions for policy debate were raised, offering the LIFT Project Board an opportunity to address positive and negative impacts arising from the implementation of the PCT's current SSDP. Questions relate to each major category area in the HIA.

Locale

1. What range of health needs have been considered when deciding the location of the local care centres and primary care centres?
2. What mechanisms have the LIFT Project Board proposed to review the SSDP against the Bradshaw range of health needs? ie has an equity profile been proposed?

Transport

3. What discussions/proposals have taken place between the LIFT Project Board and the public transport service providers in Plymouth regarding transport provision to the new LIFT centres?
4. What proportion of the population, who have transport needs and are therefore potentially vulnerable, will rely on public transport to access the LIFT centres?

Workforce

5. How far have the LIFT Project Board's plans developed towards introducing a sophisticated and holistic approach to workforce planning to meet the staffing needs of the new LIFT centres?
6. How confident is the LIFT Project Board that the new LIFT centres will be fully staffed and thereby able to offer the range of services proposed in the SSDP?

Service provision

7. What governance proposals does the LIFT Project Board have which would ensure coordination and new service development, eg outreach services across a number of sites in Plymouth, so that vulnerable members of the community are not health disadvantaged?

8. What quality assurance measures will be used in establishing contracts with support services for LIFT centres, eg cleaning, hotel services, etc?

Holistic health

9. In what ways is the LIFT Project Board actively embracing the social model of health for its centre's services?
10. What proposals are there via the LIFT Project Board for funding arrangements of the voluntary sector's involvement in LIFT services?

Social capital

11. How does the LIFT Project Board propose to encourage its centres to identify with its local community and generate trust and acceptance of services?
12. How far will local community acceptance of premises' appearance influence the design of the new LIFT centres?

Sustainability

13. What processes does the LIFT Project Board have in place to ensure that the best prevailing value for money option regarding NHS asset usage has been identified and selected?
14. What procedures are proposed for the design and build of LIFT premises to take account of the impact on the environment?

Secondary care

15. What proposals does the LIFT Project Board have in place to monitor the effect on secondary care service demands because of the new LIFT centres?
16. What mechanisms are proposed by the LIFT Project Board to evaluate referral patterns from the LIFT centres to secondary care?

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