

Clarifying approaches to:

health needs assessment, health impact assessment, integrated impact assessment, health equity audit, and race equality impact assessment

Introduction

Planners, policy makers and practitioners across all sectors in England use a range of approaches to assess health needs, inform decisions and assess impact. Use of these approaches can lead to improved health outcomes and reduced inequalities through auditing provision, access and outcomes. Five main approaches are used by local, regional and national government, voluntary agencies and the NHS:

- Health needs assessment (HNA)
- Health impact assessment (HIA)
- Integrated impact assessment (IIA)
- Health equity audit (HEA)
- Race equality impact assessment (REIA)

The appraisal of policies and services to assess their impact is not new. It has occurred for economic, environmental, political and social reasons, with health being a recent addition. Such methods are being driven within the UK public sector by the current policy consideration of inequalities, social justice and human rights within public service provision. The **mandatory requirement** for PCTs to use HEA to inform service planning and delivery was initially set out in the *NHS Priorities and planning framework 2003–06* (DH, 2002a) and has been reinforced in the planning framework issued by the Department of Health for 2005/06 to 2007/08 (DH, 2004c).

Publishing a race equality scheme and a race equality impact assessment (REIA) is now a specific duty for many public authorities, including: local authorities; central government

departments; schools, colleges and universities; police; criminal justice agencies; health authorities; NHS trusts; and non-departmental public bodies such as the Arts Council of England (for a full listing see the *Statutory code of practice on the duty to promote race equality: Commission for Racial Equality, 2002b*). This has confirmed that inequalities in health, income (and other social inclusion indicators), access to services, exposure to environmental risk and racial discrimination are the business of mainstream public services.

This publication builds on an earlier bulletin that dealt with HIA, IIA and HNA (HDA, 2004), which has now been expanded to cover HEA and REIA. It is aimed at health promotion practitioners, public health specialists, commissioners and policy makers who are interested in using planning tools to promote decision making to ensure effective public health services, in both the health and non-health sectors. This publication will be of value to those who are beginning to use one of these tools, but are not sure what will be the most effective approach.

For each tool we describe:

- What it is
- The current policy context
- Who is doing it, and on what
- Links to further information.

Finally this bulletin describes the common features and tasks, and how the different approaches may link together. A comparative table is presented on page 12.

Health needs assessment

What is HNA?

HNA is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (HDA, 2005a). The starting point in HNA is a defined population. Various models, tools and guides have been developed to support the process in recent years. The primary outputs of a community-based HNA, which is the approach promoted by the HDA, are a set of identified priorities based on multiple sources of evidence about that population, and an action strategy leading to effective and acceptable interventions and changes in commissioning and service delivery. This approach involves engagement with the target population at all stages in the process, and advocates a multi-agency team to plan and implement the programme and ensure appropriate cross-sectoral actions are taken on the findings (HDA, 2005a).

Policy context

In recent years, national health policies have strengthened links between HNA and service commissioning. *Saving lives: our healthier nation* (DH, 1999) stressed the importance of the community role in identifying health needs and priorities, and *Shifting the balance of power within the NHS* (DH, 2001) gave specific responsibility for conducting HNAs to primary care trusts (PCTs):

'Primary care trusts will be responsible for assessing the health needs of their local community and preparing plans for health improvement which recognise the diversity of local needs. A strengthened public health function will be needed in primary care trusts to support this needs assessment and to ensure that public health surveillance and population screening are carried out across local communities.'

The ability to perform an HNA is a professional competency required by the Faculty of Public Health.

Who is doing HNA, and on what?

The concept and practice of HNA developed during the 1990s (Stevens and Rafferty, 1994, 1997). It is now undertaken by people in a range of sectors at different professional levels, including strategic managers and practitioners concerned with inequalities and improvements in public health. HNA should involve a multi-agency team to collect in-depth information about specific populations, and to take actions that may involve the cooperation of several sectors. The skills and techniques needed include

Steps in HNA

- 1 Getting starting – agreeing aims, objectives and project framework
- 2 Identifying and assessing population health priorities
- 3 Assessing a priority for action
- 4 Planning for change
- 5 Moving on/review – reflective questions about the project and impact (HDA, 2005a)

project management, local data collection and analysis, and community engagement. Practitioners attending HDA training workshops on HNA (in 2003/04) reported that community involvement in decision making and improved partnership working can be strengthened through participation in HNAs.

The HNA population can be identified as people sharing:

- Geographic location – eg living in a neighbourhood or catchment area
- Setting – eg school, workplace, prison or hospital
- Social experience – eg age, ethnicity, homelessness
- Experience of a health condition – eg disease, mental illness or physical disability.

HNAs will often define populations through a combination of main and sub-categories, such as 'older people living in a deprived neighbourhood and recovering from a stroke'.

Findings from HNAs can usefully inform HEA, HIA and IIA, as well as regional and local policy documents such as:

- Local delivery plans
- Community strategies
- Specialised services commissioning
- Health and social care joint planning and commissioning
- General practice strategic development plans.

Further information

- www.publichealth.nice.org.uk – the HNA page contains news, contact lists, discussion forum, and links to case studies and resources
- *Guidance on developing prison health needs assessments and health improvement plans* (DH, 2003b)
- *Health needs assessment – a practical guide* (HDA, 2005a)
- *Health needs assessment in primary care – a pilot project* (Barwick and Glendenning, 2002), available from Public Health, Stockport Primary Care Trust, Tel: 0161 426 5033

- *Health needs assessment workbook* (Hooper and Longworth, 2002, www.hda-online.org.uk/documents/hna.pdf)
- *Mid Hampshire Primary Care Trust health needs assessment toolkit* (CD-ROM) (Mid-Hampshire PCT, 2002)
- *Norfolk needs assessment tool box* (Norfolk Public Health Nurses' Forum, 2002)

Health impact assessment

What is HIA?

The purpose of HIA is to:

- Identify the potential health consequences of a proposal on a given population
- Maximise the positive health benefits and minimise potential adverse effects on health and inequalities.

The preferred starting point for HIA is a proposal (policy, programme, strategy, plan, project or other development) that has not yet been implemented. Its primary output is a set of evidence-based recommendations to inform the decision-making process associated with the proposal. These recommendations aim to highlight practical ways to enhance the positive aspects of a proposal, and to remove or minimise any negative impacts on health and inequalities (known as a prospective HIA).

HIA is typically applied to proposals that are being developed (prospective HIA). HIAs have also been carried out on proposals that have already been completed (retrospective HIA); and on proposals that have already started (concurrent HIA).

HIA is typically used to assess the health impacts of proposals that are not health related. It is widely accepted that health is affected by factors such as the built environment, social regeneration, education or transport policy. Determinants of health including transport, housing, education, the environment and economic activity have major effects on the current and future health of a population. Therefore HIA has

Steps in HIA

- 1 Deciding whether to undertake an HIA (screening)
- 2 Deciding how to undertake the HIA (scoping)
- 3 Identifying and considering the evidence of health impact (appraisal)
- 4 Formulating and prioritising recommendations
- 5 Further engagement with decision makers
- 6 Ongoing monitoring and evaluation

a particular use outside the health sector, where most of our population's health is determined, and where considerations of health need to be placed alongside social, economic and environmental concerns. Health sector proposals are also commonly assessed using HIA.

A wide range of stakeholders can be involved in HIA, so it typically requires a high level of engagement by interested parties: recipients of services, planners, staff, voluntary organisations, etc., and should seek to balance views and experience with quantitative and qualitative research information from routine or other sources. HIA may include a significant level of community involvement and consultation, where appropriate and where resources are available. The HIA framework is designed to take account of, and to balance, the best available evidence from a variety of sources. At its best, it aims to consider a range of different types of evidence – going beyond published evidence from specific research findings to include the views and opinions of key stakeholders who are involved or affected by a proposal or area of work. The scope of HIA is very variable. Some may take several months and involve a large number of people; others could be done in a day.

Policy context

HIA has been endorsed and signalled in a range of European and national policies and strategies. At the European level, for example, Article 152 of the Amsterdam Treaty calls for the EU to examine the possible impact of major policies on health (European Commission, 1999).

In the UK there is no statutory requirement to undertake HIA, but it is beginning to be seen as a potentially useful approach to support efforts to improve health, and particularly to address health inequalities. The government has clearly signalled its acknowledgement of the importance of the determinants of health, and its commitment to promoting HIA at a policy level (DH, 1999). The recommendations of the Acheson Report on inequalities in health and the *Tackling health inequalities* report also reflect the importance of assessing the impact of policy on health inequalities (Acheson, 1998; DH, 2003a).

Most recently, the public health white paper *Choosing health: making healthy choices easier* stated: 'The impact of "non-health" interventions on population health should also be more routinely considered before implementing policies (through Health Impact Assessments)' (DH, 2004a). The UK Parliament has indicated the potential for HIA to become a statutory requirement within the Health Select Committee's Third Report (on obesity), stating that 'Major planning proposals and transport projects are already subject

to environmental impact assessment; we believe that it would be appropriate if a health impact assessment were also a statutory requirement. This would enable health to be integrated into the planning procedure and help bring about the sort of creative, joined-up solution which is required' (House of Commons, 2004, paragraph 321).

Following the impetus of the *Choosing health* white paper (DH, 2004a) the government has made the commitment that all major new government policies should be assessed for their impact on health. To achieve this, the **regulatory impact assessment** guidance has been strengthened to highlight the need for policy makers to assess health impacts (Cabinet Office, 2004). For policies that require a regulatory impact assessment, a separate HIA does not need to be undertaken. However, policy makers must now consider health impacts at all appropriate stages of policy development within the regulatory impact assessment (Cabinet Office, 2004). To assist in this, the Department of Health has set up web guidance to help policy makers determine if their policy has a significant impact on health (screening questions). If two out of three of the screening questions indicate a likely significant impact, then a health assessment must be carried out (an assessment process quite similar in approach to an HIA) (DH, 2004b).

The value and importance of HIA have been identified in a range of UK government policies, programmes and guidance, including:

- *Bringing Britain together: a national strategy for neighbourhood renewal* (New Deal for Communities) (Cabinet Office, 1998)
- *Creating healthier communities: a resource pack for local partnerships* (Office of the Deputy Prime Minister and DH, 2005)
- *Modernising government* (Cabinet Office, 1999)
- *National service framework for coronary heart disease: main report* (DH, 2000)
- *Power to promote or improve economic, social or environmental well being* (DETR, 2001)
- *The future of transport: a network for 2030* (DfT, 2004)

Knowledge of how to conduct an HIA is a required professional competency for public health specialists wishing to become members of the Faculty of Public Health.

Who is doing HIA, and on what?

Although HIA has a short history in England, there is evidence of growing activity. A number of specialist centres, specialist practitioner posts and independent HIA practitioners have emerged to support and promote HIA

and/or provide access to local-level information on health; examples can be found in the 'Further information' section below.

Such centres and practitioners are often responsible for commissioning and managing HIA. Embedding HIA in the decision-making processes within organisations is also occurring.

The recent mandate for all government policies to require consideration of health may increase the use of HIA approaches among local policy makers. HIAs are being conducted across a broad range of topic areas, transport being a clear leader with nearly one fifth of all HIAs. Other important sectors are housing, regeneration, financial investment, leisure/recreation, health, and structure/development plans. Together these six areas (plus transport) currently account for three quarters of all HIA case studies on the HIA Gateway website (www.hiagateway.org.uk).

The rapid development of HIA has been assisted by independent evaluations showing that HIA works. While more evaluation is needed, what we do have shows promising results. The most thorough evaluation to date was an independent retrospective evaluation of two HIAs carried out on the London Mayoral Strategies and a concurrent evaluation of another two (Opinion Leader Research, 2003). The evaluations showed that the HIAs raised the awareness of the social model of health among those whose roles were not primarily health-related.

This resulted in the strategy development teams taking greater account of public health issues when drafting the strategies. HIA played a role in public health considerations becoming embedded within the development of the Mayoral Strategies. Most importantly, the HIAs influenced strategy. The strategy development staff reported that they had taken health into account during the drafting stages because they knew it would be subjected to HIA, and had revised the strategy as a result.

Further information

www.hiagateway.org.uk – provides further information about HIA and links to completed HIA case studies, reports, journal articles, HIA toolkits, training courses, and contact details of people working in HIA.

Other useful HIA websites are:

- www.dh.gov.uk/PublicationsAndStatistics/Legislation/HealthAssessment/fs/en – Department of Health, Health Assessment
- www.hda.nhs.uk – Health Development Agency

- www.ihia.org.uk/about.html – IMPACT consortium (England and international)
- www.londonhealth.gov.uk/hia.htm – London Health Commission, HIA
- www.msoc-mrc.gla.ac.uk/CurrentResearch/Evaluating/evaluating.html – Medical Research Centre, Glasgow, Evaluating non-health-care policies, programmes and projects
- www.hiadatabase.net – Health impact assessment database (Netherlands and international)
- <http://online.northumbria.ac.uk/faculties/hsw/hia/index.htm> – Northumbria University HIA
- www.plymhealthimpact.co.uk – Plymouth HIA
- www.publichealth.ie – Institute of Public Health in Ireland
- www.pcpoh.bham.ac.uk/publichealth/hiaru – University of Birmingham HIA
- www.hpw.wales.gov.uk/English/national/index.htm – National Assembly for Wales, HIA
- www.whiasu.cf.ac.uk – Welsh Health Impact Assessment Support Unit
- www.euro.who.int/echp – WHO Regional Office for Europe, European Centre for Health Policy
- www.euro.who.int/eprise/main/WHO/Progs/HMS/Home – WHO Regional Office for Europe, HIA methods and strategies
- www.who.int/hia – World Health Organization, HIA

Integrated impact assessment

What is IIA?

IIA is an approach that assesses the potential impact of proposals (strategies, policies, programmes, projects, plans or other developments) on issues that previously may have been assessed separately, such as economic, environmental, sustainability, equal opportunities, health, wellbeing and quality of life. As with HIA, its primary output is a set of evidence-based recommendations geared to informing the decision-making process associated with the proposal.

Recommendations aim to highlight practical ways to enhance the positive aspects of a proposal, and to remove or minimise any negative impacts on health and inequalities. The approach is most effective when applied to proposals that are being developed (prospective IIA), but can also be used to scrutinise proposals that are already completed (retrospective IIA), or strategies that are under way (concurrent IIA).

Current IIA tools have two origins:

Steps in IIA

- 1 Scope the initiative – what is to be achieved? (objective appraisal)
- 2 Identify options for delivery – which is the most sustainable? (options appraisal)
- 3 Draft initiative proposal – what are the detailed activities? (policy or activity appraisal)
- 4 Review integration of initiative – are defined activities compatible with policy or activity appraisal? (full plan or project appraisal)
- 5 Set indicators – how will you know when you have achieved your goals? (indicator selection)
- 6 Monitor and evaluate – how will you keep the initiative on target? (appraisal for feedback and review)

- IIA focused on assessing sustainability – the balanced integration of economic, social and environmental outcomes
- IIA focused on integrating various sector-specific objectives designed to assure joined-up planning.

Nevertheless, each IIA typically carries out similar tasks. Some IIA tools provide a list of sector-specific questions that seek to check whether strategy, policy, programmes, projects, or plans:

- Are sustainable
- Provide joined-up planning or policy coherence across economic, social and environmental outcomes
- Have not missed the ‘added value’ of doing differently what is already being planned through integrating structures, processes and potential outcomes.

As IIA deals specifically with education, housing, transport and other determinants, it can be useful to think of IIA as a health determinants impact appraisal tool. The North West Region’s (2003) *Integrated appraisal toolkit* is designed to be used at any stage of an initiative’s development or review process, and recommends an iterative process to ensure sustainability and integration are properly embedded. As with HIA, IIA uses the best available evidence from a variety of quantitative and qualitative sources to develop recommendations.

Policy context

The EU has developed an IIA Framework for European Union planning and spending, operational from 2004 (Commission of the European Communities, 2002). The EU now carries out IIA on all major initiatives to improve the

quality and coherence of the policy development process. This will contribute to an effective and efficient regulatory environment, and to more coherent implementation of the European Strategy for Sustainable Development (http://europa.eu.int/eur-lex/en/com/cnc/2002/com2002_0276en01.pdf).

Who is doing IIA, and on what?

Many administrative levels of government have decided to develop their own IIA tool. Nationally, the Cabinet Office has produced a form of integrated impact/sustainability appraisal as part of its Better Policy Making Programme, focusing on regulatory impact assessment (Cabinet Office, 2003), and the Scottish Executive is piloting an IIA checklist.

English regions are also developing their own IIA-related tools, one of which is the North West Region's (2003) *Integrated appraisal toolkit*, based on the regional priorities and objectives contained in 'Action for sustainability', the North West's regional sustainable development framework. The tool has merged IIA and sustainability impact assessment to produce a tool that can be used for strategy, policy, programmes, projects or plans at all levels. It has been used in the planning of a large (£230 million) NHS private finance initiative, and in housing strategies and local community plans. Developing models of strategic environmental assessment and rural-proofing are also contributing significantly to the development of IIA and sustainability impact assessment tools. A similar tool is the East Midlands online integrated appraisal tool (East Midlands Regional Assembly, 2003) to evaluate the impacts of plans, policies and projects on the region's sustainable development objectives.

Further information

- A case study (Atmospheric pressure: 'sustainable development') (Moore, 2003)
- A guide to what is available in the UK on IIA: *Integrated impact assessment: UK mapping project* (Milner et al., 2003)
- *Better policy making – a guide to regulatory impact assessment* (Cabinet Office, 2003)
- *Environmental impact assessment: a guide to procedures* (DTLR, 2001)
- East Midlands integrated toolkit (East Midlands Regional Assembly, 2003)
- *Implementing action for sustainability: an integrated appraisal toolkit for the North West* (North West Region, 2003)
- *Rural proofing – policy makers' checklist* (Countryside Agency, 2002)

Health equity audit

What is HEA?

HEA identifies how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but, rather, relative to health need (DH, 2003c). This process assists the planning and decision-making processes of organisations. It determines whether the distribution of health outcomes, healthcare or the determinants of health are inequitable or unrelated to need, and action is then taken to remedy and monitor progress. The purpose is for health and other services to help narrow health inequalities by taking positive decisions on investment, service planning, commissioning and delivery that narrow inequalities.

The HEA approach is not complete until something changes to reduce inequalities, for example changes in resource allocation, commissioning, service provision or care outcomes. This is critical as documenting inequalities has become common, but what is less common is the clear targeting of services and resources to identified needs, and reviewing the impact of interventions designed to reduce inequalities in health.

HEA is not new – NHS organisations, local authorities and other agencies have been working for many years to identify and reduce inequalities in the health and wellbeing of different groups in their communities. The difference now is that HEA provides a framework for systematic action to tackle health, and it is embedded as a requirement of NHS service planning.

To understand HEA it is important to be clear about two terms – equity and audit. Equity is concerned with how fairly resources are distributed throughout a group of people according to population, not individual, need. Audit is concerned with systematically understanding a situation (often quantitatively) and then identifying and taking action. Once the six stages of an HEA have been completed (see box) progress towards health equity, or equal resources for equal need, may be achieved.

The HEA approach has developed over time. The box describes the latest six-step approach required to be carried out by PCTs (DH, 2004d).

HEA uses data on health inequalities to support decisions at all levels. Appropriate comparisons are made across area, ethnicity, socio-economic group, gender and age. Another important distinction is that an HEA considers the whole local population, rather than just service users.

Stages in HEA

- 1 Agree partners to work with and choose issues with highest impact, eg cancer, coronary heart disease, primary care and the dimension of inequality to be audited, eg age, area etc.
- 2 Identify any gap in service provision, service need, access, use or outcome, using collected information, and construct need/equity profiles
- 3 Agree high-impact local action to narrow the gap – consider provision, access, use, and quantity and quality of services
- 4 Agree priorities for action – identify highest-impact intervention for effective local action
- 5 Secure changes in investment and service delivery, and embed the outcome in mainstream planning, eg in NHS local delivery plans and service and financial frameworks; move resources to match need
- 6 Conduct ongoing review of progress to assess impact on how the gap is narrowing – ensure effective evaluation is occurring through indicators being in place, and identify local areas or groups where more action is required

Policy context

The public health white paper *Choosing health* (DH, 2004a) emphasises 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 audit. This is reinforced by the *Delivering choosing health* white paper delivery plan (DH, 2005), which refers to HEAs as a way of identifying and reducing inequalities in services, and states that 'PCTs will need to use health equity audits to build a better understanding of why some people or groups are less likely to use the range of available opportunities for screening, and then act to promote take-up.'

The NHS *Priorities and planning framework 2003–2006* (DH, 2002a) has an objective to reduce inequalities in health outcomes. To achieve that, the framework asks that:

'NHS improvement, expansion and reform should ensure that service planning is informed by a health equity audit' (DH, 2002a, 2004d).

It is not expected that PCTs will evaluate all their services through one HEA, but rather that an HEA will be carried out for particular priority services. The framework suggests that PCTs may wish to use HEA at a strategic level to evaluate problem areas, then back this up with more

focused and detailed HEA studies on particular areas of inequality.

This commitment is further strengthened in the 2005/06 to 2007/08 planning framework, where PCTs and their partner organisations must:

'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' (DH, 2004c).

The framework notes that all PCTs should work in partnership with local authorities, using HEA, to demonstrate that effective interventions are provided for all groups in the population, targeting those with highest needs. The audits should have a particular focus on reducing inequalities in life expectancy, infant mortality, heart disease and cancer.

The latest guidance for local delivery plans 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' (DH, 2004e).

Prior to this, the Chief Medical Officer of Health recommended in his annual report for 2001 that, as part of the development of community plans and the modernisation review of the NHS, local strategic partnerships and the relevant PCTs should produce an equity audit in relation to the health inequalities targets (Donaldson, 2002).

The Healthcare Commission's performance indicators for the 2004–05 star ratings include HEA (as a balanced scorecard indicator), that is, the effective use of HEA 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 DH) include HEA as a marker of compliance with the core and developmental public health standards.

Who is doing HEA, and on what?

A survey of HEA activity within PCTs, carried out by the London Public Health Observatory and published by the HDA (Aspinall and Jacobson, 2005), identified that only a few PCTs had passed stage 1 and few had reached stage 4.

PCTs typically lead the process of agreeing a single set of local inequalities priorities with local authorities, other NHS trusts and other partners. Ideally, HEA can be used to inform the implementation of local delivery plans, community strategies and local neighbourhood renewal strategies through local strategic partnerships. HEAs are also being undertaken on components of NHS services and/or interventions (as well as on non-NHS services and/or interventions).

HEA can be incorporated into mainstream performance reviews across the NHS, local authorities and local strategic partnerships, where it can be included as part of the review of key strategies. The process can also be readily incorporated within a local authority best value performance review. There is strong encouragement for local authorities to select cross-cutting issues for best value reviews, such as inequalities in health and social care or other social exclusion issues. The new local authority health overview and scrutiny committees can also use HEA as part of their scrutiny exercises (DH, 2003c; Hamer *et al.*, 2003). HEA can be used by performance managers to review the actual and potential effects of service decisions on health outcomes.

Further information

- www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en – DH Policy and guidance on health inequalities
- *Health equity audit made simple: a briefing for primary care trusts and local strategic partnerships* (Hamer *et al.*, 2003)
- 'Health equity audit: a guide for the NHS (DH, 2003c)
- 'Health equity audit: a self assessment tool' (DH, 2004d)
- Introduction to health equity audit (Eastern Region Public Health Observatory, 2002)
- *Making the case: health equity audit* (HDA, 2005b)

Tools for measuring health equity include:

- *A review of methods for monitoring and measuring social inequality, deprivation and health inequality* (Carr-Hill *et al.*, 2003)
- *Equity in the NHS: monitoring and promoting equity in primary and secondary care* (Majeed *et al.*, 1994)
- www.lho.org.uk/Health_Inequalities/BasketOfIndicators/BasketIndicators.htm – Local basket of indicators to support local action and priority setting to tackle health inequalities
- www.publications.doh.gov.uk/nsf/agediscuserg.pdf – User guide for age discrimination benchmarking tool

Race equality impact assessment

What is REIA?

The purpose of REIA is to work out how an organisation's policies or functions will affect people from different racial groups, pre-empting the possibility that the policy could affect some racial groups unfavourably. REIA looks at proposed policies as well as enabling the monitoring of policies once implemented.

REIA may involve substantial participation by interested parties. Organisations are required to consult on their findings and publish the results of impact assessment. The REIA approach attempts to use evidence from a variety of sources to provide balance to the conclusions drawn.

The process is similar to HIA and IIA, and the impact of policies and services on minority ethnic communities should now be in the mainstream of routine health and IIA (DH, 2002b).

Policy context

Under the Race Relations (Amendment) Act 2000 British public authorities, in carrying out their functions, shall show due regard to the need to:

- Eliminate unlawful racial discrimination
- Promote equal opportunities
- Promote good relations between people from different racial groups.

The legal duty was introduced to ensure public services are free of 'institutional racism', and that the consideration of race equality (see box) is central to the way public authorities carry out all their functions (Commission for Racial Equality, 2003, 2004a–c).

Each public authority has specific duties to produce a race equality scheme containing arrangements for:

- Assessing and consulting on the likely impact of its proposed policies on the promotion of race equality
- Monitoring its policies for any adverse impact on the promotion of race equality
- Including consulting on and publishing results.

Also, policy makers must consider these duties as part of the regulatory impact assessment process for all government policy, and directions on how this should occur are available (Home Office, 2004).

Supporting the legal duties and regulations, the government has released a strategy in 2005, 'Improving Opportunity,

Steps in REIA

REIA is made up of two stages.

Stage 1 involves screening policy or legislative proposals to see if they are relevant to race equality. The screening stage has three parts:

- 1 Identify the main aims of the policy – understand the policy under development
- 2 Collect information about the different groups that may be affected by the policy
- 3 Decide if the policy is relevant to race equality duties required by law – if yes, move to stage 2; if no, document findings and decision, and stop

Stage 2 involves assessing policies identified as relevant to make sure they do not have adverse effects on any racial groups. The full assessment stage has eight parts:

- 1 Identify all aims of the policy to be clear about all aspects of the policy proposal
- 2 Gather and consider the evidence about the different racial groups likely to be affected by the policy proposal
- 3 Assess the likely impact by bringing together all the above information and judging its likely impact
- 4 Consider alternatives if the policy proposal is found to have negative impacts, either new methods to meet the aims of the policy, or changes to the policy
- 5 Consult formally – anyone likely to be affected by the policy must have the opportunity to express his or her views, concerns and suggestions
- 6 Decide whether to adopt the policy, taking care to be able to explain and document conclusions reached, and why
- 7 Make monitoring arrangements to determine the policy's actual effects once in operation; develop adequate data collection systems for producing reports on progress
- 8 Publish assessment results

Strengthening Society' (www.homeoffice.gov.uk/docs4/race_improving_opport.pdf), that sets out how to prevent a person's ethnicity being a barrier to their success, and how to foster the cohesion necessary to enable people from minority and majority communities to work together for social and economic progress (Home Office, 2005b).

The *Health and social care standards and planning framework 2005/06–2007/08* states that PCTs and their partner organisations must '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. This should address issues of race equality' (DH, 2004c). PCTs and their partner organisations should be addressing issues of race equality. A guide written in partnership with the NHS is available, outlining where NHS organisations must make progress (Commission for Racial Equality, 2004b). Furthermore, all NHS organisations must have a race equality scheme in place.

Who is doing REIA, and on what?

REIA (like HIA, IIA and HEA) is ideally led by the person drafting the policy, so findings allow the policy to be developed in the light of a systematic, transparent and inclusive review of the risks to, and opportunities for, race equality. As with the other approaches, REIA also seeks to alter policy if racial impact is identified – therefore it not only gives a 'yes or no' to a policy, but also provides practical and constructive ideas to improve the policy.

Although the regulations have been in place for three years, most public authorities have been very slow in implementing them, and race equality schemes display limited understanding and action. Examples of REIA from the Home Office, Department of Trade and Industry and the Metropolitan Police are on the Commission for Racial Equality website at www.cre.gov.uk/duty/reia/practice.html.

Further information

- www.cre.gov.uk/duty/reia/index.html – Commission for Racial Equality website with step-by-step web guides and examples
- www.homeoffice.gov.uk/comrace/race/reia – Home Office website 'Community and race'
- *The duty to promote race equality: performance guidelines for health organisations* (Commission for Racial Equality, 2002a)
- *Public authorities and partnerships: a guide to the duty to promote race equality* (Commission for Racial Equality, 2004c)
- *Putting race equality to work in the NHS: a resource for action* (DH, 2002b)
- *Race equality in public services* (Home Office, 2005a) brings together race equality performance data, and provides statistical background to the strategy and the related public service agreement targets
- *Race is relevant* CD-ROM (Employers' Organisation for Local Government, undated), with practical guidance on dealing with a small ethnic minority population or workforce

- *The law, the duty and you. The Race Relations Act and the duty to promote race equality: a guide for public employees* (Commission for Racial Equality, 2003)
- *The strategic health authority race equality guide 2004: a performance framework* (Commission for Racial Equality, 2004b)

- HEA by redirecting investment in organisational resources to places where there is most inequity
- REIA by ensuring that policies do not affect different race groups unfavourably.

Comparing the approaches

Which approach should I use?

There can be confusion about the similarities and differences between these five approaches. It is important to remember that the approach you choose (HNA, HIA, IIA, HEA or REIA) depends entirely on your aims and objectives, and the circumstances in which you operate. However it is important to note that HEA is now mandatory for all PCTs and strategic health authorities, and by law REIA has to be conducted on new policies and functions judged to be relevant to the duty to promote equality of opportunity and good race relations and eliminate unlawful discrimination.

All five approaches can be used to take account of inequalities to help improve health and reduce health inequalities:

- HNA by providing a local picture of inequalities through describing the health needs and health assets of different groups within the population
- HIA and IIA by viewing how proposals may affect the most vulnerable groups in the population compared with how they may affect the least vulnerable

HNA, HIA, IIA, HEA and REIA can then tailor recommendations to address inequalities – for example by changing priorities and targeting resources – or at least ensure inequalities do not widen further. HIA, IIA, HEA and REIA can also be used to stimulate better use of local assets, such as local workforces, community networks and service delivery systems (this concept is known as asset release).

Starting points

Both HIA and IIA start with a proposal (either policy, programme, strategy, plan, project or other development), then try to predict what impact that proposal is likely to have. HIA predicts the potential impact on the health of the population, with a particular focus on inequalities of health, whereas IIA predicts the impact on economic, social and environmental outcomes. REIA is similar except that, so far, it has only been used on policies (although this is likely to expand in use over time); REIA tries to predict the impact a proposal will have on different races. In contrast, HNA has its starting point with a population, and determines the health assets and health needs of that population – so that proposals are put forward for the development and delivery of improved programmes and services. HEA is a broader approach than those above: it looks at how equitably services and resources can be provided for a local community (Figure 1).

Figure 1 Starting points of HNA, HIA, IIA, HEA and REIA

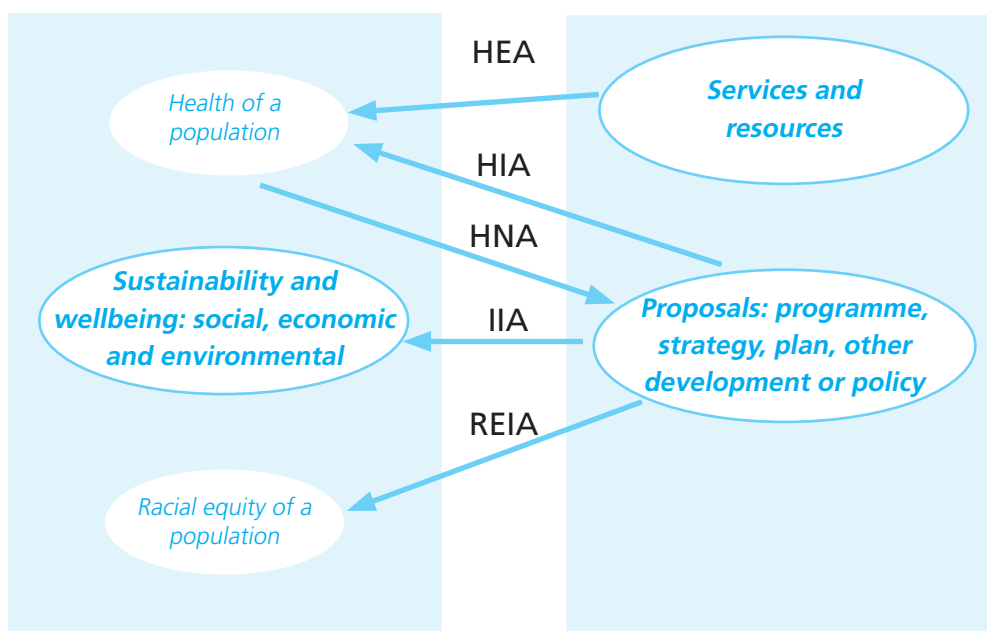
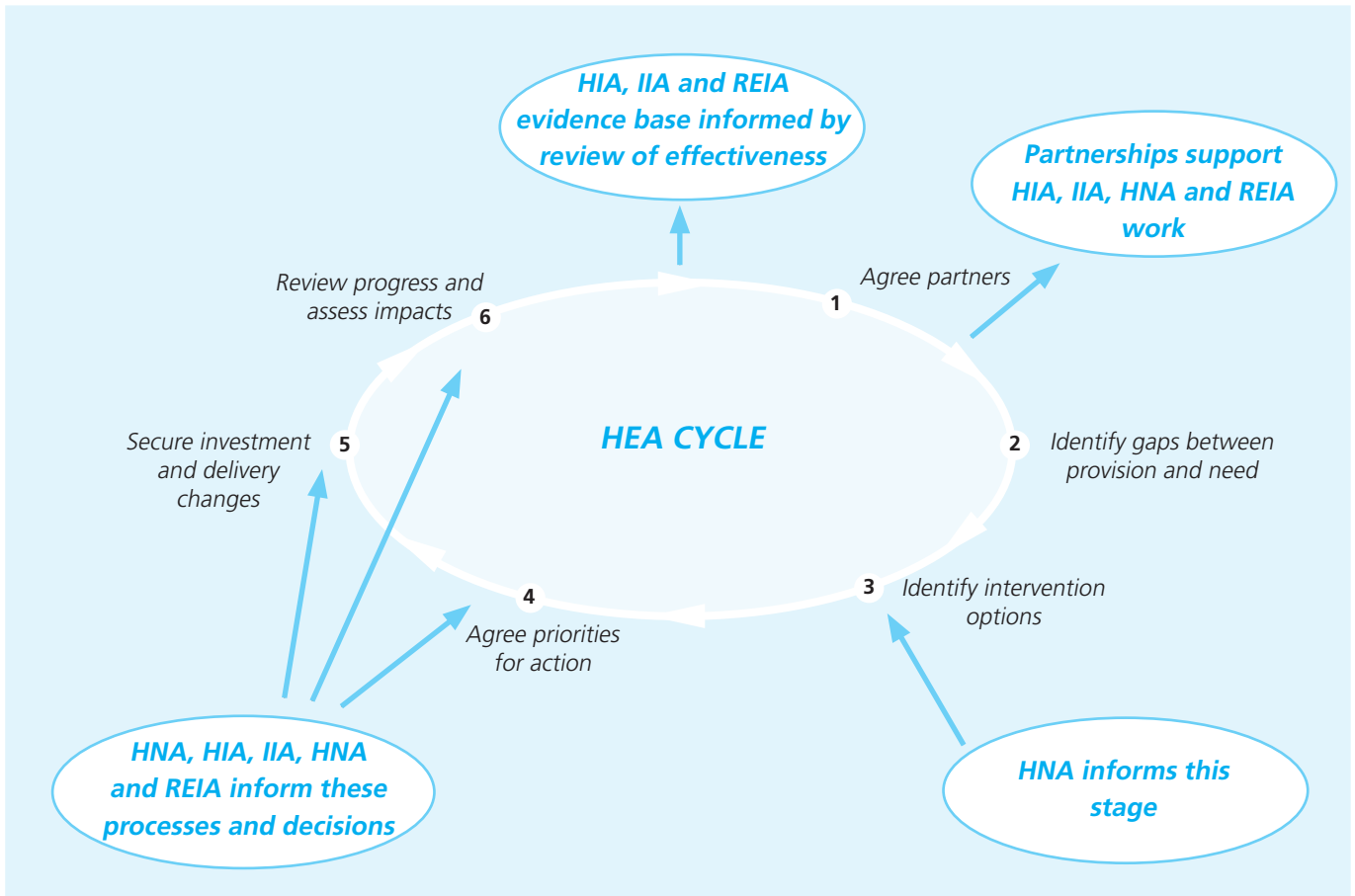


Figure 2 Relationship between HNA, HIA, IIA, HEA and REIA



Components of the approach

All five approaches work best when they involve a wide variety of stakeholders, building new ways of working together and ensuring joined-up planning/working – at project, programme, strategy, plan or policy levels (although so far REIA has only been described at policy level). A particular strength is the involvement of people across many sectors – and that the lead may be taken by people from any sector. Similarly, community involvement is typically a component of the approaches (apart from HEA), reassuring decision makers that views of the relevant groups are reflected in the recommendations and decisions made.

Within each approach, a similar range of methods are used to gather, synthesise and communicate information. For example, ways of engaging people in thinking about health issues for HNA may be equally appropriate for gathering community views within HIA, IIA, HEA or REIA. The research methods mastered for one assessment (eg HNA) may be of use for tackling a second (eg HIA) in the future.

All the methods interact and link with each other, each feeding into a different component of another, and *vice versa* (Figure 2). All the impact assessment methods (HIA,

IIA, REIA) have similar approaches, and it would be wise to consider many impacts within a single assessment, where possible, to attempt to cover the range of impacts discussed here. Where resources or necessity require an in-depth single assessment, then the assessment should retain its focus.

Primary outputs

Table 2 outlines the key features of each approach. These approaches produce information to help decision makers to:

- Recommend changes to a proposal, or to ways of working (HIA and IIA)
- Inform strategies, service priorities, commissioning and local delivery plans (HNA and HEA)
- Accept, reject or change the policy proposal (REIA).

IIA and HIA both use the determinants of health as a basis for assessing proposals, allowing both to consider how issues from outside the typical 'health frame' may exert their impact, for example on transport, housing, education, the environment or economic activity. HNA may consider some or all of these issues affecting people's health, so that recommendations can be put forward to address them.

Table 2 Common features and tasks of approaches to assessment

	Health needs assessment	Health impact assessment	Integrated impact assessment	Health equity audit	Race equality impact assessment
Starting point	Population	Proposal	Proposal	Services and resources	Proposed policy or organisational function
Primary output	Informs decisions about strategies, service priorities, commissioning and local delivery plans, and informs future HIAs and IIAs	Recommends how to maximise benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Recommends how to maximise benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Agreed and acted upon interventions that equitably distribute services and resources	Ability of organisation to demonstrate it is meeting legal requirements to promote race equality in its policies and functions
Aims to take account of inequalities	Describes health needs and health assets of different groups in local population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares health needs and outcomes in the local population with use and access to services and resources. Helps improve health and reduce inequalities	Assesses how far a policy or function may promote race equality and good race relations. Helps reduce organisational and racial inequity
Involvement of stakeholders	Always	Always	Always	Always	Always
Involvement of community	Always	Ideally (dependent on resources)	Ideally (dependent on resources)	No	Always
Involvement from many sectors	Sometimes	Usually	Always	Always	Sometimes
Based on determinants of health	Usually	Ideally	Always	Usually	No
Best available evidence used	Always	Always	Always	Always	Always
Uses data from other approaches; informs other approaches	Always	Always	Always	Always	Always

All the approaches make use of similar evidence to inform their work – local health data, local professional and community views, and (in the case of HIA and IIA) evidence of proposals' potential impacts gathered from epidemiological studies and other relevant research. In all cases the aim is to use the best available evidence given the

resources available. All the methods have a particular focus on using data about inequalities.

All the methods have evaluation/review as a component of the approach so that the impact of the work undertaken can be assessed, and the learning from the process undertaken can be shared.

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Acknowledgements

We would like to thank our two peer reviewers for providing comments that helped to shape this publication.

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.

For more information contact:
Health Development Agency
330 High Holborn, London WC1V 7BA
Tel: 020 7061 3111
Website: www.hda.nhs.uk

Authors: Robert Quigley, Sue Cavanagh,
Dominic Harrison, Lorraine Taylor and Melanie Pottle

ISBN 1-84279-349-7

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