Background

The LLB with LLF has expressed a commitment to complete a health inequality impact assessment for the next SLP. HIIA allows us to assess the potential of the policy to reduce or increase health inequalities and aims to strengthen the contribution of policies and plans to reducing health inequalities by improving equity of access, ensuring non-discriminatory practice and acting on the social determinants of health.[i] It should be conducted at a point in policy development when there is scope to make changes.

This paper provides a brief background to HIIA, what is meant by health inequality and the fundamental causes.

What is HIIA?

Impact assessment is a structured way to help us think through how a new or existing policy[1] can affect people in a positive and less positive way. While the intentions behind a policy may be to impact on people positively, it will seldom have the same effect on everyone. People are different and policies (and services) affect people in different ways. People are also not defined by any single characteristic so a narrow focus on one aspect of an individual's or group's identity may hinder understanding and responding to the reality of people's lives and experiences.[ii]

The HIIA approach was developed in response to *Equally Well*, the report of the Ministerial Task Force on Health Inequalities, which recommended the use of impact assessment that considers health inequalities and wider factors that cause them. It is an integrated approach that seeks to define the likely positive and negative health, equality and human rights impacts of a policy (including unintended impacts) and the population groups who will bear them. The HIIA approach draws on health impact assessment (HIA) methodology, which includes consideration of the social determinants of health. HIA has been used to influence policies in a wide range of sectors, such as housing and transport. HIIA helps us to look at how the proposed policy will impact on the fundamental causes, wider environmental influences and individual experiences of health inequalities.[i] Integrated HIIA satisfies the legal requirement to conduct an equality impact assessment (EqIA).

EqIA focuses on considering impacts on people covered by the nine protected characteristics included in the Equality Act 2010. These are: age; sex; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; race; religion or belief; and sexual orientation. In addition to these, HIIA considers other population groups who are vulnerable to unfair differences in health outcomes (such as people in different socio-economic groups, those involved in the criminal justice system, those living in remote/rural locations) and the social determinants of health (e.g. employment and education). HIIA also considers potential impacts on human rights, which is not usually included in EqIA. HIIA allows us to make recommendations on actions to mitigate potential negative impacts and also to enhance the positive intentions of a proposed policy.

[1] The term 'policy' is used throughout to refer to any plan, programme or service.

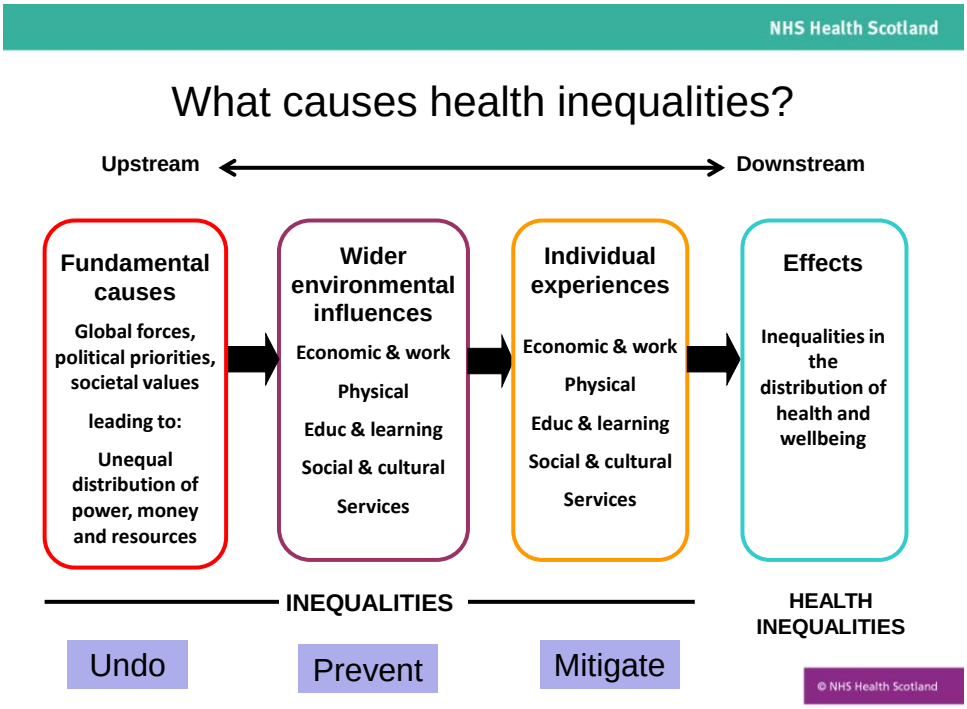
Human rights-based approaches prompt consideration of how a plan or policy might drive up standards of services and enhance positive impacts for **all** people. Scotland's National Action Plan on Human Rights (SNAP) 17 promotes a human rights-based approach known as **PANEL**: participation, accountability, non-discrimination and equality, empowerment, legality.[i] Further detail on the PANEL principles is provided in appendix 1.

What are health inequalities and what causes them?

Health inequalities are unfair and avoidable differences in people's health across population social groups and between different population groups. They are unfair because health inequalities do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual's control. Health inequalities are avoidable because there is widespread agreement that the primary causes of health inequalities are rooted in the political and social decisions and priorities. Figure one outlines the fundamental causes of health inequalities which are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of individuals and groups.[ii]

These fundamental causes also influence the distribution of wider environmental influences on health, such as the availability of good quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities in an area and in society. The wider environment in which people live and work then shapes their individual experiences of, for example, low income, poor housing, discrimination and access to health services. This all results in the effects described – unequal and unfair distribution of health, ill health (morbidity) and death (mortality). This has implications beyond health inequalities. Less equal societies, in terms of the differences in the income, power and wealth across the population show an association with doing less well over a range of health and social outcomes including violence and homicide, teenage pregnancy, drug use and social mobility.[iii]

Figure 1: Fundamental causes of health inequalities (Adapted from Beeston et al) [i]



What can we do to address health inequalities?

Tackling health inequalities requires a blend of action to undo the fundamental causes, prevent the harmful wider environmental influences and mitigate (make less harmful) the negative impact on individuals. Action must be based on evidence of need, understanding of barriers to social opportunities and what is most likely to work. The actions most likely to reduce health inequalities are those that deliver changes in high level social organisational processes. These might include anti-discrimination legislation, policies that reduce the differences between the highest incomes and the lowest, or policies to enable more equal opportunities, for example, access to high quality living conditions, healthy food or the best education. Actions least likely to reduce health inequalities are those that are targeted at individuals and depend on people coming forward, creating the potential for missing or ruling out those who are unable to take up the intervention. We know that factors such as being unable to speak English, reduced mobility, lack of social support, gender expectations, low income, discrimination and so on are linked to poor access to facilities and resources and poorer experience of service provision than the population in general. Therefore, services and prevention programmes that don't take diversity and disadvantage into account are at risk of increasing the health and social divide.[iv]

The 'Review of Equally Well' [v] promoted an asset-based approach as a way to tackle the underlying causes of health inequalities which requires a collaborative approach across different public services. Such an approach seeks positively to mobilise assets, capacities or resources available to individuals and communities. Assets can be grouped at three levels of individual, community and organisational or

institutional assets.[vi] Taking a person centred, rather than service centred, approach which involves people in all decisions that impact upon their lives links closely to methods akin to asset based approaches.

Embedding human rights-based approaches into existing impact assessment processes can help mainstream human rights into the work of public authorities. There is a legal requirement on public bodies to comply with the UK Human Rights Act (1998). The PANEL approach should help ensure that the human right to achieve the highest attainable standard of physical and mental health is met, which is recognised in a number of international agreements. 'Health' means different things to different people and these meanings can often refer to ill-health and the health care system. A positive definition of health from the World Health Organisation (WHO) is used within the draft strategic plan (p.27). Health is seen as a resource for everyday life, which includes our personal and social resources. Health is multi-dimensional and positive health means a sense of physical, social and emotional wellbeing. The '**right to health'**, as described by the WHO [iii] can provide a useful way for public sector service providers to approach health inequalities as it relates to asset based approaches, timely and appropriate care and to the underlying determinants of health, such as income and housing. There are four integrated and essential elements to the right to health[i] which will be used as prompts in the HIIA scoping workshop and are shown in appendix 2.

What is involved in doing an HIIA?

Any policy or plan with the potential for addressing health inequalities could use HIIA. There should be strong senior management level support for an HIIA to ensure resources are invested in the process and to commit to action being taken as a result of the assessment. It is best to carry out the HIIA when the policy is in draft as there is scope to make changes to it as a result of the assessment. It should be built into the early stages of planning when there is opportunity for the findings to influence decision-making.[i]

Appendix one: PANEL Principles.[i]

Participation	Everyone has the right to participate in decisions which affect them. Have those affected by the policy or plans had a say in shaping it? Does your impact assessment involve the right people?
Accountability	How will the organisation be held to account for embedding equality and human rights into its plans and policies? Who is responsible for taking action on the HIIA findings?
Non-discrimination and equality	Does the policy ensure everyone can realise their human rights? Has the HIIA considered how it can demonstrate non-discriminatory practice and advance equality?
Empowerment	How does the plan/policy build understanding or affirmation of human rights?
Legality	Has the policy respected, protected and fulfilled the full range of legally protected human rights?

Appendix two: The right to health. [i]

AAAQ:	**Is the proposed plan or policy likely to enhance or jeopardise:**
Availability	The availability of goods, facilities and services?
Accessibility	The physical and economic accessibility of goods, facilities and services?
Acceptability	The ethical and/or cultural acceptability of goods, facilities and services?
Quality	The quality of goods, facilities and services?

References

[i] Sigerson, D. and Craig, P. (2014) Health Inequalities Impact Assessment. Answers to frequently asked questions. Edinburgh: NHS Health Scotland. Available from: http://www.healthscotland.com/documents/23116.aspx

[ii] NHS Health Scotland (2013) Health Inequalities Impact Assessment- An approach to fair and effective policy making. Available from: http://www.healthscotland.com/documents/5563.aspx

[iii] World Health Organization. *The right to health*. 2013. Available from: ww.who.int/mediacentre/factsheets/fs323/en/

[v] Scottish Government (2010) *Equally Well Review 2010: Report by the Ministerial Task Force on implementing Equally Well, the Early Years Framework and Achieving Our Potential.* Available from: http://www.gov.scot/Publications/2010/06/22170625/0.

[vi] Sigerson, D. and Gruer, L., (2011) *Asset based approaches to health improvement.* Edinburgh: NHS Health Scotland.

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