Short Report
Health impact assessment and the consideration of health inequalities
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Summary
Equity and the consideration of the differential impacts of public policy within populations are core values of health impact assessment. A recent paper setting out the results of the government’s consultation exercise on tackling health inequalities argues for health impact assessment to be used as a mechanism to bring about reductions in health inequalities. However, we would contend that most, if not all, published health impact assessments have not considered the effects of public policies on health inequalities in a robust or reliable manner. In this paper we set out and explore some of the issues that require consideration if health impact assessment is to fulfil the government’s expectations.

Keywords: health impact assessment, health inequalities, review

Health impact assessment (HIA) is one process by which the differential impacts of policy on the public health may be predicted and evaluated.1 In England, the importance of HIA as a means to reduce health inequalities has been highlighted in several government papers and recent editorials.2–4 Numerous models for HIA exist (see Refs 1 and 5 for review) but all encompass the consideration of health inequalities. However, there is considerable diversity and variation in approaches, in terms of both ‘what’ (i.e. the ‘inequality’ measure that is being used as the comparator) and ‘whom’ (between which population sub-groups) are considered by the assessors. In this paper we consider some of the tensions, contradictions and problems that arise in HIA and that confront those seeking a consistent and uniform approach to inequalities impact assessment.

The present situation
A review of published HIAs and guidance for assessments would suggest that the differential impacts of interventions on subgroups of the population are given explicit consideration in the assessment process. For example, the British Columbia6 and Merseyside models7 both incorporate the use of lists of determinants of health and require the assessor to consider whether the policy intervention will change the distribution of any of the determinants across a range of population sub-groups. The model developed by the Swedish organizations8 presents a grid in which positive and negative impacts for the ‘whole population’ are recorded in columns adjacent to impacts for specified ‘target groups’, and in Wales, the Bro Taf guidelines have been specifically designed to explore population sub-group effects.9 However, not all HIA studies (including those purporting to adopt these models) have either utilized the grids to inform the process or presented the results of the assessment in such a way that comparisons of effects between groups are easily visible.

Pre-specification of population sub-groups for consideration in an HIA
In some of the published HIAs, the identification of population sub-groups whom the policy might affect differentially was undertaken on an a priori basis. In most studies, however, the decision as to which groups should be considered arose during the conduct of the assessment process itself. Does this difference matter?

The advantage of a priori identification of groups is that specific sub-groups, known to be more at risk of experiencing health inequality compared with the population as a whole, are not overlooked. However, the pre-selection of groups inevitably complicates further the assessment, for now who should be involved in the pre-determination of what is ‘relevant’ to an area or to a group is added on to an already complicated (and often controversial) process. Furthermore, in many HIAs, the pre-specification of all the necessary sub-groups to be included in the assessment may not be possible. For example, it may become apparent during discussions with key informants that a particular community is believed to at increased ‘risk’ from the proposed intervention. However, if the selection of groups is to be made...
during the conduct of the HIA itself, then it must be recognized that the decision to focus on some groups and not others might be affected, albeit inadvertently, by both explicit and implicit biases. As noted by Scott-Samuel, we need to recognize that in the actual undertaking of an HIA there may be ‘disagreement or power inequalities between different stakeholder factions’.7 In this situation, it might be helpful for workers to consider before conducting the HIA whether the establishment of some explicit and transparent criteria for the inclusion of groups would be useful.

**Specifying sub-groups**

There are many ways of partitioning the population into groups (for example, by geography, characteristics, interests or need), and these groupings are not necessarily mutually exclusive. Furthermore, among the published HIAs a blurring between the impacts and the characteristics that defined the sub-groups between whom the impacts will be compared is apparent – for example, income differentials exist between men and women (gender axis), but income itself can be a group characteristic (material status).10

If we are to suggest that an inequalities profile needs to be included in all HIAs to make explicit the assessment and reporting of the differential impacts of a proposed intervention, then which population sub-groups do we include? Although a review of case studies and models demonstrates evident heterogeneity with regard to the specification of groups for inclusion, some common themes around sex and age, ethnicity and ‘disadvantaged/vulnerable’ groups (as recommended in the ‘Gothenberg paper’) do emerge, although the specifications used to define the last three characteristics are frequently unclear. Could we therefore take these as a ‘must have’ to be included in all HIAs? If we do this, then not only should sub-groups be specified, but the characteristics of the comparator group(s) should also be made clear – a community cannot be ‘unequal’ in the abstract for its status is relative to that of others. Some models make the need for the comparison explicit – for example, the Swedish organizations model.8 Such an approach should be adopted more widely.

**Do we need ‘tight’ definitions of the sub-groups?**

Having set out which sub-groups might be included in the assessment, it is important to define more precisely their characteristics? The difficulty in measuring factors both as sub-group identity characteristics or outcome variables (e.g. ethnicity, material status) is well recognized. Perhaps it is because of this that few, if any, of the models or case studies reviewed make explicit the parameters that define their selected sub-groups (what is ‘disadvantaged’? ‘vulnerable’? ‘ethnic minority’? ‘low income’?).

If we are to consider whether or not it is acceptable for HIAs to be somewhat vague in their definition of sub-groups then we need to consider the purpose of the HIA process.15 At present, there is a paucity of evidence to underpin the prediction of health impacts from changes in the determinants of health, or indeed the differential impacts that may arise within a defined population.12–14 If the objective of HIA is to assess and then to evaluate the impacts and so to provide ‘knowledge’ to predict accurately future impacts from future interventions then it is imperative that researchers have a clear idea of ‘what impact’ was experienced ‘by whom’. In this context, the existing descriptions of sub-groups provided in the case studies reviewed will satisfy few researchers. Evaluation becomes difficult, if not impossible, when ‘target’ groups are not defined, and the generalizability of results (should they materialize) to subsequent similar interventions, problematic. However, if HIA is to act more as a ‘health promotion’ activity, then the need to be prescriptive with regard to describing sub-group parameters may be less. Here, if we demand ‘tight’ definitions of population sub-groups the utility of the HIA as a ‘bottom-up’ tool for empowerment and participation may be lost as ‘top-down’ empirical and reductionist approaches to evaluation drive the process.

**A way forward?**

In the face of the methodological and conceptual difficulties surrounding the assessment of health inequalities, it could be argued that it is simply too difficult for HIA to handle the consideration of inequalities confidently at present. Indeed, given the limitations of some of the methods proposed for, and adopted by, HIA there is the potential to arrive at incorrect impact estimates in terms of not only magnitude, but also direction.15 Undertaking an HIA may, however, encourage processes and produce outputs other than those related directly to policy evaluation; for example, the development of cross-sectoral working, more transparent decision-making, community participation and so forth. Might the process of HIA also offer a mechanism to keep ‘inequalities’ at the forefront of decision-makers’ minds?

Some might argue that this is not necessary – that the existence and cause of health inequalities are so well known that further flag waving is unnecessary. But although experts with experience in health and public health may easily consider the issue of inequalities as ‘second nature’, this may not be the case for ‘non-health’ decision-makers who may become involved in, and indeed lead, HIAs at the local level.

We believe that if HIAs are to be undertaken then they should explicitly set out the estimation of the differential distribution of effects arising from a policy- or community-based intervention. We acknowledge that, given that the aim and purpose of HIA may differ from place to place, it may not be possible to agree on a uniform approach and methods for inequalities assessment. That being said, we would argue that as a minimum, future HIAs should include an explicit consideration of the effects of intervention stratified by sex, age, ethnicity and socio-economic status relative to the ‘whole’ population, and that the criteria for the inclusion or exclusion of other relevant sub-groups be determined by clearly stated and transparent criteria.
References


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