PUTTING EQUITY INTO HEALTH IN ALL POLICIES

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Texas - Health In All Policies Project (T-HiAPP)
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Creating one size fits all policies and interventions to address the SDOH is a good start on an effort to create a context that makes it easier for communities to make good choices on the road to living more healthily.

The issue is what happens when the one-size fits all policy does not take account of differences in groups?

**Example:** The Advanced Metering Infrastructure in Chicago, examined a new technology. Smart metering technology allows utility companies to more easily communicate directly with your meter. There are two main benefits to smart meters:

1. No one has to come round to read your meter.
2. Bills are accurate - no more estimated bills, over or under-paying
Equity is thought to be distinct from equality.

Equality provides each person or community with the same amount and type of resources, whereas.............

Equity recognizes that each person, group, or community does not start at the same place and may need different policies, programs or types and amounts of resources to achieve similar outcomes.

PolicyLink (2013) Promoting Equity through the Practice of Health Impact Assessment
Health outcomes are made up of more than just each person’s individual actions.

The cumulative affects of social and economic factors over time make the effort to achieve good health harder or easier for each person to the extent that those factors increase the person’s climb towards good health.

The person in this picture (see next slide) is a single male. What happens if we place different groups on that incline and adjust the factors of the gradient according to that person's socio-economic status?

**Health Equity**

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those health differences which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible.”

The Health Gradient

Individually oriented preventive action

Health hazards

Environmental health hazards
Lack of education
Inadequate food and nutrition
Unemployment
Poor Housing
Poverty

Source: adapted from Making Partners: intersectoral action for health.
How do you design and evaluate equity-oriented policies?

How do you satisfy the dual purpose of promoting health gains in the population as a whole and reducing health inequalities?

A policy to create special taxing districts uses the property taxes from that area to fund sustainable, land use amenities such as walking trails, parks, and sidewalks.

Does this result in health gains for the entire population?
Does this reduce or increase health inequities?
How would you make these determinations?
STRATEGIES TO GAUGE EQUITY

Ensure that a central goal of a policy proposal is to identify and understand the health/socio-economic implications for populations most vulnerable or at risk for poor health. The goals should reflect a focus on expanding opportunities for good health outcomes in vulnerable populations.

Encourage agencies collecting data to inform the policy decision to gather information that would allow for stratification into key population subgroups that can reveal inequities.
When stratified data (based on SES) are unavailable, recommend that such data be collected in the future.

Review literature from other sources that have studied similar populations but in another setting or location.

Collect data from a sample of vulnerable populations using surveys, focus groups, and interviews, among other methods, to capture their unique circumstances.
Example—A systematic review of the effects of tobacco pricing on smoking behaviour did not find controlled trials but did find informative observational studies. Nine of 42 studies examined aspects of equity (such as lower versus higher income smokers, ethnicity): these suggested that pricing might have a greater effect in people with lower incomes. This observational evidence base is informative about the differential effects of a major tobacco control policy, whereas reviewing the evidence from randomised controlled trials alone would produce an “empty review”—a review with little to say about the policies’ effects.
Develop and prioritize recommendations that specifically mitigate potential negative impacts and target benefits for vulnerable populations.

Recommend monitoring of the implementation of targeted policies to ensure vulnerable populations are not being harmed and are benefiting appropriately.
The Advanced Metering Infrastructure (smart meters) study conducted in Chicago, examined metering technology that allows utility companies to remotely and more easily shut off electricity to homes without visiting them, raising concerns regarding disproportionate impacts on low income populations who may be more likely to be late in paying their bills and could easily have important heating or cooling systems shut off, creating health issues.

The study had a stated goal of “focus[ing] on ‘vulnerable populations’” as a subset of residential customers generally, because most utility proposals focus on the “average” customer. However, utility regulators or policymakers rarely possess information about subsets of residential customers who might respond differently from, or require, specific needs compared to, “average” customers. The report then goes on to define vulnerable populations” and focuses the analysis on these populations.

Megan Sandel, Emily Suther, Kristin Munsch, Lynne Snyder, and Barbara R. Alexander, “The Health Impact Assessment of the Commonwealth Edison Advanced Metering Infrastructure Deployment,” [https://docs.google.com/file/d/0B5pT1DBthVK0MTdGUGJxV3JNUTg/edit](https://docs.google.com/file/d/0B5pT1DBthVK0MTdGUGJxV3JNUTg/edit) (accessed November 19, 2012).
EXAMPLE: STRATEGIES TO GAUGE EQUITY

WHO: The San Francisco Department of Public Health

WHAT: Conducted a study of a potential road pricing policy that would charge $3 during morning and afternoon rush hours to travel into or out of the congested northeast quadrant of San Francisco, California.

EQUITY: In addition to assessing effects with respect to geographic equity on air and noise pollution, physical activity, and transportation-related injuries citywide and within the road pricing area under study, the HIA assessed equity impacts with respect to traffic-related health hazards and environmental exposures for children and youth, seniors, and low-income populations.

A variety of impact assessment tools have been used for many years to identify the effects of public and private sector initiatives on human health and/or on the environment.

The National Collaborating Centre for Healthy Public Policy (NCCHPP) documented a comparison of four main types of impact assessment used in Canada to help public health and other stakeholders select the most appropriate tools and approaches for assessing the impacts of various public policies (Mendell, 2011).
Checklists

Resource neutral if staff are adequately briefed about the methodology;

Takes no more than 30 minutes to complete; and

Questions it raises should be in the forefront at an early stage.

Disadvantage can be measured across categories of social differentiation, using the mnemonic PROGRESS-Plus. PROGRESS is an acronym for Place of Residence, Race/Ethnicity, Occupation, Gender, Religion, Education, Socioeconomic Status, and Social Capital, and Plus represents additional categories such as Age, Disability, and Sexual Orientation.

- Evans, 2003 and Oliver, 2008
Ask yourself which layer your policy addresses:- see next slide

**Layer 1:** Does this activity support/promote healthy behaviors/lifestyles among priority populations?

**Layer 2:** Does this activity foster greater social networks and community participation among priority populations?

**Layer 3:** Does this activity improve the environments where people live, work and play so that priority populations have greater access to opportunities for health?

**Layer 4:** Does this activity improve the social and economic conditions (the root causes) that put individuals at greater risk of poor health outcomes in the first place?
The “Determinants of Health”

Layer 1: General socio-economic, cultural and environmental conditions
- Agriculture and food production
- Education
- Work environment
- Water sanitation
- Health care services
- Housing
- Unemployment
- Living and working conditions

Layer 2: Social and community networks
- Age, sex & hereditary factors

Layer 3: Individual lifestyle factors

Layer 4: Graphical representation
<table>
<thead>
<tr>
<th>Social and Economic Determinants of Health</th>
<th>Example Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income &amp; Income Distribution</td>
<td>individuals living in poverty or on low-incomes</td>
</tr>
<tr>
<td>Education / Skill Building / Literacy</td>
<td>individuals with low literacy levels, individuals with limited educational opportunities</td>
</tr>
<tr>
<td>Employment &amp; Working Conditions</td>
<td>unemployed, underemployed and precariously employed individuals</td>
</tr>
<tr>
<td>Safe and Affordable Housing</td>
<td>homeless individuals and those without access to safe and affordable housing</td>
</tr>
<tr>
<td>Food Security</td>
<td>individuals without access to nutritious, safe, affordable and culturally appropriate foods</td>
</tr>
<tr>
<td>Physical and Built Environments</td>
<td>individuals living in low-income neighborhoods, individuals living in remote/underserviced communities</td>
</tr>
</tbody>
</table>
Health inequalities impact assessment: a policy audit checklist

http://www.london.gov.uk/lhc/docs/lhs/hia2/r_hia811.pdf

1. What problem does the project address?

2. Whose needs will be met by the project? (e.g. whole population or a named prioritized group)

3. Have you considered the particular needs of the following group and how the project might promote or limit access to better quality services for them?

   Please circle as appropriate and give details below.

   o · Material disadvantage, including low income (consider access to car), unemployment, the homeless and travelers
     o Promote/Limit/No change

   o · Culture and ethnicity, including those who find communication in English difficult
     o Promote/Limit/No change

   o · Families with children, pregnant women, young children and teenagers
     o Promote/Limit/No change

   o · Vulnerable people, including those who are mentally or physically disabled, frail older people, and those with learning disability
     o Promote/Limit/No change

   o · People who may be disadvantaged by reason of their gender or sexuality
     o Promote/Limit/No change

4. Having completed this checklist, are there any user groups whose needs you may not have considered?

5. Yes/No If yes, what action do you intend to take?

6. How will you monitor the impact this policy will have on meeting the needs of disadvantaged groups?
1. The checklist is a ‘rapid appraisal’ of the health impacts of a policy.
2. Will only take about 1½ - 2 hours to complete.
3. If it is felt that the health impacts are potentially serious, a more detailed HIA should be undertaken, and this checklist will help prioritise the need for this further work.

4. The checklist explores the determinants of a healthy neighbourhood and will encourage identification of the factors within a policy that can improve the quality of life for local people and tackle health inequalities.
5. Stage one offers a ‘rapid appraisal’ of the predicted health impacts based on 14 short questions. It may be useful to refer to the determinants of health to help answer the questions.
6. Stage two is designed to help decide whether a more comprehensive HIA is needed and explores the issues involved in this decision.

7. To ensure wide discussion of the health impacts, it is recommended that several people apply this checklist to a policy. Special expertise in health is not needed; just knowledge of the policy and judgement of its effects on the health of a population.
8. As this checklist is designed to be applied to all kinds of policies, some of the questions may not be relevant to the policy you are screening. Just leave these blank,
9. If you find that there is insufficient evidence about a particular health impact, be as objective as you can using your best judgment about information and record this in your decision-making.

10. What happens after the ‘rapid appraisal’?
11. After completing the 14 questions, you will be asked to explore your findings in a second table to help decide whether an in-depth HIA is needed.
12. If this is the case, general guidance on the next steps to take is included in this checklist.
13. If you find that your responses indicate further HIA is not necessary, you should document your decision why and outline what steps you will take to mitigate negative health impacts and enhance any positive health
The Equity Lens
Dans et al. (2003)

1. Is there potential for differences in relative effects between advantaged and disadvantaged populations? E.g. Are children from lower income families less likely to use bicycle helmets? (Royal, 2005)

2. Did you include relevant and important outcomes for the appropriate PROGRESS-Plus groups?

3. Did you conduct subgroup analyses across categories of disadvantage (e.g. socioeconomic status, sex, race, etc.) where appropriate?

4. Is there a reason to anticipate different effects of the policy in privileged and disadvantaged groups?

5. Are the effects of the policy valued differently by disadvantaged compared to privileged populations?

6. Is specific attention given to minimizing barriers to implementation in disadvantaged populations?
Goals of Urban HEART

The Urban Health Equity Assessment and Response Tool seeks to guide policy and decision makers at national and local levels, to:

1. Identify the differences between the health, health determinants and well being of people living in disadvantaged urban areas and the general population; and

2. Determine appropriate, feasible, acceptable, and cost-effective strategies, interventions and actions which should be used to reduce inequity gaps between people living in the same city.

Implementation of Urban HEART


Example:Tehran, Iran http://www.who.int/kobe_centre/measuring/urbanheart/tehran_urbanheart_city_report.pdf
Equity and Social Justice Initiative, King County, WA: The county government is using an Equity Impact Review Tool to intentionally consider the promotion of equity in the development and implementation of key policies, programs and funding decisions.

Race and Social Justice Initiative, Seattle, WA: City Departments are using a set of Racial Equity Analysis questions as filters for policy development and budget making.
Racial Equity Impact Assessments: A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.

REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions.

2009, Terry Keleher, Applied Research Center. www.arc.org
Proposed Racial Equity Impact Policy in St. Paul, MN: If approved by the city council, a Racial Equity Impact Policy would require city staff and developers to compile a “Racial Equity Impact Report” for all development projects that receive a public subsidy of $100,000 or more.

Race Equality Impact Assessments, United Kingdom: Since 2000, all public authorities required to develop and publish race equity plans must assess proposed policies using a Race Equality Impact Assessment, a systematic process for analysis..
THANK YOU!