

HEALTH EQUITY 2020 TOOLKIT

*Drawing up evidence based action plans to address
socioeconomic health inequalities*

Edition: 1.0

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In close collaboration with the Health Equity 2020 project partners.

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PREFACE

The aim of the Health Equity 2020 project is to assist regions in Europe in drawing up evidence-based action plans to address socioeconomic health inequalities. An important product within Health Equity 2020 is a toolkit which provides a step-by-step approach towards developing these action plans.

In the [Introduction](#), the main concepts, rationale and the general structure of the toolkit are presented. The toolkit consists of four phases that are important in developing evidence-based action plans; [Phase 1: is the needs assessment](#), [Phase 2: covers capacity assessment](#), [Phase 3: assists in selecting entry points](#) and [Phase 4: describes the impact assessment](#).

In addition, the [Action Database](#) provides examples of action that could reduce socioeconomic inequalities in health. The [Action Plans](#) section provides examples of action plans developed by regions, and are included as a source of inspiration.

The toolkit is intended for everyone who wants to learn more about how to assess and address socioeconomic health inequalities in a regional setting (the subnational setting such as state, district, province, territory, municipality, etc.). Most of the tools are also relevant for anyone wanting to learn more about how to address socioeconomic health inequalities in a local or national setting. The toolkit can be used with different starting points in the region and different user knowledge levels, although some basic knowledge of health and health determinants is required. The toolkit guides the reader through a step-by-step approach that can be sequential but is also sometimes parallel or iterative.

More information on the Health Equity 2020 project can be found on the [project website](#).

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INTRODUCTION

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What are health inequalities?

Definition of health

According to the World Health Organization, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). In general, health is determined by the genetic and biological predisposition of persons and by the context in which they are born, grow up, work and grow old. Good health helps people participate in and contribute to society.

Definition of health inequalities

Health inequalities can be defined as 'differences in health status or in the distribution of health determinants between different population groups' (WHO, glossary). In Box 1, the definition on health inequality and inequity by the WHO is given; it is particularly the term health inequities which is generally regarded as unjust and unfair. However, in this toolkit the term 'health inequalities' rather than 'health inequities' is mostly used since in practice the distinction is hard to make.

In this toolkit, health inequalities between groups of different socioeconomic status are the main concern. Socioeconomic position refers to "the social and economic factors that influence what positions individuals or groups hold within the structure of a society" (Lynch & Kaplan, 2000). It often reflects differences between individuals and groups in possession of resources such as education, which can influence access to information and benefiting from knowledge, or income, which can influence access to scarce material goods.

Health inequality exists in a social gradient; "a stepwise or linear decrease in health that comes with decreasing social position" (Marmot, 2004). This means that differences in health are not just found between the highest and the lowest socioeconomic groups, but that they exist at all levels.

Box 1: Health inequality and inequity (WHO, glossary)

"Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health

Causes of health inequalities

Socioeconomic health inequalities are influenced by an unequal distribution of economic, social, and environmental conditions in combination with individual factors. These conditions determine the risk of ill health and disability, for example because of differences in health behaviours. The more favourable these conditions, the better the prospects for good health and a longer life.

Figure 1 describes a general framework for the explanation of socioeconomic inequalities in health. Within the framework, two important mechanisms are distinguished that can explain socioeconomic inequalities in health: the causation and selection mechanism. The causation mechanism states that socioeconomic position influences health via intermediary factors such as working and living conditions. The selection mechanism states that health can influence socioeconomic position, for example because of an inability to work or study.

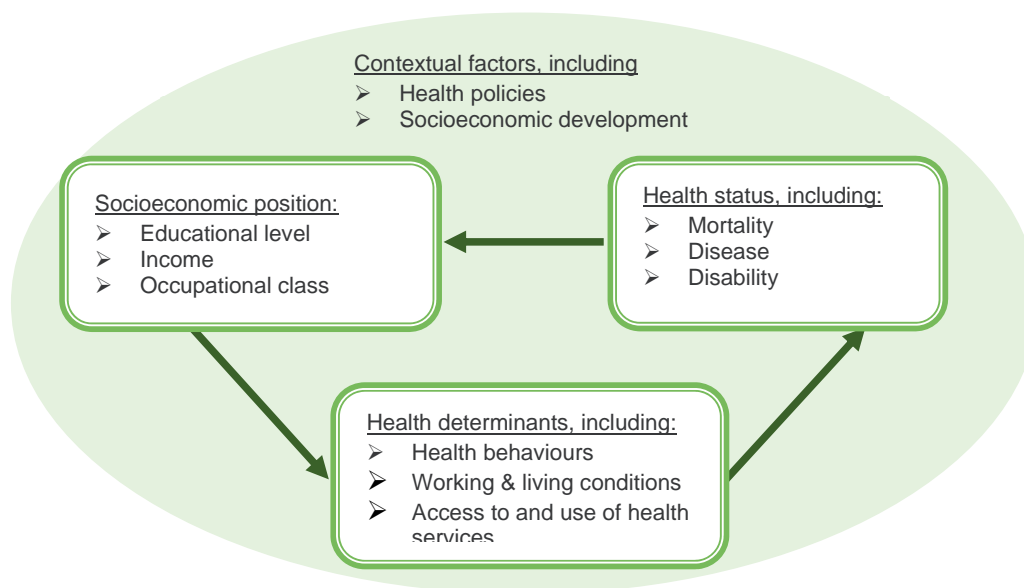


Figure 1: A framework for the explanation of socioeconomic inequalities in health (Kunst et al, 2001).

Why reduce health inequalities?

Equity perspective

Reducing health inequalities is important from an equity perspective. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 1946). It is therefore considered that preventable inequalities in health are unfair and unjust. Reducing health inequalities is therefore about fairness and justice and promotes the “right to health” as described in the constitution of the WHO (1946).

Economic perspective

Reducing health inequalities is also important from an economic perspective. For example, ill health and disability are major reasons for early retirement. With an ageing population, it is important to keep people active in the workforce. In general, ill health and disability have an impact on the economy via reduced labour supply, reduced labour productivity, less

education and training, fewer savings for investments in physical and intellectual capital, higher healthcare costs, and higher uptake of social security benefits.

A European study estimated that health inequalities-related losses to labour productivity amount to €141 billion per year in the EU. If health is valued in its own right, health inequalities-related losses amount to a staggering €1 trillion per year (9.4% of GDP) (Mackenbach et al, 2007). By improving the health of these lower socioeconomic groups, economic development of the region can be strengthened.

How to reduce health inequalities?

Actions to reduce socioeconomic health inequalities can be targeted at the socioeconomic position itself (e.g. increasing income, improving education, creating employment), via the intermediary factors (e.g. improving health behaviours, living or working conditions or access to health care) or by reducing the influence of ill health on socioeconomic position (e.g. reintegration trajectories, disability benefits).

The toolkit: a structured approach

To decide the most promising approach in a region to address socioeconomic health inequalities, priorities need to be set. The process of drawing up evidence based action plans to address socioeconomic health inequalities follows a structured approach in which four main phases can be identified (Figure 2).

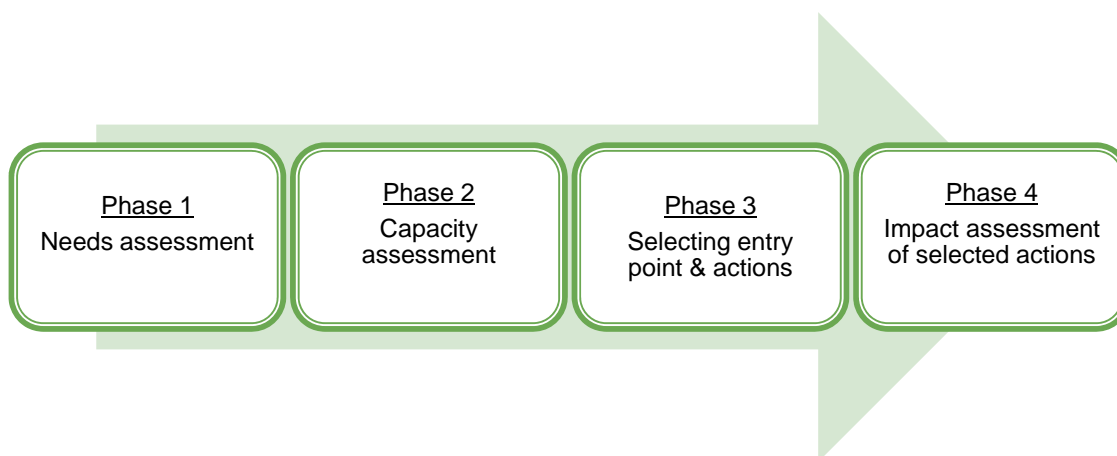


Figure 2: The process towards evidence-based action plans

Phase 1 focuses on a needs assessment: what is the current situation in the region with respect to socioeconomic health inequalities (health outcomes and determinants) and what are the desired outcomes? The gap between these two is considered to be the needs with respect to socioeconomic health inequalities. These needs form the entry points for action to address socioeconomic health inequalities. [See Phase 1 of the toolkit: Needs Assessment.](#)

Phase 2 focuses on the capacity audit and addresses capacities needed to address health inequalities such as organizational development, workforce development, resource allocation, partnerships and leadership. [See Phase 2 of the toolkit: Capacity Assessment.](#)

Phase 3 focuses on selecting entry points for action. With the information obtained in the needs assessment and the capacity audit, entry points for action can be identified. Actions can be selected that address these entry points or priority areas. [See Phase 3 of the toolkit: Selecting Entry Points & Action.](#)

Phase 4 focuses on impact assessment. An impact assessment of the selected actions can provide more information on the potential impact of each action and can therefore help in the process of deciding which action to take to address health inequalities. [See Phase 4 of the toolkit: Impact Assessment](#) (insert link when on website).

The final goal of these phases is to draw up evidence-based action plans that address socioeconomic health inequalities in the region.

The Health Equity 2020 toolkit assists regions in all these phases.

[Start the toolkit.](#)

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PHASE 1 – Needs Assessment

Assessing the magnitude and determinants of socioeconomic health inequalities

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Introduction

This needs assessment tool provides a systematic method for regional policymakers to review the current size and magnitude of socioeconomic inequalities in health situation in a region, and to identify the determinants of such socioeconomic inequalities in health. This is the first phase of the Health Equity 2020 toolkit (see Figure 3).

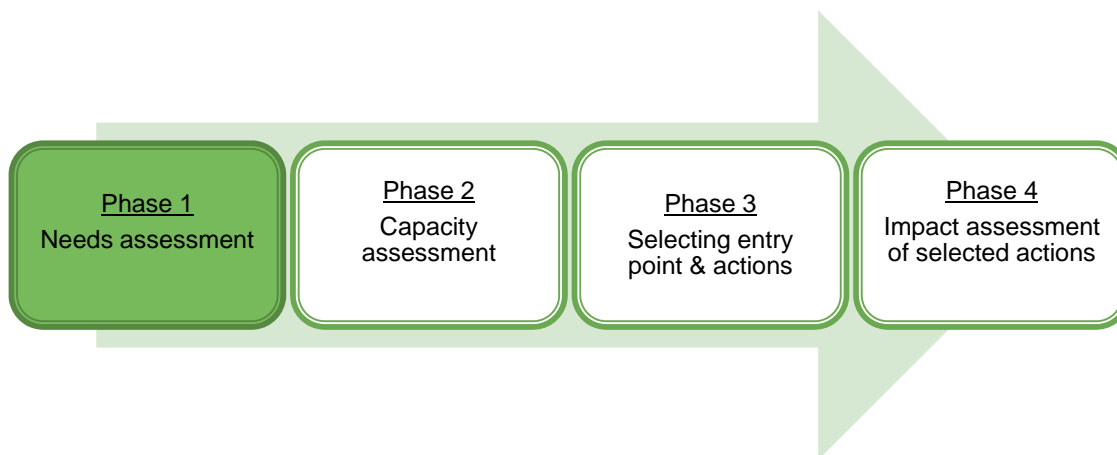


Figure 3: The process towards evidence-based action plans – phase 1

The information from the needs assessment can, in combination with the information from the capacity assessment ([phase 2](#)), assist in the process of identifying entry points for actions that will reduce socioeconomic inequalities in health. A comprehensive overview will ultimately help in making decisions regarding the allocation of resources when addressing health inequalities and regional development.

Definition of needs

In this tool, a need is defined by the gap between a current situation and a preferred situation. With respect to socioeconomic inequalities in health, the preferred situation would be the absence of preventable and unjust health inequalities. The needs are therefore defined as those socioeconomic health inequalities in the current situation that are amenable by policy or intervention. These needs inform the entry points for action to address these socioeconomic inequalities in health.

The needs assessment process

The purpose of this need assessment tool is to provide practical guidance and information in reviewing the current size and magnitude of socioeconomic inequalities in health situation in a region, and to identify the determinants of such socioeconomic inequalities in health (see Figure 4).

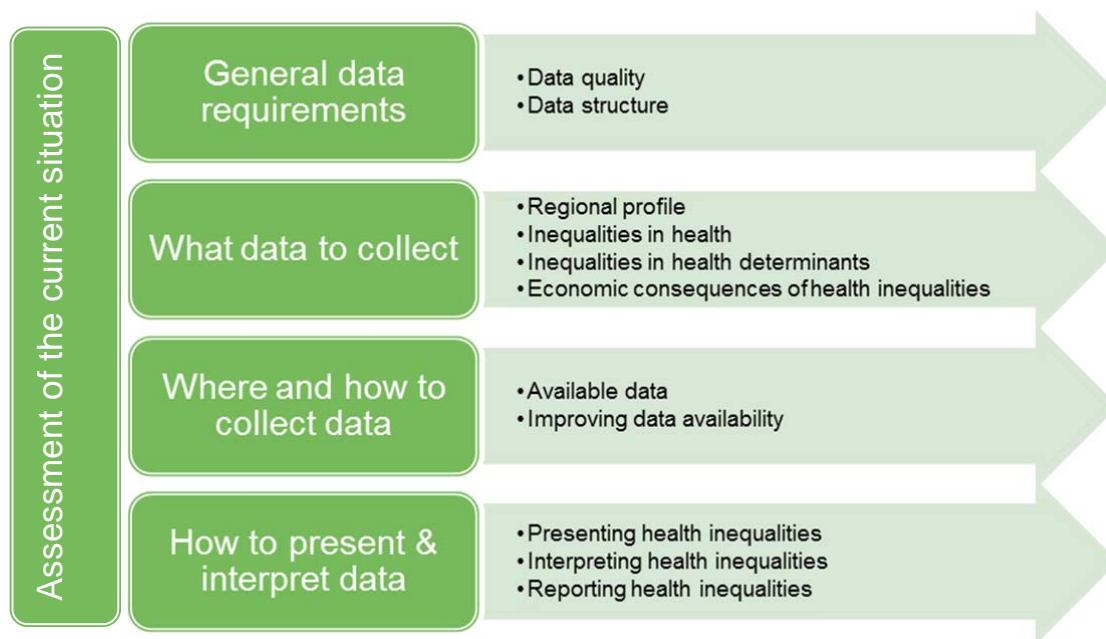


Figure 4: Elements of this Needs Assessment tool

Firstly, the tool provides information about [general data requirements](#) that should be taken into account when assessing the regional health situation. Considerations with respect to data quality and data structure are presented.

Secondly, the tool gives an overview about [data that should be collected](#). Lists are presented about important indicators of health inequalities, the main determinants of health inequalities and potential economic consequences of health inequalities. Data on these indicators should be obtained to get a comprehensive overview of regional health inequalities.

Thirdly, the tool describes [where to obtain and how to collect the required data](#). This section discusses potential sources of readily available data. In addition, some information is given how to improve data availability by collection primary data or qualitative data.

The final part of the needs assessment is about the [interpretation and presentation](#) of the data. The needs assessment should preferably result in a report that summarizes the current size and magnitude of socioeconomic inequalities in health and health determinants in a region.

The report that will result from this needs assessment, together with the results from the capacity assessment ([Phase 2](#)), will be the base for the next step in the toolkit: the selection of potential entry points for action ([Phase 3](#)).

Assessment of the current situation

General data requirements

Good quality data is essential to get a comprehensive overview of the current situation in a region with respect to health inequalities, health determinants, and consequences of ill health. Obtaining data is often a challenge. [Secondary data sources](#), such as national or regional surveys and monitoring or census data, have the advantage of being readily available and often this information is collected at regular intervals. It may however, be necessary to [collect additional data](#). More information on data collection can be found in [further on in the tool](#).

Issues regarding privacy and data protection should be considered. Anonymized data is in general easier to access than identifiable data. When dealing with personal data, it is important to work ethically according to the appropriate privacy and data protection rules.

Data quality

In a needs assessment, the following issues related to the data should be considered (Kunst et al, 2001):

1. Data should cover all or large parts of the population (e.g. all ages, men and women)
2. Estimates should be easy to calculate (e.g. percentages or rates)
3. Estimates should be representative (e.g. random or stratified sample)
4. Estimates should be reliable and precise (e.g. large sample, correct coding)
5. Estimates should be comparable over time (e.g. same methods used over time)

Not every dataset meets all five demands. For the purpose of this tool, the main focus should be on requirement 1 'data should cover all or large parts of the population of interest'. After this, the focus should be on requirement 2 'estimates should be easy to calculate'. If these requirements are met, the focus can shift towards the other three issues. More evaluation criteria to decide on the quality of secondary data, can be found in the section on [choosing between currently available data sources](#) in the chapter about [where and how to collect data](#).

Data structure

Since the focus of the needs assessment is to assess the magnitude and size of the socioeconomic health inequalities, all data should be stratified by an indicator of **socioeconomic position**, such as education, income, and/or a measurement of occupational class. More information on indicators of socioeconomic position can be found in the [section below](#).

Additionally, it is well known that the size of inequalities in health can differ between men and women. It is therefore preferred to collect information for **men and women separately**.

Finally, since health is strongly determined by age, it is also important to collect data separately for different **age** groups.

To illustrate this variability, Figure 5 presents the life expectancy of Bulgarian men and women for three ages and per educational group. The coloured vertical bars show the life expectancy by age, education and gender. For example, the first pink bar on the left hand



side shows that 25-year-old men with a high level of education on average still have 52.45 years to live (e.g. a total life expectancy of 77.45). The gradients in each of the age and gender clusters represent the educational inequalities in life expectancy.

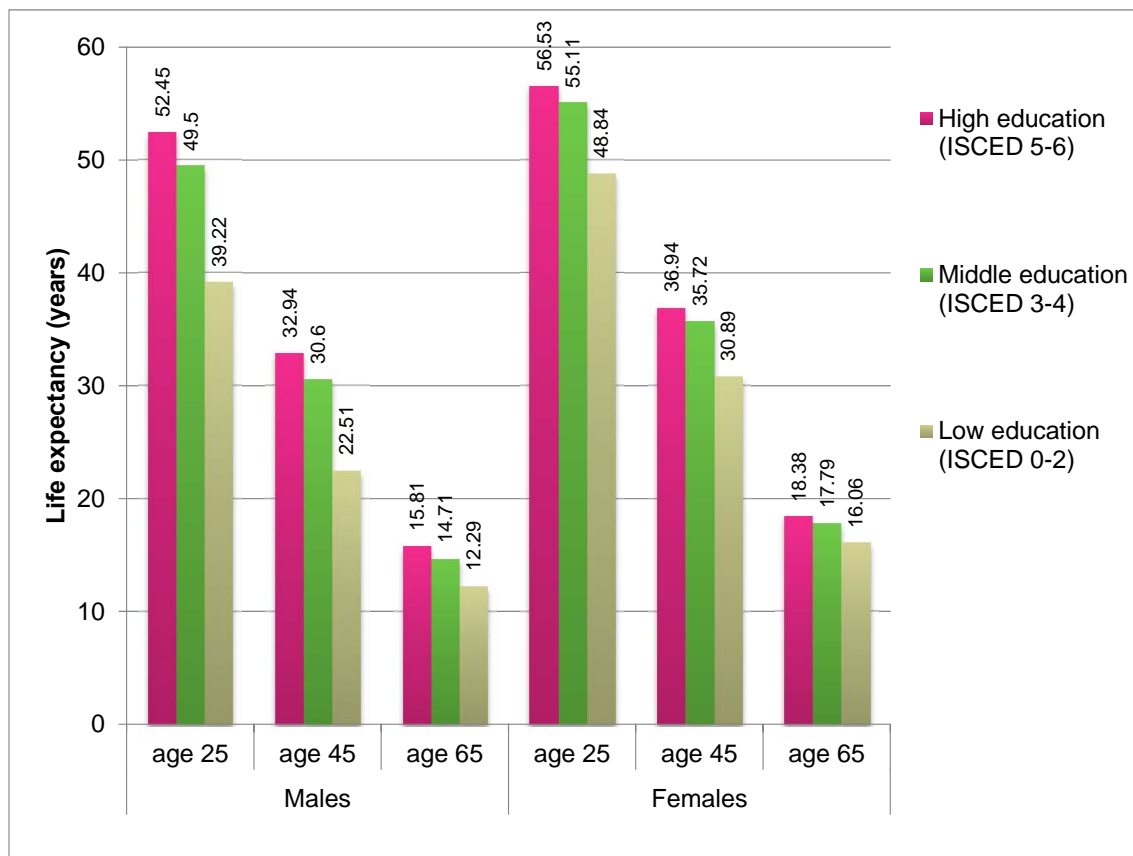


Figure 5: Life expectancy at age 25, 45 and 65 by education level in Bulgaria, 2010 (EUROSTAT)

Socioeconomic position

As mentioned, socioeconomic position refers to “the social and economic factors that influence what positions individuals or groups hold within the structure of a society” (Lynch & Kaplan, 2000). It is often an aggregate measurement that is reflected by several indicators such as education, income and occupational class. Figure 6 provides an overview of potential indicators of socioeconomic position over the life course (Galobardes et al, 2006). There is no consensus on which single indicator best reflects socioeconomic position. Indicators are complementary and reflect different aspects of the socioeconomic position. Collecting data on more than one socioeconomic indicator is therefore preferred.

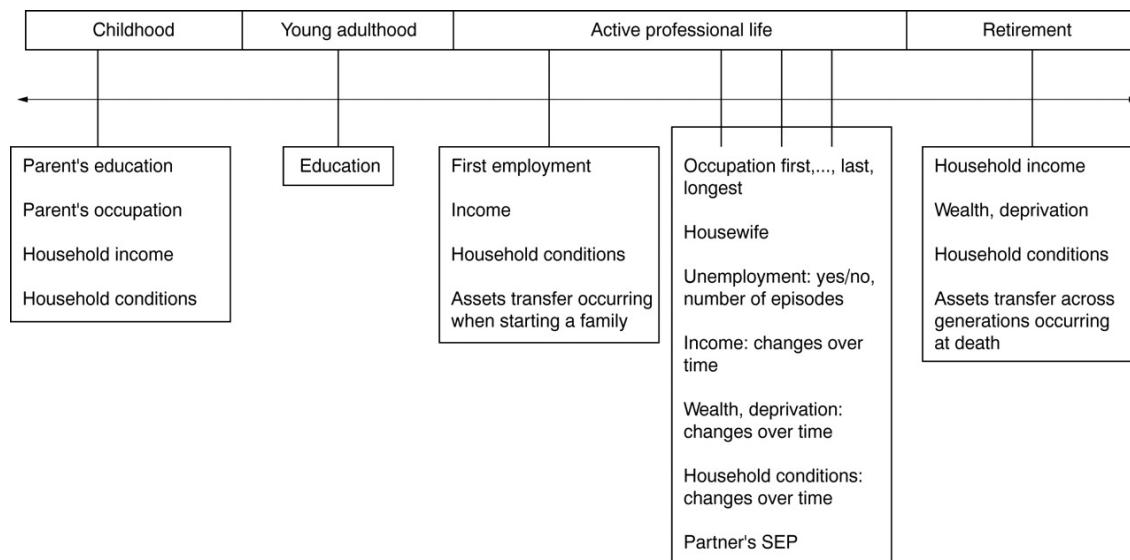


Figure 6: Examples of indicators measuring life course socioeconomic position (Galobardes et al, 2006)

There are some advantages and disadvantages to each indicator of socioeconomic position (Galobardes et al, 2006). Aspects such as reversed causality (ill health causes a lower socioeconomic position), practical availability of the data, reliability of the indicator across population groups and other content-related considerations are important in choosing the appropriate indicator or set of indicators.

For example, education is relatively easy to measure and is relevant to people regardless of their current work status or their age (from adulthood). On the other hand, the meaning of education may be different across birth cohorts, gender, or minority groups since the opportunities to get an education may have changed over time for different groups. Income has the advantage of being a very good indicator of living standards, but it may be harder to obtain information about because people consider it sensitive information. Additionally, it may be less appropriate for young and older adults because income usually follows a curvilinear path across the lifespan. There is also a possibility of reversed causality (people with ill health will have lower income because of their ill health). Occupation-based measures may also be easily obtained in surveys and registries but they are less appropriate for women and older populations and the information does not include those who are not currently employed (retired people, students, housewives/househusbands, unemployed). Finally, household conditions could also be used as an indicator of socioeconomic position (e.g. housing tenure, housing amenities). They are a relatively easy to collect measurement but they have the disadvantage of being very contextual. This may be less of an issue when only comparing data within one region. An overview of the advantages and disadvantages of indicators of socioeconomic position can be found in a series of articles by Galobardes and colleagues (2006) ([part 1](#) and [part 2](#)).

There are several international standards of measuring and categorizing certain socioeconomic factors. These standards have been developed to make international comparisons possible and more reliable. For example, educational attainment is often based on the International Standard Classification of Education (ISCED). The most recent version (2011) of the ISCED can be found at the [UNESCO website](#). Also, for occupational class

there are several standard classifications that are all based on the International Standard Classification of Occupations (ISCO) that was last updated in 2008 ([see website of the International Labour Organization](#)). Two widely used categorizations are the so called EGP, Erikson, Goldthorpe & Portocarero class categories (1979) and the International Socio-Economic Index of occupational class (ISEI) (1992).

Summary of data requirements

To sum up, data for a needs assessment on socioeconomic health inequalities should fulfil the following requirements:

1. Data should cover all or large parts of the population
2. Data should be easy to calculate
3. Data should be stratified according to a socioeconomic indicator
4. Data should be stratified according to gender
5. Data should be stratified according to age (categories)
6. Data should preferably be:
 - a. Representative
 - b. Reliable & precise
 - c. Comparable over time

Which data to collect

To get an overview of the current situation in a region with respect to the magnitude and size of health inequalities and their determinants, data is needed for all the different elements that may explain socioeconomic inequalities in health. This includes information on:

- [Regional profile](#), such as population size, population density, urbanization, economic situation, existing health policies, etcetera. This information is important since socioeconomic health inequalities develop in a regional context.
- [Socioeconomic inequalities in health](#), such as all-cause mortality, cause-specific mortality, life expectancy and disability. This information will give an overview of the size and magnitude of the health inequalities in the region.
- [Socioeconomic inequalities in health determinants](#), such as health behaviours, working and living conditions and use of health services. This information will provide evidence on potential causes of inequalities in health and may therefore inform the selection of entry points for action.
- [Economic consequences of health inequalities](#) such as labour participation and health care costs. This information can assist in building economic evidence on why to address health inequalities.

If more insight is required into the relative position of the region in the country with respect to health and health inequalities, national data or data from similar or neighbouring regions could be beneficial for comparison.

The regional profile

Socioeconomic inequalities develop in a regional context and strategies to reduce inequalities in health can only be effective if they connect to the context in which they are implemented. For example, strategies for improving access to healthcare may be more relevant in rural environments than in highly urban environments. It is therefore useful to construct a profile of the region.

Relevant information about the regional context and its population of interest include the:

- Population size
- Population density
- Distribution of the population by age and gender
- Distribution of indicators of socioeconomic position
- Degree and distribution of urbanity/rurality
- Economic situation of the region (e.g. relative poverty compared to other regions)
- Main economic drivers of the region (e.g. main industries such as tourism or forestry)
- Existing relevant health policies in the region ([see Phase 2 of the toolkit: Capacity Assessment](#))

Inequalities in health

It is recommended to obtain at least information on inequalities in all-cause mortality or life expectancy. In addition, it may also be of interest to consider cause-specific mortality to gain more in-depth information on health inequalities. The main avoidable cause-specific mortalities are: cardiovascular diseases, certain cancers (e.g. lung cancer), external causes such as injuries, infectious diseases, respiratory disease and digestive disease.

In addition to mortality, important indicators of health are: disabilities, the prevalence of chronic diseases and a more overall and subjective but robust measurement: self-reported health.

A combined health indicator may also be of interest, such as disability-adjusted life expectancy or healthy life expectancy. This is a measurement that calculates the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury (WHO).

An overview of the most important health indicators is provided in Box 2.

Box 2: Health indicators

Mortality

- *All-cause mortality*
- *Cause-specific mortality*
 - *Cancer*
 - *Cardiovascular diseases*
 - *External causes*
 - *Infectious diseases*
 - *Respiratory diseases*
 - *Digestive diseases*
- *Life expectancy*

Health during life

- *Disabilities*
- *Chronic diseases (including mental illnesses)*
- *Self-reported health*

Combined

- *Healthy life expectancies*

Figure 7 illustrates socioeconomic inequalities in self-reported health in Hungary in males and females in different age categories.

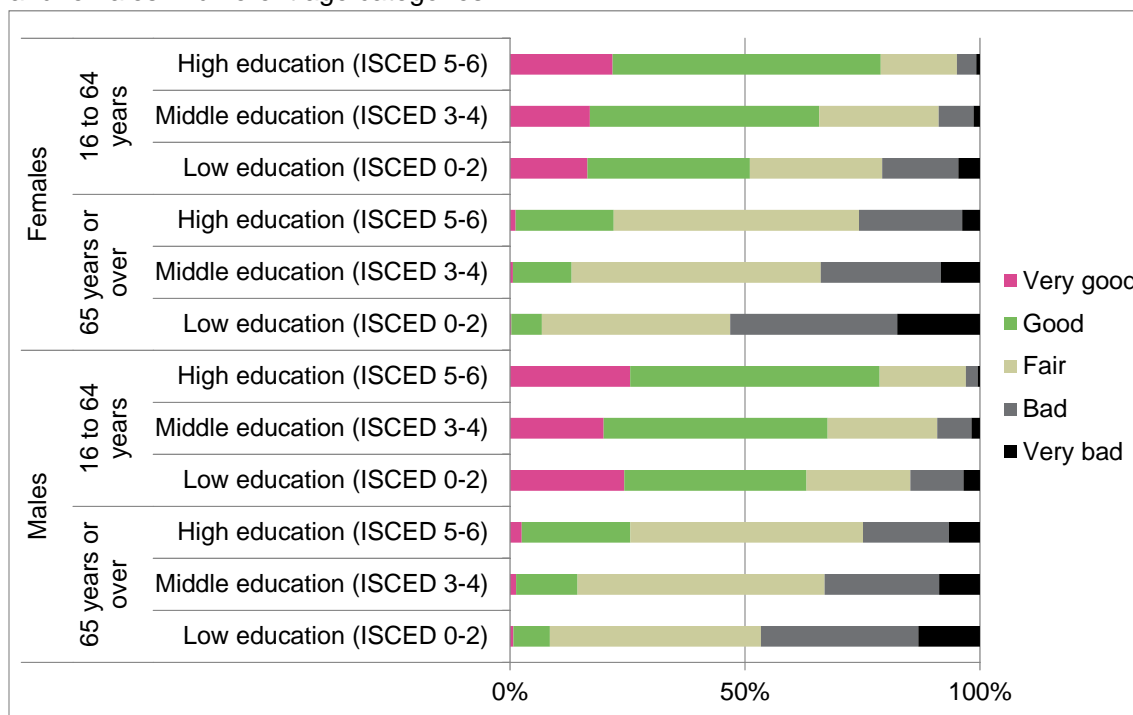


Figure 7: Self-reported health by education level, gender, and age category in Hungary in 2011 (EUROSTAT)

Inequalities in health determinants

Important determinants of health inequalities (apart from socioeconomic position) include:

- Health behaviours, such as smoking or physical inactivity
- Working and living conditions, such as air quality and traffic safety
- Access to and use of health services such as hospital visits and use of medication

An overview of the most common indicators of these three groups of determinants is provided in the sections below.

Health behaviours

In Box 3, several main health risk behaviours are given that contribute to mortality and morbidity. Easily measurable health indicators that are closely related to these health behaviours (e.g. body mass index) may be a valuable addition to information on the behaviours themselves.

The importance of health behaviours for inequalities in health may vary across the life course. For example, health behaviours such as smoking and alcohol consumption are important with regard to the general adult population, but may be of particular interest with regard to pregnant women. Also, with respect to dietary factors, life course-specific indicators can be considered (e.g. breastfeeding for infants and calcium consumption in the elderly).



Box 3: Health determinants – health behaviours

Health behaviours, such as

- Tobacco use (smoking)
- Alcohol consumption
- Illicit drug misuse
- Physical inactivity
- Nutrition, such as
 - Low intake of fruit and vegetables
 - High intake of (saturated) fat
 - Breastfeeding

Physical indicators often linked to health behaviours, such as

- High BMI
- High blood pressure
- High blood glucose
- High cholesterol

Other important health behaviour-related factors, such as:

- Health literacy ([click here for a report on health literacy](#))
- Coping skills

In Figure 8 and Figure 9, examples from Poland are given on how health behaviours and physical health indicators can be presented according to socioeconomic position.

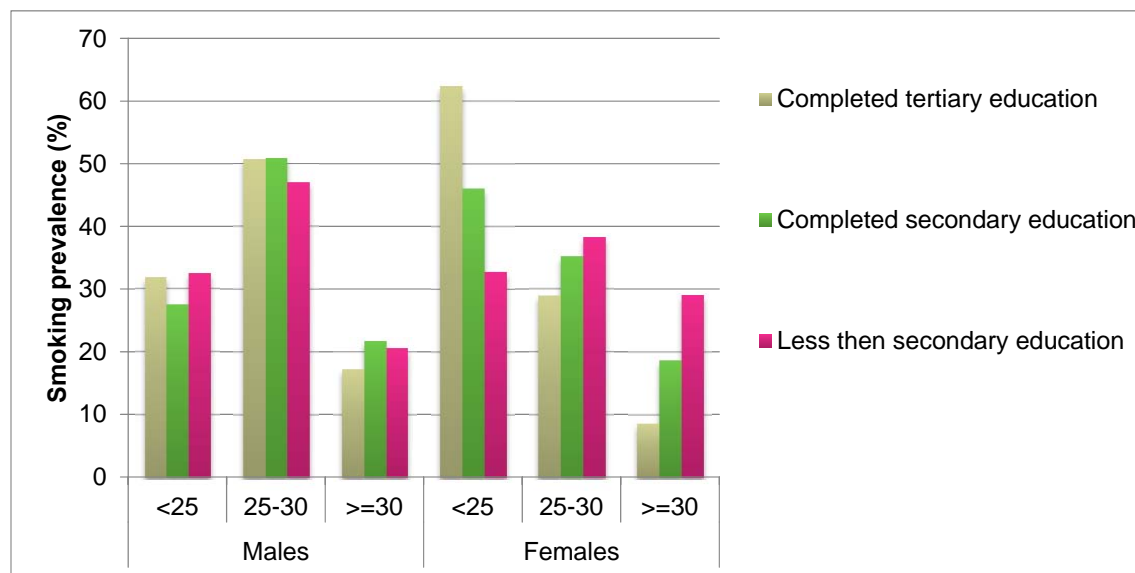


Figure 8: The prevalence of smoking among men and women in Poland, 2008 (National Health Survey data obtained via the EURO-GBD-SE project)

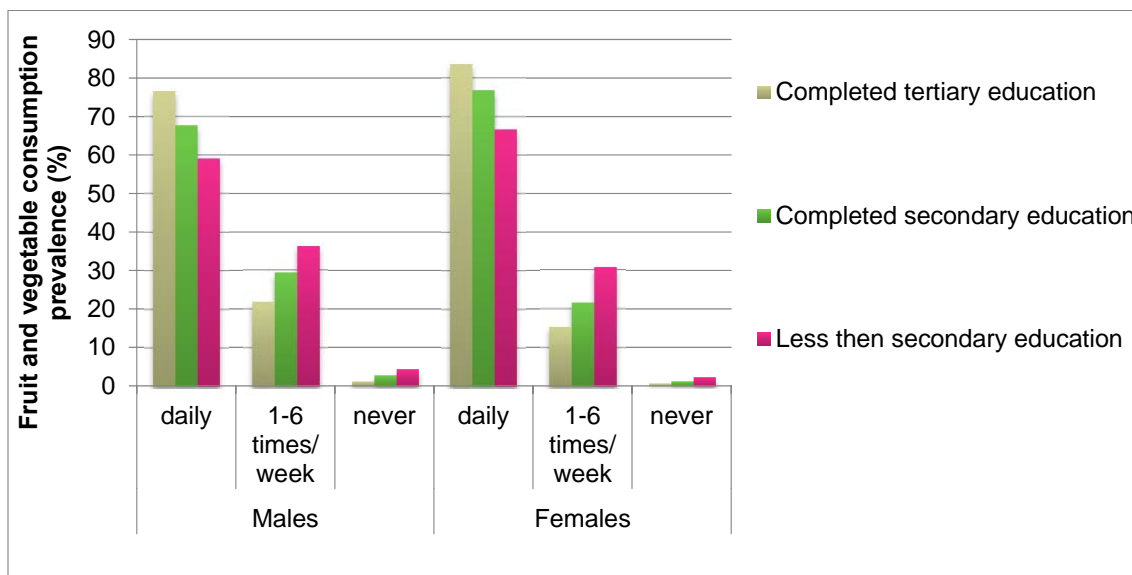


Figure 9: Prevalence of fruit and vegetable consumption among men and women in Poland, 2008 (National Health Survey data obtained via the EURO-GBD-SE project)

Working and living conditions

The most common indicators of working and living conditions that influence health and health inequalities are listed in Box 4. In this section, three main groups of working and living conditions are identified:

- Social living conditions, such as social support and social safety.
- Physical living conditions, such as the quality of housing (dampness, overcrowding, heating), sanitation (availability of a flush toilet, availability of a shower/bath), or the quality of the neighbourhood environment (traffic safety, noise, access to green areas).
- Social working conditions as the balance between work demands and work control.
- Physical working conditions, such as exposure to noise or carcinogens.

In Figure 10 and Figure 11, examples are given on how working or living conditions can be presented according to socioeconomic position. In Figure 10, the percentage of people reporting exposure to factors that can adversely affect physical well-being are presented by education level and sex for Czech Republic in 2007. Figure 11 displays overcrowding rate (percentage of population) by income quintile for several European countries in 2012.

Box 4: Health determinants – working and living conditions

Social living conditions, such as

- Social support / social isolation
- Loneliness
- Social cohesion
- Sexual violence
- Child abuse

Physical living conditions, such as

- Housing quality (dampness, overcrowding, heating)
- Water and sanitation (availability of a flush toilet, availability of a shower/bath)
- Air quality
- Food safety
- Noise
- Traffic safety
- Neighbourhood design
- Climate change

Social work conditions, such as

- Demand-control imbalance

Physical work conditions, such as

- Physical strain
- Exposure to noise
- Exposure to carcinogens

Note: income, employment status and occupational class are also factors related to the work environment. These factors are listed under [Socioeconomic position](#).

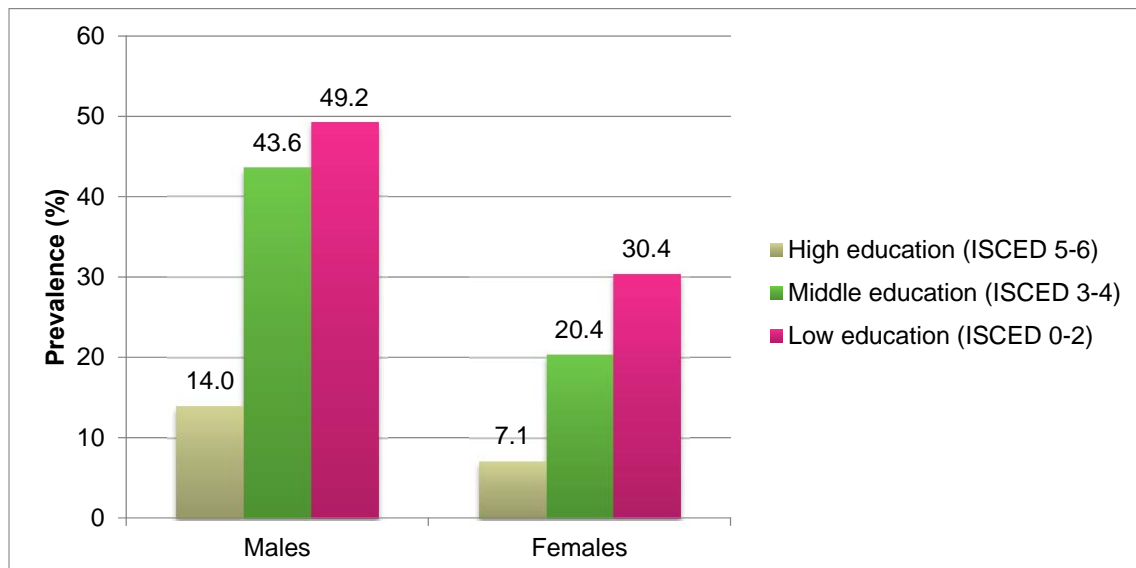


Figure 10: Persons reporting exposure to factors that can adversely affect physical well-being (at work), by sex and education, in Czech Republic 2007 (age 15-64) (EUROSTAT)

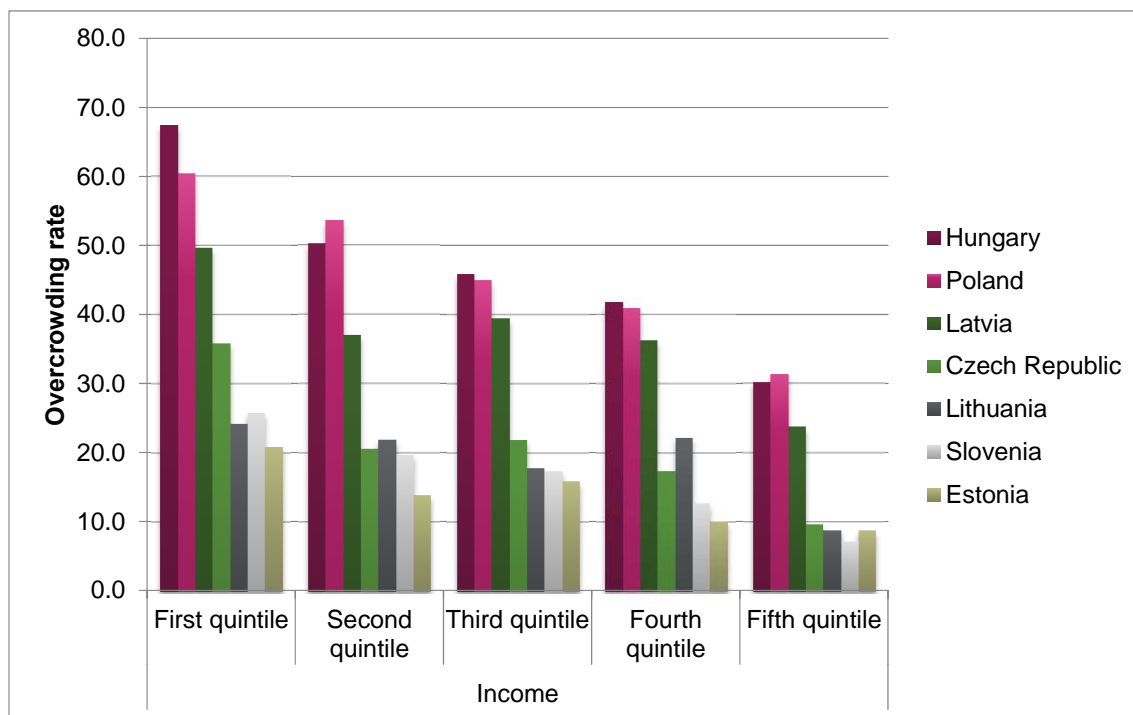


Figure 11: Overcrowding rate (percentage of population) by income quintile in several European countries in 2012 (EUROSTAT)

Access to and use of health services

Because of their worse health, lower socioeconomic groups often make more use of health care services while at the same time they may be more often denied proper access to good quality services. Box 5 lists the most important indicators of access and use of health services.

Figure 12 and Figure 13 show examples on inequalities in access or use of health services. Figure 12 displays self-reported unmet need for medical examination due to financial or geographical reasons in Latvia in 2011. Figure 13 presents data from several European countries on the percentage of women who had a cervical smear test in the past year.

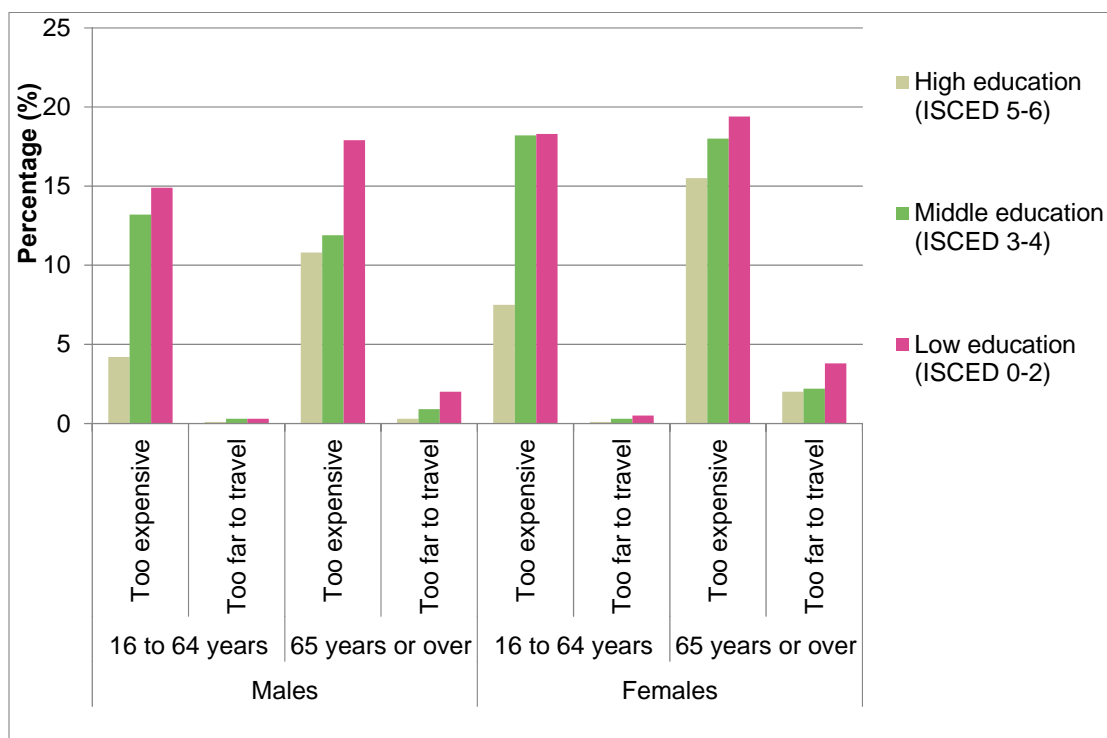


Figure 12: Self-reported unmet needs for medical examination (for financial or geographical reasons) by sex, age category and education level in Latvia in 2011 (EUROSTAT)

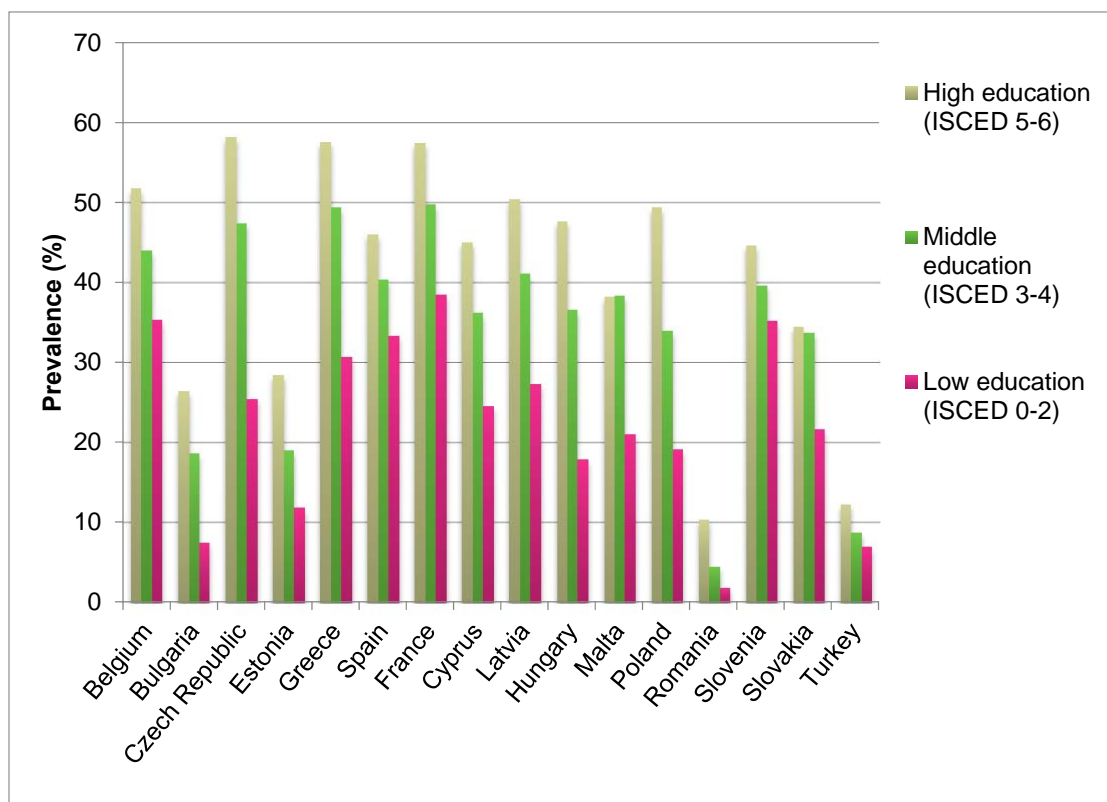


Figure 13: Women (age 20-69) reporting to have had a cervical smear test in the last year by education level in several European countries in 2008 (EUROSTAT).

Box 5: Access and use of health service

Geographical access to health services ^a, such as

- *Number of doctors/1000 citizens*
- *Number of nurses/1000 citizens*
- *Number of hospital beds/1000 citizens*
- *Number of prenatal care facilities/1000 citizens*

Financial access to health services, such as

- *Number of patients not receiving medical care due to financial restraints*
- *Number of patients not receiving dental care due to financial restraints*

Use of health care ^b, such as

- *Frequency of visits to GP*
- *Frequency of visits to specialist*
- *Frequency of visits to dentist*
- *Frequency of hospital admissions*
- *Length of stay in hospital*
- *Use of medicines*
- *Use of prescribed medicines*

Screening and prevention, such as

- *Cholesterol screening*
- *Blood pressure screening*
- *Breast cancer screening*
- *Cervical cancer screening*
- *Flu vaccination*
- *Infant and child vaccination coverage*

Other health services indicators, such as

- *National healthcare system coverage of selected procedures (primary healthcare, secondary healthcare, hospitals, drug reimbursement, etc.)*
- *Waiting time for selected medical procedure (e.g. hip replacement, cataract removal, visit to a dentist, etc.)*

Notes: There are several issues to take into account when considering the access and use of health services.

- a. Density of facilities or geographical access to facilities does not provide any information on the quality of these facilities. This should be taken into account if possible.
- b. Socioeconomic inequalities in use do not reflect and might even conceal inequalities in access to health services since lower socioeconomic groups in general have a poorer health status and therefore *need* more medical care. Equal use of health services could therefore be a sign of unequal access to these health services. To properly compare use of health care between socioeconomic groups, use should be adjusted for needs, for example by adjusting for self-reported health.

Economic consequences of health inequalities

Poor health has economic consequences, not just for the individual but also for a country or region. Poor health and disability are major reasons for early retirement, sick leave and productivity losses. Additionally, ill health will increase healthcare costs and the uptake of social security benefits. At the same time, being active in the workforce may benefit the health of the worker.

Box 6 gives an overview of several important indicators of economic consequences of health inequalities.

Box 6: Economic health consequences

Labour related indicators, such as:

- Labour participation
- Labour productivity

Direct costs related indicators, such as:

- Healthcare costs
- Costs of social benefits

Figure 14 provides an overview of the percentage of economically inactive men in several European countries.

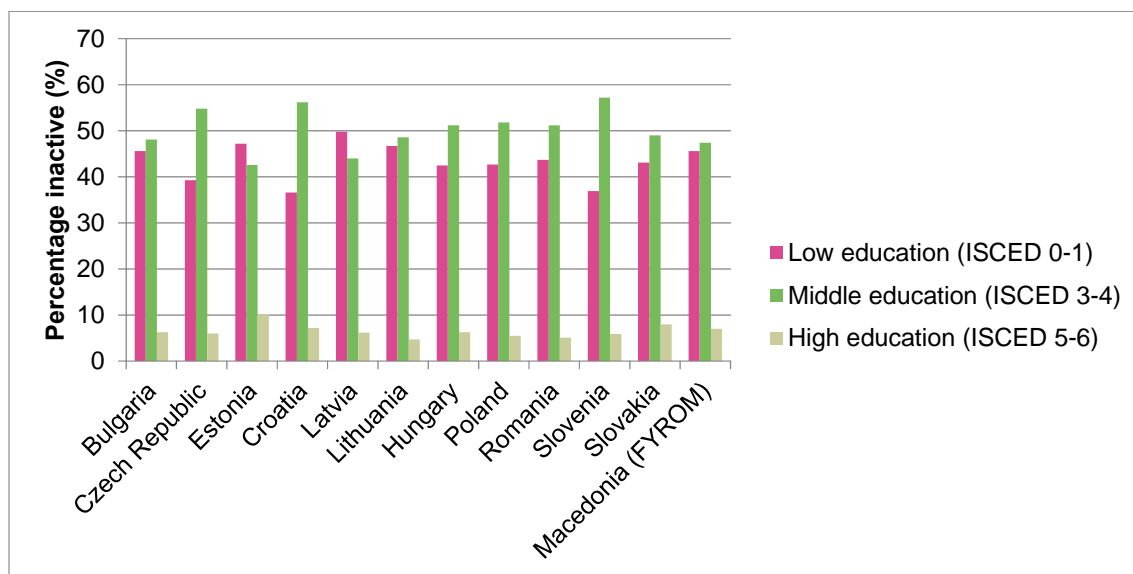


Figure 14: Percentage of men that are economically inactive according to education level in 2011 (EUROSTAT)

Where and how to collect data

Available data

Readily available data, or secondary data, are data that have been collected for another purpose or by another party. Using secondary data is efficient and often inexpensive to collect. It is a valuable source of information.

Overview of potential sources of data

Potential data sources of data for assessing the current situation on health, health inequalities, health determinants, and health consequences are described in Table 1.

Table 1: Potential sources of data for monitoring inequalities in health (Kunst et al, 2001)

<i>Data source</i>	<i>Health status indicators covered</i>
Vital registry	Mortality, length of life
Cause-of-death registry	Mortality from specific causes of death
Level/quality of living surveys and multi-purpose surveys	Disability, symptoms, general health and quality of life, risk factor prevalence
Health interview surveys	As above, plus self-reported prevalence of diseases and disability
Health examination surveys	As above, plus functional impairments and biological precursors of diseases
Health care utilization registries, e.g. hospital admissions, general practitioner consultations	Incidence, case fatality and prevalence of several diseases leading utilization of health services
Disease registers, e.g. cancer and congenital anomalies, mental health	Incidence, case fatality and prevalence of specific diseases
Surveillance systems, e.g. on infectious diseases, injuries	Incidence, case fatality and prevalence of injuries or specific (acute) diseases
Social security registries, e.g. on sickness absence, long-term work disability	Incidence and prevalence of several diseases leading to work disability (temporary or continuous) and prevalence of economic health consequences such as sickness leave and work disability itself

A valuable source of data are the **statistical authorities** in each country or even region. Data collected by these authorities are also processed and published by Eurostat, the statistical office of the European Union which is situated in Luxembourg. Advantages of using the data that are also processed by Eurostat is that they have a relatively high quality and are comparable across Europe.

The two most important surveys that are processed by Eurostat and that have individual or NUTS2 (Nomenclature of Territorial Units for Statistics, level 2 refers to the information at regional level) level data are:

- [EHIS](#) (European Health Interview Survey)
 - o First wave in 2006-2009. Second wave was scheduled in 2014. Second wave and following waves are regulated by European Commission legislation and will therefore achieve high EU coverage. The [methodological manual](#) provides information, recommendations and model questions that can also be useful use when collecting additional regional data.
- [EU-SILC](#) (European Union Statistics on Income and Living Conditions)

- Started in 2004 in the EU-15 (except Germany, the Netherlands, and the UK) plus Estonia, Norway and Iceland.
- Since 2007 in EU-27 and Norway, Switzerland, Iceland and Turkey
- Since 2010 EU-SILC was also implemented in Croatia and Former Yugoslav Republic of Macedonia (test implementation phase)
- Other potentially relevant surveys processed by Eurostat are:
 - [LFS](#) (Labour Force Survey)
 - [CIS](#) (Community Innovation Survey)
 - [AES](#) (Adult Education Survey)
 - [SES](#) (Structure of Earnings Survey)

The EHIS has often been integrated into the National Health surveys, National Health Interview Survey, Labour Force Survey or other household surveys in each country and or participating region. General information from these surveys, often on a national level, can be accessed via the [Eurostat website](#). Access to microdata (individual level and NUTS3 (sub-region) and NUTS2 (region) level data) has to be requested specifically and are in most cases more easily accessible via the national or regional statistical offices.

Choosing between currently available data sources

If several data sources are available, Kunst et al (2001) developed guidelines that can assist in deciding on the best data source to use (see Box 7 and Table 2)

Box 7: Guidelines on choosing between available data sources (adapted from Kunst et al, 2001)

- a. *When regionally representative, individual-level data is available on mortality according to socioeconomic indicators, this data should be used to monitor socioeconomic inequalities in mortality.*
- b. *Equally important sources of data are health interview surveys, multi-purpose surveys and similar surveys. When regionally representative data is available from these surveys, it should be used to monitor socioeconomic inequalities in self-reported morbidity and health determinants such as health behaviours.*
- c. *When regionally representative data on mortality or self-reported morbidity and health determinants are not available from these sources, local studies may be used under two conditions: (a) these studies are considered to be no more than a temporary substitute that are only used for as long as regional data are not available, and (b) the restriction to specific areas is explicitly recognized.*
- d. *Other data sources are not recommended for monitoring inequalities in health in general terms. This also applies to 'ecological' studies in which mortality or morbidity indicators can be linked to socioeconomic indicators at the level of small areas.*
- e. *Specific data sources may be used for monitoring inequalities in a health problem that is of particular interest, such as the incidence or prevalence of specific diseases.*
- f. *The informative value of any data source should be evaluated against the checklist given in table 2.*

Table 2: Checklist for evaluating data sources (Kunst et al, 2001; Kunst & Mackenbach, 1995)

Data quality aspect	Questions to consider
1. Relevance and timeliness	<ul style="list-style-type: none"> a. Does the data cover at least two or three of the core socioeconomic indicators (occupation, education, income)? b. In mortality studies, can a distinction be made by cause of death? c. In health interview or similar surveys, are different health status indicators included? d. Does the data refer to a recent period (less than 5 years ago)?
2. Population coverage and representativeness	<ul style="list-style-type: none"> a. Are both men and women included? b. Does the data cover all age groups or at least a substantial part of the entire age range (e.g. 15-74 years)? c. Are you sure that the data are not restricted to a specific city/area or to another sub-population (e.g. employees of a company)? d. Does the data include the institutionalized population and other specific groups such as foreigners? e. Are you reasonably sure that, if data comes from a survey, problems with non-response do not strongly bias the results?
3. Reliability	<ul style="list-style-type: none"> a. Are socioeconomic indicators linked to health indicators at the individual or household level (instead of the area level)? b. If education is used as the socioeconomic indicator, can a distinction be made between lower educational levels (e.g. elementary and lower secondary, or <7 and 7-8 years)? c. If occupational class is used, can this indicator be determined for (nearly) all people, including those who are economically inactive (e.g. housewives and retired)? d. If income is used, is data available to estimate household equivalent income? Are there no serious problems such as income unknown for many people (say, more than 20%)?
4. Precision, power	<ul style="list-style-type: none"> a. In interview or examination surveys, is the sample size fairly large (more than 5,000 respondents)? b. In mortality studies, is the number of deaths fairly large (more than 1,000 deaths)?
5. Usefulness for monitoring trends	<ul style="list-style-type: none"> a. Can three or more periods be compared? b. Do these periods together cover a sufficiently long span of time (about ten years or more)? c. In interview or examination surveys, are exactly the same health indicators used in the subsequent surveys? d. Is the measurement of socioeconomic indicators comparable over time? Can the same classification be applied to each period?

Improving data availability

When secondary data are not complete or not of sufficient quality, it may be necessary or desirable to collect primary data. Kunst and colleagues designed some guidelines on how to decide when additional data are necessary (Box 8). They also developed a minimum set of data required to create a comprehensive overview of socioeconomic inequalities in mortality and morbidity (Box 9). These guidelines should be used while considering the scope and goal of the needs assessment that is performed.

Box 8: Guidelines (from Kunst et al, 2001)

1. *Each region should aim to obtain the minimum package of information on health inequalities that is presented in box 8.*
2. *If this minimum package cannot be met with the available data, attempts should be made to improve data availability.*
3. *It is highly important to improve the timeliness of the information on health inequalities.*

In general, the most accurate needs assessment will be accomplished with detailed individual and regional data. If detailed regional data is not available, it is recommended to fill the gaps in data with national level data. If national level data is not available, it is recommended to fill in the gaps with data from other countries that are similar. The more specific the data, the better and more focused the needs assessment will be.

Box 9: Minimum package of data required to create an overview on socioeconomic health inequalities (adapted from Kunst et al, 2001)

1. *Data is available that makes it possible to monitor socioeconomic inequalities in health for both mortality (by cause of death), self-reported morbidity (for different health indicators, including perceived general health and disability), and health behaviours (for different determinants including health behaviours, working and living conditions and the access to and use of health services).*
2. *Mortality, self-reported morbidity and health determinant estimates can be presented according to at least 2 of the 3 core socioeconomic indicators (education, income and/or occupational class).*
3. *Mortality, self-reported morbidity and health determinant data are available for men and women and for all relevant age groups. Coverage of all age-sex groups should be possible for at least one socioeconomic indicator.*
4. *The data must be regionally representative. If this is not possible, local data may be used as a temporary substitute. The restriction to specific areas is explicitly recognized.*
5. *It has been possible to monitor changes in health inequalities over time since the 2000s for at least one type of health indicator and from the early 2010' onwards for several indicators of mortality, self-reported morbidity and health determinants.*

When data is missing, there are several possibilities for filling in the gap:

1. Adding socioeconomic variables to existing sources of data on population health, such as health surveys or death registries.
2. Adding health indicators to socioeconomic surveys or registries.
3. Linking data from different registries.
4. [Collect additional data](#)

Collecting additional data

Additional data that could be collected may be quantitative, by setting out a survey, setting up a surveillance or monitoring system or adding questions to existing surveys. In some cases it is also valuable to consider qualitative data in addition to quantitative data to get more insight into a health problem or health determinants.

Quantitative data

When collecting quantitative data, it may be wise to use standardized methods. For example, when conducting a health interview survey, it can be useful to consult the [methodological manual](#) of the European Health Interview survey to see how indicators are best measured. Another useful guide is the WHO publication '[Monitoring and building blocks of health systems: a handbook of indicators and their measurement strategies](#)' which is more related to the health system.

Qualitative data

Qualitative data may provide in-depth insights, especially when quantitative data is limited. There are several ways to gain more qualitative data:

- a. Individual interviews: these are time-consuming and labour-intensive but they can provide many insights when the right persons are interviewed (e.g. key persons in a certain socioeconomic group or neighbourhood).
- b. Focus group interviews: these are small group interviews with akin persons (e.g. persons form the same gender, age group and socioeconomic status)
 - i. A short guide by Dr Krueger on how to conduct a focus group interview can be found on the site of Eastern Illinois University: [Designing and Conducting Focus Group Interviews](#).
- c. Surveys: surveys with a more open character (open-ended questions) can be used to reach a larger group.

How to present & interpret data

It is likely that the information gathered on socioeconomic health inequalities in this needs assessment will be used by third parties. Therefore, some information is given on how to present and interpret data on health inequalities. Additionally, a [report format](#) is provided that can be used to note down the results of the needs assessment.

Presenting health inequalities

Socioeconomic health inequalities can be presented in several ways. Presenting the percentages or absolute numbers of a health problem or health determinant, for each of the different socioeconomic groups, provides a first impression of the socioeconomic inequalities in health or health determinants (see for example Figure 15). For a more sophisticated quantification of the magnitude of the inequalities, two main options are the presentation of the relative differences between the socioeconomic groups (for example, see Figure 16) or the absolute differences between the socioeconomic groups (for example, see Figure 17). In these approaches, mortality or morbidity rates for the lowest socioeconomic group are divided by (in case of relative inequalities) or subtracted from (in case of absolute inequalities) rates in the highest socioeconomic groups. Relative inequalities can be large, even when the rates in (and absolute differences between rates) in high and low socioeconomic groups are small (in case of a relatively rare disease). As these measures

will be often available or easy to calculate, the tool will provide more detail about the interpretation of these measures [further on](#).

More complex measures of socioeconomic inequalities in health do not compare the rates in a socioeconomic group with the rates in the highest socioeconomic group, but to the average rates in the population. Where the first approach implicitly assumes that ultimately everybody should have the rates of those in the highest socioeconomic group, the latter assumes that the ultimate aim of interventions and policies should be to increase the health of those in the lower groups to the average of the population.

Some measures also take the size of the socioeconomic groups into account. Clearly, it may be important for priority setting and economic analyses to know whether the lowest socioeconomic group is very small or very large. If very large, any effective policy to increase health in the lowest socioeconomic groups will have more impact on health in the population.

Finally, whereas some measures only take the lowest and highest socioeconomic groups into account, others allow using all socioeconomic groups in the measurement of inequalities in health. The underlying assumption of a measurement which includes all socioeconomic groups is that the socioeconomic gradient matters; health inequalities affect the whole social hierarchy and not just the lowest socioeconomic groups. Health usually increases from the bottom to the top and measures that include all socioeconomic groups take this gradient into account.

Table 3 presents an overview of different ways of measuring the magnitude of socioeconomic inequalities. Whichever measurement is most appropriate to use depends on the situation. A more complex method may provide more information, but is also more complex to calculate and more difficult to interpret.

Table 3: Different ways of measuring socioeconomic inequalities (based on Harper & Lynch, 2006)

Summary measure	Absolute or relative	Reference point	Social group size	All social groups
Relative difference (e.g. RR)	Relative	Best	No	No
Absolute difference (e.g. RD)	Absolute	Best	No	No
Regression-based relative effect	Relative	Average	No	Yes
Regression-based absolute effect	Absolute	Average	No	Yes
Population Attributable Risk %	Relative	Best	Yes	Yes
Population Attributable Risk	Absolute	Best	Yes	Yes
Relative Index of Inequality	Relative	Average	Yes	Yes
Slope Index of Inequality	Absolute	Average	Yes	Yes
Relative Concentration Index	Relative	Average	Yes	Yes
Absolute Concentration Index	Absolute	Average	Yes	Yes
Index of Disparity	Relative	Best	No	Yes
Between Group Variance	Absolute	Average	Yes	Yes

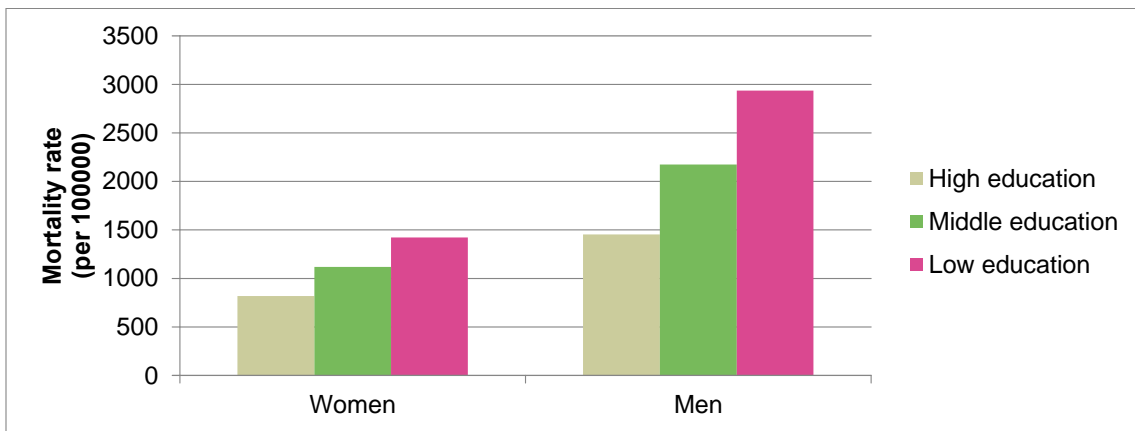


Figure 15: Mortality rate by education level for men and women in Lithuania (data obtained via the EURO-GBD-SE project)

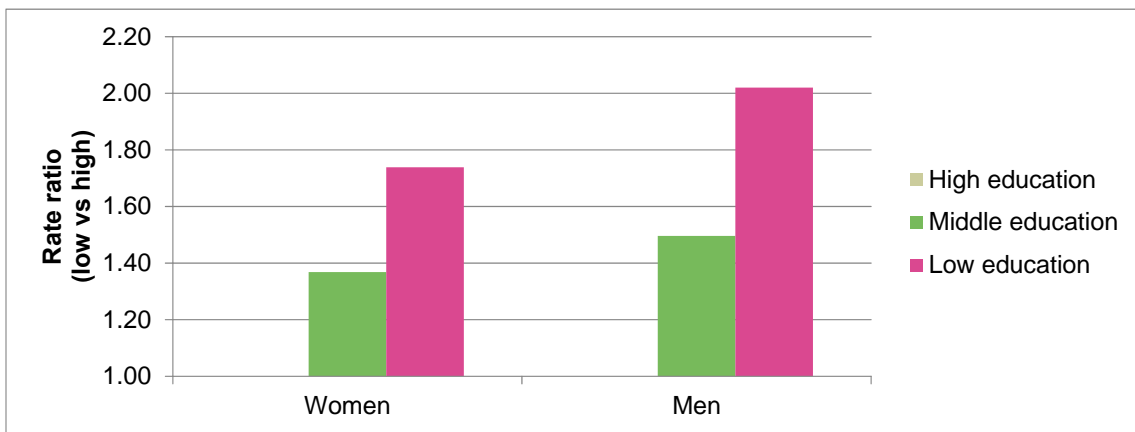


Figure 16: Mortality rate ratio (low vs high and middle vs high education) for men and women in Lithuania (data obtained via the EURO-GBD-SE project)

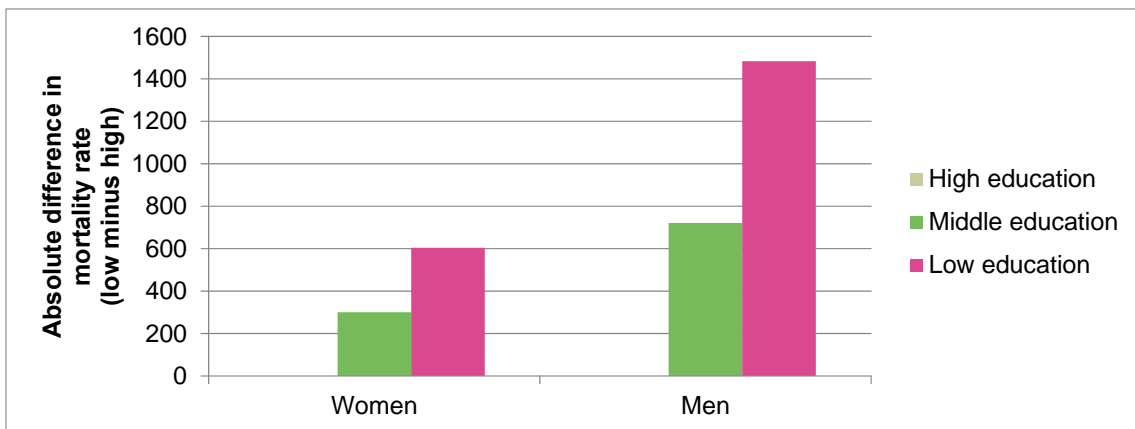


Figure 17: Absolute difference in mortality rate (low minus high and middle minus high) for men and women in Lithuania (data obtained via the EURO-GBD-SE project)

Interpreting health inequalities

When interpreting data on socioeconomic health inequalities it is important to know how the socioeconomic inequalities are presented (see previous section). The difference between absolute and relative differences is especially important, since relative inequalities can be large even when absolute differences are small (such as in the example of a relatively rare disease or determinant). Furthermore, when a policy affects the health of all socioeconomic groups equally in terms of absolute change, absolute inequalities will remain the same while at the same time relative inequalities increase. On the other hand, when a policy affects the health of all socioeconomic groups equally in terms of relative change, absolute inequalities will decline while relative inequalities will remain the same. In Table 4, a simple numerical example is given to illustrate.

Table 4: Numerical example of absolute and relative inequalities in mortality.

	Mortality rate before	Mortality rate after decrease in mortality rate of 500 in each group	Mortality rate after decrease in mortality rate of 10% in each group
Low SEP^a	3000	2500	2700
High SEP^a	1500	1000	1350
Absolute inequality^b	1500	1500	1350
Relative inequality^c	2.0	2.5	2.0
^a SEP = socioeconomic position			
^b Absolute inequality = (mortality rate low SEP) - (mortality rate high SEP)			
^c Relative inequality = (mortality rate low SEP) / (mortality rate high SEP)			

To interpret the significance of certain socioeconomic inequalities, it is important to consider the following factors:

1. Size and magnitude of inequalities
2. Size of the group at risk
3. Prevalence of the risk factor
4. Impact of the risk factor on health

For example, when the risk factor is very common (e.g. high blood pressure), small relative inequalities may still result in very large absolute differences in the number of people affected per socioeconomic group. Additionally, when a risk factor is highly unequally distributed, but has only limited effect on health (e.g. mortality) it may be less important for overall health inequalities than when a risk factor is less unequally distributed but has a large effect on health. In Figure 18, the relative risks of mortality for selected important determinants of health are provided. The higher the bar, the more impact the behaviour has on overall mortality. The most health-enhancing categories of each risk factor (e.g. never-smokers or those with a BMI below 25) do not have a bar since they are considered the reference category (relative risk = 1). For example, men who are physically inactive have about 30% more chance of dying compared to men who are physically active. For women, the increased risk for physical inactivity is about 50%.

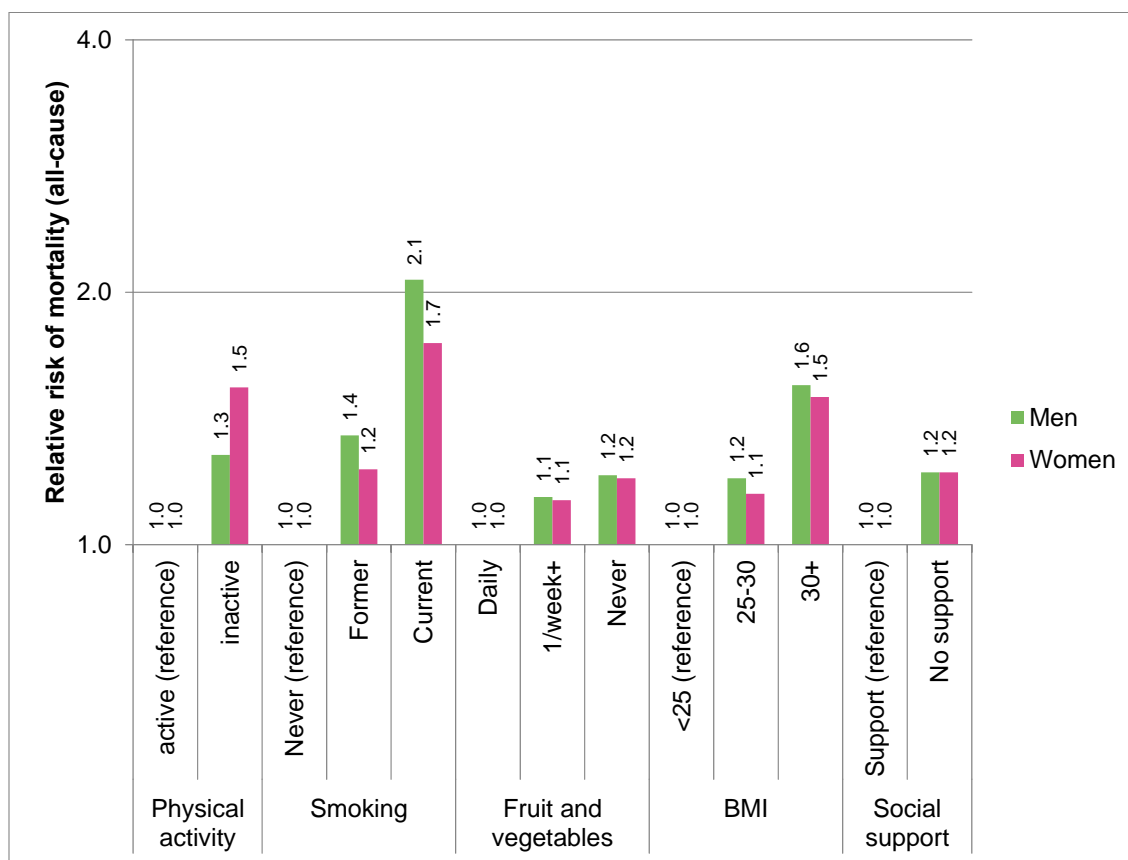


Figure 18: Relative risk of mortality selected important determinants of health for 30-59 year old men and women.

Reporting health inequalities

In order to facilitate the reporting of the needs assessment results, a report format is provided in appendix 1.

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PHASE 2: Capacity Assessment

Fundamentals and Tools

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Introduction

In previous phases, a [needs assessment](#) (phase 1) was carried out. Phase 2 (Figure 19) focuses on capacities necessary to understand the current situation, design and implement actions to address needs and gaps. This is essential in the process of identifying priorities and entry points for action, the specific changes and developments that are necessary, useful and promising (phase 3). At the same time the development and implementation of evidence-based action plans needs capacity building and development by itself (for needs assessments, capacity assessments and audits, policy formulation and impact assessments, evaluation).

In reality, the sequence of the phases is not as structured as the model might suggest. A capacity assessment can be used in line with the model – to assess the capacities to respond to any health needs identified. However, it can also include an assessment of capacities for the development of evidence-based action plans such as: capacities for needs assessments, capacity assessments, policy formulation, implementation and evaluation.

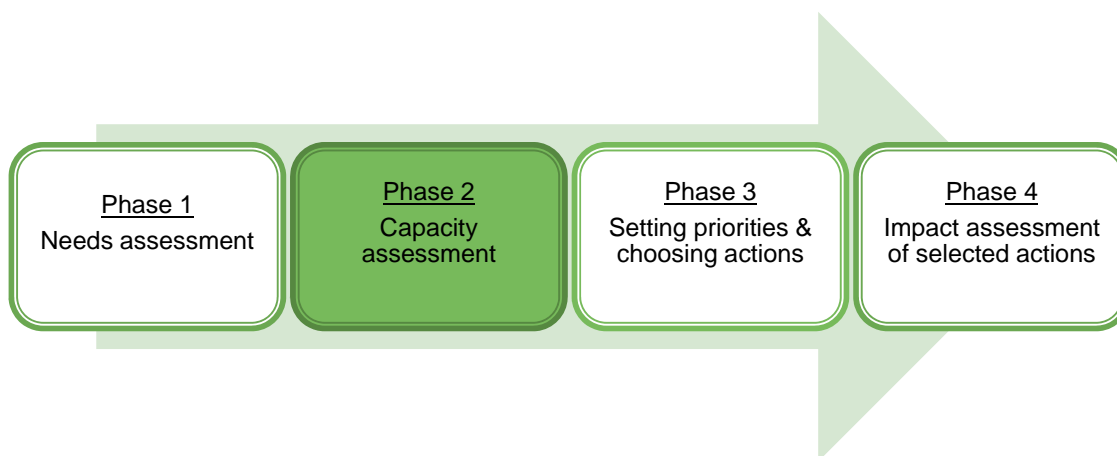


Figure 19: The process towards evidence-based action plans – phase 2

The first part of the tool aims to address capacity building and development at the level of capabilities to coordinate, plan and implement programs and projects to address health inequities, specifying which kinds of changes and developments are necessary, useful and promising. It presents two working frameworks for analysis: the Capacity Building Framework from NSW (2001) and the UNDP (2008) Capacity Development Framework. The second part describes and delivers recommendations on how to prepare and conduct capacity assessment and audits.

Capacities, Capacity Building and Capacity Development

This chapter illustrates what capacities are, the meaning of capacity building and development and why they are important.

Box 10: Capacity, Capacity Development and Capacity Building

Capacities emphasize the organizational, human, financial and other resources, which enable actions to be taken by responsible authorities to improve health and reduce health inequalities (Aluttis et al, 2013).

Capacity development highlights how capacities change over time, the process through which individuals, organizations, and societies obtain, strengthen, and maintain the capabilities to set and achieve their own development objectives over time (UNDP, 2008).

Capacity building is sometimes used interchangeably with capacity development although it refers only the initial stages of building or creating capacities and alludes to an assumption that there are no existing capacities to start from. It is therefore less comprehensive than capacity development (UNDP, 2008).

Knowledge is important, but not enough. Previous approaches to stimulating development and change at an individual / organizational / institutional / local or national level were often limited to the provision of knowledge, making the assumption that actions / interventions would be adapted to additional information and better knowledge. But while knowledge and know-how are critical, they are not compelling enough.

An adjustment in knowledge will not occur provided that individuals / organizations / other actors in the institutional framework are unwilling or not allowed to implement the change, or are confronted with external limitations (e.g. lack of resources; Sida, 2000)(Table 5). Capacity building and development strategies have to take this into account.

Table 5: Reasons for not putting knowledge into practice

	Don't know what to do (=lack of knowledge)	Don't want to do it, or not allowed to do it.	External limitations (money or material)
Individual level			
Organizational level			
The institutional framework			

(Sida, 2000)

Assets, participation and commitment. One limitation of development policies is the assumption that technical advice and expertise provided by external supervisors would be sufficient. It is not only in development policies that such approaches have often proved unsuccessful; it becomes imperative that: a) capacities should be developed by taking

existing capacities or assets (strengths) into account and b) stakeholders should participate in the development of capacities (UNPD 2008).

Within the Health Equity 2020 Project, administrative divisions such as regions, districts and municipalities are involved in developing and implementing policies that can reduce health inequities. Reducing health inequities means planning and implementing changes to the factors which create or reduce them, and capacities have to be built and developed to make these changes possible.

With regard to capacity building and development, two approaches with distinctive scopes can be identified:

- **A focused approach to develop capacities for strategies or programmes to improve health equity.**

To address health inequities, regions need to build and enhance their capacities to deliver services or other kinds of activities. This targets not only (public) health services, but also (health) education, transport, housing, architecture, social security etc.

Capacity building and development is linked to the development of programme responses to either particular health problems or an enlargement of an existing programme. It can also refer to problem-solving capabilities of organizations and communities ("capacity of a more generic kind to identify health issues and develop appropriate mechanisms to address them", NSW 2001).

This approach is particularly useful for Policy Officers, Technical Officers, Health Professionals and Health Care Service Providers.

- **integral whole approach to enhance system capability to improve health equity.**

An whole approach to enhance system capability to improve health equity looks at the "big picture". It builds on the previous focused approach but deepens the discussion by correlating gaps and needs with strategic capacities necessary to lead the change process (e.g. by looking at the enabling environment, institutional / organizational issues, technical or functional capacities).

Therefore, reducing health inequities also implies: addressing capacity building and development at the level of capabilities to coordinate, plan and implement programmes and projects to address health inequities.

As part of the Health Equity 2020 project, regions are encouraged to establish a Regional Action Group (RAG) with representatives from different sectors, e.g. regional planning, public health and management authorities for the European Structural Funds. This is a concrete approach designed to build and develop capacities for programmes and projects addressing the development of capacities for the provision of services and activities that have a direct impact on health.

Setting up Regional Action Groups and developing and implementing a regional action plan are important steps in capacity building and development to reduce health inequities at a regional level.

Capacity Building Frameworks

Frameworks for capacity building and development are helpful in identifying and focusing on different capacity domains. They might differ in their strength and weaknesses, but they provide guidance as to what kinds of capacities need to be taken into account when dealing with capacity building and development.

There are a few capacity building frameworks. This chapter will outline two of them. They have been developed for different purposes, but they are flexible enough to be expanded, contracted or used in conjunction with each other.

These tools must be adapted according to whether a focused or a whole approach is chosen, and according to the available resources, methods and time.

Capacity Building Framework 1: NSW (2001)

The (NSW 2001) framework was constructed with health promotion as its main goal. It is therefore highly suited to the approach aimed at developing capacities to design strategies and programmes for health equity.

Organizational development, workforce development, resource allocation, partnerships and leadership are seen as domains of capacities and for capacity building in the fields of infrastructure, programme sustainability and problem solving (NSW 2001, Figure 20, Figure 21, Figure 22). What needs to be taken into account is that capacity building and development can take place at different levels, e.g. programmes or systems.



Figure 20: Capacity building and development domains. Source: NSW Health Department (2001)

Organizational development means to develop policies and procedures, strategic directions, organizational structures, management support, recognition and reward systems, information systems, quality improvement (QI) systems and informal culture.

Workforce development is linked to workforce learning, the supply of external courses, professional development opportunities, the development of undergraduate and post-graduate degrees, the development of professional support and supervision, and the development of a performance management system.

Resource allocation refers to the allocation of financial and human resources, time, information, expert advice, tools and models, administrative support and physical resources.

Organizational development, workforce development and resource allocation are influenced by leadership and partnerships.

Capacity building for **leadership** means to develop interpersonal skills, technical skills, personal qualities, strategic visioning, systems thinking, visioning the future and organizational management.

Capacity building in the field of **partnerships** refers to developing shared goals, relationships, planning, implementation, evaluation and sustained outcomes.

Leadership and partnerships are also needed for workforce development, organizational development and resource allocation.

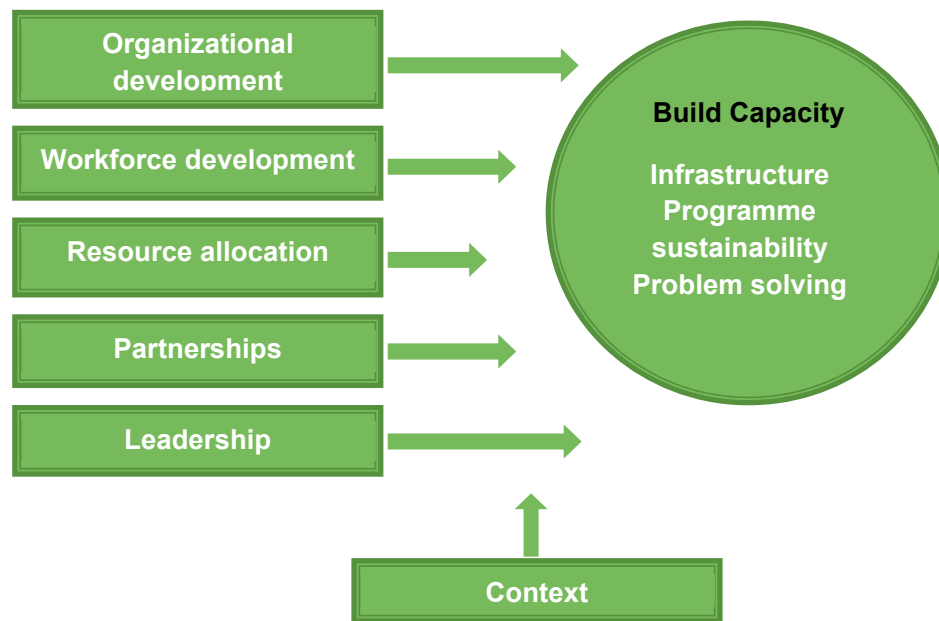


Figure 21: The Capacity Building Framework (NSW Health Department, 2001)

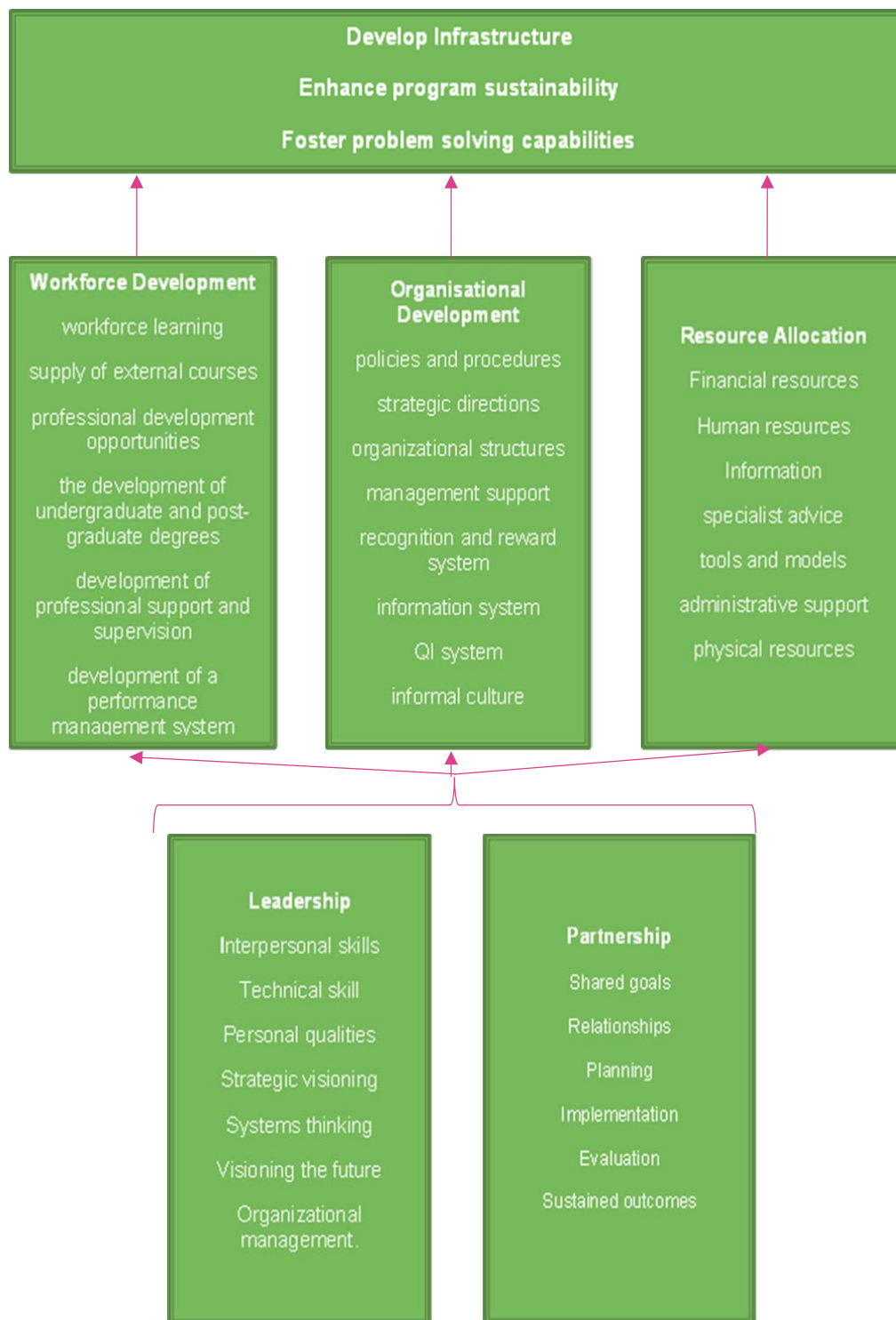


Figure 22: Capacity building framework key action areas (NSW Health Department, 2001)

Capacity Building Framework 2: UNPD (2008)

The second framework was designed mainly for development policies but as a tool it can be customized for concepts such as capacity assets and needs for policy and strategy formulation. Therefore, it is most useful to a whole approach to improve system capacity.

The UNDP capacity development framework has three mutually enforcing dimensions or levels of capacity (Figure 23):

- **Points of entry**
- **Core issues**
- **Technical and functional capacities**

A distinction is made between three points of entry:

- **Enabling environment** (societal or institutional level; regulatory and legislative environment in which organizations and individuals operate, including policies, rules, norms, values governing mandates, priorities, modes of operation, culture, game rules for interacting across sectors; national, local, sectoral level);
- **Organizations** (operating across sectors, public or private agencies, central or decentralized government and ministerial agencies, civil society and community-based organizations, and networks of organizations);
- **Individuals** (skills and knowledge of the people involved, job descriptions, training and staff development programmes).

Core issues refer to the domains encountered across sectors that drive capacity change:

- Institutional arrangements (policies, procedures and processes to manage the execution of development, rule of law, measuring change and other functions of state)
- Leadership (e.g. rally others around a common goal, create vision)
- Knowledge (using information and expertise to develop effective solutions)
- Accountability (rights holders and duty bearers deliver on their obligations)

Technical capacities (associated with particular areas of expertise and practice) and functional capacities encompass:

- Capacity to engage stakeholders
 - Identify, motivate and mobilize stakeholders
 - Create partnerships and networks
 - Promote engagement of civil society and private sector
 - Manage large group processes and open dialogue
 - Mediate divergent interests
 - Establish collaborative mechanisms
- Capacity to assess a situation and create vision and mandate
 - Access, gather and disaggregate data and information
 - Analyse and synthesize data and information
 - Articulate capacity assets and needs
 - Translate information into a vision and/or a mandate

- Capacity to formulate policies and strategies
 - Explore different perspectives
 - Set objectives
 - Elaborate sectoral and cross-sectoral policies
 - Manage priority-setting mechanisms
- Capacity to budget management and implementation
 - Formulate, plan and manage projects and programmes, including the capacity to prepare a budget and to estimate capacity development costs
 - Manage human and financial resources and procurement
 - Set indicators for monitoring and monitor process
- Capacity to evaluate
 - Measure results and collect feedback to adjust policies
 - Codify lessons and promote learning
 - Ensure accountability to all relevant stakeholders

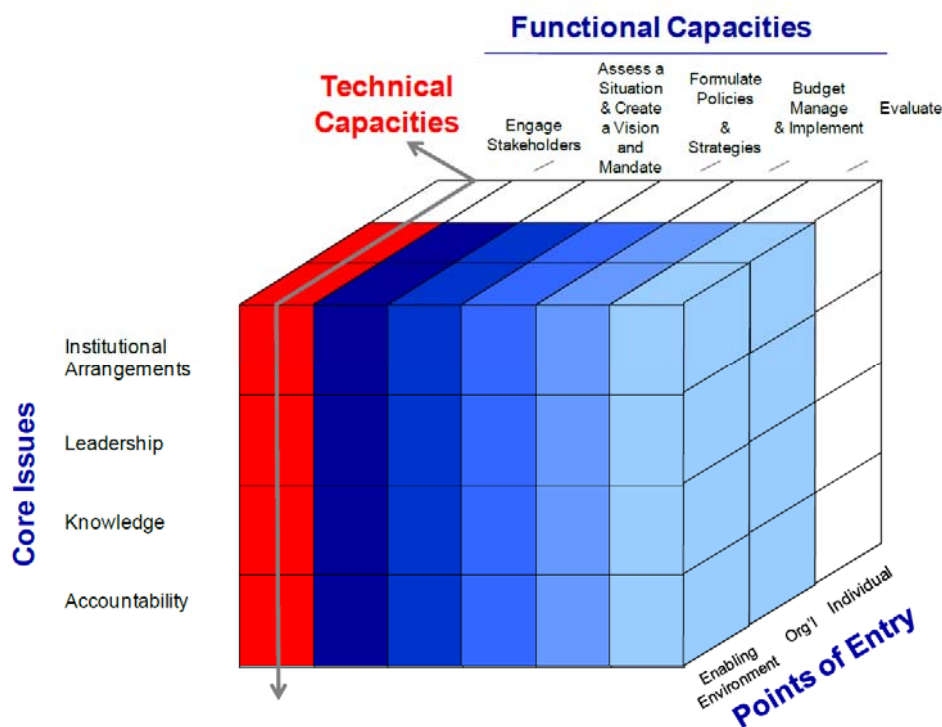


Figure 23: The UNPD Capacity Assessment Framework (UNDP, 2008, 8)

Capacity Assessment and Capacity Audit

This chapter describes and delivers practical recommendations on how to prepare and conduct capacity assessments and audits. They represent the starting point in the process of capacity development planning as they provide information about the capacities already existing or missing, allowing the setup of objectives and measurable targets to be achieved.

The concepts of assessment and audit are complementary. A capacity assessment supports a better understanding of desired and existing capacities, assets and needs. By this, it provides information about capacity development – in the sense of what needs change and or how this can be brought about. A capacity audit verifies whether capacities are in line with pre-defined standards or criteria that have been specified by certain guidelines, regulations, policies or programmes.

Therefore, the capacity assessment should be understood to be a dynamic participatory process in which audits are carried out regularly and at different stages of policy making / implementation. This creates a clear picture of the current situation, allowing monitoring of progress and enabling future interventions to be implemented. Moreover, an audit is important not only as a product for capacity assessment but also because of the knowledge and capacity building experience it provides to the individuals or organization conducting it.

Capacity assessments and audits can be used for a range of purposes. They can vary in their scope and focus but besides providing important information for and about capacity building and development they can also have the potential to:

- act as a catalyst for action and help to build consensus on priorities;
- build political support for an agenda;
- offer a platform for dialogue among stakeholders;
- provide insight into operational hurdles in order to unblock a programme or project;
- contribute directly to capacity building (awareness, motivation, learning).

Moreover, they are often conducted for preparing national, regional or sectoral strategies and plans and as well with regard to international programmes. They can be used to develop capacities at different stages of policy making:

- Assessments (what kinds of capacities are in place to conduct assessments and which of them should be further developed?)
- Policy formulation (how to develop capacities)
- Implementation and evaluation (e.g. by capacity audits).

Preparing and conducting capacity assessments and audits means converting some of the theoretical frameworks presented in the previous chapter and adapting the tools to the respective contexts and purposes. Frameworks and tools are not prescriptive and should not be followed as such but rather be understood and adapted as needed.

Consequently, the practical recommendations must not be taken as a construction plan or recipe. They have to be adapted to specific settings, aims and available resources. They should support people in conducting capacity assessments on a small scale (e.g. for an organization, for a specific aim etc.) as well as on a large scale. They have to be used in a pragmatic manner and in line with available resources and capacities. Even if an extensive capacity assessment is not possible, capacity assessments of limited scope might still prove beneficial.

Approaches to consider

A Regional Action Group

The project Health Equity 2020 aims to support regional capacity building and capacity development to reduce health inequities. One way of achieving that is by establishing a Regional Action Group (RAG) and jointly developing action plans.

Establishing a Regional Action Group is already capacity-building and development in itself; however, when preparing the setup of the RAG some of the major questions that arise are:

- Which capacities for reducing health inequities are already in place – which assets do members of the RAG already have, where are gaps?
- What could be done to develop capacities of the members still further?
- How to develop co-operation and partnership between the members of the RAG as an important element of capacity building and development?

Box 11: Gaps and assets

Asset-based approaches are important for reducing health inequities. "They focus on the positive capacities of individuals and communities rather than solely on their needs, deficits and problems" (McLean, 2011). According to Morgan & Ziglio, 2007, "a health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing and to help to reduce health inequalities.

These assets can operate at the level of the individual, family or community and population as protective and promoting factors to buffer against life's stresses." For (McLean, 2011), the different levels of health assets would address a) the individual level (resilience, self-esteem and sense of purpose, commitment to learning), b) the community-level (family and friendship or supportive networks, intergenerational solidarity, community cohesion, religious tolerance and harmony) and c) the organizational level (environmental resources necessary for promoting physical, mental and social health, employment security and opportunity for voluntary service, religious tolerance and harmony, safe and pleasant housing, political democracy and social justice).

Methodologies are e.g. a) Asset-Based Community Development (ABCD), asset mapping, co-production, appreciative inquiry and participatory appraisal (McLean, 2011).

Health Equity 2020 is not only looking at health assets, but also and mainly at assets for capacity development and building to address health inequities in cross-sector settings. Assets of interest are therefore *any factors or resources which enable the improvement of the ability of individuals, communities and populations to develop and build capacities for the reduction of health inequalities, in addition to others in the field of cross-sector communication and co-operation.*

Gaps and assets

When looking at capacities, it is necessary not only to look at gaps, but also at assets (Box 11). It is important to acknowledge and value pre-existing capacities and activities, to

develop trust, and to be responsive to context. Pre-packaged ideas and strategies should be avoided as the development of well-planned and integrated strategies should be looked into (NSW 2001).

Therefore, the capacity audit should identify and take into account what is already in place, what already works, and what should be sustained and developed further. It is important to recognize and acknowledge what has already been done to create ownership, partnerships and the motivation to go further. The challenge often lies not in the building of new capacities, but rather in the further development of the existing ones. It is important to close gaps and build upon and develop strengths.

The process of conducting capacity assessments and audits

Preparing capacity assessments and audits

The core of a capacity assessment / audit is often based on collecting data and information from key stakeholders. The full process involves several steps and is organized in a participative manner:

1. In the first phase, stakeholders need to be mobilized and the specific design of the capacity assessment should be developed. It is important to engage key stakeholders as they can “provide political and administrative oversight”, “assist in designing the assessment”, “conduct research and participate in the assessment”, “analyse and disseminate the results and set priorities for follow-up action”. Furthermore, the participation itself can contribute to stakeholders’ capacity development (UNDP 2008).

Within this phase it is important to “clarify objectives and expectations with primary clients”, to specify “priorities, goals and expectations”, and to “identify owners of assessment”. On this basis, the capacity assessment frameworks have to be adapted to the specified aims and needs (e.g. capacities for whom? capacities for what?)

2. Information and data collection & the assessment approach have to be determined. Starting with a horizon scan to understand the overall context, a quantitative (e.g. designing ranking scheme for capacities) and/or qualitative approaches (anecdotal evidence) have to be selected. Data can be collected by:
 - Semi-structured interviews or one-on-one interviews;
 - Questionnaires;
 - Focus groups;
 - Client satisfaction surveys;
 - Scorecards;
 - Workshops;
 - Case studies etc.
3. Furthermore, it needs to be decided how the capacity assessment should be conducted (who should conduct it, who should be interviewed, where and how information and data should be collected, should external experts / a third party collect data, or should a self-assessment take place?).

4. Additional questions are:
 - How important is the use of information and data for learning experiences?
 - Should it be possible to measure changes over time / across entities?
5. Finally, all decisions have to be integrated in a plan and the cost of the capacity assessment has to be evaluated.

This working framework can be discussed and agreed upon with the (potential) members of the RAG by for example organizing a workshop / meeting to discuss the topics. A possible agenda for this should include: an introduction, key terms and concepts, explaining process for capacity development and capacity assessment / audit, introducing the framework for capacity audit, adapting the framework to specific context, identifying stakeholders for participation in the audit.

Clarifying context and aims of capacity development

Another aspect worth taking into account is the coordination of capacity development strategies with the context in which they are fostered. This can be understood as a multidimensional process, where the development of capacities require or depend on an enabling policy and institutional environment. Therefore, it may occur that the actions for capacity development at an organizational, partnership or leadership level are also directed towards goals of rising awareness, dealing with mental blocks, fighting denial or indifference, creating concern and will to action (Whitehead / Dahlgren 2006).

Identifying interviewees and preparing interviews

To prepare capacity assessments and audits, attempts should be made to get a first overview of the status of affairs in the region / organization / department. This can be achieved by reflecting upon the following questions:

- What kinds of legislation are of relevance?
- Which stakeholders (individuals, organizations providing services in the public and private sector, civil society (advocacy), public administration, political system) are involved?
- How connected is the region / organization at national / international level (member of specific networks; national / international projects; availability of good practices)?
- Which activities, projects, programmes are in place?
- Which statistics (population, target group, budgets, expenditure, infrastructure, workforce, service provision etc.) are available?

Available materials should be used to identify relevant stakeholders and the right questions. Sometimes, there is very limited information available, in which case experts can become key sources of information. Professionals in public administration, health insurance, an organization that provides a health service within universities or civil society organizations etc. can help to map the situation and to identify the right people for further interviews, additional materials, stakeholders and interview partners.

As soon as the right people for an interview have been identified, research into more focused information should continue. For conducting interviews it is helpful to have as many

details as possible about their function and activities, the organizational environment as well as the environment of the organization.

At the beginning of the interview the kind of capacities the discussion should focus upon need to be known. However, interviewees cannot or do not always provide all the information required; they can mainly offer specific kinds of expert knowledge in specific areas. While it might be of relevance to identify knowledge gaps, the interview should be flexible enough not to dwell on questions that do not match the interviewee's expertise / experience. This prevents the risk of the interviewee feeling uncomfortable, with negative consequences for the interview and the capacity audit.

There are also situations in which the interviewer already has considerable information / knowledge about the capacities of interest while in many other circumstances previous knowledge is quite limited. Unfortunately, it is not always possible to prepare interviews in a very detailed manner because respective materials are not available. In such a case, you should start "from scratch" and develop knowledge from interview to interview. When information is available the person conducting the audit should be open to new information, insights and expertise from interviewees. This will prevent bias and prejudice.

Box 12: Examples for limitations of expert knowledge

A field worker might be an expert in legal issues and national / regional programmes . He can also provide information about his/her organizational environment / organization.

The head of unit or organization might have expertise in labour markets, the education of professionals or other organizations and sectors. He can also share information about his/her organization, ideas and restrictions to organizational development.

A senior official or politician at a regional or even national level could have insight into the actual situation in the region or at local level, as well as into organizations providing services. It is also highly likely that he or she would be able to provide information about political debates, policy developments, existing legislation etc.

Some people already have knowledge about capacities, some about capacity gaps, while others about capacity development and capacities needed for capacity development.

The interviewer should therefore try to find out before and during the interview what kind of expert knowledge is being offered – and use this as a strategy.

Tools for preparing the capacity assessment / audit

Stakeholder analysis

There are many tools which can help to prepare the capacity assessment or audit.¹ A stakeholder analysis might support the interviewer in identifying relevant interview partners and questions.²

Stakeholders are individuals, interest groups or organizations which are positively or negatively affected by projects and programmes, and who often have an impact on successful project and programme implementation and realization.

If the aim is to develop certain capacities for reducing health inequities, the interviewer could screen materials and/or organize a brainstorming session with colleagues or members of the RAG to identify the relevant stakeholders.

The interviewer can organize the lists of stakeholders by grouping private sector, public sector and civil society actors. After completing the lists, the interest and power of the stakeholders can be discussed and placed in a matrix similar to the one shown in Figure 24.

- Stakeholders with a high level of interest and power are particularly important. It is possible to engage them closely and actively try to influence them. They are decision makers or opinion leaders with a high degree of influence on decision makers.
- Stakeholders with a high level of interest but little power should be kept informed. They may be able to exert influence on the decision makers / opinion leaders (lobbying).
- Stakeholders with low levels of interest but a lot of power should be kept satisfied. It is unlikely they can be convinced to be very active supporters, but they could become patrons and support the project to a certain degree. The risk of negative influences on the project undertaken should be minimized as much as possible.
- Stakeholders with low levels of interest and little power are not important, but should at least be monitored should any circumstances, power and interests change.

¹The British Overseas Development Institute offers a lot of materials and introduces many interesting tools for “development”, e.g. for communication and knowledge management. While the Institute focusses on developments in “developing” countries, the tools are of course also very useful for EU countries and regions. See: <http://www.odi.org.uk/programmes/rapid> .

²<http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6459.pdf>

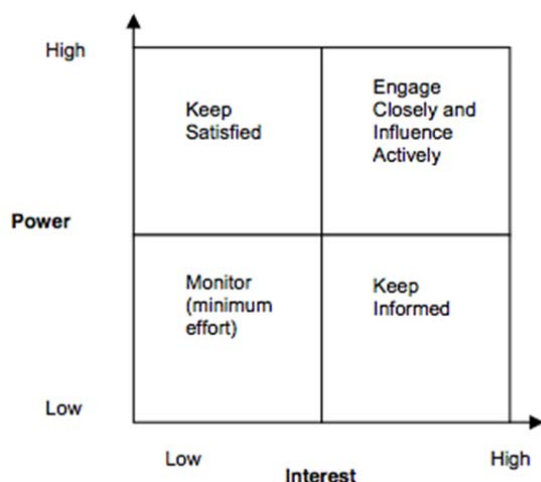


Figure 24: Matrix (ODI <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6459.pdf>)

Another tool that can be used is an influence mapping exercise.³ It provides more information about the interests, the nature of power and the stakeholders' influence and channels to influence decision makers and opinion leaders (Figure 25).

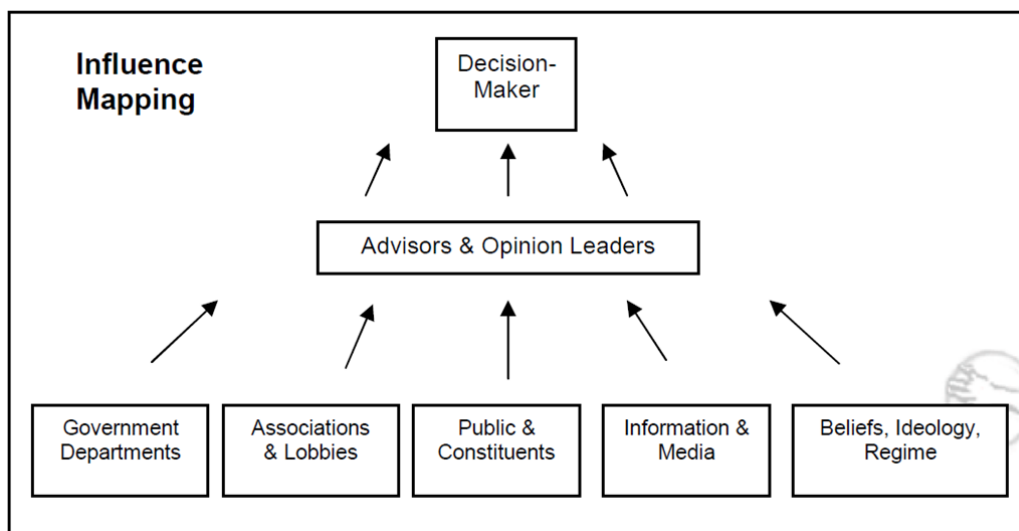


Figure 25: Influence mapping (ODI: <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7076.pdf>)

The RDIC model

Health Equity 2020 focuses on regional cross-sector co-operation. The RDIC-model (Figure 26) offers a very useful framework for mapping opportunities for and barriers to local co-operation.

³<http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7076.pdf>

With regard to “partnerships” as a capacity building and development domain, it also offers a framework for reflecting on stakeholders, capacities, capacity development needs and options and, finally, capacity assessments and audits.

The model was constructed from network theory, organizational behaviour theory, resource dependence theory and new institutional theory. It explains co-operation by a) the willingness to co-operate and b) the ability to co-operate. Willingness and ability to co-operate are explained by goals, perceptions and stakeholder resources with dependencies of and between stakeholders and institutions.

This model can be used to reflect on stakeholders and the dynamics within the RAG. It can be used to prepare and analyse interviews, identify needs and make plans for capacity building and development.

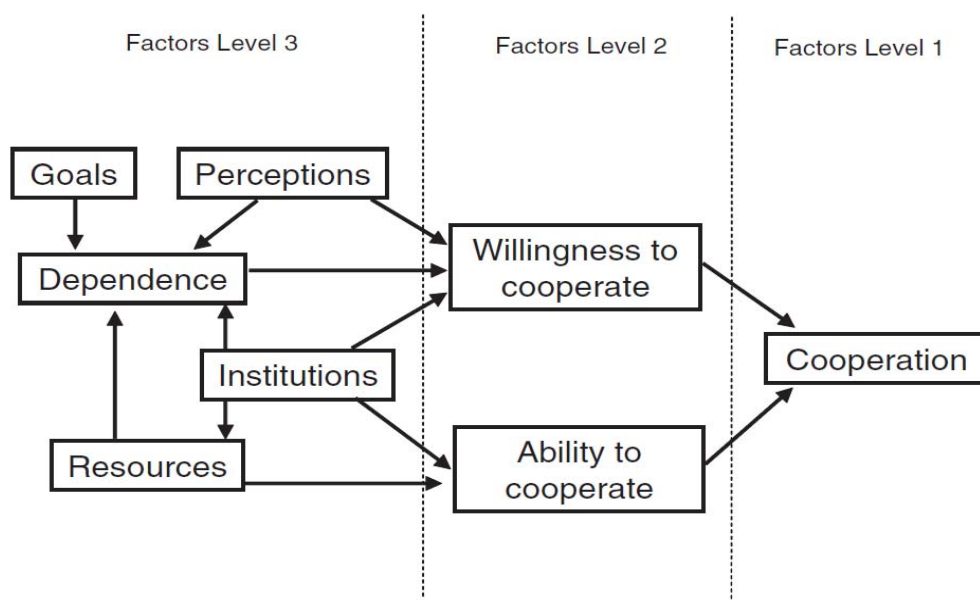


Figure 26: Resource Dependence Institutional Co-operation (RDIC) Model (de Rijk, van Raak, & van der Made, 2007)

Conducting the interview

Under the umbrella of the Health Equity 2020 project, conducting the capacity assessment / audit can be two-fold: a) it can enable the interviewer to get an overview of the region / organization / department b) it can motivate stakeholders to co-operate and build partnerships if these have not yet been established or are not strong enough (for example in the form of an RAG).

The person conducting the audit should decide which entry point or capacity domain to start with. Very often the organizational level is chosen as a first stage of analysis because it is the best way to assess existing capacities and anticipated capacity gaps. Moreover it provides an opportunity to address the individual capacities of people working in the current

organizational environment as well as the organizational environment later in the course of the interview.

Assuming the organizational level is chosen as a first step, the interviewer should find out how organizational activities are linked to health inequity issues of interest or how it can contribute to a reduction in health inequities. It is important to know whether the reduction of health inequities is an explicit objective of the organization, whether it is on the agenda, whether there is a commitment to address health inequities, whether impacts are “only” a side product of activities or whether there is any awareness at all.

It might be a challenge if an interviewee is not aware of the links or impacts that his/her organization has on a particular inequity issue. For example, a representative of a sector (e.g. education, social services, environment) might perceive health inequities as being addressed by the health sector only. To address this particular barrier it is possible to:

- ask the interviewee to give an overview of the organization and its activities,
- explain the social determinants of health approach to him/her afterwards,
- develop a common understanding about the links between the organization and the issue of interest.

The figure developed by Whitehead / Dahlgren (Figure 27) is very useful as a tool to use during interviews. One can ask the interviewee where they identify links between their organizational activities and health which can be the foundation on which to discuss step-by-step links between school / education, social determinants of health and health inequities. This should be followed by collecting more detailed information of the organizational activities of interest.

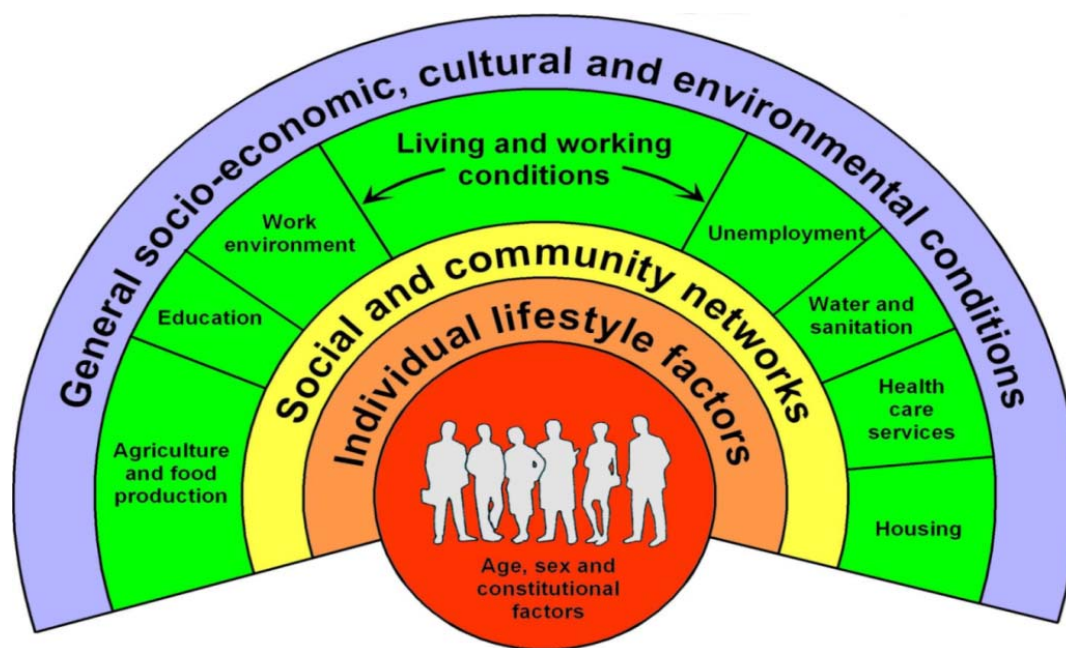


Figure 27: The main determinants of health by Dahlgren and Whitehead (1993)

When the activities of interest have been specified, it is possible to address the relevant capacities for reducing health inequities. This can be done by showing the interviewee the figure with the key action areas of capacity building (Figure 22) and asking him/her to address the different domains of the respective capacity building framework.

Reflecting on the existing capacities will allow the interviewer to take a step further and ask the interviewee to identify assets and also gaps. Both assets and gaps should become starting points for discussing opportunities and needs for the further development of capacities.

A simple table (Table 6) is helpful to structure the discussion. For each of the domains a couple of topics can be taken into account when collecting information about assets and gaps.

Table 6: Domain specific assets and gaps

Assets	Gaps
Workforce Development	
Organizational Development	
Resource Allocation	
Leadership	
Partnership	

The interviewer can ask the interviewee to assess capacities at other levels as well:

- If the interviewee is a policy maker: the perception of organizational capacities and individual capacities can be reflected upon.
- If the interviewee represents an organization: the perception of enabling environment and individual capacities can be reflected upon.
- If the interviewee is an individual: the perception of organizational and environmental capacities can be reflected upon.

Finally, it is also possible to ask about the interviewee's impressions of capacities of other stakeholders.

After the interviewer has a list with assets and gaps, their relevance and priorities for the further development of capacities can be discussed. At this stage it is important to address capacities to plan and implement capacity building and development. The following matrix can be used (Table 7) to structure the interview.

Table 7: Core issues and capacities

Core issues	Technical and Functional Capacities				
	Technical capacities	Engage stakeholders	Assess a situation and create a vision and mandate	Formulate policies and implement	Evaluate
Institutional Arrangements					
Leadership					
Knowledge					
Accountability					

Essential questions are: to what degree do core issues such as institutional arrangements, leadership, knowledge and accountability allow the development of capacities by engaging relevant stakeholders, assessing a situation and creating a vision and a mandate, formulating policies and strategies, budget management and implementation as well as evaluation? What is supportive, what is a hindrance to the development of capacities to address health inequities in another, better, more effective way? E.g.:

- Are health systems routinely designed and implemented to take the specific needs of vulnerable groups into account?
- What about the capacities to engage cross-sector planning and action within and outside the health system?
- Are there mechanisms formally supporting planning and implementing of cross-sector action in tackling health inequities?

Final remarks

Focus on the organization

All these questions can be answered by addressing organizations as well as the (regional) environment. If the interviewee is a representative of an organization, it should be discussed whether there are already organizational developments in that direction (e.g. workforce development), or if there is a positive or negative development in the environment, with consequences for the organization and their capacities to develop capacities (e.g. human resources: education and training of professionals). Does the Ministry of Health require health care service providers to regularly monitor and report on health inequities with regard to their services? Are there clear mechanisms and accountabilities for reducing health inequities within the health sector and other sectors? Have Health Impact Assessments been conducted in the policy formulation process?

Focus on the region

Within Health Equity 2020, the main focus is on capacity development at a regional level. Therefore, the question what can and what cannot be done at a regional level is of major interest. “Regions” and regional policy development vary due to differences in political and administrative autonomy and responsibilities. But even if a region is only a “statistical region”, it is important to assess opportunities of stakeholders within the region as well as opportunities for co-operation in regional networks. It is necessary to identify the stakeholders being (potentially) involved in policy development, from the health sector as well as relevant other sectors. But the focus should not be limited to the political system in a more narrow sense; it should also include stakeholders from the private sector and the civil society (NGOs).

Focus on the environment

Finally, you can address whether and how the environment supports or hinders the development of organizational capacities by covering the same core issues and functional capacities: when it comes to the issue of interest, how do core issues, institutional arrangements, leadership, knowledge, accountability and functional capacities like engaging the relevant stakeholders, assessing a situation and creating a vision and a mandate, formulating policies and strategies, budget management and implementation as well as evaluation in the environment affect organizational capacity development?

Due to time restrictions it might be necessary to shorten this part of the interview. It could be a starting point to ask if the environment is supportive in addressing the respective health inequity, how support eventually looks, or what is a hindrance. It is important to figure out if and which development agendas are already in place, e.g. regional development agendas.

A special topic of interest might be EU funding opportunities and the capacities to use them.

Political context

In assessing the opportunities for policy making within a region, the political situation / status quo must be taken into account. Are health inequities already on the political agenda, is there a shared societal value to address health inequities, or is it necessary to create more awareness? That means finding out whether legislation, policies, programmes and projects or other mechanisms to ensure that activities to address health inequities are high on the agenda and already contributing to policy development. It should be discussed whether there is an explicit political commitment to address and/or long-term political commitment to fund activities – and if a long-term agreement of funding goes hand in hand with a certain kind of flexibility to react to new developments. This also means figuring out whether and which opportunities exist for approaching policy makers with (public) concerns about health inequity issues, and to identify the advocates for addressing health inequities.

Evaluation

A topic of particular interest is evaluation. A precondition for the development of capacities is continuous effort to check developments and progress, to be able to modify and amend activities and capacities.

In a more general sense, the question addresses the availability and role of evidence in all stages of the policy cycle.

Final phase of the interview

At the end of the interview the list of questions should be checked to make sure no important questions have been omitted.

The interviewee can be asked about their vision of the future. Will there be significant change in the region in the sense that new problems will emerge and/or that capacities will be developed? What will be the major drivers or barriers?

To conclude the interview the interviewee can be asked whether they consider all relevant issues have been addressed or whether they would like to add any other information or provide additional data.

After the interviews have been conducted

After the interviews have been conducted the next step would be to analyse the materials and information gathered and formulate a capacity development response: an action plan. The following should be under consideration:

- Combining actions to address more than one issue / topic / concern
- Start the analysis by presenting strength and afterwards gaps
- Defining short and medium term initiatives as well as quick impact activities
- Allocating budgets
- Defining indicators to measure progress
- Defining the cost of a capacity development response

To develop the capacity action plan, you can also organize a workshop / meeting event and/or present and discuss the findings from the capacity assessment / audit with the stakeholders and within the RAG. This can lead to gathering additional information/perspectives on the matter or motivate stakeholders for further co-operation.

The regional action plan is developed in co-operation with the stakeholders and the regional action group. Consequently, when a capacity audit takes place should be agreed to figure out whether or to what degree the objectives and targets for capacity development are being met.

Capacity Audit in the pilot regions

Box 13: Example of CA conducted in Pomurje, Slovenia

Pomurje, Slovenia is one of the pilot regions within the HE2020 project. It conducted a capacity audit structured in two phases during May-June 2013 and the main goals were to:

- (1) test some of the tools developed by the HE2020 project with regard to conducting capacity assessments and audits
- (2) monitor the development of regional capacities in reducing health inequalities
- (3) identify strengths and weaknesses of current support of capacities building available to stakeholders.

The Centre for Health and Development Murska Sobota, already had a well-developed Regional Action Group (37 member institutions from different sectors). Identifying organizations / stakeholders that could take part in the capacity audit was a process based on: (1) a systematic review of the members of the already existing Regional Action Group (2) selecting stakeholders from variety of relevant sectors rather than focusing only on the health sector (3) assessing the prior / potential engagement and motivation of stakeholders. It included representatives from the Employment Agency, Regional Development Agency, Civic Society Representatives, important local business owners, a regional News Company, representatives from local community nurses, environment protection organizations, and rural development, and others.

The approach this capacity audit took was to conduct a series of 10 interviews with these major stakeholders following the NSW (2001) Framework to capture information on all capacity domains: Organization Development, Resource Allocation, Leadership, and Partnership. It used an adapted version of the Interview Guide for Capacity Assessment developed under the HE2020 project to be found in the appendix section.

Some relevant impressions with regard to the process of conducting interviews for a capacity audit include:

- The concepts of social determinants of health, capacities and cross-sector co-operation are more or less familiar to interviewees. It is therefore recommendable that the interviewer provides a brief explanation of health inequalities / capacity building through the use of diagrams and visuals.
- Some of the interviews followed a structured approach (similar to a questions and answers session) with specific questions for each capacity domain. Others were more flexible and took the form of a discussion. Therefore, interview style should be adapted as much as possible to the interviewee in order to enable him/her to share as much information as possible and create a relaxed atmosphere.

The capacity audit tool could deliver:

- contextual information about the situation in the region (e.g. economic situation, demographic situation, local culture and value system, political situation- relation to

- national or local level, education levels, access to services);
- an assessment of the most recurrent health inequities in the region, causes and consequences;
- an assessment of capacities (organization, workforce development – training, resources allocation, leadership, partnership) of the organization / other relevant actors / stakeholders
- the output of the capacity audit could be used as a step to set priorities for the development of capacities in agreement with the other stakeholders.

Main results and recommendations

Organizational Development. Cross-sector co-operation on health and health equity matters exists but at an informal level while knowledge about involvement in policy process is missing. One of the conclusions emerging is the clear need for community capacity-building. The system structures need to be more flexible, facilitate clear avenues of communication and co-operation and create a long-term commitment to shared goals for the region. There is no evidence-based decision making with regard to policies or interventions. However, using success stories and good practices has led to some results.

Workforce development Resources for workforce development exist but there are many structural factors that make them unattractive to employees (lack of support from management, bad time management in parallel with work requirements; costs are sometimes covered by employees). With regard to health equity in particular there is only informal training. The “learning-by-doing approach” helps build experience and interactions between colleagues with greater expertise. One possible conclusion with regard to this is the importance of investing in individuals, education and growth as opposed to infrastructure investments (e.g. hospitals) with a limited return on investment.

Resource Allocation. The availability of funding does not seem to pose challenges to health and health equity projects but rather to budget allocation. The health system is not badly financed but the allocation of resources does not match the actual needs of the population or the system. Additional funding should be directed towards human resources, investing in know-how and expertise as well as basic infrastructure (internet, technology, space). This allocation should be done more at a regional or local level where needs can be better assessed. Moreover, feedback channels should exist between the central planning and communities in terms of how resources are allocated.

Leadership. It was possible to get a picture of the region and the legal background of structures. The responsibilities regarding addressing HI in the region are not clear. It was difficult for stakeholders to identify leaders, although The Centre for Health and Development Murska Sobota appears to have managed to take on the role of promoter. However, there is no joint vision for the region; managerial support remains a decisive factor for any initiative at a local level. There is a need to build motivation among stakeholders and give them sense of ownership about the decisions they make.



Partnerships: There is a wide network of NGOs at a local level but as they do not form a large network they do not have a strong voice within the region. Partnership is undertaken usually through informal rather than formal forms of co-operation. On the other hand, health professionals cannot put health and health equity on the discussion table alone. From this perspective there are opportunities for implementing a cross sectoral approach.

Box 14: Example of Capacity Audit in Lodzkie Region, Poland

Lodzkie Region, Poland is the other pilot region within the HE2020 project. The capacity audit was conducted between September 2013 and April 2014. Medical University of Lodz, the organization conducting the assessment, produced 5 short reports based on interviews with members of the Regional Action Group (RAG): the National Health Fund, Department of Health (City of Lodz), Department of Health Policy (Regional Government), Department of Regional Policy (Regional Development) and Medical University of Lodz.

Using the interview as a benchmark, the interviewer also conducted a short report. One of the assessments was made virtually via emails but followed the same procedure. A general assessment was produced afterwards aiming to give a general picture of capacities at a regional level.

The capacity audit was done in parallel with the needs assessment. The two stages complemented each other very well as qualitative data also requires some statistical background and justification to make strategic decisions in terms of capacity building.

Impressions with regard to the process of conducting interviews for a capacity audit:

- Due to the flexibility of the NSW (2001) Framework, no major difficulties were encountered. Generally, an interviewer with a sociological background should be able to adapt the tool, describe its purpose to the interviewee and manage to conduct the capacity audit interviews successfully.
- It is advisable to provide some specific information about what capacities means and provide some useful terminology or definitions. This would make the auditing process more effective.
- Not all elements of the tool are applicable to all interviewers and presumably to all types of regions.
- The Capacity Audit proved particularly important for the identification the interests of stakeholder's, who could also use this opportunity to build partnerships for common goals.
- As a first capacity audit / assessment done in the region for health equity purposes there was no benchmarking, criteria, prior assessments for comparison. Consequently, there was no clear view with regard to a clear road map to follow or clear goals to set. However, what the capacity audit did manage to achieve was: an important stakeholder analysis; an assessment of assets and gaps in terms of capacities available at a regional level for health and health equity; opportunities for future development.

Main results & recommendations:

Resource Allocation There are no budget lines for reducing health inequalities although some financial resources are dedicated to socioeconomic intervention that could have an impact on health equity in the region. What would help investments in that direction is providing more evidence (data, indicators, statistics, measurements) on health inequalities and their impact.

Leadership. The lack of leaders in the area makes it very difficult to exchange and communicate possible strategies and good practices. When leadership can be identified in a specific area, political barriers also appear to limit their ability to transfer experience to the regional level.

Partnerships. Building partnerships at a local level is seen as a common activity for some of the sectors (the business sector) while for others it can be seen as a major challenge.

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PHASE 3 – Choosing actions

Setting priorities and choosing actions for entry points

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in collaboration with the HE2020 project partners*

Introduction

In previous phases, a [needs assessment](#) (phase 1) and a [capacity audit](#) (phase 2) were carried out. With the information obtained in the first two phases, it is necessary to identify policies and interventions which are able to address the inequalities, given the available capacity. Phase 3 (Figure 28) addresses the process of setting priorities and choosing actions based on the entry points for actions that have been identified in these previous phases.

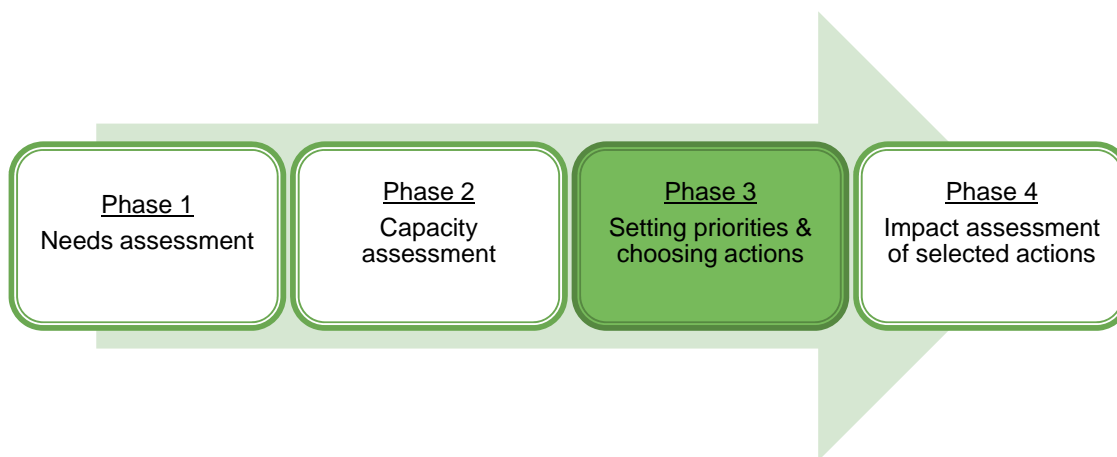


Figure 28: The process towards evidence-based action plans – phase 3

This phase aims to provide information about:

- 1. mechanisms and strategies to address health inequalities,**
- 2. setting priorities and considering appropriate actions, and**
- 3. translating actions into regional action plans**

This phase of the toolkit is accompanied by the [Health Equity 2020 Action Database](#), which contains both effective and promising policies and interventions.

Mechanisms and strategies to address health inequalities

Main mechanisms for action

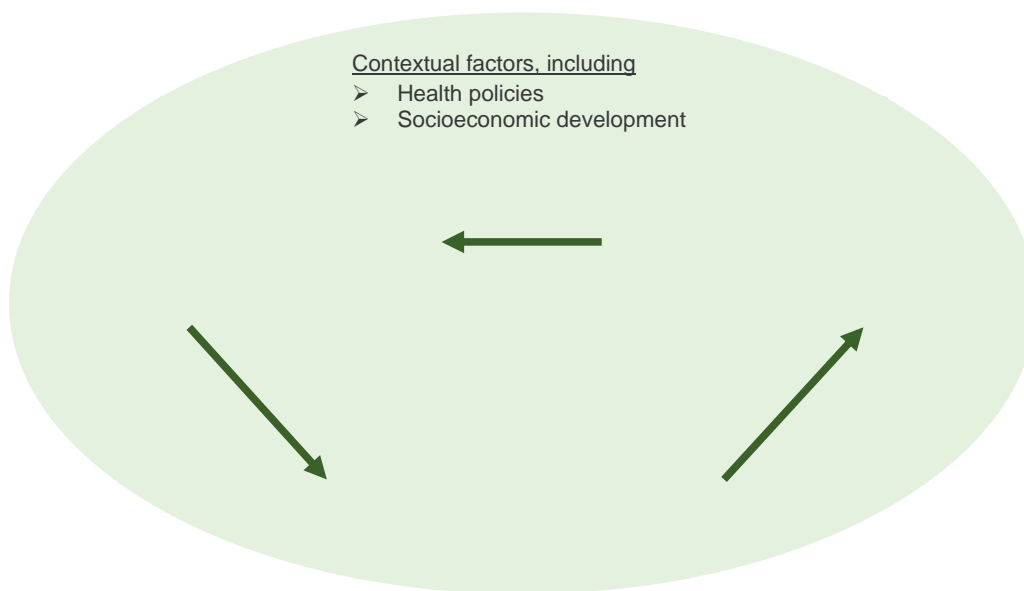


Figure 29 describes again the general framework for the explanation of socioeconomic inequalities in health. Based on this model and other expert reports (e.g. Diderichsen, Evans & Whitehead, 2001; Programme Committee SEGV-II, 2001; Dahlgren and Whitehead, 2006), three main mechanisms can be distinguished through which socioeconomic health inequalities can be reduced:

1. Reducing the inequalities in socioeconomic position itself, such as education, income, or wealth.
2. Reducing the negative effect of a low socioeconomic position on health by improving determinants of health that are more prevalent among lower compared to higher socioeconomic groups, including:
 - a. living and working conditions
 - b. health behaviours
 - c. accessibility to and quality of health care and preventive services
3. Reducing the negative social and economic effects of ill health, such as school drop-out, lost job opportunities and reduced income.

Regardless of the mechanism, policies and interventions should strive to level up, which means that the goal should be to improve health of those in the lowest socioeconomic groups, and not to worsen health of those in the higher socioeconomic groups (Whitehead and Dahlgren, 2006).

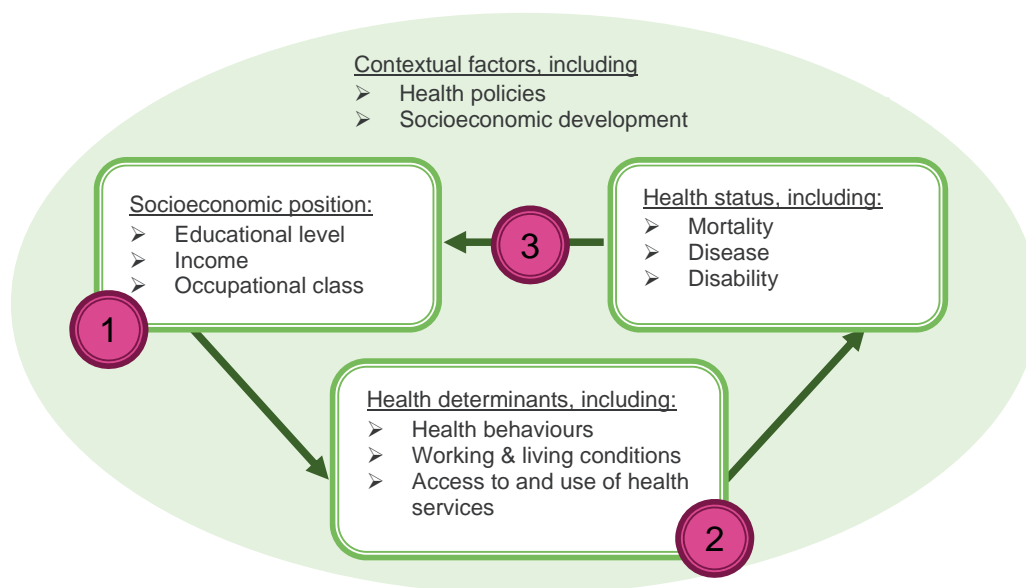


Figure 29: A framework for the explanation of socioeconomic inequalities in health (Kunst et al, 2001).

General strategies for action

Reducing socioeconomic health inequalities could be achieved by either targeting the population at risk (targeted approach), or by addressing the population as a whole (population approach).

Targeted approach

In a targeted approach, interventions and policies directly target lower socioeconomic groups, such as low income women, children living in poverty, or residents living in deprived areas. Socioeconomic inequalities in health are reduced, if the policy or intervention is not applicable or accessible (or to a lesser degree) to higher socioeconomic groups in the population. An example of a targeted approach is the improvement of housing conditions (e.g. warmth and energy efficiency) in poor neighbourhoods (see [Health Equity Action Database](#)).

Population approach

In a population approach, the policy or intervention is aimed at the whole population or a whole subgroup of the population (such as youth or men). Socioeconomic inequalities in health are reduced in this approach if the policy or intervention successfully changes a determinant of health that is more prevalent among the lower socioeconomic groups or because the policy or intervention is more effective in this group. An example of a population approach is the preventive actions via the occupational health check-ups in French companies (see [Health Equity Action Database](#)).

Life-course perspective

Health is determined by the conditions in which a person is born, grows up, works, and grows old, which suggests that socioeconomic health inequalities should be considered in a life-course perspective. Different determinants and different mechanisms (causation and selection, see [Introduction](#)) throughout the life course can contribute to socioeconomic health inequalities and actions that aim to reduce these inequalities can therefore intervene

in different stages of a person's life. For example, interventions and policies may aim at providing equal access to good quality education for children, as well as keeping chronically ill persons in the work force.

Wider social determinants of health

The determinants of socioeconomic health inequalities are diverse and changing these determinants requires collaborations with sectors outside the health sector. The previously described [model by Dahlgren and Whitehead \(1993\)](#) describes the wider social determinants of health. Potential relevant sectors outside the medical and public health sector are the housing sector (e.g. redevelopment and housing improvements), the education sector (e.g. improving (access to) schooling, educating about lifestyle), and the local industries (e.g. improving working conditions).

Setting priorities and considering appropriate actions

Setting priorities

Setting priorities is an iterative process that occurs throughout all the phases. Although defining priorities will start before the end of the need and capacity assessment, they become clearer after these phases.

Witkin and Altschuld (1995) and Hooper and Longworth (2002) provide a number of factors that could influence priority setting, including impact, changeability, acceptability, and resource feasibility.

Impact

The first factor that would influence priority setting is impact: what is the magnitude of the gap between the current situation (what is) and the desired situation (what could be) and what are the most important causes and contributing factors to this gap? With regard to socioeconomic health inequalities, 'impact' can be evaluated as the most important health inequalities in the region, and the most important contributors to these health inequalities. When inequalities in (determinants of) health are large and the potential health gain when decreasing these inequalities is large, 'impact' is considered to be high. The prevalence of health problems can also be considered here. When health inequalities are large, but the prevalence of the health outcome is low, 'impact' is evaluated lower. The results from the needs assessment provide valuable information on the potential impact of focusing on a certain priority.

Changeability

The second factor is changeability: what can effectively be done to address the need? Regarding socioeconomic health inequalities, 'changeability' can be evaluated based on the theoretical amenability of the determinants of a health problem and on the practical availability of actions known to be effective in changing the determinant or health problem. 'Changeability' would be evaluated low when inequalities in health are largely caused by factors that are difficult to change (e.g. genetic predisposition). This could also be the case in a situation where there is no feasible alternative or because the effort (financially, organizationally, or otherwise) needed to accomplish the desired change is very large. Changeability would be evaluated higher when inequalities in health are largely caused by factors that can be addressed relatively easily (e.g. living conditions). Additionally, when

there are actions known that have been proven capable of effectively changing a health problem or determinant, the changeability will be evaluated higher than when effective actions are lacking. Both the needs assessment and the capacity audit results provide valuable input on this factor.

Acceptability

A third factor is acceptability: would addressing the needs be acceptable to the population, the people delivering the actions that address the needs (e.g. community health workers), and the organizations involved in developing and implementing the actions that address the needs? The acceptability refers to ethical, political, social and cultural acceptability and includes community values, local and national priorities, and public expectations. The results of the capacity audit provide valuable input on the acceptability of the needs.

Resource feasibility

A fourth factor is resource feasibility: what are the costs of developing and implementing solutions? Resource feasibility includes the availability of human resources, funding, facilities, but also capacities needed to address the needs. The results of the capacity audit provides important information on resource feasibility.

It is also important to consider the cost effectiveness of addressing certain needs; addressing which need will achieve the greatest 'impact' on health inequalities for the resources used?

In addition to these four factors, Witkin and Altschuld (1995) also suggest evaluating the consequences (on all four factors) of ignoring the needs. What would be the costs, in terms of both health and resources, if a certain need is not addressed? What would be the effect on other parts of the system or other needs if a specific need is or is not met?

Considering appropriate actions

When priorities are set, appropriate actions can be considered to address these priorities. Formulating a set of criteria for considering actions and alternatives could support this process. In line with the factors that influence priority setting, Witkin and Altschuld (1995) suggest that a set of criteria should at least include:

- Criteria of feasibility (including resources)
- Criteria of acceptability (in the target population, in the wider society, in politicians, in those who need to adopt and implement)
- Criteria of effect on the causes (impact) (both of the action and of not doing anything)

Evaluating evidence of effectiveness

Policies that have proven to be effective in reducing socioeconomic health inequalities are still rare. This is partly because evaluating policies in a scientifically sound way is very challenging. For example, it may not be practically feasible or ethically reasonable to randomly assign people or groups to a controlled experimental condition. This does not mean that there are no effective policies that can be implemented to address socioeconomic health inequalities. In order to provide some guidance in the level of evidence that supports the effectiveness of a certain policy, a classification system was developed (see Box 15). This system builds upon previous classifications (e.g. Mackenbach & Gunning-Schepers,

1997; Loket Gezond Leven, 2014; GRADE guidelines, 2011) and is hierarchical. The actions included in the [Health Equity Action Database](#) have been assessed via this classification. This classification can assist in evaluating the level of evidence there is on impact or effectiveness of an action in reducing health inequalities.

Box 15: Evaluating evidence of effectiveness

The minimum level of evidence, category D (see Figure 33), is granted if the action is well developed and is based on sound theoretical, logical models and/or literature. The action is clearly aimed at one of the determinants known to determine socioeconomic health inequalities (either a targeted approach that improves health (or health determinants) in the most disadvantaged or a population approach that has the potential to reduce inequalities by improving health (or health determinants) more in the most disadvantaged group). There is no evidence available that indicates that the action is effective other than that based on theory, models or literature.

The second level of evidence, category C, is granted if the action fulfils the requirement of level D in combination with some evidence that the intervention has some effect. Evidence that falls into this category is for example a positive result of a simple pre- and post-measurement design without a control group or anecdotal evidence such as documented individual success stories.

The third level of evidence, level B, is granted if the action fulfils the requirement of level D in addition to reasonable evidence that the intervention works. The level of evidence required to be granted level B should be reasonably strong and could, for example, be a time-series design in which changes in a trend are linked to the implementation of the action.

The highest level of evidence, level A, is only granted if the action fulfils the requirement of level D in addition to good evidence that the intervention works. The level of evidence required to be granted level A should be strong and based on at least a pre- and post-measurement design with a control group such as a randomized control trial or a community intervention trial.

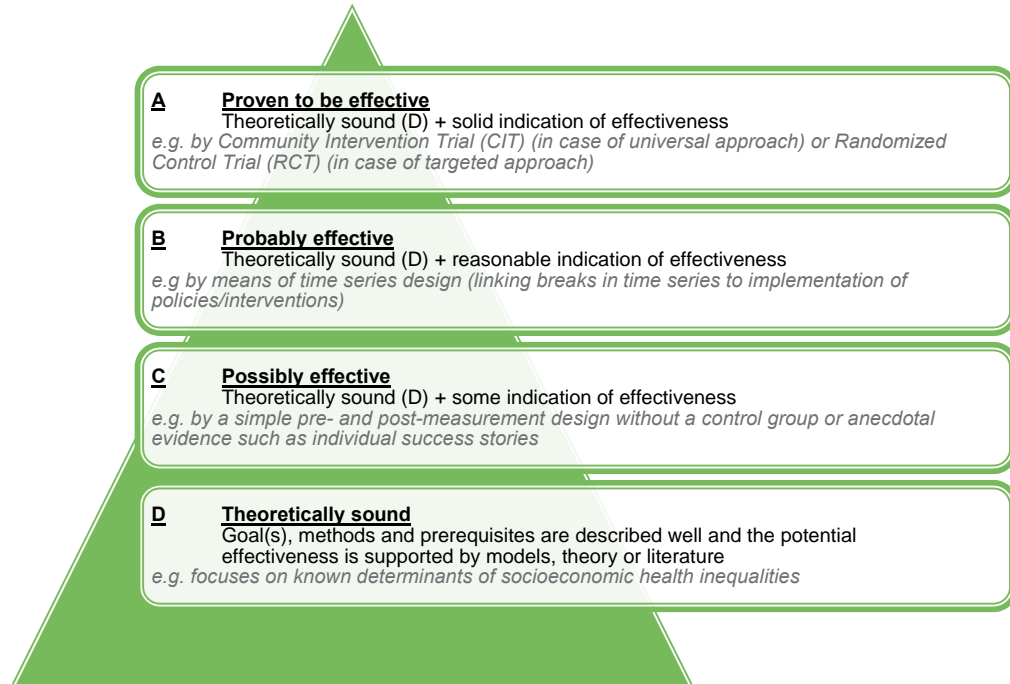


Figure 30: Classification of level of evidence of action to reduce socioeconomic inequalities in health.

Exploring existing initiatives and social innovation

Action plans never stand on their own. Integrating an action plan with existing initiatives and social innovations could increase the chances of a successful implementation. Integrating plans with existing initiatives or social innovation will have financial advantages, since several prerequisites may already be in place. It may also be easier to get public and political support, and previous or existing initiatives may provide valuable information on success and failure factors. Possible questions to answer when exploring existing initiatives and social innovations are:

- What are actions currently undertaken to address the entry points in the region?
 - Are there any local initiatives from residents that address the entry points?
 - Were any initiatives undertaken in the past that addressed the entry points?
 - Are there any initiatives at the national level that address the entry points?
 - Are there any initiatives in other regions that address the entry points?
- ➔ For all these questions: What were the main findings/experiences?

Exploring resources including European Structural and Investment Funds

European Structural and Investment Funds are a potential source of resources for funding or co-funding the proposed actions.

The most relevant European Funds are the European Structural and Investment Funds, including the European Regional Development Fund (ERDF) and the European Social Fund (ESF), and the Cohesion Fund (CF).

When considering the different funds for addressing socioeconomic inequalities in health, each of the funds offer their own possibilities:

- The ERDF aims to strengthen economic and social cohesion in the European Union by correcting imbalances between its regions and it mainly supports 'hard' projects such as investments in infrastructure. With regard to interventions that address inequalities, possibilities lie for example in improving access to medical and preventive care or e-health interventions.
- The ESF invests in people, with a focus on improving employment and education opportunities across the European Union. It also aims to improve the situation of the most vulnerable people at risk of poverty. Possibilities for interventions that address health inequalities are numerous. Examples are policies to reduce child poverty, interventions on health and safety at work, long term care, training of health professionals, promoting healthy lifestyles in youth via the school system or interventions that aim to rehabilitate ill personnel to the workforce.
- The Cohesion fund aims to reduce economic and social disparities and to promote sustainable development. It funds activities under the categories 'environment' and 'trans-European transport network'. The fund specifically addresses those Member States whose Gross National Income (GNI) per inhabitant is less than 90% of the EU average.

More information on how to use the EU Funds when addressing socioeconomic health inequalities can be found in the Health Equity 2020 document on the [Policy Matrix](#) (Appendix 4).

More information on European Funds

Within the Equity Action project. A practical tool was developed that provides information and guidance on how to use European Structural Funds for health: <http://fundsforhealth.eu/>

Also the European commission provides information on how to use European Structural and Investment Funds for health:

http://ec.europa.eu/health/health_structural_funds/used_for_health/index_en.htm

The detailed document on each of the European Funds can be found here:

- Regional Policy: http://ec.europa.eu/regional_policy
 - ERDF: http://ec.europa.eu/regional_policy/thefunds/regional/index_en.cfm
 - ESF: http://ec.europa.eu/regional_policy/thefunds/social/index_en.cfm
 - CF: http://ec.europa.eu/regional_policy/thefunds/cohesion/index_en.cfm

The national websites about the European Funds are listed below:

- Estonia www.struktuurifondid.ee
- Latvia www.esfondi.lv
- Lithuania www.esparama.lt
- Poland www.funduszeuropejskie.gov.pl
- Hungary www.nfu.hu
- Romania www.mfinante.ro
- Slovenia www.eu-skladi.si
- Slovakia www.nsrr.sk
- Czech Republic www.strukturalni-fondy.cz
- Bulgaria www.eufunds.bg

Translating actions into regional action plans

When priorities are set and a list of potential actions is created, the development of a regional action plan can be started.

RE-AIM

The RE-AIM model (Glasgow, Vogt & Boles, 1999) described five essential program elements that should be considered when developing action plans; *Reach*, *Effectiveness or Efficacy*, *Adoption*, *Implementation*, and *Maintenance*. The first two elements, *Reach* and *Effectiveness or Efficacy*, evaluate the potential impact of an action on the individual level; does the action have the ability to reach the intended target group and is the action able to change the outcome or determinant that is addressed. The elements *Adoption* and *Implementation* evaluate the impact on the organizational level; which organizations should adopt and implement the action, in which settings and how. The last element, *Maintenance*, relates to both the individual level as the organizational level. At the individual level, *Maintenance* could indicate whether an action stays effective over the long time or does the effect wear off and how could the effect be maintained. At the organizational level, *Maintenance* could indicate issues of sustainable adoption and implementation over time. Both the individual level impact and the organizational level impact should be considered when choosing an action. When an intervention or policy has the potential to reach the

population and is effective in changing the outcome but is not adopted or implemented well in the organizations that should deliver the intervention or policy, there will be no effect on health and health inequalities. On the other hand, when an intervention or policy is properly adopted and implemented at the organizational level but is not effective in changing the relevant outcome or is not able to reach the intended population, it will not have an effect on health or health inequalities either. All elements are important to make an impact on health and health inequalities.

The choice of action for the action plan should therefore be evaluated in terms of these five elements. For each strategy, policy or intervention, a few relevant questions in each of these elements can be used to evaluate the action. By considering all five elements, potential hindering and enhancing factors in each of these elements could be discussed beforehand. This will provide information about the appropriateness and achievability of the action and it will increase the impact and sustainability of the actions when they are included in the action plan.

- **Reach**; “The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative, intervention, or program.”
 - Who is the intended target population?
 - Can the target population be sufficiently reached?
 - Are there barriers to reaching the target population?
 - Could these barriers be sufficiently dealt with?
 - How can the reach of the action be stimulated?
- **Effectiveness or Efficacy**; “The impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.”
 - What is the desired effect of the action?
 - Could the action produce the desired effect?
 - Is there any evidence on the cost effectiveness of the action?
 - Are there any barriers to attaining this desired effect?
 - Could these barriers be sufficiently dealt with?
 - How can the effectiveness of the action be stimulated?
- **Adoption**; “The absolute number, proportion, and representativeness of settings and intervention agents (people who deliver the program) who are willing to initiate a programme.”
 - Who should adopt/initiate the action?
 - Are there barriers to the adoption of the action?
 - Could these barriers be sufficiently dealt with?
 - How can adoption of the action be stimulated?
- **Implementation**; “At the setting level, implementation refers to the intervention agents’ fidelity to the various elements of an intervention’s protocol, including consistency of delivery as intended and the time and cost of the intervention. At the individual level, implementation refers to clients’ use of the intervention strategies.”
 - Who should implement the action?
 - How should the action be implemented?
 - What are costs (time & resources) of implementation?
 - Are there barriers to the implementation of the action?
 - Could these barriers be sufficiently dealt with?

- How can implementation of the action be stimulated?
- **Maintenance**; “The extent to which a programme or policy becomes institutionalized or part of the routine organizational practices and policies. Within the RE-AIM framework, maintenance also applies at the individual level. At the individual level, maintenance has been defined as the long-term effects of a programme on outcomes after 6 or more months after the most recent intervention contact.”
 - What type of maintenance of the action is required?
 - How long is maintenance of the action required?
 - How can maintenance of the action be accomplished?
 - Are there barriers to the maintenance of the action?
 - Could these barriers be sufficiently dealt with?
 - How can maintenance of the action be stimulated?

(Source: www.re-aim.org, visit the website for more information, applications, tools and examples of RE-AIM)

The Health Equity 2020 Action Database

The [Health Equity 2020 Action Database](#) contains a range of policies, interventions and programmes that aim to reduce socioeconomic health inequalities. Both effective actions (evidence level A or B, Box 15) and good practices (evidence level C or B, see Box 15) are included although the focus is on effective actions.

The database can be accessed [here](#).

More information on actions for reducing health inequalities

Within other related projects, good and best practices have been collected. Other sources of policies and best practices are:

- http://www.health-inequalities.eu/HEALTH EQUITY/EN/policies/policy_database/
- <http://www.healthequity2020.eu/pages/existing-knowledge-learning-using-sf-health-investments/learning-resources/eiii-practical-knowledge-database/>

For more extensive information on concepts and principles related to addressing health inequalities, see the report by Dahlgren and Whitehead ‘A discussion paper on concepts and principles for tackling social inequities in health: Levelling up Part 1 (WHO, 2006a). For the full paper, visit: http://www.who.int/social_determinants/resources/leveling_up_part1.pdf

Dahlgren and Whitehead also thoroughly describe the link between social determinants and health and the accompanying policy options for reducing socioeconomic health inequalities in their report ‘European Strategies for tackling social inequities in health: Levelling up Part 2 (WHO, 2006b). For the full paper, visit:

http://www.who.int/social_determinants/resources/leveling_up_part2.pdf

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PHASE 4 – Impact Assessment

Assessing the potential impact of actions on health and health inequalities

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Introduction

In previous phases, a [needs assessment](#) (phase 1) and a [capacity assessment](#) (phase 2) were carried out. With the information obtained in the needs assessment and the capacity audit, [priorities and entry points for actions](#) were identified and actions to address these entry points were selected (phase 3). In the final phase, the potential impact of these actions on health and health inequalities needs to be estimated (Figure 31). A Health Impact Assessment (HIA) is a structured approach to assess the impact of an action (intervention or policy) on outcomes such as health and health inequalities.

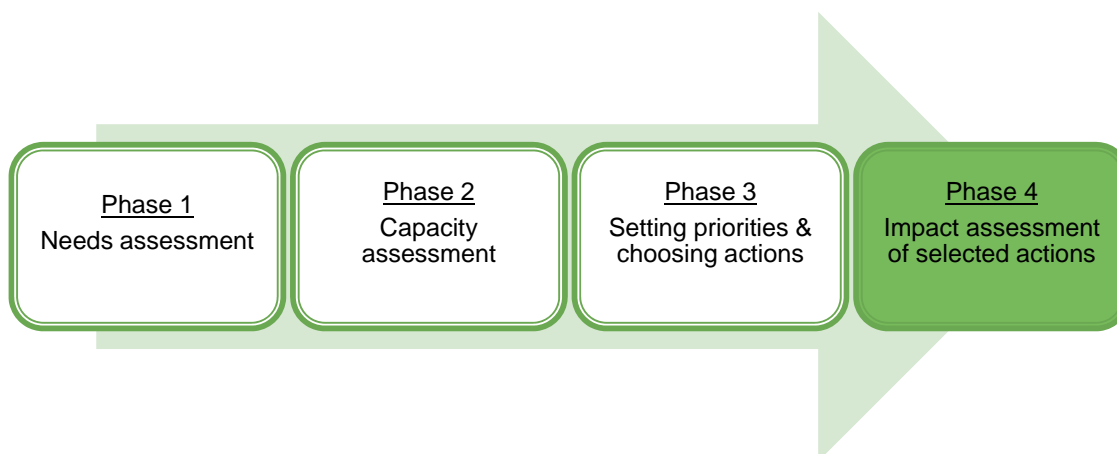


Figure 31: The process towards evidence-based action plans – phase 4

This phase aims to provide information about:

1. **what an HIA is**
2. **what the main steps of an HIA are**
3. **how to ensure an equity focus in an HIA**
4. **how to evaluate the economic impact of the action**

Furthermore, this document will provide suggestions for freely available guides and frameworks on how to do an HIA and for sources where to find examples of finished HIAs.

Definition of HIA

The definition of Health Impact Assessment (HIA) is “a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.” (EHP, 1999). In line with this definition, health impacts are considered “the overall effects, direct or indirect, of a policy, strategy, programme or project on the health of a population.” An HIA aims to assist decision makers to make choices about alternative decisions.

In addition, a good HIA should respect four core values (EHP, 1999):

- **Democracy**, emphasizing the right of people to participate in a transparent process in the formulation, implementation and evaluation of policies that affect their life, both directly and through the elected political decision makers;
- **Equity**, emphasizing that HIA is not only interested in the aggregate impact of the assessed policy on the health of a population but also on the distribution of the impact within the population, in terms of gender, age, ethnic background and socioeconomic status;
- **Sustainable development**, emphasizing that both short and long term as well as more and less direct impacts are taken into consideration;
- **Ethical use of evidence**, emphasizing that the use of quantitative and qualitative evidence has to be rigorous, and based on different scientific disciplines and methodologies to get

An HIA is not only intended to evaluate the impact of policies, projects, programs and interventions within the health sector but also, and maybe even in particular, to assess the impact of policies, projects, programs and interventions in the *non-health* sector (Lock, 2000). An HIA therefore stimulates intersectoral working.

Main steps of HIA

In the structured approach of drawing up evidence-based action plans to address socioeconomic health inequalities as adopted in the Health Equity 2020 project, the goal of the HIA is to estimate the potential health effects of actions before the actual implementation of these actions. The outcome of the impact assessment informs the decision making process, for example through the provision of quantitative, measurable estimates of the effects of an action.

An HIA in which the potential effects of the action are estimated before the action is actually implemented, is called a **prospective HIA**. In some cases, an HIA is carried out retrospectively but then the aim is to *evaluate* an action *after* its implementation.

An HIA consists of five main steps, which are depicted in Figure 32, and includes (1) screening, (2) scoping, (3) impact assessment, (4) decision making (reporting and recommendations), and (5) monitoring and evaluating. In the screening phase it is determined whether an HIA is suitable and feasible. In the scoping phase, the scope of the HIA is determined and the methods and work plan are set out. The third step, 'impact assessment' is the core step in which the actual estimation of impact on health is determined. This step can be further divided into several sub-activities. In the fourth step, the results of the HIA are reported and recommendations are formulated in order to enable the decision-making process. The final step contains of monitoring and evaluating the HIA recommendations and process.

There may be some small differences in the number or the names of the steps, depending on the specific HIA framework used. However, the core process is essentially similar.

In the next session, all steps will be briefly explained. The guidelines of all different available frameworks provide more extensive information on how to perform each of these steps. An

overview of available guides and frameworks is provided at the [end of the document](#).

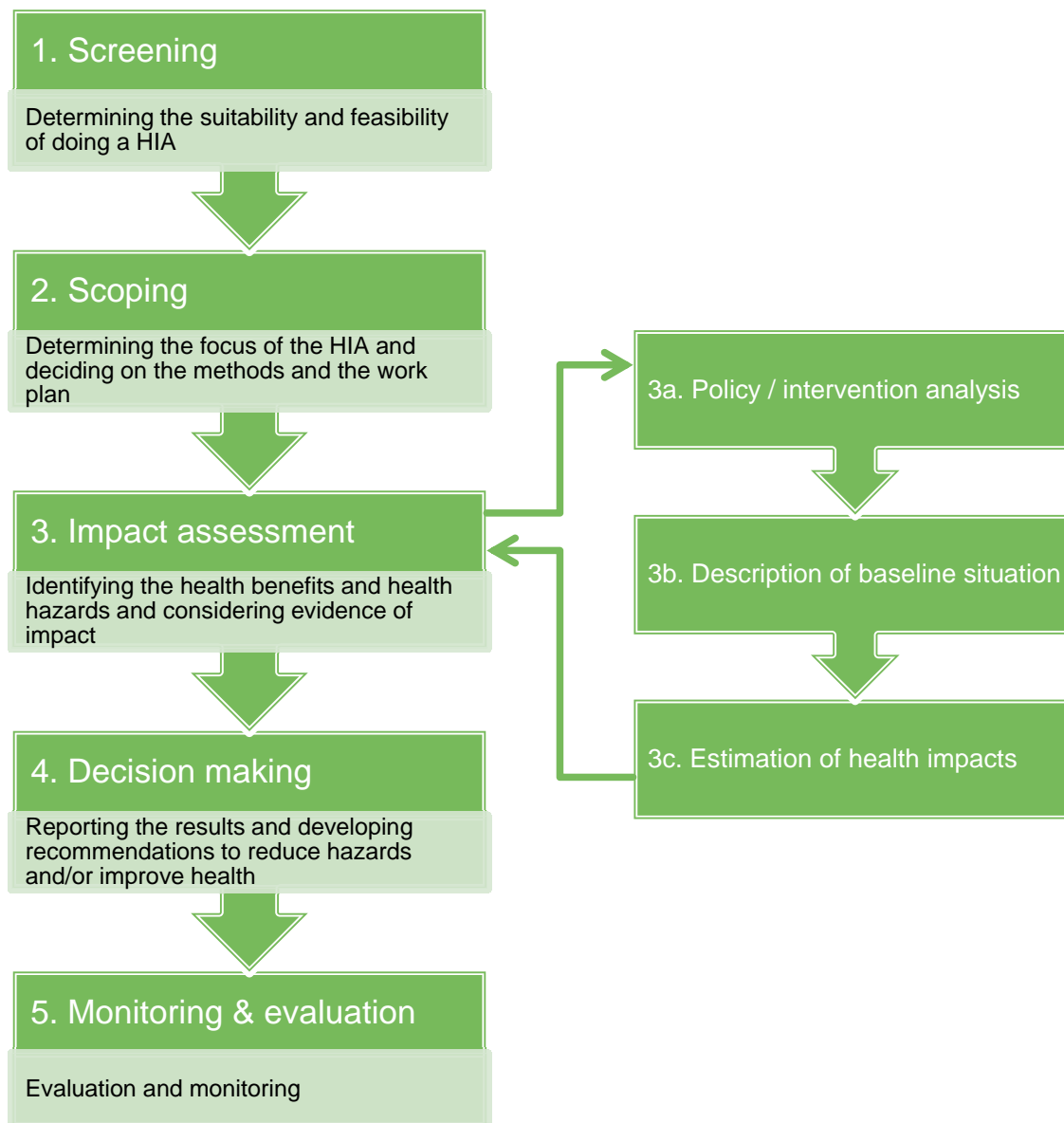


Figure 32: The main steps of a Health Impact Assessment.

Equity focus within HIA

According to the definition, an HIA not only focuses on the effects on population health, but also on the distribution of these effects within the population. In addition, equity is one of the core values of a good HIA. Therefore, equity should be an integral part of any HIA. However, since this is not always the case, this tool will provide some pointers on how to include an equity perspective.

To ensure the focus on equity within an HIA, it should be clear to all stakeholders involved what is meant by the terms “inequality” and “inequity”. These definitions are provided in the [Introduction](#) of the toolkit.

In addition to reaching agreement between stakeholders upon what health inequalities are, it is important to consider which population groups could be at risk of these inequalities. The PROGRESS Plus equity lens (Kavanagh et al, 2008; Evans & Brown, 2003) can assist in identifying these potential population groups (see Table 8). Even if a policy or intervention is designed with the specific aim of reducing inequalities between population groups (for example men and women), it is important to evaluate whether that same intervention creates inequalities between other groups (for example the poorly and highly educated).

Table 8: Categories included in the PROGRESS-Plus framework (adapted from Kavanagh, Oliver & Lorenc, 2008)

PROGRESS		
P	Place of Residence	Rural/urban, country/state/region, housing characteristics
R	(Race)/Ethnicity	Ethnic background (including Roma)
O	Occupation	Professional, skilled, unskilled, unemployed etc.
G	Gender	Male or female
R	Religion	Religious background
E	Education	Years in and/or level of education attained, school type
S	Social Capital	Neighbourhood / community / family support.
S	Socioeconomic position (SEP)	Income, means-tested benefits/welfare, affluence measures, etc.
PLUS		
P	All SEP (wider interpretation)	SEP income related, plus occupation, education, and elements of place of residence
L		
U	Age	Age range
S	Disability	Existence of physical or emotional/mental disability
	Sexual orientation	Heterosexual, gay, lesbian, bisexual, transgender
	Other vulnerable groups	School non-attenders, looked after young persons, young persons in criminal justice system, victims of abuse, runaways, teenage parents

In order to ensure that equity is considered adequately throughout the HIA process, equity-related questions can be formulated in each of the HIA phases. In [Equity Action](#), a Joint Action between the EU and Member States which aims to reduce health inequalities, a series of equity-related questions were developed which can be integrated into existing health impact assessment methods (Gunther, 2011). These questions are described in appendix 5. The full document, including this set of questions and useful tips about conducting an equity focused HIA, can be found [here](#).

Step 1: Screening

The first step in the HIA process is the screening stage. The goal of this stage is to determine whether it is appropriate and feasible to conduct an HIA. The main question to answer with respect to appropriateness is whether the policy or intervention is likely to impact population health considerably or one of the determinants of population health. If it is likely that there are significant health impacts, an HIA should be considered. Feasibility aspects, such as available resources and organizational capacity should also be considered in the decision to carry out a health impact assessment.

Potential equity-focused questions (Gunther, 2011) that can be asked during the screening step are “Which populations are currently relatively disadvantaged in the context of this policy or intervention?” and “Does the policy enhance equity or increase inequity e.g. by

affecting different population sub-groups differently because of what the policy targets are, how the policy is implemented or how it works with/against existing policy?” (Appendix 5).

The model by Dahlgren and Whitehead (1993) (Figure 27) provides an overview of the wider determinants of health and can therefore assist in determining whether the policy or intervention is likely to influence health via one of these wider determinants of health. In addition, the information from the [needs assessment phase](#) can be used in this step of the HIA.

Step 2: Scoping

The second step in the HIA process is the scoping stage. This stage is about determining the focus of the HIA, deciding on the methods and work plan. The rest of the HIA is planned in this phase.

The main question to answer in this phase is which health outcomes or determinants of health outcomes the HIA should focus on and how the HIA will be carried out.

To define the focus of the HIA, it is important to consider which population groups are likely to be affected and which geographic areas are affected (regions, cities, villages). Much of this information will already be available from the Needs Assessment. In addition, key stakeholders should be identified. Stakeholders are those who have an interest in the intervention, those who benefit from the intervention, those who may be adversely affected by the intervention and those who may impact or influence the development or implementation of the intervention. For example, important stakeholders could be those involved in developing intervention (e.g. municipality, researchers), those involved in implementing the intervention (e.g. nurses, local businesses) and those targeted by the intervention (e.g. residents of an area, members of population subgroups). Also, those who are not directly involved or affected by the intervention but who could potentially obstruct or facilitate it should be considered. The scoping phase usually involves convening a steering group that can assist in determining the focus, methods and work plan.

Which methods are to be used are determined by the main questions that need to be answered, the complexity of the HIA, and the available resources (time, staff, expertise, budget). The methods can include literature reviews, quantitative modelling, and qualitative analysis, such as expert consultations, interviews and focus groups.

Potential equity-focused questions (Gunther, 2011) that can be asked in the scoping step are “Which determinants of health (related to health equity) will be assessed in the context of the policy or intervention?” or “What evidence (quantitative and/or qualitative) will be used that will show how the health equity impact is identified?” (Appendix 5).

The focus and the required methods will determine what type of HIA needs to be done.

Types of HIA

An HIA can vary in its level of in-depth assessment and in the resources needed. The most basic form of HIA requiring the least amount of resources is the [desktop HIA](#). This type of HIA is most appropriate for policies or interventions that are expected to have only little impact on health. A desktop HIA usually takes a few hours to a few weeks and in general uses existing knowledge and evidence that is being discussed among a small number of

participants. In a desktop HIA there is normally no engagement of the community and only the most relevant external stakeholders are consulted. If the desktop HIA reveals that there are more health impacts than expected, the desktop HIA can be seen as a screening exercise to a more extensive HIA.

A more extensive, and the most common form of HIA is the **rapid HIA**. This type of HIA is appropriate for most policies and interventions. A rapid HIA usually takes a few days to a few weeks and in general involves a small steering group, a stakeholder workshop and includes community involvement. A rapid HIA is expected to include the analysis of the health impact by reviewing literature and analysing existing data with respect to the expected health effects. Within a rapid HIA there is no large scale primary data collection. It does involve the gathering of some additional knowledge and evidence from a small number of stakeholders.

The most extensive form of HIA is the **comprehensive HIA**. This type of HIA distinguishes itself from the other two types by the collection of new primary data in the field. This type of HIA requires the largest investment of resources and can take months to complete. It is especially suited for large and complex policies or interventions.

Whether it is appropriate to carry out a desktop HIA, a rapid HIA, a comprehensive HIA or anything in between is determined by the likelihood and magnitude of expected impacts on health and health inequalities and the expected footprint of the project (e.g. resources, area affected, complexity). The social sensitivity of the project should also be considered. Figure 33 provides some guidance how to decide which type of HIA is appropriate.

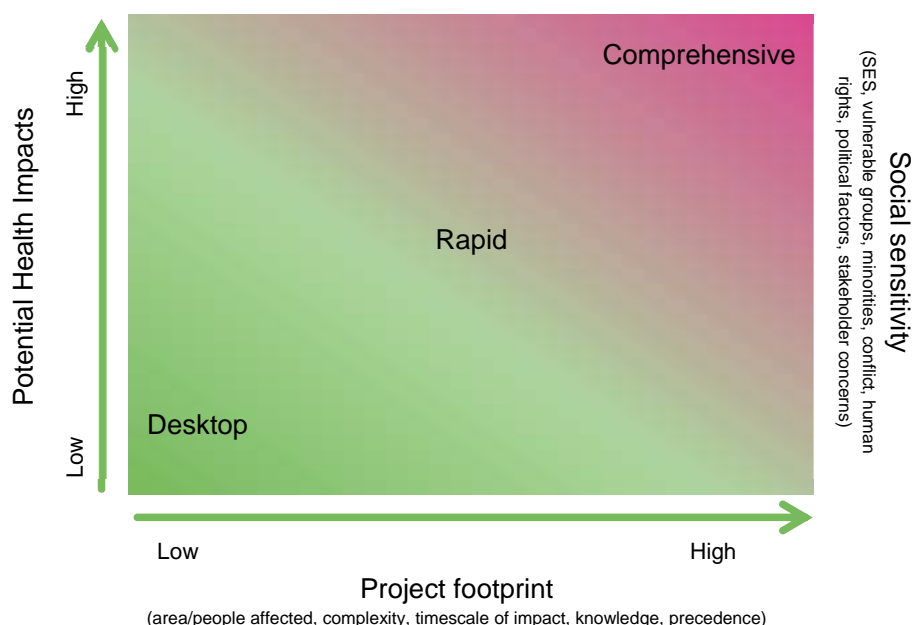


Figure 33: Selecting a HIA type (adapted from State of Alaska Program, 2011)

Step 3: Impact assessment

The third step in the HIA process is the core step of the whole process and actual impact assessment. The goal is to assess the health benefits and health hazards and to consider

evidence of impact. This stage involves the collection and analysis of quantitative and/or qualitative data and should result in information about the expected health impact, the direction of the impact (positive or negative), the likelihood and magnitude of these health impacts, and what the time frame is in which these health impacts can be expected to occur. All of these elements should be considered in an equity perspective.

Potential equity-related questions (Gunther, 2011) to be answered in this phase are “What health equity impacts (positive and negative) have been identified as likely to arise from the policy or intervention?” or “Does the intervention or policy introduce new health equity impacts?” (Appendix 5).

The data necessary to estimate the potential impacts of the action on health and health inequalities can be obtained from literature review, quantitative modelling (see step 3c), and qualitative analysis, such as expert consultations, interviews and focus groups. A combination of these methods often results in the most comprehensive information.

The impact assessment can further be split up into three sub-activities: 3a. policy analysis, 3b. description of the baseline situation, and finally 3c. estimation of the health impact.

Step 3a: Policy analysis

The first step is to do a full analysis of the proposed policy or intervention to understand what the intervention exactly will encompass and aims to achieve, and how elements of the action may influence health and health inequalities. Elements that are important to identify include the strategies used, the populations potentially affected, the key stakeholders involved, the relationship of the policy or intervention to other policies and interventions, and the results from evaluations of other similar policies or interventions. It could be useful to formulate a logic model or programme matrix. A logic model is “a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your programme, the activities you plan, and the changes or results you hope to achieve.” ([W.K. Kellogg Foundation Logic Model Development Guide](#), 2004). It visualizes how programme inputs and activities will accomplish programme outputs, programme outcomes and eventually programme impacts.

Step 3b: Description of baseline situation

To estimate the impact of the proposed action or actions, it is important to know what the baseline situation is with respect to all relevant health outcomes, health determinants and the inequalities in these health measures. Baseline information was already (largely) obtained within the [needs assessment phase](#) of this toolkit. It should encompass a profile of the population with respect to the most important health outcomes, the determinants of health and the inequalities in these health outcomes and determinants.

In addition, it may be useful to assess the opinions of important stakeholders (as defined in the scoping phase) with respect to the areas the policy or intervention addresses. This information may provide useful insights into the feasibility and acceptability of the proposed action and into potential barriers and facilitators in implementing the proposed action.

Step 3c: Estimation of the potential health impact

The estimation of potential health impacts can for example be acquired via an evaluation of the literature and interviews with stakeholders. Such qualitative methods are valuable and

provide good insights into the potential effects of the action. They can provide information about the expected direction of the impact and even about the order of magnitude of the effects. However, quantifying the expected impacts may be a useful addition to these qualitative methods. Quantitative estimates of impact are important in policy decisions since they relate to measurable goals and can be linked to economic measures. For example, a reduction in smoking may be linked to quantifiable increases in population health and therefore increased labour participation and labour productivity. It could also lead to a reduction in costs for health care and social benefits. Moreover, quantitative estimates of the health impact can be used in a cost effectiveness or cost benefit analysis.

When quantifying impacts, it is important to know how an intervention influences health outcomes. In general, an intervention or policy does not *directly* impact health but impacts the determinants of health or risk factors. This is described in Figure 34. Information about a direct relation is often unavailable (*estimate 'a'* in the figure). In order to estimate the impact of the policy or intervention on health and health inequalities, it is therefore necessary to obtain information about the effects of the intervention or policy on these determinants (*estimate 'b'* in the figure) and on the effects the determinant has on health (*estimate 'c'* in the figure). These estimates on 'b' and 'c' are normally more easily obtained from literature or previous experience. The information about 'b' and 'c' can then be used to obtain an estimate of 'a' via quantitative modelling (*estimate 'a*'* in the figure).

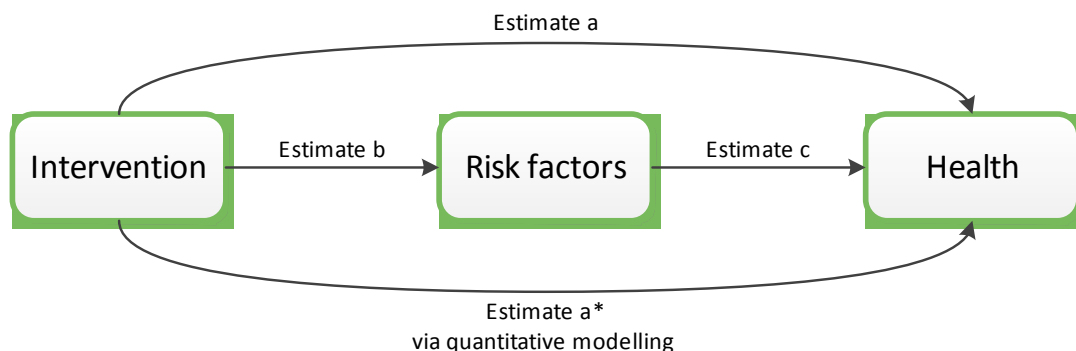


Figure 34: Quantifying the impact of an intervention on health via quantitative modelling.

For example, a question that may need to be answered is whether any lives will be saved if a ban on alcohol advertising is introduced. A literature review reveals that there is no information available on the relation between alcohol advertising and mortality (*estimate 'a'*). However, because of previous evaluations of interventions, there is evidence in the literature that provides an estimate on how much alcohol consumption will decrease when alcohol advertising is banned (*estimate 'b'*). In addition, there is information from cohort studies available on how alcohol consumption is linked to mortality (a so-called 'relative risk' of dying due to alcohol consumption, *estimate 'c'*). This information can then be used to estimate the impact of alcohol advertising on mortality via quantitative modelling (*estimate 'a*'*).

Quantitative models calculate how changes in the prevalence of determinants (risk factors), caused by exposure to an intervention, will impact the health of the population or population groups. In most quantitative modelling tools, the user can change the prevalence (such as the decrease in alcohol consumption that is expected to occur when alcohol advertising is

banned) and the model will then calculate the change in mortality or another outcome. These tools can normally be tailored to include local or regional data when such data are sufficiently available.

There are several quantitative modelling tools available. For example, the DYNAMO-HIA is a dynamic European web-based tool that includes multiple health outcomes and risk factors. The Chronic Disease Model, by the Dutch National Institute for Public Health and the Environment, is also a dynamic modelling tool in which different risk factors can be modelled together. These dynamic quantitative models are rather comprehensive and may be useful in providing relatively realistic dynamic estimations of health impacts. However, these models are also complex to use, have large data needs and are not geared to modelling health inequalities.

Therefore, a simple, user-friendly quantitative modelling tool was developed in the Health Equity 2020 project, which is specifically designed to estimate the impact of policies and interventions in inequalities in health. In this tool, a shift in risk factor distributions (for example a 15% decrease in smoking prevalence), can be modelled in order to obtain estimates of these shifts on mortality and socioeconomic inequalities in mortality. More information on the [Health Equity 2020 quantitative tool](#) can be found in the [user's guide](#) of the tool.

Quantitative models and the estimates they produce, should always be interpreted in light of some limitations. All quantitative models simplify reality and are based on assumptions (e.g. the assumption that smoking affects health of all people to the same degree) Furthermore, the quality of the estimations will depend heavily on the availability and quality of the data put into the model.

In order to be able to formulate evidence-based recommendations in the next step, the estimates of a health impact assessment should not be interpreted in isolation. They should be part of the larger health impact assessment that considers the current situation and issues in the area affected and possible alternative interventions.

Step 4: Decision making

The HIA aims to inform decision makers and one of the main products of the HIA is therefore a set of recommendations that point towards decisions to reduce hazards and/or improve health. These recommendations should be clear and concise. They should be evidence-based wherever possible but also practical, realistic and achievable. Although some interventions or policies may have a very large potential health gain, if they are not feasible in real life, they are unlikely to substantiate this gain. It may therefore be better to recommend interventions or policies with smaller potential health gains which are more realistic or acceptable within the community. To be sustainable, the recommendations should therefore be developed and agreed upon between all relevant stakeholders.

Potential equity-focused core topic areas (Gunther, 2011) that need to be covered in the recommendation are “the impact of the policy or intervention on existing health equity issues” or “the evidence-based measures that would reduce the negative and enhance the positive health equity impacts of the policy” (Appendix 5).

The results of the HIA, including the recommendations should be reported to the decision makers and all stakeholders concerned, including the affected community. Ideally, all of these stakeholders would be asked for feedback which could then lead to an improved report. This report is important for ensuring an effective adoption and implementation of the recommendations and it can also assist in securing (additional) funding.

Step 5: Monitoring & evaluation

The final step within the HIA is monitoring and evaluation. There are three different types of evaluations within an HIA that all serve a different purpose.

The first type of evaluation is the *process evaluation* of the HIA itself; did it go well, was the original plan followed, what problems were encountered and how were they solved? This process evaluation can provide lessons for future HIAs.

The second type of evaluation is the *impact evaluation*. The aim of this evaluation is to monitor and evaluate how the recommendations of the HIA were adopted and implemented by the decision makers. This impact evaluation provides information on the utility and or acceptance of the HIA within the decision making process.

A third type of evaluation is the *outcome evaluation*. The aim of this evaluation is to assess the actual impact of the proposed policy or intervention on health outcomes or health determinants after it has been implemented. This outcome evaluation provides information on the effectiveness of the proposed intervention or policy itself.

The success of the HIA or the action can be evaluated by monitoring indicators of the *process* (e.g. adherence to guidelines), the *impact* (e.g. the number of recommendations that are successfully adopted) or the *outcome* (e.g. the reduction in smoking prevalence and associated mortality).

Potential equity focused questions (Gunther, 2011) that can be asked in this step are “Have the stakeholders (including target groups) been asked what the health impact of the policy has been on them?” (process evaluation), “Did the health equity focus of the policy change in relation to the HIA and if so, how?” (impact evaluation), or “Did the policy impact health inequity (in real life) similar to the estimated impact (in the HIA)?” (Appendix 5).

Economic impact

It is generally accepted that that economic prosperity determines health at both the individual level (income inequalities in health) (e.g. Martikainen et al, 2001; Mackenbach et al, 2005) and the macro level (higher life expectancies in countries with a higher gross domestic product) (e.g. Preston, 2007).

There is also evidence that health determines economic prosperity. Ill health and disability can reduce labour supply, reduce labour productivity, influence education and training, and account for higher costs in healthcare and social security benefits (Suhrcke 2005, 2007, Mackenbach, 2007). The burden of ill health is socioeconomically patterned and therefore, the economic costs related to ill health, such as the ones related to reduced labour supply and increased healthcare, are also socioeconomically patterned. Reducing health inequalities by improving health in the lower socioeconomic groups has therefore large

economic potential. A Europe-wide study estimated that health inequalities-related losses to labour productivity amount to €141 billion per year in the European Union. If health is valued in its own right, health inequalities-related losses amount to a staggering €1 trillion per year (9.4% of GDP) (Mackenbach et al, 2007). The full report, including a detailed description of the methods used, is available [online](#).

Economic consequences will play an important role in the selection of actions. In general, standard economic evaluation tools, such as cost benefit analysis and cost effectiveness analysis can be helpful in building the economic case for action. In Table 9, the most common economic evaluation tools, including some of their characteristics are described.

Table 9: Types of economic evaluations and their main characteristics.

	Cost	Outcomes	Advantages	Disadvantages
Cost Benefit Analysis (CBA)	Monetary (€, \$)	Monetary (€, \$)	Comparison of different interventions is possible	Difficult to express health benefits in monetary values
Cost Effectiveness Analysis (CEA)	Monetary (€, \$)	Single outcome (e.g. blood pressure)	Clinically meaningful	Cannot compare across interventions with different outcomes
Cost Utility Analysis (CUA)	Monetary (€, \$)	QALY, DALY	Comparison of different interventions is possible, includes both quantity and quality of life	QALY is not disease specific or suitable for specific target populations (e.g. children)
Cost Consequence Analysis (CCA)	Monetary (€, \$)	All outcome interventions listed	Gives a comprehensive overview	Difficult to choose and compare between different policy options
Cost Minimization Analysis (CMA)	Monetary (€, \$)	Assumed to be equal between options	Only cost data need to be gathered	Equal outcomes not realistic in practice

Sources: Palmer, Byford & Raftery, 1999, Drummond, Sculpher, Torrance, O'Brien & Stoddart, 2005

It is important to acknowledge that economic evaluation tools have their limitations when it concerns actions addressing socioeconomic inequalities in health. For example, putting a monetary value on health and health related issues can be difficult. Apart from direct costs (e.g. increased healthcare costs), there are also indirect costs (e.g. costs related to labour productivity), and even intangible costs (e.g. quality of life related issues such as fear or pain). In addition, when looking at the costs of an action, it is important to also take into account the costs of not intervening (the costs of the existing socioeconomic health inequalities). Furthermore, complex long-term effects may not always be clearly visible or

measurable. Most economic evaluation tools are not properly equipped to deal with equity issues and they should always be used with care.

A brief and informative document on *understanding the economics of investments in the social determinants of health* was written by the UCL Institute of Health Equity for Public Health England (PHE) (2014). The document, including some additional interesting evidence reviews on potential action to address health inequalities, can be found [here](#).

In short, this PHE briefing by the UCL Institute of Health Inequalities covers:

- “the rationale for understanding, measuring and taking into account the economic impact of decisions and interventions that impact on the social determinants of health
- the benefits and limitations of various ‘economic measures of impact’ – commonly used terms which can be confusing, sometimes leading to misinterpretation of which measurement of economic impact is appropriate for what purpose
- what is currently known about the economic impact of intervening in the social determinants of health
- good practice and further resources which will support better decisions
- this paper complements a collection of evidence reviews on health equity commissioned by Public Health England and written by the UCL Institute of Health Equity”

Resources on economic evaluation

- Mackenbach, Meerding & Kunst (2007). Economic implication of socioeconomic inequalities in health in the European Union. [Online] Available at: http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/socioeco_inequalities_en.pdf
- Suhrcke, McKee, Sauto Arce, Tsovala & Mortensen (2005). The contribution of health to the economy in the European Union. [Online] Available at: http://ec.europa.eu/health/archive/ph_overview/documents/health_economy_en.pdf
- Institute of Health Equity (2014). Understanding the economics of investments in the social determinants of health. Local action on health inequalities: Health Equity Briefing 9. London: PHE/IHE. [Online] Available at: <http://www.instituteofhealthequity.org/projects/understanding-the-economics-of-investments-in-the-social-determinants-of-health>
 - o For the other evidence reviews and briefings in this series, visit: <https://www.instituteofhealthequity.org/projects/local-action-on-health-inequalities-series-overview>

Available HIA frameworks

There are many HIA frameworks available. Some of the frameworks have a specific focus on health equity (e.g. HIIA and the frameworks by the ACHEIA and CHETRE, table 2). Within Europe, a special HIA for European policy has been developed (the EHPHIA). The choice for one of the available frameworks depends mainly on the personal preferences and the training of the team carrying out the HIA. Table 10 lists a few of the more widely used HIA frameworks. All of the listed frameworks are publicly available via the internet and were free to download at the time of writing.

Table 10: Overview of selected existing Health Impact Assessment frameworks

Name	Full reference	Link to resource
EHPHIA European Policy Health Impact Assessment	Abrahams D, den Broeder L, Doyle C, Fehr R, Haigh F, Mekel O, Metcalfe O, Pennington A, Scott-Samuel A. (2004) <i>EPHIA - European Policy Health Impact Assessment: A Guide</i> . Liverpool. International Health Impact Assessment Consortium, University of Liverpool.	Available at: http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf
ACHEIA Equity-focused health impact assessment	Mahoney M., Simpson S., Harris E., Aldrich R., Stewart Williams J. (2004) <i>Equity Focused Health Impact Assessment Framework, the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA)</i> .	Available at: http://hiaconnect.edu.au/old/files/EFHIA_Framework.pdf
HIIA Health Inequalities Impact Assessment. An approach to fair and effective policy making.	NHS Health Scotland (2011). Health Inequalities Impact Assessment An approach to fair and effective policy making. Guidance, tools and templates.	Available at: http://www.apho.org.uk/resource/item.aspx?RID=119615
CHETRE Health Impact Assessment: A Practical Guide	Harris, P., Harris-Roxas, B., Harris, E., & Kemp, L. <i>Health Impact Assessment: A Practical Guide</i> , Sydney: Centre for Health Equity Training, Research and Evaluation (CHETRE). Part of the UNSW Research Centre for Primary Health Care and Equity, UNSW.	Available at: http://hiaconnect.edu.au/wp-content/uploads/2012/05/Health_Impact_Assessment_A_Practical_Guide.pdf
Whānau Ora Whānau Ora health impact assessment	Ministry of Health. (2007). <i>Whānau Ora Health Impact Assessment</i> .	Available at: http://www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf
PHAC A guide to health impact assessment: A policy tool for New Zealand	Public Health Advisory Committee (PHAC) (2005) <i>A guide to health impact assessment: A policy tool for New Zealand</i> . 2nd Edition, June 2005.	Available at: http://nhc.health.govt.nz/system/files/documents/publications/guidetohia.pdf
WHIASU Health Impact Assessment: A Practical Guide.	Wales Health Impact Assessment Support Unit (2012). <i>Health Impact Assessment: A Practical Guide</i> .	Available at: http://www.apho.org.uk/resource/item.aspx?RID=44257 and http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782

Name	Full reference	Link to resource
PHI Health Impact Assessment: a guide for local authorities	Public Health Institute of Scotland (2006) <i>Health Impact Assessment: a guide for local authorities</i> .	Available at: http://www.healthscotland.com/documents/1283.aspx
DH England Health Impact Assessment of Government Policy. A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process	Herriott, N. & Williams, C. (2010). Health Impact Assessment of Government Policy. A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process. In a series with also: <i>HIA – case studies from government departments</i> <i>HIA – evidence on health</i> <i>HIA – a guide to quantifying health impacts of government policy</i>	Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_120110.pdf
IAIA Health Impact Assessment. International Best Practice Principles	Quigley, R., L. den Broeder, P. Furu, A. Bond, B. Cave and R. Bos (2006) Health Impact Assessment International Best Practice Principles. Special Publication Series No. 5. Fargo, USA: International Association for Impact Assessment.	Available at: http://www.iaia.org/publicdocuments/special-publications/SP5.pdf
Merseyside Guidelines The Merseyside Guidelines for Health Impact Assessment.	Scott-Samuel, A., Birley, M., Ardern, K., (2001). The Merseyside Guidelines for Health Impact Assessment. Second Edition, May 2001. 20 pages. ISBN 1 874038 56 2. Published by the International Health Impact Assessment Consortium.	Available at: http://www.apho.org.uk/resource/item.aspx?RID=44256
Many more	Overviews are available at: <ul style="list-style-type: none"> http://www.apho.org.uk/resource/view.aspx?RID=44539 http://hiaconnect.edu.au/resources/guides/ http://www.who.int/hia/about/guides/en/ 	

Examples of HIA

A large quantity of documents on finished HIA can be found on the websites listed below. There are also several HIAs with a specific focus on equity.

HIA Connect: http://hiaconnect.edu.au/old/completed_hia_topic.htm#Health_Equity

HIA gateway: http://www.apho.org.uk/default.aspx?QN=P_HIA

WHO website: <http://www.who.int/hia/examples/en/>

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Suhrcke, M., McKee, M., Sauto Arce, R., Tsoлова, S. & Mortensen, J. (2005). The contribution of health to the economy in the European Union. [Online] Available at: http://ec.europa.eu/health/archive/ph_overview/documents/health_economy_en.pdf

List of appedices

Appendix 1: Report format for the needs assessment results

→ Belongs to Phase 1 of the tool: Needs Assessment

Appendix 2: Interview guide capacity assessment

→ Belongs to Phase 2 of the tool: Capacity Assessment

Appendix 3: Health Equity 2020 Action Database

→ Belongs to Phase 3 of the tool: Choosing Actions

Appendix 4: Policy matrix

→ Belongs to Phase 3 of the tool: Choosing Actions

Appendix 5: A series of questions to analyze equity in the policy Health Impact Assessment process

→ Belongs to Phase 4 of the tool: Impact Assessment

Appendix 6: Health Equity 2020 quantitative tool

→ Belongs to Phase 4 of the tool: Impact Assessment

Appendix 7: Users Guide – Health Equity 2020 quantitative tool

→ Belongs to Phase 4 of the tool: Impact Assessment

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