Health Inequalities - Early Years

BMA Scotland

Although Scotland’s post-devolution policy approach to addressing health inequalities has generally been well received, health inequalities have remained stubbornly persistent. Current welfare reforms and economic pressures seem likely to exacerbate health inequalities. Hence, there are still significant challenges to face in reducing health inequalities and improving general population health. It is widely recognised that the most important policy levers for responding to health inequalities are outwith the realm of health policy and include employment, education, fiscal, housing and other welfare-related policies. An integrated approach to health inequalities is therefore required if we are serious about reducing these health differences.

Existing position of BMA Scotland

The BMA has been working to improve medical and social care of children in the UK for a long time. We have policies on a wide range of areas of children’s and young people’s health including nutrition, smoking, mental health and alcohol. We believe that all health professionals have a role to play to help ensure that children and families get the best start in life and to help reduce the effect of health inequalities. A number of publications on these topics are available on our website: www.bma.org.uk.

In order to help address the causes of health inequalities, BMA Scotland is calling for an ‘Inequalities Impact Assessment’ tool to be developed and used for all Scottish legislation. Such a tool would put health at the heart of decision making and ensure that health and health inequalities are taken into account by all ministerial departments and portfolios. However, whilst there have been official commitments to undertaking Health Impact Assessments within the Scottish policymaking process, our research suggests that, in reality, these are rarely conducted and, where they are used, that they tend to be applied only to policies developed within the Health Directorate (i.e. not to the wider policy areas outlined above, which are recognised as key determinants of health inequalities). To be effective, such a tool is likely to require both legislative endorsement and sufficient resources.

Background

(i) Reducing Health Inequalities

Inequalities between rich and poor have a profound influence on the future health of children in Scotland. For both sexes, the more deprived the quintile, the shorter the life expectancy at birth and the longer the period expected to be spent in poor health. For example, in 2006, average healthy life expectancy at birth in Scotland was 67.9 years for men and 69.0 years for women. Whereas, in the most deprived 15% of areas in Scotland, healthy life expectancy at birth was considerably lower at 57.3 years for males and 59.0 years for females (healthy life expectancy is defined as the number of years a person can expect to live in good health).
The Marmot Review, *Fair Society, Healthy Lives*\(^iv\), identifies six policy areas where action must be taken in order for health inequalities to be reduced. These are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Delivering these policies clearly requires action across the whole of society and the full range of policy domains. Action taken by the Scottish Government Health Directorate and the NHS will not be sufficient to substantially reduce health inequalities\(^v\). Achieving co-ordinated action between health, education, social services, housing, welfare, fiscal and transport policy is a challenge which requires sustained cross-departmental collaboration and the development of synergistic policies\(^4\). Although there have been policy commitments to improving cross-government collaboration to address health inequalities, interviews with policymakers indicate that this has been hard to achieve\(^vi\).

(ii) Health Impact Assessment and Health Inequalities Impact Assessment

It is widely accepted that substantial improvements in public health will occur only by ensuring that health considerations are factored into projects, programs, plans, and policies concerning a broad range of non-health policies (including education, housing and welfare)\(^4,5\). For this reason, a 1998 UK government-commissioned independent inquiry into inequalities in health recommended that all policies likely to have a direct or indirect effect on health should consider their impact on health inequalities\(^vii\). Health Impact Assessment (HIA) is intended to help decision-makers identify the likely impacts of proposals that may affect health and health inequalities. As such, the use of HIA is a practical measure that could help to close the health inequalities gap in Scotland.

There are multiple definitions of HIA, the most well-known of which is the Gothenburg consensus, which describes HIA as 'a combination of procedures, methods and tools by which a policy, program 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'\(^viii\). Multiple methodological frameworks for undertaking HIA exist but most employ a mixture of quantitative and qualitative data\(^x\) and HIA can be undertaken at a variety of levels of decision-making. Closely-related variants include Health Inequalities Impact Assessment and Health Equity Impact Assessment\(^x\) (both of which highlight the distribution of impacts). Most researchers agree that HIA has two essential features:

1. It is intended to support decision-making in choosing between options;
2. It does this by predicting the future consequences of implementing the different options\textsuperscript{x}. HIA\textsuperscript{s} have been promoted by the public health community since the mid-1990s but, due to the variable use within decision-making and the mixture of approaches within HIA, it has proved hard to assess their impact. Nonetheless, a cost benefit evaluation of HIA undertaken by the York Health Economics Consortium in 2006 concluded that the benefits derived from HIA outweigh the cost of undertaking the assessment. This suggests that HIA is a cost effective use of health resources\textsuperscript{xii}.

Although there is no legislative requirement to undertake HIA in Scotland (or the wider UK), there is substantial policy support for HIA and related tools. Internationally, the WHO Commission on Social Determinants of Health\textsuperscript{xiii} calls for ‘health equity impact assessments’ of all economic agreements, market regulation and public policies. In Scotland, the 2008 Ministerial Taskforce report on health inequalities, \textit{Equally Well}\textsuperscript{3}, recommends that: ‘Integrated impact assessment processes for public policies and programmes should be developed and implemented at national and local levels’ and that health inequalities should be ‘a clear component’ of such IAs. NHS Health Scotland subsequently developed a Health Inequality Impact Assessment (HIIA) tool which combines Equalities Impact Assessment (a legal requirement) and Health Impact Assessment into a single process, whilst also considering Human Rights\textsuperscript{xiv}.

Despite all this, our conversations with NHS Health Scotland staff, other NHS Boards and members of the Scottish Government indicate that HIIAs are not yet being widely used within Scotland. Where HIIA is employed, it tends to be for local level decision-making (e.g. in NHS Boards and councils), rather than for national legislation. The few examples of national policies for which an HIIA has been undertaken have been policies with direct health implications, such as the 2013 tobacco control strategy\textsuperscript{xv}. Hence, neither HIA nor HIIA are currently being employed by the Scottish Government to assess the likely impacts of policies on the fundamental causes of health inequalities identified by the Scottish Government\textsuperscript{xvi} and the WHO\textsuperscript{13}.

(iii) Other difficulties with using HIA/HIIA in policy
To better understand why HIA/HIIA has not been more widely employed within Scotland, we systematically reviewed published evidence regarding decision-makers’ perceptions, and experiences, of using impact assessment tools to improve public health (including by reducing health inequalities) in high-income settings. This review, which located 11 relevant studies, identified a range of barriers to using HIA/HIIA in policy, as summarised in Table 1:

\begin{table}[h]
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Barrier & Broader issue \\
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1. The plethora of types of ‘impact assessment’ can cause confusion in policy contexts, especially as the results of some kinds of IA may conflict with the aims of HIAs\textsuperscript{xvii} (e.g. Business or Regulatory Impact Assessments\textsuperscript{xviii}) & Multiple types of impact assessment. \\
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\caption{10 Common barriers to the use of HIA/HIIA in policymaking:}
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<th>Barrier</th>
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<td>2. There may be resistance amongst policymakers to undertaking HIA due to concerns with the bureaucratic burden caused by multiple forms of IA$^{10, xix}$.</td>
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<td>3. Policymakers’ already feel over-burdened (particularly in a context of administrative cuts) and may therefore be resistant to undertaking any form of IA that is perceived to be time-consuming and/or unnecessary$^{xx}$.</td>
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<td>4. Insufficient skills or resources within government for HIA/HIIA$^{20,xxi,xxii}$.</td>
<td>Limited resources.</td>
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<td>5. The lack of a standard, internationally recognised approach to HIA/HIIA can lead to a lack of clarity within policy contexts about how to undertake HIA/HIIAs$^{20}$.</td>
<td>Mixed methodological and guidance related issues for HIA/HIIAs.</td>
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<td>6. Some forms of HIA/HIIA may suggest quantification is required but it can be hard to predict future impacts on health/health inequalities sufficiently accurately to enable quantification$^{17}$.</td>
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<td>7. It may be difficult to produce HIAs/HIIAs that are independent enough to be deemed credible by relevant audiences whilst having sufficient policy ‘buy in’ (research indicates that where decision-makers are closely involved in HIAs/HIIAs, the results tend to be taken more seriously but, paradoxically, external audiences can feel internally-produced HIAs/HIIAs lack credibility)$^{xxiii}$.</td>
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<td>8. The lack of any legislative requirement to undertake HIA/HIIA limits the incentive for policymakers to undertake HIA/HIIA$^{xxiv,xxv}$ (in contrast to Equalities Impact Assessments, for example$^{xxvi}$).</td>
<td>Limited legislative basis of HIA/HIIA.</td>
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<td>9. Limited cross-government understanding of the broad nature of the social determinants of health, leading to assumptions that policies developed outside departments/directorates of health do not have sufficient health-related impacts to warrant an HIA/HIIA$^{22}$.</td>
<td>Cross-cutting nature of health inequalities combined with silo-based nature of policymaking.</td>
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<td>10. Poor links between ‘health’ departments/policymakers and other policy sectors can exacerbate the above problem$^{22}$.</td>
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One consequence of these kinds of issues is, as research demonstrates, that HIAs/HIIAs are often employed as ‘tick box exercise’ where they are used, rather than being used in a meaningful or influential manner$^{xxvii}$. 

**Proposal to improve the use of HIA or HIIA in Scotland: Sufficiently resourced ‘Inequalities Impact Assessments’ supported by a legislative commitment**

This proposal makes some suggestions as to how these kinds of issues could be addressed at the national policy-making level in Scotland.
(i) Re-name and re-launch HIIAs as Inequalities Impact Assessments (IIAs)
Given two of the 10 ‘barriers’ listed in Table 1 (9 and 10) relate to the limited cross-sector understanding of the broad nature of the social determinants of health, it may make more sense to frame a tool intended to draw policymakers’ attention to the likely impacts of policies on health inequalities as simply an ‘Inequalities Impact Assessment’ tool. By disassociating the word ‘health’, it seems feasible that policymakers across a broader range of policy areas would consider the potential relevance of undertaking this kind of impact assessment. This suggestion does not necessarily entail substantially changing the HIIA tool developed by NHS Health Scotland (which is already supported by the Scottish Government and which already deals with barriers 5-6 in Table 1) but simply re-naming and re-launching this tool, with a view to ensuring its more widespread use across the Scottish Government.

(ii) Make a legislative commitment to undertaking IIAs, linked to clear, associated guidance
If the Scottish Government is serious about its commitment to using impact assessments as a means of ensuring that policies across government are directed at reducing (or at least not exacerbating) Scotland’s health inequalities, a legislative requirement may be needed. This would help address barrier 8 in Table 1. In addition, if such a requirement was linked to clear guidance as to what precisely is required (already developed by NHS Health Scotland), this could help address barriers 1-3, 5 and 6 in Table 1.

(iii) Provide sufficient resources to enable IIAs to be undertaken in a meaningful manner
The 2008 Ministerial Taskforce report on health inequalities, Equally Well\(^3\), recommended that the Scottish Government needed to ensure that resources and guidance were in place to enable impact assessments to be undertaken effectively. In theory, the Scottish Government should therefore already have addressed barrier 4 (potentially helping with barriers 1-3). However, our conversations with NHS Health Scotland, the Scottish Government and NHS Boards indicate that the limited resources available for supporting HIA/HIIA are still a significant barrier to their wider use within Scotland. Any legislative (or otherwise renewed) commitment to undertaking IIAs/HIIAs therefore needs to be accompanied by an appropriate level of resource.

(iv) Establish mechanisms for the effective monitoring and scrutiny of IIAs
To adequately address barrier 7, and to ensure that the influence of IIAs are monitored and assessed, the Scottish Government should establish an IIA Advisory Board, with representation from organisations committed to reducing health inequalities (e.g. NHS Health Scotland, third sector organisations and bodies representing health professionals). The purpose of such a Board would be to review IIAs produced by the Scottish Government, to assess decisions taken not to undertake an IIA for any legislative changes and to monitor the short to medium term impact of IIAs that are undertaken.

Summary
In the context of long-standing commitments to, but limited progress in, reducing health inequalities in Scotland, this document proposes the more intensive and widespread use of inequalities-focused impact assessments for all Scottish legislation. Relevant policy commitments and tools already exist within Scotland but our research indicates that this has had very little influence on non-health policies. To ensure that policymakers across the Scottish Government consider how non-health policies may impact on health inequalities, this proposal suggests such impact assessments should be called ‘Inequalities Impact Assessments’ (i.e. omitting ‘health’ from the title) and that the need to undertake such assessments should be supported by a combination of legislation, sufficient resources and effective monitoring/scrutinising systems.

BMA Scotland
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2 Scottish Public Health Observatory (2013) Making a bad situation worse? The impact of welfare reform and the economic recession on health and health inequalities in Scotland (baseline report)


