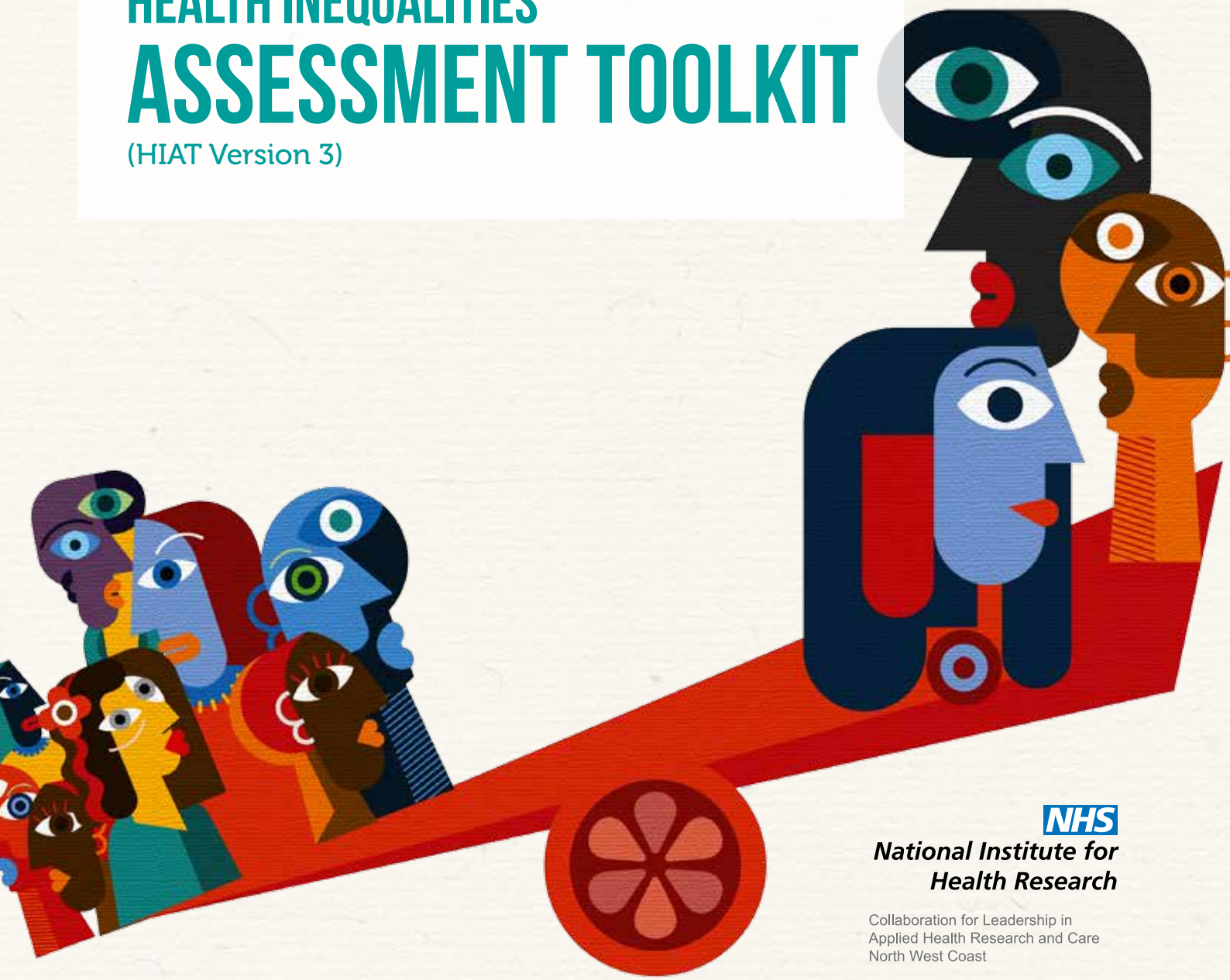
National Institute of Health Research
Collaboration for Leadership in Applied
Health Research and Care North West Coast

HEALTH INEQUALITIES
ASSESSMENT TOOLKIT
(HIAT Version 3)



NHS
National Institute for
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Collaboration for Leadership in
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THE HIAT

This health inequalities assessment toolkit (HIAT) has been developed to make sure that all our activities have the potential to contribute to reducing inequalities in health. Our steering board requires all proposals that are looking for support to include a health inequalities assessment report, which you can see at **Appendix 1.**

The toolkit explains why we are focusing on reducing health inequalities and tackling their causes. It also includes guidance on how to use it and links to resources that can help you assess whether your work considers the causes of health inequalities and has the maximum possible effect on reducing these. You can access the HIAT website to find resources such as readings, films, activities and case studies providing more information and practical examples. The website also features a downloadable short version of the toolkit for busy professionals so that they can quickly identify and understand the information they need. Visit the website here: **www.hiat.org.uk**

Our staff and partners worked together to develop the toolkit in a series of workshops in 2014-2015. This is the third version of the toolkit, which we have changed using feedback from people who have used it. We plan to revise it regularly to make sure it continues to reflect your experience.

CONTENTS

WHY FOCUS ON HEALTH INEQUALITIES?

Due North[1] (see bibliography on page 24), the report of an enquiry set up by Public Health England, recently documented the scale of the health divide between the North and the rest of England. (The North is made up of the North West, North East, Yorkshire and Humberside.) Since 1965 this 'health gap' has widened, resulting in 1.5 million premature deaths (**see diagram 1**).

This regional health divide masks inequalities in health between different socio-economic groups within every region in England. Wherever people live in the country, health declines with increasing socioeconomic disadvantage. However, while the North has 30% of the population of England, it has 50% of the poorest neighbourhoods. More shockingly, poor neighbourhoods in the North have worse health than places with similar levels of disadvantage in the rest of England (**see diagram 1**).

These stark differences between the North and South of England, and between poor neighbourhoods in the North and South, are due to a more uneven balance of wealth in the North. This, in turn, is caused by higher unemployment rates, lower wages and higher levels of chronic illness and disability, limiting people's ability to take paid work. This combination of social and economic circumstances has negative effects on people's lives. It limits the resources people have to pay for food and housing, and decides the wider environment in which people live and work. Also, it limits the control people have over their lives, helping to shape behaviour that can damage health. We call these conditions the socio-economic causes of health inequalities.

HEALTH INEQUALITIES AND SOCIO-ECONOMIC INEQUALITIES IN HEALTH: MAKING THE LINKS

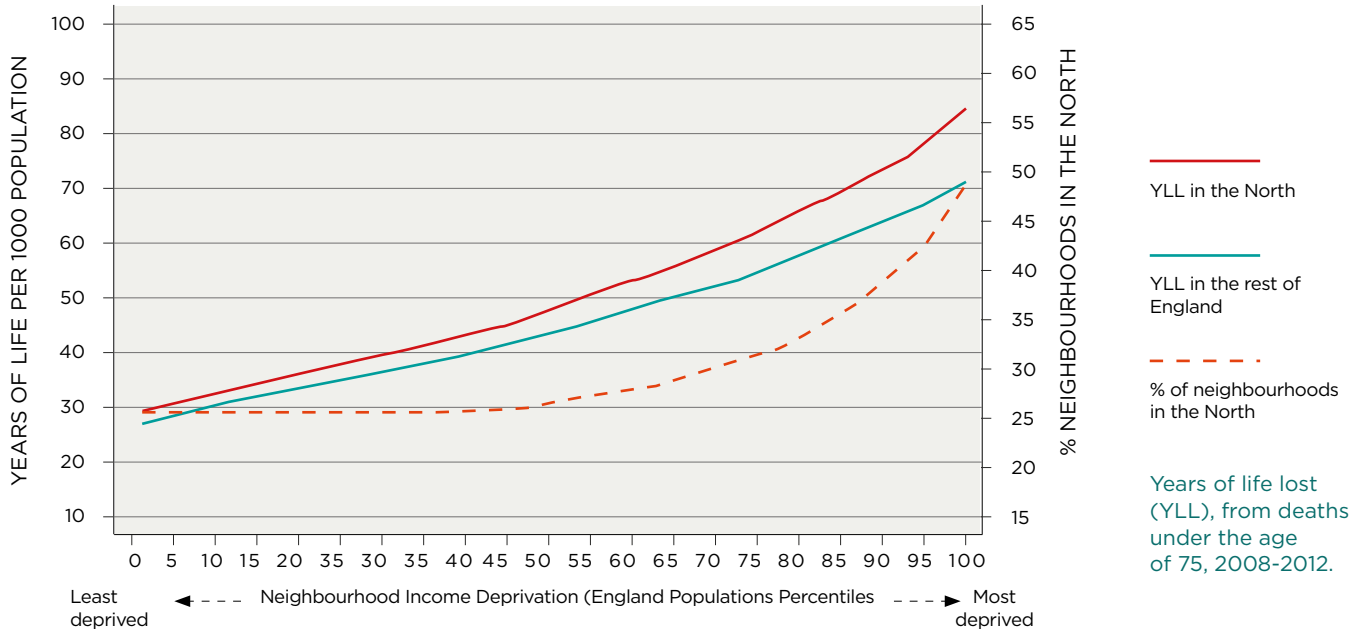
Whitehead and Dahlgren[2] define social inequalities in health as "systematic differences in health status between socioeconomic groups".

A large body of research has shown that the socio-economic conditions in which people live and work are the main causes of inequalities in health. So, our toolkit uses 'socio-economic inequalities in health' interchangeably with 'health inequalities' to emphasise the effect socio-economic conditions have on people's health. It is vital that, when deciding which health problems to tackle, and when finding and evaluating possible solutions, our work places the greatest importance on the inequalities in the health problem and in the possible socio-economic causes of these health inequalities. Only by doing this will we make the most of our potential to contribute to a reduction in health inequalities.

Other social factors, such as gender, ethnic background and disability, also contribute to health inequalities. However, we want to emphasise that inequalities in socio-economic conditions produce significant inequalities in health associated with other social factors [3,4]. For this reason, we expect all of our work will focus on the socio-economic causes of health inequalities, whatever other social factors we consider.

DIAGRAM 1

Health inequalities in the north



Source: PHE and DCLG in Whitehead et al. (2014: 28).

THE IMPLICATIONS FOR ACTION

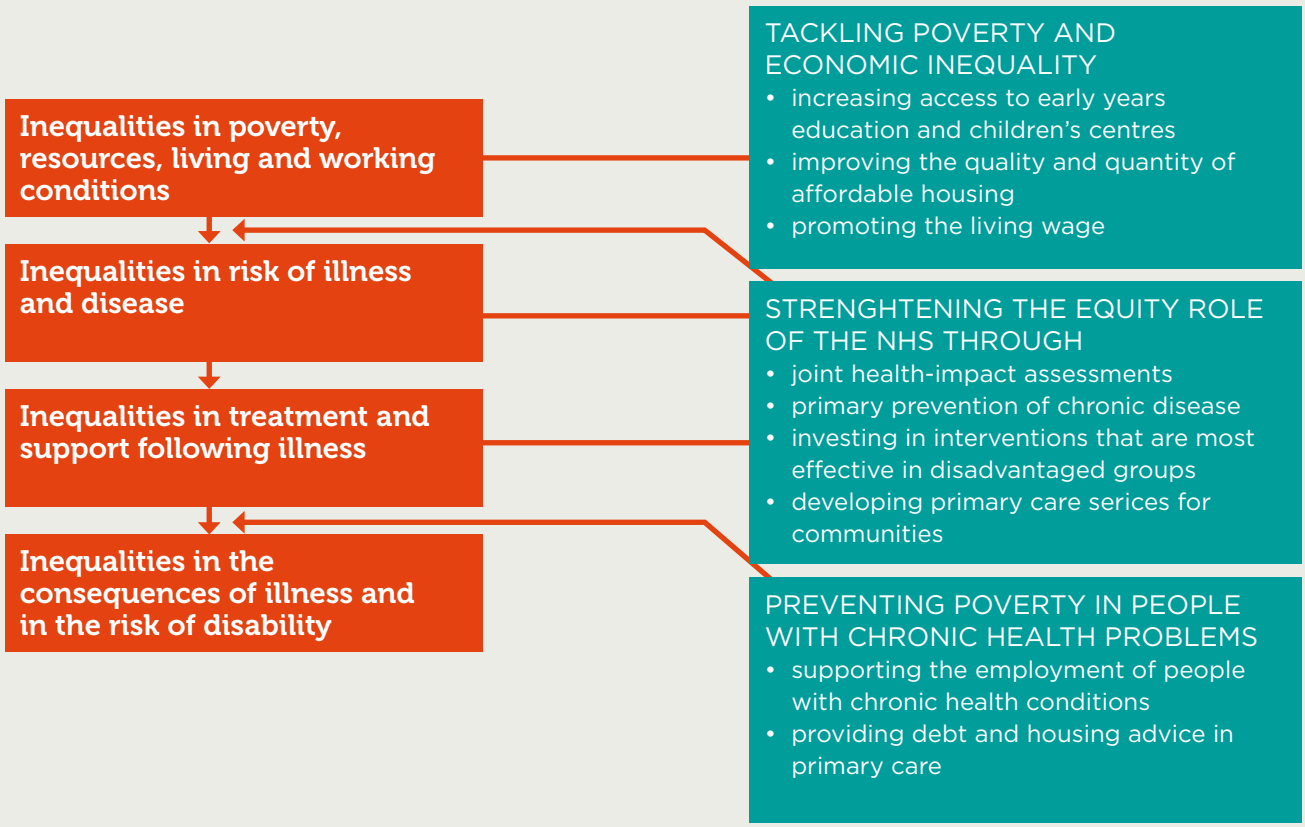
Much of the responsibility for reducing health inequalities and their socio-economic causes lies with central government. However, a lot can be done locally, despite cuts in public spending. Reducing health inequalities requires all sectors – local people, the NHS, local government, the voluntary and private sectors – to work together.

The Due North report sets out a range of actions public agencies in the North can take. These are shown in **diagram 2** and include:

- **targeting social factors that can affect health, such as poverty, economic inequalities and poor housing;**
- **preventing the onset of chronic illness;**
- **making sure people have prompt access to high-quality healthcare;**
- **creating social and physical environments that promote good health; and**
- **preventing the unequal consequences of ill-health.**

DIAGRAM 2

Acting locally to reduce health inequalities (courtesy of Ben Barr)



Health and social inequalities place a considerable burden on public services. For example, it costs the NHS at least £2.5 billion a year to treat people with illnesses caused by living in cold, damp and dangerous homes.

The evidence shows that the NHS has reduced the effect socio-economic inequalities have on health. In recent years, for example, the risk of dying from amendable conditions (conditions that can be treated by the NHS, such as heart disease and cancer) has been falling rapidly and some inequalities have reduced.

People living in disadvantaged areas in the North are still more likely to die prematurely from these conditions, but the mortality gap (the difference in death rates across socio-economic groups) with the rest of England has narrowed slightly, particularly for men (**see diagram 3**).

As the Due North report concludes, reducing health inequalities and their socio-economic causes in the North West Coast area will be challenging but can be done. This toolkit was developed to increase awareness and knowledge of health inequalities and how they can be addressed through applied health research.

DIAGRAM 3

This graph shows how the mortality gap from causes amendable to healthcare between the North and the rest of England has reduced.

Source: HSCIC. Population weighted averages of local authority rates in Whitehead et al. (2014: 65).

THE STRUCTURE OF THE TOOLKIT

The toolkit has four sections.

Section 1 helps you to clarify the inequalities associated with the health problem you want to tackle, and to identify the socio-economic causes of these inequalities.

Section 2 helps you consider how you can plan your work to address some of the socio-economic causes of inequalities identified in section 1.

Section 3 aims to make sure that you monitor or evaluate the effect of your activity on health inequalities and their socio-economic causes.

Section 4 asks you to consider how your activity will have effects on the socio-economic causes of health inequalities that you are not directly considering.

Each section includes the following.

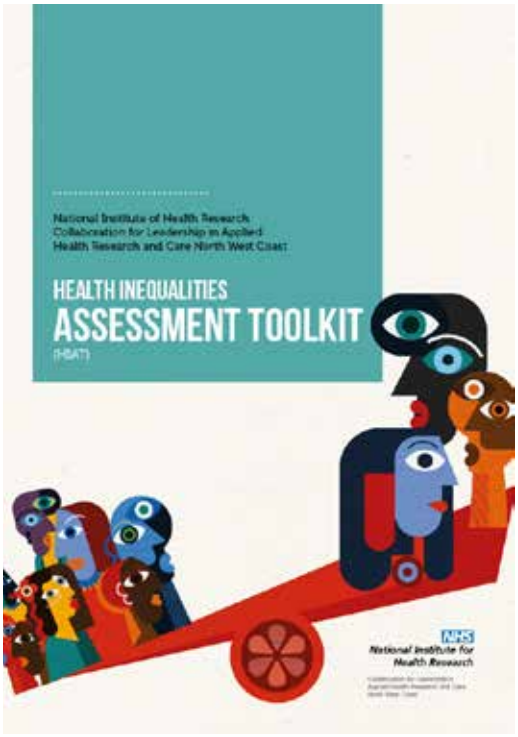
1. An explanation of its purpose.
2. Questions to help you carry out an assessment of your planned work.
3. Questions to make sure you involve appropriate members of the public in all aspects of your work (this is required by our steering board).
4. Resources such as readings, films and activities providing more information about issues covered in the section.

In each section, the toolkit questions are applied to a hypothetical outline proposal to evaluate an intervention to increase the uptake of health checks. This example aims to show how using the toolkit could increase the potential for this intervention to reduce health inequalities.

HOW TO USE THE TOOLKIT

1. Interpret the language used in the toolkit flexibly to 'fit' your activity

The toolkit aims to be relevant to all of our work – applied research, evidence synthesis, capacity building, knowledge exchange and implementation. The focus might be on biomedicine, health care, social care or wider social factors that lead to health inequalities. Finding a language that applies across all of these activities is difficult. However, the issues we are dealing with are relevant to all of our work. So please focus on the purpose of each section set out in the introduction rather than the precise wording of questions.



2.Use the toolkit to suit your needs

You do not need to follow the sections and the questions in them in order. You may find it helpful to move backwards and forwards between sections and questions as you focus on the health inequalities aspect of your work.

3. Record how your plans have changed as a result of using the toolkit or why you feel no changes are needed.

Our steering board requires all proposals to include a health inequalities assessment report. It may be helpful to keep notes of your assessment and its effect on your work to help you complete the report. You can find a report template in Appendix 1.

SECTION 1:

Clarifying what aspects of health inequalities and their socio-economic causes influence the problem your proposed work plans to address

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Clarifying what aspects of health inequalities and their socio-economic causes influence the problem your proposed work plans to address

This section is designed to help you:

(a) clarify how health inequalities influence the problem you want to tackle; and

(b) identify the socio-economic causes of these inequalities.

If you are using the toolkit to prepare an application for support from us, you can consider health inequalities associated with gender, ethnic background, age, disability and so on. However, we give priority to applications that show the potential to reduce inequalities in health resulting from socio-economic inequalities.

So whatever the specific focus of your application, you should explain how the problem is influenced by inequalities in people's social circumstances. Your application should also highlight plans to address some of these socio-economic causes of health inequalities. For example, if the problem relates to uptake of services or outcomes of treatment for a particular group (for example, women, people with disabilities, or a minority ethnic group) you will need to consider:

- whether the problem is unequally distributed within the socio-economic group you are focusing on, and if so how; and
- what particular socio-economic factors may contribute to these inequalities in the problem you want to focus on (for example, low income or poor-quality housing).

If you are proposing an evidence review or a capacity-building initiative, it will also need to focus on the socio-economic causes of health inequalities. Capacity-building activities might focus, fully or partly, on increasing understanding about health inequalities and their socio-economic causes among those taking part. Also, all applications submitted to us should consider more involvement from public advisers from underrepresented social groups.

The questions below will help you think about these issues and explain in your proposal how the work you want to do will tackle them. It is difficult to frame questions in language that applies to the broad range of activities we are involved in. If a particular question does not seem relevant to your activity, adapt it to suit the purpose of the exercise.

As you work through the questions, it might be helpful to look at the hypothetical example provided. This shows how you can use the toolkit to evaluate an activity aimed at increasing the uptake of health checks. This example is designed to help you see how considering the questions below can strengthen the focus on socio-economic causes of health inequalities in your proposed work.

Clarifying the health-inequality issues

1.1. What is the problem you plan to address and which groups do you want to work with?

1.2. What evidence is there that this health problem is unequally distributed across people living in different socio-economic circumstances?

1.3. What particular socio-economic causes of health inequalities would you expect to influence this problem?

Making sure the public are involved in an appropriate way

1.4. Have you involved relevant members of the public (for example, service users or carers, particularly those experiencing socio-economic disadvantage, or people living in disadvantaged neighbourhoods) in helping to identify the problem you want to tackle?

1.5. How have you involved them?

1.6. What effect did they have on your understanding of the problem you want to tackle?

AN EXAMPLE OF USING THE TOOLKIT: INCREASING UPTAKE OF HEALTH CHECKS

Section 1:
Clarifying what aspects of health inequalities and their socio-economic causes influence low uptake of health checks in primary care

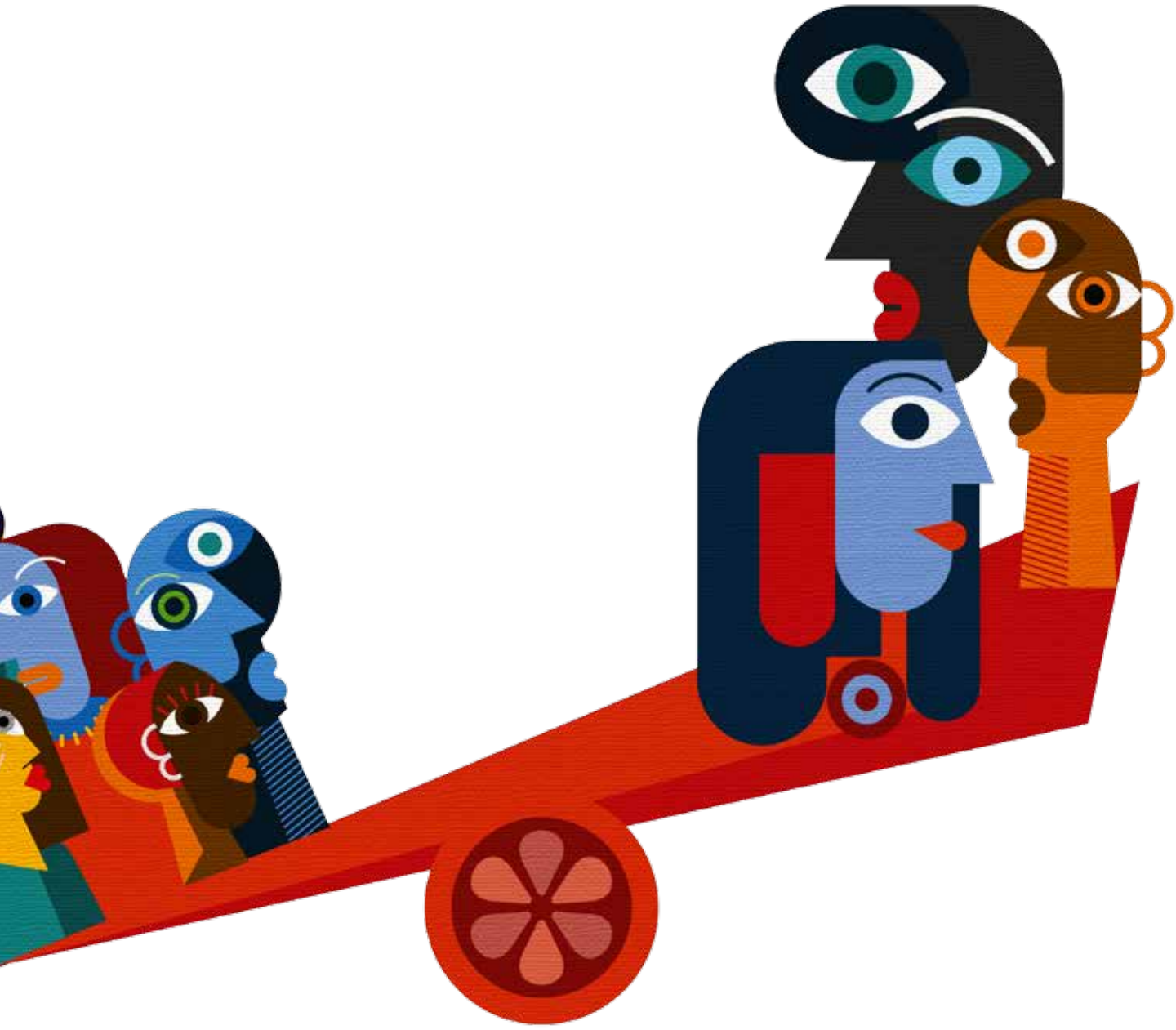
In this hypothetical proposal, the problem was originally set out as a low uptake of health checks among adults aged 40 to 75 from black and minority ethnic (BME) groups. The proposal argued that increasing the uptake of these checks would reduce the relatively high risk of cardiovascular disease (CVD) and other conditions in these groups.

The initial proposal considered factors that may influence whether people decide to have these health checks. These included lack of education about the benefits of health checks, cultural distrust of the medical establishment, and the ways in which information about health checks is communicated. In response to the questions in section 1, the team looked at evidence on the socio-economic causes of the low uptake of health checks. The team identified three ways in which socio-economic circumstances might act as barriers to uptake of health checks.

- **The evidence on rates of uptake among BME groups is limited. However, there is strong evidence of lower rates in groups who are experiencing socio-economic problems, regardless of their ethnic background. This suggests that socio-economic circumstances can create barriers to accessing health checks.**
- **The location and timing of health checks can make it difficult for people to attend, especially if they cannot access reliable and affordable public transport or take time off from work or caring responsibilities.**
- **The content of the health checks, the way they are carried out and the professionals carrying them out (in terms of their gender, or professional or ethnic background) can put people off attending.**
- **People who work long hours in poor conditions, or whose jobs are not secure, may put providing for their family ahead of going for health checks.**

As a result of the discussions, the team decided to concentrate on people of South Asian heritage and consider how socio-economic disadvantage results in inequalities in the uptake of health checks. An alternative approach might have been to focus on increasing uptake in disadvantaged neighbourhoods which have considerable ethnic diversity (and where research shows rates are low). The team did not specifically deal with the question of whether (and how) increased uptake of health checks would reduce risk of CVD or other diseases in the proposal, but it came up in the discussion and they looked at it later in the assessment.

The team were planning to involve people of South Asian heritage when refining and evaluating the intervention once funding was agreed, but they have not involved them so far in defining the 'problem' or the proposed action. They will need to do this before their proposal can be supported.



SECTION 2:

Designing your intervention or activity to have maximum effect on reducing health inequalities

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Designing your intervention or activity to have maximum effect on reducing health inequalities

In section 1 you were asked to clarify the health inequalities and the socio-economic causes of these inequalities that influence the problem you want to focus on. The purpose of section 2 is to make sure that your activity considers how the socio-economic circumstances in which people live and work may act as barriers to your intervention.

Whether you are planning to evaluate an intervention or a new service model, an implementation project, a systematic evidence review or a capacity-building activity, you should explain how and why your work will attempt to reduce health inequalities, by addressing some of the socio-economic causes of inequalities identified in section 1 [5-7].

These types of explanations are sometimes referred to as 'theories of change' or 'logic models'[8]. You may also want to consider longer-term outcomes relevant to health inequalities. Even though measuring these outcomes may not be within the timeline of your project, it can provide a case to get funding for a longer-term evaluation of the effect of your work on health inequalities. However, if your intervention is a new model of care, you could collect routine data to assess the long-term effect of your interventions (see section 4).

Finally, you need to explain how members of the public have contributed to planning your proposed action.

Questions to help you clarify what links your activity to a reduction in socio-economic inequalities in health

2.1. How do you plan to address the problem you want to focus on?

2.2. How will your proposed work tackle the socio-economic causes of the health inequalities you identified in section 1?

2.3. How could the socio-economic circumstances in which your target group live and work limit their ability to benefit from, or take part in, your activities? Are there any risks that your work may unintentionally increase inequalities in health? How would you reduce these risks?

2.4. What further partnerships (for example with local authority staff) might increase the positive effect of your work?

Making sure you involve the public appropriately

2.5. Did you involve your target group when deciding what action to take to deal with the problem, particularly about how you could address the socio-economic inequalities in health associated with the problem? If yes, how did you involve them and what effect did this have? If you didn't involve them, please say why.

AN EXAMPLE OF USING THE TOOLKIT: INCREASING UPTAKE OF HEALTH CHECKS

Section 2:
Reducing socio-economic barriers to uptake of health checks

As a result of the section 1 assessment, the team decided to concentrate on people with South Asian heritage aged 45 to 70, particularly those living in economically disadvantaged circumstances. In their initial proposal, the team had identified three factors that limit the uptake of health checks – poor understanding of the risks of cardiovascular disease (CVD), cultural mistrust of the medical establishment, and poor communication within primary care. To deal with these issues, the team planned to improve knowledge and communication, using health trainers to increase 'health literacy' in the target group. This involved creating more culturally appropriate information resources, and training staff to increase cultural awareness.

However, discussions resulting from questions in section 1 and with people of South Asian heritage highlighted other socio-economic barriers to uptake of health checks and which affect whether people act on health advice. These barriers included location and time of appointments and difficulties taking time off work or caring responsibilities.

As a result of these discussions, the team revised their plan, to do the following:

- **Include initial research into people's experiences of health checks and how they could be redesigned to meet people's needs and restrictions.**
- **Work with primary care to provide health checks in local mosques and other community settings so they are more locally accessible.**
- **Training staff on the socio-economic causes of health inequalities and barriers to people using preventive services (such as, institutional racism, lack of appointments at convenient times, and problems with access (for example, people may not have access to a car or reliable public transport).**
- **The team also recognized that the health trainers needed to be acceptable to the target group. Ideally they should be from South Asian communities, and the team decided to look into whether it would be possible for the target communities to be involved in choosing the health trainers.**

A number of issues arose from the team's discussion of the possible negative consequences of their plan.

- **Diverting resources for health checks into mosques alone would mean reduced access and lower rates of uptake for people who won't or can't go to mosques, so the team decided that they needed to include other locations in the community.**
- **The 'logic model' linking increased uptake of health checks to reduced risk of CVD and other conditions depended on people identified as 'at risk' being able to act on the advice they were given. The team recognized that some socio-economic factors affecting the uptake of health checks could also affect whether people take (and continue with) medication, or take advice about changing their diet or becoming more active (for instance, neighbourhoods may be unsafe, or may not have affordable gyms or accessible pavements and parks). Suggestions for how these risks could be reduced included:**
  - **providing more support from health trainers for people at risk to help them act on recommendations; and**
  - **finding wider support and resources for people at risk of CVD or other health problems during the health check.**

SECTION 3:

Evaluating and monitoring the effect of your activity on health inequalities and their causes

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Evaluating and monitoring the effect of your activity on health inequalities and their causes

The purpose of this section is to make sure that the methods you use to evaluate or monitor your work will demonstrate whether or not the work has contributed to reducing socio-economic inequalities in health.

For instance, if you are proposing a capacity-building activity, you will need to evaluate whether it has increased awareness of socio-economic factors that influence health outcomes and behaviours and people's confidence to act on health inequalities. If you are planning to evaluate an intervention or proposing an evidence review, you will need to test for differential outcomes between different socio-economic groups.

We realise that it may be difficult within the timeline of our funding to evaluate any long-term outcomes and major changes that could result from your work. However, you should establish effective monitoring systems to identify the effects (anticipated or not) your work could have on health inequality.

Imagine the following scenario. You are evaluating a new intervention to assess whether it has increased access to a particular service. The evaluation team also want to know whether increased access leads to improved health outcomes for different social groups, and if not, why. You know that it is not practical to get relevant data to answer this question within your evaluation timeframe. However, your team realise that this evaluation exercise is an opportunity to set up robust structures and methods to collect data that could be used to measure long-term outcomes. In this way, the team are in a strong position to get funding for a longer-term evaluation to assess whether the intervention helped to reduce health inequalities.

This section also focuses on how relevant members of the public are, or will be, involved in monitoring.

Questions to help assess whether evaluation or monitoring plans will provide evidence on how your activity will affect socio-economic inequalities in health

3.1. Which short-term and longer-term effects on health inequalities or the socio-economic causes of these inequalities (or both) will you look at?

3.2. Will your evaluation (or evidence review) provide evidence on:

(a) unequal access to services to be developed or already provided (for example, whether some ethnic groups have poorer access than others)?

(b) differential health outcomes (whether the interventions you have evaluated or included in your review are less effective for some groups than for others)?

3.3. If you are evaluating or monitoring the effects of a capacity-building initiative, will your evaluation provide evidence on increased awareness of socio-economic factors that influence health and people's confidence to act on health inequalities?

3.4. In addition to socio-economic status what key social variables will you use to assess the differential effect of your work on health inequalities? (gender, age, disability, ethnicity, place of residence, occupation, etc.)

3.5. Will you be able to identify any possible unintended effects (positive and negative) of your activity, particularly on health inequalities and their socio-economic causes. If so, how? If not, why not?

3.6. How will you measure how the costs and benefits of your action are distributed across the different groups, including different socio-economic groups where appropriate?

3.7. Are there ways in which you could lose the focus of your activity over time? How will you make sure you maintain this focus?

Involving the public

3.8. Has your target group been involved in designing the evaluation and monitoring?

3.9. If so, how did this affect the design? And if it didn't affect it, why not?

3.10. How will you involve the public in evaluation and monitoring

AN EXAMPLE OF USING THE TOOLKIT: INCREASING UPTAKE OF HEALTH CHECKS

Section 3:
Making sure the evaluation and monitoring can assess the different effects on health inequalities and their socio-economic causes

The team originally planned to set up their intervention in five GP practices which have high numbers of people from BME backgrounds. They chose a further five GP practices with similar BME numbers as control practices. The team proposed to compare the change in uptake of health checks among BME groups in the intervention and control groups. They also planned to carry out research into people's beliefs about the health checks and what people saw as barriers (or aids) to this service.

In response to the questions in section 3, the team agreed that they needed to redesign the evaluation to look at the socio-economic causes of low uptake of health checks and whether people can act on advice following a health check. They considered the following changes in research methods:

- **Choosing intervention and control GP practices based on different levels of deprivation and numbers of people of South Asian heritage registered with the practices.**
- **Matching people in both groups on ethnic background and socio-economic status but also other relevant social categories, for example, where they live, their occupation, gender, religion, education, disability, sexuality and so on, to determine how these factors influence access and health outcomes [9-11].**
- **Comparing uptake of health checks between matched groups.**
- **Comparing differences in change in relevant categories (smoking, diet, high blood pressure, cholesterol and so on) between these groups.**
- **Comparing health outcomes.**

The team also decided they should collect data on:

- **People's experiences of health checks and of barriers and aids to accessing them;**
- **The type and quality of information and advice that people get during or following the health checks; and**

- **Barriers and aids to people's ability to act on this advice. The public advisers discussed the possible barriers to people taking recommended medicines, including side effects, lack of knowledge about how the medicines should be taken, or cost.**

The team felt that they could use in-depth interviews and visual techniques to explore these issues, using a sample of people of South Asian heritage. They would base the sample on people's socio-economic status and the deprivation scores of the areas where the GP practices were based.

The sample could also be chosen to reflect other relevant social differences as defined across the research framework PROGRESS-Plus, such as gender, disability and age[11].

SECTION 4:

Planning for wider effects on health inequalities and avoiding negative ones

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Planning for wider effects on health inequalities and avoiding negative ones

The purpose of this section is to encourage you to consider whether the work you propose could have effects on health inequalities and their socio-economic causes other than those directly associated with it. If you are able to identify any wider effects, think about what action you could take to deliver positive effects or avoid negative ones.

Questions to help identify and address wider effects on health inequalities

4.1. Is there potential to increase understanding of the socio-economic causes of health inequalities among service providers, commissioners and members of the public involved in your proposed work?

4.2. If so, how might you support and evaluate this?

4.3. What benefits might there be for the members of the public involved in your work, and how could you avoid any disadvantages? How could you evaluate these benefits?

4.4. Have you thought about the most effective way you can share what you have learned from your work within the wider social and healthcare communities?

4.5. Have you developed innovations in methods for evaluating or monitoring the effects of health inequality, and if so how can you share these?

Making sure you involve the public appropriately

Throughout this assessment we have advised you to involve relevant members of the public in all stages of your planned activity. This is a requirement of any work we support.

4.6. Assuming you now have members of the public advising you on the work, have you asked them to think about the possible wider effects on:

(a) being involved in your activity;

(b) health inequalities and their socio-economic causes; and

(c) how any positive or negative effects can be delivered or avoided?

AN EXAMPLE OF USING THE TOOLKIT: INCREASING UPTAKE OF HEALTH CHECKS

Section 4:
Planning for wider positive effects of your work and avoiding negative effects

The initial proposal for research to increase uptake of health checks did not consider its possible wider effect on socio-economic inequalities in health or on the members of the public involved in the research.

However, during discussions prompted by section 4 of the toolkit, the team identified a number of potentially positive wider effects, as follows:

- **Improved relationships between primary-healthcare providers and their South Asian communities. As professionals become more aware of the socio-economic causes of ill-health and the socio-economic causes of stigma associated with consultation and treatment, judgment and respect also grows, increasing people's trust in health trainers[12].**
- **In time, health trainers could expand their role and advise people on other health conditions where inequalities exist.**
- **Health trainers could also help people to access wider social and healthcare services[13]. These changes could encourage service providers and commissioners to develop ways to help people living in socio-economically disadvantaged conditions deal with wider social problems that increase their risk of cardiovascular disease. Some of this support could be towards accessing good-quality advice about debt and benefits.**

The team were aware that putting in place partnerships and actions to make these changes and assess their effect on health outcomes is challenging. However, they agreed to consider whether it would be practical to extend the evaluation over a longer period to collect research data in one fieldwork area.

To assess the effects of involving the public in their research, the team also agreed to work through some of the exercises in the Public Involvement Impact Assessment Framework Guidance[14] with the public to see what they could gain from involving them, and to put in place an internal evaluation process to assess whether they have achieved this.

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APPENDIX 1

Steering board health inequalities assessment report

All outline and full proposals that want support from us must include a health inequalities assessment report. The steering board will use this report to decide whether your proposal 'fits' with our objective: to make sure that everything we do has the potential to reduce health inequalities and their causes.

In the form below, we ask you to briefly outline your response to each section of the toolkit.

In particular, we would like you to specify any change you have made to your planned activity as a result of your assessment, or explain why you feel changes are not necessary.

You should use the toolkit with the members of the public involved in your activity. Please briefly outline how you have involved them or explain why you did not involve them at this stage.

1. Name of your project

2. Theme of your project

3. Who was involved in the assessment (include relevant members of the public)? If you did not involve the public, please say why not.

4. Please summarize the results of your assessment under the section headings. For each stage, highlight the changes to your activity as a result of the assessment. If you did not make any changes, please give your reasons why.

What are the health inequalities that influenced or created this problem?	
How will your proposed work tackle the socio-economic causes of the inequalities in health you identified in section 1?	
How will you make sure that your evaluation and monitoring shows the effect of your activity on health inequalities and their causes?	
What wider effect might your activity have on health inequalities and their causes and how can this be delivered?	

NOTES

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