Health Equity in All Policies

Nine Case Studies of HEiAP in Action

April 2013

Introduction

It is one thing for the health sector to be interested in trying to solve its 'wicked' health problems, but why would other sectors want to work in a joined-up way to consider health in a 'Health Equity in All Policies approach — what's in it for them and where do you start?[1]

Health is currently one of the greatest single expenditures of government departments. With changing demographics, there is a risk that this expenditure will continue to grow exponentially increasing pressure on resources with all departments within our public administration. It is well documented however that improving the health and wellbeing of the population cannot be tackled by the health sector alone - all sectors can have a positive role to play reducing inequalities in health.

Our health sector provides vital quality healthcare but a strong social, economic and built environment can reduce ill health thus reducing demands on the system, supporting cost savings and maximising the share and impact of public spend.

One innovative way for government departments and agencies to demonstrate commitment to improving health and wellbeing is through a **Health Equity in All Policies approach**. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives.

Professor Illona Kickbusch an internationally renowned expert on health inequalities and instigator of a Health in all Policies (HiAP) approach in South Australia states that '***HiAP provides a lever for governments to address the key determinants of health through a systematic approach as it focuses on the health impacts of policy across all sectors and layers of Government"[2].***

To support this process Belfast Healthy Cities is currently working across departments and agencies to facilitate a partnership approach to policy design and identify ways in which policies can not only meet the organisation's specific aims, but also contribute to health and equity.

The Health in All Policies approach is still developing, and World Health Organisation (WHO) European Healthy Cities are developing further tools to facilitate this approach. This leaflet provides a number of case studies outlining work carried out by Belfast Healthy Cities in partnership with a range of health and non-health organisations demonstrating practical, straightforward ways to consider health equity in policymaking.

[1] Illona Kickbusch (2010) Implementing Health in all Policies: Adelaide 2010
[2] Illona Kickbusch (2010) Implementing Health in all Policies: Adelaide 2010

Background to Belfast Healthy Cities

Belfast Healthy Cities is a citywide partnership working to improve health equity and wellbeing for people living and working in Belfast. We focus on improving social living conditions and prosperity in a healthy way, through intersectoral collaboration and a Health Equity in All Policies approach.

Belfast is also a leading member of the World Health Organization European Healthy Cities Network, with a strong track record of meeting WHO goals and objectives which our politicians and Chief Executives signed up to. Belfast Healthy Cities' office has a staff team dedicated to working with partner organisations to facilitate and support change.

The office also acts as the link between the city and WHO, and Belfast currently provides the secretariat to the Network. All cities in the WHO European Healthy Cities Network work on the same broad themes set by WHO, and share evidence, learning and good practice through the Network. There are currently 96 cities from across Europe formally designated as members of the Network.

Belfast Healthy Cities role in health equity in all policies

An overarching goal for Belfast Healthy Cities is to generate health and health equity as a core value in all policies. BHC has developed a framework to support delivery of a Health Equity in All Policies approach which is outlined in Appendix 1.

It is not essential to follow this framework in its entirety to promote a health equity in all policies approach but the key areas include:

- collaborative working /discussions regarding health equity at the early stages of the development of the policy/strategy
- identification of health equity issues/impacts of policy which are supported by evidence based practice
- identification of policy considerations that support health equity and discussions with policy makers regarding integration of these.

The case studies outlined in this paper show that a Health Equity in all Policies approach can be achieved in a variety of ways.

The range of approaches used by BHC has included one or more of the following activities:

- Support and input through membership of existing working groups
- Completion of literature reviews to help identify health equity impacts of the policy area which can be used as evidence within the strategy
- Facilitation of consultation groups in partnership with the relevant statutory body
- Review of existing indicators and identification of gaps that would support measurement of health equity
- Development of new indicator sets to measure health equity impacts of the policy area
- Capacity building and training on health equity issues relevant to the policy area.

Case study 1: Growing Communities Strategy

During the winter of 2011/12 Belfast Healthy Cities supported Belfast City Council (BCC) and the Public Health Agency (PHA) in the development of a Growing Communities Strategy for Belfast the vision of which is that

'*All people in Belfast will have the opportunity for improved health and wellbeing through involvement in growing activities throughout their lifetimes and within their local neighbourhoods'.*

During the process of developing, the strategy Belfast Healthy Cities sought to pilot their Health Equity in All Policies Framework (Appendix 1) with the aim of increasing understanding of health equity impacts and promoting integration of health equity considerations into the strategy.

Belfast Healthy Cities supported the process in a number of ways:

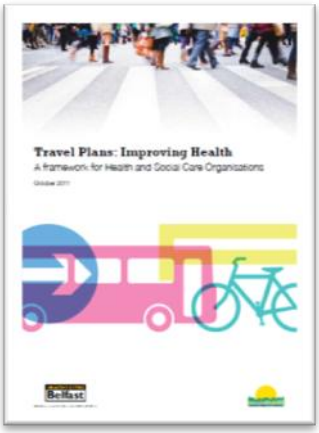
- Providing support to the operational group responsible for writing the strategy
- Jointly facilitating a wider stakeholder group which was made up of around 40 representatives from statutory, voluntary and community sectors including local gardeners. This group met 5 times between September 2011 and March 2012 providing an opportunity to contribute to and shape the content of the strategy
- Developing/facilitating workshops/questions to support wider stakeholders in the identification of health impacts of growing and priorities for the strategy. This involved consideration of the impacts of growing on the social determinants of health (e.g. lifestyles, social networks, access, economic and environment factors and impacts on vulnerable groups).
- Carrying out a literature review of health impacts of growing and developing health equity considerations for the strategy
- Supporting the development of actions for the strategy action plan chapter and indicators to measure progress

A number of achievements were made through this HEiAP pilot:

- The engagement and support from key partners organisations and wider stakeholders in the process and recognition/value placed in the process
- Complete integration of the evidence based report into the strategy
- Integration of key health equity considerations/priorities in the strategy
- Integration of key actions within the action plan which address health equity
- Firm commitment made in the strategy to addressing health equity considerations

Conclusion: Belfast City Council have committed to addressing the health equity considerations which were identified through the HEiAP process. This is documented extensively throughout the draft strategy as well as the associated action plan.

Case study 2: Travel Plans: Improving Health, a Framework for Health and Social Care Organisations



The Health Equity in all Policies framework developed by Belfast Healthy Cities was piloted in the development of a Travel Plan Framework for Health and Social Care Organisations (October 2011) in partnership with travel/estate managers and health improvement staff within four of the Health and Social Care Trusts throughout Northern Ireland (Belfast, Southern, Western, and Northern), as well as the Public Health Agency, Department of Health, Social Services and Public Safety; Business in the Community, and Travelwise/ Department for Regional Development.

The purpose of developing this framework was to provide health and social care organisations with a model that could be used to assist in the development and monitoring of travel plans, and at the same time support efforts to prevent and address inequalities and ensure that vulnerable groups would not be further disadvantaged by population based travel interventions.

A health equity assessment was carried out by the travel group on an existing hospital travel plan to help identify the 'important' determinants of health including vulnerable groups affected by travel plans. The following domains were used to categorise determinants: economic; environmental; access; lifestyle/ personal circumstances; social; and vulnerable groups.

An analysis was carried out on this assessment and was used as the basis for identifying and agreeing on which determinants of health were most important to consider within travel plans. A review of evidence of the health impacts of travel plans also supported the identification of these determinants.

A set of indicators was developed which would support organisations to monitor and review travel plans for their impact on health equity. A set of questions/checklist was also developed which would act as an additional tool to assess a draft travel action plan for its inclusion of action on the determinants of health.

The report also provides examples of action taken to strengthen/widen transport choice were gathered from a range of healthcare, local government and central government reports and publications from Northern Ireland and the UK.

Conclusion: This process has shown that Health Equity in All Policies framework can be adapted and used not only in the development of new policies/strategies but also in the development of strategic guidance documents and in this case in particular provide support for monitoring impacts. The travel plan framework has been recommended for use by the DHSSPS in the development and monitoring of travel plans regionally by HSC Trusts.

Case study 3: Developing an Active Travel Strategy for NI, DRD

The work on developing an Active Travel Strategy for Northern Ireland was initiated by the Department for Regional Development (DRD) in early 2010. The aim was to develop a high level strategy, which will link to other strategies and set the broad context for developing active travel, both in terms of infrastructure and behaviour change.

To support the process, DRD established an Active Travel Forum, which included representatives from key Departments, local government, Sport NI, Translink and also relevant community and voluntary sector stakeholders.

Belfast Healthy Cities joined the Active Travel Forum following a meeting with the director of the then Transportation Policy Division.

The Active Travel Forum had a role in supporting the Department with research on the economic, environmental, health and wider social benefits of active travel; identifying key barriers, to walking and cycling; identifying examples of good practice, and considering cross Departmental alignment to maximise potential synergies.

Belfast Healthy Cities supported the research stage of the process by commenting on draft documents and sharing evidence on the wider health impacts of active travel, focusing on equity issues, accessibility and potential social and community benefits, including mental wellbeing, community cohesion and safety. This included commenting on barriers identified, and identifying potential solutions, drawing on experience from the WHO European Healthy Cities Network.

The evidence provided was taken into account by the Departmental drafting team, which already understood and covered physical health benefits well, and was interested in integrating all key issues and synergies. Evidence of this was visible at the drafting stage of the Strategy, which included several key sections of evidence provided by Belfast Healthy Cities.

These sections considered in particular mental health, equity and accessibility impacts, and potential impacts on community cohesion. The inclusion of these issues was also highlighted and received support in debate at Active Travel Forum meetings. The final draft strategy, which was issued for consultation in December 2011 and closed in March 2012, includes an emphasis on health and equity.

Belfast Healthy Cities was also invited to participate in the sub group developing criteria for assessing the demonstration project bids aligned with the strategy. Belfast Healthy Cities introduced the concept of wellbeing as a key criterion.

Conclusion: Belfast Healthy Cities supported the development of the Active Travel Strategy from an early stage, primarily through sharing evidence and highlighting the potential synergies to be achieved from a focus on the wider determinants of health. The process was collaborative and generated a positive atmosphere in the Active Travel Forum. Participation in this process has also led to Belfast Healthy Cities being invited to contribute to a number of further emerging projects.

Case study 4: Contribution to Committee Stage of Planning Bill, 2011

In January 2011, Belfast Healthy Cities was invited by the Committee for the Environment of the Northern Ireland Assembly to submit written evidence on the Planning Bill for consideration during the Committee Stage of the Bill.

This Bill aimed to introduce into legislation the extensive reform of planning, the key element of which is the return of key planning functions – drafting Local Development Plans and determining applications - to local government. The Bill also dealt with enforcement and application process issues. In the original draft, no reference was made to health or wellbeing, and the purpose of planning was summarised broadly as the orderly management of development.

The evidence submission of Belfast Healthy Cities focused on the broad health impacts of land use planning, including impacts on job prospects, access to services and impacts on community and social networks. In particular, the submission emphasised the importance of identifying a clear purpose of planning, and proposed that this should include promoting wellbeing and sustainable development.

Following submission of the written evidence, Belfast Healthy Cities was invited to an oral stakeholder session with the Committee, which considered key issues raised within written submissions. Belfast Healthy Cities was asked to provide a brief introduction to discussion on third party right of appeal.

At this session, Belfast Healthy Cities also reiterated key points from the written submission, in particular the important opportunity to integrate wellbeing and sustainable development into the purpose of planning.

The same argument was made and echoed by a number of other organisations, in particular environmental voluntary sector organisations.

This process was one among several considered by the Committee in a very tight timescale. The final recommendations issued by the Committee, however, recommended integrating 'furthering sustainable development and promoting social wellbeing' into Clause 1, which effectively establishes the purpose of planning in Northern Ireland. The recommendation was taken into account in the final amendments to the Bill, and is incorporated into the Planning (Northern Ireland) Act 2011, which received Royal Assent in March 2011.

Conclusion: The process was positive, and opened a new area for debate around planning, and around ways of integrating wellbeing into concrete planning policy and practice. It also contributed to the development of relationships with the Environment Committee. Following this process, Belfast Healthy Cities has identified a range of potential opportunities to contribute to integrating wellbeing into the planning system, and is exploring concrete options for supporting in particular new planning policy using the Health Equity in All Policies approach.

Case Study 5: Good for Regeneration, Good for Health

It is often assumed that regeneration supports health and wellbeing, but the outcomes are not always monitored to prove this. In some cases, the necessary data is not routinely available or not collected. This project set out to develop an indicator set that can be used to monitor outcomes of regeneration, and identify the data necessary to do this in a meaningful way.

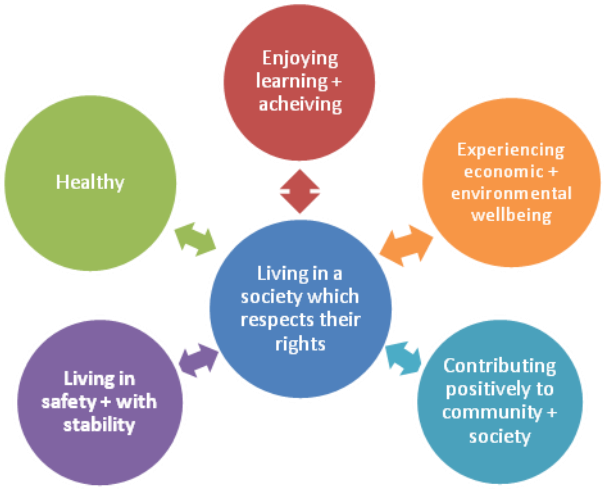
The indicator set is built around four key domains. From each domain, two vital indicators are identified into a core set of eight 'headline' indicators. The novel element of this is that for each domain, an indicator focusing on overall performance is coupled with an indicator that emphasises impacts on inequalities. This means that the indicator set can be used to monitor change in both the physical area and its people over time.

The indicator set has been developed in close collaboration with the five Belfast Area Partnerships and is based on a health impact analysis of their Strategic Regeneration Frameworks.
Piloting of the set was carried out in east Belfast and south Belfast, using a series of checklists that enabled collection of information that is not currently routinely available.

Other key partners included Belfast City Council, Belfast HSC Trust, Northern Ireland Housing Executive, and the Public Health Agency. This project was part of the Building Healthier Communities project, which was funded through the EU Urbact II fund and involved 10 cities from across the EU. In September 2009, representatives from the ten cities participated in training on Health Impact Assessment arranged in Belfast.

Conclusion: The indicator set was published in December 2011. Next steps include further piloting of the approach, prioritising data gaps and identifying ways of collecting key data currently not available.

Case Study 6: Belfast Children and Young People's Outcomes Group



Late 2011, Belfast Healthy Cities carried out a piece of work on behalf of the Belfast Children and Young People's Outcomes Group to map existing partnerships in the Belfast area who were contributing to improving better outcomes for children and young people. A questionnaire was developed and circulated widely throughout the Belfast area.

Thirty-nine partnerships responded to the questionnaire. A report was compiled providing a breakdown by geography and target group and summarising the remit/purpose of the partnership; staffing and priorities.

The information provided from the mapping exercise was used by the Belfast Outcomes Group in a number of ways:

- To begin to link with and support existing partnerships,
- To inform the Belfast Outcomes Action Plan,
- To inform the future development of locality planning and Family Support Hubs.

Conclusion: this piece of work helped build capacity for future HEiAP work in partnership with the Belfast Outcomes Group (see case study 7 for follow up work)

Case Study 7: Review of Children and Young People Indicators

A regional set of indicators to measure the work of Children's Services Planning groups was developed in 2008 and included within the Northern Ireland Children's Services Plan (2008-2011). More recently work is in progress to develop child rights-based indicators by the Children and Young People Strategic Partnership (CYPSP).

In June 2012 Belfast Healthy Cities (BHC) was asked to review these indicators and identify any gaps which would support measurement of health equity/inequalities. On review of current indicators outlined in the Northern Ireland Children's Services Plan (2008-2011) and the draft child rights-based indicators, BHC suggested a number of indicators for consideration by the Children and Young Peoples Strategic Partnership (CYPSP) which would strengthen the existing indicator set to measure health equity.

Conclusion: The review concluded that within the existing indicators set there was already an excellent range of indicators which measure inequalities effectively. For instance – there was a wide range of indicators specially looking at vulnerable groups e.g. BME groups; children at risk; deprived areas; access and uptake of services.

These could be strengthened further by ensuring where appropriate comparisons are made between geographical areas; socio-economic status; age; gender and ethnic/cultural groups.

Case Study 8: Literature review of social and environmental impacts on educational outcomes

In August 2012 Belfast Healthy Cities was asked by the Children and Young Peoples Strategic Partnership (CYPSP) to support strategic action planning through the provision of a review of literature and evidence of factors and inequalities which affect children and young people's educational attainment and outcomes.

The literature review contains mostly local research findings and statistics from Northern Ireland as well as the UK. The review examines a range of factors such as support within the family, diet and physical activity, parental and child aspirations, childhood development, pre-school and early years, school readiness, skills levels, level of income, housing conditions, specific groups such as looked after children and BME, physical and sensory disability and learning disability. These factors were examined and grouped together under the 6 high level outcomes for children as outlined in the OFMDFMNI Strategy, 'Our Children and Young People – Our Pledge, 10 year strategy 2006-2016[i] which are:

- Enjoying learning and achieving
- Experiencing economic and environmental wellbeing
- Contributing to community and society
- Living in a society which respects their rights
- Living in safety and with stability
- Health

The review highlights the importance of education, since educational attainment is a predictor of a wide range of adult situational outcomes including for example impact on type of employment and parental income. Additionally, the evidence suggests that the UK demonstrates one of the highest levels of inequality in educational outcomes in Europe. Moreover inequality is not just a function of performance at school: the gap in educational attainment between the children of affluent and less well-off parents emerges early, long before school.[ii]

Conclusion: The review of evidence demonstrates the wide range of factors which contribute to inequalities in educational outcomes, with different factors affecting different groups, and operating at different stages in children and young peoples' lives and educational careers. Of all these various influencers, the evidence suggests that family background and household income are among the key factors.

Case Study 9: Strategic direction for pharmaceutical services in the community

Between October 2012 and April 2013 Belfast Healthy Cities supported the DHSSPS in the development of a refreshed strategy for pharmaceutical services in the community. BHC's specific role was to:

- Input into a strategy board established by the DHSSPS to advise on the development of a refreshed strategy
- Chair a public health working group – this was one of five sub-groups of the strategy board which was tasked with identifying public health priorities and strategic objectives/outcomes for the draft strategy
- Produce a literature review of evidence on health equity issues relevant to pharmaceutical services in the community
- Organise and facilitate in partnership with DHSSPS and CDHN (Community Development and Health Network) a stakeholder consultation event with the community and voluntary sector to gain their views on how they would like to see the role of pharmacy in the community develop in the future

It is evident from the draft strategy that health equity issues have been considered and integrated into the strategy. Some of the comments received during evaluation of BHC's support to DHSSPS included:

"Held at an early stage in the development of the strategy the stakeholder event was extremely useful as it allowed the steering group to share high level aims

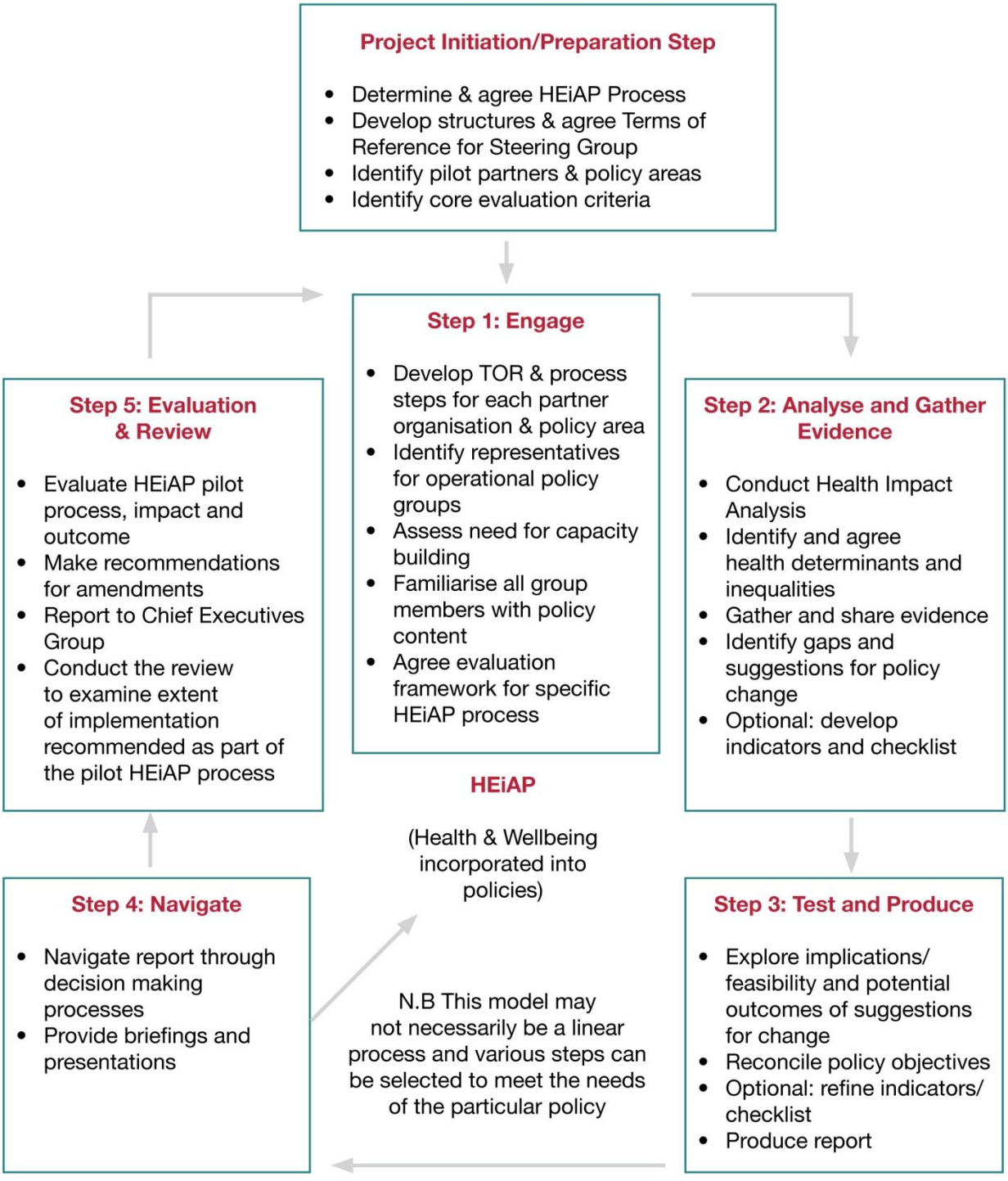
and objectives with patient, community and voluntary sector representatives. Belfast Health Cities' role as official facilitator helped to create an atmosphere which resulted in open discussion and ideas sharing. The Feedback received from the event directly informed the strategy in a number of important areas".

"The literature review highlighted a number of important health equity issues relating to literacy levels in Northern Ireland and difficulties which arise because of language differences which affect people's ability to access information, advice and services provided by pharmacists in the community".

"The support and input of BHC helped to maintain a focus on health inequalities/health equity throughout the development of the strategy particularly in respect of focussing on the expected outcomes in each chapter relating to people and communities".

Conclusion: Engagement of the community and voluntary sector during the early developmental stages of strategy development is important and useful. The DHSSPS found pre-consultation particularly valuable as it provided opportunity to gain wider views on the current and potential role of community pharmacies and how this could be fully utilised in promoting health and wellbeing of individuals and communities. It also provided opportunity to review initial draft goals proposed for inclusion within the new strategy and identify impacts and gaps.

Appendix 1: Belfast Healthy Cities, HEIAP Framework



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[i] The CYPSP delivers on the OFMDFMNI Strategy 'Our Children and Young People – Our pledge, 10 year strategy 2006-2016' http://www.delni.gov.uk/ten-year-strategy_1_.pdf

[ii] Department for Communities and Local Government (2010) Improving attainment?

Interventions in education by the New Deal for Communities Programme
http://extra.shu.ac.uk/ndc/downloads/reports/Improving%20Attainment.pdf