Equity Focused Health Impact Assessment – What it can do for Policy Development

New Zealand Ministry of Health
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Acknowledgments: The authors of this paper wish to thank the members of the steering committee for their input at key stages of this project. They would also like to thank Mary Mahoney for her support throughout the project, particularly during the mapping stage.

Disclaimer: This paper is prepared as part of the Australasian Collaboration for Health Equity Impact Assessment research project. It does not reflect New Zealand Ministry of Health policy.

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Abstract

Purpose: To apply a policy level retrospective equity focused health impact assessment (EFHIA) using the ACHEIA tool to the development of the New Zealand Ministry of Health's Healthy Eating – Healthy Action (HE–HA) strategy. The objective was to determine ‘whether the way the policy was developed had the potential to create, maintain or reduce health inequalities, with particular reference to Maori health?’

Methods: Documentary analysis of the Ministry of Health files on the strategy development and ten key informant interviews.

Results: The EFHIA tool needs to be reframed for a rapid retrospective study. The way the HE–HA strategy was developed could have been improved to strengthen the equity focus in the final document (eg, improving consultation with Maori).

Conclusions: Suggestions were made for reframing the tool to encompass a rapid retrospective study, to widen the definition of equity from socio-economic position to include variables such as ethnicity and gender, and to weave an equity perspective throughout the document. The findings of the EFHIA will be used to strengthen the implementation stage of the HE–HA strategy. EFHIA is a useful tool to ensure that policy development promotes health and equity. Trialling it intersectorally is an obvious next step.
Aims, objectives & expected outcomes

Aim: To undertake a health inequalities impact assessment of the development of the New Zealand Healthy Eating – Healthy Action (HE–HA) strategy, using the Equity Focused Health Impact Assessment Tool (EFHIA).

Objectives: To assess whether the way the HE–HA strategy was developed had the potential to create, maintain or reduce health inequalities, with particular reference to Maori health.

Expected outcomes:

1. Assessment of the applicability of the tool to the policy development process.
2. A refined EFHIA tool.
3. Information to strengthen the equity perspective in the implementation process of the HE–HA strategy.

Application of EFHIA

Screening
Ministry of Health officials agreed that reviewing the development of Healthy Eating – Healthy Action (HE–HA) strategy was suitable for an EFHIA (Ministry of Health, 2003). HE–HA identified numerous health impacts associated with a growing problem of obesity and the need to improve nutrition and increase physical activity in New Zealand that were likely to be differentially distributed by socio-economic status and also by ethnicity.

A Working Group of four was established consisting of two Ministry of Health officials, an academic and a contractor, and agreed:

• to undertake a rapid appraisal
• that differential health impacts were unfair and avoidable
• that the benefits of the development of the HE–HA strategy outweighed the costs or disadvantages of doing so
• that the objective would be ‘Did the way the policy was developed have the potential to create, maintain or reduce health inequalities, with particular reference to Maori health?’

Scoping
Key events included:

• establishing EFHIA methodology: documentary analysis of existing data on Ministry of Health files and key informant interviews with Ministry of Health and external informants
• establishing a Steering Group with nutrition and physical activity and health impact assessment expertise, including Maori and Pacific representatives, to review progress and make suggestions to the Working Group. Working Group members were members of the Steering Group
• establishing terms of reference for the EFHIA
• agreeing to a working definition of equity and to values and other principles underpinning EFHIA
• developing a project plan outlining timeframes, meeting schedules and responsibilities.

**Profiling**

Key events included:
• developing the key informant interview questionnaire and undertaking 10 key informant interviews
• analysing Ministry of Health files on HE–HA, based on the key themes in the questionnaire and triangulating these findings with those in the key informant interviews
• applying an equity lens developed by the Ministry of Health and the Wellington School of Medicine and Health Sciences to the results (Ministry of Health et al, 2002).

Key findings included:
• general agreement with HE–HA priorities and that the Ministry tried to consult widely and to listen to views
• inadequate communication/consultation with Maori led to decreased participation and potential buy-in to HE–HA
• the Ministry’s strategy development working group was seen by some to be insufficiently broad, and some input was sought late in the process
• HE–HA’s breadth could have implications for prioritising and funding of implementation strategies
• significant concerns about the workload that implementation will create, especially for Maori and Pacific workforces
• HE–HA could potentially reinforce the status quo or exacerbate existing inequalities
• concerns about the lack of evidence for many suggested interventions and the critical need for evaluation and monitoring.

**Mapping**

Five questions were posed to ascertain whether or how equity was considered by the Ministry of Health in developing HE–HA, and contributed to the overall case study objective. The main findings were:
• shortcomings identified in internal and external consultation processes reduced the equity of input and potential effectiveness of outcome of HE–HA, particularly for Maori
• many small changes were made to the content of the strategy as a result of consultation, and to increase participation and coverage in the consultation process
• the strategy has the potential to reduce inequalities, although many caveats were stated by key informants regarding its implementation (eg, need for robust evaluation and monitoring of interventions)
• factors enabling an equitable outcome included HE–HA’s broad focus on reducing inequalities and encouraging linkages and intersectoral collaboration, and the genuine attempt to consult with stakeholders
• the way in which HE–HA was developed did not entirely contribute to the aim of reducing health inequalities, as it did not fully engage groups most affected by the strategy or who had the means of assisting with developing it.
Recommendations

1. Review the current Ministry of Health Consultation Guidelines from an equity perspective (Ministry of Health, 2002)

2. Review the current implementation of the Ministry of Health Consultation Guidelines from an equity perspective (Ministry of Health, 2002)

3. Review the Ministry of Health policy development process (policy wheel) and incorporate an equity perspective at each step of the process.

4. The implementation group for the Healthy Eating – Healthy Action strategy consider the equity findings of the case study, and build on the strengths and address the weaknesses of the strategy development in the implementation phase.

Monitoring and Evaluation

1. The implementation group for the Healthy Eating – Healthy Action strategy consider the equity findings of the case study and review the implementation of the strategy from an equity perspective annually

2. The review of the current Ministry of Health consultation guidelines from an equity perspective is completed by June 2005

3. The review of the Ministry of Health policy development process to build in an equity perspective at each step is completed by June 2005

4. The review of the current implementation of the Ministry of Health consultation guidelines from an equity perspective is completed by December 2005.

Summary

Lessons learned by Ministry of Health staff pertaining to the equity and other shortcomings of the consultation process in developing the Healthy Eating – Healthy Action strategy are being taken into consideration in the implementation phase currently underway. These lessons — including the need to build in an equity perspective at each step of the consultation and policy development processes in order to more fully engage groups likely to be affected by policies or strategies — also can be applied to development of other policies within and outside of the health sector.

With regard to the application of the EFHIA tool to the case study, the main results were that the questions needed to be reframed for a rapid retrospective study such as this one, that a definition of equity that includes ethnicity and gender should be used and that questions of equity should be woven throughout the document. Suggestions have been made to ACHEIA at each point in the case study to help to refine and reframe the tool in relation to these three issues.

Retrospective application of the EFHIA tool in a policy context is useful because policy is a dynamic process and implementation can enable identified shortcomings to be addressed in future policy development.
Also, equity is about considering the needs of sub-populations, not just the total population. The same approach does not necessarily meet the needs of all population groups. This is what makes equity focussed health impact assessment different to any other health impact assessment. Without a tool to prompt equity considerations, health policy runs the risk of maintaining or even increasing health inequalities.

What has changed as a result of the EFHIA and why?

The significant results of this EFHIA related to the consultation process in the HE–HA strategy development; in particular, how to approach consultation in an effective way to make it an inclusive process that worked for all groups, not just a ‘formula’ approach. The EFHIA also showed the need to include equity at all steps of the policy development process. This includes consideration of the needs of sub-populations, not just the total population, at all steps.

The recommendations to review the Ministry of Health Consultation Guidelines to incorporate an equity perspective, and to review the Ministry of Health policy development process to build in an equity perspective at each stage of policy development, emanate from the case study findings. In the implementation stage of the Healthy Eating – Healthy Action strategy the case study findings will be put into practice.

In summary, the key thing to be changed is to make the policy consultation process more responsive to the needs of sub-populations, including addressing their capacity to respond, and to be innovative in the approach to consultation. Changing the formal documentation is an important step in achieving this, but actions at individual and policy/service level are important also.

Practical considerations when implementing EFHIA

In the health sector it should be automatic to consider both improving health and reducing inequalities in health in any policy development, but as this case study has shown, there may inadvertently be imperfections in the process that mean that this does not happen optimally. Considerations for future EFHIA include:

• it is worthwhile to do retrospective studies, as policy is a dynamic process and findings may apply to the implementation stage
• consider the wider application of any findings to policy development in general (a useful element in this case study)
• have equity at the centre of all policy development
• have equity at all steps of the policy development process, and also consider equity in the implementation phase
• consider EFHIA as ‘business as usual’ rather than a special event
• do not be overly ambitious about what you can do, or even what you need to do
• better to do ‘little and often’ rather than put effort and resources into one major equity project and ignore equity elsewhere
• allow time for the process. Even this ‘rapid’ EFHIA took 160 hours of the researchers’ time, and this excludes the management and oversight time.
The whole process took five months, but if it was done prospectively this would be concurrent with the policy development.

Concluding remarks

Participants in the New Zealand case study consider that this was a project well worth the time commitment involved. Equity Focused Health Impact Assessment is a useful tool to make sure that policy development promotes health and equity. Trialling the tool in the health sector was useful to refine the tool. The results of the case study will assist those within the Ministry to implement the Healthy Eating – Healthy Action strategy as well as future strategies developed by the Ministry.

When the results of the study come up with a systemic issue (like consultation), it is gratifying that this can be applied more widely to the consultation process. This begins to get equity into the fabric of the activities of the organisation.

The results have not yet been taken to the senior management of the NZ Ministry of Health, and are the opinions only of the working party that undertook the case study.
References


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Abstract

Purpose: This paper presents a case study of a policy level retrospective equity focused health impact assessment applied to the development of the Ministry of Health’s Healthy Eating – Healthy Action strategy.

Methods: The New Zealand Ministry of Health is part of the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). The collaboration developed a tool for undertaking health impact assessment with an equity focus. This tool was trialled in five case study sites, all within the health sector. The tool has six stages: screening; scoping; profiling; mapping; recommendations; monitoring.

The tool was applied retrospectively to the development of the Ministry of Health’s Healthy Eating – Healthy Action strategy. The objective of the EFHIA was to determine ‘whether the way the policy was developed had the potential to create, maintain or reduce health inequalities, with particular reference to Maori health?’ The method included collecting information on how useful the tool was, suggestions for improving the tool, and collecting information on the equity focus of the policy development itself. Documentary analysis and ten key informant interviews were used to gather this data.

Results: The results of the study were two-fold. The first was information to improve the equity focused health impact tool. The main result was that the questions needed to be reframed for a rapid retrospective study such as this one. The second was that the way the Healthy Eating – Healthy Action strategy was developed could have been improved at several stages to strengthen the equity focus in the final document. For example, consultation with Maori was not as robust as it could have been (in part due to lack of Ministry of Health networks with local providers), which led to decreased participation and buy-in to the strategy. This finding can be applied to the development of other policies, and also to the implementation of this strategy.

Conclusions: The case study process provided information to improve the Equity Focused Health Impact Assessment Tool produced by ACHEIA. Suggestions were made regarding ways in which the tool could be reframed to encompass a rapid retrospective study, to widen the definition of equity from socio-economic position to include variables such as gender and ethnicity, and to weave an equity perspective into each step of the EFHIA. The findings of the EFHIA will be used to strengthen the implementation stage of the Healthy Eating – Healthy Action strategy. The EFHIA also recommends that the Ministry of Health review its policy development process and consultation guidelines from an equity perspective. Equity Focused Health Impact Assessment is a useful tool to make sure that policy development promotes equity. EFHIA is likely to be effective in sectors outside of health to introduce both the health dimension and the equity dimension to any social policy development that addresses the wider determinants of health. Trialling it intersectorally in New Zealand is an obvious next step.
Aims, objectives & expected outcomes

Aim: to undertake a health inequalities impact assessment of the development of the New Zealand Healthy Eating – Healthy Action (HE–HA) strategy, using the Equity Focused Health Impact Assessment Tool (EFHIA).

Objectives: To assess whether the way the HE–HA strategy was developed had the potential to create, maintain or reduce health inequalities, with particular reference to Maori health.

NB: The original intention was to include both retrospective and concurrent components. Delays in the development of the ACHEIA tool precluded its application to the implementation of the Healthy Eating – Healthy Action strategy.

Expected outcomes:

1. Assessment of the applicability of the tool to the policy development process.
2. A refined EFHIA tool.
3. Information to strengthen the equity perspective in the implementation process of the HE–HA strategy.

Background to the case study

Healthy Eating – Healthy Action (HE–HA) is a strategy for action around nutrition, physical activity and obesity (Ministry of Health, 2003). It was launched on 6 March 2003, and is available on the New Zealand Ministry of Health (MoH) website (http://www.moh.govt.nz/). An implementation plan has since been developed. A companion document, Healthy Eating – Healthy Action: A Background was published concurrently and provides the scientific support and rationale for the directions proposed in the strategic framework (Ministry of Health, 2004). The background paper has five chapters covering Nutrition, Physical Activity, Obesity, Maori and Pacific Peoples. For each of these chapters, the issue and current situation and scope for health gain is identified, along with evidence for effective interventions and current and future work.

Briefly, HE–HA proposes high-level actions for the goals derived from the priority population health objectives of the New Zealand Health Strategy: to improve nutrition, increase physical activity and reduce obesity (Minister of Health, 2000). HE–HA uses the Treaty of Waitangi and reducing inequalities as fundamental components, and uses the Ottawa Charter framework as approaches for suggested key actions for the five key priorities [low socio-economic groups; children, young people and their families or whanau (including older people); environments; communication; and workforce] (World Health Organization et al, 1986). The framework is presented in Figure 1. The strategy deliberately does not attempt to prioritise these actions or develop these into programmes or projects. It also does not attempt to address food quality and safety issues specifically (the New Zealand Food Safety Authority has lead
responsibility for these issues), but recognises that food quality is an important component of food security.

HE-HA emphasises its broad scope 'with the focus on meeting the needs of all New Zealanders but with a special recognition of the particular needs of Maori and population groups at high risk, such as Pacific peoples'.

Figure 1

The Healthy Action – Healthy Eating Framework


Strategy development process
The Ministry of Health completed an initial project plan for the development of HE-HA and established a 14-member internal working group that included Maori and Pacific input. Terms of reference for the group were developed.
HE-HA was developed with broad sector support and key stakeholder input. Activities included:

- reviewing New Zealand policy development and existing national services and programmes purchased by the Ministry of Health
- preparing a descriptive epidemiological report and a study of estimated potentially avoidable deaths due to nutrition-related risk factors
- a literature review and a review of national strategies from other countries
- a series of focus groups held around New Zealand to seek input into the initial stage of the strategy development. Participants included Maori, Pacific peoples, researchers and academics, the public, primary and personal health providers, key interest groups, and food industry groups
- public consultation on the draft strategy, including international peer review
- analysing 162 written submissions and the results of the focus groups and publishing this analysis
- redrafting a final report, resulting in the strategy and a background paper
- external peer review of the redrafted background sections, including from Maori and Pacific peer reviewers
- launching the strategy in March 2003
- establishing a process for developing a more in-depth implementation plan.

Application of EFHIA Framework

**Screening**

Screening means undertaking a preliminary look at the policy to determine whether it warrants an EFHIA and, if so, at what level of depth. Ministry of Health officials agreed that reviewing the development of Healthy Eating - Healthy Action (HE-HA) strategy was suitable for an EFHIA. HE-HA identified numerous health impacts associated with a growing problem of obesity and the need to improve nutrition and increase physical activity in New Zealand. HE-HA's focus is on improving personal and population health and the approach taken is mindful of key determinants of health (income, poverty, employment and occupation, housing, culture, gender and ethnicity). The interventions suit a public health approach and link to other diseases such as cardiovascular disease and diabetes.

Health impacts were likely to be differentially distributed by socio-economic status and also by ethnicity. HE-HA notes that Maori and Pacific people are likely to have higher rates of obesity and less healthy diets and are more likely to suffer adverse health consequences.

An EFHIA working group of four was established consisting of two Ministry of Health officials, an academic and a contractor. The Working Group made the decision to do a rapid appraisal to reflect the retrospective nature of the review and the realities of the policymaking environment. The Working Group concluded that there were significant differential impacts in this policy arena that were unfair and avoidable therefore warranting an EFHIA.
The Working Group considered that the benefits of the development of the HE-HA strategy outweighed the costs or disadvantages of doing so. The estimated cost attributable to obesity alone was estimated at $247 million per annum. HE-HA has the potential to reduce health inequalities and the large costs they impose on New Zealand society and on groups most at risk. HE-HA emphasised the need for health providers to form strategic partnerships with key sectors that impact on the wider determinants of health in order to address poor health outcomes generated by social, economic and environmental factors outside the direct influence of the health sector.

The Working Group agreed that the objective to be examined throughout the case study would be ‘Did the way the policy was developed have the potential to create, maintain or reduce health inequalities, with particular reference to Maori health?’

**Scoping**

Scoping is setting the parameters of the EFHIA. The methods to obtain information for the rapid retrospective EFHIA assessment agreed to were to complete a brief review of existing data on Ministry of Health files and to undertake key informant interviews.

The Working Group then established a Steering Group comprising key players with expertise in the nutrition and physical activity sectors and in health impact assessment, including Maori and Pacific representatives (see appendix for membership). The Working Group established terms of reference for the EFHIA that were ratified by the Steering Group. The Steering Group met regularly to review progress and make suggestions to the Working Group. Working Group members were members of the Steering Group. It was difficult for the Steering Group members to attend the meetings. This may have been in part because the EFHIA was retrospective and therefore did not have the priority of ongoing policy development. However, there are clearly workforce capacity issues for the Maori and Pacific communities in New Zealand that may also have been reflected in this context. The issue of the capacity to be able to participate in EFHIAs of those groups who do not enjoy equity of health status needs to be considered and addressed. For example, funding may need to be made available to pay community representatives to attend meetings.

The definition of equity as formulated by Dahlgren & Whitehead (1991) in the EFHIA manual was discussed and confirmed by the Steering Group as the working definition for the NZ case study. It was noted and agreed that inequalities need to be avoidable and able to be remedied in order for action to be taken. Also, it was acknowledged that it is important to be mindful of who is involved in making the decisions about policies and strategies when seeking to reduce or eliminate inequities and inequalities, that is that people from those groups who do not enjoy equity of health must be key players.

The four values and other principles underpinning EFHIA as set out on pages 9-10 of Volume 1 of the ACHEIA-EFHIA manual were agreed to by the Steering Group as guiding the work of the NZ case study.

A project plan was produced that outlined timeframes, meeting schedules and responsibilities. The project began in mid-December 2003 and was scheduled for completion in April 2004. The screening and scoping steps were undertaken during December 2003 and January 2004. A contractor,
who was part of the Working Group, undertook the file review, carried out the key informant interviews and drafted reports, receiving guidance and support from both groups. Key informants suggested for interview were current and former Ministry of Health staff involved in the development of HE-HA, including Maori and Pacific staff members. It was agreed that key informants from outside of the Ministry who participated in strategy development would also be interviewed, including Maori and Pacific people and contractors and peer reviewers of the strategy. This was done in order to provide independent information to the EFHIA process.

Profiling
Profiling is the detailed analysis of a policy or practice (including identifying and collecting data and critically appraising literature and other evidence), to determine the potential impacts on health arising from the implementation of a policy and whether impacts are differentially distributed. Profiling took place from late January through March 2004. The Working Group developed the questionnaire that formed the basis of all interviews. Ten key informant interviews were undertaken by telephone or in person during February and March. The Ministry of Health files on HE-HA, including the 162 written submissions on the draft strategy, were analysed based on the key themes in the questionnaire and these findings were triangulated with those in the key informant interviews. An equity lens developed by the Ministry of Health and the Wellington School of Medicine and Health Sciences was applied to the results (Ministry of Health et al, 2002). The profiling report was completed in mid-April after meetings of the Working and Steering Groups.

Healthy Eating – Healthy Action combines three related but distinct areas into one high-level, broad-based national strategy aimed at improving nutrition, reducing obesity and encouraging physical activity, thereby addressing three of the priorities in the New Zealand Health Strategy. The HE-HA framework focuses on reducing inequalities, and is one of the first Ministry of Health strategies to begin to address equity issues. HE-HA is underpinned by the principles of the Treaty of Waitangi and applies Ottawa Charter approaches to interventions, including a concerted effort to increase intersectoral collaboration.

Ministry of Health and external key informants considered that HE-HA could potentially improve health status and reduce health disparities and duplication of services. Most key informants agreed with the integrated approach to nutrition, physical activity and obesity and with the five Ottawa Charter-based approaches to action. Informants expressed the view that the Ministry had tried to consult widely and to listen to views, although pointing out some shortfalls in the consultation process.

Potential shortcomings of HE-HA identified include its breadth, which could have implications for prioritising and funding strategies for implementation. Significant concerns were expressed about workforce development and the workload that implementation will create, especially for the small, already stretched Maori and Pacific workforces with little current scope or resources to train to specialise in nutrition-related interventions to address the skills shortage.
Despite a broad consultation process, communication with Maori was found wanting, mostly due to the Ministry’s lack of networks with local providers to publicise hui, leading to decreased participation and potential buy-in to the kaupapa (underlying rationale) and structure of HE-HA. Lessons learned from this experience could be shared Ministry-wide; e.g. by reviewing the Ministry’s consultation guidelines. Some academics and nutrition experts considered that HE-HA would have more credibility if they had been part of the Ministry’s strategy development working group. Input from the food industry and from people with disabilities, including within the Ministry’s internal working group, also came late in the process of strategy development.

A potential unintended consequence of the strategy is that it could reinforce the status quo or exacerbate existing inequalities by meeting the needs of those who already have the best health. Concerns about the lack of evidence for many of the suggested interventions and the critical need for evaluation and monitoring have equity ramifications. The Ministry has noted the need to develop robust indicators to measure progress, which will be especially important for groups considered to be at greater need or risk.

**Mapping**

Mapping is the appraisal of identified impacts in terms of the nature of the impact, differential aspects and equity issues. Mapping took place during April 2004. Five questions were posed to ascertain whether or how equity was considered by the Ministry of Health in developing HE-HA, and contributed to the overall case study objective (which appears last in italics).

1. **Was equity considered in strategy development? If so, how? If not, what gaps have emerged?**

   HE-HA was developed with a clear focus on equity in the planned breadth of consultation and in the strategy’s aims to reduce health inequalities and to focus on health determinants and on those most at risk. Some inequities emerged in the internal and external consultation processes, despite the Ministry’s attempts to take a broad focus and to involve representatives of risk groups.

2. **Was the consultation process addressed in an equitable fashion (e.g., who, how much, how long, when, where)? Were the ‘right’ populations asked to contribute to strategy development? If population(s) weren’t asked, why not?**

   The Ministry of Health sought input from a wide range of sources. However, deficiencies in the process identified in the profiling phase reduced the potential effectiveness and equity of input into the strategy and therefore ownership of HE-HA by at-risk groups and by others such as academics and the food industry. The process did not appear to have engaged some populations fully.

   The Ministry of Health’s internal working group included linkages with other internal and external groups. Attrition over the two-year development of HE-HA may have led to difficulties in the external consultation process. Participation from Ministry staff working in the disability and older people’s sectors was sought late and may have led to
insufficient inclusion of views and needs in the strategy, although some were included in the background document that accompanies HE-HA.

3 Were views of those consulted incorporated into the strategy? Did the strategy include or omit material on clearly articulated grounds?

Many small changes were made to the content of the strategy, most significantly to develop a separate background document to complement HE-HA. Changes were made to increase participation and coverage in the consultation process, such as extending timeframes to allow greater participation by Maori and to broaden the Ministry internal working group to include the disability and older people sectors. HE-HA appears to have clearly articulated why material was included or omitted.

4 Did the consultation process result in a strategy that has the potential to reduce inequalities?

Respondent interviews indicate that the strategy has the potential to reduce inequalities, although numerous caveats were stated regarding its implementation, such as the need for robust evaluation and monitoring of interventions.

5 Which aspects of the strategy development process enabled or hindered an equitable outcome?

Key informants agreed that the broad focus and genuine attempt to consult with stakeholders in a variety of ways and locations was seen as enabling an equitable outcome, as was the focus on reducing inequalities and encouraging linkages and intersectoral collaboration. Commitment of high-level managers in the Ministry was also seen as useful.

Shortcomings in the consultation process were seen to have limited an equitable outcome, particularly for Maori. The proposal to have a separate Maori strategy was raised during consultation and considered by the Ministry. Although not directly related to the consultation process, a significant issue raised during consultation was the potentially inequitable effects of workforce policies and strategies resulting from the implementation of HE-HA on the workload and training of Maori community health providers. HE-HA was amended to reflect these concerns.

Overall objective: Did the way the strategy was developed have the potential to create, maintain or reduce health inequalities, with particular reference to Maori health?

Most of the submissions made during strategy development and EFHIA key informants agreed with the priorities set out in HE-HA. Although the strategy is seen by key informants to have the potential to reduce health inequalities, we conclude that the process by which it was developed did not entirely contribute to this aim, as it did not fully engage groups most affected by the strategy or who had the means of assisting with developing it. Ministry staff are endeavouring to address the shortcomings of the consultation process in the implementation of HE-HA. Most key informants acknowledged the breadth of the consultation
process and felt there were opportunities to be heard. The process of managing a broad-based strategy encompassing three distinct strategies is a challenging task that was generally well managed.

**Recommendations**

Recommendations are the written options or selection of scenarios that developed out of the consultation phase and the refinement processes undertaken during the mapping phase. The recommendations phase took place during May 2004.

The Working Group agreed to the following recommendations for the retrospective case study of the *Healthy Eating – Healthy Action* strategy:

1. Review the current Ministry of Health *Consultation Guidelines* from an equity perspective (Ministry of Health 2002a).
2. Review the current implementation of the Ministry of Health *Consultation Guidelines* from an equity perspective.
3. Review the Ministry of Health policy development process (policy wheel) and incorporate an equity perspective at each step of the process.
4. The implementation group for the *Healthy Eating – Healthy Action* strategy consider the equity findings of the case study, and build on the strengths and address the weaknesses of the strategy development in the implementation phase.

**Monitoring and Evaluation**

Monitoring and evaluation entails identifying strategies for monitoring the update and impact of EFHIA recommendations and systems for evaluating outcomes and EFHIA. This phase was done during May 2004 and is outlined below.

1. The implementation group for the *Healthy Eating – Healthy Action* strategy consider the equity findings of the case study and review the implementation of the strategy from an equity perspective annually.
2. The review of the current Ministry of Health consultation guidelines from an equity perspective is completed by June 2005.
3. The review of the Ministry of Health policy development process to build in an equity perspective at each step take place is completed by June 2005.
4. The review of the current implementation of the Ministry of Health consultation guidelines from an equity perspective is completed by December 2005.
Lessons learned from implementing the EFHIA

Lessons learned by Ministry of Health staff pertaining to the equity and other shortcomings of the consultation process in developing the Healthy Eating – Healthy Action strategy are being taken into consideration in the implementation phase currently underway. These lessons — including the need to build in an equity perspective at each step of the consultation and policy development processes in order to more fully engage groups likely to be affected by policies or strategies — can also be applied to development of other policies.

With regard to the application of the EFHIA tool to the case study, the main results were that the questions needed to be reframed for a rapid retrospective study such as this one, that a definition of equity that includes gender and ethnicity should be used and that questions of equity should be woven throughout the document. Suggestions have been made to ACHEIA at each point in the case study to help to refine and reframe the tool in relation to these three issues.

Retrospective application of the EFHIA tool in a policy context is useful because policy is a dynamic process and implementation can modify shortcomings in development.

Also, equity is about considering the needs of sub-populations, not just the total population. The same approach does not necessarily meet the needs of all population groups. This is what makes equity focussed health impact assessment different to any other health impact assessment.

Without a tool to prompt equity considerations, health policy making runs the risk of maintaining or even increasing health inequalities.

Likely changes if the results of the EFHIA were implemented

The significant results of this EFHIA related to the consultation process in the HE–HA strategy development; in particular, how to approach consultation in an effective way to make it an inclusive process that worked for all groups, not just a ‘formula’ approach. The EFHIA also showed the need to include equity at all steps of the policy development process. This includes consideration of the needs of sub-populations, not just the total population, at all steps.

Health policy is, by its very nature, concerned with improving health, but only more recently has the equity dimension been considered. The Ministry of Health in New Zealand began using equity tools two years ago, but this HE–HA strategy was begun some three years ago. EFHIA is another tool to bring equity to the fore.

At an individual level, the things expected to change would include:

• consideration of equity in all policy development and at all stages of policy development
• when planning consultation, consider the most effective way of communicating with sub-populations, not just using one approach for
everyone. This would be helped by implementing the recommendations around consultation.

- consider the demands placed on the groups most at need, and consider using existing networks and processes to undertake the consultation required.

At a policy / service level, the things that would change are:

- policies would all have an overt equity dimension incorporated throughout the policy, not just as an added section
- as the policy is implemented and service delivery commences, equity considerations continue, and the need for consultation and reaching sub-populations as part of the total population also would continue
- consideration would be given to using existing networks to get the information necessary
- consideration would be given to the demands on the workforce of both consultation and policy implementation in an equitable way, and include workforce considerations in the implementation plan.

At management / institutional level, the New Zealand Ministry of Health has improving health and reducing inequalities in health as two of the four societal outcomes for the organisation. The two tools already in use to promote equity are the Reducing inequalities Intervention Framework, and the Health Equity Assessment Tool (Ministry of Health, 2002b; Ministry of Health et al, 2002). The things that would be expected to change as a result of using this EFHIA tool are:

- equity to be included at all steps of the 'policy wheel', a guide to developing policy in the Ministry, particularly in relation to consultation
- the consultation process would be reviewed and modified as a result of this study for routine use in all consultation in the Ministry
- consideration is given to establishing networks for consultation for groups who are frequently consulted and under-resourced for this.

In summary, the key thing to be changed is to make the consultation process more responsive to the needs of sub-populations, including their capacity to respond, and to be innovative in the approach to consultation. Changing the formal documentation is an important step in achieving this, but actions at individual and policy/service level are important also.

**Practical considerations when implementing EFHIA**

In the health sector it should be automatic to consider both improving health and reducing inequalities in health in any policy development, but as this case study has shown, there may inadvertently be imperfections in the process that mean that this does not happen optimally. Considerations for future EFHIA include:

- it is worthwhile to do retrospective policy studies, as policy is a dynamic process and findings may apply to the implementation stage
- consider the wider application of any findings to policy development in general (a useful element in this case study)
- have equity at the centre of all policy development
• have equity at all steps of the policy development process, and also consider equity in the implementation phase
• consider EFHIA as 'business as usual' rather than a special event
• do not be overly ambitious about what you can do, or even what you need to do
• better to do 'little and often' rather than put effort and resources into one major equity project and ignore equity elsewhere
• allow time for the process. Even this 'rapid' EFHIA took 160 hours of the researchers' time, and this excludes the management and oversight time. The whole process took five months, but if it was done prospectively this would be concurrent with the policy development.

Wider application of the EFHIA

EFHIA could be applied more widely to:

• The whole policy development part of the Ministry.
• The service funding parts of the health system, including the service funding parts of the Ministry.
• The service delivery part of the health sector.
• Indeed, it is hard to imagine any part of the health sector that would not benefit from considering equity in its work.

It should be noted that there are already equity tools available for use in the New Zealand health sector, but they are not yet universally applied.

Other comments

• the tool presupposes a policy critique, whereas the NZ case study was more interested in the "process" of the development of the HE–HA strategy rather than its content.
• the manuals were long, repetitive and often difficult to follow. We found some internal inconsistency in the wording of the questions.
• the proformas were very comprehensive. We chose instead to write separate reports at each stage of the process on the application of the tool to the case study and also to provide feedback on the usefulness of the tool itself.
• in terms of the definition of equity we discuss socioeconomic, ethnic, gender and geographical inequalities. We do not limit inequalities to SEP as this does not describe them adequately and leads to socioeconomic solutions rather than ethnic, gender or geographical ones which may also be valid or more appropriate. Too much emphasis is placed on SEP as an equity consideration throughout the tool and manual. We amended certain questions, especially in the profiling and mapping phases, to encompass gender, ethnicity, and geographic measures as well as socio-economic position within our definition of equity.
- equity questions need to be woven throughout the EFHIA tool; that is, questions about the fairness of the policy or programme need to be asked at each stage. At times health was considered without the dual consideration of equity.

- the Working Group chose to map the information gathered during profiling by writing a narrative rather than using a grid, as the process of assigning quantitative scores to a qualitative process did not prove to be the most appropriate means of analysing the data.

- the final version of the EFHIA manual needs to include a new step to reflect on monitoring and evaluating the way in which the recommendations are taken up.

- the goals listed on page 40 of the Monitoring and Evaluation phase are the right goals, but the action steps relate to the critique of the tool rather than the critique of the HIA.

Other comments:
- even a rapid assessment takes time (this case study was carried out over five months)

- there are clearly workforce capacity issues for the Maori and Pacific communities in New Zealand that may also have been reflected in the context of participation in Steering Group meetings. The issue of the capacity of those groups who do not enjoy equity of health status to be able to participate in EFHIAs needs to be considered and addressed. For example, funding may need to be made available to pay community representatives to attend meetings.

- Health Impact Assessment is usually applied outside of the health sector, considering the wider determinants of health and the agencies that can influence these wider determinants. In those cases, it is often the content as well as the process of policy development that can usefully be studied.

Concluding remarks

Participants in the New Zealand case study consider that this was a project well worth the time commitment involved. Equity Focused Health Impact Assessment is a useful tool to make sure that policy development promotes equity. Trialling the tool in the health sector was useful to refine the tool. The results of the case study will assist those within the Ministry to implement the Healthy Eating – Healthy Action strategy as well as future strategies developed by the Ministry.

When the results of the study come up with a systemic issue (like consultation), it is gratifying that this can be applied more widely to the consultation process. This begins to get equity into the fabric of the activities of the organisation.

The results have not yet been taken to the senior management of the New Zealand Ministry of Health, and are only the opinions of the working party that undertook the case study.
References


Appendix 1 Membership of Groups

NZ Case Study Working Group
Dr Ruth Richards  Public Health Directorate, Ministry of Health (Case Study Principal)
Dr Louise Signal  Wellington School of Medicine and Health Sciences (Supervisor for contractor)
Nancy Fithian  Contractor
Maraea Craft  Analyst

NZ Case Study External Steering Group
Dr Ruth Richards  Public Health Directorate, Ministry of Health
Dr Louise Signal  Wellington School of Medicine and Health Sciences
Nancy Fithian  Case Study Worker (Contractor)
Maraea Craft  Analyst
Louise Thornley  National Health Committee
Teresa Wall  Te Kete Hauora, Ministry of Health
Debbie Ryan  Chief Advisor, Pacific, Ministry of Health
Megan Grant  Public Health Directorate, Ministry of Health (HE: HA)
Diana O'Neill  Sport and Recreation New Zealand (HE: HA)
Appendix 2  Terms of Reference for Equity Focused Health Impact Assessment External Steering Committee

**Group Name**
Equity Focused Health Impact Assessment External Steering Committee (EFHIAESC)

**Purpose of the group:**
To oversee the Equity Focused Health Impact Assessment (EFHIA) of Healthy Eating – Healthy Action (HE-HA) case study.

**Background:**
The Ministry of Health, led by the Public Health Policy Group, Public Health Directorate, are currently working on a collaborative project with Australia for Health Equity Impact Assessment. The project is called the Australian Collaboration for Health Equity Impact Assessment (ACHEIA). The project runs from September 2002 to August 2004.

There are three phases within the EFHIA project. Phase 1 comprised the development of a draft Equity Focused Health Impact Assessment framework. Phase 2 encompasses the testing of the Framework across five case studies at local, state and national levels in New Zealand and Australia. Phase 3 comprises refinement of the EFHIA tool and promoting the implementation of Equity Focused Health Impact Assessment.

The focus of the case studies is on applying the EFHIA tool to the health policies and practices aimed at the health of population groups. The five case studies, one in New Zealand and four in Australia, have been selected to illustrate a variety of health policy and practice issues, and a range of methodological approaches.

The case study will provide feedback to ACHEIA on the application of the draft Equity Focused Health Impact Assessment framework.

The New Zealand Case study will involve assessing the equity impact of the development of the Healthy Eating – Healthy Action strategy. It is a retrospective application of the EFHIA tool.

*Healthy Eating – Healthy Action (HE–HA)* is a strategy for action around nutrition, physical activity and obesity. It was launched on 6 March 2003. An implementation plan is being developed currently. A companion document, *Healthy Eating – Healthy Action: A Background* was published concurrently and provides the strategic framework.

**Tasks:**
The tasks of the EFHIAESC are to:

- consider and provide comment on the process of applying the EFHIA Tool to HE–HA
- consider and provide comment on reports prepared by the Working Group
• provide direction for each step of EFHIA
• formulate final recommendations
• provide comment on the Tool
• evaluate the role of the external steering group in EFHIA
• read background material as presented
• attend meetings as required

Composition of the Committee
The Steering Group comprises representatives from the following groups;
• Public Health Directorate, Ministry of Health
• Wellington School of Medicine and Health Sciences
• Case Study Worker
• National Health Committee
• Te Kete Hauora, Ministry of Health
• Chief Advisor, Pacific, Ministry of Health
• Sport and Recreation New Zealand

Term
The term of membership extends from 23 January to 2 April 2004.

Chair
The chair of the EFHIA External Steering Committee is Dr Ruth Richards, Senior Advisor, Public Health Policy, Ministry of Health.

Meeting frequency
The EFHIA External Steering Committee will meet once a month between January 2004 and April 2004, with the possibility of a further one or two meetings during this period. There may be some requirement to comment on draft documents between meetings.
5 February 2004

Dear Colleague

I am the principal in a New Zealand case study to undertake a retrospective health impact assessment of the development of the Healthy Eating – Healthy Action strategy. This case study is one of five studies underway through the auspices of the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA), administered through the University of Newcastle, New South Wales.

ACHEIA is involved in an Equity Focused Health Impact Assessment (EFHIA) project to develop and test a framework to aid decision makers to conduct 'equity audits' of proposed or existing policies, programmes and services. The New Zealand case study focuses on policy development; i.e., a review of the Healthy Eating – Healthy Action strategy as it is written from a health inequalities perspective, with particular reference to Maori health.

One of the methods of the case study is key informant interviews within and outside of the Ministry of Health to discuss the process by which Healthy Eating – Healthy Action was developed, from a health inequalities and equity perspective. You have been nominated as a key person to speak with.

The Ministry has contracted Nancy Fithian to work with us on this project. Nancy will ring you in the next few days in order to confirm your availability and to arrange a time for an interview. The interview should take no more than an hour. The answers you give will be kept confidential to the project Steering Group established by the Ministry of Health, which I chair. Further, you will not be personally identified in the research report.

If you have any questions or comments please contact me.

Yours sincerely

Dr Ruth Richards
Case Study Principal
Senior Advisor, Public Health Medicine
Appendix 4: Questionnaire for key respondents’ interviews

New Zealand Ministry of Health Case Study: An equity analysis of the development of the Healthy Eating – Healthy Action Strategy

Thank you for agreeing to this interview. I would like to ask you some questions about the development of the Healthy Eating – Healthy Action strategy, from the perspective of reducing health inequalities. The answers you give will be kept confidential to the project Steering Group convened by the Ministry of Health. Further, you will not be personally identified in the research report. It may be that some of these questions do not seem relevant to your work or your involvement in the development of the Healthy Eating – Healthy Action strategy. It is fine for you to decline to answer any specific question.

1. Could you please describe your role or involvement in the development of the Healthy Eating – Healthy Action strategy?

2. What is your understanding of how and why the strategy was developed?

3. What are the potential positive impacts on health, arising from the implementation of this strategy in general and on different groups in the population?

4. What are the potential negative impacts on health arising from the implementation of this strategy in general and on different groups in the population?

5. Are these health impacts likely to be differentially distributed by socio-economic status, gender, ethnicity and geography? If so, in what ways?

6. What was your understanding of the populations that by the strategy will impact upon? What will the nature of the impact on their health be (good or bad, positive or negative)?

7. How do you know this is likely to happen (do you have any evidence?)

8. What might be the unintended consequences of the way the strategy was developed, in particular in relation to inequalities?

9. Could you please tell me which groups were asked to participate in the development of HE–HA? Why? Why not? Prompts; Māori, Pacific, low SES, what geographical regions?

10. Could you please tell which groups actually participated in the development of HE–HA? Why? Prompts; Māori, Pacific, low SES, what geographical regions?

11. In what way did they participate? Prompt: Attended focus group, public meeting, wrote submission, on working/steering group, other (specify)
12. Who did not participate? Why not?

13. Were the views of those who participated heard?

14. Were there changes to the draft document that you can identify as the result of this participation? What were they?

15. Were there other changes e.g. to process, participation etc?

16. [If subject identifies people who were not heard] Thinking about those people who were not heard, could you comment on why they were not heard?

17. Could you reflect on the development process of HE–HA as a whole and comment on what aspects of the process ENABLED an equitable outcome?

   Prompts: timeframe, people leading the process, where consultations were held, other (specify)

18. Could you reflect on the development process of HE–HA as a whole and comment on what aspects of the process LIMITED an equitable outcome

   Prompts: timeframe, people leading the process, where consultations were held, other (specify)

19. Do you have any other comments in relation to equity issues in the development of the HE–HA strategy?

That is all the questions I have for you today. Thank you for your time.