Tools for Health Equity Audits (HEA): The Experience of Lambeth, London, UK

Online Workshop
29th November 2012
Presented by Marie Noelle Vieu, MD, NHS Lambeth
Organised by Health Equity Initiative

Seminar aim & objectives

Aim: Advocating for equity in health & health care

Objectives:

1. To assess how useful is HEA in promoting health equity
2. To assess how transferable is Lambeth HEA experience
Learning objectives

Participants in this workshop will be able to:

- Define key concepts
- Understand HEA
- Understand drivers of HEA
- Discuss the use of HEA in promoting health equity
- Discuss levers and constraints to conduct HEA
- Access resources and relevant websites

Outlines

1. Context and drivers
2. Concepts
3. What is Health Equity Audit?
4. How to do HEA?
5. Achievements and challenges
6. Is HEA transferable to other contexts?
7. Resources
1. Background & Drivers - Lambeth

- Over 300,000 residents
- Multi ethnic
- Among most deprived areas
- Most deprived live 6 years less than the better off
- 3 in 10 children in poverty
- Resources: GPs with equity interest, Public health, Data & Datanet

1. Background & Drivers – England

- 1997: Labour government
- 2002: Government spending review emphasises reduction of health inequalities in health, education and housing
- 2003: Reducing health inequalities is a national target.
- 2003: HEA is requirement for public services & is set out in NHS planning & priorities framework for 2003-2006
- 2003: Government publication “Tackling health inequalities - A program for action”
- NHS Planning Guidance 2005-2008:
  “PCTs...taking account of different needs and inequalities within the local population ..., on the basis of a systematic programme of health equity audit and equality impact assessment.....using health equity audit”
- Since 2000, NICE reviews of evidence on Health inequalities & interventions
- HEA a core standard for PCT Public Health in 2009/10
Exercise 1

- What is the current profile of HEA in your organisation? In your country?
- How do you know in your society/country how services (health, education, housing, transport…) respond to population needs for health and well being?

2. Concepts – Health Equity

- Health Equity: “Fair” opportunity for all to achieve full health potential
- Refers to presence/absence of systematic disparities of health/wider determinants. Absence= Equity
- Health inequity = differences in health that are unnecessary, avoidable, unfair and unjust.
- Fair distribution of health care resources/ opportunities according to needs
Exercise 2

In a town by the sea, there are mainly two areas:

◦ One of raised buildings (area A)
◦ Another one of spread individual houses (area B)

Which of the 2 situations below could be classified as “equitable“:

1. Refuse collection happens in both areas every two days
2. Refuse collection happens every 2 days in area A and once a week in area B
2. Concepts - Needs for health care

- Need exists when there is an effective and acceptable intervention, or the potential for health gain.

- Population needs: the population’s ability to benefit from health care

3. What is HEA

- A process

- A framework for systematic partnership actions

- A tool to ensure resources are allocated to address health inequalities by influencing investment, planning, commissioning & service provision
3. What is HEA

At its core, Health Equity Audit compares the provision of a service with a measure of the need for it.

In this simplified example, high need is matched by high service provision: the desirable situation.

In this simplified example, those with most need get the lowest level of service: the undesirable “inverse care law”.

Examples of Inequity

Breast screening uptake by SOAS ranked based on IMD.

Smoking quit rate by ward ranked based on IMD.
4. How to do HEA - Tools

1. Agree partners & Issues:
   Stakeholder meeting

2. Equity profile - Identify gap
   - Prevalence data & modelling
   - Individual level primary care data
   - Population profile
   - Statistical analysis

3. Agree high impact local actions to reduce the gap Identify actions:
   - Community engagement
   - Focus groups
   - Literature review

4. Agree priority for actions
   - Literature review
   - Modelling cost & added value, EEIA

5. Secure changes in investment & service delivery:
   - Equity target
   - Operational plan
   - Service Specification

6. Review progress & assess impact:
   - Monitoring
   - Repeat equity profile

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4. How to do HEA – Step 2:

1. What service?

2. Fairness of what?
   - provision
   - access
   - uptake
   - Outcome

3. What measure of need?

4. Which dimensions of equity?
   - gender, age, ethnicity, social class, area of residence etc.
### 4. Step 2- Equity profile of Hypertension management

1. Primary care management of hypertension
2. Fairness of detection, and control
3. Needs: Expected number of patients with hypertension
4. Equity dimensions: Age, gender, ethnicity, deprivation

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### 4. Step 2 - Framework

**Example – Hypertension**

<table>
<thead>
<tr>
<th>Fairness issue</th>
<th>Dimensions</th>
<th>Disparity analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detected</td>
<td>Family &amp; Socio-economic environment</td>
<td>Inequalities?</td>
</tr>
<tr>
<td>Treated</td>
<td>Individual characteristics</td>
<td>Down</td>
</tr>
<tr>
<td>Controlled hypertension</td>
<td>Services characteristics</td>
<td>Inequities?</td>
</tr>
</tbody>
</table>

HEI Health Equity Initiative
4. Equity profile – Inequality
Hypertension detection by gender

1. Hypertension prevalence in the population

23% registered men

19% registered women

4. Equity profile - Inequality
Hypertension detection by gender

2. Hypertension detection

6% registered men detected

10% registered women detected
Exercise 3

- Choose a service to look at how fair it is
- Identify which aspect of fairness you wish/have looked at:
  - Provision
  - Access
  - Uptake
  - Effectiveness or benefit
- About needs:
  - Who needs the service?
  - Is the need the same for everybody in the community?
  - How do/did you measure need for the service?
- Which dimensions of equity do/did you consider?
  - Gender, age, ethnicity, social class, area of residence etc.

5. Equity profile - From inequality to inequity

- Gender, age, ethnic differences in detection of hypertension
- Unavoidable difference
- Avoidable & unjustifiable difference
- Biological
- Environmental & Socioeconomic Factors
- Knowledge
- Access
- Health services
- Individual Factors
- Cultural
4. How to do HEA - Identify local actions

- Understanding why inequities occurred
- What local interventions might help?
- Are there examples of effective action elsewhere?
- Prioritise highest impact interventions
- What is feasible and affordable?

Exercise 4

The equity profile of hypertension shows that men are much less likely to be detected:

1. How can I find why?
2. How can I find what to do to improve?
3. Can you give some example of interventions to improve gender equity
1. High premature mortality caused by CVD & cancer
Smoking a modifiable factor

2. Equity profile
4 in 10 adults smoke
More men than women smoke.
But
More women than men smokers use SSS
Black smokers less likely to quit smoking than white smokers
As deprivation increases, quit rate decreases

4. Tobacco control strategy
Equity targets for SSS
Specific resources
Social marketing
Free NRT
Community groups in deprived wards

3. Literature review & modelling
NHS SSS alone will not reduce smoking burden
Services & resources to be tailored to needs in disadvantaged areas
Tobacco control strategy to integrate prevention, sale control & SSS

5. Equity profile repeated 2 years later

Stop Smoking Services
Completed HEA cycle

4. How to do HEA

Access to Stop Smoking Services
Comparing equity profiles

<table>
<thead>
<tr>
<th>% point difference between women and men</th>
<th>2000-05</th>
<th>2005-07</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.90%</td>
<td>1.40%</td>
<td>-1.50%</td>
</tr>
<tr>
<td>% point difference between white and black smokers</td>
<td>1.60%</td>
<td>0.30%</td>
<td>-1.30%</td>
</tr>
<tr>
<td>% point difference between worst and best IMD quintile</td>
<td>-2.10%</td>
<td>-0.70%</td>
<td>-1.40%</td>
</tr>
<tr>
<td>% of variation in access explained by deprivation</td>
<td>40%</td>
<td>34%</td>
<td>-6%</td>
</tr>
</tbody>
</table>
Outcome of Stop Smoking Services
Comparing equity profiles

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Jan.00-Jan 05</th>
<th>April05-Sept.07</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>% users lost to follow up</td>
<td>47.0%</td>
<td>50.4%</td>
<td>+3.4%</td>
</tr>
<tr>
<td>Quit at 4 weeks(n)</td>
<td>1057</td>
<td>4,235</td>
<td>+3,178</td>
</tr>
<tr>
<td>Quit rate</td>
<td>32.7%</td>
<td>42%</td>
<td>+9.3%</td>
</tr>
<tr>
<td>% point difference Women to men</td>
<td>-2.6%</td>
<td>-0.8</td>
<td>-1.8%</td>
</tr>
<tr>
<td>% point difference white to black smokers</td>
<td>+9.8% (significant)</td>
<td>+5.5%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>% point difference 45y + to 16-44y olds</td>
<td>5.3% (significant)</td>
<td>+8.4%</td>
<td>+3.1%</td>
</tr>
<tr>
<td>% point difference less to most deprived</td>
<td>+11.4% (significant)</td>
<td>+4.1%</td>
<td>-7.3%</td>
</tr>
</tbody>
</table>

5. Achievements

- Reduced inequity of access & some of outcome inequity
- Brought equity from concept to reality
- Influenced planning & commissioning of services:
  - Helped to interpret performance
  - Provided an equity baseline
  - Supported EEIA
  - Provided equity standards
- Identified local best practices to address inequities
- Provided a Process to strengthen partnership
6. Challenges

- Narrowing health inequalities
- User friendly and timely process

Methodological issues:
- Measure of needs at local level
- Data issues
- Systematic measure of “avoidable” inequality

- Pressure of performance targets
- Community and stakeholders engagement
- Population mobility

8. Is HEA transferable?

- Is HEA replicable / adaptable?
- Is HEA cost effective?
- Is there a need for more equity?
- Is there a demand?
- Are there users?
- Are there drivers (political support)?
- Is there access to method & resources?
END

Thank you for participating

The space is yours

Happy to take questions, comments or suggestions

Sources of information on Health Equity Audit

HEA Learning from Practice briefing (NICE, 2006)
http://www.nice.org.uk/page.aspx?o=530514

Making the case: HEA (HDA, 2005)
http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/making_the_case_health_equity_audit.jsp

HEA: A guide for the NHS (DoH, 2003)

HEA: A self assessment tool (DoH, 2004)

HEA made simple - A briefing for Primary Care Trusts and Local Strategic Partnerships (2003) HDA/APHO

EMPHO
http://www.empho.org.uk/Themes/hex/heax.aspx

Hussey R. Johnstone F. Equity audit – A tool for monitoring regeneration

http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/ap01.asp

Braveman P. Gruskin S. Defining equity in health, J Epidemiol Community Health 2003;57:254–258
Sources of information on Health Equity Audit

Understanding the barriers to completing health equity audit in PCTs- Findings from a qualitative study. 2005 , NHS HAD
http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdpublications/understanding_the_barriers_to_completing_health_equity_audit_in_pcts.jsp

http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdpublications/health_equity_audit_a_baseline_survey_of_primary_care.jsp

The role of NICE in the development of health impact assessment, health needs assessment and health equity audit. 2006

http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdpublications/health_impact_assessment_health_equity_audit_health_needs_assessment_new_publications.jsp

About HEAs and equity profiles conducted in Lambeth :
http://www.selondon.nhs.uk/your_local_nhs/lambeth/your_health/joint_strategic_needs_assessment