Health Equity Audit - 20 (HEA-20): A methodical tool for tackling health inequality

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Introduction

Improving health and reducing health inequalities should be the primary focus of any public health oriented organisation. They are part of the same coin. This article focuses on health inequality (or equity in health and healthcare); what it is, its relevance to the Sudan, and a tool (HEA-20) developed by a team of public health specialists in Doncaster (UK) to help practitioners to address health inequality.

1. Equity in health and healthcare: definitions and principles

Equity in health

A report of WHO meeting on social justice and equity in health, held in Leeds (United Kingdom) in 1985, defined equity in health as [1]: *Equity in health implies that ideally, everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided.*

The term equity had been considered to have a moral and ethical dimension and was considered linked to fairness and justice. Equity referred to differences that were unnecessary and avoidable but, in addition, such differences were also considered unfair and unjust.2 Equity was not referring to differences arising from natural or biological variation such age, sex, or ethnicity (Table 1).

Table 1: Which health differences are inequitable?

Determinant of health differentials	Potentially avoidable	Commonly viewed as unacceptable
Natural, biological variation.	No	No
Health-damaging behaviour if freely chosen.	Yes	No
Transient health advantage of groups who take up health-promoting behaviour first (if other groups can easily catch up).	Yes	No
Health-damaging behaviour where choice of lifestyle is restricted by socio-economic factors.	Yes	Yes
Exposure to excessive health hazards in physical and social environment.	Yes	Yes
Restricted access to essential health care.	Yes	Yes
Health-related downward social mobility (sick people move down social scale).	Low income – Yes	Low income – Yes

Source: Dahlgren and Whitehead (1992) adapted from Whitehead (1990).

Equity in health care

While equity in healthcare, on the other hand, has been defined as [2]: *Equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all.*

2. Relevance to the Sudan

Equity in health and healthcare is equally relevant for health policy makers in the Sudan. Figures available for South Sudan and North Sudan have been used to illustrate the levels of health inequalities. Such levels of inequalities may also exist in other parts of the Sudan e.g. Darfur, Eastern Sudan, Blue Nile, etc.

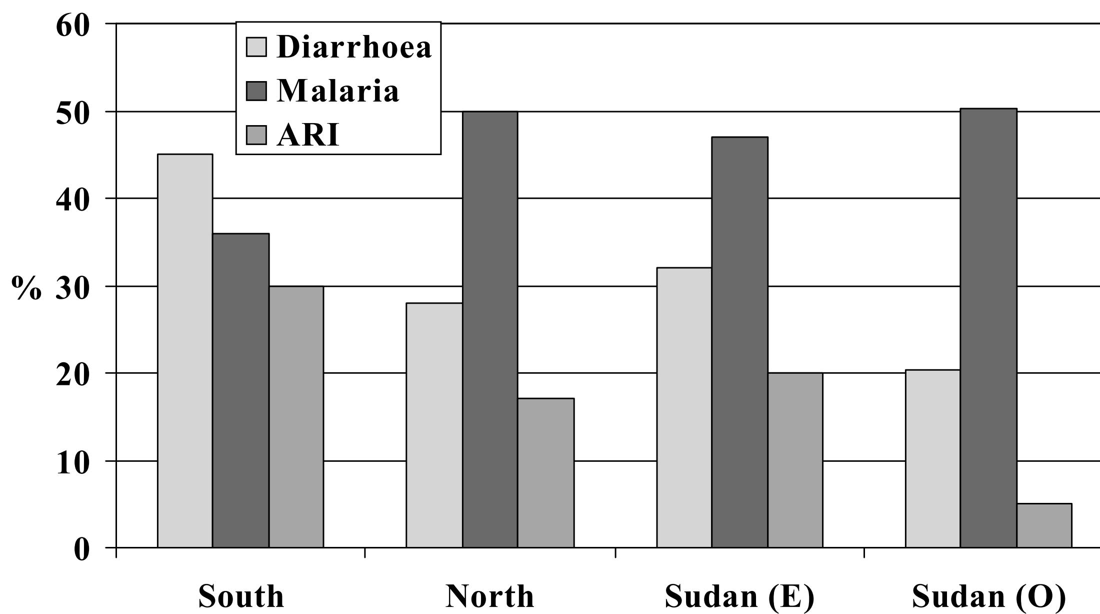
It is generally unacceptable, when citizens of the same country, or part of a country, or state experience worse health outcomes than the average for that area. Taking South Sudan as an example, evidence shows that a person born in South Sudan can expect to die at the age 42; ten years younger than their counterpart who is born in North Sudan. Other health and healthcare indicators paints a similar picture of health inequality (Table 2 and Figure 1).

Table 2: Mortality in South Sudan compared to North Sudan and the Sudan

	South	North	Sudan (Estimate)	Sudan (Official)
IMR indirect method (2000)	150	82	100	64
U5MR (Indirect)	250	130	164	94
Life expectancy (years) at birth (2001)	42	53	50.6	55
Maternal mortality ratio, 2000	1700	590	873	590
Lifetime Risk of dying in pregnancy/childbirth	11.4%	3.1%	5.0%	2.7%
Immunisation uptake (%): TB for one year olds	21	65	53	51
Access to improve water source (%)	27	60	53	75

Source: NSCSE in association with UNICEF, 2004

Figure 1: Prevalence of childhood illness (%) among under 5-year old, 2000: diarrhoea, malaria and acute respiratory illness.



Source: NSCSE in association with UNICEF, 2004

The key challenges

Emerging from a long civil war, the Sudan, especially the most deprived part of the country needs to assess its priorities. Such priorities, in order to improve the health of the population need to include the following main health determinants:

- Provision of safe water and sanitation
- Improving education
- Employment
- Decent Housing
- Access to Healthcare
- Good food
- Improving transport

Resources will always be finite. Therefore, investing in the right priorities is more likely to yield long-term health benefit in improved health. Evidence shows that there is an association between government total expenditure on health (excluding private cost of treatments by the population) and health outcomes (infant mortality rate) (Figure 2).

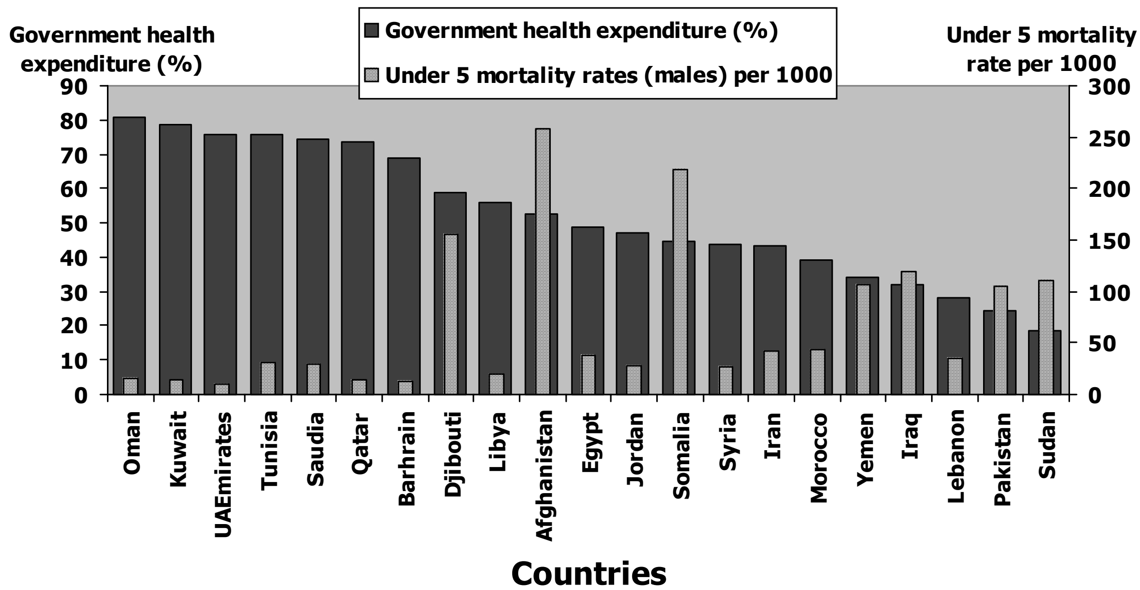
In order to help equitable resource allocation to target appropriate health priorities, a health equity audit tool (HEA-20) has been developed to decision makers.

3. HEA-20

Health Equity Audit (HEA) is a process by which local partners identify how fairly services or resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The purpose of HEA is to help services narrow health inequalities [(3)].

In England, the requirement for Primary Care Trusts (part of the National Health Service) to use Health Equity Audit to inform service planning and delivery was set out by the Department of Health in policy document, the Priorities and Planning Framework 2003–2006 [(4)].

Figure 2: Government health expenditure on health as % of total expenditure on health, 2001; and under 5 mortality rate per 1000, 2002



Source: World Health Organisation, 2004

HEA-20 is a highly developed version of HEA tool with a set of 20 questions. It builds on the Department of Health HEA cycle [1] consisting of six steps:

1. Agree partners and issues.
2. Equity profile: identify the gap.
3. Agree high impact local action to narrow the gap.
4. Agree priorities for action.
5. Secure changes in investment and local delivery.
6. Review progress and assess impact.

The Directorate of Public Health, Doncaster Primary Care Trust (PCT), developed the HEA-20. The 20 questions in the HEA-20 tool are categorised into four main groups:

- Questions 1 to 6:
  General Scope and Stakeholders
- Questions 7 to 9:
  Defining the Issues
- Questions 10 to 15:
  Evidence Based Solutions
- Questions 16 to 20:
  Implementation and Evaluation

The questions are contained in a 2-page excel sheet, and shown here in figure 1.

Figure 1: Health Equity Audit Tool – HEA20 (Doncaster PCT, 2006).

HEA20

Health Equity Audit Tool

Programme: Enter title of programme being evaluated here

Lead Officer: Enter contact name here **E-mail or tel:** Enter contact details for lead officer here

General Scope and Stakeholders

1. Was the overall scope of the work identified?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include health needs assessment, population data, service data, research, service evaluation.

2. Was the issue a priority?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include national priority, local trends, national trends, local concerns, health needs assessment.

3. Was it formally agreed as a priority?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include board papers – local or regional, partnership papers, strategy, LDP, approval from funding bodies.

4. Did consultation take place widely on the intention to address the issue?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include internal groups and communications, staff engagement, professional groups, across partnerships, full community consultation, electronic, meetings, conferences, workshops, newsletters, full media approach.

5. Were all the partners identified?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include list of partners, community / statutory / users, meeting papers, terms of reference, published reports.

6. Was a lead organisation identified?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include identified accountable body, agreement on funding body, nationally identified body, terms of reference, written agreement between partners.

Defining the Issue

7. Was all the evidence available to understand the issue?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include research evidence to define the problem, best practice available, clinical governance issues, service information, NICE guidance, HAD guidance.

8. Was there evidence of inequalities?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include service information, population information, patient information, recognised indicators e.g. deprivation, wider social indicators e.g. social capital.

9. Were the objectives and targets clearly identified?
○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only
Details of evidence obtained:
This evidence could include partnership agreement, board agreement, strategy / business plan, action plans.

Evidence-Based Solutions

10. Were evidence-based solutions considered to address the problem?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include research evidence, best practice, cost-effectiveness research, randomised controlled trials, evidence emerging through practice, clinical governance, NICE guidance.

11. Were there evidence-based prevention programmes to reduce or eliminate the issue in the future?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include research evidence, best practice, cost-effectiveness research, randomised controlled trials, evidence emerging through practice, clinical governance, NICE guidance, meeting papers, action plans.

12. Were community-based interventions considered?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include research evidence, best practice, cost-effectiveness research, randomised controlled trials, evidence emerging through practice, clinical governance, NICE guidance.

13. Was the impact of these interventions on inequalities considered?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include research evidence, meeting papers, best practice, action plans, cost-effectiveness research, randomised controlled trials, evidence emerging through practice, clinical governance, NICE guidance.

14. Was a reconfiguration of current services considered?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include meeting papers, option appraisals.

15. Was the development of new services considered?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include meeting papers, option appraisals.

Implementation and Evaluation

16. Were key priorities for change identified?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include strategies, action plans, meeting papers, consultation reports, research evidence.

17. Were key actions for implementation identified?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include strategies, action plans, meeting papers, consultation reports, research evidence.

18. Is there an agreed action plan / project plan?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include action plan in place, action plan agreed.

19. Have all resources issues been resolved?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include meeting papers, costed implementation plan, partnership agreement, service level agreement, LDP.

20. Are effective monitoring and evaluation systems in place?

○ Comprehensive evidence ○ Some evidence ○ No evidence / anecdotal only

Details of evidence obtained:

This evidence could include process in place, meeting papers, evaluation report / specification.

References

1. World Health Organisation. *Social justice and equity in health*. A report from the programme on social equity and health WHO meeting, Leeds, United Kingdom 22-26 July 1985. In Whitehead M: The health divide: inequalities in health in the 1980s. London: Health Education Council. 1987.
2. Whitehead M. *Concepts and principles of equity and health*. Copenhagen: World Health Organisation Regional Office for Europe. 1990.
3. NHS Health Development Agency. *Health equity audit: a self-assessment tool*. London: NHS Health Development Agency. 2004.
4. NHS Confederation. *Improvement, expansion and reform: the next three years: priorities and planning framework 2003-2006*. 2002.