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Reducing health inequalities: the use of Health Impact Assessment on Rural Areas¹

Reduciendo las desigualdades sociales en salud: el uso de la Evaluación de Impacto en Salud en las áreas rurales

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Abstract

Health is greatly influenced by social, economic and political determinants. Accordingly, decisions influencing people's health do not concern only health services or 'health policies', but decisions in many different policy areas have their influence on these health determinants. Health Impact assessment (HIA) is a predictive tool to support decisions in policy-making. The ultimate goal of this framework is to maximize health gains and, as far as possible, to reduce health inequalities. HIA presents a commitment to ensure that the rural dimension is routinely considered as part of the making and implementing of policy. The aim of this paper is to review the use of HIA on rural areas. Conclusions: HIA shows its great potential to contribute to local authority decision making. The use of HIA was identified in 2 key areas: strategic planning (sustainable development, EU Common Agricultural Policy, Federal Farm Bill, land-use planning work); and in specific smaller scale projects (rural health service redesign proposal, accessing healthy food, transport, health care disparities, etc.).

Keywords: Health Impact Assessment; Health in All Policies; Health Inequalities; Rural Areas; Public Policy.

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Resumen

La salud esta condicionada en gran medida por determinantes sociales, económicos y políticos. Así, la salud no es el resultado únicamente de las políticas sanitarias sino también de otras políticas de sectores no sanitarios que actúan sobre dichos determinantes. La Evaluación del Impacto en Salud (EIS) es una metodología prospectiva que trata de predecir los impactos en la salud de las políticas con el fin de modificar su planteamiento inicial para maximizar los impactos positivos, evitar los efectos negativos inesperados en la salud y reducir las desigualdades sociales en salud. La EIS asegura que la dimensión rural es considerada sistemáticamente en el diseño e implementación de las políticas. El objetivo de este trabajo es revisar el uso de la EIS en las áreas rurales. Conclusiones: la EIS muestra su gran potencial para contribuir a una toma de decisiones basada en la evidencia para las autoridades locales. Su utilización se ha identificado en dos grandes áreas diferenciadas. Por un lado, la EIS se ha utilizado en políticas estratégicas (desarrollo sostenible, Política Agraria Común de la Unión Europea, Federal Farm Bill, planificación territorial u ordenación del territorio). Y por otro lado, se ha puesto en práctica en proyectos de menor escala (propuestas de rediseño del servicio rural de salud, el acceso a una comida saludable, transporte, desigualdades en la atención, etc.).

Palabras clave: Evaluación Impacto en Salud; Salud en Todas las Políticas; Desigualdades en Salud; Áreas Rurales; Políticas Públicas.

Introduction

Rural residents face a unique combination of factors that create disparities in health not found in urban areas. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural inhabitants in their struggle to lead a healthy life (rural residents tend to be poorer, abuse of alcohol, etc). Besides, demographic ageing, chronic diseases and the increasing health inequalities require a coherent and integrated response on the part of the government. The sustainability of the health of the population is as critical as the sustainability of the environment to achieving sustained prosperity and quality of life. A healthy and skilled population is critical to workforce participation, productivity and a healthy economy and, hence, to future living standards. The main objective of this paper is to review the use of Health Impact Assessment (HIA) on rural areas. Before the introduction will first focus on the literature on the social determinants of health and the Health in All Policies (HiAP).

Defining the root causes of health disparities

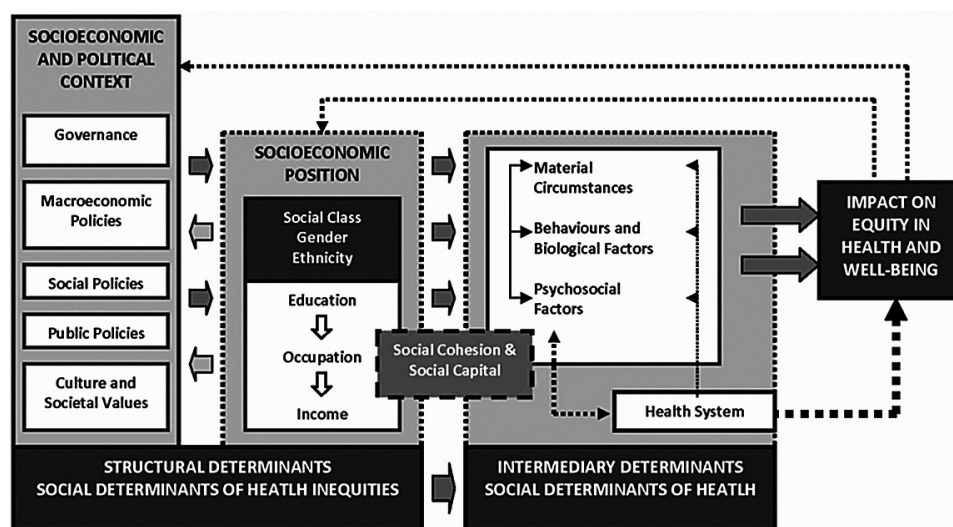
There is a broad consensus on the fact that the populations and individuals' health has a clear and deep social origin. As shown in a number of studies, health varies a lot among the different social groups in a systematic way (Marmot, 2007; Hogstedt et al., 2008). The groups and the people who occupy the highest social positions live longer and, besides, enjoy healthier lives. In fact, a great part of our society is not able to choose factors related to health which are as important as a good nutrition, living in a healthy environment or having a job which is not harmful for our health (CSDH, 2007, 2008; Solar; Irwin, 2007). The social determinants of health refer to the social conditions in which people live and work. They refer both to the social context and to the processes through which the social conditions result in consequences for your health. Social inequalities in health refers to the different opportunities and resources regarding health which people

have according to their social class, sex, territory or ethnic group. This is reflected in a worse health affecting the least favoured social groups. It's related to differences in health which are unnecessary and avoidable, as well as unjust and intolerable. The achievement of equity in health would ideally give everyone a just opportunity to enjoy their maximum health development. A number of scientific studies show that health inequalities are huge and cause, in many cases, an excess of mortality and morbidity, superior to most of the familiar risk factors for disease (Benach, 1997; Acheson, 1998; Graham; Kelly, 2004). In addition, within the studied fields, these differences increase nearly all the time, as health improves more quickly in the most advanced social classes (Dahlgren; Whitehead 2006).

The need to take action regarding the social determinants has led to the development of conceptual frameworks in order to facilitate the understanding of social processes that have an impact on health. In recent years, several models have been created so as to show the mechanisms through which the social determinants have influence over health and over the generation of health inequalities.

ties, in order to make the links between the different types of determinants explicit. The models which are stressed are the following: the influential model of Lalonde (1974), the one proposed by Dahlgren and Whitehead (1991), Diderichsen and Hallqvist's model of 1998, later adapted in Diderichsen, Evans and Whitehead (2001) and Marmot and Wilkinson's model. The model prepared by the Commission on Social Determinants of Health (CSDH) from the World Health Organisation (WHO) gives great importance to the political and socioeconomic context as a structural determinant regarding health inequalities, which is particularly interesting from the point of view of the Health Impact Assessment (HIA). This model highlights the mechanisms that play a significant role in the health results stratification, emphasizes how the social context provokes the social stratification and assigns different social positions to the individuals. These lead to different health risk exposures and vulnerability to diseases. The positions people occupy in the social hierarchy affect the conditions in which they grow up, learn, live, work and grow old; their vulnerability to diseases and the consequences of poor health.

Figure 1 - Conceptual framework corresponding to the determinants of health social inequalities.



Source: CSDH (2007)

Health in all policies: an innovative policy strategy

On the one hand, the Health in All Policies (HiAP) strategy is supported by the solid evidence that health largely depends on political, social and economic factors (Sthal et al., 2006). Work, a comfortable house, healthy food, education or recreation opportunities affect our ability to make healthy choices and, ultimately, our physical and mental health, as well as our life expectancy. Because of the solid evidence that health can be influenced by other sectors' policies and that health has, in turn, important effects on the realisation of other sectors' goals, such as economic wealth, the HiAP strategy aims to strengthen this link between health and other policies. On the other hand, this strategy is also supported by the need to achieve a healthy population as an essential resource for a country's economic development and growth. Besides, the expansion of chronic diseases and the effects caused by population's aging are increasing the demand of healthcare services. Simultaneously, healthcare costs are getting higher due to the increase of expensive technological procedures. This situation is clearly unsustainable and, therefore, a new approach on population's welfare and health improvement is necessary. Plenty of chronic diseases can be prevented or improved, but this mission cannot be carried out exclusively by the health system. An efficient prevention of disease and the encouragement of health require changes in our social, physical and economic environments. In other words, action needs to be taken regarding social determinants of health. HiAP offers an opportunity to work in a joint manner for the sake of enhancing the population's health through the tackling of health determinants and, besides, it contributes to the creation of a cost-effective sustainable health system. HiAP addresses the effects on health across all policies such as agriculture, education, the environment, fiscal policies, housing, transport, etc. The core of HiAP is to examine health determinants which can be influenced to improve health but are mainly controlled by sectors' policies other than health. This approach requires policy makers and other stakeholders to adopt collaborative and structured approaches to

consider the health effects of major public policies in all government sectors (WHO, 2010).

A HIAP approach has been successfully adopted in the European Union and in several Canadian and Australian providences. A strategy also recommended by the IOM (Institute of Medicine) from USA for the handling of chronic diseases. And within this expansion context, the Health Impact Assessment (HIA) is becoming a privileged tool so as to bring the strategy into effect.

A brief summary of health impact assessment

Since the 90's, the concerns regarding the impact on health caused by social determinants have resulted in the development of HIA, a valuable asset useful for including health into the sectorial policies and, therefore, with great potential so as to develop the HiAP strategy (Kemmer, 2006). HIA has been defined as 'a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential impacts on a population's health, and the distribution of those impacts within the population' (WHO, 1998). HIA is an eminently predictive tool useful for decision making whose main result is to provide recommendations, based on tests, so as to weaken the negative effects on health, maximize the positive ones, and reduce the impact on health inequalities on the part of non-health interventions (Mindell; Boltong; Forde, 2008; Scott-Samuel, 1998). In other words, it enhances the decision making process, providing scientific evidence and making it more transparent and participatory (Esnaola et al., 2010; Wismar et al., 2007; Sanz et al., 2012). In fact, it fosters community participation and co-responsibility in health on the part of all the significant agents. At the same time, it sensitizes the political decision makers concerning the consequences of their interventions in health and the need to take action. It's a tool characterized as having an explicit equity approach aimed at reducing the social inequalities in health (Mahoney, 2004; Mackenbach; Bakker, 2002). HIA assesses the distribution of impacts of a proposal on the whole population, with a particular reference to how the proposal will affect vulnerable people (in terms of

age, gender, ethnic background and socioeconomic status) (Taylor; Gowman; Quigley, 2003).

Citizen participation is one of the cornerstones of HIA (Elliot; Williams, 2008). The four main arguments favouring citizen participation in HIA are (National Collaborating Centre for Healthy Public Policy, 2011):

1. 'supporting the development of a democratic society: citizens have the right to express their view regarding the potential impacts of policies, programmes and projects on their health;
2. empowering communities: HIA allows people to participate in the development and implementation of proposals that may impact on their lives. Citizens can become the authors or co-authors of the political, social and economic transformations;
3. integrating citizens' knowledge and values into HIA;
4. formulating more sustainable recommendations: 'its aim is to give a voice to various stakeholders and thus identify changes that could be made to a policy (or programme, or project) so it can meet the needs of the community involved'.

Values such as transparency, sustainable development (where appropriate; HIA considers both long and short term impacts) or the ethical use of evidence (HIA uses the best available evidence from different disciplines and methodologies and places an emphasis on using transparent and rigorous processes to synthesize and interpret this evidence) are the cornerstone of HIA.

There are considerable parallels between HIA and other impact assessments including Environmental Impact Assessment (EIA) or Equality Impact Assessment (EqIA). HIA derives its approach and framework from EIA but it was developed partly as a consequence of EIA not placing sufficient emphasis on human health. HIA is based on a holistic health model and on the health social determinants model, which goes beyond the biomedical approach that is typical of EIA, mainly focused on environmental determinants such as air pollution, water quality, noises, etc. HIA is based on the healthy public policy's principles collected in the Ottawa Charter for Health Promotion and in concepts coming from political science. In addition to the risk estimation

models which characterize EIA, HIA uses different disciplines and quantitative and qualitative tools for the gathering and analysis of evidence. Finally, HIA takes equity into consideration, appreciating the distribution of the impacts on the population according to the main axes of inequality.

The HIA predictive function regarding the support of political decision making recommends that this should be prospective, that is, it must be carried out before the intervention (Scott-Samuel, 1998). Likewise, it will be possible to change its initial proposal, maximizing its beneficial effects on health and diminishing its harmful ones. However, owing to different practical reasons, HIA cannot be planned before the intervention. Therefore, the assessment is carried out during the intervention (concurrent HIA) or after it (retrospective HIA). The concurrent HIA makes it possible to act during the project implementation process, correcting some of its elements in view of the results. On the other hand, the retrospective HIA provides relevant information about the consequences affecting health that should be taken into account in similar future interventions. In the same way, depending on the available resources and time, there are different types of HIA which go from the carrying out of a literature research and a 1-2 days' workshop, in which the key informants offer their views as regards the potential impact on health (rapid HIA or mini-HIA) on the part of the intervention, up to comprehensive HIA or maxi-HIA, which take several months and require more thorough procedures of gathering/analysis of evidence, including the elaboration of new quantitative and qualitative evidence.

Finally, it's worth mentioning that there is a broad international experience regarding the use of HIA in different sectorial and administrative fields. The greatest advances have taken place in England, Wales, Ireland, Sweden, Finland, Holland, Australia, New Zealand, Thailand, Canada and USA. HIA has been used in local, regional, national and supranational fields (Esnaola et al., 2010). It has also been used in connection with different interventions on the part of numerous sectors: urban regeneration, transport, economic development, energy, climatic change, tourism, leisure, culture, social welfare, housing, waste, etc.

Ruralities and health

In the last decades, the rural environment has been through many important changes. These change processes have entailed significant advances toward a better quality of life, as well as demographic, socio-economic and territorial unbalances. The transit of industrial economies to post-industrial economies, the strengthening of the information society and the new social and economic relationships framework within the context of globalisation are different expressions of the social change.

Likewise, nowadays people can no longer talk about a single rurality either. The rural reality is diverse: from the small mountain towns to the coastal towns or the big capitals' outskirts (counter urbanisation, sprawling). Cases presenting particular features that hinder a uniform consideration of this reality. In the same way, the rural inhabitants are heterogeneous: an aged and often dependant population faces mobility difficulties with resources which are generally provided by family or informal networks. The autochthonous youth, at the same time, have never overlooked the city, either for professional expectations or for academic obligations. And women, in the third place, must face gender inequality which decisively conditions their possibilities for both personal and professional development. By comparison with the urban areas, the rural ones are characterized as being the most aged, masculinised and dependant societies with gender inequalities.

The rural economy faces different challenges. Thanks to the liberalisation and globalisation of the agricultural market, the rural population is decreasing; there are more part-time farming, low levels of farm income and the need to replace these incomes with others by means of the economic diversification is arising. Therefore, towns are not the only ones who diversify the productive activities (which are now focused on construction, commerce, tourism and industry). Families also do it. To sum up, some economic and socially heterogeneous and interdependent societies (Sanz 2008, 2012).

Starting from the definition of health provided by the WHO, the analysis of a particular population's health is carried out through the main social determinants: income and social status, social support

networks, education and literacy, employment conditions, social environments, physical environments, personal health practices, health child development, biology/ genetic endowment, health services, gender and culture.

Clearly, the economic, social and political differences which have characterized the rural areas are also materialized in social differences regarding the inhabitant's health. Generally, in every country, when we compare the urban population to the rural one in terms of health, we arrive to the conclusion that the latter is more likely to live in poorer socioeconomic conditions. They have lower educational attainment, they present a less healthy behaviour (more alcohol and tobacco consumption, less physical activity, etc.), they are at high risk of suffering from particular chronic diseases and they have a shorter life expectancy. Differences that are materialized in:

- lack of jobs in general, especially well paid jobs: the labour vulnerability is one of the main problems the rural population is dealing with. A fact related to the low rates of economic activity. The rural economies are known to be small economic markets, where 9 in 10 companies are micro-businesses with less than 10 employees, and to have poor infrastructure (transport, telecommunications, etc.);
- low income levels: in most of the countries, the same income distribution pattern is repeated. The urban areas gather the highest levels of income and the rural ones present low levels;
- low education and literacy levels: the majority of the population has completed primary education. The local labour market only offers unqualified jobs. In view of this, people with greater qualifications keep emigrating from the rural areas;
- lack of access to health services: An additional difficulty is the fact that certain groups may not have an easy access to these services, such as those who don't have their own means of transportation, those with low incomes, the youth, the elderly, etc.;
- lack of information about health and community services;
- lack of public transportation: this shortage

hinders not only the necessary mobility but also everyday life, such as access to health and educational services, etc. Usually, the scattering of the population and its reduced number endear the price of the establishment and access of services;

- lack of ability to afford healthy food.

The actions of different administrative sectors and organisations have both positive and negative impacts on rural areas. Typical characteristics of the countryside include sparse population and long distances. These are among the reasons why the impacts of decisions on rural areas often differ from the impacts on urban areas.

The use of health impact assessment on Rural Areas

This study focusses on the potential role of HIA to contribute to local authority decision making. Below we review how and where HIA has been used differentiating two areas of action: strategic level and local level.

Strategic level

In view of this situation, different plans have been developed at a strategic level so as to incorporate the rural and health dimensions into the policy design. A paradigmatic case is the one developed in the United Kingdom. The Government launched its formal commitment to rural proof all domestic policies in the 2000 Rural White Paper. A commitment that continues up to the present. 'Rural proofing' is an expression used to describe a process of checking the effect that policies and individual projects could have on rural communities. Rural proofing is a long-standing process which requires policy-makers across Government to ensure that the needs and interests of rural communities are considered in the development and implementation of all policies and programmes. It's a systematic rural impact assessment of policy developments and changes. Policy-makers are asked to consider 3 key questions on how any policy (including both new policies and significant changes to existing ones) may affect rural people and places. Specifically, policymakers are required to:

- consider whether the policies they are developing will have any impacts on rural areas;

- if there are any such impacts assess what these might be;
- and consider what adjustments or compensations might be made to ensure that the needs of those who live in rural areas are addressed fairly.

Rural Proofing focuses on matters that are uniquely or essentially rural (Swindlehurst et al., 2005). A basic principle to reduce the social differences is not to treat equally what's not equal. For example, a policy aimed at tackling household deprivation may fail to address the needs of poorer people in rural areas if the data used to target the policy is set at too high a level, as rural deprivation is more scattered and can be hidden by the relatively high average income levels in many rural areas. Rural proofing contributes to the fair treatment of the rural residents.

Besides, this process is focused on health and, because of this, it has recommended and implemented the use of HIA. Likewise, a toolkit that guides a proper policy implementation has been prepared. This toolkit includes the following areas: access to services/transport; Primary care; Community care; Specialist services; Hospital services and Patient and Public Involvement. An approach which has also been adopted in New Zealand and Finland.

Another relevant example regarding the use of HIA at a strategic level is that of Wales, a region that constitutes an international referent in the advance of the implementation of HIA. The Welsh Assembly Government commissioned the Institute of Rural Health to undertake the Rural Health Intelligence Programme (RHIP) to facilitate the development and implementation of evidence-based policies and programmes on health and well-being in rural Wales. The main objective of the RHIP is to provide a rural perspective to the government on health and well-being issues. The Welsh Assembly Government has encouraged the use of HIA as a part of a wider strategy to improve health and reduce inequalities. A programme has established the Welsh Health Impact Assessment Unit (WHIASU) to assist the development and use of this tool (Institute of Rural Health, 2005).

So far, the agricultural and food policies have mainly been object of study regarding the environmental impact. A tendency which has fallen apart

partially due to the different food crisis (bovine spongiform encephalopathy, avian influenza, etc.) which have demonstrated the need to assess such policies in terms of health and quality of life. Several projects have been undertaken in the name of HIA. In Canada, two HIA's regarding the agricultural system of Quebec have been performed (Health Canada, 1999). The health assessment is subdued and integrated into the environmental one. The cornerstone of the experience is within the assessment of specific health risks. However, HIA is not formally considered. At present, two pilot projects stand out: the Slovene case and the USA case.

Slovenia has carried out one HIA to consider the potential effects corresponding to the access to the European Union within the agricultural and food policies. It's the first project which, by including the Common Agricultural Policy (CAP), has pretended to calculate the specific impacts on health at a national level (Lock et al., 2003, 2004). Precisely, CAP is the European Union's most important policy in budgetary terms as it entails almost half of the total budget. It comprises a joint complex of political instruments and laws which regulate the production, the market and the process corresponding to the agricultural products, as well as the rural development.

The EU Common Agricultural Policy (CAP) has influenced European agriculture for decades with the objective of increasing productivity and farmers' income. In the report from the Swedish National Institute of Public Health (Shafer, 2003), the CAP is criticized for using subsidies inefficiently, damaging agriculture in developing countries and having negative public health effects within the EU. The report analyses four sectors for which it makes practical recommendations: fruit and vegetables, dairy products, wine and tobacco. It suggests how a reformed CAP could support health policies and help prevent major public health problems in Europe (Shafer, 2003; Dahlgren; Nordgren; Whitehead, 1996). However, HIA cannot be considered formally in this study.

The HIA undertaken in Slovenia has basically followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; review of research evidence relevant to the agricultural policy; analysis of Slovenian

data for key health-related indicators; a report on the findings to a key cross-government group; and evaluation (Lock; Gabrijelcic, 2003). This HIA approach involved national and regional stakeholders. A total of 66 people participated, including local farmers' representatives, food processors, consumer organisations, public health, non-governmental organisations, national and regional development agencies and officials (from Ministries of Agriculture, Economic Development, Tourism, Education and a representative of the president of Slovenia). The participants not only had to identify the possible impacts upon health taking the main health determinants into consideration, but they also had to identify which population groups were going to be the most affected ones. Once again, the Slovene experience shows the benefits of HIA when it comes to raise more general public health issues within the political agendas. It comes forth as a valuable strategy to formulate more integrated theories at an intersectoral level. Its methods flexibility, its holistic approach and the incorporation of the stakeholders into the process are the HIA features which contribute the most to the success of the intersectoral work.

Just like in the previous case, in USA, an HIA focused on the most important agricultural policy in the country, the Farm Bill, has been developed. The Farm Security and Rural Investment Act of 2002, also known as the 2002 Farm Bill, includes ten titles addressing a great variety of issues related to agriculture, ecology, energy, trade, and nutrition. The Farm Bill provides financial assistance to farmers through subsidy programmes. This HIA underlines the aspects corresponding to the new Farm Bill which can have the greatest impacts on the health status: dietary consumption, food safety, rural income and quality of life, air pollution and environmental degradation. Of these, the study is focused on evaluating whether the dietary consumption is affected by the farm subsidy policy and whether air pollution is affected by the ethanol production. In general terms, this HIA is trying to prove, on the one hand, the links between the changes in the agricultural policy and the results regarding health. On the other hand, it's seeking to show that HIA can be a valid tool for a quick assessment of the impacts on health caused

by a far-reaching national policy (Sumner, 2003; Dannenberg et al., 2006, 2008; UCLA, 2011). Just like the Slovene experience, the main difficulties have constituted the complexity itself corresponding to the assessed policies and the shortage and/or lack of evidence of the impacts on health.

Local level

In spite of more than a decade of experience in the planning and implementation of the sustainable development at a local level, there are still significant barriers that hamper the union of the political agendas and the development of integrated approaches. Two of the greatest weaknesses regarding the Local Agenda 21 and the sustainable development agenda refer to the fact that they haven't adopted a wide approach with respect to health and its determinants and they haven't considered health as a key resource for the economic and social development in the decision making process. In this sense, since 2002, staff of the WHO Regional Office for Europe have studied how to introduce HIA into the WHO European Healthy Cities programme. The use of HIA by four cities in the Network—Belfast, Onex-Geneve, Helsingborg, Bologna—illustrates the challenges and successes experienced in the initial stages of Phase IV (Ison, 2009). An experience which seeks to be transferred to the rural associations, institutions and areas. HIA comes forth as the best-suited tool to increase the acknowledgement of the health social model among the local associations, organisations and governments and to develop the responsibility sense regarding health during the planning of local policies.

In rural areas, at a more local level, HIA has been used to a larger extent and in a bigger number of sectors: rural transportation planning, aboriginal health, health service delivery, natural heritage, housing, accessing healthy food, social services, health care disparities, etc. A graphic example of how this tool can help is the HIA carried out so as to consider the possible impacts of a re-arrangement in the rendering of health services on a small Australian rural community (Neumayer; Chapman; Haberecht, 2007). The foreseen changes are applied in order to deal with the problems concerning the small rural communities, such as sustainability, access to he-

althcare services, healthcare staff retention and a decreasing and aging population's needs. Within the framework of this methodology, the idea of taking into account 2 scenarios was considered necessary: 1) the one where no changes had taken place in the current service and 2) the rearranged service. After revealing the impacts identified for each scenario, the re-arrangement of the current model was unanimously chosen. A process which is successful not only for determining the important impacts but also for giving recommendations adapted to the population's needs in every stage of the restoration of health services.

Another interesting case is HIA presented to the Humboldt County Planning Commission. Humboldt County (California) is currently considering three development plans to accommodate future population growth, and the described HIA process successfully identified and analysed potential health impacts associated with each (Harris et al., 2009). Likewise, as a result of this process, "Rural Healthy Development Measurement Tool" has been developed so as to take the matter of health into account when making decisions regarding rural development, thus helping to plan more equal, fairer and healthier communities. This tool includes 73 health indicators suitable to a rural context and it can be used for incorporating health analysis into built environment projects in other rural locations in the future.

Benefits and challenges

The implementation of HIA in rural areas enjoys the same benefits obtained in urban areas. HIA provides a framework for determining how positive and negative health impacts are distributed across different segments of the population. Decisions that benefit the general population could have negative impacts in the short or medium run upon certain rural areas or upon specific social groups. HIA helps to identify groups at risk and to reduce health inequalities. HIA provides a systematic approach for integrating the principle of equity into decision making. HIA also provides a better understanding of local needs for public services and the way they are used, enabling sectors to better target resources.

The HIA implementation process allows and

demands to sensitize the communities and the people who make decisions concerning the social determinants of health. In this sense, politicians are also sensitized with respect to the influence of their actions and policies on the population's health, making them co-responsible to a large extent. This tool, when taking into account the opinions on the part of those to whom this policy is addressed, favours the democratisation of the decision making process and raises awareness of the way in which the health determinants are interrelated and affect the people in real social contexts. It's a tool which gives place to an integrated, intersectoral, participatory and long-term approach to the policies design and development for the sake of helping and enhancing the decision making process which involves an improvement in the local population's health.

In connection with the difficulties identified for the HIA implementation, it can be seen that these are worse in rural areas. At an individual level, the lack of knowledge, skills and experience regarding this methodology constitute barriers identified repeatedly. The identified barriers are diverse at an organisational and external level. The lack of evidence increases when taking rural-specific issues into account, such as the aforementioned case regarding the agricultural policies. The geographical access, the longest travel distances and its additional time and money costs also hinder its implementation on these areas. Likewise, the lack of information suitable for the study and assessment of the rural areas constitutes one of the main barriers. Most of the existing data are regional and make the possible features corresponding to the rural areas invisible in a significant way. We need information about these small rural areas. This information must be sensible to "rurality" and, at the same time, it must ensure confidentiality. Besides, public, private and voluntary organisations in rural areas tend to be smaller than their urban counterparts and have very limited resources, in terms of staff and budgets. This will impact on their ability and capacity to work up partnerships, submit bids for funding, etc. Finally, it's worth mentioning that resistance to change and innovation can also represent a significant barrier among the elected members and the municipal staff (Welsh Assembly Government, 2005).

Conclusions

The incipient and growing experience in the HIA implementation in rural areas shows us its powerful potential. Its use on these areas, taking care of their diversity, singularity, contradictions and difficulties, is precisely what makes it an effective tool useful for reducing the social inequalities in health. The implementation of this tool makes it possible to include the rural dimension into the development of national, regional and local policies, maximize health profits and reduce or avoid the negative impacts. An efficacy mainly known due to its huge versatility: in strategic planning, small scale projects or in promoting partnership working.

HIA raises awareness and understanding of the effects upon the population's health caused by policies regarding food and agriculture, development, employment, housing, transport, social services, healthcare services, etc. In this sense, it determines a health definition shared among a wide range of stakeholders and it creates a sense of responsibility between the different sectors' representatives. HIA provides evidence to contribute with political decision making and it constitutes a tool which makes the intersectoral collaboration easier.

In order to move on with the HIA implementation in rural areas, it would be necessary to provide additional assistance to achieve a proper development. In view of the aforementioned difficulties, economic and technical assistance is recommended (support on the part of specialized staff, implementation of proper statistics, etc.).

All in all, people in good health are more productive and can participate more effectively in the labour market and education. Improving population health then becomes a shared goal across all sectors.

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