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Building Equity into Public Policies Designed to Promote Health

A study of health equity impact assessment tools

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make history.

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Executive Summary

Health Equity Impact Assessment (HEIA) provides a structured approach for considering the potential impact of policies, programs or other initiatives on health equity. Health inequities are the systematic inequalities in health caused by unfair distribution of resources or other unjust processes. HEIA can be applied prospectively or retrospectively at various stages of policy and program development, implementation or evaluation. A legislative framework can help ensure the uptake of the HEIA process, but its application may also arise through more ‘erratic pathways’ such as significant events (e.g. the COVID-19 pandemic). Many HEIA tools have been developed, and in this report we present a summary of tools published and referenced in the academic literature and online during 2018-2023.

Fifty-five HEIA tools were reviewed to determine the intended use of the tools in the policy development process, to compare the theoretical orientation of tools, to consider public and practitioner involvement in the tools, and to identify the extent of the tools’ application and evaluation. Some key learnings from the review were:

- There are multiple opportunities throughout the policy lifecycle to incorporate HEIA;
- HEIA is informed by principles and values, and is rich in theoretical constructs, drawing on related concepts such as Critical Theory, Social Justice and First Nations Knowledges. In this way, the HEIA process has the potential to ‘speak’ to a wide range of stakeholders;
- HEIA is presently primarily concerned with ‘disadvantaged’ priority populations, rather than action aimed at levelling the social gradient in health;
- There is no set prescribed manner for developing HEIA tools and implementation approaches also vary, however a combination of evidence-informed methods and stakeholder engagement methods that consider power dynamics appear to be important considerations;
- Further research and evaluation of HEIA processes and impacts is warranted.

Many aspects of the local context will influence the HEIA journey. With this in mind, we applied key learnings from the literature review to support a co-design process, involving partner organisations in South Australia (SA) and Tasmania.

During co-design workshops, participants identified eight key themes relevant to the development of HEIA tools in their jurisdictions. These related to the level of understanding of health equity among stakeholders; preferences for a ‘tool’ versus a ‘process’; the need for an iterative, flexible approach; attention to practical considerations; organisational capacity and commitment; community engagement; data; and a focus on structural determinants. The co-design process culminated in the development of a Health Equity Impact Assessment Tool (Wellbeing SA) and a Health Equity Impact Assessment Frame (Healthy Tasmania). Plans are underway to pilot test the tools to further refine their utility.

1.0 Introduction

Improving population health and health equity relies on a political commitment to equity and action across all sectors of public policy (Baum et al., 2021). The most significant drivers of health outcomes and health equity are people's living circumstances, such as their housing, employment and neighbourhood (Commission on the Social Determinants of Health, 2008; Marmot & Allen, 2014). Government public policy holds much potential to shape the availability, nature, and equitable spread of these social determinants of health (Baum & Friel, 2017; Baum et al., 2018; Freeman et al., 2020). Addressing health equity in public policy is important given the increase in health inequities in Australia (Campostrini et al., 2019; Musolino et al., 2020; PHIDU, 2023). However, a focus on health equity has proved hard in practice (Cairney et al., 2021).

Defining health equity

We define health inequities as systematic inequalities in health caused by unfair distribution of resources or other unjust processes (Braveman & Gruskin, 2003).

Assessing health equity

One approach to assessing the impact of policy on health equity is through Health Equity Impact Assessment (HEIA). It provides a structured method to consider and reorient—if necessary—the health equity implications of policies, programs and other initiatives. It can be applied prospectively during the planning stage, or retrospectively during evaluation to identify opportunities to improve or change practice.

Health impact assessment (HIA – without 'equity' in the title) has a substantial history and assessing potential equity implications was always intended to be part of the process, yet attention to health equity has often been overlooked in practice (Cole et al., 2019). There are however many assessment tools and approaches with an explicit focus on health equity. This report provides a snapshot of HEIA tools and processes reported in the academic literature over the past five years (2018-2023), as well as web-published HEIA guides and resources. The publications are reviewed in light of the following research question: *How can current literature on instruments designed to increase the equity sensitivity of public policies and practice be utilised to develop an equity tool for application to Health in All Policies (HiAP) processes in Australia?*

To further aid in considering this question, we applied key learnings from the literature review to support a co-design process, involving partner organisations in South Australia (SA) and Tasmania, which resulted in the development of two potential HEIA approaches. Wellbeing SA was inspired to develop a HEIA tool

following a visit from Professor Jennie Popay (Lancaster University) in 2022, who advocates for the uptake of HEIA (Porroche-Escudero & Popay, 2021). In Tasmania, the Government's Healthy Tasmania Five Year Strategic Plan 2022-2026 includes a commitment to apply an equity lens across all Healthy Tasmania policies and services to ensure the specific needs of priority populations are considered and that actions have no adverse impacts.

This report provides the equity assessment tools that were developed with staff from the two partner agencies, as well as details about the process and findings of the literature review.

2.0 Methods

The research reported here was carried out in the second half of 2023, and was jointly funded by Wellbeing SA, the Department of Health Tasmania, and a University of Adelaide Faculty of Arts, Business, Law, and Economics Research Grant. The first stage involved a literature review of academic articles and web-based publications of processes and tools used to undertake HEIA, primarily of policy. Subsequently, the findings of the review were used to guide a co-design process to develop HEIA tool(s) for two partner organisation, Wellbeing SA and the Department of Health, Tasmania (Healthy Tasmania initiative). The method for the literature review is presented in **Section 2.1** below, and details of the co-design process are provided in **Section 2.2**.

2.1 Literature Review

A scoping review of published HEIA approaches was conducted in August 2023 (with a final scan for any additional articles carried out on 19 December 2023). The objectives of the review were to:

1. Scope health equity impact assessment tools' intended uses in the policy development process;
2. Compare the theoretical orientation of tools;
3. Consider the coverage of public and practitioner involvement in the tools; and
4. Identity the extent of the tools' application and evaluation in practice.

While the aim of the review was focused on assessing policies, it should be noted that several authors considered that particular HEIA tools were not only suitable for assessing policies, stating that the tool could equally be applied to either policies, programs OR other initiatives—even sometimes research.

The review involved searching the following academic databases: Web of Science, Proquest and Medline. Subsequent searches were conducted using Google (and Google Scholar) to identify additional tools referenced in academic articles. An initial

search using few key words (health equity AND policy AND tool/lens/assessment/impact) and with no date limits was carried out in July 2023, and yielded in excess of 400,000 results in one database only. The search process was therefore refined, with the final search conducted on 16 August 2023. The final search terms were:

> "health equity / inequity (inequities)" or "health inequality (inequalities)" AND
>
> "policy" or "health in all policies" or "health equity in all policies" AND
>
> "tool" or "lens" or "resource" or "assessment" or "framework" or "impact"

The search limitations included: published between 2018-2023, English language, and search terms present in title/abstract/key words.

Selected full articles were uploaded to NVivo, where analysis was conducted (by researcher MV) using a coding framework based on the research objectives, which included identifying: the tool name (developers, references to other tools); development of the tool (process, practitioner engagement, citizen engagement); theoretical orientation (aim of tool, policy focus, equity focus, other); implementation of the tool (domain, setting, retrospective application, prospective application, practitioner engagement, citizen engagement); evaluation of the tool (evidence of findings); barriers and enablers (current tool, others' findings); recommendations/learnings; and other significant findings.

2.2 Co-design of HEIA process/tool for application to specific Australian government agencies

The second component of the project involved collaborating with staff from Wellbeing SA and the Tasmanian Department of Health (the Healthy Tasmania collaboration) to co-design a HEIA approach that could be applied to decision-making. Research staff met with representatives of the two respective organisations to co-design the scope, expectations and timeframes for the development process. Two workshops were planned in collaboration with the project partners in each jurisdiction. Both workshops in SA were held face-to-face, whereas in Tasmania, they were conducted online using Zoom. Participants were identified and invited by staff from the respective lead organisations. All participants received an information sheet about the study and were invited to complete a consent form before participating in a workshop. The research was approved by the University of Adelaide Human Research Ethics Committee. The group discussions at the workshops were voice recorded and transcribed. Researchers reviewed the transcripts and identified key themes, which were used to inform the development of a two-component HEIA Tool for Wellbeing SA and a Frame for Healthy Tasmania.

The first workshop was held with staff from Wellbeing SA at their offices on 20th September 2023, involving eight participants who worked in public health policy, program delivery and evaluation. In Tasmania, invitations to participate were extended beyond internal staff, to include staff working for partner organisations (government and non-government) who were involved in the implementation of the Healthy Tasmania strategy. The first workshop was held on 23rd November 2023 and involved 19 participants. At each workshop, either researcher FB or TF facilitated the workshop and researcher MV presented the preliminary findings of the literature review and invited participants to reflect on key aspects of HEIAs and how these could be practically applied through the work setting.

Participants next broke into small groups to discuss the following questions, before returning to the main group to consolidate key points:

- How does <the organisation> currently act to address health equity?
- What more does <the organisation> need in order to address health equity in planning and evaluation?
- What are enablers and barriers to <the organisation> doing that? How might a tool help?

Following the first workshop, a draft two-part HEIA Tool was developed for Wellbeing SA and a draft Frame was developed for Healthy Tasmania. The documents were sent to key contacts in each of the agencies, who circulated the tools to other staff and partners, with a request for feedback to be provided directly to researchers (TF and MV). A second workshop was held for Wellbeing SA on 27th November 2023 and for Healthy Tasmania on 30th November 2023 where feedback was discussed in detail and the tools/frame were 'tested' in respect of real-life scenarios. The workshops were attended by four participants in SA and 17 in Tasmania. The majority of participants in workshop two had also participated in workshop one. The tool and frame were further refined and the end results are provided in **Appendices A** and **B** of this report.

3.0 Results and Discussion

3.1 Literature Review

Fifty-five HEIA approaches/tools were identified during the literature review. **Figure 1** provides the PRISMA diagram to illustrate the selection process. A list of the tools identified through the literature review can be found in **Appendix C**.

Figure 2 illustrates the publication date of the HEIA tools and **Figure 3**, the jurisdiction. Although the literature search was confined to 2018-2023, we were interested in identifying tools and approaches that were referenced in current

literature, even if the tool itself had been produced prior to 2018. As such we included 21 ‘older’ tools that were still being cited in more recent literature.

The findings of the review are presented below in relation to the objectives of the project, i.e. the intended use of tools in policy development, the theoretical orientation, public and practitioner involvement, and application and evaluation in practice.

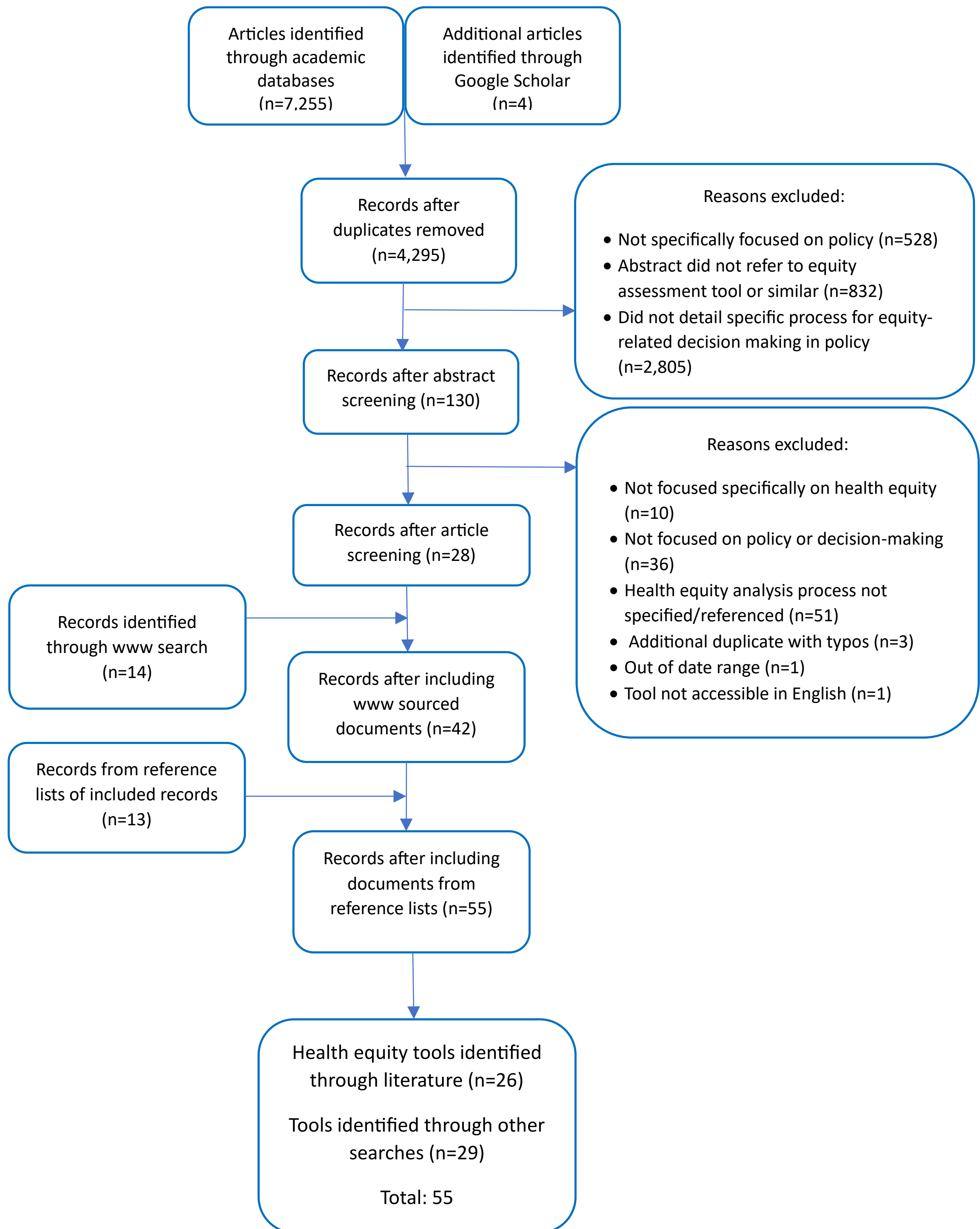

Figure 1: PRISMA diagram for literature review to identify health equity impact assessment tools

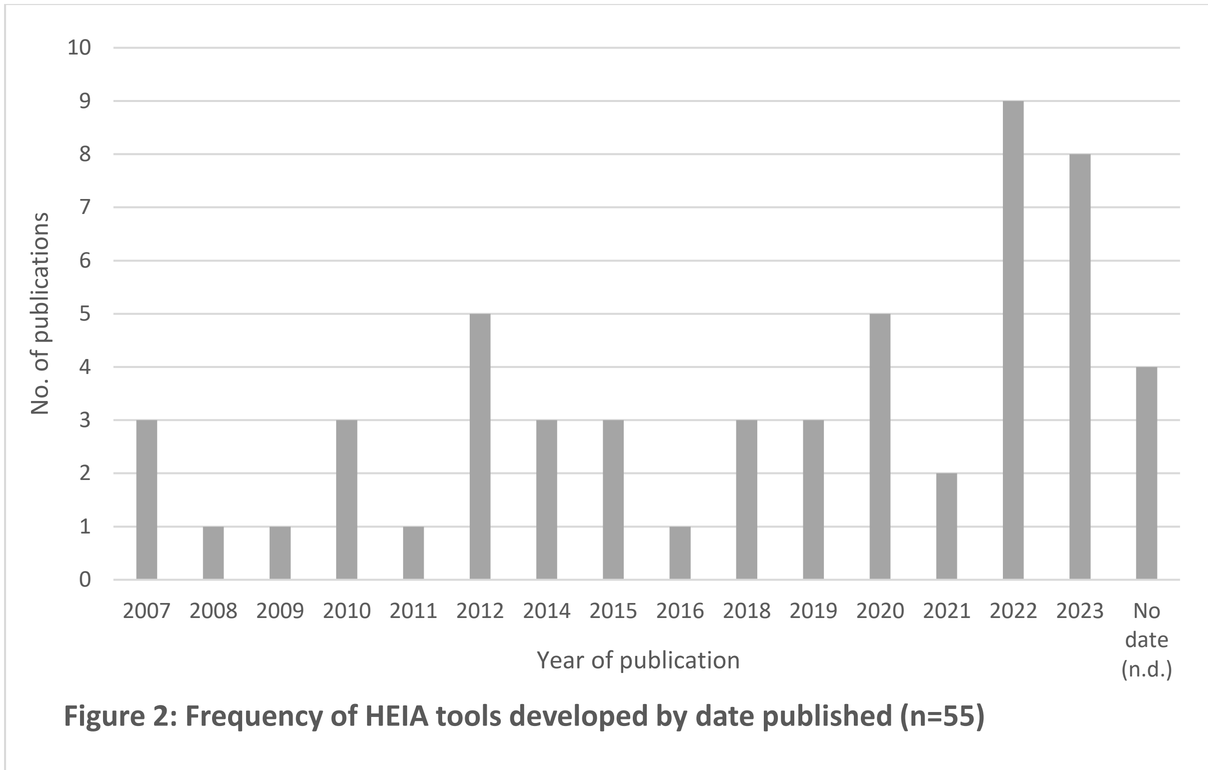

Figure 2: Frequency of HEIA tools developed by date published (n=55)

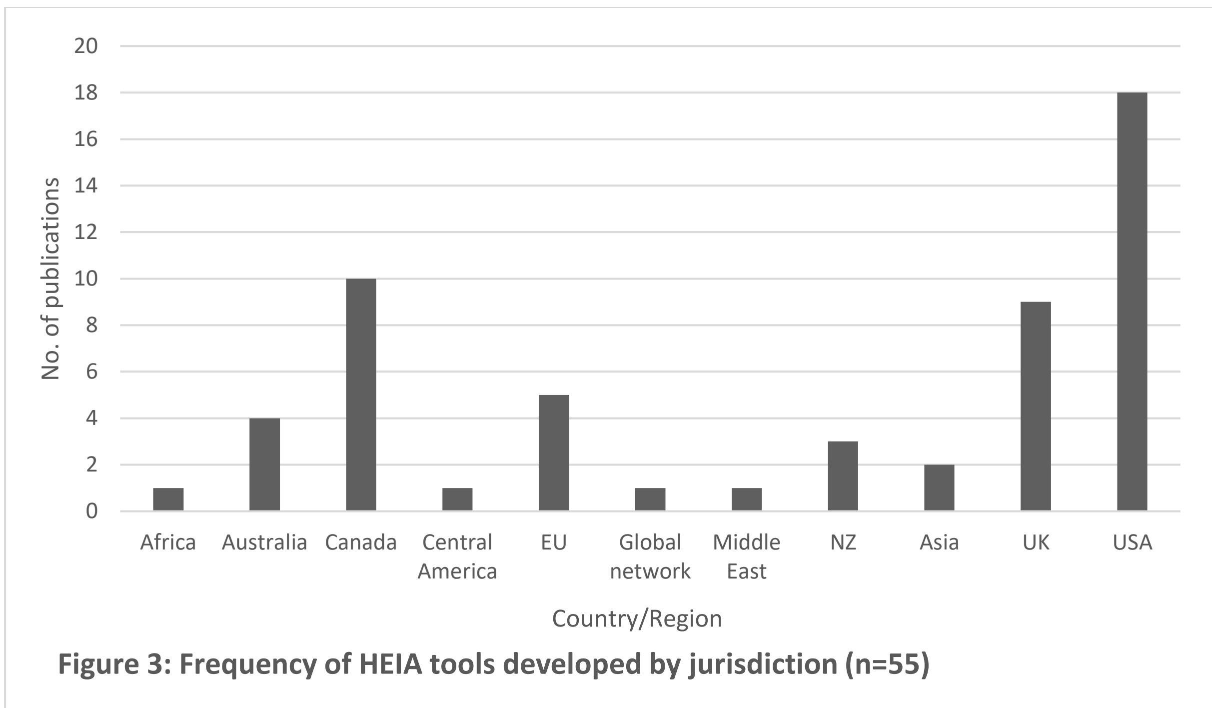

Figure 3: Frequency of HEIA tools developed by jurisdiction (n=55)

3.1.1 The Purpose of HEIA Tools

The purpose of the HEIA process is to embed equity into decision-making in a structured and sustainable way (Canadian Public Health Association, 2020). HEIA approaches assist practitioners, policy makers and academics to identify the potential impact of policies, programs or other initiatives on health equity, and make

recommendations to enhance positive health equity impacts and reduce adverse outcomes associated with proposals.

Often there is an emphasis on **unintended** impacts, suggesting that usual policy and project development processes may inadvertently overlook health equity implications and may even potentially increase health inequities. In this way, HEIA provides a systematic process that facilitates reflection and critical thinking, particularly in relation to assumptions, and the positioning of health or social problems and proposed solutions. It also calls for a critique of the way data are integrated into the decision-making process, including how to progress a health equity agenda in the face of low quality or missing data.

Although the review was focused on the use of HEIA for policy development and implementation, some of the tools were developed for other purposes. For example, Jumah et al. (2023) developed a HEIA tool to address challenges in providing equitable cancer screening for First Nations peoples in Canada. Such tools were included in the review if the researchers recognised the wider application of the tool for policy development purposes. For example, Jumah et al. (2023, p. 1) further state that:

> *Even though the Indigenous Lens Tool was created for this purpose, the principles contained within it are translatable to other health and social service policy applications.*

Some examples of the stated aims of HEIA approaches and tools in the literature review are outlined below.

> *HEIA is a flexible and practical assessment tool that can be used to identify unintended potential health impacts (positive or negative) of a policy, program, or initiative on vulnerable or marginalized groups within the general population.* (Ontario Health, 2012, p. 8)
>
> *Critically assessing policies and processes can help reveal hidden assumptions, which then can lead to development of a different set of explicit, shared assumptions and open up opportunities for new ways of thinking and acting.* (Minnesota Department of Health, 2018, p. 1)
>
> *Equity assessments are systematic examinations of available data and expert input on how various groups—especially those facing inequity or disparities— are or likely will be affected by a policy, program, or process. They aim to minimize unintended adverse outcomes and maximize opportunities and positive outcomes.* (Bradley et al., 2022, p. 1)
>
> *The … values underpinning the use of HIA in the decision-making process are ... Ethical use of evidence: emphasizing that the use of quantitative and qualitative evidence has to be rigorous, and based on different scientific disciplines and methodologies to get as comprehensive assessment as possible of the expected impacts.* (Mahoney et al., 2014, p. 7)

As these quotations illustrate, there were also several supplementary objectives identified. These related to:

a) **Health equity action:** For numerous authors, embedding a HEIA process was seen as a way to take practical action to advance health equity in line with organisational values. The structured nature of the HEIA process provided clear, achievable steps towards advancing this agenda.

> *The purpose of a health equity lens tool is to ... Embed equity across HCA's (Washington State Health Care Authority) existing and prospective decision-making models, so that it reflects our core value.* (Washington State Board of Health, 2020, p. 2)

b) **Knowledge sharing and collaboration:** Researchers identified that HEIA processes offer a mechanism to facilitate dialogue among stakeholders from across government, non-government and community sectors to advance health equity.

> *The aim ... is to present a framework of eight questions that might make it easier for researchers and policymakers to understand each other's needs.* (Diderichsen et al., 2022, p. 875)
>
> *The framework focuses deliberately on the goal of questioning, a central aspect of scientific inquiry, and encourages sharing of thoughts and ideas based on the current level of understanding—with intent of driving further investigation and action to address inequities.* (Cheng & Mistry, 2023, p. 639)

c) **Drawing related concepts into one assessment process:** A number of HEIA tools in this review brought together important related concepts—such as social justice, human rights, racial and gender equity, and intersectionality—into one assessment process.

> *People are not defined by any single characteristic. A narrow focus on one aspect of an individual's or group's identity may work to hinder understanding and responding to the reality of people's lives and experiences. HIIA therefore encourages consideration of the intersections of different potential impacts on individuals and communities ....*(Sigerson & Craig, 2014, p. 6)
>
> *<This lens> can bring an idea into focus, or alternately, expand it outward and upward. In this particular case, this Lens does both, by asking us to focus in on how equity and racial justice relate to a particular issue at hand, and then how that issue also exists in relation to a much larger system of factors.* (Balajee et al., 2012, p. 8)
>
> *The gender and equity perspective ... supports three, partly overlapping underlying assumptions <in the policy analysis process>: quantification and objective knowledge, inequalities as unidimensional and, categorization and labelling.* (Fagrell Trygg et al., 2022, p. 1)
>
> *EquiFrame identifies the degree of commitment of a given policy to specified Vulnerable Groups and to Core Concepts of Human Rights. We see social inclusion and human rights as key components of equity in the context of service provision.* (Mannan et al., 2011, p. 4)

d) Citizen engagement: Authors noted that HEIA tools can be a mechanism for fostering self-determination and aid citizens to have a voice in the policy process. For example, Came et al. (2020) used decolonisation theory to develop a critical policy analysis process, noting that one of the goals was to:

> *…<evaluate> the strength of Māori participation in policy making and the extent to which Māori aspirations and expectations are positioned to influence policy decisions. It rejects the assumption of a nonpartisan, ethically constituted Pakeha Crown, making just and equitable policy for Māori and the nation.* (Came et al., 2020, p. 450)

Similarly Henson et al. (2019) and SOPHIA (2016), took a community-centred approach:

> *The goal is to systematically assess how different groups might be affected by a decision, identify adverse consequences, and propose recommendations to address impacts. And since equity is a process and an outcome, community involvement is a core component*. (Henson et al., 2019, p. 3)
>
> *The conceptual framework and tools in this resource emphasize building community power through the practice of HIA as a key process for advancing equity. Building community power is the process by which communities gain control over the factors that shape their lives, including access to information and opportunity, decision-makers, and policy-making.* (SOPHIA, 2016, p. 1)

e) Capacity building: A number of authors commented on the capacity building aims of HEIA tools, including the goal of advancing knowledge about health equity among stakeholders, providing support for those undertaking the assessment and for those outside the health sector (SOPHIA, n.d.). For example, in Multnomah County Health Department's (USA) Equity and Empowerment Lens (2012, p. 4), the authors argue that:

> *Using the Lens will significantly increase the capacity of your organization to identify and eliminate the root causes of racial and ethnic inequities. It will provide . . .*
>
> *• An eye on quality improvement with an internal and external focus;*
> *• An increased awareness of individual and organizational roles in achieving equity and racial justice;*
> *• A more accurate assessment of client needs and understanding of how to improve satisfaction and service delivery;*
> *• New opportunities to influence operational processes and decisions;*
> *• Increased ability to explain what you do and the value of your services to clients and community members;*
> *• A stronger integration of budgeting and workforce development with future program needs based on data and community partner input;*
> *• Increased contribution to positive social and economic impact on the community*
> *• Increased organizational capacity in: - strategic planning - capacity building with partners - performance measurement - data collection and analysis - process improvement.*

3.1.2 Positioning HEIA in the policy development process

In some jurisdictions, undertaking HEIA is legislated or required through policy or a commitment to best practice (for example, Healthier Wales, 2018; Public Health England, 2021; STAKES National Research and Development Centre for Welfare and Health Finland, 2007; Washington State Board of Health, 2020). Such mandates can provide clarity around what/when/who initiates the HEIA process. In other contexts, tools provide general guidance and rely on proactive leadership. In Australia, HEIA is not legislated and Harris et al. (2007, p. 8) note that a structured approach that provides clarity on how the process is initiated and progressed can be valuable:

> *<The process benefits> from having a transparent governance structure ... with terms of reference <and> an explicit, agreed upon, structured process of how the deliberations of the screening will feed into the development or modification of the proposal.*

Few authors articulated the interaction of the HEIA process with policy theory. Those that did (Campbell et al., 2022; Davies & Sherriff, 2012; Douglas et al., 2019; Green, Ashton, Bellis, et al., 2021; Kehoe et al., 2022) recognised how an understanding of the policy space contributes important contextual insight into factors that may shape the process, as well as the likelihood of uptake of recommendations. For example, Douglas et al. (2019, p. 333) note that:

> *Systematic evaluation of the policy landscape is critical for identifying and contextualizing factors across the entire policy cycle…*

Campbell et al. (2022, p. 171) recognised how different actors engage in the policy space to influence decision making:

> *The ... policy space ... denotes the 'room'<that> actors—both governmental and non-actors—have to address a policy issue <including> room available to government actors to develop policies …and room for non-governmental actors, including civil society, to engage with the policy process.*

Although many tools did not clearly articulate the relationship between HEIA and policy theory, in some cases, authors provided 'tips', that were not always part of the formal assessment process, but that could help uncover valuable insight related to the policy space that could accelerate the uptake of health equity-oriented recommendations. For example, in the NSW Health Impact Assessment Guide, Harris et al. (2007) discuss the need to understand the possibility of influencing decision-makers with respect to health equity-orientated recommendations for particular policies or programs.

If considering the more traditional, cyclic policy development process (**Figure 4**), HEIA is commonly applied during the policy formulation stage (Harris et al., 2014). This prospective application of HEIA is focused on identifying, raising awareness and altering any aspects of the proposal that might inadvertently be unfair, prior to

finalising and implementing the initiative. Many HEIA approaches and tools incorporate templates to aid in this process (an example is provided in **Figure 5**).

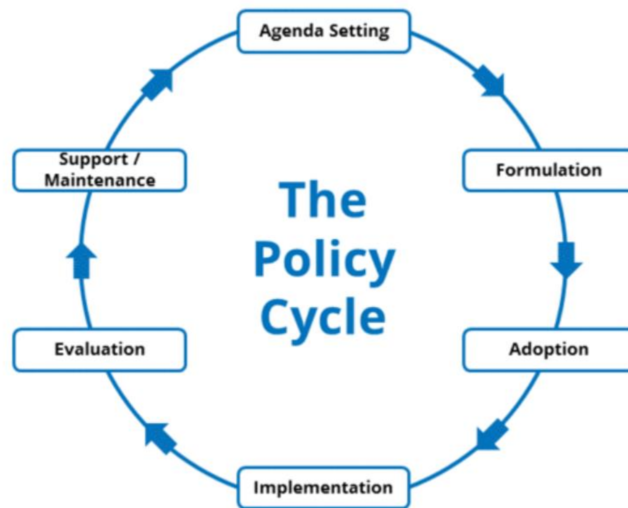

Figure 4: Stages of the policy cycle (Source: EGU blogs)

HEIA Template

Population(s) Identification [Section 1]		Potential Health Impacts [Section 2]			Mitigation Strategies [Section 3]	Monitoring & Evaluating Outcomes [Section 4]	Sharing Results [Section 5]
Using research evidence and other knowledge, identify population groups that may experience unintended (positive or negative) health impacts as a result of the program.	Identify potential social determinants of health factors and health inequities that may affect the identified population groups.	Unintended Positive Impacts.	Unintended Negative Impacts.	More Information Needed.	Identify ways to reduce potential negative impacts and amplify positive impacts.	Identify ways to measure success for each mitigation strategy.	Identify ways to share results, lessons learned, and recommendations to address health equity.

Guide to Applying a Health Equity Impact Assessment (HEIA) Tool

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Figure 5: Example of HEIA template (Windsor Essex County Health Unit, n.d., p. 38)

Several tools also incorporated pre-assessment screening questions intended to be used prior to undertaking a HEIA—both, to determine the need for a deeper investigation into the potential health equity implications of policies/programs (for example, Balajee et al., 2012; Windsor Essex County Health Unit, n.d.) and/or to

reflect on the broader policy/program environment and organisational capacity to undertake the assessment (for example, Harris et al., 2007). An example is provided below in **Figure 6**.

To your knowledge:	*Conduct a HEIA*	*No Need to Conduct a HEIA at this Time*
Is there potential for negative health impacts as a result of the policy, program, service or initiative? *(Although the intention of the program is to affect positive outcomes, consider that it could inadvertently create health inequities for other groups.)*	Yes/Don't know	No
Are the potential negative health impacts likely to affect a large number of people? *(Include consideration of future and intergenerational impacts.)*	Yes/Don't know	No
Are the potential negative health impacts likely to be disproportionately greater for disadvantaged or vulnerable groups in the population? *(Think about which groups in the population could be affected.)*	Yes/Don't know	No
Is there uncertainty about what the potential health impacts might be?	Yes/Don't know	No
Are there public or community concerns about potential health impacts?	Yes/Don't know	No

Figure 6: Example of pre-HEIA screening questions (Windsor Essex County Health Unit, n.d., p. 29)

While researchers generally agreed that HEIA should be initiated as early as possible in the planning process (Agic, 2019; Cole et al., 2019; Green, Ashton, Bellis, et al., 2021; Health Equity Network of Ohio, 2022), authors also recognised its usefulness at other stages of policy/program planning, implementation and evaluation. For example, **Figure 7** is from Ontario Health (2012) and indicates that a health equity lens can be applied both prospectively and retrospectively at various stages of the policy/program lifecycle, from defining and understanding health problems, through to the realisation of outcomes.

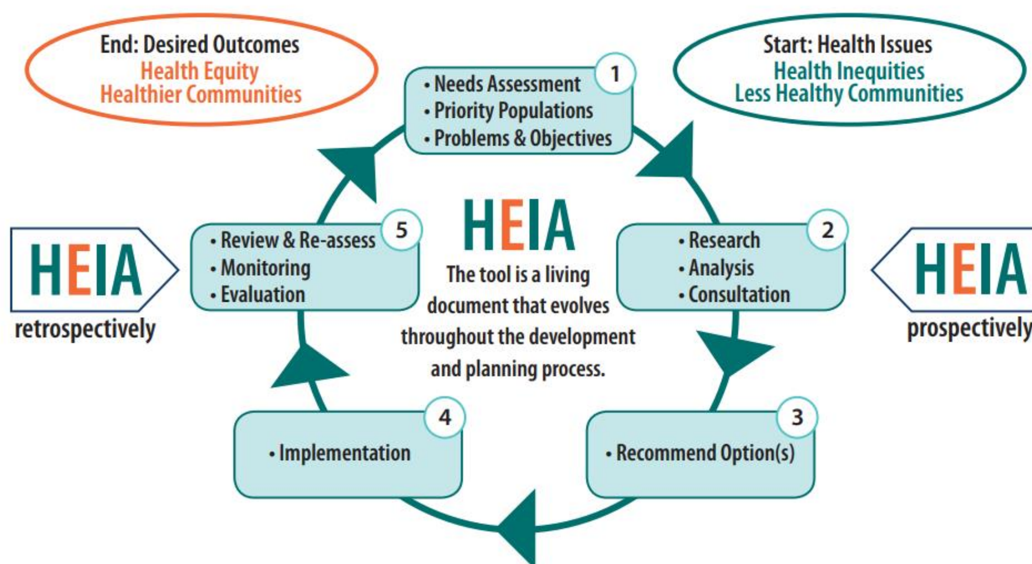


Figure 7: Opportunities to apply HEIA throughout the policy/program cycle (Ontario Health, 2012, p. 10)

Researchers also commonly reported on the retrospective application of HEIA (Came et al., 2020; Campbell et al., 2022; Cheng & Mistry, 2023; Cole et al., 2019; Cortes et al., 2018; Douglas et al., 2019). In this case, the HEIA—at least in theory—*"seeks to strengthen the focus on equity by identifying the unintended impacts of an existing policy or practice to inform future action. Essentially the goal is to look back to look forward"* (Mahoney et al., 2014, p. 6). The extent to which learnings from HEIA of policies in a jurisdiction are subsequently used to inform future action—through the agenda setting phase of the policy cycle—is unclear, although Lawless et al. (2012) indicate that engaging with the HEIA process can lead to a positive disposition toward employing a similar process in future work. A tool known as *EquiFrame* was specifically developed for retrospective application. The authors state: "*EquiFrame has been developed very deliberately to focus on the assessment of "policy on the books". It is not an alternative but, hopefully, it is complementary to, the related and complex processes involved in assessing the development, implementation and evaluation of policy"* (Mannan et al., 2011, p. 4). An excerpt from *EquiFrame* is provided in **Figure 8** below, to illustrate the nature of the questions included in the tool.

Green, Ashton, Bellis, et al. (2021, p. 6) argued that different tools may have different entry points into the policy development cycle, commenting on the difference between Health Lens Analysis (HLA) and Health Impact Assessment in South Australia:

> *The main difference is the entry point... A HLA starts early in the policy process and the HLA team is involved in developing policy responses and then gaining approval for them. A HIA is an assessment of a policy proposal or decision that has already been defined … and the HIA team is not necessarily involved in further policy development after making recommendations… A comparison of HLA and HIA, as used in two Australian states, found that both approaches enabled evidence-based recommendations to develop a policy that improved health and equity... The main difference was in the organisational positioning, rather than the mechanism used.*

No	Core Concept	Key Question	Key Language	Supporting Literature
1.	**Non-discrimination**	Does the policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e. Living away from services; Persons with disabilities; Ethnic minority or Aged).	See Annex I
2.	**Individualized Services**	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services.	See Annex II
3.	**Entitlement**	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant	See Annex III
4.	**Capability based Services**	Does the policy recognize the capabilities existing within vulnerable groups?	For instance, peer to peer support among women headed households or shared cultural values among ethnic minorities.	See Annex IV
5.	**Participation**	Does the policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.	See Annex V

Figure 8: Example of core concepts and questions in EquiFrame (Mannan et al., 2011, p. 14)

Cairney (2023)'s description of policy development reflects a more complex, and potentially irrational process (**Figure 9**) than the linear process described elsewhere (and summarised in **Figure 4**). The literature review provided examples of how HEIA can 'piggyback' on this more complex and organic policy development process. For example, researchers demonstrated how the context, specific global or local events, connection through networks and actors at various levels in the policy space, institutional change and ideas can provide windows of opportunity to facilitate HEIA processes. Some examples are provided below.

Events & Context

The combination of violence against black people in the US and the COVID-19 pandemic drew attention to *"long-standing racism at the heart of the ... health* care system*"* and the *"health disparities experienced by patients of colour"* (Olszewski et al., 2021, p. 418). These events triggered the development of *"a formal equity impact assessment tool*" which has since been systematically applied to policies and programs throughout a US health department. Olszewski et al. (2021) provide a case study of how the tool was applied to COVID-19 visitor restriction policies. Similarly, Green et al. (2020, p. 1) report on a HEIA of Brexit on Wales, and note that the assessment process has since been used *"to progress the practice of HIA in Wales and demonstrates the value of HIA as a method to inform and influence complex decisions."* Another example is provided by Campbell et al. (2022), who developed a conceptual framework for analysing the policy space, applying it in Myanmar during the period of political transition, to understand how changing policy circumstances offered opportunities for advancing pro-equity policy. The sustainable development goals and the COVID-19 pandemic were identified as key contextual factors for encouraging the development of health equity-friendly policy.

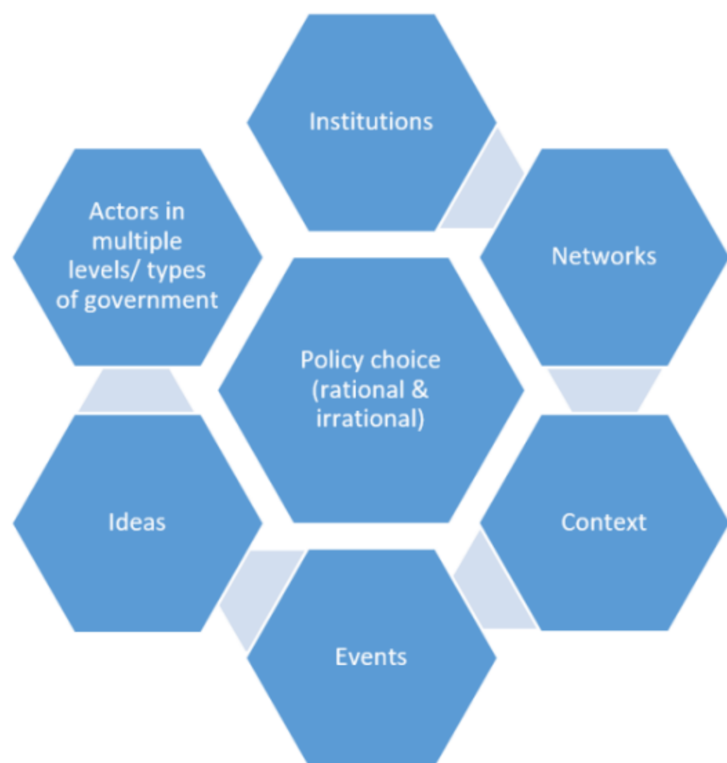


Figure 9: Alternative policy process (Cairney, 2023)

Networks

As many of the determinants of the health equity gradient lie outside of the health sector, it is imperative that public health practitioners relinquish sole ownership of health equity and engage with non-health sector 'champions'. Williams et al. (2023) illustrated how HEIA can be advocated by urban planners to build healthy communities by directing action at housing, transport, environmental justice and economic development. The researchers provide a series of guiding questions that planners can consider to better gauge their role in addressing health inequities. Similarly, other parts of the health system (outside of public health) may not routinely

consider equity assessment as part of their core duties. Tools such as that published by the Canadian Nurses Association (2006)—who developed a social justice gauge, off which health equity is a key attribute, to assist in policy development—and Diderichsen et al. (2022)—who developed an equity assessment tool for policy decisions related to inequities in disease incidence and treatment options—demonstrate the potential for health equity assessment in clinical settings.

Institutions

Weisman et al. (2019) report on efforts to embed an equity lens through institutional change in three US states. State-specific examples show how equity is being operationalized and woven into the fabric of state governance—including legislative, policy and funding decision making processes. One example comes from Minnesota where among other developments, a Chief Inclusion Officer was appointed, with the authors describing these developments as *"<A> braiding together of equity-rooted policy, politics, leadership, and community power <which> suggests a durable formula for transformational change"* (Weisman et al., 2019, p. 119). A number of tools have also pursued institutional change in relation to colonisation. Through the development of HEIA processes, researchers such as Jumah et al. (2023), Kehoe et al. (2022) and Came et al. (2020) aimed to advance health equity through decolonisation practices.

Actors & Ideas

Douglas et al. (2019) identified how HEIA processes can be used to engage and empower actors at multiple levels—including grassroots advocates. The researchers developed a health equity lens and applied it across five project areas relating to a range of health issues, including maternal-child health. The lens was applied retrospectively to measure and evaluate policy outcomes—downstream, midstream and upstream. In relation to maternal-child health, researchers assessed parents' desire to advocate for improved policies relating to healthy child development, noting how the process leveraged community members in the policy process to advance health equity. Similarly, SOPHIA (n.d., p. 1) is aimed explicitly at building community power in the policy process. The authors state that: "*Building community power is the process by which communities gain control over the factors that shape their lives, including access to information and opportunity, decision-makers, and policy-making."*

3.1.3 Theoretical orientation of HEIA tools

The literature review protocol focused on identifying articles and assessment processes that included reference to two key terms (inclusion criteria): health equity and policy. The positioning of policy theory has been described above. In this

section, we describe how health equity was framed within the HEIA tools, and identify other theoretical concepts identified in the studies and tools.

Social Determinants of Health Equity Theory

Many articles and tools define the term 'health equity' by drawing on widely accepted definitions such as that from the World Health Organisation (WHO):

> *... the systematic differences in health between social groups, places, or across the socio-economic gradient - exist both within and across all countries* (WHO 2018). (Davey et al., 2022, p. 1)

and Dahlgren and Whitehead:

> *Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible* (Whitehead and Dahlgren 1991). (Mahoney et al., 2014, p. 3)

Publications also provided definitions of related terms like 'social determinants of health', and many tools provided lengthy lists of the various determinants (for example, **Figure 10**).

Stage I: What is the impact on determinants of equity? (continued)

Stage One lists determinants of equity that may be affected by the proposed program/policy that you are considering.

Review this list and circle the determinants of equity that apply to your policy or program. *If your answer is none, then you are done.*

Equity in county practices that eliminates all forms of discrimination in county activities in order to provide fair treatment for all employees, contractors, clients, community partners, residents and others who interact with King County;

Job training and jobs that provide all residents with the knowledge and skills to compete in a diverse workforce and with the ability to make sufficient income for the purchase of basic necessities to support them and their families;

Community economic development that supports local ownership of assets, including homes and businesses, and assures fair access for all to business development and retention opportunities;

Housing for all people that is safe, affordable, high quality and healthy;

Education that is high quality and culturally appropriate and allows each student to reach his or her full learning and career potential;

Early childhood development that supports nurturing relationships, high-quality affordable child care and early learning opportunities that promote optimal early childhood development and school readiness for all children;

Healthy built and natural environments for all people that include mixes of land use that support: jobs, housing, amenities and services; trees and forest canopy; clean air, water, soil and sediment

Figure 10: Example of a list of determinants of health (King County, 2010)

Few authors took a deeper dive into underlying structural determinants of health equity, such as hierarchical systems related to class, gender and race. This may be in part because many of these determinants are complex, deeply embedded and difficult to change. A couple of notable attempts however include Balajee et al. (2012)'s Equity and Empowerment Lens and Davies and Sherriff (2012)'s Gradient Framework. Authors of the Equity and Empowerment Lens state:

> *In line with national equity efforts that define the three main drivers of inequities – racism class oppression, and gender inequity – the ... Lens will focus specifically on how to identify policies, procedures, and practices that contribute to institutional racism, classism, and sexism.* (Balajee et al., 2012, p. 62)

Multnomah County Health Department (USA) (2012) provided a series of practical suggestions for challenging harmful systems of inequity (**Figure 11**).

- **Acknowledge the existence of institutional hierarchy.** Change does not happen amidst denial. We know that the further down the hierarchy an individual or group exists the more they experience stress.
- **Make a commitment to examining how institutional hierarchy functions**, and mitigate the negative impacts.
- **Recognize when viewpoints from the dominant paradigm are privileged** and/or more readily adopted than viewpoints from non-dominant paradigms. Using a racial justice focus, integrate non-white paradigms into the work.
- **Intentionally include perspectives from multiple paradigms** in every discussion and decision-making process.
- **Adapt your structure and timeline** to integrate communities who value greater collaboration and deeper dialogue processes.
- **Examine where and how multiple areas of oppression exist in relation to the experiences of people affected (the existence of intersectionality).** When looking at the impact of a program on racial and ethnic populations, think also about how the program is affecting women and children of color, immigrants and refugees. Ask yourself how are people who identify as LGBTIQ who are also members of communities of color, immigrant, and refugee populations being affected?
- **Engage and value the perspectives of employees** from all levels or professional classes, top to bottom.

Figure 11: Recommendations for challenging systems that perpetuate inequities (Balajee et al., 2012, p. 68)

In the Gradient Framework, Davies and Sherriff (2012) distinguish between social and structural determinants of health, advocate a 'systems' perspective and argue for action across upstream, midstream and downstream levels:

> *<The Gradient Framework is> a tool that can be applied to different policy contexts including upstream (targets the circumstances that produce adverse health behaviours such as the determinants of health that are ingrained in structural inequalities of society); mid-stream (affects working conditions or targeted lifestyle measures) and/or downstream (attempts to change adverse health behaviours and lifestyles directly). However, <it> places more of a*

focus on up-stream actions which can have a greater impact on addressing the determinants of social inequalities in health, and thus levelling-up the gradient in health inequalities. (Davies & Sherriff, 2012, p. 22)

For many authors, the concept of priority populations was central to HEIA. For example, Sadare et al. (2020, p. 213), define priority populations as:

... those that are experiencing and/ or are at increased risk of poor health outcomes due to the burden of disease and/or factors for disease; the determinants of health including the social determinants of health; and/or the intersection between them. They are identified using local, provincial and/or federal data sources; emerging trends and local context; community assessments; surveillance; epidemiological and other research studies…

Priority populations were commonly presented as lists, for example see **Figure 12**.

Population Groups **(Remember many people are in several of these groups which may add to their vulnerability)**	How could these groups be affected differentially by the proposal?
• Older people, children and young people • Women, men and transgender people (include issues relating to pregnancy and maternity) • Disabled people (includes physical disability, learning disability, sensory impairment, long term medical conditions, mental health problems) • Minority ethnic people (includes Gypsy/ Travellers, non-English speakers) • Refugees & asylum seekers • People with different religions or beliefs • Lesbian, gay, bisexual and heterosexual people • People who are unmarried, married or in a civil partnership • People living in poverty / people of low income • Homeless people • People involved in the criminal justice system • People with low literacy/numeracy • People in remote, rural and/or island locations • Carers (include parents, especially lone parents; and elderly carers)	

Figure 12: An example of a list of priority population groups (Douglas, 2019).

Authors frequently used deficit-oriented language such as 'vulnerable', 'disadvantaged' and 'marginalised' to describe priority populations. For example,

Wherever possible, representatives of affected populations and communities should be actively engaged ... For example ... identifying what groups within the community or population may be ***disadvantaged*** *or* ***marginalised****.* (Harris et al., 2007, p. 23)

> *The following are some general questions that could help when making recommendations ... who is likely to be **disadvantaged** by the policy proposal, how many of them are there, how serious is the **disadvantage**, and how could they be compensated?* (New Zealand Ministry of Health, 2007, p. 32)
>
> *The tool has the potential to incorporate health equity into mental health service planning and improve access to and quality of care for **marginalized** and **vulnerable** populations.* (Agic, 2019, p. 42)

Although targeted initiatives to address the specific needs of population groups facing additional challenges are important to advance health equity, universal social and health protection policies are equally important for flattening the social gradient in health. Recognition of the social gradient and related concepts such as proportionate universalism (NHS Health Scotland, 2014) were less common in the articles and tools in this review, though there were some examples, such as:

> *…equity means reducing systemic barriers to equitable access to high quality health care for all; addressing the specific health needs of people all along the social gradient, including the most health disadvantaged populations; and ensuring that the ways in which health services are provided and organised contributes to reducing overall health disparities.* (Toronto Central LHIN, 2009, p. 3)

While some authors provided a definition or explanation of the social gradient in health (for example, Beenackers et al., 2015; Came et al., 2020; Canadian Public Health Association, 2020; Signal et al., 2008; Windsor Essex County Health Unit, n.d.), there were few tools that translated the theory into practical action. Again, the Gradient Framework (Davies & Sherriff, 2012) was a notable example as it specifically included assessment questions aimed at understanding the potential impact of an initiative on the gradient. Another example was provided by Davey et al. (2022), who present a framework to guide decision-making aimed at 'levelling the social gradient in health' (**Figure 13**).

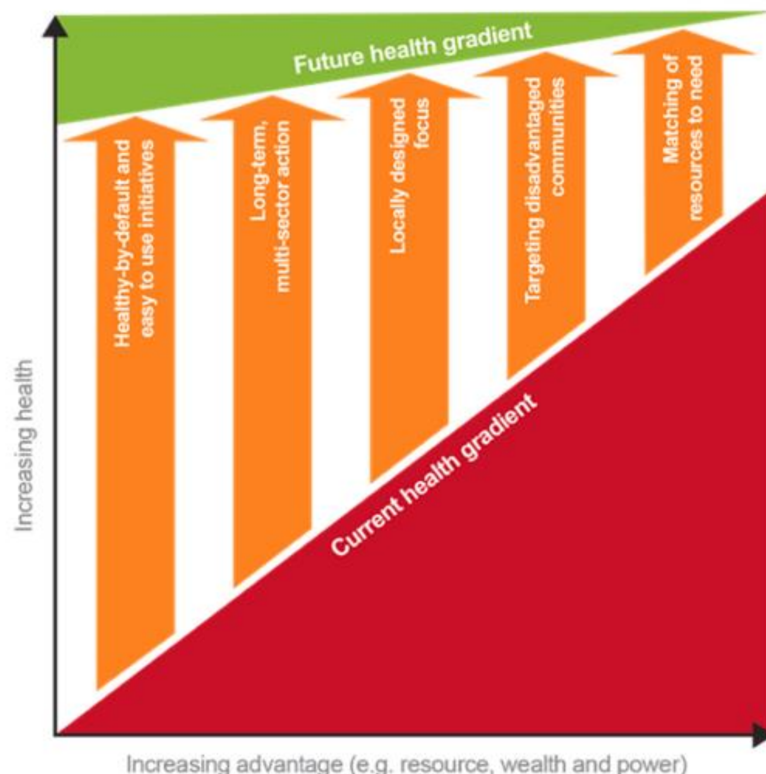


Figure 13: A Framework for Levelling Up Health (Davey et al., 2022)

Researchers noted that there appears to be confusion about what is actually meant by levelling the gradient, with policy makers focusing on priority population groups so as to ‘reduce disadvantage’ and ‘close the gap’ rather than ‘level the gradient’. Davies and Sherriff (2012) argue that levelling the gradient and reducing health gaps and disadvantage are not the same. They point to the Norwegian National Strategy to Reduce Social Inequalities in Health (Norwegian Ministry of Health and Care Services, 2007) as an important example of policy aimed at levelling the gradient.

HEIA approaches are grounded in evidence of the social determinants of health equity, however, there were also a number of other theoretical concepts identified in the publications. The theoretical orientation of HEIA approaches is reported to support tool utility if the concepts and associated language aligns with an organisation’s values (Pauly et al., 2018). **Table 1** provides a summary of the theoretical concepts identified through the literature review and the contribution of these concepts to the HEIA process.

Table 1: Theoretical concepts identified in HEIA tools

Theoretical concepts	***Contribution to HEIA***	***Examples of relevant articles and tools***
Critical theory	A paradigm that helps to identify and challenge the social structures that perpetuate inequities (such as racism).	(Hankivsky, 2021; Hull et al., 2023; Plamondon et al., 2023)
First Nations Knowledges and Decolonisation	Brings the rights and voices of First Nationals peoples to the fore and advocates that colonisation practices cease.	(Came et al., 2020; Hankivsky, 2012; Jumah et al., 2023; Kehoe et al., 2022)
Democracy and civil rights	Advocates that sovereign power resides equally among all peoples and that people have the right to participate in policy/program development.	(Canadian Nurses Association, 2006; Cole et al., 2019; Mahoney et al., 2014; Public Health Wales, n.d.)
Empowerment theory	Seeks to build power and self-determination among communities, groups and individuals as part of the HEIA process.	(Guichard et al., 2015; Human Impact Partners and Big Cities Health Coalition, 2020)
Gender studies	Assists in understanding gender representation in policy/programs.	(Balajee et al., 2012; Fagrell Trygg et al., 2022; Hankivsky, 2012)
Human rights	Contributes principles of value, dignity and respect regardless of identity labels.	(Canadian Nurses Association, 2006; Mannan et al., 2011; Sigerson & Craig, 2014)
Intersectionality theory	Contributes understanding of the ways that multiple forms of inequality interact and can	(Hankivsky, 2012; Hull et al., 2023; Williams et al., 2023)

	compound to influence health equity outcomes.	
Medical care	Considers equitable access to health care.	(Agic, 2019; Cheng & Mistry, 2023; Hankivsky, 2012)
Intersectoral partnerships	A means to incorporate complementary skills, resources and perspectives.	(Beenackers et al., 2015; Mahoney et al., 2014; Sadare et al., 2020)
Policy space	Can help identify barriers and enablers related to the policy environment that have implications for equity.	(Campbell et al., 2022; Kehoe et al., 2022)
Power	An understanding of who has power and how it is exercised is important to directly and indirectly interact with policy/program development and implementation.	(Came et al., 2020; Hankivsky, 2012; Plamondon, 2020; Plamondon et al., 2023)
Reflexivity	Essential for critical reflection and challenging assumptions.	(Hankivsky, 2012; Kehoe et al., 2022; Plamondon et al., 2023)
Social gradient & proportionate universalism	Recognises that health equity gains require action across the social gradient i.e. a combination of universal and targeted approaches.	(Davies & Sherriff, 2012; Guichard et al., 2015)
Complexity theory	Contributes a deep understanding of how multiple determinants combine to influence health equity.	(Davies & Sherriff, 2012; Hankivsky, 2012; Public Health Wales, n.d.; Williams et al., 2023)

3.1.4 Public and practitioner involvement in HEIA

The literature review revealed that community members/citizens may be involved in the development as well as the application of HEIA processes. For example, Hull et al. (2023), in the development of their intersectionality-oriented toolkit, described how citizens participated in an expert working group to review existing tools and provide guidance on drafting a new tool. The researchers noted:

> *We developed the Toolkit by engaging the intended end users at each phase. We sought guidance and feedback from policymaking experts, CBO staff and leadership, advocates, community members, and academics in the conceptualization and development, with multiple rounds of refinement.* (Hull et al., 2023, p. 632)

Researchers informed by decolonisation theory also described engagement with First Nations peoples in the development of tools. For example, as part of their decolonising framework for Aboriginal and Torres Strait Islander health policy analysis in Australia, Kehoe et al. (2022, p. 8) consider the principle of power sharing:

> *Our principle of power sharing is defined as policy environments where Aboriginal and Torres Strait Islander control and partnership is supported by legal or contractual requirements;*

Aboriginal and Torres Strait Islander Peoples and organisations are sufficiently resourced to participate in policy processes on an equal footing with government; and where their rights to free prior and informed consent are upheld.

Similarly, Came et al. (2020)'s critical Tiriti policy analysis grants the 'final word' to Māori.

Cole et al. (2019, p. 311) state that community engagement—including *"assessing and reporting concerns of community stakeholders ... to give voice to the views off disenfranchised communities"* should be a key feature of HEIA that sets it apart from HIA, where it is often overlooked. Authors who adapted the six step HIA process (screening, scoping, assessment, recommendations, reporting, monitoring and evaluation) to develop an equity assessment process commonly incorporated citizen engagement into the scoping or assessment phases.

More innovative approaches incorporated citizen engagement throughout the entire policy process. For example, (Hull et al., 2023) recognised citizen engagement as an essential ongoing thread woven throughout every stage of HEIA of the policy lifecycle (**Figure 10**).

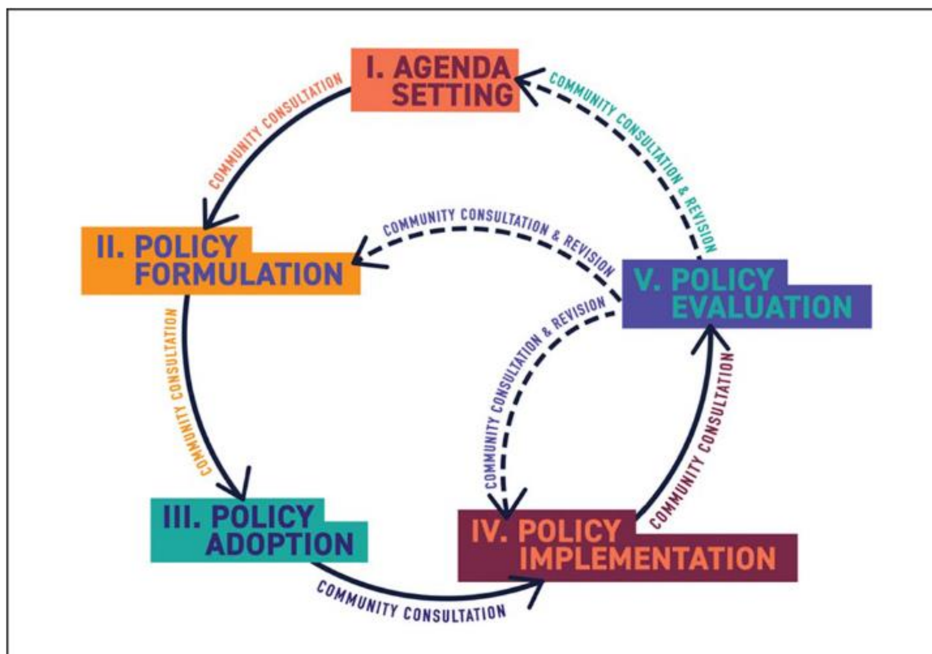


Figure 10: Community engagement incorporated at different stages of the policy cycle (Hull et al., 2023)

Several authors recognised the role of power in relation to citizen engagement in the HEIA process, both in terms of existing power imbalances and how to use the process to build power (Balajee et al., 2012; Hankivsky, 2012; Kehoe et al., 2022; SOPHIA, 2016). Balajee et al. (2012)'s Equity and Empowerment Lens, includes four key concepts—people, place, process and power—considered to influence equity (Figure 11). Balajee et al. (2012, p. 9) state:

To further help guide your transformational change process, the Lens employs a holistic and culturally responsive framework that includes reference to the key areas that influence equity. Research indicates that equity and inequity are driven by a set of interrelated factors. Examining these interconnections between people, place, process and power is an accessible way to deeply understand your organization's impact on communities.

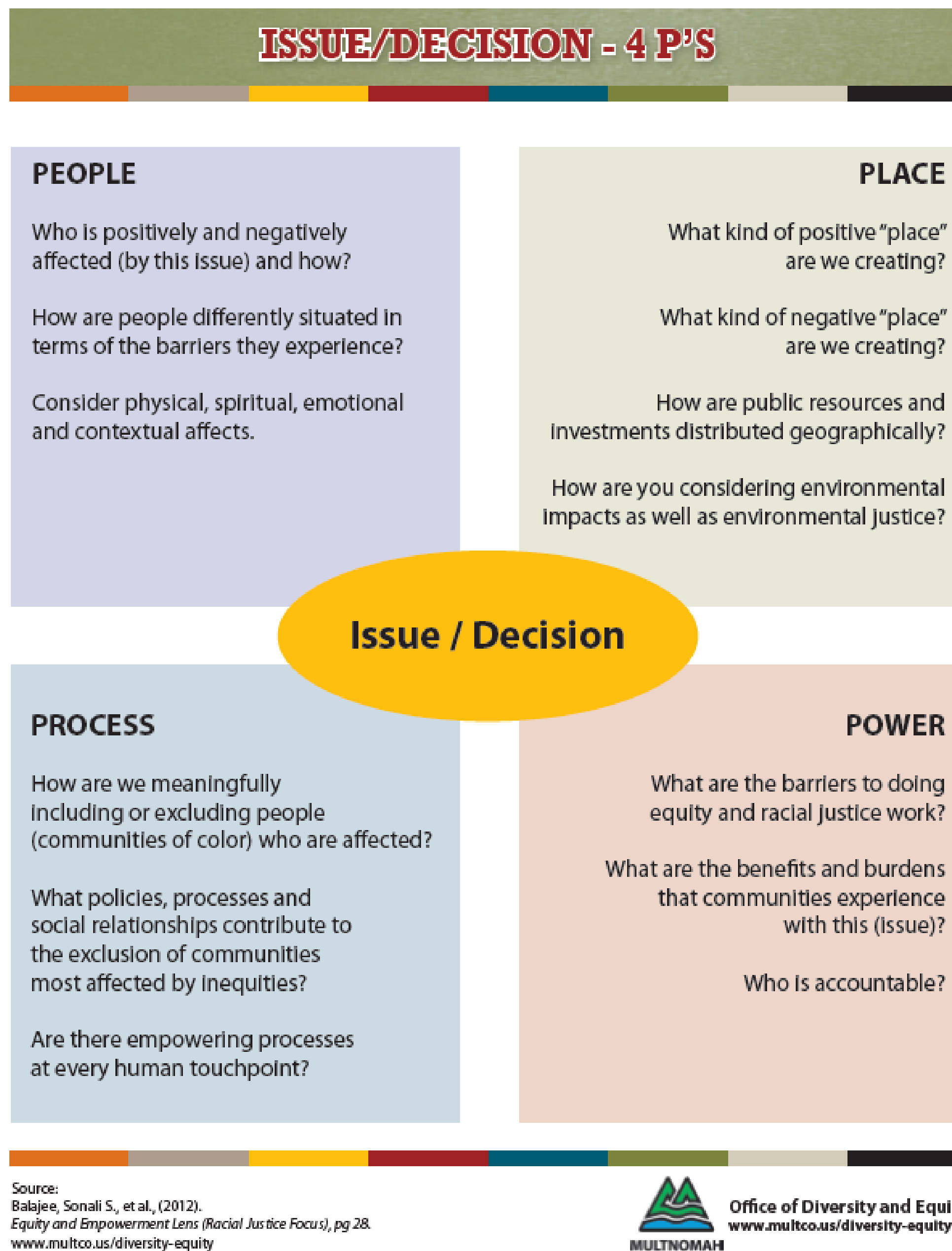


Figure 11: The 4 Ps as described by Balajee et al. (2012)

In terms of practitioner involvement, there were a variety of approaches across the HEIA literature. Some tools were developed by researchers, informed by existing frameworks and the academic literature (Fort et al., 2023; Hull et al., 2023); others were developed with policy practitioner involvement (Campbell et al., 2022; Cortes et al., 2018; Green et al., 2020), sometimes using 'action-research' and capacity building processes (Mahoney et al., 2014). In a number of cases, little information

was presented about how tools were developed and who was involved (King County, 2010; STAKES National Research and Development Centre for Welfare and Health Finland, 2007).

3.1.5 Identity the extent of the tools' application and evaluation in practice

Despite the large number of HEIA tools available, there appears to be relatively limited subsequent research on the application and evaluation of the tools. Web and database searches of the tools identified in this review revealed a limited number of examples of the uptake of tools by other practitioners or researchers (**Table 2**).

Table 2: Examples of reporting on the applying HEIA tools developed by others

Name of tool	***Reference reporting on application of tool***
Human Impact Assessment developed by STAKES National Research and Development Centre for Welfare and Health Finland (2007)	Guglielmin et al. (2022) report on the use of Human Impact Assessment in Finland.
NSW's Health Impact Assessment: A practical guide developed by Harris et al. (2007), Australia	The tool is applied by Harris-Roxas et al. (2014) as part of health service planning and by Harris-Roxas et al. (2011) to develop an implementation plan for chronic conditions prevention in Australia.
An intersectionality-based policy analysis framework developed by Hankivsky (2012), Canada	Williams et al. (2023) draw on Hankivsky's framework for urban planning in the USA.
The Gradient Framework, developed by Davies and Sherriff (2012), UK	Fosse et al. (2019) applied the Gradient Framework to investigate the implementation of Norway's Public Health Act at the municipality level.
Multnomah County's Equity and Empowerment Lens, developed by Balajee et al. (2012), USA	Olayiwola and Rastetter (2020) don't fully apply the lens but do reference it as useful tool for breaking down "exclusionary policies and procedures." The authors discuss the tool in terms of the example of food security.
The Health Equity Impact Assessment developed by Ontario Health (2012), Canada	Pottie et al. (2019) report on the development of the Migrant Population Equity Extension – a supplementary assessment process to Ontario's Health Equity Impact Assessment to specifically address the needs of migrant population within a program and policy framework.
Equity Focused Health Impact Assessment, developed by Mahoney et al. (2014), Australia	A widely recognised tool that was developed prior to the reporting period but is still commonly referenced (for example, Agic, 2019; Green, Ashton, Bellis, et al., 2021; Williams et al., 2023), was applied retrospectively by Cortes et al. (2018), to Portuguese law on smoking prevention and tobacco control. Also used by Olayiwola and Rastetter (2020) to look at food security in Iran.
Advancing Health Equity through Health Impact Assessments developed by SOPHIA (Society for Practitioners of HIA) Equity Workgroup (2016)	Goff et al. (2016) evaluated three case studies in the USA where HIAs were conducted, against specified equity metrics.

Rapid Response Equity Lens Tool, developed by Washington County (2019), USA	Myint et al. (2022) applied this tool to aid in rapid decision making during the COVID-19 pandemic in the USA.
Health Impact Review developed by Washington State Board of Health (2020), USA	Pollack Porter et al. (2019) investigate the use of Health Impact Reviews in Washington State in the USA.
EquiFrame developed by Mannan et al. (2011)	Trezona et al. (2018) used EquiFrame in combination with another tool (Analysis of Determinants of Policy Impact) to inform the development of another framework for analysing health literacy in public policy documents in Australia. Rono et al. (2022) used EquiFrame to assess how health equity was incorporated into Maternal, Newborn and Child Health (MNCH) policy in Ethiopia.
Checking Assumptions to Advance Equity developed by the (Office of Health Equity, n.d.), USA	Weisman et al. (2019) report on Colorado State's use of the tool.
Health Impact Assessment developed by Public Health Wales (n.d.)	Green, Ashton, Azam, et al. (2021) use the tool to consider the implications of COVID-19 staying at home and social distancing policy in Wales. Green et al. (2020) use the tool to consider the impact of Brexit in Wales.

In addition to the use of HEIA tools reported in the academic literature, there were examples of HEIA uptake in grey literature documents (deRosset & Zachary, 2018) and examples of their use are also available on websites (for example, Public Health England and Washington State Board of Health).

Several authors of review articles reflected on the challenges and/or facilitators to the successful implementation of the HEIA process and/or arising recommendations (Green et al., 2020; Guglielmin et al., 2018; Hull et al., 2023; Pottie et al., 2019; Weisman et al., 2019). These researchers highlight a range of issues, including the need for structural support for the HEIA process, aligning with existing statewide initiatives and long term, government-led stewardship (Green et al., 2020; Guglielmin et al., 2018; Weisman et al., 2019). The importance of meaningful partnerships and trusting relationships including with community were also highlighted (Pottie et al., 2019; Weisman et al., 2019). Hull et al. (2023) report in detail on their tool's acceptability (i.e., design fit with workflow, visual presentation, information flow and volume), the potential for adoption (i.e., design features that foster/inhibit adoption), relevance (i.e., relevance to the audience, relevance inequities and policy), and feasibility (i.e., practical utility). Sigerson and Craig (2014), in respect of HEIA in Scotland, argued that a robust HEIA must involve timely planning, meaningful engagement, systematic consideration of impacts, evidence-informed and recommend proportionate action.

Outside of this review, other researchers have specifically commented on the barriers/enablers to HEIA application. For example van Roode et al. (2020) identified seven critical elements necessary to support advancing health equity-oriented approaches, including: creating a systems value for health equity, engaging health

equity champions, explicitly naming health equity as a priority, requiring health equity in decision-making, designating resources for health equity, building capacity and competency for health equity, and coordinating a comprehensive approach. Tyler et al. (2019) found that practitioners experienced challenges in using evidence and data for completing equity focused impact assessments. Pauly et al. (2018) investigated the factors that make HEIA tools practical and useful, identifying six clusters considered to be important and feasible. These were related to: 1) evaluation for improvement; 2) user friendliness; 3) explicit theoretical background; 4) templates and tools; 5) equity competencies; and 6) client engagement.

Review researchers and others have reported that the HEIA process resulted in enhanced understanding of health equity among stakeholders, increased capacity for advancing health equity and increased deliberation of policy/program alternatives in favour of health equity (Guglielmin et al., 2018; Harris-Roxas et al., 2014; Harris-Roxas et al., 2011; Lawless et al., 2012; Pollack Porter et al., 2019). Hall and Jacobson (2018) note that practitioners use HEIA selectively and strategically, and found that users of the process shift in their focus from health generally to health equity specifically over time.

Heller et al. (2014) moved beyond process measures and developed a set of metrics to assist practitioners to evaluate progress towards equity in HIA, including indicators to help evaluate shifting power dynamics and reduced inequities in social determinants of health; with positive outcomes reported by Goff et al. (2016). Researchers elsewhere have reported mixed results (Braughton et al., 2020; Cole et al., 2019; Hall & Jacobson, 2018; Leuenberger et al., 2019; Povall et al., 2014; Sohn et al., 2018; Tyler et al., 2019). Cole et al. (2019), in examining how HEIA is operationalised in the respect of transport policy in the USA, found that fewer than half of the assessments adequately incorporated data on the distribution of health inequities in assessment processes. Povall et al. (2014) agree, noting that equity was inadequately addressed in HIA amidst inadequate guidance, absence of definitions, poor data and evidence, and low capacity. However, a scoping review of HEIA use in sub-Saharan Africa found *“positive effects on the health of vulnerable population groups in context where rigorous HIA was commissioned by extractive industries”* (Leuenberger et al., 2019, p. 8). In addition, a review of 62 HIAs in 2020 to help answer the research question: *Do health impact assessments help promote equity over the long term?* found that HIA may promote systemic changes that could advance health equity but that more research is needed to identify effective ways to research the long-term effects of HIAs (Braughton et al., 2020). Further research and translation into practice to close the gap between what is often presented as a ‘neat and straightforward’ HEIA and how the process behaves in practice, as well as the ultimate health equity impact, would be worthwhile.

3.2 Key themes from co-design workshops

Participants of the two workshops in each jurisdiction identified eight key themes relevant to the development of HEIA tools. These are outlined below.

1. **Level of understanding of health equity:** Participants noted that stakeholders' knowledge and understanding of health equity can vary widely. This was considered relevant to those who work in the health sector, as well as those working in other sectors. Some participants commented on the apparent reluctance among health practitioners to recognise gaps in their own knowledge, particularly in relation to local cultural knowledge, and that it can be challenging to encourage colleagues to critically reflect and engage with the holders of other knowledges. Participants noted that the HEIA process has the potential to get stakeholders 'on the same page', build a shared understanding of the concept of health equity and challenge assumptions. The proviso being that there is a supportive structure (endorsed by senior management) that fosters a common language, deep listening, reflecting and gcollaboration with local knowledge.

   Participants expressed the need for a simple process that can be used by a wide range of stakeholders, and that allowed for some flexibility. Short, simple tools were considered to provide 'higher level questions' for reflection rather than an interrogation of the detailed components of policies/programs and were considered useful for cross-sector engagement (where levels of knowledge may vary) and for use in time-poor contexts. Others perceived rapid assessment tools as 'more entry level', that didn't allow for enough deep thinking of the issues.

   Some examples of participants' comments are outlined below:

   "…working with say, partner organisations that are less along in equity journey, we've got <to have> a description - if there's too much jargon, that might lose people."

   "…I like the Finnish model in that it's three questions and they're quite clear, and it can be interpreted as wide or as small scale as you want it to be."

   "…to make sure that as many people as possible could use a tool and still have flexibility to have a consistent approach..."

   "…we're quite often time poor and time pressured and you know we want to get these things right but we need to have concise and understandable information in order to be able to really make the right decisions as well."

   "…some of the tools that were presented were quite complex."

   "So, at the start when we're conceptualising something, there might be some really high-level questions that we need to be thinking about when we're talking about equity from whichever

lens we’re looking at it. But then when we get into the detailed planning stage, that’s when you need to break out your higher level or more detailed audit questionnaire or tool to specifically look at each element of the project to make sure you’re applying this lens. And then when you’re implementing, if you have the ability like we said to tweak and kind of reassess as you’re going, what’s the tool look like then to be able to make sure you’re continuing to consider equity, and if things have changed, how do we pivot to make sure we’re still considering it?”

“…and I particularly like the idea of questions that make you interrogate your assumptions and to think about, you know, other ways of working.”

2. **A tool versus a process:** While some participants were initially drawn to simple HEIA tools with limited questions, group discussions highlighted examples of potential barriers and enablers to implementing HEIA processes, including how the process might be influenced by the characteristics of the policy or program, and the wider context. Participants reflected that at times a rapid assessment might be appropriate, whereas at other times a more comprehensive approach may be warranted. Participants drifted in their thinking as the workshops progressed towards greater consideration of the context in which HEIA takes place and process issues that might arise—such as workplace capacity, how the HEIA might be initiated and progressed, and how monitoring and evaluation can be part of HEIA. Participants agreed that the actual tools are only one part of HEIA, and that there are many other factors that influence the life course and impact of HEIA. In Tasmania, participants expressed a desire to develop a frame to guide practice, that could be adapted and added to over time. The notion of a ‘toolbox’ made up of different methods and tools was considered an appropriate way forward. Wellbeing SA staff also recognised the importance of developing a HEIA process that found facilitate the engagement with stakeholders, enable knowledge and skills sharing, and enhance monitoring and evaluation practices.

“My concern is that the tool could become a tick box exercise too quickly ... and so I prefer the more in-depth and detailed tool.”

“…we thought that there were a couple of questions perhaps missing or things that we could add. So one thing was before they even described stage was, well, what has happened to get us here? How did we get to this point, and how did we identify this need? So something about the how did we get here and how did we identify that we need to do this work?”

“<I’d rather > a framework, not and I wouldn't like to see a tick-a-box, but something that makes you think deeper than really looks at what you're doing and the impact.”

3. **An iterative process:** Participants commented that they often work on complex health and social problems, such as addictions and communities with low socio-economic resources, and that this needed to be reflected in the HEIA process. Some participants felt that simple tools did not compliment the

complex nature of many health problems, and that the process should allow for a deeper level of consideration of potential impacts. Participants expressed a need for an iterative process, that fostered reflective learning and allowed practitioners to change the order or repeat steps in the HEIA process, such as data collection and community engagement, as needed.

"Apart from thinking about answering yes <or no – in a tool> it could be ... yes BUT… open to increasing yeses ... Yes, I've kind of been thinking about it but I'm not convinced that I know everything but I think I know something so this is an open thing so we keep adding more ... have we thought about this or that < > as things come to light <we can ask> what do we try to do to improve that…"

"But I do wonder how we can expand our thinking around not just getting to implementation but through implementation because I think we're trying to shift the way we do things, it's not just about set and forget, it's actually about allowing reflection points through the whole process."

"We did wonder whether the way that the frame is at the moment is a little bit too linear in its steps because and the ability to sort of be able to have something where it reflected that iterative learning process as you go, and even the way that the measure is framed up, it's all about kind of like the end product and we know that complex systems, you never get an end product."

4. **Practical considerations:** Several participants perceived there to be a high level of understanding of what health equity assessment involved and that it was already part of their practice, but that the process was not structured, documented or reproducible in an agreed manner. There were many questions raised about how the HEIA process would fit into existing practice, how it would be initiated, resourced and documented, and how accountability could be ensured.

"So, the practitioners here, it's just part of their DNA to consider equity in the work that they do but it's not made explicit how they've gone about it and systematically addressed. I was kind of describing earlier how it's not made explicit. I think everyone is kind of thinking in that space but by not making it explicit, by not having a systematic approach, it's not necessarily always –"

"We talked about I guess incorporating equity whether it's a tool or as a concept or as a process into some of the existing project planning tools that we already utilise. So, as <participant> said, we already have some processes around having new project proposals being signed off and they have an executive sponsor. So, I guess in terms of considering capacity for people to do this, embedding it into something existing."

5. **Organisational capacity and commitment:** Participants spoke about the need for capacity building strategies to support the HEIA process. They also called for an umbrella organisational culture that proactively advances and supports health equity-related practice. This was true in respect of all aspects of the HEIA process, including specific concepts such as the relationship of initiatives to the social gradient in health. Participants felt that through the

HEIA, organisational capacity (knowledge, skills, partnerships, data collection, community engagement and other resources) could be bolstered.

“We also had a discussion about the potential of the tool to be an education tool in itself. So not just asking the question, will this have a negative impact on certain groups? But like… using that opportunity of people having to go through the tool to do a bit of education as well.”

“…what we found was that some of the barriers that might get in the way of the, the lack of skills, experience from the people who are facilitating the process. And so having some resources training, having organizational buy in and a commitment to equity in the first place would be very important, particularly when you're describing the situation, because if you can be explicit about the equity issues right from the start, that will kind of flow through.”

“The other thing that we talked about that the tool, whether it's a tool, frame, whatever process you use that it needs to be supported by the culture and the system and the structure to do so, both that's terms of time and resources. But it's also kind of the that conversation is welcomed and seen as important, and that people feel safe that it's an equitable space to talk about equity, I guess in itself.”

6. **Community Engagement:** The importance of quality community engagement, listening to community voices and being mindful of power dynamics when engaging with community were raised by many workshop participants as being central to the HEIA process. Participants said that community engagement should take place early in the process, and practitioners should consider returning to this step throughout the HEIA lifecycle.

“I just think that's important to consider, particularly around the listening. And if you're involving people in shaping decisions to do, you have the buy in from the people who are paying for the process to that they are prepared to listen to the people who may not have the power in the room.”

“…consultation was another theme that we discussed about how to do it. The timing of it, make sure we're getting the right voices, but also not over consulting and ... making sure that we aren't, yeah, consulting those have been consulted too much and perhaps if we've already got some data, maybe we need to go back to that and look at what have we missed.”

7. **Data:** Workshop participants raised numerous issues about the use of data in the HEIA process, including the lack of quality data, resource constraints in collecting further data, challenges associated with interpreting data and recognising the value of other sources of ‘data’ such as local knowledge.

“So the first part of <it is> about the data. So the idea that we never have good data, it's never standardized and there's no problem if you can't measure and demonstrate the problem with the data. Uh, so that's always an ... ongoing concern.”

8. **Structural Determinants:** Some participants, in both jurisdictions, recognised the need to focus on systems of inequality, rather than individual identities, throughout the HEIA process. They also identified the challenges associated

with this, given that many of the determinants of health lie outside the health sector. None-the-less, incorporating structural-oriented questions into the HEIA tool to encourage critical thinking was considered important. For other participants, the focus of HEIA was more aligned with targeting priority populations.

"... sort of trying to make sure when we're talking about issues like positioning them as being driven by the structures and systems rather than representing them as personal issues, so trying to have those kind of questions to I don't know, make us step back just to make sure we are taking that systems kind of approach.

"…the balance between all the sort of identity markers and individual identities that you can list and how that's never ending. And maybe one way around that is to focus more on systems of inequality rather than individual kind of identity groups. So looking at racism and patriarchy and colonialism, rather than those, you know, the how they play out with individuals."

"For me, it's about guiding questions to help whoever's using the tool consider who might be left out or disadvantaged by the decision."

3.2.1 Draft HEIA tools in context

While there were common themes raised by participants of the four workshops in the two locations, the final tools that were developed were further shaped by the local context including current opportunities to apply the tools, the level of understanding of the HEIA process, and organisational readiness and willingness to progress the health equity agenda. For example, during the second workshop with staff from Wellbeing SA, where participants reflected on the draft tool, the following contextual factors were identified:

- The agency frequently works with partner organisations, including other government agencies, therefore the HEIA tool needs to be able to be used by all parties, who will invariably have different levels of knowledge and understanding of health equity concepts. Participants identified that there may be times when one tool may be more appropriate than the other depending on whether the partners have worked together before and their mutual understanding of the process.
- There are times when rapid responses are needed (e.g. when responding to ministerial requests). At such times, a more comprehensive tool may not be feasible however a 'high level' question-style tool may be appropriate.
- The agency has a strong focus on evaluation, and staff could foresee using a HEIA tool to aid in evaluation design and implementation. There was considerable interest in applying the tool both prospectively and retrospectively. Participants identified how the questions in the tools could also be answered by participants of initiatives (e.g. the public).

- Questions were raised about how to 'stop the tool becoming a tick-a-box' exercise and how the tool's use will be recorded. There is no legal framework to support the implementation of HEIA and as such embedding the tool into practice will require a combination of strategies, e.g. HEIA champions, 'managing up', knowledge sharing, developing mechanisms to capture the tool's use and incorporating the tool into existing processes. Participants noted that bureaucratic structures are prone to change so spending time *"getting new people on board"* with the process may be necessary. Leadership was also identified as a key contextual factor because of its impact on the nature of shared decision-making and power dynamics.

In Tasmania, an equity lens is called for in the Healthy Tasmania Five Year Strategic Plan. While the Tasmanian Department of Health has been actively progressing a health equity agenda, the Healthy Tasmania initiative is a collaborative work area, involving partners from within, across and outside the agency. Early on in the co-design process, Tasmanian partners determined that 'a process' rather than a specific tool was more appropriate at this point in time. A Frame was developed, with the aim that this could be further developed and include a 'toolbox' that staff and partners could draw on depending on particular scenarios. Much of the discussion among the Tasmanian team focused on values, theory-informed concepts and priority principles of practice—these were built into the Frame to provide a clear foundation for progressing HEIA.

Both the Tool developed with staff from Wellbeing SA and the Frame developed with the Healthy Tasmania team can be found in the **Appendices**. Wellbeing SA and Healthy Tasmania staff suggested pilot testing as a next step.

4.0 Conclusion

HEIA has much potential not only to shape policy and program development and implementation, but also as a vehicle to engage with non-health sectors in decision-making, to challenge power imbalances across social hierarchies, and to build capacity for advancing a health equity agenda. Assessing the health equity impact of policy and other initiatives is not a new concept, but its application as a global movement to advance the health equity agenda has not been particularly progressive. Despite the many tools and guidelines available, many of these approaches focus on identifying priority population groups, closing health equity gaps and downstream approaches at the exclusion of considering the social gradient in health. Although several equity gradient-focused HEIA tools exist, there appears to be limited application and evaluation of such approaches that call for more focus on upstream determinants. Further research is needed to fully understand the likely impact of gradient-focused HEIA application on levelling the health equity gradient. Adapting existing HEIA tools to critique macro-level policies may also be worthwhile,

as well as further consideration of how to engage gatekeepers involved in upstream, structural decision-making.

Co-designing HEIA approaches with public health practitioners and their various partners provided useful insight into policy makers and other (government and non-government) stakeholders' enthusiasm for the approach, how HEIA is perceived and understood, the behaviour of the authorising environment and the contextual factors that are likely to influence its application. This experience suggests that a 'one-size-fits-all' approach to HEIA may not always be appropriate. Instead facilitating stakeholders' access to the range of tools available, adapting them to suit the decision-making setting and maintaining a pragmatic focus appears to be worthwhile.

References

Agic, B. (2019). Promising Practices in Equity in Mental Healthcare: Health Equity Impact Assessment. *Healthcare Papers*, *18*(2), 42-47. https://doi.org/10.12927/hcpap.2019.25921

Balajee, S. S., Cross, T., Curry-Stevens, A., Duncan, B. B., Fuller-Poe, K., Gaonkar, R., Hermanns, N., Hofrichter, R., Holbert, T., Johnson, K., Johnson, R. H., Johnson, S., Lindahl, K., Lynch, T. H., Lyons-Eubanks, K., Maciel, G., Mahar, J., McClendon, B., McSharry McGrath, M., Managers of Color, Pizacani, B., Green, A., Wiggins, N., & Zaragoza, P. (2012). *Equity and Empowerment Lens*. Portland, Oregon: Multnomah County.

Baum, F., Freeman, T., Musolino, C., Abramovitz, M., De Ceukelaire, W., Flavel, J., Friel, S., Giugliani, C., Howden-Chapman, P., & Huong, N. T. (2021). Explaining COVID-19 performance: what factors might predict national responses? *BMJ*, *372*.

Baum, F., & Friel, S. (2017). Politics, policies and processes: a multidisciplinary and multimethods research programme on policies on the social determinants of health inequity in Australia. *BMJ Open*, *7*(12), e017772. https://doi.org/10.1136/bmjopen-2017-017772

Baum, F., Popay, J., Delany-Crowe, T., Freeman, T., Musolino, C., Alvarez-Dardet, C., Ariyaratne, V., Baral, K., Basinga, P., Bassett, M., Bishai, D. M., Chopra, M., Friel, S., Giugliani, E., Hashimoto, H., Macinko, J., McKee, M., Nguyen, H. T., Schaay, N., Solar, O., Thiagarajan, S., & Sanders, D. (2018). Punching above their weight: a network to understand broader determinants of increasing life expectancy. *International Journal for Equity in Health*, *17*(1), 117. https://doi.org/10.1186/s12939-018-0832-y

Beenackers, M. A., van Lenthe, F. J., & Mackenbach, J. P. (2015). *HEALTH EQUITY 2020 TOOLKIT - Drawing up evidence based action plans to address socioeconomic health inequalities*. Rotterdam, the Netherlands: Department of Public Health Erasmus MC,.

Bever, E., Dills, J., Lindberg, R., & Whitehead, S. (2022). *Minimum Elements and Practice Standards for Health Impact Assessment*. USA: Society of Practitioners of Health Impact Assessment (SOPHIA). https://hiasociety.org/resources/Documents/HIA%20ME-%20PS%20v4%202022.pdf

Bradley, K., Aguillard, K., Benton, A., Erickson, L., Martinez, S., & McGill, B. (2022). *Conducting Intensive Equity Assessments of Existing Programs, Policies, and Processes*. Washington, District of Columbia, USA: US Department of Health and Human Services, Office of the Assistant Secretary for Planning & Evaluation.

Braughton, M., Chung, J. P., Ferer, M., Greene, J., Maciel, D., Marasigan, J., Shiman, L., Sohn, E. K., & Wolpoff, A. (2020). *Do Health Impact Assessments Help Promote Equity Over the Long Term? An examination of HIAs' contribution to improvements in community health outcomes*. USA: Health Impact Project, Robert Wood Johnson Foundation, PEW Charitable Trusts. https://www.pewtrusts.org/-/media/assets/2020/10/do_health_impact_assessments_report_v3b.pdf

Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health*, *57*(4), 254-258. https://doi.org/https://doi.org/10.1136/jech.57.4.254

Cairney, P. (2023). *Politics & Public Policy*. University of Stirling. Retrieved 18 November 2023 from https://paulcairney.wordpress.com/

Cairney, P., St Denny, E., & Mitchell, H. (2021). The future of public health policymaking after COVID-19: A qualitative systematic review of lessons from Health in All Policies. *Open Research Europe*, *1*(23), 23.

Came, H., O'Sullivan, D., & McCreanor, T. (2020). Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities*, *20*(3), 434-456. https://doi.org/10.1177/1468796819896466

Campbell, F., Sein, T. T., Htoo, T. S., Khine, W. Y. K., Howard, N., & Balabanova, D. (2022). Policy space and pro-health equity national policymaking: a case study of Myanmar during political transition (2006-16). *Health Policy and Planning*, *38*, 170-180. https://doi.org/10.1093/heapol/czac076

Campostrini, S., Dal Grande, E., & Taylor, A. W. (2019). Increasing gaps in health inequalities related to non-communicable diseases in South Australia; implications towards behavioural risk factor surveillance systems to provide evidence for action. *BMC Public Health*, *19*(1), 37. https://doi.org/10.1186/s12889-018-6323-7

Canadian Nurses Association. (2006). *SOCIAL JUSTICE… a means to an end, an end in itself*. Ottawa, Canada: Canadian Nurses Association.

Canadian Public Health Association. (2020). *Health Equity Impact Assessment*. Ottawa, Canada: Canadian Public Health Association.

Cheng, T. L., & Mistry, K. B. (2023). Clarity on Disparity Who, What, When, Where, Why, and How. *Pediatric Clinics of North America*, *70*(4), 639-650. https://doi.org/10.1016/j.pcl.2023.03.003

Cole, B. L., MacLeod, K. E., & Spriggs, R. (2019). Health Impact Assessment of Transportation Projects and Policies: Living-Up to Aims of Advancing Population Health and Health Equity? *Annual Review of Public Health*, *40*, 305-318. https://doi.org/10.1146/annurev-publhealth-040617-013836

Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organization.

Cortes, A. C. M., Nunes, C. S. E., Nogueira, P., & Shivaji, T. (2018). Equity-focused health impact assessment of Portuguese tobacco control legislation. *Health Promotion International*, *33*(2), 279-287. https://doi.org/10.1093/heapro/daw076

Davey, F., McGowan, V., Birch, J., Kuhn, I., Lahiri, A., Gkiouleka, A., Arora, A., Sowden, S., Bambra, C., & Ford, J. (2022). Levelling up health: A practical, evidence-based framework for reducing health inequalities. *Public Health Practice*, *4*, 100322. https://doi.org/10.1016/j.puhip.2022.100322

Davies, J. K., & Sherriff, N. S. (2012). *The gradient evaluation framework (GEF): A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families*. University of Brighton. https://doi.org/10.13140/RG.2.1.2594.0881

deRosset, L., & Zachary, C. (2018). *Health Equity Impact Assessment Tool*. Noth Carolina, USA: NC Department of Health and Human Services.

Diderichsen, F., Whitehead, M., & Dahlgren, G. (2022). Planning for health equity in the crossfire between science and policy. *Scand J Public Health*, *50*(7), 875-881. https://doi.org/10.1177/14034948221082450

Douglas, M. (2019). *Health Impact Assessment Guidance for Practitioners*. Glasgow, Scotland: Scottish Health & Inequality Impact Assessment Network (SHIIAN).

Douglas, M. D., Josiah Willock, R., Respress, E., Rollins, L., Tabor, D., Heiman, H. J., Hopkins, J., Dawes, D. E., & Holden, K. B. (2019). Applying a Health Equity Lens to Evaluate and Inform Policy. *Ethnicity and Disease*, *29*(Suppl 2), 329-342. https://doi.org/10.18865/ed.29.S2.329

Dreaves, H., Pennington, A., & Scott-Samuel, A. (2015). *Urban Health Impact Assessment methodology (UrHIA)*. Liverpool: IMPACT, University of Liverpool.

Fagrell Trygg, N., Gustafsson, P. E., Hurtig, A. K., & Månsdotter, A. (2022). Reducing or reproducing inequalities in health? An intersectional policy analysis of how health inequalities are represented in a Swedish bill on alcohol, drugs, tobacco and gambling. *BMC Public Health*, *22*(1), 1302. https://doi.org/10.1186/s12889-022-13538-6

Fort, M. P., Manson, S. M., & Glasgow, R. E. (2023). Applying an equity lens to assess context and implementation in public health and health services research and practice using the PRISM framework. *Front Health Serv*, *3*, 1139788. https://doi.org/10.3389/frhs.2023.1139788

Fosse, E., Sherriff, N., & Helgesen, M. (2019). Leveling the Social Gradient in Health at the Local Level: Applying the Gradient Equity Lens to Norwegian Local Public Health Policy. *Int J Health Serv*, *49*(3), 538-554. https://doi.org/10.1177/0020731419842518

Freeman, T., Gesesew, H. A., Bambra, C., Giugliani, E. R. J., Popay, J., Sanders, D., Macinko, J., Musolino, C., & Baum, F. (2020). Why do some countries do better or worse in life expectancy relative to income? An analysis of Brazil, Ethiopia, and the United States of America. *International Journal for Equity in Health*, *19*(1), 202. https://doi.org/10.1186/s12939-020-01315-z

Goff, N., Givens, M., Heller, J., Yuen, T., Bourcier, E., & Gould, S. (2016). *Promoting Equity through Health Impact Assessment: Evaluating Three Case Studies Using the Equity Metrics*. SOPHIA and Human Impact Partners. https://hiasociety.org/resources/Documents/EquityMetricsWhitePaper.pdf

Green, L., Ashton, K., Azam, S., Dyakova, M., Clemens, T., & Bellis, M. A. (2021). Using health impact assessment (HIA) to understand the wider health and well-being implications of policy decisions: the COVID-19 'staying at home and social distancing policy' in Wales. *BMC Public Health*, *21*(1), 1456. https://doi.org/10.1186/s12889-021-11480-7

Green, L., Ashton, K., Bellis, M. A., Clemens, T., & Douglas, M. (2021). 'Health in All Policies'-A Key Driver for Health and Well-Being in a Post-COVID-19 Pandemic World. *Int J Environ Res Public Health*, *18*(18). https://doi.org/10.3390/ijerph18189468

Green, L., Ashton, K., Edmonds, N., & Azam, S. (2020). Process, practice and progress: A case study of the health impact assessment (HIA) of brexit in Wales [Article]. *International Journal of Environmental Research and Public Health*, *17*(18), 1-14, Article 6652. https://doi.org/10.3390/ijerph17186652

Guglielmin, M., Muntaner, C., O'Campo, P., & Shankardass, K. (2018). A scoping review of the implementation of health in all policies at the local level. *Health Policy*, *122*(3), 284-292. https://doi.org/10.1016/j.healthpol.2017.12.005

Guglielmin, M., Shankardass, K., Bayoumi, A., O'Campo, P., Kokkinen, L., & Muntaner, C. (2022). Tools for local health in all policies implementation: evidence from an explanatory case study of Kuopio, Finland. *Scand J Public Health*, 14034948221090076. https://doi.org/10.1177/14034948221090076

Guichard, A., Ridde, V., Nour, K., Lafontaine, G., Hebert, C., Benoit, M., & Tardieu, E. (2015). *Taking Better Account of Social Inequalities in Health - The Reflex_ISS Tool*. Quebec, Canada: Centre intégré de santé et des services sociaux de la Montérégie-Centre and the Canadian Institutes of Health Research.

Hall, R. L., & Jacobson, P. D. (2018). Examining Whether The Health-In-All-Policies Approach Promotes Health Equity. *Health Aff (Millwood)*, *37*(3), 364-370. https://doi.org/10.1377/hlthaff.2017.1292

Hankivsky, O. (2021). Understanding pandemics through a sexand gender-based analysis plus (SGBA+) lens. In J. Gahagan & M. K. Bryson (Eds.), *Sex- and Gender-Based Analysis in Public Health* (pp. 123-135). https://doi.org/10.1007/978-3-030-71929-6_10

Hankivsky, O. E. (2012). *An Intersectionality-Based Policy Analysis Framework*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Harris-Roxas, B., Haigh, F., Travaglia, J., & Kemp, L. (2014). Evaluating the impact of equity focused health impact assessment on health service planning: three case studies. *BMC Health Services Research*, *14*(1), 371. https://doi.org/10.1186/1472-6963-14-371

Harris-Roxas, B. F., Harris, P. J., Harris, E., & Kemp, L. A. (2011). A rapid equity focused health impact assessment of a policy implementation plan: An Australian case study and impact evaluation. *International Journal for Equity in Health*, *10*(1), 6. https://doi.org/10.1186/1475-9276-10-6

Harris, P., Harris-Roxas, B., Harris, E., & Kemp, L. (2007). *Health Impact Assessment: A Practical Guide*. Sydney, NSW: Centre for Health Equity Training, Research and Evaluation (CHETRE) Part of the UNSW Research Centre for Primary Health Care and Equity, UNSW.

Harris, P., Sainsbury, P., & Kemp, L. (2014). The fit between health impact assessment and public policy: practice meets theory. *Soc Sci Med*, *108*, 46-53. https://doi.org/10.1016/j.socscimed.2014.02.033

Health Equity Network of Ohio. (2022). *Health Equity Assessment Tool for State and Local Governments*. Ohio, USA: Children's Defense Fund – Ohio • Healthy Community Partnership of Mahoning Valley • Network for Public Health Law • Ohio Consumers for Health Coverage • Ohio Public Health Association • Policy Matters Ohio • UHCAN Ohio.

Healthier Wales. (2018). *Working for Equality in Wales, Equality Impact Assessment*. Wales: Welsh Government.

Heller, J., Givens, M. L., Yuen, T. K., Gould, S., Jandu, M. B., Bourcier, E., & Choi, T. (2014). Advancing efforts to achieve health equity: equity metrics for health impact assessment practice. *Int J Environ Res Public Health*, *11*(11), 11054-11064. https://doi.org/10.3390/ijerph111111054

Henson, R. M., McGinty, M., Juliano, C., & Purtle, J. (2019). Big City Health Officials' Conceptualizations of Health Equity. *J Public Health Manag Pract*, *25*(4), 332-341. https://doi.org/10.1097/phh.0000000000000866

Hull, S. J., Massie, J. S., Holt, S. L., & Bowleg, L. (2023). Intersectionality Policymaking Toolkit: Key Principles for an Intersectionality-Informed Policymaking Process to Serve Diverse Women, Children, and Families. *Health Promot Pract*, *24*(4), 623-635. https://doi.org/10.1177/15248399231160447

Human Impact Partners and Big Cities Health Coalition. (2020). *Ensuring Equity in COVID-19 Planning, Response, and Recovery Decision Making: An Equity Lens Tool for Health Departments.* USA: Human Impact Partners and Big Cities Health Coalition.

Jumah, N. A., Kewayosh, A., Downey, B., Campbell Senese, L., & Tinmouth, J. (2023). Developing a Health Equity Impact Assessment 'Indigenous Lens Tool' to address challenges in providing equitable cancer screening for indigenous peoples. *BMC Public Health*, *23*(1), 2250. https://doi.org/10.1186/s12889-023-16919-7

Kehoe, H., Schutze, H., Spurling, G., & Lovett, R. (2022). Development of a Decolonising Framework for Aboriginal and Torres Strait Islander Health Policy Analysis in Australia. *International Indigenous Policy Journal*, *13*(3). https://doi.org/10.18584/iipj.2022.13.3.11269

King County. (2010). *King County Equity Impact Review Tool*. USA: King County.

Lawless, A., Williams, C., Hurley, C., Wildgoose, D., Sawford, A., & Kickbusch, I. (2012). Health in All Policies: Evaluating the South Australian Approach to Intersectoral Action for Health. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, *103*, S15-S19. http://www.jstor.org/stable/41995670

Leuenberger, A., Farnham, A., Azevedo, S., Cossa, H., Dietler, D., Nimako, B., Adongo, P. B., Merten, S., Utzinger, J., & Winkler, M. S. (2019). Health impact assessment and health equity in sub-Saharan Africa: A scoping review. *Environmental Impact Assessment Review*, *79*, 106288. https://doi.org/https://doi.org/10.1016/j.eiar.2019.106288

Mahoney, M., Simpson, S., E., H., Aldrich, R., & Stewart Williams, J. (2014). *Equity Focused Health Impact Assessment Framework*. Australia: The Australasian Collaboration for Health Equity Impact Assessment (ACHEIA).

Mannan, H., Amin, M., M., M., & Consortium, t. E. (2011). *The EquiFrame Manual: A tool for Evaluating and Promoting the Inclusion of Vulnerable Groups and Core Concepts of Human Rights in Health Policy Documents*. Dublin: Global Health Press.

Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. *American Journal of Public Health*, *104*(S4), S517-S519.

Minnesota Department of Health. (2018). *Advancing health equity: Key questions for assessing policy, processes, and assumptions*. USA: Minnesota Department of Health.

Musolino, C., Baum, F., Womersley, R., van Eyk, H., Freeman, T., Flavel, J., & Earl, C. (2020). *SA: The Heaps Unfair State: why have health inequities increased in South Australia and how can this trend be reversed?* . Adelaide: SACOSS/Soutgate Istitute Flinders Unversity

Myint, P., Hawes, E., Ellis, G., Boman-Davis, M., & Montgomery, G. (2022). Embedding Equity in a Local Government's Response to COVID-19 [Article]. *Journal of Public Health Management and Practice*, *28*, S54-S57. https://doi.org/10.1097/PHH.0000000000001429

New Zealand Ministry of Health. (2007). *Whanau Ora Health Impact Assessment*. New Zealand: New Zealand Ministry of Health,.

NHS Health Scotland. (2014). *Proportionate universalism and health inequalities*. MHS Health Scotland. Retrieved 11/01/24 from https://www.healthscotland.com/documents/24296.aspx#:~:text=Proportionate%20universalism%20is%20the%20resourcing,the%20level%20of%20presenting%20need.

Norwegian Ministry of Health and Care Services. (2007). *National strategy to reduce social inequalities in health* Norway: Ministry of Health and Care Services. https://extranet.who.int/mindbank/item/272

Office of Health Equity. (n.d.). *Checking Assumptions to Advance Health Equity*. USA: Office of Health Equity, Colorado, USA Department of Public Health & Environment,.

Olayiwola, J., & Rastetter, M. (2020). Aiming for health equity: the bullseye of the quadruple aim. *Journal of Hospital Management and Health Policy*, *5*. https://doi.org/10.21037/jhmhp-20-101

Olszewski, A. E., Adiele, A., Patneaude, A., Zerr, D. M., & Kett, J. C. (2021). The Health Equity Impact Assessment: A Case Study in COVID-19 Visitor Policy. *Hosp Pediatr*. https://doi.org/10.1542/hpeds.2021-006128

Olyaeemanesh, A., Takian, A., Mostafavi, H., Mobinizadeh, M., Bakhtiari, A., Yaftian, F., Vosoogh-Moghaddam, A., & Mohamadi, E. (2023). Health Equity Impact Assessment (HEIA) reporting tool: developing a checklist for policymakers. *Int J Equity Health*, *22*(1), 241. https://doi.org/10.1186/s12939-023-02031-0

Ontario Health. (2012). *Ontario health equity impact assessment workbook*. Ontario, Canada: Ontario Health.

Pauly, B., Martin, W., Perkin, K., van Roode, T., Kwan, A., Patterson, T., Tong, S., Prescott, C., Wallace, B., Hancock, T., & MacDonald, M. (2018). Critical considerations for the practical utility of health equity tools: a concept mapping study. *International Journal for Equity in Health*, *17*(1), 48. https://doi.org/10.1186/s12939-018-0764-6

Pennington, A., Dreaves, H., Scott-Samuel, A., Haigh, F., Harrison, A., Verma, A., & Pope, D. (2017). Development of an Urban Health Impact Assessment methodology: indicating the health equity impacts of urban policies. *European Journal of Public Health*, *27*(suppl_2), 56-61. https://doi.org/10.1093/eurpub/ckv114

PHIDU. (2023). *Social Health Atlas of Australia*. Retrieved 21st July from https://phidu.torrens.edu.au/current/graphs/sha-aust/quintiles-time-series/aust/avoidable-mortality-sex.html

Plamondon, K. M. (2020). A tool to assess alignment between knowledge and action for health equity. *BMC Public Health*, *20*(1), 224. https://doi.org/10.1186/s12889-020-8324-6

Plamondon, K. M., Dixon, J., Brisbois, B., Pereira, R. C., Bisung, E., Elliott, S. J., Graham, I. D., Ndumbe-Eyoh, S., Nixon, S., & Shahram, S. (2023). Turning the tide on inequity through systematic equity action-analysis. *BMC Public Health*, *23*(1), 890. https://doi.org/10.1186/s12889-023-15709-5

Pollack Porter, K. M., Lindberg, R., & McInnis-Simoncelli, A. (2019). Considering health and health disparities during state policy formulation: examining Washington state Health Impact Reviews. *BMC Public Health*, *19*(1), 862. https://doi.org/10.1186/s12889-019-7165-7

Porroche-Escudero, A., & Popay, J. (2021). The Health Inequalities Assessment Toolkit: Supporting integration of equity into applied health research [Article]. *Journal of Public Health (United Kingdom)*, *43*(3), 567-572. https://doi.org/10.1093/pubmed/fdaa047

Pottie, K., Agic, B., Archibald, D., Ratnayake, A., Tapia, M., & Thanos, J. (2019). HEIA tools: inclusion of migrants in health policy in Canada. *Health Promot Int*, *34*(4), 697-705. https://doi.org/10.1093/heapro/day016

Povall, S. L., Haigh, F. A., Abrahams, D., & Scott-Samuel, A. (2014). Health equity impact assessment. *Health Promot Int*, *29*(4), 621-633. https://doi.org/10.1093/heapro/dat012

Public Health England. (2021). *Health Equity Assessment Tool (HEAT)*. Public Health England. Retrieved 8 October 2023 from https://www.gov.uk/government/publications/health-equity-assessment-tool-heat/health-equity-assessment-tool-heat-executive-summary

Public Health Wales. (n.d.). *Wales Health Impact Assessment A Practical Guide*. Wales: Public Health Wales, Cardiff Uni, Wales HIA Support Unit.

Rono, J., Kamau, L., Mangwana, J., Waruguru, J., Aluoch, P., & Njoroge, M. (2022). A policy analysis of policies and strategic plans on Maternal, Newborn and Child Health in Ethiopia. *International Journal for Equity in Health*, *21*(1), 73. https://doi.org/10.1186/s12939-022-01656-x

Sadare, O., Williams, M., & Simon, L. (2020). Implementation of the Health Equity Impact Assessment (HEIA) tool in a local public health setting: challenges, facilitators, and impacts. *Can J Public Health*, *111*(2), 212-219. https://doi.org/10.17269/s41997-019-00269-2

Sigerson, D., & Craig, P. (2014). *Health inequalities impact assessment*. Scotland: NHS Health Scotland.

Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *The Health Equity Assessment Tool: A user's guide*. Wellington: Ministry of Health.

Snyder, J., Wagler, M., Lkhagvasuren, O., Laing, L., Davison, C., & Janes, C. (2012). An equity tool for health impact assessments: Reflections from Mongolia. *Environmental Impact Assessment Review*, *34*, 83-91. https://doi.org/https://doi.org/10.1016/j.eiar.2011.08.006

Sohn, E. K., Stein, L. J., Wolpoff, A., Lindberg, R., Baum, A., McInnis-Simoncelli, A., & Pollack, K. M. (2018). Avenues of Influence: the Relationship between Health Impact Assessment and Determinants of Health and Health Equity. *J Urban Health*, *95*(5), 754-764. https://doi.org/10.1007/s11524-018-0263-5

SOPHIA. (2016). *Communicating About Equity in Health Impact Assessment: A Guide for Practitioners*. USA: The SOPHIA Equity Workgroup.

SOPHIA. (n.d.). *How to Advance Equity through Health Impact Assessments*. USA: The SOPHIA Equity Working Group.

STAKES National Research and Development Centre for Welfare and Health Finland. (2007). *Human Impact Assessment*. Finland: Municipal Welfare Strategies Group in the Municipality Services Division of the National Research and Development Centre for Welfare and Health (STAKES).

Toronto Central LHIN. (2009). *Workbook: Using the Health Equity Impact Assessment Tool*. Toronto, Canada: Toronto Central LHIN, Wellesley Insititute, Ministry of Health & Long Term Care.

Trezona, A., Dodson, S., Mech, P., & Osborne, R. H. (2018). Development and testing of a framework for analysing health literacy in public policy documents. *Global Health Promotion*, *25*(4), 24-33. https://doi.org/10.1177/1757975918769616

Tyler, I., Pauly, B., Wang, J., Patterson, T., Bourgeault, I., & Manson, H. (2019). Evidence use in equity focused health impact assessment: a realist evaluation. *BMC Public Health*, *19*(1), 230. https://doi.org/10.1186/s12889-019-6534-6

van Roode, T., Pauly, B. M., Marcellus, L., Strosher, H. W., Shahram, S., Dang, P., Kent, A., & MacDonald, M. (2020). Values are not enough: qualitative study identifying critical elements for prioritization of health equity in health systems. *International Journal for Equity in Health*, *19*(1), 162. https://doi.org/10.1186/s12939-020-01276-3

Washington County. (2019). *Abbreviated Emergency Operating Centre rapid response equity lens tool*. USA: Washington County.

Washington State Board of Health. (2020). *Health Impact Review*. USA: Washignton State Board of Health.

Weisman, S., Ben-Moshe, K., Moua, V., & Hernandez, S. (2019). Equity in Action: Operationalizing Processes in State Governance [Article]. *Journal of Law, Medicine and Ethics*, *47*(2_suppl), 116-120. https://doi.org/10.1177/1073110519857333

Williams, C., Wildgoose, D., Sawford, A., & Williams, L. (2010). An introduction to health lens analysis. In I. Kickbusch & K. Buckett (Eds.), *Implementing Health in All Policies Adelaide 2010* (pp. 111-118). Department of Health, Government of South Australia.

Williams, P. C., Binet, A., Alhasan, D. M., Riley, N. M., & Jackson, C. L. (2023). Urban Planning for Health Equity Must Employ an Intersectionality Framework. *Journal of the American Planning Association*, *89*(2), 167-174. https://doi.org/10.1080/01944363.2022.2079550

Windsor Essex County Health Unit. (n.d.). *No Barrier – Health Equity for All Toolkit & Practical Guide for Health & Community Service Providers*. UK: Windsor Essex County Health Unit.

Appendices

Appendix A: Health Equity Impact Assessment Tool

Appendix B: Health Equity Impact Assessment Frame

Appendix C: HEIA tools identified during the literature review

Appendix A

Health Equity Impact Assessment Tool

This tool was developed by staff from Wellbeing SA and Stretton Health Equity, University of Adelaide in 2023.

It includes two parts:

Part A: Provides a rapid six step 'checklist'. This part of the tool may be used as a quick reference check, when resources do not permit a more detailed assessment. It should be noted however that if the potential health equity impacts are significantly serious, a more detailed assessment (Part B) is recommended.

Part B: Provides a more detailed flow chart with opportunities to gather further information (e.g. qualitative or quantitative data, community engagement, power dynamics, the policy space) for greater consideration of potential health equity impacts.

Useful Terms

Equity Group	A risk group defined according to demographic criteria associated with increased risk of poor health, where risk factors associated with the population include exposure to structural or systemic socioeconomic or cultural disadvantage. Examples would include people subject to low socioeconomic status (socioeconomic inequality), women (sex discrimination, gendered violence), Aboriginal and Torres Strait Islander peoples (colonisation, racism, incarceration).
Health Equity	Is achieved when everyone can attain their full potential for health and wellbeing. Health outcomes do differ between groups however, health inequities are the differences in health outcomes and their risk factors between groups that are socially produced, avoidable and unfair.
Health Inequalities	The differences in health between different groups. An equality approach involves providing equal services, resources and treatment, regardless of need or outcome. This differs to an equity approach which recognises that some groups need more support or resources to achieve the same health outcomes as others.
Intersectionality	Describes how multiple social aspects of identity, such as gender, race, class and sexual orientation, intersect or interact with each other.
Lifestyle Drift	When policy starts off recognizing the need for action on upstream social determinants of health only to drift downstream to focus largely on individual lifestyle factors.
Proportionate Universalism	A strategy that aims to benefit the whole population or community (universal population) but that focuses effort and resources proportionate to need, to reduce inequities.
Risk Group	A group defined according to demographic criteria associated with increased risk of poor health, where known risk factors associated with the population do not include exposure to structural or systemic socioeconomic or cultural disadvantages. Examples would include older people, youth, men, children, construction workers or health professionals. (Of course, sub-parts of these groups may be subject to such disadvantages, e.g., unemployed men).
Social Determinants of Health	The social, economic, cultural and political factors that influence health and wellbeing. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces, wealth and power imbalances and systems shaping the conditions of daily life.
Social Gradient in Health	There is a social gradient in health that runs from the highest to the lowest socioeconomic positions, so that the lower a person's socioeconomic position, the worse their health. The social gradient in health appears in all social indicators (e.g. employment, housing, education).

RAPID HEALTH EQUITY ASSESSMENT QUESTIONS		YES	NO	Unsure
Potential Impact	**1. Have I/we considered the potential impact of the policy/program on the SA Population as a whole, as well as different demographic groups?**			
	Tip: Identify the impact of the policy/program on the SA population as a whole as well as the impact on those who experience discrimination, adverse living conditions and powerlessness on the basis of demographic factors such as culture, gender and social class. Consider whom among the population may have been excluded from the policy/program conversations and take steps to include 'invisible groups'.			
Intersectionality	**2. Have I/we ensured that the policy/program responds to the needs of people who experience multiple discriminations, adverse circumstances or other forms of powerlessness?**			
	Tip: Engage with groups that experience powerlessness on the basis of multiple demographic factors, for example, gender and geographic area and culture. Meaningfully involve the groups that are likely to be most affected by the policy/program in decision-making at each stage of the policy making process.			
Downstream Determinants	**3. Is the policy action a downstream measure i.e. seeking to directly alter health behaviours such as smoking or increasing breastfeeding rates through the health sector alone**?			
	Tip: Downstream determinants of health are micro factors that change biological functioning and focus on individual impact. For example, genetics and individual health care are downstream determinants. In relation to addressing food security, emergency food relief services are an example of a downstream approach.			
Midstream Determinants	**4. Is the policy action a midstream measure i.e. focusing on psychosocial factors that influence behaviours?**			
	Tip: Midstream determinants are factors in the environment or community that can affect the choices people make. For example, midstream measures to reduce smoking rates are price control and restricting access to supply.			
Upstream Determinants	**5. Is the policy action an upstream measure i.e. focusing on the wider circumstances that produce health outcomes (e.g. government policies, social determinants of health, cultural factors)?**			
	Tip: Upstream determinants are structural factors (e.g. social and economic policies that affect housing, income and education) beyond individuals that may negatively affect people's access to, use of and/or benefit from the policy/program. For example, an upstream initiative would increase income support payments to help shift people out of poverty.			
Multiple Approaches	**6. Does the policy action represent an interaction between upstream, midstream, and downstream measure**?			
	Tip: Multiple approaches are important and need to include upstream action to maximise impact on health equity. If your policy/program is not focused on upstream determinants, consider if you can form partnerships with other sectors/policy makers whose policies/programs do have an upstream focus.			
The Equity Gradient	**7. Is the policy/program designed to reduce health inequities aimed solely at the most disadvantaged groups? If so, are other universal policies in place to ensure action across the gradient?**			
	Tip: Start by considering potential differences in the impact of your policy/program within and between different population groups. If targeted measures are to be used, ensure these are of a scale and intensity to fit the level of disadvantage. Also consider if targeted actions may stigmatise population groups or cause more harm than good.			

Mitigation	**8. Do I/we know how the potential negative impacts can be reduced and amplify the positive impacts of the policy/program?**			
	Tip: Consider what changes need to be made to the policy/program to maximize the positive effects or benefits to improve health equity.			

Part B

Step 1: Do we want to incorporate health equity into our decision-making?

Yes

Incorporating health equity into our decision making involves:

- Developing policies/programs/initiatives that focus on our community as a whole in a way that takes account of the needs of priority population group/s
- Developing actions to reduce the social gradient in health
- Acting on the social determinants of health
- Ensuring that evidence guides our approach
- Avoiding lifestyle drift

No

If we are not incorporating health equity into our decision-making, consider the following questions:

- How will we ensure our decisions are inclusive of everyone in our community?
- How will we take account of intersectionality to help people feel safe and included in our decisions?
- If different groups in your community have different needs, how will we ensure our decisions respond to needs fairly?
- How will we monitor how well our decisions are succeeding in being inclusive?

You may still like to review the questions below and access the suggested further reading.

Continue to STEP 2

Step 2: Do we know <u>why</u> we want to incorporate health equity into our decision making?

Yes

Use this opportunity to consider **WHY** you want to incorporate health equity into decision making (e.g. because research shows that some groups have poorer health than others, for reasons related to social justice, to better allocate resources, and/or to make a sustainable difference). Discuss your understanding of the health equity concept with your colleagues and be clear about your purpose before progressing.

No

Explore the health equity concept by accessing the suggested further reading at the back of this tool. In addition, consider your organisation's values, goals and capacity, and how these relate to incorporating health equity considerations into your organisation's activities. Return to Step 2 when you feel ready to progress.

STEP 3: Do we know how to incorporate health equity into our decision making?

No

Begin by identifying and scoping the population as a whole as well as the population groups potentially impacted by the policy/program/decision.

Yes

YES: If you already know how to incorporate health equity into your decision making, you may still like to work through the reflective questions in this tool.

Q.1 Do we know our community, as a whole as well as the diverse groups within it?

• Do we understand the available social and health data* for the community/groups and how to apply it to our decision making? • Do we understand the difference between risk groups and equity groups?
• Have we engaged with the community/groups and do we know how to incorporate their views into our decision making? ** data may include quantitative and qualitative data, as well as stories and informal sources of information*

Yes | **Yes, partly** | **No** → **More information needed**

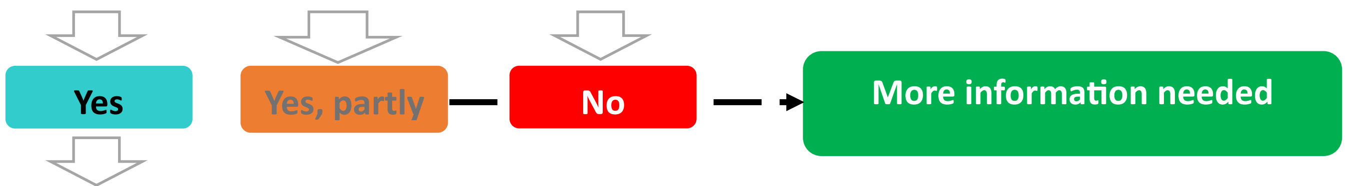
Q.2 Do we understand that people may belong to more than one population group (intersectionality) and that this may expose them to overlapping forms of discrimination?

• Do we understand how intersectionality relates to the policy/program/decision?

Yes | **Yes, partly** | **No** → **More information needed**

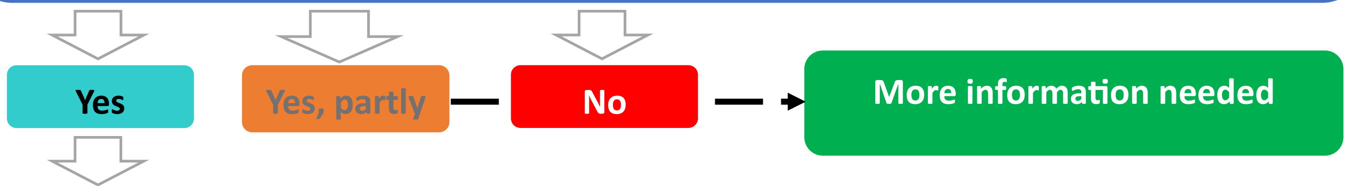
Q.3 Do we understand how different groups in our community are affected by social, economic & cultural determinants of health and wellbeing?

• Do we know which groups are denied the same opportunities as others to protect and improve health and wellbeing? • Do we know how these social, economic and cultural determinants relate to the policy/program/decision?



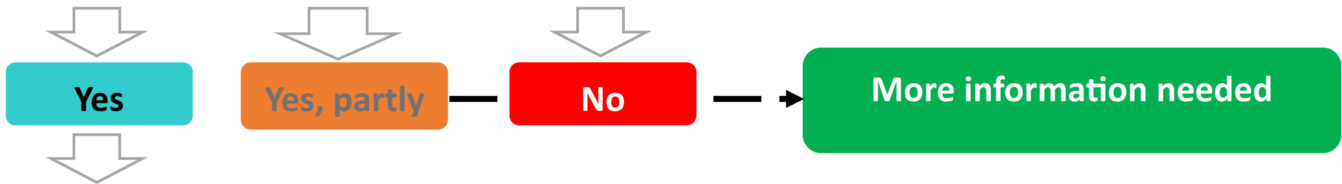
Q.4 Do we understand the wider social factors at play?

• Are there other policies and social movements affecting our community's health and wellbeing that might relate to the policy/program/decision? • Do we understand who has the power to make things better for the community/groups? • Do we need to advocate for change in other sectors/policies/systems?



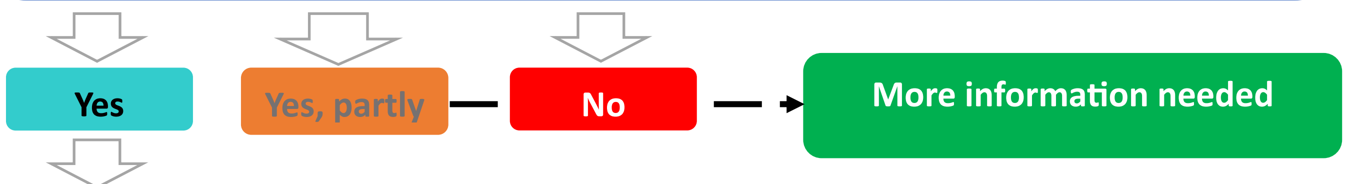
Q.5 Do we understand local knowledge?

• Do we know who we need to work with to incorporate local knowledge into our decision making, so as to foster pathways for self-determination? For example, are there systems of knowledge embedded in Aboriginal & Torres Strait Islander cultures or other cultures that we need to be aware of?



Q.6 Are we best placed to develop and/or implement this policy/program or make this decision?

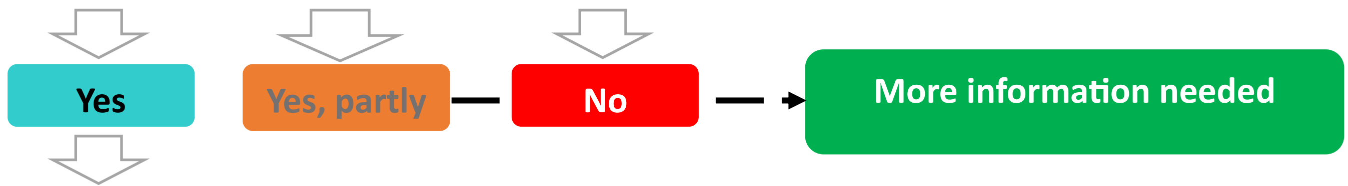
• Are there other organisations that might be better placed to lead this decision-making process – in the case of Aboriginal & Torres Strait Islander peoples, would it be more appropriate for an Aboriginal Community Controlled Health Organisation (ACCHO) to lead the work? Are there organisations that we need to partner with in developing and/or implementing this policy/program/decision? Are we committed to the principles of co-design?



Step 4: Explore the details of the initiative and how these relate to health equity.

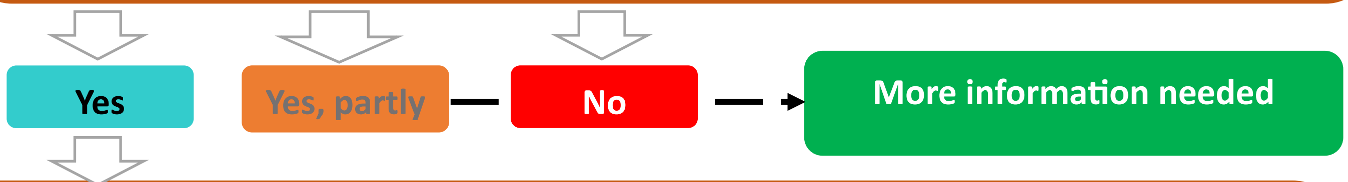
Q. 7 Do we know what the goals and objectives of the policy/program/decision are?

• Are the goals and objectives acceptable to the community/groups? • Do the goals and objectives reflect a health equity approach? • Are they measurable?



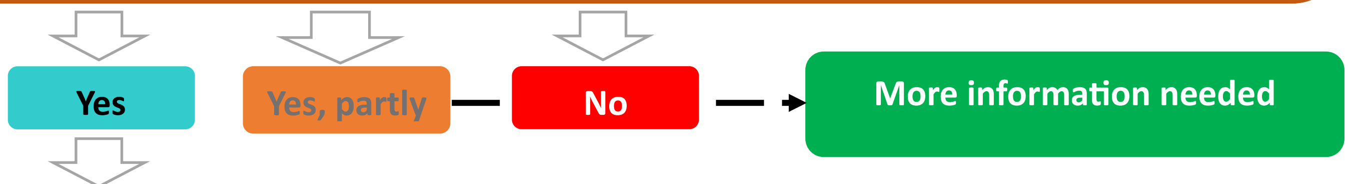
Q.8 Does the policy/program/decision aim to 'work with' rather than 'work on' our community and those population groups most likely to be impacted?

• Are members of relevant community/groups involved? • Is power shared and transparent? • Are there clear governance arrangements?



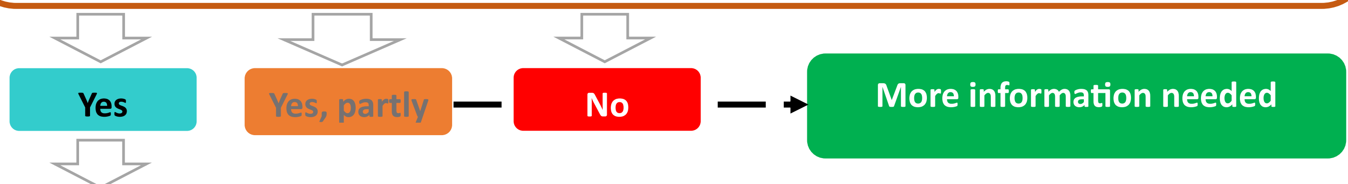
Q. 9 Does the policy/program/decision act on social, cultural and economic determinants that are fundamental to the health and wellbeing of our community and population groups?

• Given capacity and scope, does the initiative act on the underlying causes of poor health and wellbeing, while also meeting immediate needs?



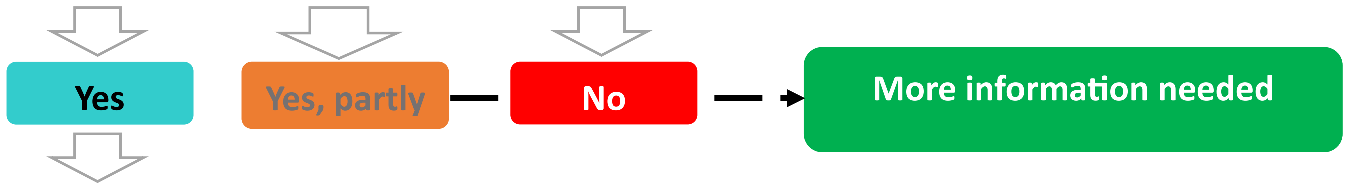
Q. 10 Is the policy/program/decision informed by equity-related research/evidence?

• Is it based on best-practice principles such as those outlined in the Ottawa Charter or Declaration of Alma Ata? • Does the initiative recognise health-equity related principles such as proportionate universalism? • Does the initiative move away from lifestyle drift? • Is it long term? • Could research be incorporated into the decision-making process so as to contribute further to the health equity evidence base?



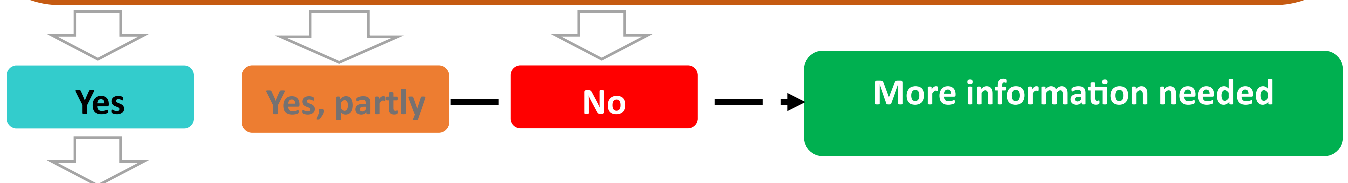
Q. 11 Is the policy/program/decision inclusive of the spectrum of needs across our community, including our priority population groups?

• Do we understand important concepts like culture and language, social hierarchies and power relations, and systems as they relate to health equity, which can help us understand health complexities and inform our decision making?



Q. 12 Is the policy/program/decision aimed at downstream, midstream or upstream determinants OR a combination of all three?

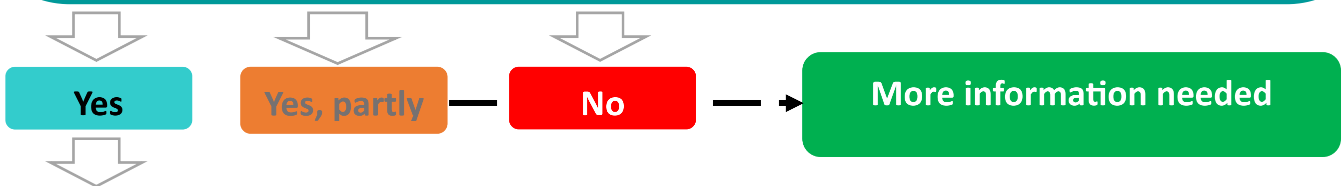
• Downstream determinants of health are micro factors that change biological functioning and focus on individual impact. For example, genetics and individual health care are downstream determinants. In relation to addressing food security, emergency food relief services are an example of a downstream approach. • Midstream determinants are factors in the environment or community that can affect the choices people make. For example, midstream measures to reduce smoking rates are price control and restricting access to supply. • Upstream determinants focus on the wider circumstances that produce health outcomes (e.g. government policies, social determinants of health, cultural factors). • Consider which determinants the policy/program/decision is aimed at, remembering that without upstream action, we are unlikely to enhance health equity.



Step 5: Identify the potential unintended impact (both positive and negative) of the policy/program/decision on health and wellbeing.

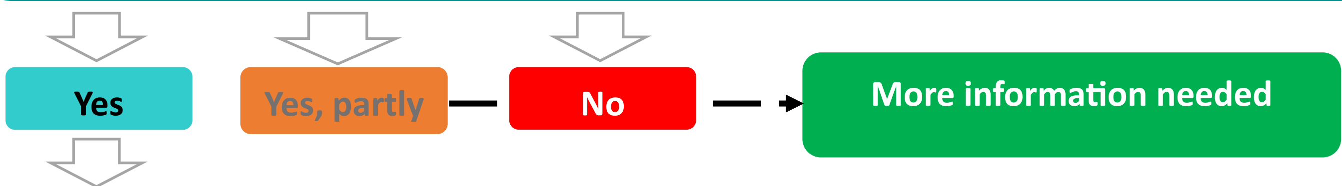
Q.13 Do we know what the potential positive and negative impacts of this policy/program/decision are – for the community as whole as well as the diverse groups within it?

• What are the potential positive and negative impacts for the population as a whole as well as each priority population group? • Is it likely to have positive impacts or effects that enhance health equity? • Will providing this policy/program/decision, or improving access to it, help to narrow the gap between the best and worst off in terms of health outcomes? • If we don't know, what more do we need to know and how will we find out? • Will some people or groups benefit more from the policy/program/decision than others, and why? • *Your appraisal should also consider:* • *The nature and quality of the evidence we are using to assess impact;* • *The probability of the predicted impact(s);* • *The severity and scale of the impact(s); and* • *Whether the impact(s) will be immediate or latent.*



Q.14 Will the policy/program/decision increase (rather than decrease) health inequities?

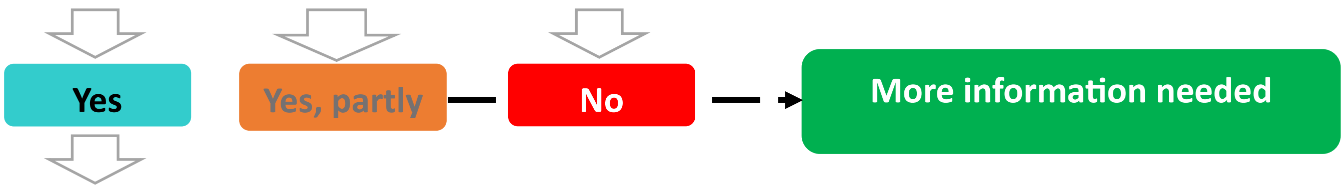
• Is the initiative likely to have negative effects that contribute to, maintain or strengthen health inequities?



Step 6: Identify ways to reduce potential negative impacts and amplify the positive impacts, and measure outcomes.

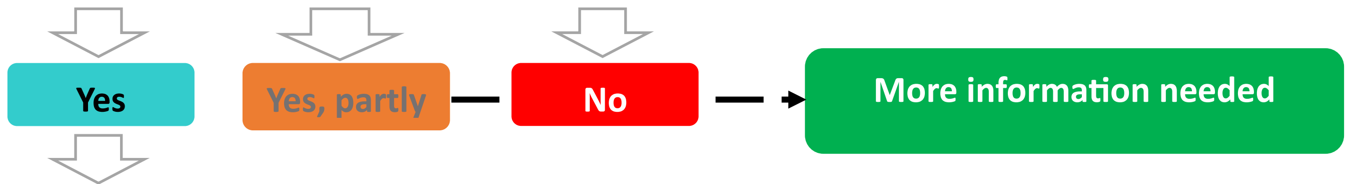
Q.15 Do we know how we can reduce the potential negative impacts and amplify the positive impacts?

• How can we reduce or remove barriers and other inequitable effects? • How can we maximize the positive effects or benefits that enhance health equity? • What specific changes do we need to make to the initiative so it meets the needs of the community and priority population groups? • Could we engage the population in designing and planning these changes or consult with key stakeholders?



Q.16 Do we know how we can monitor and evaluate the policy/program/decision from a health equity perspective?

• In what ways have we affected health equity? • How will we know when the program is successful? • What equity indicators and objectives will we measure, and how?



Document your findings, make recommendations and/or amendments to your policy/program/decision as appropriate.

Some suggested further reading

- Health inequalities impact assessment, Answers to frequently asked questions (NHS Health Scotland: Health inequalities impact assessment (healthscotland.scot)
- Health Equity Toolkit: A resource inventory for health care organisations (Access Alliance and Alliance for Healthier Communities: Health Equity Toolkit: A Resource Inventory for Health Care Organizations (allianceon.org)
- Health Equity Impact Assessment A Primer (Wellesley Institute: Health_Equity_Impact_Assessment_Haber.pdf (wellesleyinstitute.com)

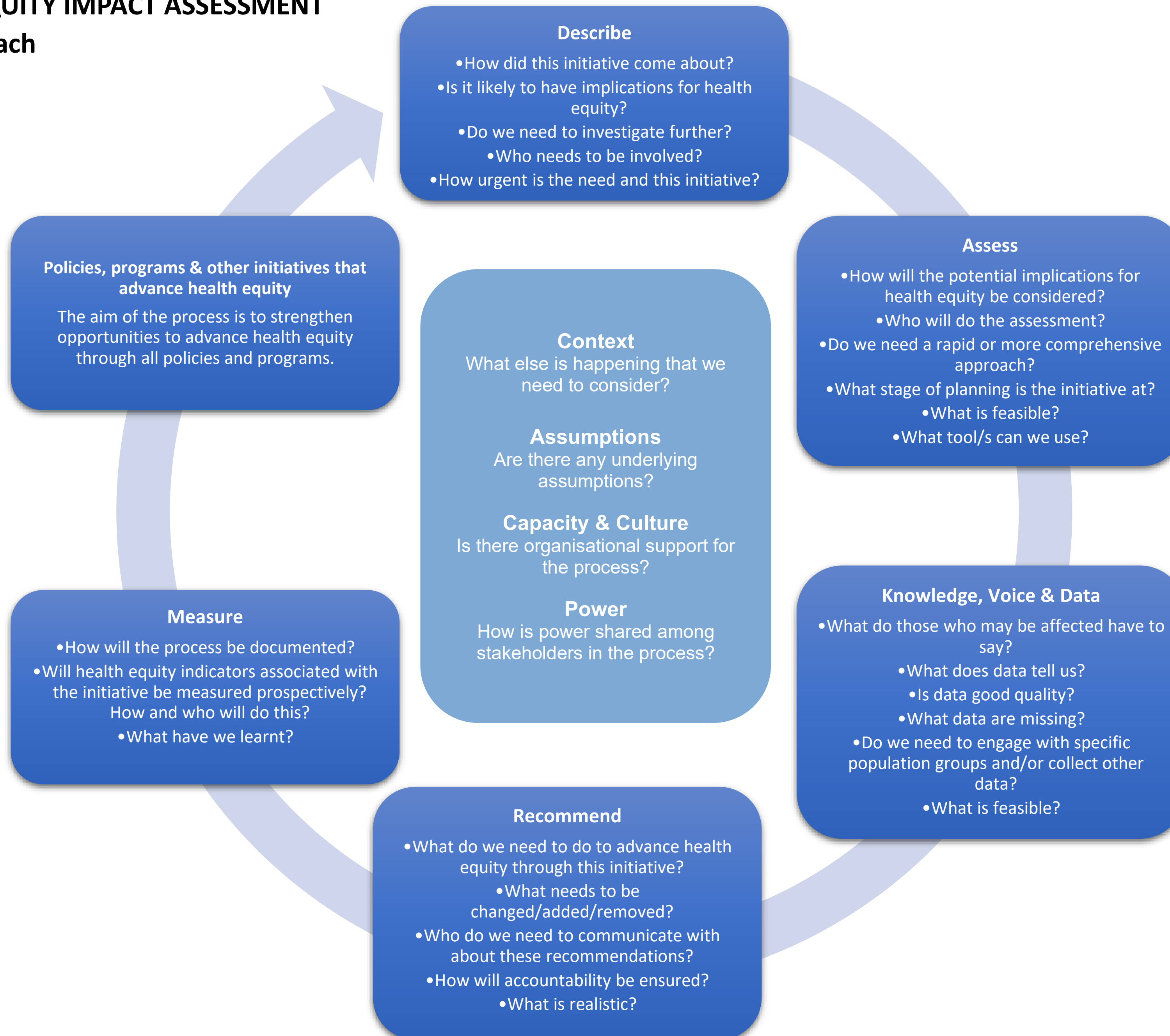
Appendix B

Health Equity Impact Assessment Frame

This tool was developed by staff of the Healthy Tasmania initiative and Stretton Health Equity, University of Adelaide in 2023.

HEALTH EQUITY IMPACT ASSESSMENT

Our Approach



Health Equity Impact Assessment Frame: Description of components

<table>
<tr><td>Context

Context relates to the overall environment (local, national, international) in which the policy/program is proposed and other ‘key activities’ that offer opportunities for change.</td><td>Things to think about
What else is happening that is relevant to the policy/program (e.g. other organisational priorities; other assessment processes e.g. gender or racial impact assessment; other policies/programs including universal approaches)?
How the policy/program relates to systemic inequities i.e. written and unwritten policies, practices and beliefs that produce, condone and perpetuate unfair treatment of people based on characteristics such as race, gender and social class?
What the ‘policy space’ looks like and what barriers/enablers exist (e.g. views/opinions on health equity?</td></tr>
<tr><td>Assumptions

Assumptions are uncritiqued beliefs and cause us to take a position of power.</td><td>Things to think about
An essential first step in health equity assessment is critical analysis of how we* see the problem and our assumptions. If we don’t critique our assumptions, we may inadvertently perpetuate health inequities.
Researchers have found that commonly held health equity assumptions include an over-reliance on ‘statistics’ to describe the problem, an ‘either/or’ way of thinking, and a focus on categorising people as well as places?
In addition to the assumptions made by those undertaking the health equity assessment, we also need to consider what underlying values and principles shine through the proposed policy/program, and whether we need to ask more questions or challenge these?
Asking questions about ‘How’ and ‘Why’ (in relation to the need and the proposed response) can help identify unhelpful assumptions.
It is hard to identify assumptions in a policy or programs, particularly if we were responsible for drafting it. Differing perspectives should be used to assist in the task.
* The term ‘we’ is used to refer to those applying the frame to practice</td></tr>
<tr><td>Capacity & Culture

Capacity relates to the resources (knowledge, skills, time, funding, leadership, partnerships) available to undertake a health equity assessment. Organisational culture plays an important role in developing capacity and creating a ‘safe space’ for health equity assessment.</td><td>Things to think about
What knowledge, skills and partnerships can add value to the process, and ensure timely and appropriate action?
How can our learnings from undertaking a health equity assessment contribute to further build capacity within our organisation, and among stakeholders?
All organisations have cultures, which are made visible through language and behaviour, shared values and goals, and beliefs and assumptions. Both the culture of an individual and the culture of an organization affect decision-making.
Create organisational conditions for health equity assessment through leadership support, mandating the use of health equity assessment processes, developing a common language, clarifying roles and responsibilities, and embedding quality improvement strategies.</td></tr>
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Power Power is one of the fundamental causes of health inequities, and it also has a role in the health equity assessment process itself.	Things to think about • In relation to the policy/program itself as well as the health equity assessment process consider from the source of power, who has power and where power exercised. • How can the health equity assessment process redistribute power equitably? • How to respond to those losing power? • View all community engagement through a lens of helping build power among those who are most impacted.
Describe Summarise the policy/program being considered, including any relevant background information.	Things to think about • How did this initiative come about (e.g. data, community needs assessment, advocacy, policy levers, crisis)? • What is it aiming to achieve? • Is it likely to have implications for health equity (e.g. are some population groups more affected, is the proposal aimed 'upstream' or 'downstream')? • Do we need to investigate further? • Who needs to be involved? • How urgent is the need and this initiative (e.g. do we need to use an 'action learning' approach)?
Assess Having decided that a more structured health equity assessment process is needed, decide how you will go about this. There are many tools available to assist in conducting a health equity assessment.	Things to think about • How will the potential implications for health equity (both positive and negative) be considered? • Who will do the assessment? • Do we need a rapid or more comprehensive approach? • What stage of planning is the initiative at (aim to undertake an assessment early in the process if possible, as there will be more opportunities for change)? • What is feasible? • What tool/s can we use?
Knowledge, Voice & Data Health equity assessment is critical process that should be guided by evidence, including the voices of those who are most likely to be involved/impacted by the policy/program.	Things to think about • What do those who may be affected have to say? • What do data tell us? • Are the data good quality? • What data are missing? • Do we need to engage with specific population groups and/or collect other data? • What is feasible?
Recommend A health equity assessment should result in suggested changes to the policy/program, so as to mitigate against potential negative	Things to think about • Recommendations should be solution-focused, clear and concise, and evidence-informed. • What do we need to do to advance health equity through this initiative? • What needs to be changed/added/removed?

impacts and enhance positive impacts.	• Who do we need to communicate with about these recommendations? • How will accountability be ensured? • What is realistic? A prioritisation process may be necessary.
Measure This stage involves investigating what action was taken as a result of the health equity assessment's recommendations.	**Things to think about** • Monitoring and measuring processes and impacts associated with the health equity assessment process are necessary for accountability, strengthening the evidence-base and continuous improvement. • How will the health equity assessment process be documented? • Will health equity indicators associated with the initiative be measured prospectively? How and who will do this? How will findings be shared? • What have we learnt and what do we need to do differently?

Appendix C

The table below lists the HEIA tools identified during the literature review.

	Name of tool or article title	Authors/developers/year/jurisdiction	Comments
1.	Health Impact Assessment: A practical guide	Harris et al. (2007), Australia	Advocates the standard six-step HIA approach. Recognises equity as a core concept of HIA.
2.	Human Impact Assessment	STAKES, National Research and Development Centre for Welfare and Health, The Municipal Welfare Strategies Group, 2007, Finland	Impacts may be assessed from a range of equity-related perspectives; human, child, gender, health, social, equality, linguistic, environmental, land use planning, economic and business.
3.	Whanau Ora HIA	Ministry of Health, 2007, New Zealand	Four step process: screening, scoping, appraisal and evaluation.
4.	Health Equity Assessment Tool: A user's guide	Signal et al. (2008), New Zealand	Has 10 questions and includes a specific questions on Māori health.
5.	Workbook: Using the Health Equity Impact Assessment Tool	Toronto Central LHIN, Wellesley Institute, Ministry of Health & Long-Term Care, 2009, Canada	Advocates the standard six-step HIA approach.
6.	Social Justice, a means to an end, an end in itself	Canadian Nurses Association, 2010, Canada	Assesses initiatives from a social justice perspective, recognising that social justice is key to the advancement of global health and equity.
7.	**Health Lens Analysis**	Williams et al. (2010), Australia	A five-step process: Engage, gather evidence, generate, navigate and evaluate.
8.	King County Equity Impact Review Tool	King County, 2010, USA	Incorporates three stages: What is the impact of the proposal on determinants of equity?; Assessment: Who is affected?; Impact review: Opportunities for action.
9.	EquiFrame: A framework for analysis of the inclusion of human rights and vulnerable groups in health policies	Mannan et al. (2011), Dublin, Ireland	A detailed framework with 21 questions.

10. An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity	Hankivsky (2012) Institute for Intersectionality Research & Policy, Simon Fraser University, Vancouver, Canada	An intersectionality tool (with connections made to health equity), includes seven principles and 12 questions.
11. Gradient Evaluation Framework (GEF): A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families	Davies and Sherriff (2012), University of Brighton, UK and other European partners	A comprehensive tool that includes templates that is specifically intended to facilitate the assessment of current or future policies in terms of their 'gradient friendliness'.
12. Ontario Health Equity Impact Assessment	Public Health Ontario, 2012, Canada	Five step process: Scoping, impacts, mitigation, monitoring and evaluation. Workbook and evaluation templates available. There are additional supplements related to French, Indigenous, LGBT2SQ and Immigrant groups: Visit this link.
13. Equity & Empowerment Lens	Balajee et al. (2012), Multnomah County, USA	A seven-step process based on the 4 Ps framework: Place, people, power and process. Includes a focus on organisational readiness and transformation.
14. An equity tool for health impact assessments: Reflections from Mongolia	Snyder et al. (2012), Mongolia	A four step process with a template.
15. Equity-Focused Health Impact Assessment Framework	Mahoney et al. (2014) Australian Collaboration for Health Equity Impact Assessment	Six step HIA-based approach: Screening, scoping, impact identification, assessment of impacts, recommendations, evaluation and monitoring. Widely referenced.
16. Health Inequalities Impact Assessment	Sigerson and Craig (2014), NHS Health Scotland, 2014	Considers upstream and downstream impacts using the common six-step HIA approach. A practical resource addressing frequently asked questions.
17. No Barrier – Health Equity for All Toolkit & Practical Guide for Health & Community Service Providers	Windsor Essex County Health Unit, 2015, Canada	Outlines a five-step decision making tool with templates and additional useful information.
18. Health Equity 2020 Toolkit (Phase 4)	Beenackers et al. (2015), Netherlands in collaboration with other European partners	Present impact assessment as part of a four-step process. Phase 4 is similar to the standard HIA process and Appendix 5 provides questions to analyse equity in policy. Has a range of other

		resources related to needs assessment, capacity assessment, and setting priorities and choosing actions. Appendices and templates can be found at Health Equity 2020.
19. Taking better account of social inequalities in health the REFLEX ISS	Guichard et al. (2015), Canada	Includes 44 questions across the areas of planning, implementation, evaluation, sustainability and empowerment.
20. Urban Health Impact Assessment methodology (UrHIA)	Dreaves et al. (2015) Liverpool, UK Development reported by (Pennington et al., 2017)	Involves screening questions, followed by six steps if it is determined that a full HIA is required.
21. How to Advance Equity through Health Impact Assessments	SOPHIA (Society for Practitioners of HIA) Equity Workgroup, Online Network, 2016	Provides a template to assist in HIA equity planning. There are other useful documents in this series, including: Communicating About Equity in Health Impact Assessment: A Guide for Practitioners.
22. Advancing health equity: Key questions for assessing policy, processes, and assumptions	Minnesota Department of Health, 2018, USA	Simple tool with questions aimed at answering What art the outcomes, Who benefits and Who doesn't.
23. Working for Equality in Wales, Equality Impact Assessment	Healthier Wales, Welsh Government, 2018, Wales	Includes an example of a completed template.
24. Developing a Health Equity Impact Assessment 'Indigenous Lens Tool' to address challenges in providing equitable cancer screening for indigenous peoples	Jumah et al. (2023), Canada	An Indigenous Lens Tool that consists of four scenarios, with supporting documentation that provides context for each step.
25. Health Equity Impact Assessment	North Carolina Dept of Health & Human Services, 2018, USA	A detailed resource with templates. Also provide a facilitator's guide. Need to complete a brief survey to access the free tool.
26. Applying a Health Equity Lens to Evaluate and Inform Policy	Douglas et al. (2019) , USA	A five-step process: 1) identify the health equity issue and affected population; 2) analyse the relevant policy impacts and opportunities for policy improvement; 3) develop policy-relevant research strategies (downstream, midstream, upstream) in partnership with community stakeholders; 4) measure and evaluate policy outcomes and impacts

		on heath disparities; and 5) disseminate findings to relevant audiences and stakeholders, including policy makers, communities, public health officials, and health care providers.
27. Health Impact Assessment Guidance for Practitioners	Douglas (2019), Scotland	Advocates the standard six-step HIA approach. Recognises equity as central to all HIA.
28. Abbreviated Emergency Operating Centre Rapid Response Equity Lens Tool	Washington County, 2019, USA	Simple tool with four questions: 1. Who are the key groups who would directly benefit from the [decision or action]? 2. Who is burdened or excluded from [decision/action] benefits? 3. Are people directly impacted by [decision/action] engaged in the decision and in keeping us accountable to the outcomes? 4. What revisions are needed in the decision for [decision/action] to avoid or mitigate inequitable impacts?
29. Health Impact Review	Washington State Board of Health, 2020, USA	Includes assessing equity impact. Examples of the process and completed assessments are provided at the link.
30. Health Equity Impact Assessment	Canadian Public Health Association, 2020	Five step process: Scoping, potential impact, mitigation, monitoring and dissemination. Provides for rapid/standard/ comprehensive assessments.
31. Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy	Came et al. (2020), New Zealand	A five-step process focused on Māori health in relation to health policy development and implementation: Orientation, Close Examination, Determination, Strengthening Practice and Māori final word.
32. Health Equity Assessment Tool	Public Health England, 2020, UK	Involves four main stages: Prepare, assess, refine and apply and review. Includes full and simplified versions.
33. A tool to assess alignment between knowledge and action for health equity	Plamondon (2020), Canada	Framework with questions focused on the causes of health inequities. Considers the following themes:

		Discredit, distract, disregard, acknowledge, illuminate and disrupt.
34. The Health Equity Impact Assessment: A Case Study in COVID-19 Visitor Policy	Olszewski et al. (2021) , USA	An eight-step process: 1. Engage stakeholders, 2. Identify inequities, 3. Examine causes, 4. Clarify purpose, 5. Consider adverse impacts, 6. Advance equitable impacts, 7. Examine alternatives and improvements, 8. Identify outcomes and benchmarks.
35. Conducting Intensive Equity Assessments of Existing Programs, Policies, and Processes	Bradley et al. (2022) Assistant Secretary for Planning & Evaluation (ASPE), DHHS, USA	An easy to follow six-step checklist.
36. Development of a Decolonising Framework for Aboriginal and Torres Strait Islander Health Policy Analysis in Australia	Kehoe et al. (2022), Australia	A decolonisation framework with seven principles each with questions: 1) Power sharing, 2) transparency and accountability, 3) defensible policy basis, 4) legitimate policy content and logic, 5) ways of working that advance decolonisation, 6) responsible policy implementation, 7) monitoring and evaluation.
37. Minimum Elements and Practice Standards for Health Impact Assessment	Bever et al. (2022), Society of Practitioners of Health Impact Assessment (SOPHIA)	Promotes the standard six-step HIA process with a focus on equity.
38. Ensuring Equity in COVID-19 Planning, Response and Recovery Decision Making: An Equity Lens Tool for Health Departments	Big Cities Health Coalition and Human Impact Partners, USA, 2022	A useful tool for health departments that provides core questions and detailed questions. Provides templates which are useful beyond the pandemic context.
39. Health Equity Assessment Tool for State and Local Governments	Health Equity Network of Ohio, USA, 2022	A simple tool that considers likelihood/degree/scale of impact.
40. Policy space and pro-health equity national policymaking: a case study of Myanmar during political transition (2006-16)	Campbell et al. (2022), Myanmar	A five-step policy analysis process that covers: Contextual factors, actor engagement, policy circumstances, policy characteristics and policy spaces.
41. Reducing or reproducing inequalities in health? An intersectional policy analysis	Fagrell Trygg et al. (2022), Sweden	A six-step process applied to addiction policy.

of how health inequalities are represented in a Swedish bill on alcohol, drugs, tobacco and gambling		
42. Levelling up health: A practical, evidence-based framework for reducing health inequalities	Davey et al. (2022), UK	Proposes five considerations to flatten the gradient: Is it (the initiative) healthy-by default/easy to use? Is it long term, multi-sectoral? Is it locally designed? Is it targeted at disadvantaged communities? Do resources match need?
43. Planning for health equity in the crossfire between science and policy	Diderichsen et al. (2022), Denmark	Question-based tool focused on equity in disease/treatment-related decision making. Aims to 'untangle policy implications by distinguishing between determinants of unequal incidence and unequal consequence' using eight questions.
44. Equity Impact Assessment: Intake Form	Seattle Children's Hospital, 2023, USA	A template with five steps: 1. Initiative information, 2. Identifying disparities, 3. Addressing disparities, 4. Evaluation, 5. Viability and sustainability. Although it's called an intake form, it is aimed at assessing proposed initiatives.
45. Health Equity Toolkit	Washington State Health Care Authority, 2023, USA	A five-step tool that considers: The action, accountability and bias, community involvement, tribal implications and the end result.
46. Intersectionality Policymaking Toolkit: Key Principles for an Intersectionality-Informed Policymaking Process to Serve Diverse Women, Children, and Families	Hull et al. (2023), USA	Develop an intersectionality checklist with links to health equity. Poses questions related to agenda setting, policy formulation, policy adoption, policy implementation and policy evaluation.
47. Urban Planning for Health Equity Must Employ an Intersectionality Framework	Williams et al. (2023), USA	Aimed at planners. Includes six questions.
48. Applying an equity lens to assess context and implementation in public health and health services research and practice using the PRISM framework	Fort et al. (2023), Guatemala	Identifies nine elements of an equity lens: Assess structural drivers, assess capacity and infrastructure needs, design monitoring and evaluation, consider representativeness, ask who is not participating, document and facilitate equity enhancing

		adaptations, support representation, consider trade-offs, be conscious of costs and feasibility
49. Turning the tide on inequity through systematic equity action-analysis	Plamondon et al. (2023), Canada	Outlines questions related to four themes: Worldview, coherence, potential and accountability.
50. Clarity on Disparity Who, What, When, Where, Why, and How	Cheng and Mistry (2023), North Africa	Poses five questions: Who has the disparity? What kind of disparity? When/Where did the exposure underlying the disparity occur? Why/How did the disparity occur? Argue that using the who, what, when, where, and how framework can assist in designing interventions in practice and policy.
51. Health Equity Impact Assessment (HEIA) reporting tool: developing a checklist for policymakers	Olyaeemanesh et al. (2023), Iran	A template with five sections: Policy introduction (eight subsections), managing the HEIA of policy (seven subsections), scope of the affected population (three subsections), HEIA results (seven subsections), and recommendations (three subsections)
52. Health Equity Impact Assessment for New and Existing Policies	Lawrence-Douglas County Health Department, USA, n.d.	A simple resource that applies the standard HIA process with an equity focus. Includes templates.
53. Health Impact Assessment - A practical guide	Public Health Wales, Cardiff Uni, Wales HIA Support Unit, n.d.	A five-step process incorporating equity into HIA, with templates provided.
54. Checking Assumptions to Advance Equity	Office of Health Equity, Colorado, USA Department of Public Health & Environment, n.d.	Simple tool with two sets of questions for new and existing initiatives.
55. Health Equity Lens	Pima County, USA, n.d.	A brief web-based health equity lens with four concepts: People, process, power and place.