Building Equity into Public Policies Designed to

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

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

3.1.1 The Purpose of HEIA Tools

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:

3.1.2 Positioning HEIA in the policy development process

In some jurisdictions

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**.

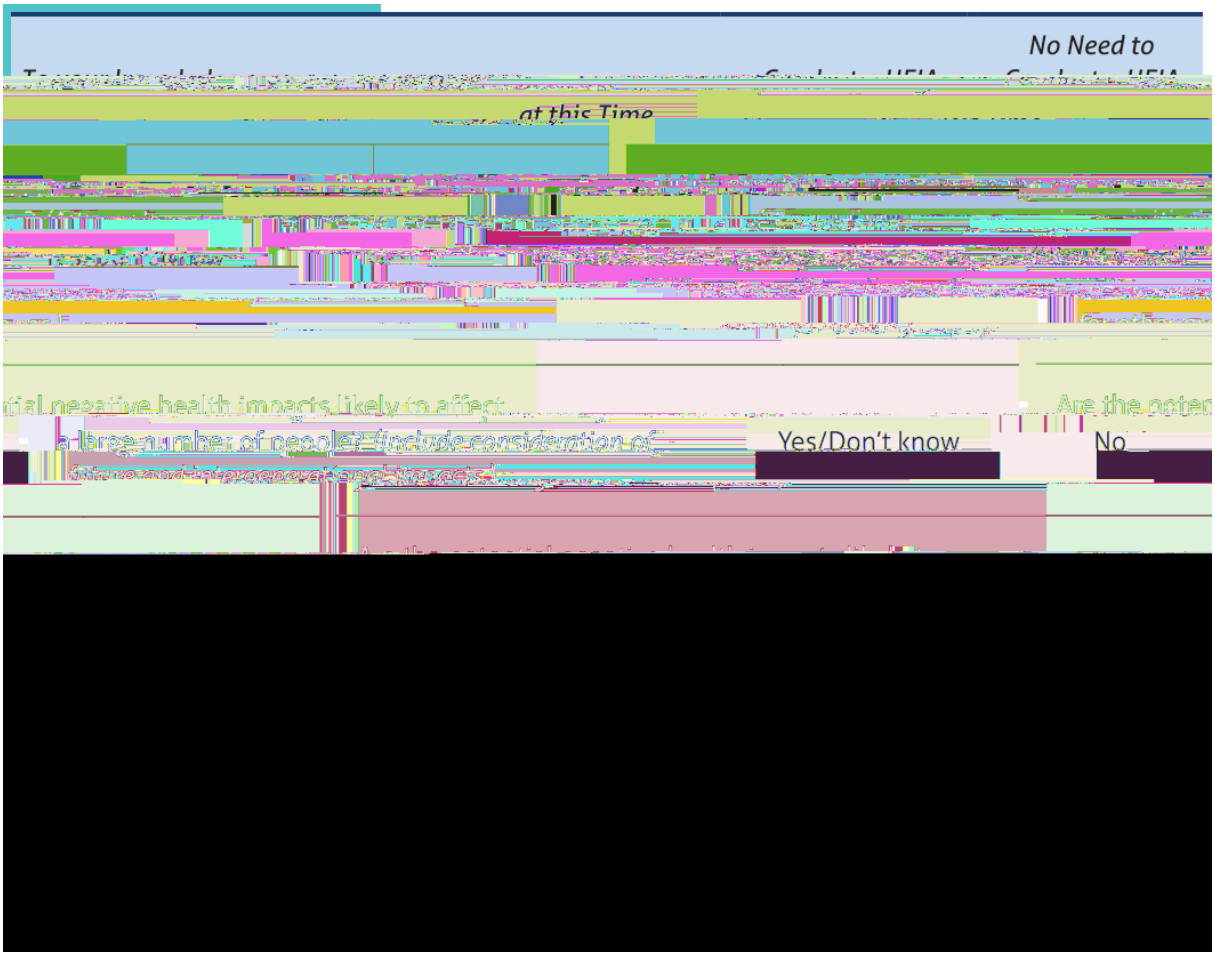

Figure 6: Example of pre-HEIA screening questions (Windsor Essex County Health Unit, n.d., p. 29)

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 iden t fying the unintended impacts of an exis t ng po ţ ® ȷ M ɔ ts Mc ч ʌ Ά o c D] 6 ; Ł t œ e*

a{ Æ p { n` is ɑ u

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* caℕe ǎèǎűemɛ and the

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**).

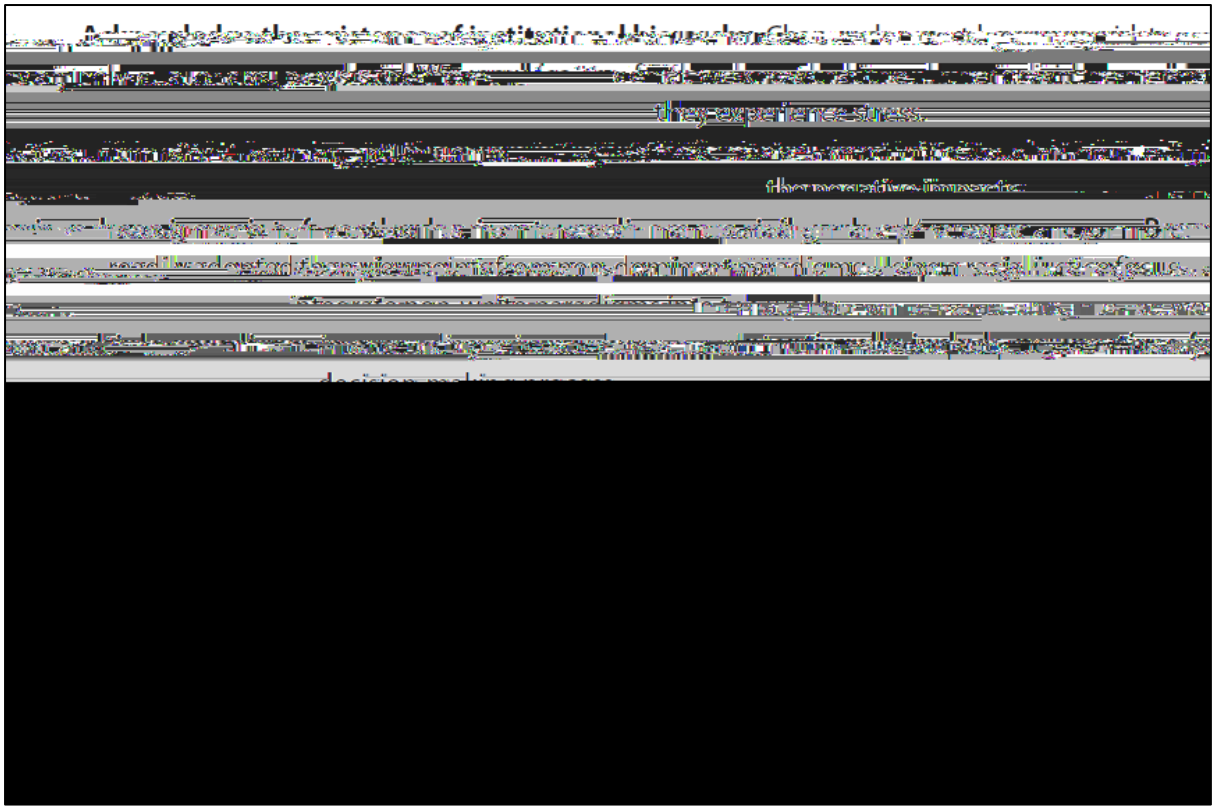

Figure 11: Recommendations for challenging systems that perpetuate inequities (Balajee et al., 2012, p. 68)

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**.

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 or .* (Harris et al., 2007, p. 23)

ait 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 upheld5 hel

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 Bhatia 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-

was presented about how tools were developed and who was involved (King County,

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

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

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

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.

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. , (1), 37. https://doi.org/10.1186/s12889-018-6323-7

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Davies, J. K., & Sherrif, N. S. (2012). . University of Brighton. https://doi.org/10.13140/RG.2.1.2594.0881

deRosset, L., & Zachary, C. (2018). . 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. , (7), 875-881. https://doi.org/10.1177/14034948221082450

Douglas, M. (2019). . Glasgow, Scotland: Scotish 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. , (Suppl 2), 329-342. https://doi.org/10.18865/ed.29.S2.329

Dreaves, H., Pennington, A., & Scot-Samuel, A. (2015). . Liverpool: IMPACT, University of Liverpool.

Fagrell Trygg, N., Gustafsson, P. E., Hurtig, A. K., & Månsdoter, 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. , (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. , , 1139788. https://doi.org/10.3389/frhs.2023.1139788

Fosse, E., Sherrif, 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. , (3), 538-554. https://doi.org/10.1177/0020731419842518

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Norwegian Ministry of Health and Care Services. (2007).

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 of 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	

Mitgaton	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 positve effects or benefts to improve health equity.			

Part B

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

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 os eal Ł h, Ĭ et ľ

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

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?

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?

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 a fec t ng our community's health and wellbeing that might relate to the policy/program/decision? • Do we understand who has the power to make things be t er for the community/groups? • Do we need to advocate for change in other sectors/policies/systems?

Q.5 Do we understand local knowledge?

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?

Yes

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?

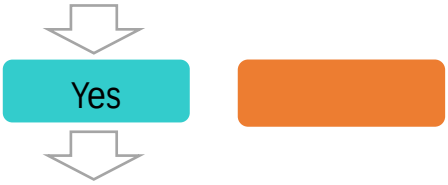
• Given capacity and scope, does the initiative act on the underlying causes of poor health and wellbeing, while also meeting immediate needs?

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 populaton groups?

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



More informaton needed

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

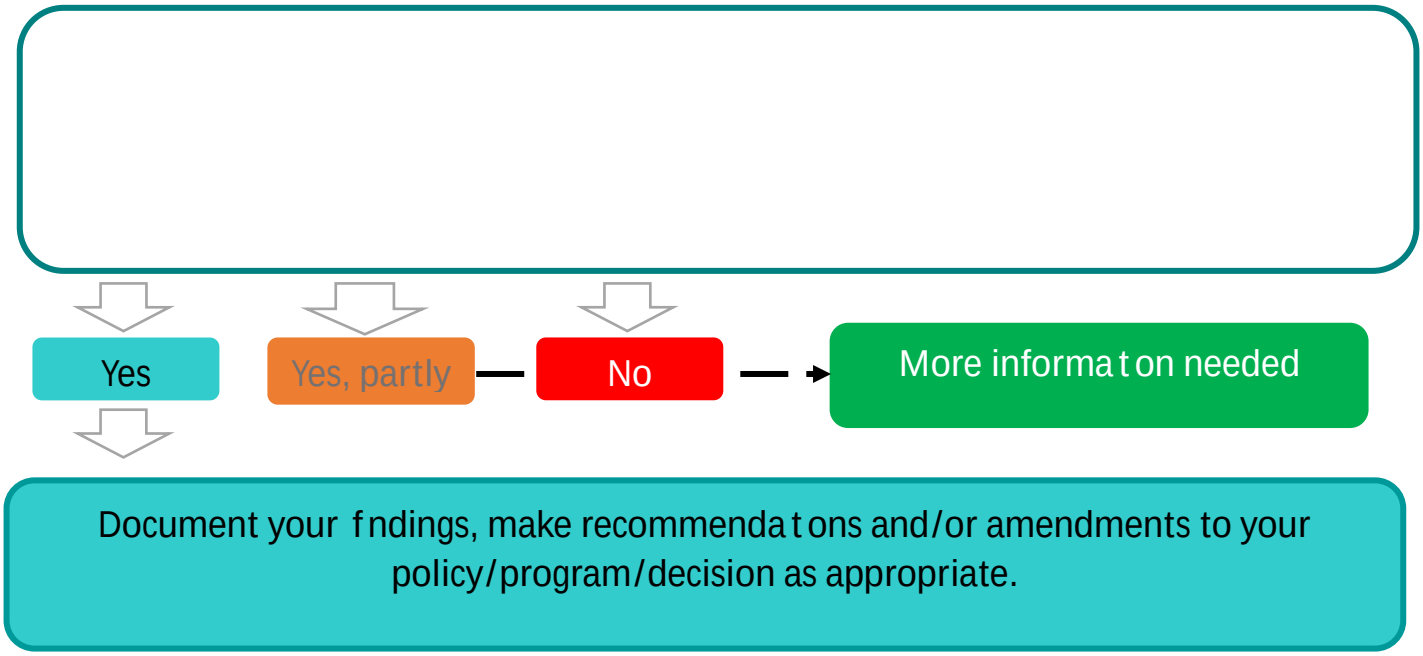
• Downstream determinants of health are micro factors that change biological functoning and focus on individual impact. For example, genetcs and individual health care are downstream determinants. In relaton to addressing food security, emergency food relief services are an example of a downstream approach. • Midstream determinants are factors in the environment or community that can afect the choices people make. For example, midstream measures to reduce smoking rates are price control and restrictng 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 acton, we are unlikely to enhance health equity.

Q.13 Do we know what the poten t al posi t ve and nega t ve impacts of this policy/program/decision are – for the community as whole as well as the diverse groups within it?

• What are the poten t al posi t ve and nega t ve impacts for the popula t on as a whole as well as each priority popula t on group? • Is it likely to have posi t ve impacts or e f ects 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 o f in terms of health outcomes? • If we don't know, what more do we need to know and how will we f nd out? • Will some people or groups bene f t more from the policy/program/decision than others, and why? • w will

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

• Is the ini t a t ve likely to have nega t ve e f ects that contribute to, maintain or strengthen health inequi t es?



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.

P2ǿeN

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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

10. An intersectonality-

		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. Iden t fy inequi t es, 3. Examine causes, 4. Clarify purpose, 5. Consider adverse impacts, 6. Advance equitable impacts, 7. Examine alterna t ves and improvements, 8. Iden t fy outcomes and benchmarks.
35. Conduc t ng Intensive Equity Assessments of Exis t ng Programs, Policies, and Processes	Brad ů N M 02) [redacted]	

of how health inequalities are