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A Case Analysis of the Equity-Focused Health Impact Assessment on Reducing Health Inequality in Canberra

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Abstract

In relation to COVID-19, people in policy settings are exposed to a number of health inequalities that are interconnected with many complex determinants. However, few Equity-Focused Health Impact Assessment (EfHIA) studies have been highlighted as relevant to the ongoing pandemic. The EfHIA is regarded as a mechanism for identifying multidimensional causes of health inequality and presents an opportunity to improve interventions in the development of policies or programmes. This research uses an EfHIA Community Funding Programme (CFP) conducted in Canberra to evaluate the performance of EfHIA, evaluating its process and influences on reducing health inequality, with the main findings being that this assessment performs well in relation to health promotion. This study provides a systematic literature review of the theoretical and practical literature, with the evidence reviewed suggesting that it is essential to adopt effective EfHIA strategies and tools to address root issues of health inequality in relation to policy. In this regard, this research considers the extent to which positive changes can be attributed to strategies of the EfHIA across. Finally, in pursuit of effectiveness and equity, the twin-track approach of health promotion and health equality should be utilised in making decisions, the EfHIA having been implemented over a short period with only few resources in most cases. More theoretical research and empirical studies are therefore required to contribute to the use of EfHIA tools so as to reduce health inequality in the future.

Keywords: the Equity-Focused Health Impact Assessment, health inequality, healthy public policy

1. Introduction

1.1 Background

Recent times have seen a renewed interest in discussing health inequality, with COVID-19 having been witnessed to affect all people in different ways, especially people lacking access to health services, with community funding resources being stretched thinner during such a time of crisis. Recent commentary from *The Lancet* notes that the impact of COVID-19 has spread faster throughout the most vulnerable regions and populations, affecting people in conflict zones, prisons and refugee camps (Ahmed et al., 2020; Sam 2020). In relation to this, Burki (2020) reports that, in the Marion Correctional Institution in the USA, which has around 2,500 prisoners, more than 2,000 of these people have tested positive for COVID-19. This is a major problem given that the supply of protective equipment is constrained to prioritise disadvantaged populations. This limitation is therefore more visible to request equal health treatment consciously rather than widening this gap given that an inequitable response to COVID-19 is already evident in decision making (Ahmed et al., 2020). To address this issue, the EfHIA framework presents a means by which to identify potential inequitable influences across various dimensions of vulnerable populations and assesses the extent to which health inequality as it affects vulnerable populations is avoidable. This trend and this innovative assessment constitute the motivation to analyse select studies within the literature that recognises the necessity of introducing EfHIA into policies or

programmes as a means of addressing the issue of health inequality.

To assess the value of EfHIA in this issue, a systematic literature review is carried out in the present research, together with a case study examining CFP in the Australian Capital Territory (ACT), based in Canberra. Given that CFPs have been shown to be effective in health promotion among many projects, the Australian Government has funded an EfHIA team to assess whether the CFP facilitates equitable outcomes for all stakeholders. However, the report by Simpson et al. (2010) on the implementation of this programme, stresses that vulnerable groups in Canberra do not benefit to a proportional extent, there being no convincing evidence that the CFP might benefit all focus groups. This report also points towards the possibility that the number of people suffering as a result of health inequalities might increase because of the design and implementation of the programme. The EfHIA for the CFP therefore serves as a useful case to evaluate, given that an EfHIA was introduced into this programme to improve the likelihood of equitable outcomes. There is also an urgent need to evaluate the limitations associated with eliminating inequitable impacts through applying EfHIA.

1.2 Research Question

To evaluate the EfHIA in the Canberra programme, this dissertation considers the following research question: how can health inequality be reduced through the application of EfHIA? There are three primary areas that fall to be examined in considering this question: the first is to ascertain how to identify potential inequitable causes using this assessment; the second is to ascertain how to prevent potential inequitable influences identified by this assessment; third, there is a need to consider what strategies and tools are effective in reducing health inequality.

1.3 Structure of the Dissertation

This dissertation is structured as follows. Chapter 2 outlines a theoretical basis for health inequality, vulnerable populations and the EfHIA, before analysing research gaps relating to causes of health inequality for vulnerable populations, potential inequality influences and assessment tools and strategies. Chapter 3 outlines the methodology of the systematic literature review and case study to ensure that secondary information from literatures are adequately and effectively investigated and filtered. Subsequently, Chapter 4 discusses findings from the literature and key documents from the EfHIA programme. The three different areas pertaining to the research question are addressed to evaluate the performance of EfHIA in reducing health inequality based on a highly targeted approach. Finally, Chapter 5 presents a summary, together with limitations associated with this study and implications for future research.

2. Literature Review

2.1 Introduction

Healthy Public Policy (HPP) has been isolated as a means of labelling a policy with a strong concern for health and equality. However, use of the main criteria associated with policies or programmes is sometimes open to criticism given that there are few policymakers who argue that their proposals are less than beneficial for the promotion of health equality (Tilley & Cowan 2011). Only a limited number of potential causes for inequitable policy responses have therefore been identified for research, potentially giving rise to causes for inequality in polices or programmes as they pertain to vulnerable people. The resulting research gaps therefore constitute blind spots for designing fair strategies to address health issues. The Health Impact Assessment (HIA) is regarded as an approach that can meet decision-making requirements as well as formulate means of assessing policymaking based on its intention to add health value. But research gaps still exist regarding policy choice between HIA and EfHIA. Given the higher levels of equity and technical requirements, the effectiveness of EfHIA in reducing health inequality is still open to debate. This chapter begins by identifying appropriate concepts of EfHIA and vulnerable populations in relation to health inequality as they are considered in the literature, ensuring that a principled view of these subjects is reached. This entails the analysis of studies about causes of health inequality in vulnerable populations, with this constituting a possible source of analysis regarding the points of dispute in relation to the necessity of introducing EfHIA into this programme. In terms of potential causes of inequality and vulnerable groups, this chapter identifies the gap in the research regarding the identification of potential influences and focus groups. Furthermore, views put forward in the literature also compare different impact tools in relation to the use of HIA and EfHIA in HPPs, allowing their effectiveness to be evaluated. The research gaps identified are able to provide insight into how the application of EfHIA can facilitate more equal opportunities for health.

2.2 Understanding Perceptions of Health Inequality

2.2.1 The Definition of Health Inequality

The health resource distribution among different populations can provide insight into the level of health equality within that society. In a widely used paper on the concept of health inequality, Whitehead (1991) defines health inequity as unfair differences or disparities stemming from complex causes. Previous studies have tended to

concentrate to a greater extent on the health disparities among different population, whereas more current research frames the new definition such that every person is regarded as having the opportunity to obtain assistance in connection with their health. As Braveman and Gruskin (2003) state, differences as they are considered in these approaches are unsatisfactory as a criterion because not all differences are unfair, for example, the resource distribution based on differences in immunisation levels across different genders. However, there has been few controlled research studies adopting the view that differences have been readily reconciled with inequality in decision making. This may not engender a comprehensive or consolidated understanding of health inequality to satisfy attitudes regarding fairness in practice. This gap suggests that there is an urgent need to separate the concept of health inequality from health disparities for identifying the real causes of vulnerable population in health inequality so that causes of potential inequitable influence can be explained. For this purpose, turning our attention to Canberra, health disparity is unsuitable for analysing the causes of health equality. In this regard, Braveman and Gruskin (2003) highlight that health disparities emphasise narrowing the health differences between different groups. However, the term 'health inequality' is used in this dissertation to refer to emphasise the disruption of the unequal distribution of opportunities underpinning health differences, for example, disadvantaged groups being at a disadvantage such that they are deprived of opportunities for their health to be improved. In practice, different contexts make clear the need for terms that are more accurate descriptors of the concepts under consideration.

2.2.2 The Causes of Health Inequality

The definition of health equality can have important implications for considering the causes of health inequality. There are a number of studies arguing that causes of health inequality have deeper economic causes in terms of the variation in health studies among different groups in terms of income (Marmot, 2007). Illustrating this trend, Tolosana (2015) states that it is reasonable to believe these economic determinants take an important role in leading to health inequality across one or more different kinds of factors, meaning that such factors that are associated with income disadvantages may themselves be linked with health determinants. The findings from Canberra suggest that lower income groups are less likely or are at least slower to receive funding, with this being convincing evidence that health inequities exist at the levels of lower income, with the affected individuals facing difficulties associated with the programme (Martens et al., 2010). Such economic causes linked to vulnerable populations and inequality are therefore considered more frequently and play a central role in decision making. However, given the complicated results arising from potential social determinants in most cases of inequality, such as social exclusion or racial consideration, Simpson et al. (2005) argue that causal assumptions are not only based on relationships between economic advantage and general health issues. Specifically, when an inequality in health is seen among different income groups, the potential causal differences might be in elements related to social gradients as opposed to solely income, such as gender discrimination as it relates to salary. There is therefore a danger of overlooking factors that play a central role in accessing the opportunity for equality if one only makes efforts to increase income to reduce any such potential inequality.

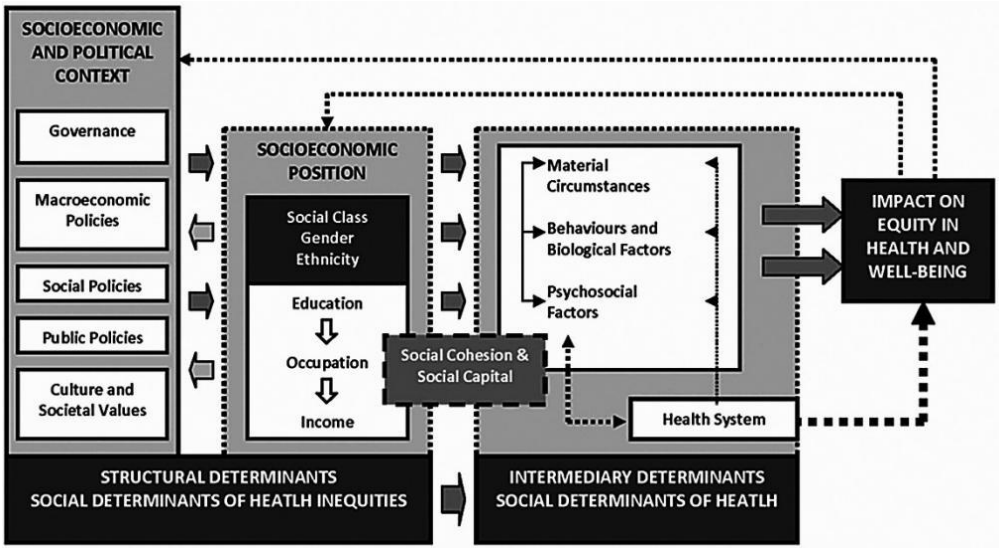

Figure 1. Conceptual framework corresponding to the determinants of health social inequalities (WHO, 2010, 35)

For the purpose of identifying potential social determinants, it is necessary to review these possible causal assumptions regarding health inequality causes through the lens of EfHIA. The model (Figure 1) formulated by the Commission on Social Determinants of Health from the World Health Organisation (WHO) serves as a resource demonstrating that identified causes are extremely diverse across both social contexts and positions, including both outside and inside causes, from which state of affairs it can be inferred that a lack of information and evidence for identifying causes for a population's vulnerability as regards health equality might constitute one of the main barriers to be overcome in addressing health inequality. However, in their sample survey, Davenport et al. (2006) conclude that the EfHIA has the ability to gather information when most existing health data are regional and are associated with possible health risks to invisible vulnerable. Although their sample studies, which are conducted only in regional areas, might not constitute the strongest evidence conceivable, the research gap regarding the lack of evidence to identify causal assumptions about potential causes of health inequality would be addressed by application of EfHIA.

2.2.3 The Identification of Vulnerable Populations

Preventing potential inequitable influences is based on identifying vulnerable groups within one programme. In comparison with the relatively clear focus of the causes of health inequality, there have been different perceptions regarding vulnerable populations within the area of health. But it is important to state in advance one's definition regarding vulnerable populations when allocating priority in implementing programmes, for vulnerable populations, whoever this is regarded as encompassing, often include those who are identified as focus groups. As Leight (2003) states, vulnerable populations include those who are at risk of poor physical and psychological health, an epidemiological concept well accepted by researchers in early studies. This emphasises that those in vulnerable populations are those who experience increased risk of suffering health issues because of their physical status. However, more recent attention has focused on its definition of sociology in order to analyse the health resource distribution for marginalised groups at the national and community levels. Shi et al. (2008) provide an illustrative example of this, defining the vulnerable population as those who are at greater risk of suffering health issues because of their marginalised social status and their associated ability to benefit from health-related opportunities. The social gradients of vulnerable groups and health policy responses appear to be closely linked. In a word, previous definitions are less likely to survey the key focus groups under potential the influences of policy implementation.

De Chesnay (2008) discusses a broader perspective, concluding that there appears to be an intention on the part of researchers to extend the range of vulnerable populations to include, for example, those who are negatively influenced by policy. However, Corburn and Sverdlik (2017) claim that these groups still constitute a small proportion in research areas, and vulnerable populations regarding health equality should not be construed in such a limited manner to include only people at risk in more traditional concepts of this concept. Rather, there is also the need to involve potential populations with multiple social roles. The difficulty associated with identifying potential vulnerable populations constitutes a research gap, for it is difficult for the criteria used to identify vulnerable groups to be used to support a new conceptualisation based on previous literature. The application of EfHIA may be able to ameliorate this situation on a case-by-case basis.

2.3 Understanding Perceptions of Health Impact Assessment

2.3.1 Health Impact Assessment

Some developed countries, such as the United Kingdom and Australia, have sufficient experience of HIA implementation. However, HIA is still taking shape in terms of the direction that it will continue to progress in, with this giving rise to difficulties in relation to meeting health needs and reducing constraints in reducing health inequality (Huang, 2012). It is obvious that the emphasis on the introduction of HIA in relation to its influence on health public policies has its roots in many countries, with varying degrees of application and policy emphasis regarding the problem of health inequality. In order to understand similar applications of strategies and degrees across such policies to reduce health inequality, this section reviews perceptions of HIA.

Given the various definitions of HIA, Cole and Fielding (2007) state that HIA is a multidisciplinary assessment that provides recommendations on HPPs through the provision of a range of scientific evidence relating to health impacts and a broad range of theoretical models of health that take account of economic, political and social elements. Using this definition, Wismar et al. (2007) identify HIA as a consolidation of scientific approaches to exploring potential health effects. Some features are therefore summarised for review by Cole and Fielding (2007), with this research being: 1) an all-inclusive consideration of possible health effects with a multidisciplinary analytical approach; 2) an open, evidence-based attitude that contains various deciding factors and dimensions of health; 3) a well-structured and flexible process. But there is room to criticise this summary on the grounds that it is too idealistic given its high degree of dependency on the objectivity of this assessment, especially when drawing comparisons with the most widely accepted definition of HIA proposed by the Gothenburg consensus paper (WHO 2007). EfHIA as an innovative HIA operational process for making

decisions is therefore also criticised by Kemm (2006) on the grounds that its system idealises matters in terms of a procedure based on fairness to a greater extent than that of traditional HIA. Having reviewed and refined the perceptions of HIA across different theoretical concepts, Buse et al. (2012) conclude that it has been long recognised that HPPs with HIA attitude, in the form of laws and guidelines, have a profound effect on health inequality reduction because these stress the public perspective for healthcare outcomes, outlining priorities and informing people of their rights in relation to matters of health. However, several complicated challenges in terms of the practical application of these remain. There is a research gap given that HPPs with HIA are often insufficiently effective in meeting their expected equity goals when policymakers try to follow advanced models in the absence of sufficient related experience. In stressing this point, Hartsfield et al. (2007) report that there is lack of evidence-based HIA policies for vulnerable populations across the board, identifying 107 typical laws and covering 16 themes relating to health issues. Only 6.5% of policies demonstrate that their HIA policy was informed by fully engaged scientific information and a fairness assessment. Hartsfield et al. (2007) therefore argue that the performance of traditional HIA is still far from satisfactory in relation to meeting the fairness and "Health in All Policies" (HiAP) expectations expressed by the WHO (2014). Having reviewed the traditional HIA in practical experience, the equity-focused theoretical model should be introduced from the analysis of research studies to facilitate a more comprehensive discussion within the scope of this research, with this being a model for narrowing the research gap between traditional HIA and expected health equality goals.

2.3.2 Equity-Focused Health Impact Assessment

HIA is becoming a practical reality, coupled with an increasing number of useful strategies and tools to share among countries in relation to the question of improving health through policies. Notably, different degrees of development and different health-related problems stand to affect the application of different theoretical frameworks. The EfHIA framework is therefore selected here due to its corresponding features for vulnerable populations suffering as a result of health inequality. In this regard, the framework can usefully applied in focus areas to achieve its goals.

The EfHIA framework for CFP in Canberra is a model from a two-year research study funded by the Australian Government's Public Health Education Research Programmme. This is different from other HIA models in relation to its focusing on vulnerable populations and consideration of balancing the relationship of effectiveness and health equality (Mahoney et al., 2004). Much of the extant literature debates the relationship between effectiveness and equality in the progress of designing and implementing in funding programmes because it cannot be ignored that principles of equity sometimes conflict or are in tension with other factors (Tones & Tilford, 2001). Nevertheless, this framework emphasises the relatively independent role of EfHIA in maximising the potential benefits for reducing social gradients. The evidence presented in the EfHIA for Support Scheme for Rural Specialists, a continuing education programme for specialists in rural Australia, uses videoconferencing directly with disadvantaged stakeholders as a convenient means of engaging in both delivery and response, with no additional local staff being provided to carry out the EfHIA (Simpson et al., 2005). It was hypothesised that the EfHIA framework could receive information independently and quickly in relation to equity issues without interventions on the part of other interest groups (Dalton et al., 2004). However, these benefits are not always accepted by researchers. In this regard, an example from Woodward and Kawachi (2000, 924) demonstrates that positive assumptions may not be fully evidenced by the balance in performance of EfHIA if there is a lack of participation on the part of policymakers' in this programme:

"The failure of policymakers to incorporate an explicit consideration of the health impact may partly explain why little progress has been made in terms of reducing health disparities despite decades of evidence documenting HIA's existence."

But, drawing on this rural model, Cohen et al. (2016) arrive at a more positive conclusion regarding the grassroots level of information collected by the CFP. Consider the as an example the innovative method of the EfHIA community workshop. This workshop has increased equity-focused effectiveness and gained the opinions of members of hard-to-reach vulnerable populations, training government members to play the effective role of consulting members. This model appears to be positive having regard to the fact that the vulnerable groups affected by health inequality were well-represented in recommending such informed planning policies. Although there is still an obvious information gap relating to reducing inequality barrier to increasing effectiveness through this assessment, current evidence suggests more positive prospects in relation to the matter of applying EfHIA tools in balancing the interests of different stakeholders.

2.3.3 Comments on Health Impact Assessment Tools

To ascertain the importance of EfHIA application, it is also important to ascertain how HIA tools function in relation to health inequality improvement. Some HIA studies include the following traditional HIA tools, which are used at least to a partial extent within the EfHIA framework (Kemm et al., 2004; Birley, 2013): 1) screening tools, for filtering out projects that do not need an HIA; 2) scoping tools, for determining what should be

assessed and how this should be done in relation to the progression of an HIA; 3) assessments or recommendations, assessing the performance of programmes or providing recommendations relating to equity focus. In his case research, Wilmsen (2018) found that these tools are suitable for most cases involving the environment, such as the HIA conducted in respect of the Three Gorges Dam on the Yangtze River in China, which was well-planned using HIA tools for resettling residents. However, little is available in the literature regarding the matter of identifying the most effective tools for vulnerable populations in relation to health inequality. In terms of EfHIA with more complex fairness-related requirements, by contrast, there is a need for significantly more sophisticated equity tools to fulfil their function (Simpson et al., 2005). Some researchers have therefore come to a view similar to that of Forsyth et al. (2010): there is a gap in relation to the degree of difficulty associated with introducing EfHIA tools in order for them to be accepted as a fair and useful complement for policies or programmes as opposed to a demanding technical requirement.

In relation to this matter, McCaig (2005) raises similar concerns regarding one strategy from his experience: equity-focused identification. This is an important tool of EfHIA framework that is used across all stages to formulate an analysis for identification. This tool can consider whether the identified potential health impacts engender inequitable effects among the concerned populations (Harris & Simpson, 2003). Most importantly, it is a professional tool by which EfHIA workers can identify correct policy impact tools for vulnerable groups. However, while this EfHIA provides an attractive means by which to approach policy preparation, it may be regarded as being packaged as an equity-related matter on the grounds that the framework of EfHIA represents an ideal model and policymakers are often unfamiliar with professional toolkit, as Mahoney et al. (2004) note. Consequently, vulnerable populations in health inequality may adopt a more central stand in policymaking, meaning that the focus of policy and the design space of policymakers may be limited by EfHIA-related attitudes. But, as is well known, there is still an insufficiency in relation to the depth of analysis for health inequality, and there is a lack of studies associated with identifying what the most effective policy and assessment tools are for vulnerable populations. These studies therefore indicate that EfHIA strategies should provide the appearance of increased attention on equity in the longer term. In the event that policymakers are using their policy tools across different vulnerable populations, it might not be an optimal choice to place health equality within a more central position.

2.4 An Interim Conclusion

The literature presented in this section constitutes only part of the theoretical understanding relating to the EfHIA, vulnerable populations and health inequality. A variety of tools have been applied to this programme and other EfHIA projects, with this resulting in certain outcomes regarding health equality. However, as an assessment for supporting vulnerable populations through public means in recent years, there are some limitations that cannot be neglected in relation to widening the scope of research. Three research gaps have emerged in this chapter, and so there is a need to identify: first, the key causes of vulnerable groups in health inequality, especially the potential influences engendering inequality that result from polices or programmes; second, the method by which to isolate potential vulnerable groups, helping to prevent potential negative influences at the pre-implementation stage; third, the suitable strategies and impact tools that can be used to reduce health inequality. In relation to the experience of the EfHIA case study, the application of EfHIA has already been demonstrated to assist with positively addressing health inequality and the effectiveness of health policies and programmes. This matter is therefore further discussed below.

3. Methodology

This chapter outlines the analytical approach taken in this research for addressing the following research question: how can health inequality be reduced through the application of EfHIA? It begins with the research aims and discusses the research design adopted, explaining the motivation underlying the choice of research approach used so as to gain an in-depth analysis. Finally, this chapter also considers the matter of limitations associated with this means of conducting research.

3.1 Research Aims

Many researchers utilise economics and political principles to evaluate the influence of EfHIA in relation to health equality. These studies focus on the results of applications as they apply to general focus groups. Such groups are considered as representative of the majority and, ignoring some special features of programmes, have less connection with the very worst situations and potential negative influences faced by underprivileged focus groups. This chapter offers a systematic literature review to evaluate the evidence in favour of implementing EfHIA through policies or programmes. Articles by experts on conceptual frameworks are useful in the literature analysis, but there may be deficiencies in terms of shortage of practice as applied to other specific programmes. It is therefore the purpose of this research to combine the former theoretical methods with practical experience through identifying typical cases to investigate ongoing issues in relation to both theory and practice.

3.2 Research Design

This research design features a combination of a systematic literature review and a case study method in the conducting of desk-based research. This method is utilised in order to address the research question. The first step involves selecting suitable research studies, analysing obvious or potential interactions between different types of evidence and following principled search criteria. The second step involves comparing interview results and secondary data from the literature to identify suitable cases, together with any other similar successful experiences or limitations apparent from other cases. These resources are analysed to ascertain the useful dimensions that could be applied to evaluate existing findings drawn from the literature. The final step involves summarising the limitations of methods that are not strictly applicable to future EfHIA research.

3.3 Research Approach

3.3.1 Systematic Literature Review

The systematic literature review is a "form of research that identifies, describes, appraises and synthesises the available research literature" (Gough et al., 2012, 5). This research utilises a systematic review to gather and analyse theoretical and empirical evidence relating to the research question.

In terms of reviewing theoretical evidence, this research surveys literature on EfHIA and health inequality produced by scholars, governments and HIA groups operating within these fields. The application of the EfHIA model in Canberra is covered in this literature, with this research often referring policymakers or other readers to more reliable academic information about this method of assessment. A systematic literature review is therefore chosen as the core of the research design, with desk-based investigation of official documents from across a range of subjects considered to address the research question. There is also a need to obtain a better understanding of the status of theoretical evidence. Within the contemporary context, without conducting a field trip to investigate local governments, even other designs and methods, such as interviews and focus groups, seem less appropriate for the present research because it is unlikely that there would be many individuals with sufficient theoretical knowledge of this professional assessment to enable the research question to be addressed. In particular, there is a need to consider the question of how the workflow of EfHIA is implemented within the policy circle of public sectors. But secondary data collection drawing on public responses from interviews and workshops in the literature nevertheless constitutes an important aspect of the present study. Research on the ongoing COVID-19 pandemic serves as an important background and means by which to supplement the findings of previous literature and policies. Furthermore, Ginieis et al. (2012)'s literature review methodology is a well-established approach that assists with minimising bias through reviewing articles that are relevant, using explicit and replicable criteria in selecting articles for consideration and investigation.

In terms of reviewing empirical evidence, this research adopts empirical data or information from the literature as the key element of the analysis, with this evidence providing scientific experience useful for addressing the research question. Because the application of EfHIA and health inequality constitute the core of this dissertation, a high degree of internal validity can be gained from one typical empirical case. But there are also limits associated with the externality of application that result from relying on one representative empirical case from the literature. There is therefore still a need for fruitful contribution to the debate on external validity through drawing comparisons with other cases considered elsewhere in the literature (Flyvbjerg, 2006). To meet these purposes, a systematic literature review is utilised within the context of this research. The criteria set for searching suitable literature and research studies are outlined below (Table 1):

Table 1. Criteria for inclusion

Criteria	**Explaining Reasons / Comments**
Dates of publication: 1999-2020	The Gothenburg Consensus Paper in 1999 is one of the earliest HIA landmarks, and so this date is chosen as the starting point for potentially qualifying studies.
Types of literature	Literatures are chosen from: - Academic journals, in particular professional public health assessment journals from official organisations; books - "Grey Literature" - Websites (e.g., WHO, which has the HIA website from 2003)
Keywords: EfHIA, health	The research addresses how the workflow of EfHIA affects health inequality,

inequality, health promotion	which is related to many health promotion projects.
Focus Area: the ACT of Canberra	The CFP of Canberra had been identified as a pilot programme in central Australia with its various population components, constituting a challenge to the application of EfHIA.
Group Focus: Vulnerable population	- Vulnerable population are the main focus groups in an EfHIA programme, with these being closely related to the problem of health inequality. - Some research studies will also be included if the targeted groups are not generally regarded as vulnerable populations.
Elements of research topic: - EfHIA frameworks - EfHIA tools - Equity-focused attitudes - Health inequality	Literatures should stress key points as: - These literatures should consider clear evidence regarding the performance of EfHIA frameworks. - Impact tools of EfHIA should be included, and there is also scope for inclusion if practitioners break this tool into sub-steps to in relation to implementation. - Focus on health inequality.

3.3.2. Identification of Case Study for Research

The Canberra programme was undertaken in 2003, and this section considers the reason why this particular programme is to be isolated for analysis. There are three requirements for research to be considered, relating to 1) its significance in the public health area; 2) its application of EfHIA; 3) the presence of positive outcomes in reducing inequality, albeit there may be some limitations. The case considered within the present research is the EfHIA for a CFP in Canberra, which is one of five pilot EfHIA case studies. There are several reasons why this particular case should be chosen. Firstly, there are considerations that require to be met regarding reliability and validity after the EfHIA application for several years while getting improved its inequality situation. Secondly, the ACT health promotion sectors had a strong intention to assess this particular programme, factoring in the potential influences of the CFP for reducing health inequalities and point outing what elements of the CFP can be adjusted to enhance the focus on equity. Finally, this case serves to provide experience to similar community funding programmes across both Australia and the world generally in terms of its outcomes. There is therefore scope to use this particular case to analyse the relationship between the application of EfHIA and health inequality given the aim of this programme to prevent potential inequitable influences through setting real priority groups and applying useful strategies to mitigate and reduce inequality.

3.4 Limitations

There are several limitations associated with the methodology adopted here. First, the drawback of the systematic literature review stems from the fact that if this research quotes primary sources, the results of their primary information may be easily adopted, with this being a potential weakness in terms of comparing these with direct results. Okoli (2015) argues that, in reviewing an academic paper, one should use available materials to offer a more independent critique. Second, under such an approach, inequality in health cannot be directly measured without the collection of data. But it is still possible to quantify the degree of health inequality if this research follows criteria relating to the inclusion of literature as prescribed. Third, choosing cases in terms of these criteria might not meet all the general requirements of programmes when considering complex relationships involving different factors based on typical features of other cases. The further EfHIA applications for other programme to influence health equality in vulnerable populations is therefore afforded a certain degree of latitude in relation to the causality analysis offered here.

4. Findings and Discussion

This chapter first presents the evidence from the systematic literature review to illustrate the context of Canberra for discussing findings relating to health inequality. This chapter then addresses the research question in relation to three different areas, analysing how the impacts of each EfHIA workflow can reduce health inequality. The final section discusses the implications of applying this assessment to other programmes, together with the understanding of health equality described in the literature review.

4.1 The Context of Canberra

There are some findings and evidence that have been considered from the wider context of Canberra in the

implementation of this EfHIA framework. Prior research from the ACT Chief Health Officer's Report organised by Dugdale and Kelsall (2003) notes that Canberra does not have higher levels of regional poverty than other regions of Australia, with this being due to the small population and local types of industry. However, disadvantaged populations are worse off in relation to several different areas. For example, poverty is not only concentrated in suburbs; children are 2.5 times more likely to suffer poverty than grown-ups; a large number of poor Canberrans are less likely to be integrated within a family and obtain meaningful work than poor Australians more generally (Dugdale & Kelsall, 2003). The most obvious finding emerging here is that there is a strong basis for the application of EfHIA, there being evidence to suggest that it is important for policymakers in the ACT to design their community funding programmes with principles of equity in mind.

4.1.1 Living Standards

Compared with the social indicators relevant to health and the $24,677 disposable income per year enjoyed within Australia, Canberrans enjoyed an average of $36,831 per year from 2002 to 2003. Furthermore, Canberrans enjoy the lowest unemployment rates in Australia. From 2002 to 2003, this rate reached 4.4% on average, compared with 6.5% across the of whole Australia. However, it can also be seen from the report that 1/13 adults live in poverty. Such individuals are also more likely to be members of a younger generation. Moreover, about 60% of the ACT women with children under the age of five are involved in heavy work, with the rate across Australia as a whole being only 50%. In 2008, the unemployment rate of the ACT decreased to 2.3% but the level of income was high in comparison to national levels (Simpson et al., 2010; Australian Capital Territory, 2010). A comparison of the data in this period thereby implies that the social disadvantages could be reduced using suitable policy adjustments.

4.1.2 Health and Well-Being

In general, a good quality of life is indicated by statistics relating to life expectancy in Canberra, with ACT having the highest life expectancy for both men (80.3) and women (84) in 2007. However, there were 38,100 residents facing obstacles to their activity and requiring assistance from community groups. The 2001 National Health Survey investigated 27,500 people in Canberra, with 8.8% of the population reporting a long-term mental health problems. These disorders constituted 15% of the total burden regarding disease and injury in the ACT in 2003, as compared with 13.3% at the national level. This survey also reported that 10% of the population in this location suffered increased levels of psychological pain (Simpson et al., 2010; Australian Capital Territory, 2010). This evidence reflects that of Corburn and Sverdlik (2017), who found that vulnerable populations from the perspective of health equality are limited to people who are at risk in terms of more traditional views. Populations facing multiple sources of inequality therefore require to be considered in the analysis of this research.

4.1.3 Access to Health Services

The health services are able to serve most Australians, albeit there is evidence pointing to difficulties associated with accessing health services because of shortages of specialists, transportation, and health spending in Canberra. The ACT General Health Survey (ACTGHS), conducted since 2007, provides data on certain different factors influencing access to health services. In 2007-2008, the most commonly recorded service accessed by ACT residents was their General Practitioner (GP), reaching 95% per year. This figure is followed by those for specialist (31%) and community healthcare centre services (13%). 21% respondents to ACTGHS indicated that they delayed using this service because they were unable to pay, with 6.7% reporting that gaining access to health service is not (Simpson et al., 2010; Australian Capital Territory, 2010). Such evidence mirrors the findings of Braveman and Gruskin (2003), indicating that it is important to break the distribution of opportunities behind health services, with 21.1% respondents stating a belief that health provision in their local communities is inadequate. These results further support the importance of funding most vulnerable populations and making use of EfHIA in health policies.

4.1.4 A Brief Analysis of Community Funding Programmes

Other findings can be drawn from the CFP in Canberra. First, as Simpson et al. (2010) points out, there is no doubt that the CFP has had positive impacts in many cases through providing funding to different projects. However, this programme potentially focuses on economic determinants, encouraging applicants to consider health issues without considering a more comprehensive perspective. These determinants may not be the root causes of health inequality. An EfHIA can therefore screen potential causes of inequality and inequitable effects to highlight the need for action and the relevant areas to address. Second, the CFP may have had increased opportunity to build connections with healthier communities, indicating that it potentially serves to benefit those who already enjoy an advantage. For example, the application process for CFP potentially favours applicants who are adept in relation to preparing in terms of resources and capacity. It is a reasonable inference that certain equity-focused projects are less likely to attract funding because of their weaker strategic priorities. Hence, an

EfHIA for a CFP can identify priority groups and key issues. For the purposes of equality, an EfHIA may therefore evaluate what methods and strategies can be applied to the programme in question.

4.2 Screening Key Documents to Identify Potential Causes

To address the first aspect of the research question (regarding how to identify potential inequitable causes through the EfHIA), there is a need to consider the first step of EfHIA workflow, viz. screening with equity, with this step being used to assess whether an EfHIA is required for a programme. From the perspective of equity, this can help policymakers consider their findings in relation to factors such as policy failure, social status, or culture, helping to predict whether such differences unfair and should be mitigated (Mahoney et al., 2004). The predictions made by the screening step, drawing on other HIA cases, is often stressed in reviewing key documents. An illustrative example comes from the case of the Three Gorges Dam, in relation to which the screening environment documents helped to highlight that the forced resettlement of local communities suffering from inequitable health effects might be affected by certain marshlands around the dam that were associated with schistosomiasis diseases (Simpson et al., 2005; Jackson & Sleigh, 2000). Kemm (2001) the importance of predictions made regarding similar cases in comparable settings to make the rationale for equity explicit in this step, for it is often the case that well-intentioned programmes may lead to unanticipated and unequitable results. Given such practical evidence, the EfHIA steering team screened key documents to find potential causes resulting from design and implementation while outlining a profile of potential health inequalities. This profile strong suggests that this EfHIA step can identify causes of inequity in terms of the following analysis:

This step first establishes different understandings of health equality from key documents. For instance, the Canberra Social Plan has a particular commitment regarding its goal of promoting health:

"[to] improve the good health of the Canberra population and narrow the health gap between the general community and the poor and disadvantaged." (Dugdale & Kelsall, 2003, 7)

However, using the screening step within EfHIA, it emerges that none of these key official documents identify a comprehensive government commitment to stressing health inequalities situation within the ACT. As discussed above, the performance of decision makers in designing programmes is still far from satisfactory in meeting the HiAP attitude that emphasise the importance of health-related obligations and the accountability of decision makers (WHO 2014; Collins & Koplan, 2009). The ACT issue emerging from this document is as Shi et al. (2008) stressed: causes of inequitable health are often linked with potential influences regarding policy design and implementation. The consolidation of health equality action was therefore organised and matched using the international indicator within the screening tool, improving the accountability on the part of the decision makers. The EfHIA steering team found that the definitions of 'disadvantaged' or 'vulnerable' across different documents were used in accordance with different criteria, with this serving as a potential factor influencing the identification of potential causes and focus groups. Similar to many programmes, stakeholders within the CFP concentrate on establishing the causal relationship between perceived vulnerability and economic determinants: what is evident from the list of funded programmes is that recreation projects tend to attract funding through their ability to generate high returns (Simpson et al., 2010). This reflects a simple criterion in funding projects, albeit these issues are isolated within the screening step to guide the programme into correct starting point with consolidating better understandings and searching for causal assumptions underpinning potential health impacts.

This step also filters information useful for outlining the rationale of a decision. Decision makers may be misguided by complex information without equity-focused rationales or the professional capacity to analyse how many causes are addressed by the programme. More specifically, the necessity of health equality in policies is at risk of being ignored when it is these individuals who screen the documents. As noted above, some researchers may therefore adopt the position that gathering information using equity as a criterion may be a demanding technical requirement for decision makers (Forsyth et al., 2010) being a top-to-down progress for objectively filtering information to make assumptions underpinning this programme. In consequence, there are a number of valued findings attributable to the screening step of EfHIA. The steering team reviewed 6 key documents (Table 2):

Table 2. Key documents reviewed by the Steering Group **(Simpson et al., 2010, 20)**

1. ACT Health Promotion Board Strategic Plan 2002-2005
2. Advertisement in print media for the 2003/2004 funding round of the CFP
3. Guidelines and application form for the 2003/2004 funding round
4. ACT Chief Health Officer's Report 2000-2002
5. ACT Health, Health Action Plan 2002

6. Service Agreement between: The ACT Department of Health and Community Care and the ACT Health Promotion Board, September 2002.

To filter the list of documents, the requirement of consolidation understanding for health equality and the context of health inequality in the ACT are identified in document 4 to 6, with this indicating that the negative causes of health inequality in policy design can be identified by this step earlier. Furthermore, policy strategies and funding rules are adjusted on the basis of documents 1 to 3 so as to reduce health inequality through following the instructions of the EfHIA. The most obvious EfHIA reflection from the screening documents of the programme is that these documents are assessed objectively and used to develop a profile of EfHIA application rationale for all stakeholders. A preliminary assessment from the screening step of EfHIA can therefore avoid potential inequitable causes associated with negative policy responses at the very beginning by means of identifying key information from documents, guiding decision makers to re-examine their decisions. In this step, the reorientation of making decisions is reflected to ensure that equal outcomes result through use of the EfHIA.

4.3 Scoping Equality Parameters to Prevent Inequitable Influences

To address the second aspect of the research question (regarding how to prevent potential inequitable influences), it is important to understand the purpose of scope, viz. setting the parameters of the EfHIA. More specifically, Mahoney et al. (2004) state that this step can set the boundaries by which to identify vulnerable populations that should be prioritised, what issues should be considered, and what health promotion interventions within the programmes should be targeted for improvement. Collins and Taylor (2007) report that, from their urban development HIA experience in London, parameters provide a critical means by which to consider the information collected regarding equity-related range and types. In this step, there is an intention to isolate practical actions to test the analysis output by the screening step.

4.3.1 Interviewing Experts for Analysing Key Issues

The interviews associated with the previous step are done to identify key issues to prevent potential health inequality, involving the analysis of both sides of health impacts through interviewing informants. Through assessment techniques, such experts generally demonstrate the ability to highlight potential issues regarding inequality and make recommendations as to how to engender positive effects (Table 3). In this programme, several key issues were targeted for improvement:

Table 3. Potential impacts of the Community Funding Programme identified by key informants (Simpson et al., 2010, 42)

Potentially positive	*Potentially negative*
• The CFP is a funding base that organisations can call upon — this is essentially positive.	• The way that the CFP is administered means it has potential to be placed in areas that are ineffective i.e., it funds projects that have unrealistic outcomes. • CFP as just another potential source of funding rather than resources for building health promotion capacity.
• CFP funded projects can be used as demonstration projects and made attractive to other markets/funders who then take them up and fund them in the longer term.	• The CFP may encourage linear thinking about funding sources e.g., instead of looking at other potential and longer term sources of funding such as Westpac and/or using knowledge of corporate sector in developing three year business plans etc. HealthPact can only do so much through the CFP.
• The program gets people involved and active in health promotion work rather than just slogans, branding or advertising.	• Application process for the CFP invites strength building so that those who are good at preparing applications and have the infrastructure to do this get funded rather than funding on strategic priorities.
• Funding community organisations to undertake health promotion is potentially positive because they are more likely to be working with disadvantaged groups and therefore potentially more likely to reach people who are marginalized and/or experiencing health inequalities.	• Communities are “addicted” to the small grants process. • CFP does a great job of improving the health of those who are already well. • Sponsorships are potentially negative (i.e., because they are about branding, linked with “elite” sporting organisations etc.) but have a place.

First, this step improves the portfolio of health promotion sectors. One finding of note is that the ACT Health Promotion Board is recognised as the only stakeholder that should be responsible for health promotion in Canberra. The result of this setting therefore indicates that the CFP may encourage linear thinking regarding supporting projects through funding instead of focusing on resource distribution, as made clear by Table 3. This may stem from a lack of professional knowledge or potential wariness regarding making recommendations outside of one's area of responsibility. However, interventions for preventing equitable influences are more workable when a broader fair commitment is accepted by more stakeholders (Simpson et al., 2010). This board clearly occupies an important position in advocating a strong equity-focus in health promotion within the public sectors of Canberra. However, the distribution of responsibility across all sectors is also important. On the one hand, the understanding of these different funding stakeholders regarding health equality implies that it would be necessary to build a common equality parameter for this key issue. Such a step could set parameters to prevent equitable influences of the public sector's structure through clarity in relation to health goals, and the relative status of different staff (Franco et al., 2002). On the other hand, this is an interview result that outlines different roles and collective responsibilities of other stakeholders when the parameters are set in relation to each sector's accountability, with the distribution of responsibility being considered by each health sector with a view to ensuring that equitable effects result.

Table 4. Funded and unfunded grants based on Project Type, 2003/2004 Funding Round (Simpson et al., 2010, 52)

Project Type	Total received	Funded	Unfunded
1. Recreation	2	2	0
2. Sport	6	4	2
3. Drama	5	4	1
4. General Arts	2	1	1
5. Music	0	0	0
6. Festival	0	0	0
7. Capacity building within your community	21	9	12
8. Community development	15	9	6
9. Health Promoting Schools	15	12	3
10. Health Promoting Workplace	3	1	2
11. General Health	14	8	6
12. Other	9	6	3

Second, this step can identify hard-to-reach projects. The information from interviewing experts based on the 2003/2004 funding round (Table 4) demonstrates that project types highlighting applications in relation to health promotion or schools enjoy increased chances of receiving funding, gaining 85% of the total proposal amount. However, project regarding community building were relatively unsuccessful. In this regard, Simpson et al. (2010) state that one in three workplace applications that were funded received only reduced funding. This indicates that official institutions potentially influence health equalities, giving rise to inequality problems as a result of the difficulty associated with self-examining when it is much easier to simply identify other projects. The expert interviews within the scoping phase may therefore help to identify less obvious issues as a result of their professional abilities in relation to inequitable influences.

4.3.2 Workshops for Analysing Key Focus Groups

The workshop within scoping step is included to identify key focus groups to mitigate potential health inequality, involving the analysis of organisations and potential applicants within the ACT in intensive workshops. Participants in this step were asked to answer health-related questions and share their experiences in relation to health inequality. Through workshop information collection and analysis, the EfHIA were able to review community outcomes of the CFP as they compared to official reports, while renewing the thinking of the participants. These workshops were designed to emphasise health promotion in respect of each individual. If the programme discovered that there was difficulty associated with opportunities to accessing health services on the part of those who are most in need, this would be regarded as evidence that more focus required to be placed on the relevant factors. Focus groups are therefore identified within workshops for preventing inequitable

influences.

This step can help to highlight less visible vulnerable groups. The EfHIA noted that there is consensus about several less common vulnerable groups who suffer inequalities in Canberra. For example, 10% of the population with mental illness were suffering higher-level psychological pain but were not able to gain suitable access to health services (Australian Capital Territory, 2010). At the same time, a certain level of controversy was associated with certain groups who were not identified in the progress of the workshops, such as individuals from culturally diverse backgrounds who might have reported experiences regarding unequal experiences:

"… the ACT is a sanitised environment and groups such as recent migrants, refugees and their concerns are not visible. Because issues are diffuse (i.e., geographically spread) they're not seen to exist…" (Simpson et al., 2010, 45)

It was not easy for this programme to establish whether these groups could be identified as focus groups to access more health services in through traditional identification methods. Potential differences between funded and unfunded projects for choosing traditional key focus groups are often difficult to perceive. For example, local younger generations are often regarded as key groups in both types of projects, meaning that support for other potential groups (e.g., refugees or migrants in the community) were sometimes not consulted to the extent that might be hoped. In the workshop, the identification of vulnerable population was discussed in relation to an equity perspective through reviewing existing focus groups and creating a set of questions to identify these groups based on workshop reflections. The use of this step reduced the disturbance engendered by other advantaged recipients and eliminated the blind spot associated with public sectors in the ACT.

This step can also involve amplifying the voice of disadvantaged recipients. As a funding programme that is benefit to those people who are involved in these projects, health inequality is often still hidden behind the funding allocation within one project, especially in relatively richer communities within the ACT. As the EfHIA steering team stated:

"People on low incomes – this impact on all aspects of their lives, especially because they live in an affluent community where they become more isolated and are far less able to access services such as primary health care." (Simpson et al., 2010, 38)

The current allocation might potentially favour such stakeholders who dominate the conversation within funding organisations. Funding is not always allocated to organisations that expect to reduce health inequalities in communities (e.g., only nine community capacity building projects were funded in the round from 2003 to 2004). The remaining issue, however, is that such equity-focused organisations that did not receive funding may not have provided more equity-focused evidence than organisations that did receive funding. As Wallerstein and Duran (2010), in their community-based research, reported, local knowledge and unique cultures may influence the allocation of health services in communities, with this not being a simple intersection between EfHIA knowledge and local public health knowledge. The scope of EfHIA therefore engenders a relatively sound communication platform for potential applicants and sponsors, providing an equity-focused prior check of the CFP through gathering comments from stakeholders within the workshop.

4.3.3 The Intervention Review for Health Promotion

The final stage in relation to scoping involves contributing a comprehensive review in relation to improving promotion interventions, such as adjusting application progress and restricting appropriation. Such actions can help to evaluate the sustainability of different interventions in communities to prevent inequitable influences. As an EfHIA for CFP, findings may be explained by the fact that health interventions in the ACT stand to benefit more from projects that take account of individual risk factors but pay less attention to the community capacity, with being potentially useful in maintaining the sustainability of interventions. Chaskin (2001) argues that the systemic capacity of delivering community service requires continuous effort, united objectives and ongoing levels of resources. However, a large number of projects funded through this programme receive funding only once a year, indicating that many interventions in the form of grants and sponsorships are less likely to maintain more extended influence in addressing inequalities. Research studies have therefore leveled criticism regarding these funding programmes in relation to the matter of sustainability. But this does not mean that funding projects in relation to which sustainability is not considered will necessarily be unsuccessful in promote health outcomes. It might be claimed that funding allocations should be congruent with project characteristics without there being a need for necessarily equal results. However, it is apparent that many health promotion interventions should produce sustainable equitable effects in relation to community capacity if they are to address inequality-related influences (Swerissen & Crisp, 2004). Hence, the intervention-related choice of scoping may be useful for strengthening the sustainability of health projects in reducing inequality. Given this purpose, several changes were made by the EfHIA.

Firstly, this step provides a revised application form including considerations regarding equity. These

adjustments to promotion interventions in this programme suggested that the application form and information collection tools should be renewed, with members of the EfHIA pointing out that the current application form should be rewritten in plain language, preferably including questions to encourage applicants, especially small-scale organisations, to reconsider potential influences in their proposals. Furthermore, such questions should be more closely related to the existing HIA or equity-focused instruments. Taking the equity tool of New Zealand as an example, this suggests posing questions about instruments used within other cases, enabling the reviewers to consider how an intervention could be approached so as to address inequality (Te Karu et al., 2018, 14).

This step may also provide evidence to change the proportion of funding with equity in mind. The comprehensive review of scoping may work for balancing the sustainability and effectiveness of interventions within the CFP, this being a problem regarded as being hard to address across many programmes. In relation to this, Simpson et al. (2005) suggest the strategy of minimising the inequality impacts by restricting the direct allocation of money to focus groups and funding sustainable resources following equity-related parameters. Putting this simply, this involves adjusting dual methods to ensure that vulnerable population not benefitting from the grants receive equal treatment in relation to the opportunities provided by the health service. In summary, this stage of scoping is done to address inequitable influences and improve the sustainability of health interventions within the ACT.

4.3.4 An Interim Conclusion

By way of an interim conclusion, it is obvious that the scoping step is the most essential in the preliminary assessment. Further, setting parameters within each stage can address the element the research question regarding how to prevent potential inequitable influences. As noted in some published HIA projects, the outcome of one programme might be revised to some extent when this programme is undertaken on a prior basis. The advantage of prior identification of key issues is that specific negative impacts, identified as being more likely to engender health inequality, are not overlooked. However, Parry and Scully (2003) point out that the pre-selection of key groups and key areas inevitably complicates the assessment, adding the matter of who or what needs to be engaged in the pre-determination to an already complex process. Furthermore, pre-determination by parameters may not be possible if all EfHIA-relevant groups are included in the assessment. It is clear that even if the selection of groups is to be made during the conduct of the HIA itself, it requires to recognised that the decision to concentrate on some groups might be influenced by both explicit and implicit biases, engendering the same problems associated with decision design on the part of decision makers. It might therefore be helpful to analyse their recommendations for the practice of the CFP, for the following step might concentrate on some practical methods that could be engaged in with relation to health promotion sectors, such as results tracking and performance assessment, helping to follow the EfHIA in a more informed way.

4.4 Recommendations for Improving Health Promotion

To address the third aspect of research question (relating to the strategies that can be evaluated as suitable and effective in reducing health inequality), it is helpful to analyse recommendations for the CFP from the EfHIA team. This step involves the provision of recommendations that are related to the equity-focus of the EfHIA. Indeed, these recommendations should be based on preliminary findings and should be flexible for adoption by policymakers. If evidence associated with the recommendations is insufficient, then the process of adoption must be transparent for, ideally, the role of the EfHIA members in the context of programmes does not involve unduly influencing decision makers (Simpson et al., 2005; Connelly & Richardson, 2005; Kemm, 2001). Hence, although the framework comprises consideration of equity at each step of the CFP, it also should be evaluated whether these recommendations allow for high flexibility in their implementation:

First, there is a requirement to consider recommendations for project investment in health promotion agencies. The EfHIA team highlights that decision makers should invest in certain projects that pertain to health equality. On the one hand, there is a requirement to consider the wider social determinants of health that influence personal behaviour risk factors. On the other hand, there is also the requirement to consider opportunities regarding gaining access to healthcare or receiving funding outcomes such that this benefits the vulnerable population. As Simpson et al. (2010) stress, such recommendations are how promotion agencies can address equity in projects without engendering inequalities in communities, the aim being to balance effectiveness and equity through balancing investments. However, there is often insufficient evidence to accept such recommendations because the information collected from the early steps might be prioritised according to the acceptability of key stakeholders (Petticrew & Roberts, 2003). So only if the EfHIA collates evidence regarding funding on the basis of their own data collection for prioritising investment can an initial fair standpoint be arrived at. In fact, adopting the information from stakeholders and information from literature in the early steps of EfHIA steps means that the EfHIA does not have the ability to routinely collect and report community health indicator data to provide continued evidence in one programme without systematic long-term application of the

EfHIA. In this regard, Navarro et al. (2007) argue for the benefits associated with adding health promotion agencies' promotion monitor response systems, not only tracking individual risk factors but also community health indicators. They also argue for the need for ongoing cooperation with the EfHIA to re-examine the programme, facilitating the purpose of fostering equity.

Second, there is a need for recommendations associated with the advocacy of the ACT Health Promotion Board. The EfHIA team points out that the ACT Board should develop an articulated advocacy such that the Board demonstrates a commitment to regarding equity as one important change in health promotion actions. To achieve this goal, the EfHIA team recommended a health promotion portfolio statement in respect of the ACT, including a brief statement by stakeholders, and their responsibilities and contribution to health promotion, as well as their roles in addressing health inequalities through revised equity objectives for the CFP. Criticism have been raised, however, that EfHIA practitioners require to recognise that these declarations should move from appealing purely to equity objectives to recommending more actions regarding equality that go beyond the existing service statements. In this regard, some informants within this programme argued:

"[It is] hard to see new options – important to build on what exists and works to deliver more of a good service." (Simpson et al., 2010, 41)

Therefore, it is not a short-term task to build common values such that the starting point is people in local communities and the method is unreliable advocacy. There needs to be a phased approach for any advocacy changes that are accompanied by strategies relating to communication and participation such that stakeholders are made aware of the reasons for the change. In this regard, Kemm (2001) claims that there is tension between HIA, which seeks to reach a fair health situation from different options, and health advocacy, which is often committed to one option. In addressing this matter, Navarro et al. (2007) suggest the method of Community-based Participatory Research (CBPR) within and outside of promotion boards to counter this issue. CBPR is a collaborative method for research that contributes the balance of knowledge acquisition with social action and equitably involves all stakeholders, with the advantages engendered by each stakeholder being particularly strongly stressed in this method (Israel et al., 1998). CBPR particularly involves local community residents and professionals in designing and conducting agendas, thereby strengthening issues of community relevance and increasing the possibility of equity sustainability and lasting positive health promotion change. The consequence of this is that stakeholders can further understand and coordinate with the advocacy strategy.

Third, there are recommendations to consider for the improvement of the capacity of the ACT secretariat. The EfHIA team summarised that the ACT should have an improved workforce capacity, helping the CFP to prevent health inequality in a timely and professional manner. Workers in public health sectors play a key role in ensuring the top-down/down-top management of the ACT communities. Training and capacity building therefore requires to be in place to ensure that the workforce has the professional tools to implement health promotion. As matters stand, the existing public health workforce is not fully engaged to implement an equity-focused programme. As Anand and Bärnighausen (2012) point out, working within an equity-focused framework requires the capacity to complete different kinds of works (e.g., cultural capacity, community indicators analysis, partnerships engagement). In this regard, Magnus et al. (2016) emphasise that, if EfHIA is to become a part of health practice, the associated framework requires to combine the work capacity of health workers with that of EfHIA members. Capacity building strategies and strategies for improvement can be evaluated as the effective approaches by which to reduce health inequality.

Having considered these recommendations, it is crucial to consider when an EfHIA strategy is more suitable than an HIA, for different programmes or policies have different features and benefits. The power of the HIA framework stems from its ability to combine each stage with programmes in a free manner. More specifically, some EfHIA cases illustrate that there is potential for success through just taking the screening step or only using screening tools for proposals that may have unintended outcomes (Harris-Roxas et al., 2014). It is therefore expected that EfHIA-based recommendations can encourage decision makers to think about health equality in the earlier stages of design so that the subsequent EfHIA-based strategies do not require to be applied later.

4.5 Monitoring and Evaluation for Reviewing Assessment Outcomes

The application of EfHIA has expanded quickly and there is a rising need to evaluate the associated benefits and costs for reducing health inequality. At the later stages of the EfHIA, an evaluation process is undertaken. To reconsider the third aspect of the research question regarding the EfHIA tools that can be evaluated as suitable and effective methods to reduce health inequality, it is important to consider monitoring and evaluation, this step being used to record the performance of implemented recommendations, possibly including a sample of other similar cases. The benefits and costs of EfHIA strategies therefore require to be evaluated to justify why they should be chosen. Several plans are set to monitor the EfHIA for the CFP: first, monitoring recommendations authorised by the Board; second, evaluating the progress of the EfHIA; third, evaluating the actual impacts resulting from changes of the CFP. Indeed, the monitoring and evaluation workflow in this programme is very

close to the HIA framework organised by Harris-Roxas and Harris (2013), offering a common choice for many HIA programmes to review their strategies in terms of context, process and impacts.

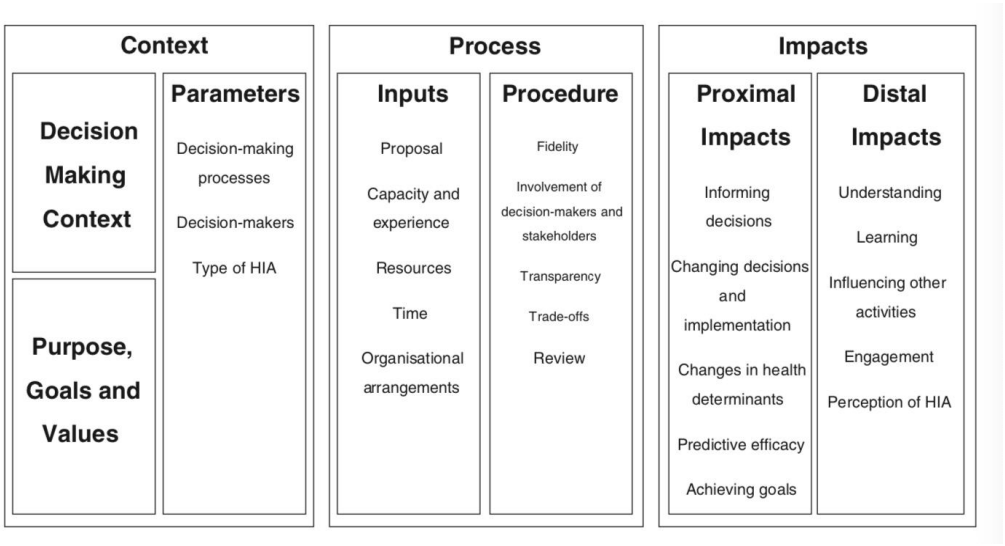

Figure 2. Conceptual framework for evaluating the impact and effectiveness of health impact assessment (Harris-Roxas & Harris, 2013, 53)

However, in applying this evaluation workflow to Canberra, any potential benefits associated with applying an EfHIA are difficult to identify and to quantify due to the types of inputs (Figure 2). In this regard, Atkinson and Cooke (2005) reference three aspects of benefits that require to be discussed to evaluate the performance of EfHIA strategies in this programme. First, process benefits can be obtained from applying the EfHIA, including the wider identification of health determinants and strengthening workers' capacity. Second, impact benefits can be realised through accepting recommendations, with other impact benefits possibly also including the building of increased community capacity. Finally, outcome benefits are sometimes postponed in accordance with recommendations put forward. Parry and Stevens (2001) raise doubts regarding outcome benefits and the associated difficulty of assessing these, the accuracy of the predicted health effect being difficult to gauge. But even there are many difficult problems, it must be recognised that different benefits will manifest at different stages. EfHIA is a policy tool to be used at each stage, so it is important to clarify whether any benefits were self-determined, or whether they were due to other complex factors operating at the same time. This issue requires to be addressed further in the adoption of other programmes with equity-focused elements.

In relation to evaluating the cost of applying the EfHIA, this may be relatively more straightforward to gauge than other practical plans in theory. For example, it is possible to record numbers of attendees, meetings, community activities and to estimate the time cost associated with completing assessment reports (Atkinson & Cooke, 2005). However, in practice, the required information is often not available after the completion of the EfHIA. Records may be incomplete or inadequate, and the allocation of expenses may be uncertain. (Kemm et al., 2004). Further, as Krieger et al. (2003) argue, this assessment might incur a high level of cost, and it is not clear to whom it should fall to bear this burden. Therefore, if an EfHIA strategy is required, notwithstanding the associated cost, this could further strain sources for addressing health problems in poorer areas of otherwise wealthy countries. Although its effectiveness is already seen, the limitation affecting its widespread use in inequality reduction still requires to be witnessed, meaning that the effect and cost of strategies and tools should be estimated with some accuracy so as to facilitate subsequent evaluation.

In conclusion, the matter of whether EfHIA tools can be evaluated as effective tools to reduce health inequality from this evaluation step depends on the combination of the effectiveness of programme of effectiveness and value for equity, as well as evidence-based benefits and costs. Further, there is also the need to satisfy decision makers to apply this assessment such that it yields visible benefits. Having addressed this problem, it may be possible to make use of a wider application of EfHIA such that it can serve as a health equality assessment system standardly used to address health equality issues.

4.6 Implications for Other Applications

Health promotion ventures have the potential to advance health equality and there is a demand to enhance the equity of health promotion through the CFP. Given that the findings of the EfHIA from the ACT have

implications for wider applications in relation to reducing health inequality, the experience of Canberra should be disseminated so as to be considered by other funding programmes. Notably, the equity-focused policy orientation mapped by the EfHIA framework is relatively idealised unless transferred into specific action. The experience of Canberra therefore offers a basic workflow of EfHIA by which the promotion agencies can operate in a structured manner, enabling informed discussions to take place regarding whether to introduce this means of assessment.

One the one hand, intersectoral cooperation and implementation are important for EfHIA progress in relation to health inequality reduction. This is because it is often the case that structural determinants among key focus groups in communities can only be tackled by means of policy strategies that fall beyond health promotion sectors. In previous sections, it was demonstrated that many of the concerns of the EfHIA regarding the cooperation among health agencies and various identification and improvements within health equality pertain to different sectors, so intersectoral cooperation constitutes an important matter to consider. This poses another challenge for the EfHIA, but it also means that health inequality effects can be considered in a comprehensive manner. On the other hand, each step of the EfHIA process can use different evidence-based combinations to address inequality effects according to the context at hand. The EfHIA is not sequential but rather series of several iterative steps. Therefore, although preliminary reports of the CFP follow the common logical progression in assessing the Canberra case, this assessment can identify further issues to decide which step might not work for these issues: the EfHIA is not a single stage but an integral and comprehensive assessment (Kemm, 2000). In sum, critical debate around the effectiveness, equity objectives and drawbacks associated with the EfHIA require to be further informed by multiple perspectives across diverse regions, thereby fostering the most effective combination for reducing health inequality for other applications of EfHIA.

5. Conclusion

5.1 Summary

In light of the recent COVID-19 crisis and the accompanying evidence that health inequality is on the rise, this research considered the role of EfHIA in addressing health inequality. The research of the EfHIA is a set of recommendations to guide health policies or programmes for equity-related purposes for the next several years. This dissertation considered causes of inequity that tended to focus on the negative response of health polices according to the outcome of the EfHIA steering team, using a work comprising both a systematic literature review and a case study. In this way, the three aspects of the research question could be addressed through analysing each step of the assessment to illustrate the possible influences of the application. This assessment first filters important information from key documents to analyse the potential causes of inequality. The EfHIA funding programme then sets equality parameters to apply to key issues, and establishes key focus groups and interventions in a more specific manner in the step of scoping whether challenges have been identified that stakeholders have failed to consider in accessing vulnerable groups. This helps to ensure that their voices are heard so as to inform future practice. Finally, this assessment provides recommendations for improving health promotion strategies and evaluating these in a practical manner. This study therefore identified several EfHIA strategies making a practical contribution to the work of decision makers for reducing health inequality. This dissertation also provided a theoretical contribution to consider more factors relating to inequality issues, transforming the Canberra recommendations into effective action within the context of other programmes. The final section below considers the limitations and implications for further research and practice.

5.2 Limitations of the Present Research

This research evaluated a systematic workflow from the EfHIA for the CFP to consider its effectiveness and ability to handle health equity. However, there are certain limitations associated with the present research that require to be borne in mind. Firstly, although this research was able to draw correlations between health inequality and the application of this assessment, as is well known, correlation does not entail causation, especially considering there are still various strategies for addressing health inequality. There is a common view that the evaluation of the EfHIA's performance is based on the outcomes of health programmes. However, it is a difficult matter to simply quantify equity factors or outcomes attributable to the introduction of the EfHIA, given that most of the initial HIA research gathers outcome information via a secondary source involving policymakers or decision makers. Another limitation relates to establishing the importance and necessity of popularising this equity-focused assessment on a broader scale. With different HIA patterns, the spread of EfHIA may be unclear in terms of macroscopic aspects due to the different situations of different countries. In this research, the small sample accessed did not allow the analysis of all possible results of the application. However, albeit this research did not research many cases involving EfHIA, it did partially substantiate the equity-focused systematic workflow in terms of the benefits to the programmes across each step of the policy circle. Notwithstanding these limitations, this research adds to our understanding of how inequality effects can be improved by this assessment. Future studies should therefore engage with more cases and potential factors from various political systems,

testing more HIA models and providing a well-rounded picture of this assessment to increase its universality and practicability.

5.3 Implications for the Future

This research also provides insights for future practice. This dissertation has taken steps towards understanding the ways in which EfHIA may play an important role in transforming current health programmes such that fairer levels of access are provided. Participatory strategies are therefore required in the future to analyse how vulnerable groups can be supported by stakeholders using this assessment. This would be a strategy goal to ensure that in-depth and broad scope of information can be collected within the application process. On the one hand, it would be useful for policymakers to integrate their actions into a wide and longer-term EfHIA cycle to renew their knowledge of health inequality regularly. On the other hand, collaboration among all stakeholders could be effective for health promotion. In this regard, the twin-track approach to health promotion and health equality provides a useful means by which stakeholders can promote both effectiveness and equity with health services.

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List of Abbreviations

ACT	Australian Capital Territory
ACTGHS	ACT General Health Survey
CFP	Community Funding Programme
CBPR	Community-Based Participatory Research
EfHIA	Equity-focused Health Impact Assessment
GP	General Practitioner
HIA	Health Impact Assessment
HiAP	Health in All Policies
HPP	Healthy Public Policy
WHO	World Health Organisation