The essential elements of Health Impact Assessment and Healthy Public Policy and the relationship between them. A critical realist empirical study.

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001245
Article Type:	Research
Date Submitted by the Author:	05-Apr-2012
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Primary Subject Heading:	Public health
Secondary Subject Heading:	Qualitative research
Keywords:	PUBLIC HEALTH, QUALITATIVE RESEARCH, sociology

TITLE:

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KEYWORDS

Health impact assessment, healthy public policy, health in all policies, empirical, critical realism

Word count (excluding title page, abstract, references, figures and tables).

3116

ABSTRACT

Objectives:

This study investigated the research question "What is the relationship between Health Impact Assessment (HIA) and Healthy Public Policy (HPP)". The objective of the study is to clarify what the essential elements of HIA and HPP are, and the relations between them.

Design:

Data collection - Qualitative interviews and a workshop were conducted with HIA and HPP practitioners working in HIA and HPP in differing contexts.

Data analysis - Critical realist 'structural analysis' identified essential elements of HIA and HPP, the relationship between them, and other influences on the practice of both.

Participants

Nine interviews were conducted with purposively sampled participants working in Europe, the U.S., and Australasia. 17 self selected participants attended the workshop who worked in Europe, South East Asia, Australasia and Oceania.

Results

HIA and HPP are different but mutually supporting. HIA is one, flexible yet structured, mechanism for enabling the systematic inclusion of health in public policy. HPP is broader than HIA, and rests on a broad definition of health and intersectoral policy collaboration. Public Policy was identified as an important additional consideration presupposed by both HIA and HPP. Seven contingencies to HIA and HPP practice were identified.

Conclusion

This study adds empirical weight to the literature on HIA and HPP. Established essential elements of HIA and HPP are supported and extended. The emphasis on public policy processes returns the literature to original conceptualisations of HPP. The paper also moves the field away from conflation of factors involved in HIA and HPP to a more nuanced understanding of what is essential and what is contingent to that practice. This will enable greater connection between empiricism and theory, as has been identified as required for the field to progress.

INTRODUCTION

Clarity is being sought in practice and policy arenas about how health impact assessment (HIA) fits with healthy public policy (HPP) (1, 2). However there has been limited empirical investigation into practitioners' understandings of either HIA or HPP practice. Since HIA was introduced as a healthy public policy intervention in the late 90's (3, 4), practice has grown considerably (5-8). Despite recurring attempts at providing conceptual boundaries for HIA (9-12) and HPP (13, 14), ambiguity about the relationship between both remains (1, 15, 16). For example, situating HIA as the principle vehicle for HPP (3, 17) risks conceptually conflating one with the other (18). However, previous empirical research has demonstrated difficulties in disentangling HIA and HPP and what else is required for these to be influential in the policy arena (19, 20). This empirical study, therefore, investigated experienced professionals' knowledge about the essential elements involved in HIA and HPP practice and the relationship between them.

METHODS

This study forms part of a broader piece of research investigating the question, 'What is the relationship between HIA and HPP?', following critical realist methodology (21, 22). This methodology begins with empirical analysis of heuristic understandings of practice to identify the essential elements underpinning that practice (23, 24). Such results are reported here. Subsequent phases – beyond the scope of this paper – iterate between these results and broader theory to explain how and why the elements in the relationship operate and interact (23). A qualitative research design was chosen to capture the depth of participants' experiences and knowledge (22).

Ethical approval was granted by UNSW Human Research Ethics Committee (HREC 10270).

Research team and reflexivity

As HIA and HPP advocates, practitioners and researchers we have an interest in better understanding HIA and HPP. All three authors are experienced qualitative researchers.

Data collection

Data was collected during interviews and a workshop.

Interviews

A convenience sample of 9 professionals with collectively over 100 years' experience working in HIA and / or HPP from 7 different countries was identified to elicit a range of experiences in different contexts (Table One).

One to one unstructured interviews, lasting 40 to 90 minutes, were conducted in late 2010 and early 2011. Two interviews were face to face and seven via telephone. One week before the interview participants were provided a consent form, information on the purpose of the interview and the interview guide (Box 1). At the outset of the interviews the purpose of the research and the interview approach was discussed. This approach, following critical realism, was a 'teacher – learner' conversation whereby the interviewer and informant learn from each other through a naturally flowing conversation (22, 25). Participants were prompted to answer the interview guide questions only if these had not been previously discussed. Issues that arose from previous interviews were added as discussion points in later interviews to assist conceptual refinement (25). Interviews were tape-recorded and professionally transcribed. Notes were taken immediately following interviews and later analysed.

Table One: Characteristics of the nine participants

Profession	*Length of Experience (yrs)*	*Expertise (HIA, HPP, both)*	*Disciplinary background*	*Region*
Consultant	15+	Both	Public Health	Europe
Consultant	5	HIA	Political science	Europe
Consultant	10	Both	Public Health	Europe
Government	10	Both	Public Health	Oceania
Academic and Consultant	15 +	HIA	Urban Planning	North America
Academic	15+	HPP	Health promotion	Oceania
Government	15+	HPP	Health promotion	Oceania
Not for profit organisation	5	HIA	Science	North America
Institute	15+	Both	Public Health	Europe

Box One: Interview Guide

- Would you say your experience is in Health Impact Assessment, Healthy Public Policy, or both? What are or have been your roles in relation to this work? How long have you been doing this?
- Can you please describe what you think HPP is?
- Can you please describe what you think HIA is?
- Can you please describe what you think HPP is trying to achieve and how this can be achieved? (there may be more than one thing)
- What do you think HIA for public policy is trying to achieve and how this can be achieved?
- Bringing them both together, can you describe the relationship between them both?
- What are some broader influences on the relationship between the two? How do these exert their influence?
- Please describe what else is being used to achieve healthy public policy, and how this relates to HIA?

Workshop

17 self-selected participants attended a workshop during an international HIA conference in October 2010. Participants worked in a range of roles: policy development (8), academia (4), public health (3), HIA (4), health services management (1) and consultancy (1) (some nominated more than one role). Participants identified over 100 years experience of working in their field (ranging from 1 to 15 years). Participants were from New Zealand (n = 7), Australia (n = 6), Thailand (n = 2), Tonga (n = 1), and England (n = 1).

Following an explanation of the methodology the workshop was divided into two sessions facilitated by PH. Three small groups took 45 minutes to discuss and write a 'policy brief' – either a drawing or words or both – about how HIA related to healthy public policy. This was followed by large group discussion for 30 minutes, facilitated by PH. Main points were written on a whiteboard and photographed. Notes were taken immediately following the workshop. The policy brief, photograph and notes were later analysed.

Data analysis

PH initially coded the data. Results were written up as analysis progressed, sent to the other authors and refined based on discussions that either supported and/or questioned findings and interpretations. Results were further refined, collaboratively, while developing this paper.

Data analysis identified necessary and contingent characteristics of HIA and HPP practice (21, 22). Necessary characteristics are essential for the functioning of either HIA or HPP. Contingent characteristics may not be necessary but may have an influence in certain circumstances (25). To use a familiar analogy, building a house has necessary features while also requiring planning for 'contingencies' that could, but not necessarily will, eventuate. To this end critical realist data analysis proposes a series of 'structural analysis' questions about investigated phenomena, or objects of research, as follows:

- "What does the existence of this object (HIA / HPP / the relationship between HIA and HPP) presuppose?"
- "Can this object exist on its own? If not, what else must be present?"
- "What is it about the object which enables it to do certain things?"; (22) p. 91), and
- "What cannot be removed from the object (including all the other identified objects of influence) without making it cease to exist in its present form (in relation with HIA or HPP)?" (21)p. 47)

First, four interview transcripts with participants from differing disciplinary backgrounds and professions, and the workshop data, were coded for emergent core categories by asking 'What is interesting?', 'Why is it interesting', and then 'Why am I interested in that?' (26). Further analysis searched for each category in all nine interview transcripts, beginning with the five interviews not yet analysed and then returning to the initial four and the workshop data. Categories were refined against the four structural analysis questions.

Initial results were presented at and further refined following two forums in 2011. One was with practitioners working in HIA for public policy in California. The other was at the International Association for Impact Assessment meeting in Puebla, Mexico. These meetings confirmed the initial results as practically adequate and 'rational', although results were also described as 'abstract' and 'deconstructed' – all of which are intended aspects of critical realist analysis (21, 22).

RESULTS

Results are shown in Table two. Overall, HIA and HPP were conceptually differentiated from each other, with each having discrete essential characteristics. HPP was characterised as the systematic input of health (broadly defined) into public policy. HIA was discussed as one important, systematic, mechanism for HPP. Given the aim of both is to influence public policy both presuppose the existence of public policy, and the elements of public policy that influence HIA and HPP practice were identified. Analysis also revealed a finite number of additional influential factors as contingencies on HIA and HPP practice. These results are explained here in four corresponding sections.

Table 2: Essential characteristics of HIA and HPP and the influence of Public Policy and other contingencies.

HIA essential characteristics	**'Healthy public policy' essential characteristics**	**Public policy influential characteristics**	**Other contingencies**
Assessment to make predictions Structured stepwise process Making recommendations Equity / distribution of impacts Flexibility	Broad definition of health Incorporating population health and equity into policy Intersectoral collaboration Works across policy development and implementation	Economics, not health Differing levels: policies and plans Competing demands, crowded and contested agendas, and struggles based on power and politics	Health system Public Health Government: organisation and structure Personalities, skills, relationships, values The evidence base Community Society Time

HIA's essential elements

Five essential elements of HIA were identified. First HIA rests on assessing a draft policy proposal, based on knowledge of the effects of past decisions, to predict the potential impacts of that policy. Second, HIA is a structured, stepwise process. Third, making recommendations is essential as the point at which HIA becomes relevant (or not) and absorbed (or not) into policy development and implementation. Fourth, consideration of the distribution of a policy's impacts on different population groups is a fundamental benefit HIA offers public policy. Fifth, HIA is flexible: in some instances HIA can be rational and undertaken outside the policy process whereas in others it can occur as part of the (irrational) policy process.

HPP's essential elements

Four essential elements of HPP became apparent. First, HPP's conceptual foundation is the broad definition of health as wellbeing rather than a disease; correspondingly explicit discussion of the word 'health' is not required. Second, the purpose of HPP is to incorporate equity and population health considerations into policy. Third, HPP rests on intersectoral collaboration (with Public Health involvement as a contingency, discussed below). Fourth, HPP works systematically across policy development from inception to end.

Notably participants iterated between the terms HPP and Health in All Policies (HIAP) as descriptors (see (27) for conceptual differences). Only one differentiated HiAP as the intentional engagement of the health system in public policy from HPP being any public policy with health consequences. Therefore the remainder of this paper uses the term HPP as a catch-all phrase.

The relationship between HIA and HPP

HIA was described as providing HPP with one important systematic method for intersectoral policy collaboration. HIA's structure allows dialogue to occur between potentially disparate HPP stakeholders, thereby making transparent the (often complex) consideration of policy causes and proposed solutions and the potential impact of these solutions. HPP was identified as bigger in scope (including negotiation, advocacy, lobbying and the use of evidence in policy), but less easy to define than HIA. Participants felt that HIA's clear structure and the corresponding lack of structure in HPP had led to HIA, mistakenly, becoming the de-facto method for HPP. HIA and HPP were also recognised as mutually supportive but able to be practised separately.

Public Policy

Both HIA and HPP presuppose the existence of public policy. Four essential features of public policy became apparent as influences on the practice of both HIA and HPP.

The nature of policy development was seen as a critical influence. However, some participants explained public policy as linear, following various basic stages, others observed policy as iterative and incremental, with no common pathway. This contested view of policy development necessitates the essential element of HPP across the policy cycle and the requirement for HIA to be flexible, as discussed.

Economic growth, not health, was recognised as driving public policy development. The inclusion of analyses of economic costs was therefore recognised as an important, often missing, element of both HIA and HPP.

Public policy is made at different levels, from government 'green' and 'white' papers, and ultimately legislation, to local implementation plans. Both policies and plans were recognised as essential elements of public policy, where the latter develop the actions of the former. Systemic practice of HIA and HPP requires inclusion in both policies and plans.

Public policy making incorporates a great number of competing demands, crowded and contested agendas, and struggles based on power and politics. While some participants felt HIA required being separated from these struggles, others felt this was neither possible nor desired if HIA was to be effective in influencing policy.

Other influences on HIA and HPP

Seven influences on HIA and HPP were identified as contingencies, without consideration of which the essential elements of HIA and HPP practice are insufficient.

Both HPP and HIA require collaborative engagement, and investment, from Public Health. However participants felt Public Health had not yet created a mandate for itself within the Health sector to legitimate its engagement in intersectoral public policy development.

Government was identified as critical, mainly because government's siloed structure and the different (often chaotic) ways that different government departments operate makes intersectoral collaboration difficult (particularly at central government levels). Whole of government targets were discussed as a mechanism for working across siloes.

Personalities, skills, experience, values and interests are all important contingencies. Interest and involvement in either HIA or HPP was seen as stemming from values of social justice, equity and improving population health. Being open to new ideas and ways of working were felt to be important. However over-reliance on entrepreneurial individuals rather than building a critical mass was identified as a problematic characteristic of the HIA and HPP fields to date. Skills were mainly discussed in terms of the skills of Public Health people in supporting those outside public health to understand public health evidence.

The evidence base is an important contingent influence. Participants described both HIA and HPP practice as being at the mercy of the available evidence. All identified complexities in capturing the links between policy and health, and especially wellbeing, outcomes as problematic. Non-health sectors often require cost rather than health outcome data. Despite this, systematically using and articulating evidence to inform policy is valued by intersectoral partners.

Other contingencies were community, society and time. Community are the point where the effects of policy decisions are felt. HIA (but not HPP) was identified as enabling communities to have a democratic voice, currently often missing, within policy development. However community voice is not always aligned with public health evidence. Managing community expectations of what HIA can and cannot deliver was considered important. Societal values toward equity (or not) and the role of government (or not) were identified as influential on both HIA and HPP. Several participants pointed out an important long-term goal of their work in HIA and HPP was to change societal values to become more equitable. The time required to influence policy was highlighted as an often unrecognised contingency.

DISCUSSION

What is already known?

HIA has been consistently defined as a structured approach to prospectively assessing the health impacts of a draft proposal.

HPP is less well defined but has two essential normative characteristics: resting on a broad definition of health in rejection of the medical model, and emphasising intersectoral collaborative policy development.

The relationship between the two is not well known, and untangling the essential elements of each from what else is required for policy influence has been shown to be difficult.

What that this study adds

This study investigates practitioner understandings of the relationship between Health Impact Assessment (HIA) and (HPP):

- HIA was seen as one systematic mechanism within a broader HPP approach.
- HIA is structured, providing a process for disparate healthy public policy stakeholders to collaboratively assess, predict and recommend actions to improve a policy proposal.

The findings provide empirical support for the essential elements of both HIA and HPP identified in the literature. They add flexibility to adapt to the policy process as essential to HIA. However further work is required to realise this in practice. They also suggest HPP practice, rather than being limited as rhetoric, is occurring but requires developing capacity and structures for intersectoral healthy public policy development and implementation.

Public policy is separate to, and presupposed by, both HIA and HPP.

Seven external contingencies are identified that influence the practice of HIA and HPP.

This research empirically supports and adds depth to the, mostly non-empirical, HIA and HPP literature. The essential elements of HIA suggested here are similar to those identified in established definitions of HIA (10). These findings however add to these definitions that HIA is essential flexible (9, 28). This means HIA can be conducted in a manner responsive to the policy context while retaining its other essential characteristics. Turning to HPP, this study supports the essence of HPP as being concerned with a broad definition of health (14, 17) and intersectoral collaboration (29, 30). However, rather than being rhetoric (14, 18), participants here suggested collaborative work that could be healthy public policy is regularly occurring, be it advocacy, lobbying, HIA or the use of health evidence within policy development. The real problem suggested here and elsewhere is building capacity and administrative structures to facilitate and support HPP, including the use of HIA (31), starting within Public Health (18, 32, 33).

The finding that HIA and HPP pre-suppose the existence of 'public policy' returns to the original healthy public policy literature (34). Conceptually the importance of public policy processes in relation to HIA for HPP has been recognised (28, 35) but not yet widely adopted (1). Notably Thailand, arguably the most successful country at embedding HIA for HPP, has based this on theoretical conceptualisations of public policy processes (36).

The findings also help clarify the currently uncertain relationship between HIA and HPP (1, 15). The two are different and mutually reinforcing although each can and does exist without the other. Most importantly HIA was understood as one important mechanism to enable the systematic

consideration of health in public policy (17, 37), but as one of a broader suite of HPP activities (14). Additionally, separating essential HIA and HPP elements from contingent influences helps practitioners and researchers identify what can be directly controlled or changed to improve practice, and what else needs to be planned for as contingencies largely outside the control of HIA or HPP practitioners (28). Methodologically this is not a question of homogenising or flattening difference (23). Rather this aids practice and future research to identify, empirically and substantively, whether essential properties exist or not, and how these exert influence on practice or not. Previous work linking the evidence base as contingent to HIA practice (38) shows the utility of this approach.

This study design has some necessary limitations. Participants were largely HIA advocates or using HIA in their work. Given the research question which explicitly aims to understand HIAs fit with healthy public policy this purposive sampling was required. However future research should investigate the relationship from the perspective of those working in HPP and public policy which may or may not include HIA. In addition the qualitative design was necessary to investigate the depth of participants' experience. Future research could use, verify and extend these qualitative findings as factors influencing the design, achievements and struggles of the many programs and projects currently being undertaken internationally to progress health and equity within public policy.

CONCLUSION

This research has provided empirical depth to the knowledge of the relationship between HIA and HPP by focussing on the international experience of a group of highly experienced practitioners in the field. However, empirical experience is necessary but not sufficient to explain the relationship between HIA and HPP. Explanation, sufficient to inform practice, requires integrating empiricism with theory (24). This was supported by participants in this study and is increasingly recognised in the field (10, 15). As a result our research will subsequently situate the findings reported here within the broader theoretical literature.

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Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1:		
Research team and reflexivity		
Personal Characteristics		
1	Interviewer/facilitator	Which author/s conducted the interview or focus group?
		First author
2	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
		First author BaHons, MPH
		second author PhD, BHSc, RN
		third author MBBS, MHP, PhD
3	Occupation	What was their occupation at the time of the study?
		First author – PhD student, Research Fellow
		second author – Director Research Centre
		third author - Director Population Health
4	Gender	
		First author Male
		second author Female
		third author Male
5	Experience and training	What experience or training did the researcher have?
		All three are experienced qualitative researchers
Relationship with participants		
6	Relationship established	Was a relationship established prior to study commencement?
		One participant was a colleague with whom we piloted the interviews.

No Item Guide questions/description

7.
Participant knowledge of the interviewer
What did the participants know about the researcher?
Participants were familiar with the researcher's work in health impact assessment. Participants were provided a background document describing the purpose of the interview.

8.
Interviewer characteristics
What characteristics were reported about the interviewer/facilitator? Our professional bias toward understanding the research question was reported.

Domain 2: study design

Theoretical framework
9.
Methodological orientation and Theory
What methodological orientation was stated to underpin the study?
Critical realism

Participant selection
10. Sampling
How were participants selected? *e.g. purposive, convenience, consecutive, snowball*
Purposive, self-selected
11. Method of approach
How were participants approached? e.*g. face-to-face, telephone, mail, email*
Email, Face to face
12. Sample size
How many participants were in the study?
26
13. Non-participation
How many people refused to participate or dropped out? Reasons?
None dropped out.

Setting
14.
Setting of data collection
Where was the data collected? e.*g. home, clinic, workplace*
Phone, place selected by participants, conference workshop

No Item Guide questions/description

15.
Presence of nonparticipants

Was anyone else present besides the participants and researchers?
No
16. Description of sample
What are the important characteristics of the sample? *e.g. demographic data, date*
Relevant demographic characteristics are reported
Data collection
17. Interview guide
Were questions, prompts, guides provided by the authors? Was it pilot tested?
Yes the interview was pilot tested. Interview approach is described in the methods section
18. Repeat interviews
Were repeat interviews carried out? If yes, how many?
Nil
19. Audio/visual recording
Audio recording for interviews, notes for workshop
20. Field notes
Were field notes made during and/or after the interview or focus group?
Yes
21. Duration
What was the duration of the interviews or focus group?
Variable. 40 to 90 minutes.
22. Data saturation
Was data saturation discussed?
Yes
23. Transcripts returned
Were transcripts returned to participants for comment and/or correction?
No critical realist research does not emphasise this
Domain 3: analysis and findingsz
Data analysis
24. Number of data coders
How many data coders coded the data?
Three
25. Description of the coding tree
Did authors provide a description of the coding tree?
Yes but not in the article
26. Derivation of themes
Were themes identified in advance or derived from the data?
Questions from theory, themes from data
27. Software
What software, if applicable, was used to

manage the data?
Nvivo, Microsoft word
28. Participant checking
Did participants provide feedback on the findings?
This is not emphasised in critical realist research
Reporting
29. Quotations presented
Were participant quotations presented to illustrate the themes / findings?
No
Was each quotation identified?
N/A
30.
Data and findings consistent
Was there consistency between the data presented and the findings?
Yes
31. Clarity of major themes
Were major themes clearly presented in the findings?
Yes
32. Clarity of minor themes
Is there a description of diverse cases or discussion of minor themes?
Yes

The essential elements of health impact assessment and healthy public policy: practitioner perspectives

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001245.R1
Article Type:	Research
Date Submitted by the Author:	30-Jul-2012
Complete List of Authors:	Harris, Patrick; UNSW, Centre for Primary Care and Equity Kemp, Lynn; UNSW, Centre for Primary Health Care and Equity Sainsbury, Peter; Sydney and South West Sydney Local Health Districts, Population Health Directorate
Primary Subject Heading:	Public health
Secondary Subject Heading:	Qualitative research
Keywords:	PUBLIC HEALTH, QUALITATIVE RESEARCH, sociology

TITLE:

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KEYWORDS

Health impact assessment, healthy public policy, health in all policies, empirical, critical realism

Word count (excluding title page, abstract, references, figures and tables).

3995

ABSTRACT

Objectives:

This study uses critical realist methodology to identify the essential and contingent elements of Health Impact Assessment (HIA) and Healthy Public Policy (HPP) as operationalised by practitioners.

Design:

Data collection - Qualitative interviews and a workshop were conducted with HIA and HPP practitioners working in differing contexts.

Data analysis Critical realist analytic questions identified the essential elements of HIA and HPP, the relationship between them, and the influences of public policy and other contingencies on the practice of both.

Participants

Nine interviews were conducted with purposively sampled participants working in Europe, the U.S., and Australasia. 17 self selected participants who worked in Europe, South East Asia and Australasia attended the workshop.

Results

The results clarify that HIA and HPP are different but mutually supporting. HIA has four characteristics: assessing a policy proposal to predict population health and equity impacts, a structured process for stakeholder dialogue, making recommendations, and flexibly adapting to the policy process. HPP has four characteristics: concern with a broad definition of health, designing policy to improve people's health and reduce health inequities, intersectoral collaboration, and influencing the policy cycle from inception to completion. HIA brings to HPP prediction about a policy's broad health impacts, and a structured space for intersectoral engagement, but is one approach within a broader suite of HPP activities.

Five features of public policy and seven contingent influences on HIA and HPP practice are identified.

Conclusion

This study clarifies the core attributes of HIA and HPP as separate yet overlapping while subject to wider influences. This provides the necessary common language to describe the application of both and avoid conflated expectations of either. The findings present the conceptual importance of

public policy and the institutional role of public health as distinct and important influences on the practice of HIA and HPP.

INTRODUCTION

Since health impact assessment (HIA) was introduced as a healthy public policy (HPP) intervention in the late 90's [1, 2], practice has grown considerably [3-6]. Clarity is now being sought in practice, policy and academic arenas about how HIA fits with HPP[7-9].

There are numerous definitions of HIA in the literature [10, 11], the most cited being:

"a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population"[12].

Despite clarity over these technical elements, HIA has historically been associated with occurring outside the policy making process and once a proposal has been drafted. However, concern has been expressed that this 'rational' approach to HIA does not fit with the incremental nature of policy development [13].

HPP is less clearly defined, but was initially developed by the World Health Organisation as "Putting Health on the agenda of policy-makers in all sectors and at all levels" [14]. The WHO glossary, noting concern for contextual variation, provides a generic definition 'Healthy public policies improve the conditions under which people live...', focussing instead on positioning HPP within other policy constructs [15].. 'Health in All Policies' (HiAP) has recently been promoted as a strategy to help strengthen the link between health and other policies, "through structures, mechanisms and actions planned and managed mainly by sectors other than health." (p. xviii; [16]. HiAP incorporates both HPP and 'intersectoral action for health' whereby activities are not confined to the health sector [17]. Others, in the HIA literature, argue that HiAP and HPP are the same concept [9].

Despite attempts at linking HIA and HPP [6, 18, 19], ambiguity about the relationship between them remains [7, 20, 21]. For example, situating HIA as the principal vehicle for HPP [1, 18] has been noted as conceptually conflating one with the other [17]. However, empirical research has demonstrated difficulties in disentangling HIA and HPP and what else is required for these to be influential in the policy arena [22, 23]. This study seeks to understand how the essential and contingent elements of HIA and HPP are operationalised by experienced practitioners working in HIA, HPP, or both. The results identify the core attributes of HIA and HPP, and recognise them as separate yet overlapping

while also subject to wider influences. This provides a means to describe the application of both and avoid conflated expectations of either.

METHODS

This study forms part of a broader piece of research investigating the question, 'What is the relationship between HIA and HPP?', following critical realist methodology [24, 25]. This methodology begins by identifying the essential elements of objects of research through empirical analysis of heuristic understandings of practice [26, 27]. The results reported here concern this opening phase. Subsequent phases will relate these results to broader theory to explain how and why the elements in the relationship operate and interact [26]. A qualitative research design was chosen to capture the depth of participants' experiences and knowledge [25].

Ethical approval was granted by UNSW Human Research Ethics Committee (HREC 10270).

Research team and reflexivity

As HIA and HPP advocates, practitioners and researchers we have an interest in better understanding HIA and HPP. All three authors are experienced qualitative researchers.

Data collection

Data was collected during interviews and a workshop.

Interviews

A purposive sample of 9 professionals working in HIA and / or HPP from 7 different countries was identified to elicit a range of experiences in different contexts. Participants were selected purposively for three reasons [28] based on our explicit intention to understand the core elements of HIA and HPP and the relationship between these: 1) chosen participants were knowledgeable about one or both of the HIA and HPP and the relationship between them (their collective experience amounted to over 100 years); 2) they were willing to talk; and 3) they were representative of a range of potential points of view. Participants all identified working to influence policy focussing on HIA (n=3) or HPP (n=2) or both (n=4). All identified working with government either within (n=3) or outside but collaborating with government (n=6). Participants' organisations ranged from public health focussed government agencies (n=3), public health institutes external to government (n=2), academic institutions (n=3), and not for profit organisations (n=1). Eight were in senior positions as policy officers (n=1), managers (n=3), directors (n=3) or advisers (n=2) and one had also conducted a PhD on HIA and policy. Each identified their professional background as public

health (n=4), health promotion (n=2), science and public health (n=1), political science (n=1) and urban planning (n=1).

One to one unstructured interviews, lasting 40 to 90 minutes, were conducted by PH in late 2010 and early 2011. Two interviews were face to face and seven via telephone. One week before the interview participants were provided a consent form, information on the purpose of the interview and the interview guide (Box 1). At the outset of the interviews the purpose of the research and the interview approach were discussed. This approach, following critical realism, was a 'teacher – learner' conversation whereby the interviewer and informant learn from each other through a naturally flowing conversation [25, 29]. Participants were prompted to answer the interview guide questions only if these had not been previously discussed. Issues that arose from previous interviews were added as discussion points in later interviews to assist conceptual refinement [29]. Interviews were tape-recorded and professionally transcribed. Notes were also taken immediately following interviews and later analysed.

Box One: Interview Guide

- Would you say your experience is in Health Impact Assessment, Healthy Public Policy, or both? What are or have been your roles in relation to this work? How long have you been doing this?
- Can you please describe what you think HPP is?
- Can you please describe what you think HIA is?
- Can you please describe what you think HPP is trying to achieve and how this can be achieved? (there may be more than one thing)
- What do you think HIA for public policy is trying to achieve and how this can be achieved?
- Bringing them both together, can you describe the relationship between them both?
- What are some broader influences on the relationship between the two? How do these exert their influence?
- Please describe what else is being used to achieve healthy public policy, and how this relates to HIA?

Workshop

To provide additional data to the interviews 17 self-selected participants attended a workshop during an international HIA conference in October 2010. Participants worked in a range of roles:

policy development (8), academia (4), public health (3), HIA (4), health services management (1) and consultancy (1) (some nominated more than one role). Participants identified a range of experience of working in their field (from 1 to 15 years). Participants were from New Zealand (n = 7), Australia (n = 6), Thailand (n = 2), Tonga (n = 1), and England (n = 1).

Following an explanation of the methodology the workshop was divided into two sessions facilitated by PH. Participants were provided a document detailing the background to the research including specific questions (see Box Two) which built on findings from the interviews.

Box Two: Workshop Questions

1. What are the goals or desired outcomes of 'healthy public policy'?
2. How can HIA influence public policy, if at all? What is required to make HIA a successful policy intervention? What other policy interventions and strategies are being used and how do these relate to HIA?
3. How do broader issues underpinning public policy development influence the conduct and impact of HIAs?
4. How can programs be designed to effectively use HIA to influence public policy?

Three small groups took 45 minutes to discuss and write a 'policy brief' – either a drawing or words or both – about a hypothesised 'healthy public policy' program using the following:

- What achievements would the program work towards?
- What is it about HIA that helps or hinders the program making these achievements?
- What else is required beyond HIA?
- What contextual factors would need to be taken into account?

This was followed by large group discussion for 30 minutes, facilitated by PH. Main points were written on a whiteboard and photographed. Notes were taken immediately following the workshop. The policy brief, photograph and notes were later analysed.

Data analysis

PH initially coded and analysed the data. Results were written up as analysis progressed, sent to the other authors and refined based on discussions that either supported and/or questioned findings and interpretations. Results were further refined, collaboratively, while developing this paper.

Analysis of the data from the interviews and workshop identified necessary and contingent characteristics of HIA and HPP practice [24, 25]. Necessary characteristics are essential for the functioning of either HIA or HPP. Contingent characteristics may not be necessary but may have an

influence in certain circumstances [29]. To use a familiar analogy, building a house has necessary features while also requiring planning for 'contingencies' that could, but not necessarily will, eventuate. To this end critical realist data analysis proposes a series of analytic questions about investigated phenomena, or objects of research:

- "What does the existence of this object (HIA / HPP / the relationship between HIA and HPP) presuppose?"
- "Can this object exist on its own? If not, what else must be present?"
- "What is it about the object which enables it to do certain things?"; [25] p. 91), and
- "What cannot be removed from the object (including all the other identified objects of influence) without making it cease to exist in its present form (in relation with HIA or HPP)?" [24]p. 47)

First, four interview transcripts with participants from differing disciplinary backgrounds and professions, and the workshop data, were coded using NVIVO software by asking 'What is interesting?', 'Why is it interesting', and then 'Why am I interested in that?'[30]. Further analysis searched for each category in all nine interview transcripts, beginning with the five interviews not yet analysed and then returning to the initial four and the workshop data. Categories were refined against the four structural analysis questions until data saturation occurred [28].

Initial results were presented at and further refined following two forums in 2011. One was with practitioners working in HIA for public policy in California. The other was at the International Association for Impact Assessment meeting in Puebla, Mexico. These meetings confirmed the initial results as practically adequate and 'rational', although results were also described as 'abstract' and 'deconstructed' – all of which are intended aspects of critical realist analysis [24, 25].

RESULTS

The essential elements of HIA and HPP, the relationship between them, and the influences of public policy and other contingencies on the practice of both are shown in Table one and described below.

Table 1: Essential characteristics of HIA and HPP and the influence of public policy and other contingencies.

HIA essential characteristics	**'Healthy public policy' essential characteristics**	**Public policycharacteristics influencing HIA and HPP**	**Other contingent factors influencing HIA and HPP**
Assesses the	Defines health broadly	Staged but not	Public health's

population health and equity impacts of a policy proposal to inform policy makers Provides a structured stepwise process to enable stakeholder discussion of policy problems, solutions and their potential impact Makes recommendations to influence policy development and implementation Is flexible in relation to the incremental nature of public policy	as connected to social, economic and environmental issues Influences the design of policy to improve people's health and reduce health inequities Works through intersectoral collaboration (which includes skilled public health engagement) Engagement occurs across policy making from inception to completion	necessarily linear or clear processes, necessitating HIA to be flexible Driven by economic growth over and above concerns for public health Made at different levels and includes both policies and plans. Both must be included in HIA and HPP.Involves competing demands and struggles based on power and politics. Progressing a health agenda risks adding unwanted complexity. Sector specific agendas shape policy making in specific sectors. Health is secondary to these policy agendas, requiring skilled engagement from the health sector which avoids health imperialism.	organisational capacity and institutional mandate for intersectoral public policy collaboration Government has siloed structures oriented to specific policy concerns that are not automatically connected to population health and equity People's characteristics and competencies including public health practitioner values and required skills for intersectoral engagement The evidence base capturing the link between a policy issue and population health and wellbeing. Non-health sectors require support with navigating the evidence base. Community feels the effects of public policy.

			HIA is a process to enable community engagement in (democratic) policy development Societal values about health, economic development, and equity influence and are influenced by public policy The long time usually required for policy influence and change

HIA's essential elements

Four essential elements of HIA were identified (Table 1). First HIA rests on assessing a draft policy proposal, based on knowledge of the effects of past decisions and events, to predict the potential health and equity impacts of that policy and influence policy making. One participant characterised this aspect of HIA as 'applied epidemiology' and this predictive aspect of HIA was identified as powerful, valuable and important. Second, participants emphasised how HIA is a structured, stepwise process which enabled dialogue to occur between sectors and stakeholders. One participant explained how HIAs structured 'created shared meaning' and another commented how:

"… in public policy when we talk about using HIA it is a dialogue process…the dialogue with the other government department."

Third, making recommendations was described as essential because it is the point at which HIA becomes relevant (or not) and absorbed (or not) into policy decision making.

Fourth, the positioning of HIA in the policy process is flexible: in some instances HIA can be rational and undertaken outside the policy process whereas in others it can occur as part of the () incremental policy process. This relationship was explained as follows:

"… So that makes it difficult if you are trying to define a common approach to HIA. That when you reach point X, you do an HIA and you don't get past that point unless you have done it. You just can't do it that way. We need to be much more flexible than that. And we are not going to change that."

HPP's essential elements

Four essential elements of HPP became apparent (Table 1). First, HPP's conceptual foundation is the broad definition of health as wellbeing rather than disease.In this way HPP was connected to social, economic and environmental issues in public policy making, and differentiated from 'health policy' concerns with hospital or health care services. Correspondingly some felt that explicit discussion of the word 'health' is not required. This avoidance of health 'imperialism', particularly in initial engagement with other sectors, was seen as a hallmark of HPP engagement:

"...we need to … not impose our social model of health but just initiate discussion"

Second, while avoiding health imperialism, the purpose of HPP was to design policy to improve people's health and reduce health inequities.

Third, HPP rests on intersectoral collaboration. This was originally coded as intersectoral action. During analysis however it became clear that collaboration with public health was essential. Participants explained how, despite avoiding health imperialism particularly in early engagement, public health brought to policy development the necessary expertise linking policies to population health.

Fourth, HPP was characterised as involving systematic collaboration from inception to end of policy development. In this way HPP was seen as the ideal type of policy engagement (subject to contingent influences).

Most participants used the terms HPP and Health in All Policies interchangeably. Therefore the remainder of this paper uses HPP to cover both concepts..

The relationship between HIA and HPP

HIA was described as one important structured method for HPP. On the one hand HIA offers HPP a technical prediction about the potential population health consequences of public policy proposals. On the other HIA offers HPP a process for structured dialogue thereby making transparent the (often complex) consideration of policy problems, proposed solutions and their potential population health impact.

HPP was identified as bigger in scope than HIA, including negotiation, advocacy, lobbying and the use of evidence in policy. HIA and HPP were also recognised as mutually supportive – HPP provided a rationale for HIA and HIA a mechanism for HPP - but also able to be practised separately. However participants felt HPP was less clearly defined than HIA which had led HIA, mistakenly, to become the de-facto method for HPP. As a result, participants felt too much expectation had been placed on HIA to deliver:

"We expect too much from it…it is unrealistic to expect…that you can slip in, do an HIA, and all your recommendations will be implemented and then you can go away…That's just not how life works at all."

The relationship was also characterised as straightforward, where HIA was seen as a process to influence policy to include health considerations, and not straightforward because of the values and systemic or institutional constraints influencing both HPP and HIA. These constraints are identified in the following sections.

Public Policy

Both HIA and HPP presuppose the existence of public policy. For example:

"… we need to start thinking a bit more about this public policy process and what we're actually trying to get at."

Five essential features of public policy became apparent as influences on the practice of both HIA and HPP (Table 1).

First, public policy was emphasised as a process. When discussing policy making, some participants explained public policy as linear, following various basic stages. Others observed policy as iterative and incremental, with no common pathway. Importantly the two are not mutually exclusive as the finding that there is common pathway to policy does not necessarily negate policy occurring in (non-linear) stages. However, the policy pathway was, as a result of being incremental or 'skipping stages', characterised as making it 'not clear' where HIA is best undertaken. Participants also suggested that in practice HIA risks coming in too late in the policy making cycle. The structured process of HIA was however recognised as flexible enough to fit alongside policy-making.

Second, economic growth and productivity, not public health, was recognised as driving public policy development. The inclusion of analyses of economic costs was emphasised as an important, often missing, element of both HIA and HPP. Importantly however the inequitable effects of economic focussed policy were felt by some as the reason they engaged in HIA and HPP.

Third, participants recognised how public policy is made at different institutional levels, from government 'green' and 'white' papers, and ultimately legislation, to local implementation plans. Further, both policies and plans were recognised as essential elements of public policy, where the latter develop the actions of the former. Participants also felt that the systematic practice of HIA and HPP requires inclusion of both policies and plans at multiple levels. Local level policy development was often framed as easier to influence than that of central government.

Fourth, the public policy making environment was recognised as incorporating a great number of competing demands – including other regulated impact assessments -and struggles based on power and politics. Adding health, and the complexity accompanying a broad definition of health, was suggested as risking adding another complexity to already complex policy environments.

Fifth, sector-specific agendas were explained as essential in shaping the way sectors approach policy making and how they see the place of health as supporting, or not, their specific ways of developing policy. For example one participant recalled how in his work with other government departments health outcomes were seen as secondary objectives that required support from the health sector if they were to be adopted:

"What they saw was that health was a secondary benefit from the work they did...And we got a lot of that. You know education similarly, 'Our aim is to get people educated for economic reasons…as long as we hit our primary objectives, health is a good secondary objective, and we will have a look at that, and if you help us as a health department.' So there are issues around agendas… about health imperialism. We shouldn't feel ashamed of it [health], we have to recognise that other people won't see it as legitimate…for them it is actually, 'why can't we [e.g.education] come and tell you [health] what you should do to help us.'"

Other influences on HIA and HPP

Seven influences on HIA and HPP were identified as contingencies, without consideration of which the previously identified necessary elements of HIA and HPP practice are in reality insufficient.

First, HPP and HIA require collaborative engagement, and demonstrated investment, from public health. For example the participant from land use planning identified public health involvement as the main factor in successful HIAs she had been involved in;

"Typically it was where there was strong Public Health... where Public Health would have a good relationship with Planning and actually, show Planning that they could bring something to the table."

Public health, specifically population health, was described as the institutional resource best able to develop intersectoral collaboration:

"...we in the population health arena seem to me to have a very special place because we do look, we do see where the gap does lie. And nowhere else in the health system has that sort of mandate…, and nor does anyone else really have the skill to look outside."

However participants felt Public Health – notably "those of us who are persuaded by all this" –had yet to create a mandate within the health sector, and by extension broader government, to legitimate a role in intersectoral public policy development.

Second, government structures were identified as critical. Linked to the central role of agendas in policy making, government progresses specific agendas through siloed structures, each with different ways of developing and implementing policy. This was identified as making intersectoral collaboration difficult (particularly at central government levels). Whole of government targets were identified as facilitating working across siloes. These enable people to start thinking outside traditional lines of accountability. Participants suggested HIA had provided a process for doing this.

Third, people's characteristics and competencies were seen as important contingencies. Interest and involvement in either HIA or HPP was seen as stemming from values of social justice, equity and improving population health. However these values were discussed as not being uniformly held amongst public health practitioners and organisations. Being open to new ideas and ways of working were felt to be important. However over-reliance on entrepreneurial individuals rather than building a critical mass of skilled practitioners was identified as a problematic characteristic of the HIA field to date. Skills were mainly discussed in terms of public health collaboration in intersectoral policy development and creating the necessary relationships for this to occur. .

Fourth, the evidence base was identified as an important contingent influence. Participants described both HIA and HPP practice as being at the mercy of the available evidence. Complexities in capturing the links between policy and health, and especially wellbeing, outcomes were noted as problematic issues that influenced the practice of HIA. The relevance of health data on disease or

mortality was questioned because non-health sectors often require cost rather than health outcome data. Despite this, systematically using and articulating health evidence to inform policy was seen as being valued by intersectoral partners, although using this evidence to inform HIAs was noted as requiring support from public health practitioners

Fifth, the community was described as the point where the effects of policy decisions are felt. HIA was thereby singled out as enabling communities to have a democratic voicewithin policy development. Notably participants suggested that community voice is absent from HPP. Additionally, participants cautioned that managing community expectations of what HIA can and cannot deliver was important.

Sixth, societal values were identified as influential on both HIA and HPP. This was couched in terms of societal values being oriented toward individuals rather than communities or populations. Several participants pointed out an important long-term goal of their work in HIA and HPP was to change societal values to become more equitable. For example:

"I think the real trick is... moving people from the... the individual, you know, 'everybody has responsibility for their own health kind of thing' to there are social reasons why we have these health outcomes and that, I think, is a really very broad battle that has to happen that's way beyond healthy Public Policy, or Health Impact Assessment, but those are pieces that can help move in that direction." (8)

Finally, the time required to influence meaningful policy change was highlighted as an often unrecognised contingency by HIA and HPP advocates and practitioners

DISCUSSION

What is already known?

HIA and HPP have been used interchangeably to characterise the increasing interest and activity in influencing public policy to improve health and health equity. This has the potential to conflate expectations about what either approach can deliver, limits understanding of the relationship between them and fails to identify wider influences on the practice of each.

What that this study adds

HIA and HPP are demonstrated to be separate yet overlapping entities, each of which has four essential characteristics.

HIA's essential characteristics are: assessing a policy proposal to predict population health and equity impacts, a structured process for stakeholder dialogue, making recommendations, and flexibly adapting to the policy process.

HPP's essential characteristics are: a concern with a broad definition of health, designing policy to improve people's health and reduce health inequities, intersectoral collaboration, and influencing the policy cycle from inception to completion.

HIA brings to HPP prediction about a policy's broad health impacts, and a structured space for intersectoral engagement, but is emphasised as one approach within a broader suite of HPP activities.

Five characteristics of Public Policy and seven other contingent factors were also identified that influence HIA and HPP and the relationship between them.

Public policy's influence occurs through being: a staged yet incremental process, driven by economic growth, made at different institutional levels, made in a complex and political environment, and shaped by sector specific agendas.

The contingent factors are: Public health's organisational capacity and institutional mandate, the siloed structure of government, people's characteristics and competencies, the health evidence base, community engagement in public policy, societal values, and the long term nature of policy change.

Separating the essential elements of HIA and HPP from contingent influences helps practitioners and researchers identify what can be directly controlled or changed to improve practice, and what else needs to be planned for as contingencies largely outside the control of HIA or HPP practitioners. This will help establish realistic expectations about implementing and developing HIA to achieve HPP.

This research empirically supports and adds depth to the, mostly non-empirical, HIA and HPP literature. The essential elements of HIA suggested here are similar to those identified in established definitions of HIA [10]. These findings however add to these definitions that HIA is essentially flexible in the way it is applied to the public policy process [31, 32]. Turning to HPP, this study supports the essence of HPP as being dependent on a broad definition of health [18, 33] and intersectoral collaboration [34, 35]. However, the institutional mandate for public health to play a coordinating and supporting role in the intersectoral use of HIA for HPP is emphasised but currently underdeveloped. .

The finding that HIA and HPP pre-suppose the existence of 'public policy' returns to the original healthy public policy literature [36]. Conceptually the importance of public policy processes in relation to HIA for HPP has been recognised [31, 37] but not yet widely adopted [7]. Notably Thailand, arguably the most successful country at embedding HIA for HPP, has based this activity on established theoretical conceptualisations of public policy [38].

The findings also help clarify the currently uncertain relationship between HIA and HPP [7, 20]. The two are different and mutually reinforcing although each can and does exist without the other. Most importantly HIA was understood as one important mechanism to enable the systematic consideration of health in public policy [18], while being part of a broader suite of HPP activities [33].

Separating essential HIA and HPP elements from contingent influences helps practitioners and researchers identify what can be directly controlled or changed to improve practice, and what else needs to be planned for as contingencies largely outside the control of HIA or HPP practitioners [31]. Methodologically this is not a question of homogenising or flattening difference [26]. Rather this aids practice and future research to identify, empirically and substantively, whether essential properties exist or not, and how these exert influence on practice or not.

The qualitative design was used to investigate the depth of participants' experience. This study design has some limitations. Participants were few and largely HIA advocates or using HIA in their work. Given the research question, which explicitly aims to understand HIA's fit with healthy public policy, this purposive sampling was required. However future research should investigate the relationship from the perspective of people working in HPP and public policy who may not include HIA in their work. Future research could use, verify and extend these findings as factors influencing the design, achievements and struggles of the many programs and projects currently being undertaken internationally to progress health and equity within public policy.

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Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups

Table 1

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1:	**Research team and reflexivity**	
	Personal Characteristics	
1	Interviewer/facilitator	Which author/s conducted the interview or focus group?
		First author
2	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
		First author BaHons, MPH
		second author PhD, BHSc, RN
		third author MBBS, MHP, PhD
3	Occupation	What was their occupation at the time of the study?
		First author – PhD student, Research Fellow
		second author – Director Research Centre
		third author - Director Population Health
4	Gender	
		First author Male
		second author Female
		third author Male
5	Experience and training	What experience or training did the researcher have?
		All three are experienced qualitative researchers
	Relationship with participants	
6	Relationship established	Was a relationship established prior to study commencement?
		One participant was a colleague with whom we piloted the interviews.

No Item Guide questions/description

7.
Participant knowledge of the interviewer
What did the participants know about the researcher?
Participants were familiar with the researcher's work in health impact assessment. Participants were provided a background document describing the purpose of the interview.

8.
Interviewer characteristics
What characteristics were reported about the interviewer/facilitator? Our professional bias toward understanding the research question was reported.

Domain 2: study design

Theoretical framework
9.
Methodological orientation and Theory
What methodological orientation was stated to underpin the study?
Critical realism

Participant selection
10. Sampling
How were participants selected? *e.g. purposive, convenience, consecutive, snowball*
Purposive, self-selected
11. Method of approach
How were participants approached? e.*g. face-to-face, telephone, mail, email*
Email, Face to face
12. Sample size
How many participants were in the study?
26
13. Non-participation
How many people refused to participate or dropped out? Reasons?
None dropped out.

Setting
14.
Setting of data collection
Where was the data collected? e.*g. home, clinic, workplace*
Phone, place selected by participants, conference workshop

No Item Guide questions/description

15.
Presence of nonparticipants

Was anyone else present besides the participants and researchers?
No
16. Description of sample
What are the important characteristics of the sample? *e.g. demographic data, date*
Relevant demographic characteristics are reported
Data collection
17. Interview guide
Were questions, prompts, guides provided by the authors? Was it pilot tested?
Yes the interview was pilot tested. Interview approach is described in the methods section
18. Repeat interviews
Were repeat interviews carried out? If yes, how many?
Nil
19. Audio/visual recording
Audio recording for interviews, notes for workshop
20. Field notes
Were field notes made during and/or after the interview or focus group?
Yes
21. Duration
What was the duration of the interviews or focus group?
Variable. 40 to 90 minutes.
22. Data saturation
Was data saturation discussed?
Yes
23. Transcripts returned
Were transcripts returned to participants for comment and/or correction?
No critical realist research does not emphasise this
Domain 3: analysis and findingsz
Data analysis
24. Number of data coders
How many data coders coded the data?
Three
25. Description of the coding tree
Did authors provide a description of the coding tree?
Yes but not in the article
26. Derivation of themes
Were themes identified in advance or derived from the data?
Questions from theory, themes from data
27. Software
What software, if applicable, was used to

manage the data?
Nvivo, Microsoft word
28. Participant checking
Did participants provide feedback on the findings?
This is not emphasised in critical realist research
Reporting
29. Quotations presented
Were participant quotations presented to illustrate the themes / findings?
No
Was each quotation identified?
N/A
30.
Data and findings consistent
Was there consistency between the data presented and the findings?
Yes
31. Clarity of major themes
Were major themes clearly presented in the findings?
Yes
32. Clarity of minor themes
Is there a description of diverse cases or discussion of minor themes?
Yes