BMJ open
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The essential elements of health impact assessment and healthy public policy: a qualitative study of practitioner perspectives

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To cite: Harris PJ, Kemp LA, Sainsbury P. The essential elements of health impact assessment and healthy public policy: a qualitative study of practitioner perspectives. *BMJ Open* 2012;**2**:e001245. doi:10.1136/bmjopen-2012-001245

► Prepublication history for this paper are available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2012-001245).

Received 5 April 2012
Accepted 15 October 2012

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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 analytical 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, USA 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.

Conclusions: 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.

ARTICLE SUMMARY

Article focus

- 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.

Key messages

- HIA and HPP are demonstrated to be separate yet overlapping entities, each of which has four essential characteristics.
- Five characteristics of Public Policy and seven other contingent factors were also identified that influence HIA and HPP and the relationship between them.
- 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.

Strengths and limitations of this study

- The strength of this study is in providing an empirical, qualitative, investigation into how practitioners working in HIA and HPP operationalise their work.
- The purposive sampling used is a necessary limitation of the study. Participants were few and largely HIA advocates or using HIA in their work. 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 programmes and projects currently being undertaken internationally to progress health and equity within public policy.

INTRODUCTION

Since health impact assessment (HIA) was introduced as a healthy public policy (HPP) intervention in the late 1990s,[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, programme 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 WHO as 'Putting Health on the agenda of policymakers 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'. (ref. 16, p xviii). 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 were collected during interviews and a workshop.

Interviews

A purposive sample of nine professionals working in HIA and/or HPP from six different countries (UK = 2, Ireland = 1, US = 2, Australia = 2, New Zealand = 1, Netherlands = 1) 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 focusing 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-focused 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 min, were conducted by PH in late 2010 and early 2011. Two interviews were face to face and seven were 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

Box 1 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?

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 were later analysed.

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 2) which built on findings from the interviews.

Box 2 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 programmes be designed to effectively use HIA to influence public policy?

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

- What achievements would the programme work towards?
- What is it about HIA that helps or hinders the programme 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 min, 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.[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 analytical 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).
- "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 1.

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 that 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 well being rather than

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 policy characteristics influencing HIA and HPP	Other contingent factors influencing HIA and HPP
Assesses the 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	Defines health broadly 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	Staged but not 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	Public health's 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, Health Impact Assessment; HPP, Healthy Public Policy.

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 an 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 the inception to the 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 HiAP 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 (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 economically focused 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 the inclusion of both policies and plans at multiple levels. Local-level policy development was often framed as easier to influence than that of the 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 (eg, 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 the 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 that Public Health—notably 'those of us who are persuaded by all this' –was yet to create a mandate within the health sector, and by extension broader government, to legitimise 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). The 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 among 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 well being, 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 voice-within policy development. Notably, participants suggested that community voice is absent from HPP. In addition, 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 towards 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.

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 presuppose 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 the 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 programmes and projects currently being undertaken internationally to progress health and equity within public policy.

Acknowledgements The authors would like to thank Fiona Haigh and Elizabeth Harris for valuable comments on drafts of this paper.

Contributors PH and LK conceived the idea of the study. PH designed the research, carried out data collection and led data analysis. LK and PS provided input into all aspects of the research and contributed to interpretation of the results. The initial draft of the manuscript was prepared by PH, with PS and LK critically revising successive drafts. All authors contributed to the final document.

Funding Australian Government's National Health and Medical Research Council.

Competing interests None.

Ethics approval UNSW Human Research Ethics Committee.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement De-identified transcripts are available on request from the corresponding author patrick.harris@unsw.edu.au

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