Australia-Thailand Project

“Public policy and governance to improve health equity – sharing Australian and Thailand expertise”

POLICY PAPER

31st March 2013

The Australia - Thailand project is a collaboration between The National Health Commission Office of Thailand, International Health Policy Program of Ministry of Public Health, The Thai Health Promotion Foundation, Mahidol University, Flinders University, South Australia Government Department of Health, The Victorian Health Promotion Foundation, The Australian National University and Asia-Pacific HealthGAEN.

The project “Public policy and governance to improve health equity – sharing Australian and Thai expertise” is supported by the Commonwealth through the Australia-Thailand Institute of the Department of Foreign Affairs and Trade.
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Section 1: Summary

Background

This paper is an output from the Australia-Thailand project “Public policy and governance to improve health equity – sharing Australian and Thai expertise”, which is supported by the Commonwealth through the Australia-Thailand Institute of the Department of Foreign Affairs and Trade. The paper serves as a background document for the project meeting in Bangkok December 2012.

The governments of Australia and Thailand are both committed to improving health equity within their populations, and both countries have developed world-leading policy approaches to promote a more equitable distribution of health and its wider determinants. These include Thailand’s National Health Assembly to promote public participation in health policy-making and its comprehensive system for monitoring health and social inequalities, as well as Australia’s “Health in All Policies” approach to intersectoral policy-making for issues that affect health equity, and recent leadership on plain packaging for tobacco. Both countries are world-leading on Health Impact Assessment in policy-making, and the use of hypothecated taxation on tobacco and alcohol to fund health promotion.

The project will develop policy linkages between Australia and Thailand, through the participation of representatives from government agencies from both countries (the National Health Commission in Thailand, and the federal Department of Health and Ageing, and the South Australia Government from Australia). The project will generate increased institutional and people-to-people contacts between Australia and Thailand through the process of development of the policy paper, through a meeting in Bangkok December 2012 and through on-going collaborative research and policy sharing.

Aim of the paper

The aim of the paper is to describe key policies and programs that have addressed the social determinants of health inequities in Australia and Thailand, and tools that have been used to assess them. The focus of the paper is on health equity rather than average population health. The purpose of the paper is to enable each country to learn and consider approaches that are being used in the other, as well as share challenges and learnings relating to strategies that are common to both countries. By doing this, the paper will also provide useful tools and mechanisms that can be adapted in other countries across the region and globally.

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**Key Findings**

Both Australia and Thailand have developed world-leading policy approaches and tools to promote a more equitable distribution of health and its wider determinants. The paper pays particular attention to national and local mechanisms and tools that are used to assess the impact of these actions on the social distribution of health and wellbeing outcomes. Examples of the types of actions and tools included in the paper are Health (Equity) in All Policies, Government of South Australia; National Health Assembly, Thailand; Programs and practices of Health Promotion Foundations (VicHealth, ThaiHealth); Health (Equity) Impact Assessment (in Australia and Thailand); Programs of research that address the social determinants of health and health inequities (in Australia and Thailand). A summary of the key findings is provided below.

**Public Policy and Governance Approaches**

Both the Thai and Australian approaches to public policy and governance aim to influence decision making across the portfolios and agencies of government in ways that promote health and wellbeing and health equity. In Thailand, the structure and operation of the National Health Assembly provides an important mechanism for public participation in these processes, whereas the South Australian Health in All Policies approach works within government to create healthy and equitable public policy. Interestingly even with these significant differences, both approaches share common guiding principles and experience similar implementation challenges.

In Thailand, where identification of community priorities for potential policy action is invited and facilitated by national government, the application of NHA resolutions to public policy solutions...
is still heavily influenced by a range of external factors which do not always align to open windows of opportunity for policy change. In Australia, the HiAP initiative uses health lens analysis to increase awareness within government of the potential health and wellbeing impacts of non-health policies, and as a result, influence the way these public policies are developed and implemented. In both cases, evidence (whether generated by communities, governments, non government organisations or a combination of the three) is only one of a number of inputs into the policy making process. This requires both the Thai and Australian approaches to draw on other forms of support and resourcing for decision making, including the development of strong partnerships across sectors.

The Health Promotion Foundations of Thailand and Victoria (Australia) share a common focus on addressing the major risk factors for chronic disease and the major social determinants of health through an approach to health promotion which emphasizes the development of healthy communities, organisations and environments. VicHealth was established in 1987 and ThaiHealth in 2001, and as such are at different stages of organisational development themselves. Where ThaiHealth’s focus on addressing the social determinants of health is relatively recent, VicHealth now has an established program of work in this area.

Both organisations share a focus on disadvantaged populations, or populations experiencing health inequity as an ‘entry point’ for health promotion action. VicHealth however, has more recently attempted to shift more towards primarily influencing the underlying structures and conditions in which people live and which ultimately create disadvantaged populations and places. ThaiHealth’s focus on education and literacy through the Quality Learning Foundation is an example of addressing the structural drivers of disadvantage for the benefit of a range of population groups.

**TOOLS**

Both Thailand and Australia use Health Impact Assessment methodologies to influence the development of public policy, programs and projects such that they promote health for all. In Thailand, HIA has developed within a strong legislative framework – both the Constitution and the National Health Act require the conduct of HIA on any project which may be harmful to health. HIA is also encouraged to be done at the policy and program level but it is not required. There is a strong public scrutiny process of HIA, facilitated by the National Health Commission Office.

HIA has been on the Australian public health agenda for over 15 years, with health impact assessment activity on projects, programs and plans increasing over time. In recent years, an equity focus has extended the HIA framework to promote the explicit consideration of equity and the differential distribution of impacts of a policy or program on the health of a population, as well as on specific groups within a population – referred to as equity-focused HIA (EFHIA). This has been driven

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largely by the research sector but working closely with local government and communities. Another interesting development is rapid HIA. Having arisen out of a policy need in the state of New South Wales, a 4 day rapid EFHIA was developed to apply to a policy implementation plan. The Australian experience has found that government support and capacity building initiatives are more effective than legislated HIA in progressing equity-focused HIA. The rapid EFHIA found more attention was needed at the policy implementation stage, as this was where many unintended and previously unidentified impacts had potential to arise.

Lessons from the Thai and Australian HIA experiences are that HIA should be conducted early, at the strategic planning stages. This would enable better engagement throughout the conceptual and strategic development of projects and plans. It is good practice for HIA to be designed in a way that all sectors, especially local people who will be impacted upon by decisions/policies/programs can participate as the owner of the assessment. The development of analytical frameworks, of interactive research tools, of critical mass of HIA practitioners, and strategic policy moves are very crucial for the success of HIA in Thailand, Australia and elsewhere.

A health lens analysis (HLA) is another policy analysis tool that has been used in Australia (state of South Australia) as part of the Health In All Policies work. The HLA aims to identify key interactions and synergies between the Strategic Plan targets, government policies and strategies, and population health and wellbeing. An HLA project aims to devise evidence-based recommendations that inform decision-making, to maximise gains in health and wellbeing and to reduce or remove negative impacts or inequities. Importantly, equal emphasis is placed on achieving the goals and objectives of the partner agencies and improving health and wellbeing outcomes.

There are five stages in the HLA approach: Engage. Establishing and maintaining strong collaborative relationships between Health and other sectors; Gather evidence. Establishing impacts between health and the policy area under focus, and identifying evidence-based solutions or policy options; Generate. Producing a set of policy recommendations and a final report that are jointly owned by all agencies with responsibility for the target; Navigate. Helping to steer the recommendations through the decision-making process, and Evaluate. Determining the effectiveness of the HLA.

**COMMUNITY LEVEL ACTION**

The Thai health assembly model is one of the few in the world which provides a formal mechanism for communities and government sectors to participate in policy development at local, regional and national levels. It is defined as ‘a process in which the public and related State agencies exchange their knowledge and cordially learn from each other through an organized systematic forum with public participation, leading to suggestion of healthy public policy or public healthiness.’ The issues
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Section 2: Mechanisms and tools to address the social determinants of health inequity in Australia and Thailand

2.1 Governance

Thai National Health Assembly - National Health Commission of Thailand

The National Health Commission of Thailand was established in 2007 in line with the National Health Act (1, 2). The Commission is chaired by the Prime Minister and acts as an advisor to Cabinet on health and social issues affecting the population. Recommendations of the Commission are derived from participatory policy making processes which use tools specified in the Act, such as the health assembly.

The health assembly has 3 models that can be used to suit differing purposes. In addition to a National Health Assembly (NHA) which convenes once a year, an Area-based Health Assembly (AHA) and an Issue-based Health Assembly (IHA) can take place throughout the year. The 3 different models are based on the same principles of inclusive participation, evidence based support, a consensus system and a process of learning and sharing.

Any organization or network can propose agenda items for consideration at a National Health Assembly through the NHA Organizing Committee. Once the Committee confirms the agenda items for an Assembly, technical working groups are formed to undertake extensive preparatory work, including public consultation, in order to develop draft resolutions for the NHA. Then, at the NHA, 1500 people from a range of sectors – government, academic institutions and people organizations – representing more than 200 constituencies deliberate and eventually adopt the resolutions on a consensus basis (3). The adopted resolutions are submitted to the National Health Commission for consideration or action.

NHA resolutions are considered a soft power. The potential for implementing resolutions is strengthened through the year-long process of the NHA that invites stakeholders to participate from agenda setting to adoption of the resolutions. With the design of the NHA process emphasizing public participation, agencies or networks are able to use the resolutions as a reference to back up their own related plans or activities, even though they are not stipulated in the resolutions as the responsible agencies.

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The National Health Commission established the NHA Resolution Monitoring Committee in 2010 to work in parallel with the NHA Organizing Committee. The NHA Resolution Monitoring Committee is tasked to develop a strategy to drive the resolutions into action and follow up the implementation of NHA resolutions. The significant role of this committee is to build understanding and cooperation with agencies involved in each resolution as well as central agencies responsible for national policies.

What has the National Health Assembly achieved in terms of health equity and social equity?
The process of a calling for NHA agenda items provides a chance to highlight issues of inequity. Marginalized groups and people working in the inequity field wisely use NHA as a channel to draw public attention and drive social and political movement (4). Of the 40 resolutions from first four years of NHA (2008-2012), equity-focused issues addressed include stateless people’s access to basic public health care, disabled people’s fair access to health services, well-being of informal workers, occupational health and safety of workers in the industry and service sector and southern regional development that is unresponsive to eco-culture and people’s need (National Health Assembly Resolutions available at http://en.nationalhealth.or.th/).

It is too soon to measure the achievement of NHA in improving equity, although there are positive signs. For example, a Cabinet resolution in 2010 announced that basic public health care including health promotion, treatment, rehabilitation and prevention will cover stateless people, and assigned the National Health Security Office with charge of this issue. This is in line with the resolution of NHA 2008 on equal access to basic public health care. The National Disabled Commission has been in place in 2012 in line with the NHA 2010 resolution on the disabled.

The National Health Assembly plays an important role in bringing issues of inequity to the attention of the public and decision makers, and provides a valuable mechanism for the participation of community members, government and non-government sectors in problem-solving. However, the process of driving NHA resolutions into action is not without significant challenges, particularly when resolutions related to issues of structural inequity call for changes in/creation of laws, regulations, budgeting, financing, organizational and governances structures or policy decisions at the national level. Some of these key learnings from this process over the past four years are summarized below:

1. Despite their development through a systematic and bottom-up approach, the resolutions from the NHA are not always priorities for action at the national decision making level. The translation of resolutions to policy relies on political will and requires the alignment of a

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range of factors, only some of which are within the control of the National Health Commission.

2. A sense of ownership is a key success factor in implementing the resolutions. As a result, it is important to involve stakeholders at the beginning of NHA process, especially at the stage of drafting the resolutions. Sharing information at this drafting stage helps stakeholders to comprehend alternate views and have more realistic expectations of the outcomes.

3. The selection process for representatives of the 76 provinces of Thailand by NHA constituencies (including government agencies, academic institutions and people organisations) is as important as the competence of the representatives in terms of ensuring that the needs of minority groups are presented and that representatives are accountable and have appropriate authority for decision making.

4. The more that the public understand problems raised and solutions proposed in the resolutions, the higher the potential for translation of the resolutions in policy. In addition to forums, meetings and workshops organized by the NHA Organizing Committee, media is a key mechanism used to build understanding of the public and influence policy makers. The resolution on the equal access to basic public health care in particular to stateless people is one of the examples where media played a major role in broadcasting the issue and keeping the policy makers in the public eye.

**Health in All Policies in South Australia**

The Health in All Policies initiative commenced in South Australia in 2007. It works within government to influence public policy in ways that promote health and wellbeing and health equity, through increasing the positive impact that these polices have on the populations’ access to the social determinants of health. Clearly it is about building healthy public policy.

The Health in All Policies initiative operates under the mandate of the South Australian Government and is supported directly by the Department of Premier and Cabinet and South Australian Department for Health and Ageing. The approach works within and supports the Government’s Strategic framework, which at the time of writing (December 2012) is concerned with implementing Seven Strategic Directions for Cabinet. These were adopted by the Premier who took office in October 2011. It is flexible and adaptable approach and it has been able to respond to changing political and strategic imperatives.
South Australia’s approach is facilitated by a small Health in All Policies Unit located within the Department for Health and Ageing. The Unit’s role is to work collaboratively with senior policy makers across government to promote the health and wellbeing of the South Australian population by addressing the determinants of health and at the same time, working to support the core business of partner government agencies. Five key strategies are used to guide this work;

1. Partnering with government agencies on the policy imperatives underlying their core business
2. Operating under the directive of central government
3. Leveraging from existing government decision making structures
4. Jointly generating evidence-based solutions with project partners
5. Informing solutions with qualitative and quantitative data generated from social science methodologies

The Unit uses health lens analysis (HLA) to identify interactions and synergies between government policies and strategies and the health and wellbeing of the population. It is an iterative process and uses flexible methodologies to deliver evidence-based recommendations to guide policy implementation, and eventually health outcomes. The South Australian Health in All Policies Model, shown in Figure 1 below, details the importance of the central governance structure and outlines the five stages of the HLA process: engagement, evidence gathering, generating, navigating and evaluating. Short descriptions of HLAs in progress in 2012 are given in Box 1.

Figure 1: South Australian Health in All Policies Model

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Central to the process is the objective of mutual benefits so that equal emphasis is place on achieving the objectives of other sectors as well as improving health. For example in the HLA on digital access the aim of partners was to increase digital access for South Australia’s population and the health concern was to raise awareness of digital access as a social determinant of health(5) and ensure that the government’s plans sought to ensure increased access did so in a way that increased equity of access. A brief description of South Australian Health Lens Projects in process at April 2012 in included as Appendix 1.

Collaborative and respectful partnerships built on underpinning partnership principles (see Appendix 2) have been one of the common underlying features of South Australia’s approach and in many ways positive and effective partnerships can account for the initiatives early success. More recently individual project partnerships have expanded into a community of practice amongst senior policy makers where joined up policy making, social determinants of health and health in all policies concepts and processes are discussed, shared and extended.

*Evaluation of the South Australian Health in All Policies*

From the early days of the South Australian HiAP there has been a focus on developing evidence-based policy and evaluating the process of HiAP. Process evaluation has been conducted on the HLAs and this work has been reported (6). Key findings include:

1. The HLAs have led to increased understanding by policy makers of the impact of their work on population health and health equity.
2. In the first three completed projects – water sustainability, regional migrant settlement and digital technologies it was reported that the HLAs resulted in the final policies taking greater account of health and well-being issues than they would have otherwise.
3. Gaps in data and evidence were noted in all HLAs and the HiAP Unit were able to commission university researchers to provide further data which informed policy development.
4. Engagement through the HLAs resulted in greater understanding and stronger partnerships between health and other government departments. The evaluation indicted that there was a sense of joint ownership between health and the other departments.
5. Participants felt their experience had been positive enough to mean that would consider being involved in a HLA in the future.
A five year, NHMRC funded evaluation of the South Australian HiAP experiment commenced in 2012. The multi-disciplinary research team is led by the Southgate Institute for Health, Society and Equity at Flinders University.

**Health Promotion Foundations**

**Thai Health Promotion Foundation (ThaiHealth)**

ThaiHealth was established under the Health Promotion Foundation Act 2001 to stimulate, support and develop a systematic approach to health promotion in Thailand. Its vision is for everyone in Thailand to have capability, living in a society and environment conducive to good health. To achieve such vision, ThaiHealth works with a wide range of multi-sectoral implementation partners. Each year, it funds over 1,000 health promoting projects and activities. ThaiHealth’s 14 plans emphasize health-promoting public policies, issue-based/area-based/setting-based programs and holistic approaches.

In response to recommendations from a 5-Year Review of the organisation in 2007, ThaiHealth’s governing board emphasized the foundation’s role in addressing social determinants of health. The reduction of health inequality was also subsequently incorporated as a specific strategy in the ThaiHealth strategic vision. Today ThaiHealth projects and activities therefore aim to tackle social determinants of health, most notably the projects on different disadvantaged population groups. In Thailand, disadvantaged population groups include cultural minority groups, the poor and marginalized, the disabled, informal workers, stateless people, and people affected by conflict and violence, among others. ThaiHealth utilizes the same empowerment principles that it uses to apply to local communities, where the groups themselves decide on their own health promotion priorities, while ThaiHealth facilitates the process and outcomes. Below are examples to highlight ThaiHealth’s activities in this area.

**Informal Workers**

ThaiHealth supports the Quality of Life for Informal Workers program to address the working conditions of the informal workers in Thailand. In 2010, informal workers numbered 24.6 million, constituting 62.6% of all workers and contributing 45.6% of Thailand’s GDP. However, there was no specific labour law that protects or supports this group of workers to have a basic social safety net, worker health coverage, or old age financial security. The program has so far been successful in catalyzing the establishment of the National Committee on Informal Worker Management chaired by the Prime Minister, which recently adopted 2012-2016 strategy towards the vision of “informal workers receive proper protection and have social security which leads to a better quality of life.”

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The plan involves 9 ministries, 21 organizations and it is budgeted at 39.5 billion baht. Other concrete achievements include the establishment of worker health services in 2 piloted provinces supported by the NHSO, the organization of the 1st national assembly of informal workers, and the acknowledgement by the Prime Minister of the need to address worker health services, old age security, and workers’ skill development.

**Thai Muslims**

Health Promotion for the Muslim Community Program is one of several ThaiHealth projects to support *well-being of culturally diverse communities*. This program addresses the gap in healthcare services for Thai Muslims who live in the southern provinces. ThaiHealth initiated the creation and promotion of specialized health programs in Muslim communities through cooperation with the Thai Muslim Network led by local Muslim leaders to promote health through an improved understanding of the religious belief system and different health lifestyle and cultural behaviour. Some of inequalities experienced by Muslim groups were addressed, such as the inclusion of circumcision for Thai males as part of the benefit package of the Universal Coverage Scheme (in 2005); and the drafting of the Zakat Fund Act to ensure that the fund will be accessible to the disadvantaged and the poor in the Muslim community. In addition, ThaiHealth established the Health Research Centre at the Prince of Songkla University to develop and implement strategies guaranteeing access to basic health services even in areas of unrest in the Southern provinces.

**Stateless people**

ThaiHealth has advocated for a systematic resolution to the problem of stateless people’s lack of access to health-care services. On 20 March 2010, the Cabinet allocated 472 million baht to hospitals along border areas in 15 provinces to provide health-care services to 457,409 stateless people. This is to ensure the right to health and universal coverage to all people living in Thailand, regardless of their citizenship. This is another important achievement as access to health care is an important social determinant of health for stateless people in border communities.

**Improving Quality of Education**

ThaiHealth has supported a number of education-related initiatives, one of which is the Quality Learning Foundation (QLF). Set up in May 2010, QLF is a ThaiHealth spin-off organization which explores the value of early childhood enrichment and literacy programs for disadvantaged children and their mothers. The establishment of the QLF by ThaiHealth is a practical new model of intervention for social determinants based on a health promotion foundation. The QLF addresses
health literacy and works to ensure equality of learning outcomes for students from disadvantaged population groups such as children with disability, refugees, minority ethnic and religious groups, as well as children from impoverished areas.

**Victorian Health Promotion Foundation (VicHealth)**

VicHealth was established by the Victorian Parliament of Australia under the Tobacco Act 1987 with a mandate to promote good health for all Victorians. VicHealth is an independent statutory authority with a Board of Governance that is responsible to the Minister for Health. The organisation receives funding of approximately $32 million per annum from the Victorian Government to address a range of traditional health promotion risk factors (such as smoking, physical activity, nutrition and alcohol), as well as to focus on key social and economic determinants of health. VicHealth’s programs and projects focus on improving the health of all people in Victoria, while reducing the differences in health status between population groups.

VicHealth recognises that the social and economic conditions in which people live have a significant influence on their health and on inequalities in health. The organisation therefore focuses on making changes in society to provide all people with the opportunity to live a healthy life. Sometimes this involves working directly with priority populations (including people from lower socioeconomic groups, Aboriginal and Torres Strait Islander people, people from culturally diverse communities, and people with disabilities), and other times focusing on the broader conditions in which they grow, live, work and age.

VicHealth’s current strategic plan prioritizes five key issues within these broader living conditions: increasing opportunities for social connection; preventing violence against women; reducing race-based discrimination; economic participation and; creating environments that improve health. Where a focus on social and economic determinants is often situated at the margins of health promotion practice, it has been considered the core business of VicHealth, and one of the unique characteristics of the organisation.

The establishment of VicHealth (and a growing number of health promotion foundations across the world that have followed in its footsteps) has resulted in the development of a quasi-autonomous organisation which is in an unmatched position amongst health promotion stakeholders within Victoria. This is both in terms of the organisation’s focus on determinants of health, as well as a range of roles that the organisation plays in order to influence public policy in relation to these...
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determinants. These roles include: building of a health promotion evidence base; advocating for health promoting policies; addressing equity issues; trialing innovative programs in sensitive areas that may expose governments to political criticism; bringing disparate parties to the table to work together and; working with government but not as government.

Although getting the determinants of health and health equity onto government agendas is often identified as a key function and a success of VicHealth, the specific components of this work and the characteristics of the organisation that make it possible have not been examined in detail in any published material. However, VicHealth’s ‘practice cycle’ for work addressing the social and economic determinants of health (see Figure 2 below) has been established over time to reflect key stages involved in advocating for the development of policy and strategy by government.

The key stages represented in the cycle include: getting an issue onto VicHealth’s agenda; raising its profile as a public health issue in relevant sectors; understanding how best to address the issue through health promotion intervention (via an evidence review and development of a conceptual framework); testing these interventions through research and practice which is funded by VicHealth and ideally, also through the support of external partners; building the capacity of key stakeholders to address the issue through their own work through education and training and; advocating for state government to address the issue through policy and strategy.

Figure 2: VicHealth’s ‘practice cycle’ for work addressing the social determinants of health
Perhaps the most successful application of the practice cycle to date has been in VicHealth’s program of work focused on the prevention of violence against women, which fundamentally aims to improve gender equity. Many years of work involving all stages of the practice cycle and a wide range of partners resulted in state government commitment (including the development of specific policy for the first time) to address the prevention of violence against women in Victoria. This work is by no means complete, but is a strong demonstration of policy advocacy in relation to the social determinants of health equity and provides an example of the type of change that VicHealth, as a unique health promotion stakeholder within Victoria can facilitate.

Summary

Comparisons between Thai and Australian Public Policy and Governance approaches

Both the Thai and Australian approaches to public policy and governance aim to influence decision making across the portfolios and agencies of government in ways that promote health and wellbeing and health equity. In Thailand, the structure and operation of the National Health Assembly provides an important mechanism for public participation in these processes, whereas the South Australian Health in All Policies approach works within government to create healthy and equitable public policy. Interestingly even with these significant differences, both approaches share common guiding principles and experience similar implementation challenges.

In Thailand, where identification of community priorities for potential policy action is invited and facilitated by national government, the application of NHA resolutions to public policy solutions is still heavily influenced by a range of external factors which do not always align to open windows of opportunity for policy change. In Australia, the HiAP initiative uses health lens analysis to increase awareness within government of the potential health and wellbeing impacts of non-health policies, and as a result, influence the way these public policies are developed and implemented. In both cases, evidence (whether generated by communities, governments, non government organisations or a combination of the three) is only one of a number of inputs into the policy making process. This requires both the Thai and Australian approaches to draw on other forms of support and resourcing for decision making, including the development of strong partnerships across sectors.

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2001, and as such are at different stages of organisational development themselves. Where ThaiHealth’s focus on addressing the social determinants of health is relatively recent, VicHealth now has an established program of work in this area.

Both organisations share a focus on disadvantaged populations, or populations experiencing health inequity as an ‘entry point’ for health promotion action. VicHealth however, has more recently attempted to shift more towards primarily influencing the underlying structures and conditions in which people live and which ultimately create disadvantaged populations and places. ThaiHealth’s focus on education and literacy through the Quality Learning Foundation is an example of addressing the structural drivers of disadvantage for the benefit of a range of population groups.

2.2 Tools

Health (Equity) Impact Assessment, Thailand

Health Impact Assessments can offer a formal and structured process to assess the potential effects of policies (from either the health sector or non-health sectors) on health, wellbeing and equity. Health Impact Assessment (HIA) is increasingly recognized internationally as a mechanism to maximize the potential health benefits of policies, programs and projects and minimize the potential negative health consequences of health risks. They provide utility as a structured and transparent method of enabling the systemic consideration of health inequalities early on in the development of policies.

The concepts of healthy public policy and HIA were initially introduced to the Thai public during the process of the National health system reform, which commenced in 2000. This reform provides important opportunities and processes for several changes in Thai society, including the expansion and deep-rooting of healthy public policy and HIA. Combined with drastic changes in social and political conditions during the 1980s and 1990s, the national health system was increasingly forced to reform. A climax was reached in 1997 when the new Thai constitution was adopted and implemented, which was heavily influenced by civil society. Under this constitutional reform, health became a part of human rights - not just public welfare. Consequently, the government was required to provide public health services of the same standard to all population groups. Concurrently, all development programs and projects that had adverse impacts on health are now required to conduct impact assessment with a public scrutiny process. The civic roles in policy formulations and
public decision-making, as well as in their implementation had been asserted in the Thai constitution (10).

**HIA Development in Thailand**

The issues of healthy public policy and HIA were raised firstly during the national seminar on “The Desirable Health System in Thailand” in 2000 and echoed during the public hearings at the provincial level in 2001. This issue has become more important for Thai society, mainly because of the increasing trend of health risks from environmental hazards; such as air pollution, pesticide contaminations, improper waste treatments and so on, as well as the evidence and concerns of health impacts from development projects; such as large dams, power plants, trans-national gas pipelines, highways, and so on.

Later, in 2001, the issue of healthy public policy became the first topic of discussion in the first National Health Assembly, showing its relevance and importance in the Thai health reform context. In the assembly discussion, two HIAs conducted on the industrial development project and agricultural policy were presented, showing clear negative health impacts from these well-known government initiatives. As a result, the concepts of healthy public policy and HIA were included in the first draft of the National Health Act, paving the way for HSRI to develop a research program on healthy public policy and health impact assessment which started in 2002, in order to support further development in healthy public policy and HIA in Thailand (11). The draft stresses that the expected health system shall have guidelines and measures to establish healthy public policy and the process for HIA from the public policy, aimed at joint learning of all sectors in society. Furthermore, the draft also asserts the right of Thai people to participate in using the assessment outputs and making decisions on policy implementation and crucial projects that may have an impact on health (12).

**HIA in the Legislative Process**

In Thailand, the constitution allows Thai people to collectively submit a bill to the parliament. The recommendations and academic syntheses were included in the content of the National Health Bill, which was then taken to the public consultation process through all provincial health assemblies. Finally, on 4 January 2007, the National Legislative Assembly approved the National Health Bill. As mentioned earlier, this time the rights and participation of the citizens in HIA are restored in Sections 10 and 11, while the prescription of HIA criteria and methods is stated in Section 25(5) of the Bill (4).
The National Health Act B.E.2550 (2007) (see box 1) is amongst the few laws in Thailand which have the most extensive people participation process in the history of Thailand. It is the first Act that includes several sections on HIA. The Act covers the right, responsibilities, and functions for health and health securities (13).

**Box 1: Extracts from the National Health Act B.E.2550 (2007)**

<table>
<thead>
<tr>
<th>Section 10</th>
<th>In the case where there exists an incident affecting public health, a State agency having information relating to such incident shall expeditiously disclose such information and the protection thereof to the public.</th>
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<tbody>
<tr>
<td>Section 11</td>
<td>An individual or group of people has the right to request for estimation or participating in the estimation of impact on health resulting from a public policy. An individual or group of people shall have access to information, explanation and underlying reason prior to a permission or performance of a programme or activity which may affect his or her health or the health of a community, and shall have the right to express his or her opinion on such matter.</td>
</tr>
<tr>
<td>Section 25 (5)</td>
<td>National Health Commission (NHC) shall have powers and duties to prescribe rules and procedure on following up and evaluation in respect of national health system and the impact on health resulting from public policies, both in the levels of policy making and implementation.</td>
</tr>
</tbody>
</table>

**Moving into the Constitution**

After the success in implementing the HIA National Health Act, HIA was discussed in the drafting process of the new constitution. The National legislative assembly, which passed the National Health Act, also suggested adding HIA in the decision process of projects and activities that may be harmful to the health of Thai people. Later, HIA was added into the draft of the national constitution and was passed through the first national referendum in August 2007. Since August 2007, the Constitution of the Kingdom of Thailand BE.2550 (2007), section 67 stipulates that:

“Any project or activity which may seriously affect a community’s environmental quality, its natural resources or its people’s health, is prohibited unless (a) these environmental and health impact are studied and assessed (b) a public hearing process is undertaken to obtain the opinions of people and stakeholders and (c) independent organization formed by representatives of non-

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governmental organizations and higher education institutes provides opinions and comments, prior to the implementation of such a project or activity…”

Present HIA mechanisms in Thailand

Based on both the National Constitution and the National Health Act, HIA in Thailand has been applied in four main ways:

Firstly, as mentioned earlier, according to the Constitution, all potentially harmful projects require the conduct of HIA in their decision-making processes. In the HIA process, regarding possible harmful projects, local people and the public can participate meaningfully in public scoping and public review. According to the constitution, each HIA report must be reviewed by the independent organization in order to ensure the quality of the HIA process and report.

Secondly, any governmental organizations may apply HIA in the policy and planning development. Therefore, in addition to the project level, HIA can also be applied at the policy and program levels, such as for nuclear/energy power development plan, for mining development strategy, or for regional development policy. The National Health Commission Office must co-ordinate with, and support, the relevant organization to conduct HIA in their planning process and facilitate for public participation in the HIA process.

Thirdly, any local people who may be concerned about the impacts of a specific policy on their health also have the right to request for a HIA to be considered in order to ensure that the policy would not lead to negative health impacts. In this case, the National Health Commission Office would facilitate the HIA process, especially the co-ordination between local people, policy-makers, and relevant organizations in conducting HIA and in applying HIA to the policy-making process.

In Thailand, after the completion of a project or activity where health impacts have occurred, people can still request a retrospective HIA for such a project or activity as stipulated by the National Health Act. Although, in principle, HIA should be used prospectively, the retrospective HIA can also be very useful for policy evaluation. As a result, owners of the project or activity may have to undertake measures to eliminate the impact.

Lastly, local governments, the public and other organizations can apply HIA as a social learning process to solve their own problems or to plan for their better future health. In this case, HIA can be done locally without any law requirement and can communicate with National Health Commission Office for technical support and for an exchange of ideas and information.
To coordinate the overall development of HIA in Thailand the National Health Commission has established the National HIA Commission. Moreover, and HIA Co-ordination Centre has been set up by National Health Commission Office to facilitate all these HIA implementations.

Critical Reflection Towards Practical Solutions

In reality, the implementation of HIA in Thailand has not always run smoothly. In the beginning HIA was regarded as a “social learning process” to come up with the best policy, or so-called healthy public policy that would be beneficial to Thai people’s health and well-being. The effort was successful to a certain degree but locally affected people still hoped that HIA should have more influential power on actual government’s decisions. Therefore, HIA in the Thai constitution remains stuck between a governmental approval process and as a social learning process. This dilemma led the National Health Commission Office to organize the critical reflection workshops for further HIA development in the next five years in 2010 and 2011 with participants from four parties; namely governmental, private, locally affected people, and academic sectors. The results of the workshop are quite critical and interesting as discussed in the following sections (13, 14).

• Moving Upstream of Development Process
The lesson from HIAs conducted on project developments has been that HIA should be conducted earlier at the strategic planning stages. This would enable better engagement throughout the conceptual and strategic development of projects and plans, rather than solely at the end stage of project development when approval is required, which, in several cases, leads to conflict between proponents and opponents of the projects. Therefore, if we want to maintain the spirit of deliberative decision-making within society, HIA must be used as a planning and decision-making tool at the very beginning of project development. Even though each group may have different expectations and ideas about the project development, as long as they have not decided on their standpoints or specific ideas of the project, then there is still some room for social learning and mutual understanding instead of arguments and conflicts where everybody only focuses on the benefits or problems that they will desire to receive from the project.

• Providing Alternative Policy Options
Although moving towards the upstream in the development process would provide a broader opportunity to share and learn within society, this opportunity cannot be effectively linked to policy solutions until the new strategic policy options would be presented, discussed and analyzed through
the HIA process. This is because, without policy options, it is quite difficult for Thai society to exchange, learn, and making decisions together. Therefore, HIA should not only focus on comments and critiques of a specific government policy but it also needs to stimulate and accumulate new ideas and initiatives from different stakeholders within the society.

- **Linking to Other Aspects of Sustainable Development**
  Another major problem for HIA implementation in Thailand is how to link all health determinants into HIA and into the government’s decision-making process, especially in the case of social determinants of health. Since the accuracy of data within the scope of social determinants is often criticized, HIA in Thailand has mostly focused on the physical and biological environmental aspects rather than psychological, social or spiritual aspects, as stressed in the National Health Act. The challenge of HIA, therefore, is how to develop a HIA scheme that reflects changes in social and spiritual health dimensions. Recent developments in the last 2 to 3 years, including the survey of happiness levels of Thai people and the survey of progress indicators all over the country are important steps for the development of databases and tools for HIA to link with and utilize.

- **HIA Co-ownership**
  Last but not the least, it is necessary for HIA in the near future to be designed in a way that all sectors, especially local people who will be impacted upon (both positively and negatively), can participate as the owner of the assessment in order to ensure that the assessment is really a social learning process. Consequently, we must be careful when developing tools and databases not to lessen the sense of ownership of HIA in both the community and other sectors. Tools should only support communication and sharing of information and opinions amongst various parties rather than be used as the sole answer in the decision-making process.

Within just one decade, HIA development in Thailand has travelled far from being an initial idea in 2000, to becoming part of an overall institutional framework. HIA in Thailand has moved from conferences and case studies towards the constitution. In this aspect, HIA can work as a process and tool for Thai people to protect their right and, at the same time, for Thai policy-makers to share with all stakeholders. However, focusing on an institutional infrastructure cannot lead to fully development of HIA as a desirable social learning. The development of analytical frameworks, of interactive research tools, of critical mass of HIA practitioners, and strategic policy moves are very crucial for the success of HIA in Thailand. If the previous decade is the period of initiating and institutionalizing the act and the constitution, this decade should be the period that we will turn the
(national health) act into (real-life) action and turn the constitution into our culture of collective decision-making.

Health Equity focused Impact Assessment, Australia

Health Impact Assessment (HIA) has been on the Australian public health agenda for over 15 years, with health impact assessment activity on projects, programs and plans increasing over time (15). However, despite enjoying increased attention, robust use and meaningful implementation of Health Impact Assessments has been limited and inconsistent (9). HIA first entered the policy agenda conceptualized within Environmental Impact Assessment (EIA), later transforming to find direction under “Policy HIA” and finally came to develop a more nuanced approach under Equity focused Health Impact Assessment (EFHIA) (16).

EFHIA extended from the HIA framework to promote the explicit consideration of equity and the differential distribution of impacts of a policy on the health of a population, as well as on specific groups within a population. EFHIA seeks to identify and assess differential health impacts and make judgments as to whether the potential health impacts are unfair or avoidable (16). Discussion of EFHIA in Australia will draw on the experience of NSW in the implementation of the rapid EFHIA on the NSW Department of Health Australian Better Health Initiative (ABHI) implementation plan.

The Rapid EFHIA on NSW Department of Health Australian Better Health Initiative implementation plan

The NSW Department of Health Australian Better Health Initiative (ABHI) was developed in 2006 as a government Health Promotion implementation plan, focused on the prevention and early detection of chronic disease (16). The Department of Health was required to formulate ABHI initiatives and intervention plans within a limited period of time. The University of NSW Centre for Primary Health Care and Equity, Centre for Health Equity Training and Research Evaluation (CHETRE) conducted a rapid four-day EFHIA of the NSW department of Health ABHI implementation plan.

The rapid EFHIA aimed to identify potential links between implementation of initiatives, health improvement and potential health inequities. The successful application of EFHIA in NSW was reliant on three main tools: i) capacity training courses, ii) ‘learn by doing’ programs and iii) an established EFHIA framework:

The project “Public policy and governance to improve health equity – sharing Australian and Thai expertise” is supported by the Commonwealth through the Australia-Thailand Institute of the Department of Foreign Affairs and Trade.
i) Key to the success of any EFHIA or HIA is an established capacity to conduct these assessments. A defining feature in the rapid EFHIA conducted on the NSW ABHI implementation program was the use of the CHETRE multilevel capacity training courses(17). These training courses outlined the concepts of health equity, HIA, EFHIA, their aims and strategies used to achieve them. Clarification of the aims and expectations of individuals was central to ensuring the production of a consistent, coherent and strong assessment (16 p. 7). These capacity training courses proved to be essential for progressing the knowledge, skills and practical application of HIA.

ii) The ‘learn by doing’ program sought to extend EFHIA capacity training by teaching through conducting an EFHIA (17 p. 120). The rapid EFHIA working group utilized this program by selecting an expert group who had previously conducted HIAs and were familiar with the process. The ‘learn by doing’ program produced skilled individuals with the necessary skills base to conduct a rapid EFHIA. Without such opportunities to develop HIA capacity, a rapid EFHIA would not have been completed within the four-day period.

iii) The final tool essential in conducting the rapid EFHIA was the Equity Focused Health Impact Assessment Framework outlined by the Australian Collaboration for Equity Focused Health Impact Assessment (ACHEIA) (18 p. 1). The framework sought to provide a structured and transparent method of determining the unanticipated and systemic health inequities that may exist within the decision-making processes or activities of a range of organisations and sectors. The framework was a guide, with a transparent 6-step process that clearly detailed the work and time required by each assessor.

The rapid EFHIA resulted in two immediate successes. They were the incorporation of EFHIA recommendations into the revision of the ABHI and the successful implementation of a rapid EFHIA process. The incorporation of EFHIA recommendations into the ABHI revision saw changes to the redistribution of ABHI funds to favour rural health services (16 p. 5). This was an acknowledgement that rural areas required greater funds to set up infrastructure and jobs to generate the same outcomes as would be achieved in urban areas. EFHIA recommendations also requested policy officers and managers to explicitly detail how recommendations would be implemented. This was a direct result of new insight into the significance of the implementation stage as the stage where unanticipated differential health impacts were mostly realised.

Although the EFHIA working group and health professionals contested the extent of some of the impacts, all were unanimous that the EFHIA had some impact on the further planning and decision-making of health policy (16 p. 6). Disagreement over the influence of EFHIAs is an issue common in
many other HIA and EFHIA impacts assessments. Attributing changes solely to an EFHIA is problematic as changes can often be the indirect result of a combination of external factors.

A major success of the rapid EFHIA is its application within a 4-day period. The success of the rapid EFHIA is significant as a demonstration of the successful integration of EFHIA framework to a time-constrained and politically charged policy-making process. However, the successes of the EFHIA are not all visible and immediate. The rapid EFHIA impact evaluation found the EFHIA encouraged the explicit consideration of health equity implications, rather than being implicit in the policy development process (16 p. 6). The rapid EFHIA also allowed health sector workers the opportunity to consolidate existing knowledge, transforming equity from an under-considered concern to a central goal.

The rapid EFHIA confronted three major challenges, which are commonly evidenced across other EFHIA and HIA experiences. They include a limited range of literature, limited capacity to carry out EFHIA and the lack of clarity surrounding EFHIA among health professionals. The uncertainty in the evidence of what changes could remedy potential health inequities consequently limited the ability of assessors to connect and prevent differential health impacts from arising.

The second challenge common within EFHIA processes and also evidenced in the rapid EFHIA was the limited capacity of the health sector to carry out an EFHIA. The rapid EFHIA addressed this issue using capacity building training workshops and expert panels. Although opportunities to participate in training workshops are available, access to expert panels familiar with the EFHIA and the way the public health sector and development policy processes operate is rare and limited.

Finally the lack of clarity among health workers limited and threatened the perceived value of HIA (16 p. 6). Clarity was required in the conception of an EFHIA, or HIA as differing expectations potentially served to create confusion and tension within the EFHIA team. The NSW rapid EFHIA experience highlights three important lessons for the successful growth and use of EFHIA in the policy-making process. The three lessons relate to a need for state-level capacity building, EFHIA focus at the implementation level and finally promotion of continued collaboration and engagement.

The Australian experience has found that state government support and state level capacity building initiatives are more effective than legislated HIA in progressing EFHIA (9 p. 430). Harris and Spickett
also emphasise the role of the state government, arguing state level leadership is essential to embedding HIA into the policy development process. Secondly, the rapid EFHIA found more attention was needed at the policy implementation stage, as this was where many unintended and previously unidentified impacts had potential to arise.

Health lens analysis: an example from South Australia’s Health in All Policies work

The health lens analysis (HLA) is a central feature of South Australia’s HiAP approach. The HLA aims to identify key interactions and synergies between the South Australia’ Strategic Plan targets, government policies and strategies, and population health and wellbeing. The HLA process aims to develop systemic change through evidence-based recommendations. The HLA process is iterative and uses flexible methodologies to ensure that the approach fits with the project proposal in question, the resources available and the local populations affected. Importantly, equal emphasis is placed on achieving the goals and objectives of the partner agencies and improving health and wellbeing outcomes. An HLA project aims to devise evidence-based recommendations that inform decision-making, to maximise gains in health and wellbeing and to reduce or remove negative impacts or inequalities. It also seeks to support the development of sound policy outcomes for all agencies involved, in particular the lead agency. To this end, a win–win outcome is sought in all cases.

The following questions informed the development of the HLA: how would partner agencies respond to the concept; what resources (including staff and financial) would be available and be required, and to what extent would the HLA be a priority for the partner agencies. A strong “learning by doing” approach was adopted for the first HLA. There has been a clear evolution of understanding by Health staff as the methodology has developed and the process has evolved accordingly. While a more robust and well understood process now exists, the process remains flexible.

The South Australian HLA approach involves five stages. The developmental nature of the process means the stages are both sequential and overlapping. Stage 1 “engage” continues throughout the entire project. The five stages are:

1. **Engage.** Establishing and maintaining strong collaborative relationships between Health and other sectors.
2. **Gather evidence.** Establishing impacts between health and the policy area under focus, and identifying evidence-based solutions or policy options.

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3. **Generate.** Producing a set of policy recommendations and a final report that are jointly owned by all agencies with responsibility for the target.

4. **Navigate.** Helping to steer the recommendations through the decision-making process

5. **Evaluate.** Determining the effectiveness of the HLA.

1. **Engage**

A Working Group is established early in the development of each HLA. Members are drawn together by the lead agency (the agency with responsibility for the policy), following preliminary discussions with the Department of Health. The initial role of the working group is to determine a specific policy focus for the HLA and to oversee the project, providing expert information and advice throughout the process, in particular in providing relevant and up to date evidence where available and also in formulating the final recommendations. A project proposal is developed and approved by the Chief Executives (CE) of the partner agency(s) and the Department of Health. It is important that the members of the working group are in a position to make decisions relating to policy change or development on behalf of their agency, as well as playing a role in implementing the recommendations where applicable. Where it is not possible to have all relevant agencies around the table at the commencement of a project, other agencies may be invited to join later in the process when it is determined that their input is necessary or that it is possible that the anticipated recommendations may impact their core work. In many ways, the engagement phase is the most important as relationships are established or strengthened, forming a firm basis for the conduct of the project. Strong engagement with the right agencies and members at this stage is critical in the success and ‘smooth running’ of the project.

2. **Gather evidence**

Each HLA utilises evidence-based approach to policy development, in particular in understanding the potential health and wellbeing implications of a policy, plan, or program. The collation and development of an evidence base is a collaborative process with all relevant agencies involved. As the links between health impacts and the policy area need to be clearly articulated, providing clear or pathways which are supported by good evidence is crucial. Evidence can come from a range of sources and can be either qualitative or quantitative in nature, and generally a combination of each of these is used. Qualitative evidence is used in all of the HLAs, generally including literature reviews and analysis as well as some form of social research such as focus groups or interviews. Quantitative evidence may include existing data or a survey may be conducted as part of the project design (though this is time consuming and requires large sample sizes in order to provide meaningful results.)

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so is rarely done). The evidence gathering phase is intensive, and generally the longest. During this phase it is important to keep all members engaged to ensure they have a clear understanding of where the evidence has come from and what it means.

3. **Generate**

The evidence is collated, analysed, and then compiled into a draft report and are reviewed by the working group. Input from members at this stage is critical to ensure that all aspects of the relevant, available evidence have been included as this evidence will be used to inform the development of a series of recommendations and these recommendations are be owned by the key agencies. The working group shapes and refines the recommendations to ensure they are meaningful and achievable.

4. **Navigate**

Once recommendations have been drafted and agreed on by working group members, they are then sent to the CE of the partner agency(s), including health, for approval. A summary of the evidence and brief description of the process is also provided to demonstrate the development of the recommendations and to show they are supported by a strong evidence base. The recommendations are approved firstly by each partner and then by the central governance structure with responsibility for oversight of HiAP.

5. **Evaluate**

Each Health Lens is evaluated to determine whether it has influenced policy decisions, whether it assisted the agency(s) to achieve their goals, and what determinants of health were influenced. In addition it is also important to gauge whether the process has resulted in a strengthening of existing relationships between the partners or the development of new relationships. Ongoing evaluations will also ensure that the HLA process can be refined so it is flexible and adaptable to all government agencies, as well as being able to deliver policy options that contribute to improved health outcomes.

**Summary**

<table>
<thead>
<tr>
<th><strong>Comparisons between Thai and Australian tools</strong></th>
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<tr>
<td>Both Thailand and Australia use Health Impact Assessment methodologies to influence the development of public policy, programs and projects such that they promote health for all. In Thailand, HIA has developed within a strong legislative framework – both the Constitution and the</td>
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National Health Act require the conduct of HIA on any project which may be harmful to health. HIA is also encouraged to be done at the policy and program level but it is not required. There is a strong public scrutiny process of HIA, facilitated by the National Health Commission Office.

HIA has been on the Australian public health agenda for over 15 years, with health impact assessment activity on projects, programs and plans increasing over time. In recent years, an equity focus has extended the HIA framework to promote the explicit consideration of equity and the differential distribution of impacts of a policy or program on the health of a population, as well as on specific groups within a population – referred to as equity-focused HIA (EFHIA). This has been driven largely by the research sector but working closely with local government and communities. Another interesting development is rapid HIA. Having arisen out of a policy need in the state of New South Wales, a 4 day rapid EFHIA was developed to apply to a policy implementation plan. The Australian experience has found that government support and capacity building initiatives are more effective than legislated HIA in progressing equity-focused HIA. The rapid EFHIA found more attention was needed at the policy implementation stage, as this was where many unintended and previously unidentified impacts had potential to arise.

Lessons from the Thai and Australian HIA experiences are that HIA should be conducted early, at the strategic planning stages. This would enable better engagement throughout the conceptual and strategic development of projects and plans. It is good practice for HIA to be designed in a way that all sectors, especially local people who will be impacted upon by decisions/policies/programs can participate as the owner of the assessment. The development of analytical frameworks, of interactive research tools, of critical mass of HIA practitioners, and strategic policy moves are very crucial for the success of HIA in Thailand, Australia and elsewhere.

A health lens analysis (HLA) is another policy analysis tool that has been used in Australia (state of South Australia) as part of the Health In All Policies work. The HLA aims to identify key interactions and synergies between the Strategic Plan targets, government policies and strategies, and population health and wellbeing. An HLA project aims to devise evidence-based recommendations that inform decision-making, to maximise gains in health and wellbeing and to reduce or remove negative impacts or inequities. Importantly, equal emphasis is placed on achieving the goals and objectives of the partner agencies and improving health and wellbeing outcomes. There are five stages in the HLA approach: Engage. Establishing and maintaining strong collaborative relationships between Health and other sectors; Gather evidence. Establishing impacts between health and the

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Before this issue was considered in the NHA, detailed background information and draft resolution were developed by a Working Group comprising of all sectors in the Triangle that moves the mountain approach—academics from universities, representatives from the NESDB, Ministry of Public Health, Ministry of Natural Resources and Environment, Ministry of Interior, Ministry of Industry, Tourism Authority of Thailand, and representatives from people sector through NGOs, including those from the Ecology Realization Program and the Community Network for Health Impact Assessment of the Southern Development Plan. This was to ensure active participation of all stakeholders in the issue from the beginning.

After discussion of this agenda in the NHA, the assembly finally adopted a resolution which recommended that Cabinet instruct the NESDB to review the Draft Master Plan focusing on the aspects of quality of life of people in the region, natural resources and biodiversity, and the importance of the many cultures of the people in the area, as well as their participation in determining development issues. The NHA resolution was later agreed and endorsed by the National Health Commission and the Cabinet, and the following activities have since been completed:

1. The NESDB hired a technology consulting company to conduct a study regarding the sustainable development of the southern region.
2. Communities raised concerns that this study did not adequately invite participation from communities and therefore proposed a community-driven plan called ‘Peaceful and Happy South Plan’. At the same time, there was a community movement named ‘Petchakasem 41’, which is a network of people from 14 provinces in the southern region, established to raising awareness and objection (like a watch dog) on the development of southern region as a new industrial estate.
3. An area-based health assembly of the southern region was organized for finding a resolution for a sustainable plan of the south, which has been used as an agreement among all the 14 provinces to work and move the region together towards wellbeing.
4. Since the issue of development of the southern region is of national significance, it was linked to the Thailand Reform Assembly which also addressed in its resolution that the Draft Master Plan of the NESDB should be reviewed and revised concerning more a participatory process for people in the region.

This case study demonstrates that a problem which is beyond the management of the local government can be brought up to the decision making at the national level through NHA.
Communities can use an area based health assembly to drive the decision into action at the community and regional level.

**VicHealth programs**

As described earlier, VicHealth investment to address health inequalities involves working directly with priority populations, as well as focusing on the broader conditions in which they grow, live, work and age.

The legislation that established VicHealth specifies that 30% of the organisation’s annual funding must be provided to sporting bodies, ensuring that sport is a key setting for both the promotion of physical activity, as well as for addressing a range of social determinants of health and health equity. A major investment in this space is the State Sporting Association Participation Program (SSAPP), which aims to build the capacity of State Sporting Associations to be more inclusive and welcoming of population groups who are under-represented in terms of player participation, as well as in decision making roles and paid employment. These groups have been identified as women and girls, culturally and linguistically diverse communities, people with disabilities and Aboriginal Victorians. Focusing on action to increase the participation of Aboriginal Victorians, the mechanisms utilised by the SSAPP program to address the social determinants of health and health equity within a sports setting or sporting environment will be briefly described here.

Four sports (Surfing, Canoeing, Rugby League and Rugby Union) have been funded to increase the participation of Aboriginal Victorians in their activities through SSAPP. VicHealth’s investment in strengthening governance and inclusion at the State level will assist the Victorian sport sector to more actively include Aboriginal individuals and communities and in turn, strengthen and broaden the contribution of sport to improving the health and wellbeing of Aboriginal Victorians. In this way, sport’s role broadens from providing an opportunity to be physically active to also providing increased access to the social determinants of health, including social connection, education and employment. Perhaps the clearest way to demonstrate how sport can provide these opportunities is through a case study from Surfing Victoria’s Indigenous Surfing Program.

**Case study: Surfing Victoria’s Indigenous Surfing Program**

Twelve years ago, Surfing Victoria and key partners VicHealth, Play it Safe by the Water (Victorian Government), Sport and Recreation Victoria, Wathaurong Aboriginal Cooperative and the surfing industry, have developed a program which provides opportunities for Aboriginal people living in coastal and inland Victoria to participate in the sport of surfing and much more.
The program began with Surfing Victoria’s Executive Director aiming to provide one young Aboriginal man with a scholarship to undertake the Level 1 Surf Coaching qualification. He could see the potential pathway to employment that the qualification could provide but never imagined that today that young man would be working at Surfing Victoria alongside the Aboriginal Program Manager (another graduate of the Level 1 Surf Coaching course), to deliver a statewide Indigenous Surfing Program which engaged over 1500 community members in the past 12 months.

Members of Aboriginal communities across Victoria participate in the program in a range of ways, with the most obvious being getting on a surf board or in the water through activities such as: learn to surf and water safety programs; life saving carnivals; learn to swim classes and carnivals; satellite surf competitions and; the annual Woorangalook Victorian Koori Titles (statewide surfing carnival).

While surfing is an activity with significant appeal, particularly to young people, getting more people surfing has never been the primary aim of the Indigenous Surfing Program. Surfing Victoria describes surfing as the vehicle for a range of other outcomes including connection within the Aboriginal community and between Aboriginal and non-Aboriginal Victorians, increased levels of confidence in individuals, the development of role models and leadership in the community and, the provision of education and employment opportunities.

Examples of program activities which deliver these of outcomes include provision of: Level 1 Surfing Coaching courses; Surf Rescue qualifications; Resuscitation courses; VicSwim/AusSwim Qualifications; Level 2 Surf Judging Courses and; work experience programs at sport events managed by Surfing Australia such as the Rip Curl Pro. Most recently, VicHealth funding has supported the program to provide 12 month traineeships for young people to work in the surf industry and related aquatic/recreation industries.

The success of the Indigenous Surfing Program to date highlights the potential of community-based sport to address the determinants of health when the contribution of sport to health is seen as being broader than the physical activity benefits. Where sport and the arts are major settings for VicHealth action on a range of determinants, significant investment and investigation is also underway in a range of other important settings, including housing.

Community level campaigns and social movements for the disadvantage and marginalized groups:

ThaiHealth

Promoting community health has been one of the mandates of ThaiHealth since 2001. An important objective of ThaiHealth’s community plan is to support local communities to establish well-being systems managed by communities. Each local community is empowered to decide on its own health

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promotion priorities and to take ownership of implementing the activities to address the selected priorities.

In community level projects, ThaiHealth plays the role of a facilitator by providing basic tools and facilitating local processes. For example it may assist through the provision of a software tool to collect community data, and facilitate the community’s subsequent determination its health priorities. Often when seeing the evidence from the collected data, local communities select among their priorities those that assist their disadvantaged and marginalized people. One such example is the Pak Poon model of local administration in Nakorn Si Thammarat province, which includes a comprehensive plan for promoting health in the community. The Pak Poon model comprises early childhood development programs, support units for disabled children, alternative learning programs for drop-out students, programs oriented to reducing obesity among children and ageing people, and programs to encourage people to live self-sufficiently by having their own gardens. Under the Pak Poon model, among other things, staff capacity to care for elderly people with chronic diseases has been strengthened and the emergency unit improved.

Other ThaiHealth community level projects that aim to address the social determinants of health include the following:

- The Pleasant Tambon Program - Initiated in 336 Tambons and covers 1.7 million people. This is a complex program where each Tambon defines the steps to take towards community strengthening and including often marginalized groups such as people with disabilities, impoverished families, refugees and immigrants.
- Senior Citizen Volunteer Caregivers Program - Volunteers provide care to 6,000 senior citizens across 204 Tambon Administrative Organizations. This initiative provides health benefits to older people where volunteers are assisting them to participate in their local communities.
- The Community Radio Network - ThaiHealth started to support the network in 2005. By 2009 there were 303 stations providing information and offering possible solutions to problems posed by local citizens. The development of local communication networks is an important contribution to addressing the social determinants of health. Many of the community broadcasting stations now broadcast health information.

Summary: comparison of Thai and Australian approaches

<table>
<thead>
<tr>
<th>Comparisons between Thai and Australian community level action</th>
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*The project “Public policy and governance to improve health equity – sharing Australian and Thai expertise” is supported by the Commonwealth through the Australia-Thailand Institute of the Department of Foreign Affairs and Trade.*
The Thai health assembly model is one of the few in the world which provides a formal mechanism for communities and government sectors to participate in policy development at local, regional and national levels. It is defined as ‘a process in which the public and related State agencies exchange their knowledge and cordially learn from each other through an organized systematic forum with public participation, leading to suggestion of healthy public policy or public healthiness.’ The issues discussed at the national health assembly are often developed by a locally-based group of people from across the different sectors (academia, government and NGOs), which then uses the mechanisms of the national assembly to bring an issue for national policy consideration and implementation.

Promoting community health among socially disadvantaged and marginalised communities is the main mandate of Thai and Australia health promotion foundations - ThaiHealth and VicHealth. An important objective of ThaiHealth’s work is to support local communities to establish well-being systems managed by communities. Each local community is supported to decide on its own health promotion priorities and to take ownership of implementing the activities to address the selected priorities. In community level projects, ThaiHealth plays the role of a facilitator by providing basic tools and facilitating local processes. Often when seeing the evidence from the collected data, local communities select among their priorities those that assist their disadvantaged and marginalized people.

Community empowerment is also a major focus of the Victorian Health Promotion Foundation, VicHealth. VicHealth’s work also focuses on the broader conditions in which socially disadvantaged groups grow, live, work and age. The legislation that established VicHealth specifies that 30% of the organisation’s annual funding must be provided to sporting bodies. This has been used in a such a way that sport is a key setting for both the promotion of physical activity, as well as building the capacity of sporting associations to be more inclusive and welcoming of population groups who are under-represented in terms of player participation, as well as in decision making roles and paid employment. In this way, sport’s role broadens from providing an opportunity to be physically active to also providing increased access to the social determinants of health, including social connection, education and employment.

2.4 Research

Research on health equity in Thailand

In Thailand, health equity is one of key policy goals of the Thai government and has been raised by a number of policy statements and legal documents. For example, the Thai Constitution 2550(B.E.)

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Chapter 9 Section 51 & 80, the Statute on National Health System 2008, Chapter 3, Section 16, Patient’s and Human Rights, and government policy on health sector reform.

Thailand has employed evidence from research findings for policy formulation, implementation, monitoring and evaluation for decades. Changes in equity in access to and utilization of health services among different socioeconomic groups, and distribution of government subsidies for health prior to and after implementation of the policy on universal health coverage (UHC) were extensively conducted by IHPP and other research institutes in and outside the Ministry of Public Health. More details on research findings can be found from the following link:

Analyses of MICS data in 2005-2006, the nationally representative household surveys in Thailand including Health and Welfare Surveys (HWS), household Socio-economic Survey (SES) indicate that there were numerous gaps of health risks of population, a huge gap of health risk inequity between gender was observed: higher tobacco and alcohol consumptions were found among men, huge gaps of inequity of traffic injury prevention practices among population in different levels of education: the lower educated people used less helmets and seat belts and had less physical exercise(19). There was a huge gap of using seat belt inequity among population in different economic classes: the poor used less. There was an inequity of alcohol consumption among regions, the northern people drank more than those residing in other regions.

There was a huge gap of family planning service and cervical cancer screening inequity among people in different levels of education, the lower educated women used less, also we observed a huge gap of economic inequity on cervical cancer screening, the poorer women had less screening. There were small gaps in term of urban and rural area for all dimensions. Huge gaps of inequity in alcohol consumption and access piped-water services were observed among four regions, the northern people drank more, and the southern household accessed least piped-water services.

Another research finding on inequity in MCH was generated from the analysis of MICS data 2005-2006(20). IHPP assessed distribution of nine MCH indicator groups using concentration index across the household wealth index. For each MCH indicator, we also compared the richest and poorest quintiles or deciles, urban and rural domiciles, and mothers or caregivers with or without secondary school education. Research findings indicate that child underweight and stunting were least equitably distributed, being disproportionately concentrated among the poor; these were followed by teenage pregnancy, and child pneumonia and diarrhoea. Distribution of the MCH interventions was fairly equitable, but richer women were more likely to receive prenatal care and delivery by a skilled health worker or in a health facility. The most equitably distributed interventions were child immunization and family planning. All undesirable health outcomes were more prevalent among rural residents, although the urban–rural gap in MCH services was small. Where mothers or caregivers had no formal education, all outcome indicators were worse than in the group with the highest level of education. From this investigation, it is concluded that equity of coverage in key MCH services is high throughout Thailand. Inequitable health outcomes are largely due to socioeconomic factors, especially differences in the educational level of mothers or caregivers.

Another significant study on health equity in Thailand after implementation of UHC policy is a study on distribution of government subsidies on health among different socio-economic groups conducted by Supon et al in 2011(21). This study employed benefit incidence analsysis (BIA) with

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equity and Aboriginal health and build capacity to conduct such research. The Southgate Institute operates as a network of multi-disciplinary researchers working in a supportive research environment. Its primary focus is on providing robust evidence on what can be done about the underlying factors that determine the distribution of health and well-being outcomes, with a particular emphasis on labour market, social exclusion, housing, the structure of suburban environments; economic, social and structural determinants of risky and unhealthy behaviours; and social, cultural and economic barriers to health and other related service use. It also focuses on Aboriginal health research. The Southgate Institute’s work provides empirical and translational research that is directly relevant to the practices, policies and reform agenda of the South Australian and Australian health system. A significant part of the Institute’s work is to evaluate government, non-government and other agency interventions and programs which are designed to improve health and health equity and determine to what extent and why they are effective. The Institute’s largest constituent unit, the South Australian Community Health Research Unit (SACHRU) provides the South Australian health system with a dedicated research unit which specialises in program planning and evaluating primary health care and health promotion and on the social determinants of health, as well as training and workforce development. This Unit receives core funding from the SA Department of Health & Ageing. Critical to the Southgate Institute’s work is forging and strengthening collaborative relationships with many partners across universities and government and non-government organisations throughout Australia and internationally.

Health Equity Group, National Centre for Epidemiology and Population Health, The Australian National University: The Health Equity Group (HEG) was established in January 2010, and sits within the National Centre for Epidemiology and Population Health. The group comprises a diverse disciplinary mix, including epidemiology, sociology, psychology & economics. HEG focuses on research aimed at informing public policy such that it contributes to a fairer society and fairer distribution of health, both within Australia and internationally. In pursuit of this, HEG is concerned with policy-relevant research in the social determinants of health in Australia, the Asia-Pacific region and globally. Some of the areas of research expertise include: trade policy and health equity; food policy and diet-related inequities; climate change and health equity; urbanization and health and health systems and health inequalities. HEG members use a mixture of methods to address the deficits in the evidence base including literature synthesis, large-scale cohort study analyses, complex systems qualitative and quantitative modelling, qualitative techniques and policy analysis. HEG is increasingly working closely with other parts of the ANU such as The Crawford School of Public Policy, Menzies Health Policy Centre and the Indigenous Health Interest Group. HEG co-ordinates
Asia Pacific HealthGAEN. HealthGAEN (Global Action for Health Equity Network – www.aphealthgaen.anu) is a follow on global initiative to the WHO Commission on Social Determinants of Health and was co-founded by the Director of HEG. (http://nceph.anu.edu.au/research/groups/health-equity)

Centre for Health Equity Training Research and Evaluation, University of New South Wales: The Centre for Health Equity Training Research and Evaluation (CHETRE) was established in 1998 in collaboration with the Division of Population Health, Sydney South West Area Health Service. CHETRE’s mission is to provide leadership and focus in training, research and evaluation in the area of health equity, with a particular emphasis on the development and evaluation of interventions to reduce health inequities. CHETRE’s work focuses on the description and measurement of health inequalities and health equity, development and evaluation of policies, programs and other actions that aim to achieve health equity, and developing the capacity of the health system to more effectively address health equity through policy and program development. Their work includes projects in the areas of community and primary health care service development, disadvantaged communities and populations, early childhood, Aboriginal health, unemployment, and Health Impact Assessment and Healthy Public policy. CHETRE works closely with the NSW Department of Health, Area Health Services and local government and non-government organizations. (http://notes.med.unsw.edu.au/CPHCEWeb.nsf/page/CHETRE)

Public Health Information and Development Unit, University of Adelaide: The Public Health Information Development Unit (PHIDU), located at The University of Adelaide, was established in 1999 to assist in the development of public health data, data systems and indicators. PHIDU is committed to the development of an integrated health information system in Australia that can provide information on a broad range of health determinants across the life course. A major emphasis is on the development and publication of small area statistics for monitoring inequality in health and wellbeing. They have been producing social health atlases since the late 1980s. Their website includes an interactive site where a range of health equity indicators can be mapped http://www.publichealth.gov.au/interactive-mapping/

McCaughey Centre, VicHealth Centre for the Promotion of Mental Health and Community Wellbeing, University of Melbourne: The McCaughey Centre aims to build knowledge about the social, economic and environmental foundations of community wellbeing and mental health. A defining feature of the

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Centre’s research is a commitment to improving social and health equity and reducing health inequalities. The Centre undertakes research, policy development, teaching, workforce development and knowledge translation with a focus on: Reducing violence; Reducing race-based discrimination; Increasing social participation and inclusion; Strengthening economic participation and security; Addressing the impact of climate change on community wellbeing; Improving intergenerational health and wellbeing; Improving understanding of knowledge translation and exchange. The Centre’s work takes place in a range of key settings and contexts, including in early years services and schools, workplaces, communities and neighbourhoods, public policy and service delivery agencies and in other culturally diverse contexts. The Centre includes The Jack Brockhoff Child Health and Wellbeing Program. This program is dedicated to improving child health and wellbeing through comprehensive, evidence-based health and wellbeing programs delivered in partnership with communities, governments and the service sectors.

(http://www.mccaugheycentre.unimelb.edu.au/about/profile)

Section 3: Opportunities for future collaboration between Thailand and Australia

The “Public policy and governance to improve health equity – sharing Australian and Thai expertise” project enabled the sharing of experiences regarding the latest research and policy initiatives to address health equity in both countries and has highlighted the often innovative policies, programs and tools that are being used in both countries in an attempt to address the determinants of health and improve health equity.

The interaction through the project meeting in Bangkok December 2012 and the collaborative paper development before and since then has strengthened the ties developed between key technical experts and policy leaders in health equity, from both Australia and Thailand, established previously during 2009-2011 through Asia Pacific-HealthGAEN (Global Action for Health Equity Network), a regional network that brings together leading academics, policy-makers and non-government organisations committed to health equity.

The project has also helped expand the network of Australian and Thai colleagues working together in this area, initiating discussions among various researchers from different Thai research institutions through a side meeting held at the Thai National Health Assembly. These discussions will be ongoing, partly through a multi-country research project looking at the social determinants of health activities that have taken place since the WHO Commission on Social Determinants of Health reported in 2008.
Discussions took place in the meeting in Bangkok about the establishment of a formal program of collaborative research and exchange between researchers, senior officials and opinion leaders, forming a bilateral country specific project (think tank) within AP-HealthGAEN. The aim is to conduct research, engage in, debate and advocate policy agendas. It was agreed that if the project is to survive, commitment and equal ownership is indispensable. At the meeting in Bangkok, a technical working group was appointed to draft the proposal for founding the project and elaborating how it could move forward. The working group comprises 4 representatives, two from Australia and the other two from Thailand. Of the two representatives from each country, one is a policy person while the other is from academia.
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References

Appendices

Appendix 1. South Australian Health Lens Projects in Progress as at April, 2012

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Description</th>
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<tbody>
<tr>
<td>Water Sustainability HLA</td>
<td>focused on the potential health impacts associated with increasing use of alternative water sources - rainwater, stormwater and greywater.</td>
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<tr>
<td>Regional Migrant Settlement HLA</td>
<td>examined the interplay between the social, economic and health factors impacting on migrant settlement in three regional areas of South Australia.</td>
</tr>
<tr>
<td>Digital Technology HLA</td>
<td>supported increased use of digital technology amongst low socioeconomic status groups in ways that promote health.</td>
</tr>
<tr>
<td>Transit Orientated Developments HLA</td>
<td>explored the complex links between health and planning, with a particular focus on the potential health impacts (both positive and negative) of more condensed, walkable, sustainable urban development. The project resulted in the “Healthy TOD Principles” designed to guide policy makers and planners.</td>
</tr>
<tr>
<td>Healthy Weight Desktop Analysis</td>
<td>examined opportunities to strengthen healthy weight action by facilitating cross-government collaboration between DHA and other government departments.</td>
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<tr>
<td>Castle Plaza Transit Oriented Development, City of Marion</td>
<td>aimed to improve how urban environments support health and wellbeing at the Castle Plaza site and to test the applicability of the ‘Healthy TODs Principles’ as a guide in a local government development assessment process.</td>
</tr>
<tr>
<td>International Students Health and Wellbeing HLA</td>
<td>identified the health and wellbeing needs of international students, the structures and services available to address these needs, and the barriers to access and opportunities to improve student information &amp; support</td>
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<tr>
<td>Active Transport</td>
<td>undertook a targeted policy review to strengthen economic arguments for investment in cycling and walking infrastructure.</td>
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<tr>
<td>*Aboriginal Road Safety HLA</td>
<td>identified ways of increasing Aboriginal healthy life expectancy by improving road safety through increasing safe mobility options. It examined the impact of the drivers’ licensing system and court diversionary programs on Aboriginal peoples’ ability to obtain and retain their drivers’ licences.</td>
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<tr>
<td>*Parental Engagement in Children’s Literacy HLA</td>
<td>aimed to raise parental engagement with literacy to improve literacy outcomes for children in the early years of schooling, and ultimately improve their health.</td>
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<tr>
<td>*Healthy Sustainable Regional Communities HLA</td>
<td>identified mechanisms and strategies to enable communities in the Upper Spencer Gulf Region of South Australia to capitalise on emerging regional development opportunities in the mining sector and the rollout of the National Broadband Network leading to improved health, sustainability and economic positioning of these communities.</td>
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</table>
**Promoting active ageing through supporting workforce participation** HLA used desk top analysis to consider the determinants of active ageing, with a particular focus on assisting older people in country South Australia to remain in the workforce.

**Learning or earning** HLA aims to improve the successful transition of young people aged 15-24 years of age from education to employment and re-engage young people in learning or earning.

**The South Australian Cycling Strategy** HLA aimed to facilitate engagement and cross government ownership through applying a HiAP approach.

Source: (S)
Appendix 2: Health in All Policies Partnership principles

<table>
<thead>
<tr>
<th><strong>Flexibility and Responsiveness</strong></th>
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<tbody>
<tr>
<td>• Working within the time constraints, policy context and organisational structure of our partners</td>
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<tr>
<td>• Using different methodologies according to organisational needs</td>
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<tr>
<th><strong>Recognition and Mutual Respect</strong></th>
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<tbody>
<tr>
<td>• Working with the existing skills and knowledge within partner organisations</td>
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<tr>
<td>• Sharing recognition for outcomes within partner organisation’s spheres of influence and with state and international audiences</td>
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<tr>
<th><strong>Support and Resources</strong></th>
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<tbody>
<tr>
<td>• Providing knowledge and expertise</td>
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<tr>
<td>• Accessing and brokering expertise</td>
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<tr>
<td>• Assisting in establishing government networks</td>
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<tr>
<td>• Facilitating the HiAP process and equipping organisations with the tools and processes to achieve their aim</td>
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<tr>
<th><strong>Outcome-Focused</strong></th>
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<tr>
<td>• Increasing political support for organisations</td>
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<tr>
<td>• Providing evidence-based solutions</td>
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<tr>
<td>• Documenting the process and outcomes according to organisational needs</td>
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<th><strong>Clarity and Collaboration</strong></th>
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<td>• Ensuring respective roles and responsibilities are clear</td>
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<tr>
<td>• Working on the partnering organisation’s policy agenda</td>
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<tr>
<td>• Modelling consultation and clear communication</td>
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<tr>
<td>• Taking on joint ownership of the work</td>
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<tr>
<td>• Following through on commitments</td>
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</table>
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