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Article

The Health System Equity Action Framework: a review of Australian health equity frameworks and their operationalization of the Ottawa Charter

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Abstract

Four decades after the Ottawa Charter called on health systems to advance equity, health equity frameworks are increasingly used across Australian health systems. However, little is known about how these frameworks conceptualize or operationalize equity within health systems. This scoping review identified 45 national, state, regional, and local health equity frameworks, with 18 analyzed in depth. Documents from health departments, Local Health Districts, Hospital and Health Services, Primary Health Networks, and Aboriginal Community Controlled Health Organisations were examined using structured data extraction and thematic analysis. We found frameworks consistently articulated equity as a fair and just opportunity for health and drew on concepts, such as the social determinants of health and proportionate universalism. Aboriginal and Torres Strait Islander–led frameworks emphasized self-determination, community governance, cultural governance, and accountability mechanisms. While most frameworks established strong principles and policy commitments, they provided limited guidance on implementation and accountability. Frameworks broadly aligned with the Charter's five strategic action areas but engaged less fully with healthy settings, developing personal skills, and contemporary determinants of health. Synthesizing findings across frameworks, we propose the Health System Equity Action Framework, which identifies four modes of health system action and six organizational domains through which equity commitments are operationalized. Equity frameworks play an important role in institutionalizing equity within health systems but often lack mechanisms linking principles to action. The Health System Equity Action Framework provides a conceptual model for translating the Ottawa Charter's commitments into organizational practice four decades after its call to reorient health services towards health equity.

Keywords health equity, frameworks, implementation, Australia, health systems, Ottawa Charter

Contribution to Health Promotion

- This scoping review shows how Australian health systems define and operationalize health equity through equity frameworks.
- It highlights that many equity frameworks outline strong principles but provide limited practical guidance on how to implement equity in practice.
- Aboriginal and Torres Strait Islander–led frameworks emphasize self-determination, community, and cultural leadership along with accountability as key to achieving equity.
- We introduce the Health System Equity Action Framework, a new model setting out four modes of health system action and six organizational domains for operationalizing equity.
- Australian health equity frameworks broadly align with the five Ottawa Charter strategies but show gaps in healthy settings, developing personal skills, and contemporary determinants of health.

Introduction

Health equity is commonly understood as the absence of avoidable and unjust differences in health, such that all people have a fair opportunity to attain their full health potential (Whitehead 1992, p. 433). Achieving health equity requires access to both the conditions necessary for health [the social determinants of health (SDH)] and appropriate health care (Whitehead 1992).

Despite decades of research and policy attention, health inequities persist as a global challenge, reflecting deeply embedded social, economic, and political structures that shape risk and access to resources across the life course (Whitehead 2007, World Health Organisation 2008, Bartley 2017). These gaps are widening in many countries, including Australia, particularly among socially marginalized groups (Gong *et al*. 2025, World Health Organisation 2025). Indigenous peoples, culturally diverse communities, low-income populations, and those in rural and remote areas bear the greatest burden of such inequalities (Gong *et al*. 2025). Australians in the poorest areas die up to 7 years earlier than those in the wealthiest areas and Aboriginal and Torres Strait Islander Australians live about 8 years less than non-Indigenous Australians (Timonin *et al*. 2025). The World Health Organization (WHO) identifies these differences as socially produced and rooted in policy decisions (World Health Organisation 2025). The COVID-19 pandemic brought renewed attention to the scale and consequences of health inequities, exposing and amplifying preexisting social and structural advantages (Bambra *et al*. 2020). Postpandemic recovery has further highlighted the uneven distribution of the determinants of health, reinforcing the need for equity-oriented system reform.

Understanding of the causes of health inequities has evolved considerably over time (Haigh *et al*. 2025). Early scholarship often focused primarily on differences in socioeconomic position and material conditions (Black 1980, Mackenbach 2012). More recent frameworks expand this to recognize the roles of racism, colonialism, gender equity, and intersecting forms of marginalization (Bowleg 2012, Krieger 2014, Devakumar *et al*. 2022). These explanations all highlight how health inequities are caused by the uneven distribution of the SDH (World Health Organisation 2008, Breilh 2021). Addressing health inequities, therefore, requires action not only on the SDH but also on the structural determinants that shape the distribution of power, money, and resources (World Health Organisation 2008, Breilh 2021). While the evidence base for both the drivers of inequity and effective responses is well established, translating this knowledge into meaningful change requires supportive governance arrangements, policy mandates, and institutional mechanisms to guide and sustain action (Cairney 2016, Bambra *et al*. 2025).

Public health systems have an important role in acting on these structural drivers. Health-care access has been identified as one of four proven approaches alongside welfare state expansion, economic equalization, and political incorporation that can reduce health inequities (Bambra *et al*. 2025). How effectively health systems play this role, however, depends on how they are positioned. The Ottawa Charter for Health Promotion marked a shift in how health is understood and advanced (World Health Organization *et al*. 1986). Moving beyond the dominant bio-medical model of health, the Charter created a positive vision of health understood as a product of social, economic, and environmental conditions and orientating public health action toward people's living conditions and health equity (Potvin and Jones 2011). It does this by articulating five key strategies for action: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. The participants in the signing of the Ottawa Charter pledged to "move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors" (World Health Organization *et al*. 1986).

Four decades on, this vision remains highly influential, yet its operationalization within contemporary health systems remains uneven (Potvin and Jones 2011). While the Charter clearly defined the domains of action required to advance health equity, it provided limited guidance on the institutional, governance, and implementation mechanisms needed to operationalize these strategies within health systems. Health systems are still focused on treating the effects of inequity rather than its causes. Recognizing this limitation, more recent WHO guidance emphasizes the need to embed equity across areas such as governance, financing, service design, and intersectoral action (WHO Regional Office for Europe 2019).

Equity frameworks are one mechanism for embedding equity. As a policy tool, they are "techniques of governance that are used to give effect to stated policy objectives" (Howlett 2022, p. 3). They provide a link between policy aspiration and administrative practice, providing guidance, establishing accountability relationships, and ideally driving operational change. Policy literature distinguishes between substantive tools that directly affect service delivery (such as funding, regulations, and workforce requirements) and procedural tools that shape how decisions are made (Bali *et al*. 2021). Equity frameworks function primarily as procedural instruments: defining concepts, establishing principles, and guiding planning processes. However, they can also include substantive features, e.g., through allocating resources. In practice, they vary considerably in their specificity, their implementation mechanisms, and their capacity to drive meaningful institutional transformation.

In Australia, the development of health equity frameworks across national, state, and regional health systems reflects renewed efforts to embed these commitments within governance, service delivery, and intersectoral action. Australia is a federation of six states and two self-governing territories. Publicly funded health services are organized across commonwealth, state and territory, and regional levels: in New South Wales (NSW), public services are delivered through Local Health Districts (LHDs) and specialty networks; in Queensland, through Hospital and Health Services (HHSs); primary care is coordinated regionally through Primary Health Networks (PHNs); and Aboriginal Community Controlled Health Organisations provide community-controlled comprehensive primary health care. In NSW, the Ministry of Health has identified health equity as a focus for all action under the Future Health Strategic Framework, NSW Regional Health Strategic Plan 2022–2032 and the NSW Aboriginal Health Plan 2024–2034 (NSW Ministry of Health 2023, 2024c).

A particularly important dimension of health equity in Australia is the recognition of Aboriginal and Torres Strait Islander self-determination, with increasing acknowledgement that addressing inequities requires not only targeted action but also structural changes to governance and accountability. The NSW Health Aboriginal Governance, shared decision-making, and accountability framework provides an example of

government acknowledging the need for health system and government organization transformation (NSW Ministry of Health 2024b). Its aim is to better enable Aboriginal shared decision-making in partnership with other government and nongovernment stakeholders, in partnership agreements, funding contracts, and joint programs and procedures. Similar commitments exist across other Australian jurisdictions. Queensland Health has mandated health equity strategies through legislative reform, requiring all HHSs to develop, publish, and report on equity strategies (Queensland Health and Queensland Aboriginal and Islander Health Council 2021). This represents a significant shift toward institutionalizing equity within health system governance. However, little is known about how these frameworks conceptualize equity, how they align with the foundational principles of the Ottawa Charter, or how effectively they support implementation and accountability.

This paper addresses this gap through a review of Australian health equity frameworks, examining how health systems are seeking to operationalize equity and identifying the mechanisms through which the Ottawa Charter's vision is being realized within Australian health system governance. Specifically, the review aimed to identify equity frameworks used at state and regional levels by health services and systems and to synthesize their components, conceptual foundations, and implementation approaches (Supplementary Table S1). The research questions were: (i) What equity frameworks are currently being used within Australian health systems? (ii) What are their key components, conceptual foundations, and implementation approaches? and (iii) How do these equity frameworks compare in addressing health inequities, and what insights can they provide for equity framework development? Synthesizing findings from this review, we propose a Health System Equity Action Framework (Fig. 2), which conceptualizes how health systems operationalize equity through four modes of action and six organizational domains and discuss its relationship to Ottawa Charter principles.

Methods

The scoping review was conducted in accordance with the Joanna Briggs Institute methodology (Peters *et al*. 2024) to identify literature current equity frameworks at both state and regional levels in Australia. No ethical approval was required for this study.

Positionality: The authors bring backgrounds in public health, health systems research, and Indigenous governance and share an interest in advancing health equity through policy and systems change. The research team comprised academic researchers, NSW Health policy partners, and Health Eating Active Living (HEAL) Equity Guide Working Group members from multiple NSW LHDs, supporting practice-informed interpretation. The Working Group was co-chaired by two Aboriginal members, and the research was guided and informed by Aboriginal project team members and representatives.

Information sources and search strategy

A Google search of publicly available policy documents and relevant gray literature and organizational reports from PHNs, nongovernmental organizations, and research institutes was conducted. Government reports and policy documents, such as state and federal health equity frameworks, LHD strategic plans, and public health policies that guide equity initiatives, were also considered.

Databases searched included Scopus using the Medical Subject Headings and keywords used as search terms included: "health equit*" OR "health disparit*" OR "health inequalit*" OR "health inequit*" OR ("social determinants" AND health) AND ("framework*" OR "model*" OR "approach*" OR "strateg*") AND ("Australia*" OR "NSW" OR "New South Wales" OR "QLD" OR "Queensland" OR "VIC" OR "Victoria" OR "WA" OR "Western Australia" OR "SA" OR "South Australia" OR "TAS" OR "Tasmania" OR "ACT" OR "Australian Capital Territory" OR "NT" OR "Northern Territory"). In addition, the research team drew on an extensive Zotero database (Corporation for Digital Scholarship 2026) that was developed for informing previous projects containing equity frameworks, tools, and academic literature.

Study selection

Health equity frameworks, policies, and strategies developed in Australia from 2000 to 2025 were included along with documents that explicitly discussed health equity frameworks within the health system. Papers were excluded if they were a non-Australian policy, a public health discussion that did not focus on health system equity, or an equity-focused intervention that was not a framework or policy. After discussion within the project working group and advice from the HEAL Equity Guide Working Group Aboriginal co-leads and researchers, Aboriginal Governance Frameworks were also included. Where a single framework was published across more than one document (e.g. a framework together with an accompanying detailed guide or background paper), these were counted as one framework. Using these inclusion and exclusion criteria, all identified reports were collated and uploaded into Zotero and duplicates removed. Titles and abstracts were then screened for assessment against the inclusion criteria for the review. Potentially relevant sources were retrieved in full. The full text of selected citations was assessed in detail against the inclusion criteria. Any uncertainty that arose at each stage of the selection process was resolved through discussion and consensus with the other authors.

Data extraction

Data were extracted using a tool developed by the review team, informed by the review questions and our previous reviews of health equity literature (Haigh *et al*. 2025). Each framework was analyzed for its definitions of health equity; framework purpose, assumptions, and components; strategic approaches and theoretical foundations; mechanisms for governance, implementation, and accountability; priority actions; stakeholder involvement; resourcing; and monitoring and evaluation mechanisms; and alignment with Ottawa Charter areas of action.

Data analysis

Thematic analysis using NVivo software (QSR International 2023) was used to identify reoccurring themes within the topic areas.

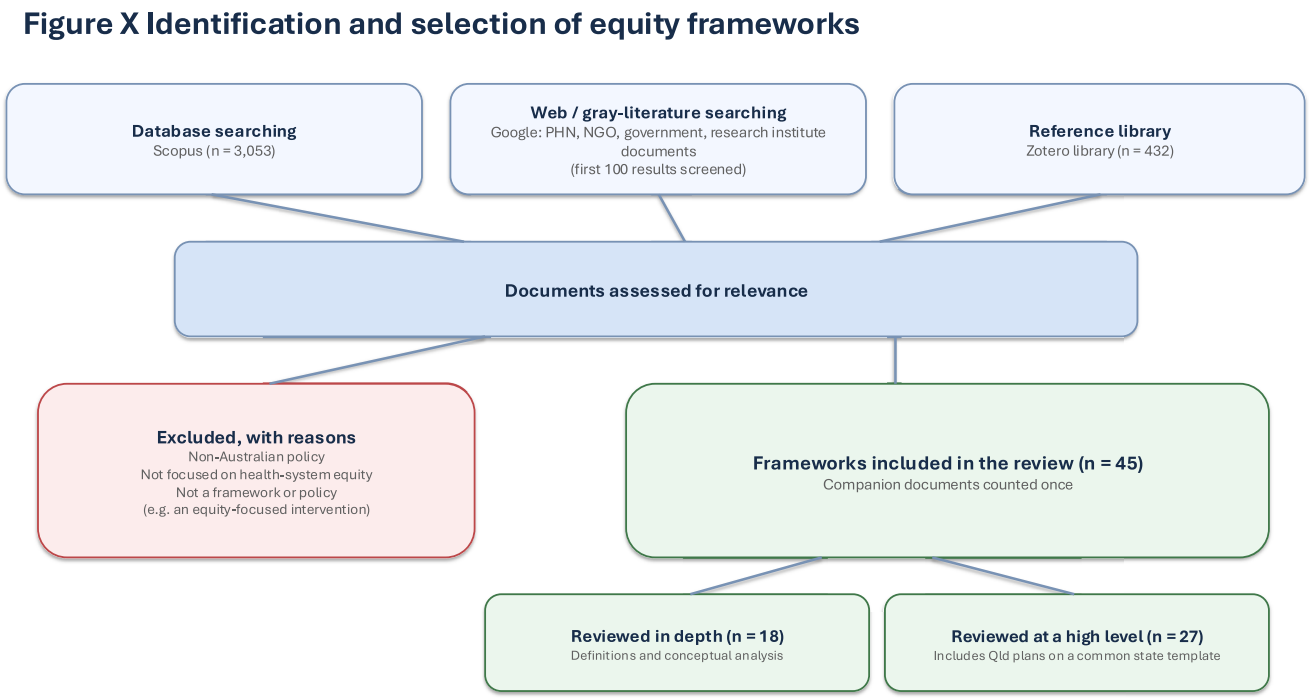

Figure 1 Identification and selection process of equity framework.

The research team summarized main themes across all topic areas and identified features of Aboriginal and Torres Strait Islander Equity and Governance Frameworks.

A separate analysis of Aboriginal and Torres Strait Islander–focused health equity and governance frameworks was carried out by Wendy Jopson, an Aboriginal researcher with experience in Aboriginal health planning and Aboriginal public health research. Analysis of Aboriginal and Torres Strait Islander–focused health equity and governance frameworks was undertaken from a position of Indigenous Standpoint Theory (Rigney 1999).

Rigney's three foundational principles of (i) resistance as an emancipatory imperative, (ii) political integrity, and (iii) privileging Indigenous voices and experiences as authoritative knowledge sources, formed the analysis for the Aboriginal and Torres Strait Islander frameworks.

1. How do the frameworks actively challenge colonial structures and practices that continue to marginalize Aboriginal and Torres Strait Islander peoples and knowledge systems?
2. How are the frameworks accountable to Aboriginal and Torres communities and aligned with their aspirations, priorities, and governance structures?
3. How do the frameworks privilege Aboriginal and Torres Straits Islander voices and experiences as authoritative knowledge sources?
4. How are Aboriginal and Torres Strait Islander Australians lived experience, cultural knowledge, and leadership recognized as legitimate and authoritative sources of knowledge?

Results

Landscape of Australian health equity frameworks

A total of 45 equity frameworks, strategies, and implementation plans were included in the review, and 18 were reviewed in depth (Fig. 1). The equity frameworks reviewed are summarized and numbered in Supplementary Table S1. The decision to review 18 in depth was based on avoiding duplication of content, particularly in Queensland where one state-level framework guides 27 local-level implementation plans that follow the same structure and key performance areas (KPAs). Most equity frameworks ($n = 32/45$) were issued by LHDs or HHSs, with a smaller number ($n = 13/45$) of frameworks were developed by state-level health departments, PHNs, or national organizations such as the National Aboriginal Community Controlled Health Organisation (NACCHO). Most equity frameworks ($n = 40/45$) originated from Queensland and NSW, reflecting jurisdictional activity in health equity planning. In Queensland, the development of multiple HHS-level equity strategies between 2021 and 2024 was driven by recent legislative mandates to strengthen Aboriginal and Torres Strait Islander health equity. In Queensland, there is one state-level equity framework and 27 local-level HHS frameworks with accompanying implementation and evaluation plans that respond to 5 KPAs in the state-level framework. NSW equity frameworks spanned a broader timeframe, from 2004 to 2024, including both early equity initiatives and more recent updates. Equity frameworks from Victoria and Western Australia were fewer in number but contributed perspectives on health promotion

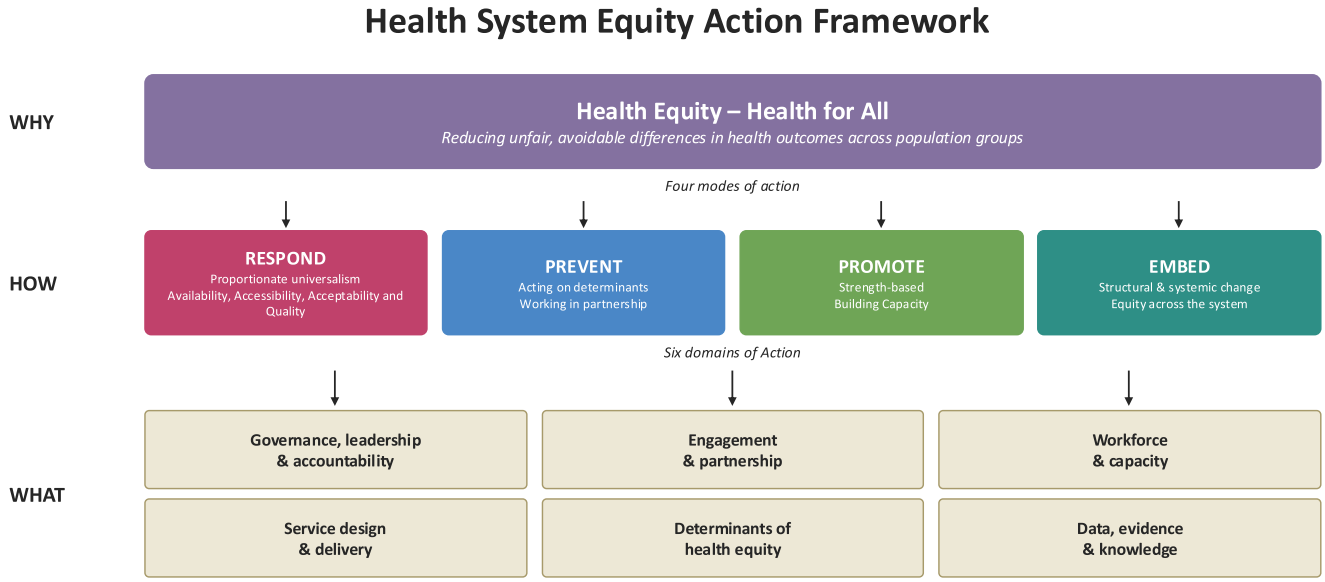

Figure 2 The Health System Equity Action Framework.

and cultural governance. No equity frameworks were found for South Australia, Northern Territory, the Australian Capital Territory, or Tasmania. Notably, 32 of the 45 equity frameworks specifically focused on improving health outcomes for Aboriginal and Torres Strait Islander peoples, the remaining frameworks targeted broader population health equity goals.

In depth review: definitions and conceptual foundations

In the 18 frameworks that were reviewed in-depth, health equity was consistently defined as ensuring everyone has a fair and just opportunity to attain their full health potential (2, 4, 6, 7, 11, 12, 15, 16, 17) encompassing fairness, social justice, and the removal of systemic barriers (2, 4, 5, 6, 7, 8, 9, 10, 14, 16). While a minority ($n = 4/18$) of equity frameworks lacked an explicit definition of equity (1, 3, 13, 18), most described health inequities as avoidable, unfair, and systematic differences in health outcomes or access to care, arising from social, economic, and environmental disadvantages (2, 4, 5, 6, 7, 8, 9, 10, 14, 16). Several equity frameworks, particularly those focused on Aboriginal and Torres Strait Islander health, emphasized the need for culturally safe, community-led approaches to achieve equity (1, 8, 12, 14, 16, 18). Health equity was sometimes distinguished from equality, recognizing that different groups may require different approaches to achieve fair health outcomes (3, 4, 7, 11, 16).

Recent strategies (2020–2024) show a shift toward incorporating concepts, such as intersectionality, anti-racism, and Indigenous governance, while older equity frameworks (2004–2012) tended to focus primarily on social determinants and fairness.

Six main theoretical models underpinned the equity frameworks. SDH was the most frequently cited concept ($n = 16/18$), with frameworks drawing on socio-ecological approaches that emphasize how health is shaped by living conditions such as housing and employment and highlight the need for cross-sectoral partnerships to address upstream causes of inequities (1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17). Proportionate universalism (PU) was referred to in eight frameworks (2, 4, 5, 6, 7, 9, 10, 16). Intersectionality was incorporated in two recent strategies, recognizing how multiple, intersecting forms of marginalization (e.g. Indigeneity, socioeconomic status, and gender) interact to produce distinct patterns of marginalization (9, 16). Life-course approaches were referenced in six frameworks, focusing on critical periods, cumulative advantage and disadvantage, and intergenerational health impacts (1, 5, 6, 9, 10, 14). Aboriginal and Torres Strait Islander–focused frameworks also recognized intergenerational trauma as a driver of health inequity, with Children's Health Queensland acknowledging "ongoing intergenerational trauma and racism" (12) and the WA Country Health Service noting that "Aboriginal experiences of intergenerational disempowerment, dispossession and trauma are largely ignored" (18). Human rights, critical race theory, and anti-racism were explicitly cited in a smaller subset of frameworks, particularly those led by Aboriginal and Torres Strait Islander organizations, to address institutional racism and colonial determinants of health disparities: human rights (1, 4, 8, 11, 14, 16), critical race theory (14), and anti-racism (1, 3, 8, 12, 14, 18).

Priority groups

Equity frameworks consistently identified specific groups for targeted attention, with Aboriginal and Torres Strait Islander peoples as the highest priority group across the review (14/18) then socioeconomic disadvantage (6), CALD/culturally diverse (5), disability (5), refugees/migrants (3), rural/remote (2), lesbian, gay, bisexual or bi+, transgender, people with innate variations of sex characteristics (commonly referred to as intersex), queer, asexual or aromantic, and other sexuality and gender diverse people (LGBTIQ+) (2), and people experiencing mental illness (1). Several equity frameworks also identified priority places and settings, such as geographic areas with higher concentrations of disadvantage, remote communities, and specific institutional settings. Terminology used to describe these populations varied,

reflecting different conceptual approaches, including "priority populations," which implies targeted resource allocation; "vulnerable populations," used more frequently in earlier frameworks; "marginalised communities," emphasizing systemic exclusion; and "communities experiencing inequity," which foregrounds inequitable outcomes rather than inherent group characteristics.

Sources of equity framework authority

Equity frameworks derive legitimacy from multiple, often overlapping sources. Most commonly, legitimacy is established through alignment with policy and legislative priorities, positioning frameworks within broader state, national, and international policy architectures (14/18: 3, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18). Some frameworks further legitimize action by framing equity as core business for health services (rather than an additional or discretionary activity). The community mandate is more variably articulated. Aboriginal and Torres Strait Islander–led equity frameworks consistently ground their authority in community partnership and self-determination, while general frameworks tend to position community engagement as supportive rather than constitutive of authority (1, 8, 12, 14, 18). Ethical and rights-based imperatives, including human rights and Indigenous rights frameworks, are most explicit in Aboriginal and Torres Strait Islander–led frameworks, which ground equity in self-determination and the United Nations Declaration on the Rights of Indigenous Peoples (1, 8, 14). Human rights are also invoked in some general frameworks through a rights-based or right-to-health framing (4, 11, 16).

In addition to these sources of legitimacy, frameworks draw on different sources of authority to drive change. Organizational leadership and governance structures were the most-cited mechanisms, alongside varying forms of community engagement. While many frameworks reference co-design and participation, community involvement is often described in consultative terms, with limited detail on how decision-making power is shared in practice. Three main models of stakeholder involvement were identified: co-design partnerships (10: 1, 3, 8, 10, 11, 12, 13, 14, 16, 18); cross-sectoral collaboration to address social determinants (12: 1, 2, 4, 5, 6, 8, 10, 12, 13, 15, 16, 17); and general consultation and feedback (13: 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 14, 16, 18). Empowerment models that explicitly shifted decision-making authority to communities were less common (6: 1, 8, 12, 15, 16, 18).

Across frameworks, descriptions of stakeholder engagement were often limited, with engagement frequently articulated as a principle rather than an operationalized action, constraining assessment of its influence on priorities or outcomes (2, 3, 4, 5, 6, 7, 10). Five guiding principles frequently underpinned practice: fairness and justice, cultural safety, co-design and community participation, accountability and transparency, and capacity–building implementation. Explicit guiding-principle statements appear in 10 of 18 (2, 3, 4, 5, 6, 7, 10, 12, 13, 14).

Aboriginal and Torres Strait Islander frameworks differ markedly in their articulation of authority and governance. These frameworks explicitly center self-determination through Aboriginal-led governance and formal mechanisms that shift decision-making authority to Aboriginal Community Controlled Organisations.

Co-design is positioned as the core strategy for engagement with Aboriginal and Torres Strait Islander peoples, communities, and organizations by government agencies and is specifically featured in the QLD Aboriginal Health Framework at both state and local levels. Although there is an emphasis on engagement and inclusion into the co-design of public health plans and services, there is little detail on how Aboriginal governance and/or agency in decision-making should or does occur (Working Together with Aboriginal Communities 2021). In March 2026, the Lowitja Institute published an outcomes report from a national roundtable on how co-design processes have been operating in terms of Aboriginal and Torres Strait Islander engagement and decision-making (Lowitja Institute 2026). Key themes reported include the need to change funding models to support Aboriginal Community Controlled Health Organisations to lead co-design and not just be participants and that commissioning organizations such as PHNs and governments often retain tight control over priorities, funding, and decision-making within co-design processes (Lowitja Institute 2026).

Framework components

Our review identified five main components of equity frameworks that embed health equity within organizational structures, processes, and actions.

Conceptual foundations establish what is meant by equity and why it matters, including definitions of health equity, the framework's vision and purpose, strategic drivers and commitments, guiding values and principles, and the program logic or theory of change through which equity will be achieved (Rondinelli *et al*. 2024). Scope delineates roles and responsibilities by clarifying how health services position themselves within the broader health equity landscape, acknowledging that the causes of health inequities extend beyond the health sector while defining collaborative ways of working (Downie *et al*. 2023). Governance and accountability establish oversight and responsibility through designated roles at state and local levels, co-designed equity measures and targets developed with communities, aligned resourcing and funding arrangements, and defined timeframes for implementation, review, and reporting (Lewis and Pettersson Gelander 2009). Priority action areas translate equity commitments into practice through identifying the types of actions that can be taken to address health equity (Corrigan and Adams 2003). Implementation strategies and guidance address the practical "how" of equity work, providing mechanisms for operationalization and impact assessment, including implementation guidance, the use of diverse and disaggregated knowledge sources (research evidence, routinely collected data, lived experience, and Indigenous knowledge systems), and monitoring and evaluation processes to support continuous quality improvement and community accountability (Pereira *et al*. 2022).

Areas of organizational action observed across frameworks

Health systems are recognized as having both a direct role in delivering equitable care and a broader role in addressing the determinants of health equity. Frameworks described multiple

ways in which health systems engage with health equity, including improving equitable access to care, supporting prevention and health promotion initiatives, engaging in cross-sector advocacy and partnerships, and embedding equity within organizational governance and planning processes. A consistent theme across frameworks is the need for health systems to work both inwardly, by addressing institutional practices that may perpetuate inequity, including racism, workforce, and governance structures, and outwardly, through partnerships and advocacy to address broader social determinants.

Across the frameworks reviewed, several recurring organizational areas of action were observed. These included governance and leadership arrangements, community engagement and partnership, workforce capability development, service design and delivery, action on the broader determinants of health, and the use of data, evidence, and knowledge systems.

Governance, leadership, and accountability were frequently referenced as mechanisms for embedding equity within organizational decision-making. For example, frameworks emphasized executive commitment, formal governance structures, resourcing, and the use of performance indicators or reporting mechanisms, although there was limited detail on how responsibility for equity outcomes would be assigned or enforced. Some reflected executive commitment and formal governance structures by embedding equity within organizational planning and decision-making and using performance reporting to track progress [e.g. 2 "Include action on equity in facility performance indicators and senior management performance reviews." (p. 19) and 16 "All activities will be monitored, evaluated, and reported on through a health equity lens." (p. 13)]. Other frameworks emphasized organizational leadership and integration of equity into planning and service delivery, alongside monitoring and evaluation [9 "Leadership and commitment to equity as a strategic priority, embedding it into every process." (p. 10)], and highlighted community governance, workforce responsibility, and culturally informed accountability (18).

What these mechanisms looked like in practice and how responsibility for equity outcomes would be assigned or enforced was rarely specified except for Aboriginal and Torres Strait Islander–led Frameworks [e.g. 12 "It will describe key actions, targets, partnerships, accountability, resourcing requirements, milestones and key performance indicators" (p. 38)]. Engagement and partnership were also widely emphasized. Frameworks commonly described collaboration with communities and other sectors through approaches, such as community participation, co-design processes, partnerships with priority populations and Aboriginal Community Controlled Services, and cross-sector collaboration. However, the degree to which communities were positioned as decision-making partners versus consultation stakeholders varied considerably. Examples from the included frameworks reflect this broader pattern. Some frameworks emphasized partnerships, co-design, and collaboration with Aboriginal and Torres Strait Islander communities, including shared ownership and decision-making, consistent with stronger models of community-led governance [e.g. 12 "includes Mayors and community representatives from Aboriginal and Torres Strait Islander communities" (p. 38) and 14 "The voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples are integral to the co-design, co-ownership and co-implementation of the Health Equity Strategies" (p. 12)]. In contrast, other frameworks described community engagement and co-design processes but positioned communities primarily as consultation stakeholders, with decision-making authority largely retained within health service governance structures [e.g. 10 "Conduct more meaningful community consultation, become better at listening and truly hearing what is said, and directly act upon what service users and communities tell us" (p. 28)].

Workforce development and organizational capacity were typically framed in terms of building staff capability to address inequities. This included increasing workforce diversity, strengthening cultural competency and cultural safety, and supporting organizational learning and development. Examples from the included frameworks explicitly identified developing a culturally safe, skilled, and valued Aboriginal and Torres Strait Islander workforce as a core priority, linking workforce capability to addressing inequities [e.g. 1 "ACCHSs workforce development…Aboriginal and Torres Strait Islander career pathways, lifelong learning" and 18 "A workforce that has strong cultural connections and knowledge." (p. 6)). Similarly, other frameworks emphasized increasing workforce representation, strengthening cultural safety, and embedding cultural competency across services [e.g. 12 "increase in workforce representation of Aboriginal people… across all levels" (p. 13) and 14 "…delivering equitable, culturally safe and clinically effective care that genuinely responds to patient's needs." (p. 7)]. Other frameworks focused more broadly on organizational capability. For example, they highlighted workforce training, cultural competency, and staff capability development as key strategies [e.g. 5 "determine a suite of staff equity capabilities…for each level of the organisation" (p. 18)], while others emphasized workforce diversity across multiple dimensions and organizational capacity [e.g. 11 "Develop and implement equity-focused human resource practices" (p. 13)].

Service design, transformation, and delivery frequently focuse on improving accessibility and responsiveness of services. Strategies included removing structural barriers to care, developing more integrated and community-based models of service delivery, and tailoring services to meet the needs of diverse populations. For example, integrated, population-focused models of care embedded equity across systems and targeted community-level needs [e.g. 6 "…developing integrated planning, service delivery…" (p. 9)]. Other frameworks addressed barriers to accessing services through outreach, telehealth, and improved geographic access, particularly for rural populations [e.g. 16 "Different modes of service delivery are provided e.g. outreach, telehealth, group service provision programs." (p. 17)]. Culturally safe and tailored service delivery was emphasized in several frameworks, including community-led and culturally appropriate services [e.g. 14 "…delivering equitable, culturally safe and clinically effective care that genuinely responds to patient's needs." (p. 7)]. Finally, removing access barriers and tailoring services (e.g. affordability, cultural appropriateness, and location) were also outlined in some frameworks [e.g. 16 "…[health services] must be available, accessible, acceptable, of appropriate quality." (p. 13) and 4 "…ensure that services are accessible, appropriate and treat everyone…" (p. 8)].

Many frameworks also highlighted the importance of addressing the broader determinants of health. This included cross-sector partnerships and policy advocacy related to social determinants, such as housing, education, and employment. However, the scope of these actions varied, with relatively limited attention given to commercial determinants or

environmental drivers of health. For example, some frameworks identified inequities as arising from unequal access to social and economic conditions, including housing, education, and employment [e.g. 2 "…access to the social determinants of health—for example good housing, education, adequate income, social relationships." (p. 6)]. While others emphasized cross-sector and systems approaches to address these determinants, such as investigating outwards and partnering beyond the health system to address social and economic drivers of health [e.g. 7 "Investigating Outwards…in collaboration with our current and future partners and communities." (p. 8)]. In Aboriginal and Torres Strait Islander–focused frameworks, inequities were more explicitly linked to structural and historical drivers, including colonization, systemic racism, and socioeconomic disadvantage, alongside social determinants [e.g. 12 "We will dismantle structures, policies and processes that disadvantage Aboriginal and Torres Strait Islander peoples and develop mechanisms to resolve systemic and interpersonal racism." (p. 27) and 14 "We must consider the context of colonisation and former policies and practices that resulted in enduring intergenerational trauma" (p. 17)]. In contrast, few non-Indigenous frameworks explicitly acknowledge historical power imbalances or the role of colonization, tending instead to adopt ahistorical framings of inequities.

Finally, data, evidence, and knowledge systems were frequently identified as supporting equity-oriented action. Frameworks often emphasized the use of disaggregated data, research evidence, lived experience, and Indigenous knowledge systems to inform planning, monitoring, and evaluation. Frameworks commonly highlighted the use of data, evidence, and knowledge systems to support equity action, including monitoring through indicators, audits, and impact assessments, alongside the use of disaggregated epidemiological data [e.g. 5 "Develop an Equity audit tool for services." (p. 19)]. Many also emphasized diverse knowledge sources, including lived experience, community input, and Indigenous knowledge systems to inform planning and evaluation [e.g. 14 "…the voices, lived experiences and cultural [authority] of Aboriginal and Torres Strait Islander peoples…" (p. 31)].

Aboriginal and Torres Strait Islander–focused and –led frameworks

Overall, Aboriginal and Torres Strait Islander–focused frameworks adopt an expanded and applied conceptualization of health equity that explicitly addresses the social, historical, economic, and cultural determinants of health. These frameworks consistently embed principles such as self-determination, community governance, cultural governance, community control, and culturally safe care directly into service delivery, governance, workforce development, and funding models. Strengthening the Aboriginal and Torres Strait Islander health workforce and establishing sustained, place-based partnerships are core implementation strategies, underpinned by comprehensive primary health care and Aboriginal models of well-being.

The NACCHO approach operationalizes equity through comprehensive primary health care, articulated in its Core Services and Outcomes Framework, which integrates governance, community empowerment, clinical care, and partnerships to advance self-determination and structural change (1). At the state level, the Western Australian Cultural Governance Framework and the Queensland Aboriginal Health Equity Framework extend these principles system-wide (14, 18). Notably, the Queensland framework legislates accountability, requiring all HHSs to co-design, implement, and report on locally tailored Health Equity Strategies with Aboriginal and Torres Strait Islander peoples, supported by defined performance areas, indicators, and governance arrangements (Anti-Discrimination Act 1991 1991, Hospital and Health Boards Act 2011 2012, Queensland Health and Queensland Aboriginal and Islander Health Council 2021).

Discussion

This review provides the first comprehensive analysis of health equity frameworks across Australian health systems. The findings show that while frameworks consistently articulate strong normative commitments, including principles of fairness, partnership, and cultural safety and establish conceptual frameworks, such as definitions, theories, and principles, they vary considerably in how these commitments are translated into operational structures, governance arrangements, and implementation mechanisms. Four decades after the Charter called for reorienting health services toward health promotion and equity, these frameworks suggest that Australian health systems have made substantial progress in establishing equity as a policy priority, yet significant challenges remain in embedding Charter principles into routine organizational practice. As a result, frameworks often function as guiding policy statements with limited links to action. This pattern reflects broader policy and implementation literature, which shows that equity-oriented reforms frequently stall at operationalization despite clear policy intent (McLoughlin *et al*. 2024).

This review has several limitations. Our analysis was based on the content of frameworks as published; we did not assess how, or whether, these frameworks have been implemented, or what impact they have had in practice. We searched publicly available documents and gray literature, supplemented by an existing reference database, so frameworks that are internal, in draft, or not publicly available may not have been captured, while 45 frameworks were identified, a smaller number were analyzed in depth, and Queensland local plans were grouped because they follow a common state–led template; the analysis of definitions and conceptual approaches focuses on this in-depth subset. All documents were Australian and many focused on Aboriginal and Torres Strait Islander populations, so the findings may have limited application to other countries particularly low- and middle-income settings. However, two features support wider transferability. First, the prominence of Aboriginal and Torres Strait Islander–led frameworks, which center self-determination, community governance and cultural safety, may make these findings particularly relevant to other countries with Indigenous populations and histories of colonization. Second, the Health System Equity Action Framework we propose is general and consistent with the broader health equity literature, so it is likely to be useful and adaptable beyond the Australian setting, particularly in countries with publicly funded health systems.

Synthesizing findings across the reviewed equity frameworks, we propose the Health System Equity Action Framework, which

conceptualizes how health systems operationalize two complementary dimensions of equity action identified in the analysis: the roles health systems play in advancing equity (Fig. 2) and the organizational domains through which equity commitments are translated into practice.

Conceptualizing the role of health systems in advancing equity

The first dimension of the Health System Equity Action Framework identifies four modes through which health systems act on equity: responding to inequities, preventing inequities, promoting equity, and embedding equity within systems. These capture the different ways in which health systems engage with health equity through both direct service delivery and broader system reform.

First, health systems respond to inequities by ensuring equitable access to appropriate and culturally safe health-care services. This includes identifying underserved populations, removing barriers to care, and adapting services to meet diverse needs. These approaches frequently draw on PU, combining universal programs with targeted support for communities experiencing greater disadvantage.

Second, health systems prevent inequities through preventive and health promotion strategies that address differential risk exposure and early intervention. Prevention also involves partnering with other sectors and communities to address the uneven distribution of the SDH.

Third, health systems promote health equity through advocacy, cross-sector partnerships, and policy engagement that address the broader SDH. In this role, health systems extend beyond service delivery to influence structural drivers and resources for health, such as housing, education, and employment. This work draws on strength-based approaches that recognize and build on the knowledge, assets, and resilience within communities, including Aboriginal and Torres Strait Islander leadership and self-determination.

Finally, health systems embed equity within organizational governance, planning, workforce practices, and decision-making processes. Embedding equity involves institutionalizing equity principles within policy frameworks, resource allocation, monitoring systems, and accountability structures.

Together these four modes of action form a typology of health system roles in advancing health equity, highlighting that equity-oriented health system must act simultaneously across service delivery, prevention, advocacy, and internal organizational reform.

Operationalizing equity: organizational domains of action

The second dimension of the Health System Equity Action Framework describes the organizational domains through which equity action is operationalized. While the four modes of action describe the role of health systems, frameworks operationalize these commitments through a set of action domains. Across the frameworks reviewed, six domains of action were consistently identified. These domains are governance, leadership and accountability; engagement and partnership; workforce development and organizational capacity; service design and delivery; action on the determinants of health equity; and strengthening data, evidence, and knowledge systems. Each domain represents a distinct set of organizational activities required to translate equity principles into practice.

Governance and leadership establish institutional responsibility for equity outcomes through leadership structures, reporting arrangements, and accountability mechanisms. Engagement and partnership shape how health systems collaborate with communities and other sectors. Workforce development builds the skills and diversity required for equity-focused practice. Service design and delivery address barriers within health-care systems. Action on the determinants of health equity expands health system influence beyond health-care services. Data, evidence, and knowledge systems support monitoring, learning, and accountability using disaggregated data, research evidence, lived experience, and Indigenous knowledge systems. Together these six domains form an implementation framework describing how equity frameworks are translated into organizational practice.

Although frameworks generally offered limited operational detail, a minority specified concrete tools for embedding equity in practice, most notably equity-focused impact assessment. South Eastern Sydney LHD commits planners to complete an Equity Impact Assessment (including Rapid EFHIA) on draft plans (10), the NSW and Nepean Blue Mountains frameworks use health impact assessment to appraise the equity effects of new initiatives (6, 7), and others apply equity-lens checklists, audit tools, or dedicated toolkits across planning and governance (5, 9, 14).

Governance challenges and implementation gaps

From a public administration perspective, equity frameworks function as instruments intended to embed and operationalize normative commitments within institutional structures. The review highlights several implementation challenges common across Australian frameworks. Our review found that most frameworks succeed in establishing principles but provide limited direction on operationalization. Accountability emerged as an important gap across the reviewed frameworks. Many lacked specifics of responsibility for equity outcomes, including who is accountable, to whom, and through what mechanisms. Few articulated how progress would be monitored or assessed over time. Aboriginal and Torres Strait Islander–led frameworks were a notable exception, more often specifying accountability through co-designed measures, co-governance, and reporting arrangements. Similarly, while frameworks frequently emphasized the importance of partnerships and community engagement, they offered limited practical guidance on partnership models and co-governance arrangements.

These findings reflect broader insights from policy and public administration literature, which highlight the difficulty of translating normative policy commitments into operational systems within complex organizations (Greenhalgh *et al*. 2004, Grayson 2007). Equity frameworks function primarily as procedural policy

tools: they shape decision-making processes, define priorities, and establish governance expectations. However, without accompanying mechanisms for implementation, their capacity to drive organizational change may remain limited.

Another issue relates to how frameworks identify and prioritize populations experiencing inequities. Most frameworks identified priority populations, commonly Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and people experiencing socioeconomic disadvantage, yet the rationale for these selections was rarely articulated. Intersectional analysis was largely absent, with few frameworks acknowledging how multiple social positions and structural determinants interact to shape health opportunities and outcomes. While identifying populations experiencing poorer health outcomes can help direct attention and resources, a focus on population groups alone risks obscuring the structural processes that produce inequities in the first place.

Intersectionality theory highlights that health inequities are rarely generated by a single determinant or social position. Rather, they emerge through the interaction of multiple systems of power and oppression, including racism, colonization, sexism, ableism, and socioeconomic exclusion (Crenshaw 1989, Bowleg 2012). The predominance of single-axis approaches, therefore, has important implications. Categorizing populations into discrete groups may overlook the experiences of people located at the intersections of multiple forms of marginalization, such as Aboriginal women with disability or LGBTQ+ people from culturally diverse backgrounds. Priority population approaches may also unintentionally reify categories such as "Aboriginal," "CALD," or "low SES," treating them as homogenous groups rather than recognizing the diversity of experiences within them and the structural conditions that shape those experiences. In addition, emerging or less visible inequities may be overlooked when they do not align with established priority population categories. Together, these limitations limit the capacity of frameworks to inform responses that address the intersecting and structural drivers of health inequities. Incorporating an intersectional lens would strengthen equity frameworks by shifting attention from who experiences inequities to how inequities are produced, enabling responses that address both intersecting forms of marginalization and the structural conditions that shape health outcomes.

The analysis also highlights variation in how frameworks derive institutional authority. Many frameworks draw legitimacy from alignment with broader policy agendas or legislative alignment positioning equity as a core business responsibility and response to ethical and/or human rights imperatives. Aboriginal and Torres Strait Islander frameworks notably establish legitimacy through an explicit commitment to self-determination and Aboriginal-led governance. The Queensland approach represented a distinctive model of "mandated framework governance" with legislative requirements driving framework development across all HHSs with standardized KPAs. This contrasts with more organic framework development in other states. The reform of state government legislation in Queensland was the 2017 landmark Human Rights Commission Health Equity Report which detailed institutional barriers to health equity for Aboriginal and Torres Strait Islander peoples in Queensland's public HHSs provided a measurement of institutional racism within the health system (Marrie 2017, Toombs *et al*. 2023). In 2021, amendments to Queensland's Hospital and Health Boards Act 2011 mandated First Nations membership on each Hospital and Health Board and required HHSs to co-design, co-deliver, and co-monitor health equity strategies with First Nations communities, with key performance measures agreed upon with the Chief First Nations Health Officer. Statutory obligations include equitable access to care, culturally safe and responsive services, action on the social, cultural and economic determinants of health, proportionate First Nations workforce representation, and active elimination of racial discrimination and institutional racism (Queensland Government 2012). To operationalize and respond to the legislative requirements, all 16 HHSs across Queensland co-designed and released 3-year strategies and implementation plans.

Equity frameworks function as instruments designed to embed normative commitments within institutional structures. Their effectiveness depends on how successfully they navigate several tensions. One concerns the balance between principles and operationalization. Frameworks must articulate guiding principles while also specifying operational requirements capable of shaping organizational behavior. The review suggests that many frameworks succeed in establishing principles but provide limited guidance on how these should be translated into practice. A second tension concerns incremental reform approaches that work within existing structures and transformative approaches that aim to reconfigure those structures (Smith 2013). Most frameworks in our review adopted reformist orientations, improving service delivery and enhancing access, rather than challenging the structural conditions that produce inequities.

Recommendations for policy and research

Strengthening the operational impact of equity frameworks requires greater attention to the organizational domains identified in the Health System Equity Action Framework. Policymakers should prioritize clearer governance arrangements and accountability mechanisms that specify responsibility for equity outcomes and establish processes for monitoring progress. Embedding equity expectations within performance systems, funding arrangements, or legislative mandates may help strengthen institutional uptake.

Future research should examine how equity frameworks are implemented and governed in practice, particularly at organizational and regional levels. Comparative and longitudinal studies could assess whether frameworks lead to sustained changes in governance arrangements, service delivery, and health outcomes. Further work is also needed to develop practical approaches for integrating intersectionality into health system planning and evaluation.

Future equity frameworks should function as governance instruments that establish the mandate and authority for equity action across health systems. Their role is not necessarily to specify all operational details but to set the parameters within which implementation mechanisms can be developed and enforced.

With the Australian government current emphasis and directives to utilize co-design as a methodology for Aboriginal and Torres Strait Islander engagement and emerging concerns regarding levels of Aboriginal agency in decision-making, there is a need for further research to examine Aboriginal and Torres

Strait Islander perspectives and experiences of how Aboriginal agency and self-determination are operating in co-design initiatives (Lowitja Institute 2026).

Ottawa Charter

When interpreted through the lens of the Ottawa Charter, the findings demonstrate that Australian health equity frameworks broadly align with the Charter's core strategies for health promotion. Governance, leadership, and accountability arrangements embedded in equity frameworks demonstrate embedding equity within organizational decision-making and planning processes. Frameworks consistently emphasized action on the SDH, cross-sector collaboration, and community engagement, reflecting commitments to building healthy public policy, creating supportive environments, and strengthening community action. But provide less guidance on how health systems should engage with sectors beyond health care to address housing, education, employment, and other structural determinants. The Charter recognized that health is created in the everyday settings where people live, learn, work, play, and love and called for transformative action across these settings, not only within health services (World Health Organization *et al*. 1986). Reference to healthy settings, including schools, workplaces, and neighborhoods as sites for health promotion, was limited in the reviewed frameworks, which focus primarily on health service settings. This service provision–focused orientation may reflect the institutional location of most frameworks within health departments and health services, whose mandate centers on health-care delivery. Frameworks consistently address service design and delivery, emphasizing accessibility, cultural safety, and responsiveness to diverse population needs, aligning with the Charter's call to reorient health services. While workforce development features as a domain of action (addressing staff skills, organizational capacity, and diversity), frameworks pay less attention to developing personal skills and strengthening the health capabilities of communities and populations.

Health equity frameworks also provide links to the Charter's foundations of action—advocate, enable, and mediate. Frameworks are strongest in their enabling function, establishing structures and guidance that support equity-focused practice within health services. Frameworks define concepts, identify priority populations, and provide tools for planning and assessment. The frameworks reviewed are predominantly inward-facing, addressing how health services can improve their own practices, but they do also identify cross-sector advocacy and partnerships as areas of action, reflecting the need for health systems to work both inwardly and outwardly (advocate and mediate).

We found limited engagement of Australian equity frameworks with contemporary determinants of health that have emerged since the Ottawa Charter was adopted, such as commercial determinants of health, digital determinants of health, and cultural determinants of health (Haigh *et al*. 2025). The commercial determinants, the private sector activities and practices that influence population health, were largely absent, named in only one framework and there only in a glossary rather than in the body of the strategy (8). The digital determinants were similarly underdeveloped. Where digital technologies were mentioned, they were generally framed as a mode of service delivery, such as telehealth, rather than as a determinant of health, although one framework identified digital literacy as a barrier to access (9). In contrast, the cultural determinants of health were well developed in the Aboriginal and Torres Strait Islander–led frameworks, which positioned culture, cultural identity, connection, and cultural safety as determinants of health. Making Tracks Together calls for "embedding the cultural determinants approach into public health policy" (14), and the Children's Health Queensland strategy describes the social and cultural determinants as including cultural identity, family, and participation in cultural activities (12). This reflects long-standing recognition within Aboriginal and Torres Strait Islander health that culture is a determinant of health and well-being. These gaps suggest that Australian health equity frameworks may require updating to address the evolving determinants landscape and to align with the Charter's foundational commitment to creating supportive environments. The recent Geneva Charter for Wellbeing (World Health Organisation 2021) provides an extension of Ottawa Charter principles, emphasizing that a "wellbeing society" can only be achieved through meaningful engagement of people, communities, sectors, and government at all levels (Lin *et al*. 2022). This framing reinforces the need for equity frameworks to move beyond health service delivery toward broader transformation.

Table 1 Mapping the Ottawa Charter to the Health System Equity Action Framework.

Ottawa Charter strategy	Health system mode of action	Organizational domains of implementation
Build healthy public policy	Respond, promote, embed	Governance and accountability; action on the determinants of health; data, evidence, and knowledge systems
Create supportive environments	Prevent, promote	Action on the determinants of health; engagement and partnership; service design and delivery
Strengthen community action	Promote	Engagement and partnership; governance and accountability
Develop personal skills	Respond, prevent	Workforce capability; service design and delivery
Reorient health services	Embed	Governance and accountability; service design and delivery; workforce capability

Table 1 maps the five Ottawa Charter strategies for health promotion to the four modes of health system action and six organizational domains identified in this review.

Conclusion

Forty years after the Charter, Australian health equity frameworks show that its vision is being partially operationalized but

remain uneven in reorienting health services toward health promotion and equity. Synthesizing findings across the analysis of Australian health equity frameworks, this study identifies four modes of health system action for advancing health equity and six organizational domains through which equity frameworks operationalize action. The Health System Equity Action Framework provides a conceptual model for understanding how health systems operationalize equity through both organizational structures and modes of action.

For frameworks to drive meaningful institutional change, they require clearer accountability mechanisms, explicit implementation pathways, and collaborative governance. Aboriginal and Torres Strait Islander–led frameworks offer a model for how this can be achieved, demonstrating that equity gains are more likely when authority, decision-making, and accountability are formally shared with communities experiencing inequities.

Ultimately, the effectiveness of equity frameworks depends on the political mandate, resourcing, institutional commitment, and accountability mechanisms that accompany them. Without these conditions, frameworks risk functioning as symbolic commitments rather than drivers of structural change.

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Author contributions

Fiona Haigh (Conceptualization, Investigation, Methodology, Visualisation, Supervision, Project administration, Writing—original draft, Writing—review & editing), Nouhad El-Haddad (Investigation, Writing—original draft, Writing—review & editing), Margo Barr (Funding acquisition, Supervision, Writing—review & editing), and Wendy Jopson (Investigation, Methodology, Writing—original draft, Writing—review & editing)

Supplementary material

Supplementary material is available at *Health Promotion International* online.

Conflicts of interest

The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

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Data availability

The data supporting this study are derived from published sources, all of which are cited in the reference list. No new data were generated in this study.

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