



Public Health
England



Local wellbeing, local growth

Background information about Health and Health equity in All Policies

Version 1.0/ October 2016

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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The Local Government Association (LGA) is a politically led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government.

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Published October 2016

PHE publications gateway number: 2016372



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Introduction

We know that health, wellbeing and health inequalities (and associated behavioural risk factors) are largely determined by living conditions and wider social, economic, environmental, cultural and political factors. These in turn are controlled by policies and actions outside the health sector.^{1, 2} Many of our most pressing 21st century challenges are ‘wicked’ problems that involve multiple interacting causal factors, lack a clear linear solution and are not the responsibility of any single government department or organisation. Effective solutions to such challenging and entrenched problems require a new policy paradigm that connects disparate silos, exposes conflicts – and prioritises synergies and co-benefits across diverse policy areas. This creates incentives for an inter-sectoral and cross-government Health- and Health Equity-in-All-Policies (H&HEiAP) approach.

At the international level, there has been growing interest in H&HEiAP (see Appendix A). Rooted in the emergence of new approaches to public health, key points in its development include:

- the 1986 Ottawa Charter for Health Promotion,³ which advocated the importance of building healthy public policy
- the 2006 Finnish presidency of the European Union, which prioritised a Health in All Policies (HiAP) approach
- the 2012 publication of Health 2020, the European Policy Framework for Health and Wellbeing,⁴ which emphasises the value of Health in All Policies (HiAP)
- the 8th Global Health Promotion Conference on Health Promotion, which produced as key outputs the Helsinki Statement on HiAP⁵ and the HiAP Framework for Country Action.⁶

At the national level, Public Health England (PHE) has seven priorities: obesity, smoking, alcohol, dementia, every child getting a good start in life, antimicrobial resistance and tuberculosis. These represent complex challenges. To address them effectively demands policy and action across the whole of government and the whole of society. Furthermore, it is apparent that many more issues not primarily labelled ‘health’ (eg climate change, transport, housing, planning, poverty) have important health components and/or consequences. They also rely on joined-up government if they are to be meaningfully addressed in ways that maximise positive and minimise negative impacts. The white paper ‘Healthy Lives, Healthy People’⁷ set out that the government’s intention for PHE to “harness the efforts of the whole of government...to improve the public’s health.” More recently, Due North⁸ suggests that PHE has “a specific role in leading change and advocating for health inequalities to be addressed in all policies.”

At the local level, the transition of public health to local government has been widely heralded as an opportunity to reduce health inequalities by addressing the wider social determinants of health that are influenced by a range of local authority policies and services^{9, 10} As profiled in a recent King's Fund publication¹¹, there are already excellent examples of HiAP approaches being implemented by local authorities as a means of extending influence and harnessing the potential contribution of public health across the whole of the council (or councils). Likewise, it is acknowledged that effective commissioning for health, wellbeing and health equity must harness action across multiple policy domains.¹²

Whilst HiAP includes a focus on health equity, it is widely recognised that there has been limited success in incorporating this in a way that is meaningful and more than an add-on, as discussed in the final report of the EU-funded Equity Action project.¹³ The Commission on Social Determinants of Health¹⁴ and subsequent reviews undertaken by the Marmot Team have sought to make this focus more explicit through emphasising the importance of health equity in all policies (HEiAP) – including an inter-generational focus on how policies can impact into the future.

In summary, an H&HEiAP approach can help PHE achieve its mission and remit effectively through both national-level activity and support to local authorities and the wider public health delivery system. This background paper:

- provides an overview of the approach
- outlines how it has been rolled out in other countries, and
- summarises implementation models

About Health in All Policies

What is a Health in All Policies approach?

Health in All Policies (HiAP) has been defined as “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.”¹⁵

The rationale for the approach

The rationale for the approach lies in an appreciation of what has become known as the ‘social determinants of health’: health and health inequalities are largely the result of the circumstances and conditions of daily life, which are influenced by multiple factors, not least policies and services which are the responsibility of a range of central and local government departments.¹⁶

Interest in the approach has been driven by an appreciation that many priority issues are “multi-factorial with many interdependencies, difficult to fully define, lacking a clear solution, and not the responsibility of any single organisation or government department.”¹⁷

Explaining the approach

Founded on health-related rights and obligations, the approach seeks to improve accountability for the health and health-related effects of policy-making. At the same time, there is an appreciation that governments at all levels have a range of priorities and that health is not always a core objective. Furthermore, the approach understands health to be a major societal goal of governments and a cornerstone of sustainable development. It also acknowledges that government policy is not created in a vacuum and that policymakers are often challenged by the interests of powerful economic and market forces – these may be antithetical to ‘healthy’ policy and resistant to its possible regulatory effects.

A Health in All Policies approach thus seeks to provide a framework to manage competing and conflicting interests transparently, supporting all sectors to find ‘win-win’ solutions and to contribute positively to health and wellbeing outcomes.

HiAP includes within its definition a focus on health equity. However, there is an appreciation within the field that more needs to be done to ensure that equity is central to the approach and its implementation, as highlighted by the Marmot

reviews. The lack of success in incorporating health equity into HiAP and health impact assessment points to the need for pragmatic ways forward. Suggested mechanisms include:¹⁸ improved information and research and data collection; promotion and capacity building to strengthen health equity within health impact assessments; involving people living in poverty and experiencing inequalities within the HiAP process; and improving political understanding of the context of health inequalities and the distribution of the social determinants of health in society.

A whole-of-government and whole-of-society focus

The language of HiAP is increasingly used alongside a focus on governance^{19 20} and whole-of-government and whole-of-society approaches.^{21, 22} It is argued that the effective delivery of the HiAP approach (and, indeed, a consideration of other key challenges in all policies – such as sustainability) requires new approaches to governance that facilitate joined-up and synergistic approaches to policymaking and implementation.

A whole-of-government approach combines multi-level (local to global) government actions; prioritises building trust and new skills; and emphasises the need for improved coordination and integration, focused on overarching societal goals.

A whole-of-society approach is a form of collaborative governance that complements public policy, engaging civil society, communities, individual citizens and the private sector. However, in engaging with the commercial determinants of health, it is crucial to appreciate the vested interests referred to above. In the words of the director general of WHO:²³ “Efforts to prevent non-communicable diseases go against the business interests of powerful economic operators ... It is not just big tobacco anymore. Public health must also contend with big food, big soda and big alcohol. All of these industries fear regulation, and protect themselves by using the same tactics... Market power readily translates into political power. Few governments prioritise health over big business.”

The emergence and spread of Health in All Policies

The Health, and Health Equity in All Policies approach has gained ground over recent years. In addition to trans-national developments, it is valuable to consider how it has been implemented by different countries. A review published in 2011^{24, 25} and accompanied by a set of case studies identified whole-of-government Health in All Policies (HiAP) approaches in 16 countries and states: Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales. A further review summarised HiAP and health impact assessment activity in a number of countries²⁶ and at the sub-national state level.

Finland

Finland's commitment to HiAP reflects its long history of horizontal health policy. The roots of the Finnish HiAP approach can be traced back to 1972 when the Economic Council of Finland recognised the need for comprehensive health policy and set sector-specific health objectives outside the health sector. Over time, the health sector gradually increased its cooperation with other sectors and government departments – and other sectors increasingly took the health and the wellbeing of citizens into account in their policies.²⁷ Building on this experience, Finland used its EU presidency to advocate for a focus on HiAP, which led naturally to this approach being centre-stage at the 2013 Global Conference on Health Promotion, held in Helsinki.

Ireland

Ireland's Framework for Improved Health and Wellbeing²⁸ recognises that improved health status relies on actions and developments beyond the health sector. It also highlights the importance of whole-of-government and whole-of-society approaches that address the broader societal determinants of health and health inequalities such as education, employment, housing, transport and the environment. Likewise, it emphasises that the H&HEiAP approach needs to be supported by tools and mechanisms to manage complex policy processes – including cabinet committees, interdepartmental groups and health impact assessments.

Norway

The Ministry of Health in Norway plays a central role in coordinating and supporting HiAP. There is a whole-of-government challenge and commitment to a society in which there is equal opportunity for a healthy life for every individual.²⁹

Sweden

In Sweden, HiAP is understood to be a national priority. It is operationalised by the National Public Health Institute having a small critical mass of staff who are proficient in HiAP, and who work with other sectors to make things happen.³⁰

Wales

Closer to home, Wales is committed to progressing a HiAP approach as a central plank of its Future Generations Bill. The Welsh government's recently published Public Health white paper³¹ emphasises that the elimination and prevention of health inequalities can only be achieved when linked to the underlying inequalities of income, wealth and power across society. It argues that the fundamental causes of poor health, and its unequal distribution across different parts of Wales, lie outside the health service.

South Australia

Catalysed by Ilona Kickbusch's 2007 appointment as its Government's 'Thinker in Residence', South Australia has prioritised the HiAP approach as a means of supporting delivery of its cross-government strategic plan (as explored in more detail below).³² Initial evaluation findings³³ suggest that the HiAP approach has been successful in developing robust processes to enable action on the wider determinants of health and has effectively navigated a complex and fast changing policy environment.

California

California has invested strongly in the HiAP approach. Its HiAP Task Force came about because a number of the State's leaders across multiple agencies had a common interest in climate change, health, and childhood obesity. At the same time, a governor's executive order provided high-level support and accountability, created a structure and provided a clear focus. Drawing on this experience, the Department of Public Health collaborated with the American Public Health Association and Centers for Disease Control to produce a 'Guide for State and Local Governments'.³⁴

Implementation models

In moving from concept to implementation of a Health in All Policies (HiAP) approach, much emphasis in the literature has been placed on health impact assessment – defined as a “combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.”³⁵ Whilst this can help maximise positive impacts and minimise negative impacts, concerns have been raised about its limits and pitfalls as a means to enhance recognition of societal determinants of health.^{36, 37}

It is also clear that effective implementation requires a broader perspective and active engagement with different dimensions of the policy process. This was made clear in an EU-funded review of evidence identifying opportunities for and barriers to the implementation of a HiAP,³⁸ which identified seven key themes: leadership, governance and strategy, ‘Partnership and Stakeholder Engagement’, ‘Capacity and Technical Skills’, ‘Health Equity’, tactics and culture and values.

WHO HiAP: Framework for Country Action

More recently, WHO has produced a Framework for Country Action for HiAP, which highlights six implementation components:

1. Establish the need and priorities for HiAP
2. Frame planned action
3. Identify supportive structures and processes
4. Facilitate assessment and engagement
5. Ensure monitoring, evaluation, and reporting
6. Build capacity

Approaches to policymaking

As Baum et al ³⁹ highlight, “policymaking is not a value-free, linear and technical process of implementing evidence but rather a political process of making choices influenced by prior values and principles, and perceived opportunities.”

Ollila ⁴⁰ suggests that there are two broad approaches to policymaking involving HiAP: firstly, proactively identifying opportunities for improving health through

influencing policies that impact on underlying determinants; secondly, identifying and analysing policy trends and shifts in sectors other than health that potentially have important health implications, and reacting to take advantage of these opportunities.

Olilla goes on to suggest that there are four types of strategy underpinning the effective implementation of HiAP.

Health strategy

How other sectors and policy areas can impact positively on health (eg tobacco control reduces negative health impacts)

Win-win strategy

How focusing on health can help to achieve mutual or co-benefits (eg good spatial planning increases physical activity and reduces carbon emissions; promoting the health of school children improves educational attainment)

Cooperation strategy

How the health sector can work collaboratively with other parts of government to support them in achieving their policy objectives and overall government goals – thereby addressing the social determinants of health (eg reducing levels of obesity through cross-government action decreases demand on over-stretched health services and health care budget)

Damage limitation strategy

How potential negative consequences of policy developments outside of the health sector can be identified and mitigated (eg achieving limited changes to alcohol licensing can mitigate the worst health impacts).

Securing partner support

Greer and Lillvis ⁴¹ suggest that there are two interrelated challenges involved in securing intersectoral or joined-up government for health:

Co-ordination

Getting different government departments to work together toward the achievement of health objectives despite bureaucratic inertia and divergent priorities.

Durability

Ensuring that cross-government policies impacting on health are sustained over time despite political and bureaucratic changes.

Through reviewing political science literature, they go on to identify three broad approaches to addressing these challenges:

Political leadership

This involves direct action by policymakers to shift agendas and forge cross-government policy. Techniques frequently employed include plans, targets and public health specific political appointments.

Bureaucratic changes

Politicians and policymakers can create new structures, make new appointments and integrate new processes. They can also focus on activities and investments that build relationships and trust across sectors and silos. All of this will encourage a cross-governmental focus on health and help to ensure that decisions endure beyond a particular politician's or political party's time in office. Examples include: the merging of departments to strengthen the health focus; the creation of a cross-departmental public health sub-committee; the requirement for all sectors to undertake health or integrated impact assessment; and the creation of joint appointments whereby health expertise is aligned with other policy areas (and/or other expertise is aligned with health).

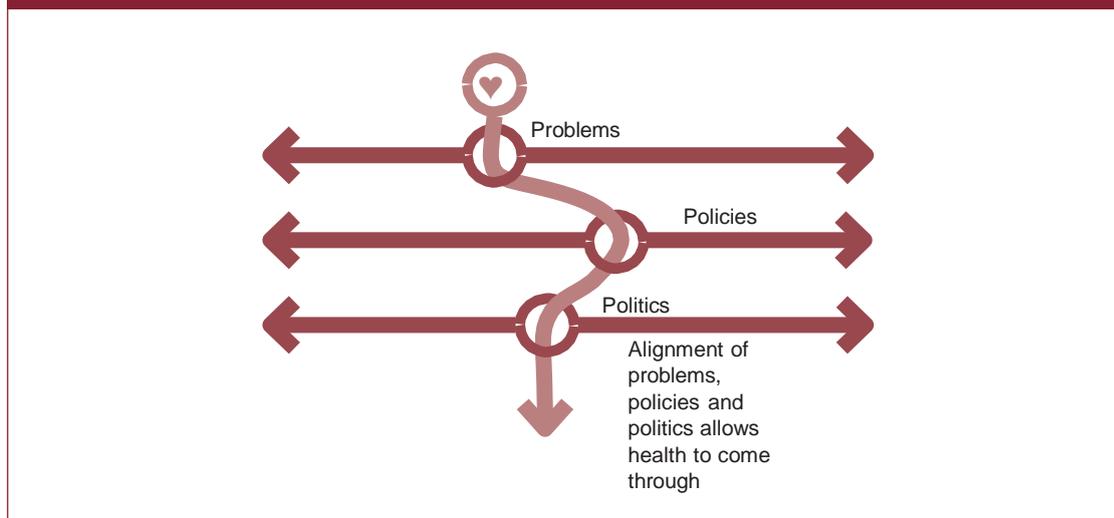
Indirect future-shaping strategies

These prioritise learning about 21st century governance⁴² by developing opportunities for those outside of government to influence and thereby contribute to durability. Examples include: increasing access to health indicators and other data; empowering interest groups, networks and non-governmental agencies in health-related advocacy; and extending ombudsman procedures to allow citizens to challenge government decisions.

Windows of opportunity for HiAP decisions

Much of the recent literature on HiAP draws on the work of Kingdon,⁴³ whose multistream framework suggests that there are three non-linear streams in policymaking – problems, policies and politics – which interplay to open windows of opportunity for policy decisions (see Fig. 1).

Figure 1: Illustration of Kingdon's Multistream Non-Linear Framework for Policymaking



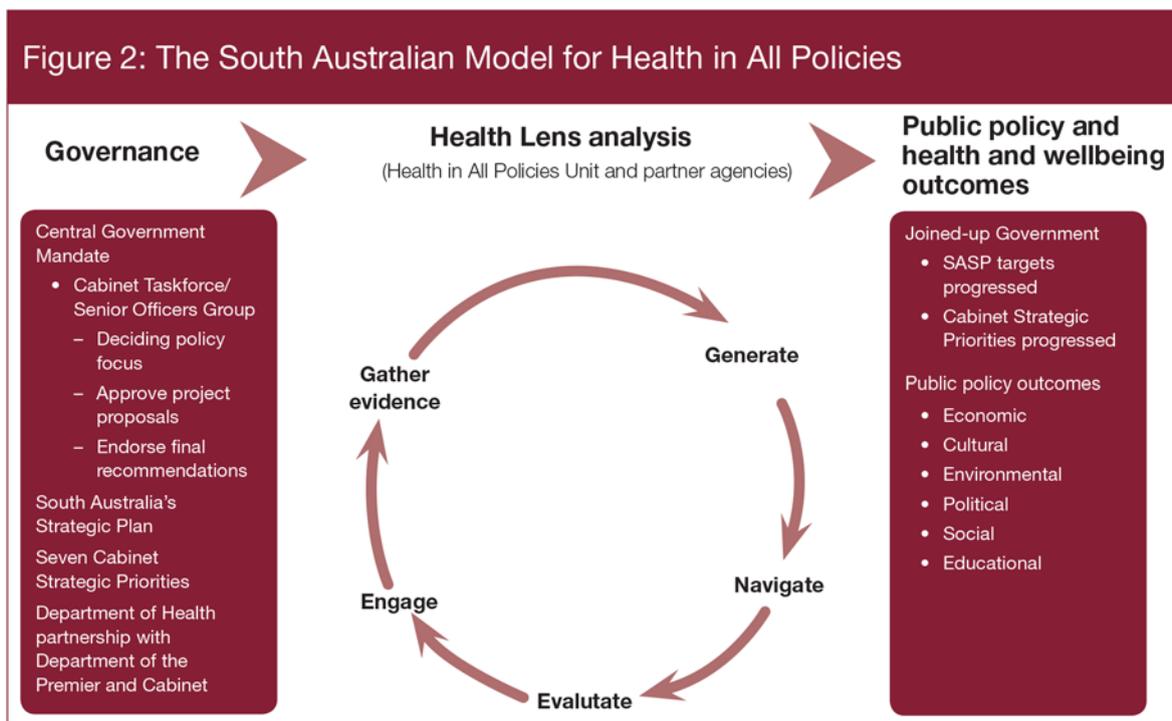
Recognising problems

Firstly, a condition or issue needs to be recognised as a problem before it can be raised in the policymaking agenda. Whilst most easily achieved through high-profile crises or disasters that command media attention, other mechanisms are also important – for example, research, social movements and major reports (e.g. CSDH, Marmot Reviews).

Crucially, this highlights how important it is to frame health-related concerns appropriately. Kickbusch et al⁴⁵ discuss the South Australia HiAP experience (see Fig. 2), reflecting that the complex and contested nature of health inequalities has prevented them from readily being elevated to 'policy problems'. Whilst disease prevention and healthcare are key agendas, the social determinants of health are not necessarily perceived as problems requiring a response by policymakers, despite a convincing evidence base.

In South Australia, the healthcare budget crisis provided an opportunity for a wider perspective on health to be articulated as a problem requiring a policy response. They were able to establish a virtuous circle, whereby tackling the 'causes of the causes' contributed to population health improvement and reduced pressure on

health services and the health care budget – all of which were already key government priorities).



Developing appropriate policies

Secondly, proposed solutions to problems require the development of policies – some of which will gain traction and be ratified and implemented, whilst others are discarded. Effective policies must be technically sound, and culturally, ethically and economically acceptable. Also, the creation of a context that is supportive and conducive to HiAP may take a long time and require active networking between politicians, civil servants and civil society.

In South Australia, the HiAP approach gained leverage through utilising the existing Strategic Plan, an overarching, cross-government policy framework. This allowed advocates of HiAP to harness the commitment of senior decision-makers and insert public health issues into areas not traditionally seen as being related to health.

Alongside a focus on central governance and accountability, the South Australia HiAP model appreciates that policymakers require tangible mechanisms to facilitate cross-governmental action – and therefore introduces the concept of a ‘health lens analysis’. This seeks to identify interactions and synergies between government policies and health and wellbeing. Informed by health impact assessment, a health lens analysis involves five stages that result in agreed evidence-based policy recommendations with the aim of delivering improved policy outcomes for all

agencies involved and improving population health through increased action on the social determinants of health.

Being exposed to the right politics

Thirdly, policy change is possible only if the political environment is right. The definition of politics is contested – and Bambra⁴⁶ identifies four aspects: politics as power, politics as government, politics as public life and politics as conflict resolution. Highlighting its relationship to power, Raphael⁴⁷ argues that the politics stream is about the ideologies and belief systems of ruling authorities and the ability of interest, advocacy and opposition groups to make their views heard. Likewise, Bambra comments that despite widespread acknowledgement of the importance of public policy as a key determinant of health, there remains limited engagement with how ideology, power and politics underpin this.

The political stream can be understood to include factors such as the overall political climate, changes in administration or key personnel and lobbying. There may also be particular times when there is more likely to be the political will to embrace new and innovative ways forward (eg during the lead-up to an election, during the establishment of a new government or when there is a particular challenge or crisis with political ramifications).

A common barrier to building intersectoral partnerships is health imperialism, whereby health is articulated as the only priority and there is a failure to take account of the interests and priorities of all sectors or departments. In South Australia, the HiAP approach was committed to advancing the core business of other government departments and sectors, assisting them to achieve their objectives as well as promoting health.

Opening the window in South Australia

According to Kingdon, a window of opportunity opens when the three streams coexist – but does not necessarily stay open. In South Australia, a number of factors converged to align problem, policy and politics streams. The appointment of Ilona Kickbusch as the Government's 2007 'Thinker in Residence' allowed the window of opportunity to be taken advantage of. She acted as a policy entrepreneur, with HiAP being consequently proposed and adopted as a key way forward.

Final remarks

The paper offered background information on a Health in All Policies (HiAP) approach, information about implementation models, and examples of how HiAP has been applied in different countries around the world.

There is an increasing recognition that health is an important asset for society and that it can contribute to the economy, productivity and overall development of society.

Concerted effort by public bodies – ranging from employment and social protection strategies to local weight management services and town planning – will help influence and shape this for better futures of our population.

Appendix A

History and Development of Health and Health Equity in All Policies

The origins of Health and Health Equity in All Policies (H&HEiAP) can be traced back over many years and key stages in the development of the approach are summarised below:⁴⁸

19th century	<p>Public Health Reforms and Social Movements</p> <p>These reflected the realisation that many of the factors determining health lie outside of the health care sector – and that appropriate policy requires a combination of civil and political action.</p>
1978	<p>Alma-Ata Declaration and Health for All by the Year 2000</p> <p>Informed by the experience of development in low-income countries and the centrality of working across sectors such as education, housing, sanitation and agriculture, WHO’s Health for All by the Year 2000 strategy embodied a commitment to ‘Intersectoral Collaboration and Action’. In the same year, the Alma-Ata Declaration⁴⁹ reflected a vision focused on tackling social determinants of health.</p>
1986	<p>Ottawa Charter for Health Promotion</p> <p>This charter,⁵⁰ the main outcome of the 1st Global Conference on Health Promotion, reflected a shift from disease prevention to salutogenesis (or ‘health creation’) and advocated the importance of building healthy public policy. It contended that health promotion goes beyond healthcare and must put health on the agenda of all policymakers, such that they are aware of and take responsibility for the health consequences of their decisions. This thinking was developed and strengthened through the Adelaide Recommendations on Healthy Public Policy⁵¹ and other subsequent conferences – and through practical initiatives such as the WHO Healthy Cities programme.</p>
2006	<p>EU Finnish Presidency</p> <p>In the EU context, HiAP has its foundation in the 1992 Maastricht Treaty,⁵² which stated that “health protection requirements should form a constituent part of the Community’s other policies” – but was launched more specifically during the second Finnish EU Presidency in 2006.⁵³ The subsequent 2009 Lisbon Treaty⁵⁴ incorporates HiAP in Article 168.</p>

2007-2010	<p>South Australia</p> <p>Beyond Europe, the Government of South Australia was pivotal in the development of HiAP through appointing Ilona Kickbusch as its 2007 ‘Thinker in Residence’ to assist in formulating new approaches to health, wellbeing and health governance. Kickbusch focused on HiAP, identifying South Australia’s Strategic Plan as the key vehicle to enable joined-up government for tackling determinants of health to become a reality. She then worked with the Government to develop the health lens process; and helped organise the Adelaide 2010 International Meeting on HiAP⁵⁵ – a key outcome of which was the Adelaide Statement on Health in All Policies.⁵⁶</p>
2008-2013	<p>Commission on Social Determinants of Health (CSDH) and Marmot Reviews</p> <p>The CSDH was rooted in a human rights view of health. Its recommendations⁵⁷ included a call for health equity in all policies, systems and programmes – noting that coherent action across government at all levels is essential for improvements in health equity. Subsequent Marmot Reviews for England⁵⁸ and the WHO European Region⁵⁹ similarly identify the importance of embedding health equity in all policies – and of adopting whole-of-government and whole-of-society approaches.</p>
2009-2013	<p>WHO Healthy Cities European Network</p> <p>During Phase V of the network, the WHO Healthy Cities European Network built on the findings and recommendations of the CSDH by including as its overarching goal ‘Health and Health Equity in all Local Policies’.⁶⁰ This goal has informed Phase VI,⁶¹ which reflects the priorities and language of Health 2020 (see below).</p>
2012	<p>Health 2020 European Policy Framework for Health and Wellbeing</p> <p>This policy framework⁶² prioritises the centrality of whole-of-government and whole-of-society approaches and emphasises the value of HiAP.</p>
2013	<p>Helsinki Conference and Declaration</p> <p>The 8th Global Health Promotion Conference on Health Promotion focused on HiAP, informed by a Finnish publication <i>Health in All Policies: Seizing Opportunities, Implementing Policies</i>.⁶³ Key outputs were the Helsinki Statement on HiAP¹ and the Health in All Policies (HiAP) Framework for Country</p>

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