# Chapter 16
# Health in All Policies

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Nowadays, looking at its current state of art, it may be strongly stated that Health in All Policies (HiAP) represents one of the key principles of the European Union (EU) Health Strategy and is recognized as an integral part of all policies at the European level as well as at the global level. As a horizontal, policy-related strategy, HiAP has a high potential for contributing to improved population health but the implementing challenge may find several barriers once into practice. The institutionalization of HiAP within the governmental process, for instance, implies a strong leadership of the health sector in order to make population health a priority of the highest level of government. Evidences from case studies have been reported below to show how various mechanisms can be included and potentially adopted for pursuing the defined strategy for health protection and social gradient improvement. Final key recommendations have been provided for supporting policy makers in effectively implementing HiAP.

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## Definitions of HiAP

HiAP is a policy-related strategy addressing determinants of health which are controlled by policies belonging to different sectors [1]. The HiAP approach relies on the fact that the population health is a product of both health sector activities and social, environmental, and economic factors. The latter may be influenced by policies and actions beyond the health sector which are put in place at all levels of governance, including European, national, regional, and local ones. The goal of HiAP is to improve evidence-based policy making in order to promote the health and well-being of countries. In particular, HiAP is directed to improve the accountability of policy makers for health impacts across all decisions, emphasizing the consequences of public policies on health determinants, and to contribute to sustainable development [2].

Because of its application to policy development and implementation, a possible barrier to HiAP is represented by political factors preventing long-term and shared strategies. The promotion of a "trans-sectoral" approach to policy making as well as the development of strategies and tools to collect and systematically analyze the impact of HiAP actions could be useful to overcome potential barriers and resistances [3].

## Current Status

HiAP is by now recognized as a necessary approach at both the European and global level [4].

In Europe, HiAP was formally legitimated as an EU approach in 2006 with the Finnish EU presidency [5, 6] even though the topic of HiAP was tackled by several EU presidencies such as the Portuguese, the German, the British, and the Dutch ones [1]. Furthermore, the need for the integration of health protection in community policies was pointed out in several resolutions of the European Council in the 1990s [7–9]. Nevertheless, the European Commission, which is the only institution able to make initiatives, did not act on the matter so far despite the Council recommendations [6]. Nowadays, HiAP represents one of the key principles of the EU Health Strategy and is recognized as an integral part of all policies at the EU level [1]. Furthermore, HiAP is required by the EU treaties as an approach to be followed in the development of EU policies. Health protection in all policies was signed as a European priority in 1992 first with the Maastricht Treaty which stated that "health protection requirements should form a constituent part of the Community's other policies" [10]. Later on, this statement was strengthened in the Amsterdam Treaty, in particular, article 152 incorporated a strong public health statement, requiring the EU to protect and promote the health of all European citizens. The guarantee of high level of health protection in all policies was also maintained in the Lisbon Treaty which included HiAP in article 168 using similar wording to article 152 of the Amsterdam Treaty [11, 12].

The incorporation of health into EU policy areas with respect to social policy, taxation, environment, education, and research was promoted also by the Directorate of Health and Consumer Protection through project funding.

As suggested by the European Observatory [13], there are several tools useful in order to implement HiAP. They address organizational structures — such as establishing committees, networks, or dedicated organizations/unions; processes—in that planning and setting priority, policy formulation, and joined-up evaluation; finance mechanisms and regulation—such as laws and agreement protocols. The promotion and the strengthening of the use of these tools have received recognition by European governments.

The institutionalization of HiAP within the governmental process implies a strong leadership of the health sector in order to make population health a priority of the highest level of the government.

Furthermore, a formal commitment is envisaged within countries. The implementation of HiAP in governmental processes should depend upon and, at the same time, encourage the interaction between the different sectors of public administration promoting a horizontal management approach [14].

In brief, key findings from literature reviews, qualitative interviews, and institutional recommendations [15] suggest the following top tips for implementing HiAP and ensuring that it functions better than has traditionally been the case: (a) a transparent and clear mandate for HiAP guarantees effectively joined-up government to coordinate policy-making processes; (b) the presence of systematic processes supports the evaluation of all possible interactions across sectors; (c) different interests need to be mediated; (d) mechanisms of transparency, responsibility, and accountability, alongside with engagement into the process have to be developed and maintained; (e) partnerships and trust can be better built through practical integrative initiatives across sectors; and (f) stakeholders outside of government are required to be involved [16].

With reference to this last point, experience with stakeholder engagement has taught that barriers and limits to HiAP are usually heterogeneous and that such engagement may present several strengths and opportunities. Key stakeholder commitment is considered essential for intersectoral action and social participation aimed at positively affecting the social determinants of health, although this approach does not necessary ensure equity to be achieved. A strong awareness of the influence of social determinants of health across all sectors must to be sustained in order to also guarantee equity.

In addition, tight coordination between national–regional–local levels is required and intersectoral action needs a structure to support it, with a specific budget and human resources dedicated to spend time and pay due attention to the project.

On the other hand, strengths can be identified once a legal framework (i.e., a New Public Health Act) is enacted and there is a potential to effect the necessary capacity building on HiAP. Intersectoral work is also taken into account during the planning phase in order to better perform HiAP. The external context, therefore, can contribute to undermine the health protection initiatives with the pressure of the current financial crisis (i.e., budget shortcuts; aggravation of social determinants of health) and the lack of thorough methodology and know-how. On the other hand,

the international agenda is increasingly recognizing the importance of social determinants of health, promoting and supporting institutional commitment, as well as other sectors have begun to include health in their intersectoral work. The role of synergies with key tools such as health impact assessment is also to be considered fundamental in encouraging a new model towards social determinants of health approach [15].

In this context, England, Finland, New Zealand, Norway, Sweden, and Québec are leading examples because of the establishment of a cross-departmental collaboration at the highest level of government [13].

At the worldwide level, HiAP was recognized in the World Health Organization (WHO) Adelaide Statement which introduced a strategic approach for governments to take in planning and setting policies, as part of a broader strategy across WHO regional and national members [16].

The awareness of the relevance of a global and strategic approach to health has gradually developed. In 1978, the Alma Ata declaration defined health as a "social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." Later on, the Ottawa Charter on Health Promotion called for health-promoting public policy and supportive environments and underlined the importance of health promoters' action across sectors. The 1997 WHO Conference on Intersectoral Action for Health strived health authorities to establish partnership with other sectors and in 2005 the WHO Commission on Social Determinants of Health encouraged health-promoting policies in education, industrial affairs, taxation, and welfare [17].

From a literature search run until July 2013 on PubMed with the keywords "Health in all policies" OR "HiAP," several case studies or initiatives aimed at promoting HiAP were identified.

In Spain, Franco et al. used the HiAP approach in order to point out a series of policies aimed to prevent and control childhood obesity epidemics [18]. For their relevance and their role with respect to socioeconomic status, gender differences and the work–life balance, authors identified advertising, transportation, built environment, education, and food environment as the main areas to be studied. The authors discussed several actions helpful in order to control obesity such as advertising regulation policies, the building of track for bicycling and walking as well as of recreational areas, the adjustment of school curriculum, the adaption of school cafeteria menus, and the development of policies aimed at making healthy food available at reasonable prices. Also, Israel's National Program to Promote Active, Healthy Lifestyle addressed obesity through an inter-sectoral, interministerial approach which encompassed joint planning, integration in the policy agendas, and budget sharing [19].

In Finland, the need to influence health determinants through sectors beyond the health sector became evident since the early 1970s [20]. In particular, in the 1970s, Finland launched several inter-sectoral actions to change national diets in order to reduce mortality associated with cardiovascular diseases [21]. In 1972, following a report delivered by the Economic Council emphasizing the need for measures outside the health sector, the North Karelia Project was launched. The project led

to innovative partnerships with industry in product development and relied on the work of an inter-sectoral advisory board set up by the Ministry of Agriculture and Forestry.

With the political consensus, the government set up a committee—the Coronary Heart Disease Committee—entrusted to make proposals on the practical implementation of recommendations. The Committee had representatives of the Ministries of Social Affairs and Health, of Finance and of Agriculture and Forestry, as well as administrative sectors of the Ministries of Trade and Industry and of Education. The Committee worked on the reduction in consumption of animal-based fat through several actions including tax policies, switching in priority for agricultural production, educational campaigns, and product labeling [20].

In The Netherlands, municipal organizations are entrusted to develop and implement HiAP [22, 23]. Notwithstanding, the level of implementation of HiAP is quite heterogeneous. Most of the municipalities recognize the importance of HiAP and describe it in policy documents but few are carrying out concrete collaboration agreements and structural consultations or are sharing HiAP vision [24]. The regional Public Health Service of South Limburg together with the National Institute on Health Promotion and Disease Prevention developed a coaching program for nine municipals in order to improve HiAP, using obesity as an example. Several initiatives were launched at the strategic, tactical, and operational level. With respect to the first, three regional conferences were held for municipal councilors with a public health portfolio. At the tactical level, managers were informed by the municipal councilors and civil servants about the coaching program, the need for HiAP, and organizational transition in order to facilitate inter-sectoral collaboration. Finally, at the operational level the active learning was stimulated and a masterclass for regional civil servants and Public Health Service professionals was organized with the aim of stimulating inter-sectoral collaboration. At the end of the day, concrete outcomes in terms of HiAP proposals were observed in six out of nine coached municipalities [25].

Another experience carried out in The Netherlands was about the reduction of health inequalities [24]. The National Institute for Public Health and the Environment was committed to analyze opportunities to address health inequalities through the HiAP strategy. On the basis of data derived from the document analysis, 38 out of 153 policy resolutions were identified to have a potential impact on determinants of health inequalities. Resolutions often consisted of a combination of policy measures, projects, and programs and were mostly released by the Ministry of Housing, Communities, and Integration and by the Ministry of the Education, Culture, and Science. Fifteen resolutions were on the enhancement of socioeconomic position; 4 on striving participation of people with health problems; 19 on improving living and working environment and lifestyle; and 4 on accessibility and quality of care. Interestingly, only 11 were inter-sectoral collaboration between the Ministry of Health and other ministries. This aspect allows us to conclude that even though HiAP is officially recognized as a strategic approach to be followed in setting policies and programs, further efforts are needed at European and global levels in order to implement in a practical manner.

## *Identification of Best Practices*

The essence of a healthy population lies in tackling and reducing health and social inequalities. Good health equates with good quality of life, enhances workforce productivity and education, strengthens social relations and safety within the community, promotes behavioral and environmental sustainability, and reduces poverty and social exclusion.

The adoption of the HiAP approach has been offered to governments by WHO as a framework to develop healthy populations, this being a desirable policy achievement for highly developed societies. Stronger coordinated action has been increasingly demanded by key stakeholders and this has reached the top of political agenda at the international level. Yet, key factors such as the financial crisis and the increasingly costs of an infinite demand for health and social care are placing unsustainable burdens on national and local resources. This threatens to undermine further enhancement of the HiAP multifaceted policy approach [16]. Further obstacles derive from the ill-defined boundaries of the many complex interdependencies.

A cooperative mechanism, aimed at promoting a new policy paradigm and innovative solutions beyond sectional and organizational silos, is strongly required to address social gradient improvements avoiding duplication and fragmented actions [16]. Such a complex HiAP policy-making process aimed at health protection, prevention, and promotion has been piloted, challenged, and applied across several countries at different levels (local–national–international). It is undoubtedly supportive to decision makers and leaders providing integrative suggestions and consultations on health, well-being, and equity while defining, applying, and assessing policies and public services [16].

The English experience in tackling health and social inequalities is worth a mention as an interesting example in terms of cross-sectoral methods. This country in fact has been characterized for the broad range of policy initiatives and programs addressing health inequalities, especially since the advent of the Labour Government in 1997. “Reducing health inequalities: an action report” represents the first example of formal recognition of the consistent influence of social policies on the reduction of health inequalities, with measures addressing living standards improvement, the reduction of road traffic accidents, as well as a safe walking environment and the cycling routes diffusion. Additionally, the joint interplay of policy-making processes across different departments has been enhanced under the pressure of the “cross-cutting review” operated by Her Majesty’s Treasury. Thus, the resulting health outcomes have been strongly related to diverse sectors and their coordinated actions, gaining more “out-health” outcomes rather than just “in-health” outcomes. Multi-sectoral plans and future priorities for health protection and equity have to be sustained by HiAP and government initiatives have to consider how health inequalities track the social gradient and pursue cross-sectoral work in all areas to promote progress [1].

In this sense, a remarkable experience has been tested by Wales where the government is currently leading a national consultation on whether and how to introduce the HiAP principles to tackle inequalities and better the health of the nation. According to the proposed "mass strategy" approach, healthier public policy would be made statutory and certain public health duties should be made compulsory for public bodies across all sectors (education, social care, housing and working places, transport, environmental and urban planning, etc.). If this plan succeeds, Wales would be the first country to establish a legal obligation for improving health across all non-health sectors; this HiAP duty would be a pioneering and radical action in response to WHO's inputs and definitely a leading best practice that would challenge policy makers all over countries [26, 27].

Such a strategy, indeed, lays on the previous South Australian (SA) Government experiences of the HiAP through the "health lens analysis" approach. This method, used for a set of different areas (i.e., water security, digital technology access), is a key tool that includes also health impact assessment considerations (see *Health Impact Assessment Chapter for further reading*) and provides evaluation results to sustain continuous improvement of policy models, ongoing processes and future policy directions. According to this approach, South Australia has included health in its national strategic plan (so-called SASP) and, above all, it has called for a new outlook of shared governance where public health is an essential element for strategic policy adjustments across all sectors. This implies a mutual contribution, benefiting well-being and health through the other sectors influence and, conversely, using health inputs to gain achievements in other sectors achievements.

An outstanding experience, in this sense, has been recorded with reference to regional migrant settlement in SA, run in 2008 by the Department of Trade and Economic Development in partnership with Multicultural SA and SA Health. A multiple stakeholders commitment was developed, involving participants from different departments (Department of Education and Children's Services; Department of Premier and Cabinet and Department of Further Education, Employment, Science and Technology) in order to promote population growth in regional areas of South Australia through overseas migration programs. The health lens application to settlement services and the reported assessment brought about new and more complete understandings of migrant settlement dynamics (conceptual learning). The interaction between the socioeconomic and health factors impacting on migrant settlement emerged and led the involved stakeholders to a better understanding and redefinition of their top agenda priorities (social learning). All participants' positive attitude toward HiAP, favored by an initial engagement process and an early establishment of partnership processes, resulted in a unified vision and shared language, key elements for driving and supporting further intersectoral work, model, and policy processes [28, 29].

## Key Elements for Decisions Makers

HiAP is a collaborative approach that has been used internationally to address multifactorial health and social inequalities. The implementing challenge of HiAP, as described above, has shown how various mechanisms can be included and potentially adopted for pursuing the defined strategy for health protection and social gradient improvement (i.e., health impact assessments, advocacy promotion and preventive campaigns, key stakeholders commitment in policy consultations up to the publication of national policy reports and bills) [6]. In particular, the policy-making processes have witnessed to be effectively supported by different tools, each of them better fitting a different stage of their cycles: establishment of interministerial and interdepartmental committees; use of community consultations; team working action across different sectors; activation of partnership platforms; definition of integrated budgets and accounting; cross-cutting information and evaluation systems; "health lens" analysis assessments and health impact assessments; and set-up of joined-up workforces and definition of legislative frameworks [16]. Anyway, no matter what the tools, as highlighted by evidences review and qualitative interviews [15], policy makers' willingness to implement HiAP is likely to be more successful once they consider the following key areas:

- The *leadership role:* HiAP has to be clearly supported by governments and at the top level of decisional processes. Call and advocacy for HiAP approach has to be exercised by health systems and departments, with an explicit political commitment capable of facing the current reluctance due to the economic crisis.
- *Joined-up governance and clear strategy* to endorse the HiAP approach is suggested. Action plans and an overarching strategy help to better mediate once potential contrasting goals between sectors would raise, define shared achievements across government and finalize the use of resources for specific projects.
- Stakeholders' commitment as well as working with key partners are considered essential for intersectoral action and social participation. Particular attention has to be paid to *partnership promotion* and *stakeholder engagement* that can, indeed, include potential reluctance among different parts to cooperate and team working at the national level and sometimes also integration among private and community services.
- Moreover, there is an evident need to encourage *capacity building* and *technical skills* for managing and implementing HiAP both within and external to the health sector. Softer skills related to conflict resolutions, team working, and integrated communication, in addition to core abilities (i.e., data analysis and interpretation), are capable of supporting the common awareness of health equity.
- *Health equity* remains an elusive concept that needs further data and investigations. Both national and local levels have to be able to appropriately distinguish among health equality and health equity and evidence should better focus on providing good equity examples of HiAP.
- Additionally, a precise *tactic* is a useful technique for a successful implementation of HiAP. A truly cooperative approach would be, then, possible through the

use of "win–win" policies with mutual benefits for health and other areas clearly stated and shared ("Health for All Policies" as well as "Health in All Policies").
- *Culture* and *values* of the implementing context is a key factor, too often not properly considered in the literature and by policy makers. Public health history and tradition can, in fact, strongly affect the way interventionists accept and play the HiAP approach [15].
- Finally, it is clear that there is a need for *research* to strengthen HiAP investigations as well as for policy makers to advocate for it. Multidisciplinary capacities in policy analysis and methods have to be developed and different perspectives taken into account to guarantee a reasonable success of implementation. Furthermore, HiAP has to move from rhetoric to action and reports and follow-up on the concrete outcomes of implementing HiAP are ultimately required [30].

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