COMMENTARY

Health in All Policies – All Talk and Little Action?

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ABSTRACT

For three decades, Canadian and international researchers have been suggesting that improving population and public health requires attention to a range of determinants and factors and that concerted and coordinated action on the part of non-health ministries and organizations might be necessary to achieve this goal. Suggestions have been made for collaboration and integration by explicitly designing intersectoral actions and interventions and assessing the impact of all policies and programs for their effects on health. While some progress has been made on these goals, it is minor compared to the size of the problem. This article addresses one type of intersectoral action, Health in All Policies (HiAP), and asks questions about why it has not gained a place in governments across Canada. Possible barriers are suggested, such as current structural and political factors that prevent long-range, shared strategies to improve health. Suggestions are made for generating economic and evaluative data on HiAP, developing more sensitive tools for measuring HiAP and adopting explicit "trans-sectoral" approaches to policy-making.

Key words: Health in All Policies; social determinants; equity; intersectoral action

La traduction du résumé se trouve à la fin de l'article.

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Canada has long been a leader in establishing direction on population and public health through the release of inspiring documents such as the Ottawa Charter for Health Promotion and the Epp Report, both published in 1986,[1,2] and legislation such as the Canada Health Act in 1984.[3] Numerous reports have been released over the past three decades establishing the importance of improving the determinants of health and reducing inequities, generating upstream interventions, or designing policies with health uppermost in mind.[4-7] These have parallels in other countries, notably England, in initiatives such as the Whitehall studies (beginning in 1967) and the Marmot Review.[8] Recently, the World Health Organization held a Commission on the Social Determinants of Health, led by Sir Michael Marmot and engaging Canadian leaders such as Monique Bégin in key roles.[9]

Health in All Policies (HiAP) is a type of large-scale intersectoral action to improve health through attention to the full range of determinants. Because it does not take a single form and tends to develop seamlessly out of other initiatives, it is difficult to pinpoint exactly when or how it started. According to some researchers, it was first instantiated in Sri Lanka in 1980, but the term has become much more common in the last decade.[10] Finland, which has been recognized as one of the pioneers in implementing HiAP, promoted HiAP as a theme of its 2006 presidency of the European Union, releasing a comprehensive report on prospects for improving the social determinants of health through cross-government policy;[11] these principles have been reiterated at international conferences in Rome (in 2007)[12] and Adelaide (in 2010).[13]

Full operationalization of HiAP often requires new structures and processes, whether a cabinet committee (England),[14] joined-up evaluation processes (Norway),[14] a network of committees (Iran, Malaysia), or other arrangements.[15,16] There have been several tools designed to help policy-makers analyze and document the potential effects of HiAP. Developing new structures, processes and tools challenges both political and public service leaders to rise above their own interests, consider shared goals and commit to steps for reaching them. However, despite these precedents, little disagreement with their rationale, and Canada's early leadership on these issues, the operationalization of these strategies has been limited in Canada. Quebec is the only province to have formalized a system of assessing policies for health impacts,[14] and other provinces, such as British Columbia, have at best adopted short-term initiatives to address health across government. We identify several reasons for this state of affairs.

First, most governments are still divided into departments or ministries responsible for a specific area. These "silos" not only have their own goals and ministers, but also their own cultures and budgets, and do not, as a rule, work together. Health is often the largest ministry or department in provincial governments, taking up an average of 46% of provincial budgets in Canada.[17] Further, these monies are primarily spent on health *care*, with few designated ministries or budgets for health promotion or prevention. HiAP and other forms of intersectoral action require a paradigm shift from silos to joined-up government. The task of balancing departmental or ministerial budgets must be transformed by seeing the government-wide budget as one purse. This attitude is not encouraged by the current protocol of making estimates and reporting expenditures by ministry or department. Currently, cost savings resulting from coordinated and integrated approaches to policy development across sectors are not calculated. Hence, non-

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health ministers responsible for budgets and deliverables do not consider saving health expenditures, or even improving health, to be their work, their savings or their achievement.

Second, because of this situation, it is especially important that there be evidence to illustrate that HiAP approaches work and are measurable and that non-health ministries have achieved results using HiAP in other jurisdictions. However, such evidence is limited. While there is evidence that HiAP is a sound direction for addressing population health, it is generally correlative and descriptive, resting on assumptions about the links between inequities and economic demands on the health care system.[7,18] Economic data or modelling that would convince cash-strapped politicians and civil servants to launch large change initiatives like HiAP are often missing.

Third, electoral cycles are not conducive to long-term strategies such as HiAP. Most governments have approximately four years between elections. This concentrated period is spent on reviewing and meeting platform commitments, in time for successful campaigning on met promises and achievements. Presumably the benefits of HiAP and related initiatives typically appear over the long term when the ministers and government responsible for implementing them will be long gone, and methods of counting the outcomes of such initiatives lost. Sustained commitment over several mandates may be required to see results. For example, England's reports on the Programme for Action reveal that policies in place since 1997 have begun to make a dent in child poverty, but that ongoing efforts are needed to address persisting inequalities.[8] In most governments, HiAP remains on the "back burner", never becoming a critically important issue on which to build support.

Fourth, ideological commitments do not always support the long-term, structural changes that bolstering health and well-being across a population may require. Many governments in recent years have argued that the best way to improve health is to improve income and raise employment levels, and the shortest route to these goals is economic stimulation, lower taxes, and creation of pro-business environments. Social determinants approaches often require more investment in social programs, wealth redistribution, and expensive public projects. For example, Brazil makes direct income transfers to approximately 45 million people living in poverty who, in return, agree to follow certain health protocols.[19] Such approaches have not been consistently popular over the last thirty years, particularly in times of recession.

Finally, while many politicians and bureaucrats agree with, or do not disagree with, the goals of intersectoral action to improve health, specifically HiAP, the changes required to effect it seem overwhelming. Politicians and policy-makers typically need a special impetus to undertake this type of large-scale change, along with leadership, a vision and excellent messaging. For example, the 2010 Vancouver Olympics provided a window for the government of British Columbia to generate enough support to launch ActNow, an intersectoral effort geared at making British Columbia the healthiest jurisdiction ever to host an Olympics.[20] Quebec is another Canadian jurisdiction that found an opportunity to broaden its approach to health during the rewriting of its Public Health Act in 2002. Section 54 was added to mandate Health Impact Assessment as part of the policy process in all Government departments.[21] Without timely entry points such as these, HiAP-like efforts may not take root.

There is much agreement that HiAP is "the right thing to do", "makes sense" and is intuitively understood to save resources. However, there is little empirical evidence of the outcomes of HiAP, and especially its economic impact. This presents a huge barrier to governments, especially in a recession, when experimentation is not likely to occur.

What are the solutions to this blockage? Three directions are critical. First, more evaluation and economic modelling must be done by researchers and health advocates who see HiAP as a solution. If clear economic models were developed according to policy-makers' guidelines for measurement and evaluation, more data would emerge to convince leaders to endorse HiAP. Some work is emerging in this area but it needs to be more specific.[18] In addition, evaluation schemes need to be developed that have some common outcome indicators across jurisdictions, so that HiAP can be examined over time at a cross-jurisdictional level. Leadership and vision are required by a provincial or federal leader to push these ideas forward.

Second, effective tools need to be developed, tested and encouraged for assessing non-health policies for their effects on health. While Health Impact Assessment (HIA) is mandated in Quebec, there is a need for increasingly critical and analytic tool development that can help to embed HiAP in non-health ministries.[21] Health Equity Impact Assessment (HEIA) tools have been developed in some jurisdictions, including Ontario; even more comprehensive tools to support HiAP are required to integrate gender and diversity factors into analysis and encourage an intersectionality lens that identifies complex relations between determinants of health.[22] These components would make sure that HiAP rhetoric is backed up by mandatory analyses, allow for accountability measures, and provide data regarding the predictions and processes of policy-makers as they consider HiAP.

Finally, a shared paradigm needs to be developed and rendered mainstream in policy circles. An analogy can be drawn with trends in academic research over the past thirty years. At first, single disciplines were encouraged to engage in inter- and multidisciplinary work, to increase the number of perspectives on an issue. Later, entirely different pillars of research were encouraged to create *trans*-disciplinary approaches, generating new methods, shared language and new theoretical approaches, again to better solve complex problems. Problems became redefined in holistic terms, rather than as pieces of separate disciplines. Similarly, the time of encouraging "inter"-sectoral action among policy-makers and politicians may be over, given the crisis of increasing health costs and inequities. Efforts to integrate and collaborate between areas of government, and indeed, between governments, will require a shared approach involving "trans"-sectoral action with concomitant supra-structures and processes. Leadership and vision from the highest levels are required, and HiAP needs to become one of those platform commitments against which government performance is judged. Only then will life be pumped into thirty years of rhetoric in the service of achieving some increasingly timely health goals.

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RÉSUMÉ

Depuis 30 ans, les chercheurs canadiens et internationaux font valoir que l'amélioration de la santé publique nécessite de porter une attention particulière à un ensemble de déterminants et de facteurs, et qu'une action concertée et coordonnée de la part des ministères et organismes non liés au secteur de la santé est nécessaire. Pour réaliser cette collaboration et cette intégration, il a été suggéré de concevoir des plans d'action et d'intervention explicitement intersectoriels et d'évaluer l'impact sur la santé de toutes les politiques et de tous les programmes. Bien que de nombreux progrès aient été réalisés, ceux-ci restent mineurs face à un problème de cette taille. Notre article se penche sur une catégorie d'actions intersectorielles, « La santé dans toutes les politiques (SdTP) », et s'intéresse aux raisons pour lesquelles ce programme ne s'est pas imposé dans les différentes administrations du Canada. Certains facteurs sont abordés, tels que les structures et politiques actuelles qui font obstacles à l'amélioration de la santé publique par des stratégies communes de longue portée. Nous suggérons des moyens de produire des données économiques et évaluatives sur les actions SdTP afin d'élaborer des outils plus sensibles pour mesurer ces actions et d'adopter des approches « transsectorielles » plus claires dans les processus décisionnels.

Mots clés : La santé dans toutes les politiques; déterminants sociaux; équité; action intersectorielle