Health in All Policies: a pathway for thinking about our broader societal goals

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Introduction

Improving the health and life chances of the population cannot be achieved by the health sector working alone. The important role of other sectors in shaping health is not a new idea. As we move from the Declaration of Alma-Alta,[1] the Ottawa Charter[2] and the Adelaide Recommendations on Healthy Public Policy[3] to the Healthy Cities Movement, the Halifax Conference on Intersectoral Action for Health[4] and, most recently, the Adelaide Statement on Health in All Policies,[5] we can see that intersectoral action for health has been constantly rebranded to give new impetus to action that tries to look beyond hospital waiting lists and curative services to improve the health of the population.

Evidence and pathways of the relationship between population health and the social, economic and political environments in which people live are now better understood. We also have a better idea of the factors that will encourage other government sectors to collaborate with the health sector to achieve common goals. Many of these were powerfully highlighted at the Adelaide 2010 Health in All Policies International Meeting.[6] They include high-level political support; a clearly understood overlap in goals that could best be met by working together; cross-sectoral processes for priority setting and governance; and an in-depth understanding of how partner organisations work and operate, and their disciplinary bases.

The purpose of this paper is to discuss how our increased sophistication in understanding and taking action on the social determinants of health is forcing us to identify the values and goals of society that are driving the distribution of these determinants. We then consider how Health in All Policies (HiAP) and health impact assessment (HIA) provide a way of increasing links between sectoral interests to achieve common societal goals.

The distribution of the social determinants of health

The World Health Organization (WHO) Commission on the Social Determinants of Health[7] has expanded our understanding of the determinants of health to include the broader forces that determine the distribution of the determinants—also referred to as the 'causes of the causes' (Figure 1). The broader forces that systematically produce an inequitable distribution of the social determinants of health include history; the power and stability of social, economic and political institutions; the values and norms of mainstream society; and the role of the state (Figure 1). For example, we know that education is a major social determinant of health, but what are the wider forces that shape school participation, the quality of schools, parental attitudes to schools, levels of investment in education and the variable nature of health-promoting environments?

This is new territory for many people who have adopted the social determinants of health framework. Recognising the importance of factors such as unemployment, transport and food in determining health is not synonymous with recognising the importance of other factors that determine their distribution. In other words, the social determinants of health by themselves do not explain the systematic patterns of health inequity in society.

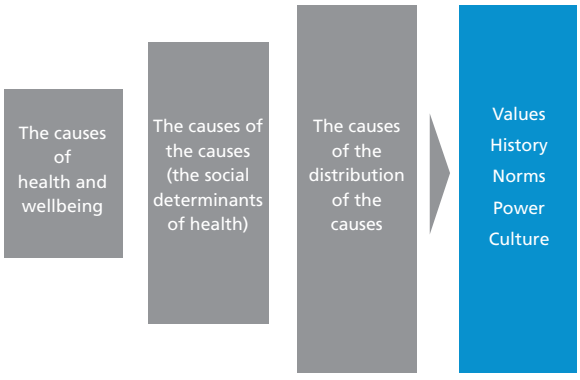

Figure 1: The determinant of the distribution of the determinants of health

Identifying 'broader societal goals'

The importance of HiAP as a means of achieving broader societal goals was raised several times during the Adelaide meeting.[6] Unfortunately, while these goals were alluded to, they were not systematically explored. Working to address these broader factors that determine the distribution of the determinants of

health will require the development of new theoretical and practical (and potentially more political) approaches to creating environments for health. It will also involve identifying and discussing values and assumptions that often influence but are rarely explicit in the policy making process, such as equity, justice, transparency, sustainability, democracy and fairness.

Without such an explicit discussion, we will continue to be locked into a health model where health outcomes continue to be seen as the primary outcomes of intersectoral action. The HiAP process, with its emphasis on 'win–win' outcomes, attempts to address this, but we can anticipate that eventually there will be challenges from the health system investing in the core priorities of other sectors if there are not clear benefits to the health sector. Linking HiAP closely with government priorities and a central agency overview is helping to minimise this risk.

We in the health sector are not alone in discovering that many of the complex problems we face in society are interconnected. Tackling the so-called 'wicked' problems has seen the emergence of many groups working for joined-up policy.[8] As the Business Council of Australia's submission to the National Health and Hospitals Reform Commission makes clear, the health of the workforce is seen as a central concern for business in Australia:

> *'…that improving health is essential to increasing workforce participation and productivity and improving the capacity of all citizens to fully participate socially and economically. Improved health is an investment in future prosperity in the same way that school education, industrial research and roads are investments in the future. Without improved health we cannot lift participation in the workforce by many under-represented groups and lift productivity.'*[9]

New stakeholders are also emerging. In our work in HIA[10–12] we have observed increased interest in capacity building for intersectoral action from extractive industries, non-government organisations, remote Aboriginal communities, local government and many government departments. In the short term their focus is often on engaging with HIAs or building their workforce and organisational capacity to undertake HIAs. In the longer term these HIAs often result in an improved understanding of health, enabling engagement across the planning cycle (Figure 2)—beyond the point prior to implementation when HIA is usually undertaken.

The health lens as part of the policy development process

The linear nature of the policy cycle often reflects a conceptual ideal rather than reality;[13] however, there are numerous examples of HIAs enabling subsequent collaborative problem identification, needs assessment, options discussions, evidence collection and synthesis, and planning.[14–16] Flexibility and responsiveness to the needs of partners is essential in trialling new ways of working together. The health lens used in the HiAP process lends itself to being brought into the policy development cycle in a flexible way.

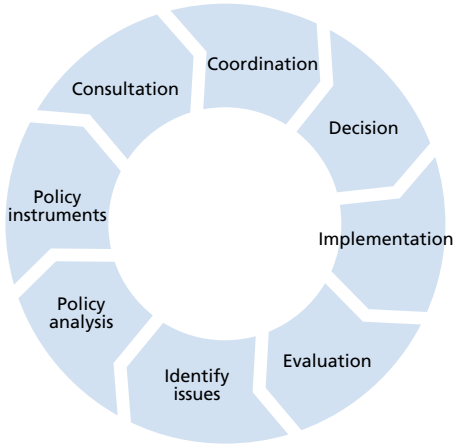

Figure 2: The policy cycle
Source: Bridgman and Davis 2006[26]

The development of the health lens[17] was a response by the South Australian Department of Health's concern that the HIA process is generally undertaken at the point in the planning process prior to implementation where there is a substantive proposal to be assessed. This occurs later in the planning cycle and often means it is difficult to fundamentally change decisions that have already been made. The health lens represents a complementary approach that can be used when a policy is less developed, thus enabling analysis of more fundamental alternatives than would be possible if the policy was already in draft form. The health lens has many procedural similarities to HIA, and it is worth noting that the use of HIA in several contexts emphasises the importance of assessing policy alternatives in a manner that is consistent with the health lens.[18–21]

Like HIAs, all health lens analyses are undertaken to learn something, although the nature, scope and purposes of this learning are not usually recognised as an issue. Glasbergen[22] describes three types of learning that can

result from using decision-support tools, namely:

1. technical learning, which involves searching for technical solutions to fixed objectives
2. conceptual learning, which involves redefining goals, problem definitions and strategies
3. social learning, which emphasises dialogue and increased interaction between stakeholders (this is distinct from the concept of social learning used in psychology).

This is worth considering because the health lens was developed with the goal of informing activity earlier in the planning cycle, before a proposal has been developed. This will involve both conceptual and social learning. These types of learning require more sustained and meaningful stakeholder involvement when compared with other, more technical and technocratic, decision-support tools such as HIAs and health lens analyses. The main issue is to use them in ways that are transparent, evidence informed and fit for purpose. Our work on HIA suggests that there are four broad purposes for conducting HIAs[23] (Table 1). The health lens, with its focus on government policy, is probably best seen as a decision-support tool that, in its current form, has limited scope to be community-led or used for advocacy reasons by groups outside government. Like HIA, its process is 'fit for purpose' in progressing policy goals.[24,25]

Table 1: A comparison of the potential forms of health impact assessments (HIAs) and health lens analyses

Forms	Purpose	HIA	Health lens
Mandated	Meeting a regulatory or statutory requirement	✓	✓
Decision-support	Voluntarily improving decision-making and implementation	✓	✓
Advocacy	Ensuring that under-recognised health concerns are addressed in design, decision-making and implementation	✓	
Community-led	Ensuring that health-related concerns are identified and addressed, and enabling greater participation of communities in decisions that affect them	✓	

Based on Harris-Roxas and Harris[24]

Conclusion

There is a growing acceptance of the role of the social determinants of health in creating healthy populations. We believe that this is allowing us to seriously ask ourselves what are the forces driving the distribution of these social determinants and how do they shape and reflect our broader societal goals. This will bring new challenges in developing the language to discuss values and principles as central to health improvement. Both HiAP and HIA provide practical ways of increasing links between sectoral interests to achieve broader societal goals.

Author details

Ms Elizabeth Harris is the Director of the Centre for Health Equity Training, Research and Evaluation (CHETRE), which is part of the Division of Population Health and one of the Centres for Primary Health Care and Equity at the University of New South Wales. Originally trained as a social worker, she has worked as a clinician, manager and researcher in hospital, general practice, community health and public health settings in rural, regional and urban areas of Australia as well as several Pacific countries.

Ms Harris's research interests are in the areas of comprehensive primary health care and equity, with a special focus on early childhood intervention programs in disadvantaged populations and communities; and the development of healthy public policy, including health impact assessment (HIA). In 1995 she was part of a team that undertook a review of intersectoral action for health in Australia. CHETRE's work on HIA has recently been recognised by the International Association of Impact Assessors and awarded their 2010 Institutional Award.

Mr Ben Harris-Roxas has been involved in the field of HIA since 2003. He has been involved in more than 20 HIAs and has trained more than 300 people in HIA. He coordinates a Masters-level course on HIA and has published widely on the topic. Mr Harris-Roxas is part of a team that has received Australian Research Council funding to evaluate the impact and effectiveness of HIAs conducted in Australia and New Zealand over the past five years. He maintains the HIA Connect website and the HIA blog, as well as the HIA Asia Pacific and HIA Academic listservs. He also edits the International Association for Impact Assessment's Health Quarterly.

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