PRACTISING A HEALTH IN ALL POLICIES APPROACH—LESSONS FOR UNIVERSAL HEALTH COVERAGE AND HEALTH EQUITY

A policy briefing for ministries of health based on experiences from Africa, South-East Asia and the Western Pacific
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The World Health Organization (WHO), its Member States and the global community have a clear commitment to improving health for all and acting on inequities in health outcomes and coverage. In 2008 the WHO Commission on Social Determinants of Health (CSDH) provided advice on what could be done to address the social determinants of health inequities. Of critical importance was the finding – not new but reinforced – that success requires action within and between health and non-health sectors.

This notion of intersectoral action for health equity put forward by the CSDH and WHO, following endorsement of the CSDH report, Closing the gap in a generation: Health equity through action on the social determinants of health, builds on scientific work over many years including a focus on healthy public policy and intersectoral action (ISA) in the Ottawa Charter and the Alma-Ata Declaration on Primary Health Care. Since 2010, WHO has reinforced the fundamental importance of public policy reforms to address the social determinants of health inequities under the banner of Health in All Policies (HiAP) through the Adelaide Statement on Health in All Policies, and more recently, the Helsinki Statement on Health in All Policies. Member States have endorsed this approach in the form of the Rio Declaration on Social Determinants of Health and associated World Health Assembly resolutions.

A key achievement for health on the intersectoral agenda has been the 2011 United Nations high-level meeting on noncommunicable diseases (NCDs), which capitalized on the heightened international concern of the increasing cost of NCDs to focus more attention on the importance of intersectoral (or multisectoral) activity as an aid to address determinants of the burden of disease associated with NCDs.

Alongside these developments, and from a health systems perspective, there is a worldwide push to coordinate efforts within health in order to progressively realize Universal Health Coverage (UHC). Universal Health Coverage represents the health sector’s contribution to producing health in society. Strengthening UHC – and in particular its equity-orientation – requires attention both to the way in which health systems and programme designs interface with populations and their care needs, as well as with how health interfaces with government agencies both through all levels of government and across policy sectors to influence the health impacts of policies.

Viewing the UHC aims in the context of the NCD agenda, it becomes clear that improved coverage requires the health sector to have better competencies with Health in All Policies approaches. NCD “best buys” demand the health sector to act in new roles to achieve coverage. An example of this is partnership or advocacy roles required to improve availability and relative pricing of fresh fruit and vegetables. Evidence-based interventions in primary prevention areas of environmental and social determinants, such as air quality improvements and conditional cash transfers also contribute to reducing NCDs, yet are not areas where health is perceived as having a lengthy history. Moving beyond an NCD-focus it is no different. For early child development health goals the primary care provider or nurse home visitor needs to be able to refer families for social protection assistance if housing conditions are inadequate. For multidrug-resistant TB patients, income support is needed to compensate for lower earning capacities. Transport subsides are needed to overcome geographical barriers. WHO recommendations on all of these issues are essential.

In spite of its importance, familiarity with the terminology of Health in All Policies, which is a relatively new term, is still low. The practice itself is still developing and draws on the practical experiences in health sector with intersectoral work. As such, the systematization of the learning from intersectoral action for the practice of Health in All Policies is still in its infancy. There is no standard set of public health competencies recommended for intersectoral work by WHO, for example.
In the context of the larger requirements about what needs to be done regarding increased awareness and knowledge on HiAP, this policy briefing has humble aims. It aims to contribute to a growing familiarity with the Health in All Policies concepts by pointing to specific aspects of intersectoral and, in some cases, Health in All Policies experiences. It aims to provide ministries of health with a practical policy overview of key issues and approaches. Its specific target audience within ministries of health is professionals or high-level decision-makers, who are not experts on determinants of health but who have responsibilities for dealing with complex problems where HiAP is required to address the social determinants of health inequities.

The briefing is based on several WHO reports. It uses literature reviews, case studies and dialogues among health stakeholders on existing intersectoral work. This background work was conducted between September 2012 and August 2013 across three WHO regions: Africa, South-East Asia and the Western Pacific. The significance of the work concentrated in these three regions is that they cover a high proportion of the world’s population and many developing countries, which have not previously been the focus of this type of analysis.

The briefing does not aim to cover all the implementation areas important for Health in All Policies or all the elements that constitute the approach. WHO is working on other guidance and training materials to support that. Rather, this briefing highlights key rationales and examples pertaining to implementing HiAP by drawing out examples from the three regions with a focus on the health sector roles, entry points in policy design and implications for health equity. As will be seen, Health in All Policies approaches can embody a whole-of-government approach or be built in a staged way around particular issues or in specific administrative arenas. Using different issues as entry points is also possible. NCDs and policies to reduce exposure would be an example of this. Also, focusing on particular difficulties associated with development, for example managing the distribution of the benefits of economic growth for informal workers, might represent a development entry point with an intermediate or structural focus.

Underpinning the briefing is the premise that HiAP implementation is essential. Although there are many challenges, much has been achieved thus far, and there are opportunities to strengthen this approach. Doing so will address current and future health needs in a way that contributes to building fairer health systems and equity in health outcomes and service and financial risk protection coverage.
There are various terms in use to describe work between the health sector and other sectors designed to promote and protect equitable health outcomes using a policy focused approach (rather than discrete one-off project approach). These include: intersectoral action, multisectoral action, and now there is the new term, Health in All Policies. Each term has pros and cons:

- As a new term, HiAP is not favoured by some as it suggests a new way of doing things, failing to acknowledge previous success under the banner of intersectoral action. The rhetoric around Health in All Policies has also not always been explicitly associated with health equity as an outcome. It is considered by some to be health jargon and has intimations of “health imperialism”, with other sectors required to prioritize health concerns over their own. On the contrary, intersectoral work specifically requires health or any actor working intersectorally to modify language for a specific target audience.

- All of the cases reviewed included a focus on public policy to some degree as part of the intersectoral work they describe. Generally the terms intersectoral and/or multisectoral action were used because they are more familiar than Health in All Policies. Not all the cases described the specific elements deemed important for creating Health in All Policies approaches. But intersectoral practices as they are now are informative for understanding how best to implement Health in All Policies. The development of a body of practice around which mechanisms, tools and processes are important for implementing Health in All Policies is one potential advantage of having a new term to denote a more systematic collection of practices. It is favoured by some for its focus on the policy environment that shapes the flow of power, money and resources, and therefore for its potential to address health inequities.

- There are also wide-ranging views on whether HiAP is best described as a strategy, an initiative, a systematic approach, a method or a policy tool with all terms being used. How it differs from Health Impact Assessment (HIA) has also been reviewed at length (e.g. at the 2013 International Union for Health Promotion and Education meeting in Thailand), with a fundamental difference being that HIA is a specific tool, while Health in All Policies is a policy practice that uses HIA and other tools (such as Health Lens Analysis) to change policies for health and health equity.

The WHO Helsinki Declaration of 2013 defines HiAP 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.” It further states that HiAP has the potential to improve the accountability of policy-makers for health impacts at all levels of policy-making, in particular if it includes a focus on the principles of targeting within universalism those with the greatest health needs and with the greatest social disadvantage. It states that HiAP approaches include an emphasis on the consequences of public policies for health systems and coverage, and for other determinants of health and well-being.

While intersectoral action has traditionally embraced a wide range of practices including project-based efforts, the work promoting Health in All Policies aims to delineate an area of public health practice that is closely associated with governance and policy-making. Traditional silo-based governance and policy approaches don’t work well for the complex problems facing governments and communities. Governments’ decisions are based on multiple factors and conflicting interests and can have positive or negative impacts on health; innovative, collaborative, joined-up
approaches to negotiating and designing policies and their implementation, help to ensure the impacts on health are positive, equitable and sustainably embedded into future decision-making. Cross-government and participatory governance mechanisms that support joint strategic assessment and collaboration are also hallmarks of the Health in All Policies approach.

Health in All Policies approaches position health outcomes as part of the development agenda, in line with other societal goals related to well-being, wealth and productivity improvements. Health thus is at the same time an outcome and an integral part of the goals for policies and strategies in other sectors. Health is a social indicator that can tell us much about the impacts of other policies on development. HiAP is not just about a policy statement or a piece of legislation, important as they are, but about a whole way of working that is politically astute and informed.

For example, the development philosophy of Bhutan, “gross national happiness”, has attracted international attention. It contains health as one of nine domains (including education and living standards) to measure gross national happiness (GNH) in the country. The Gross National Happiness Commission (GNHC) is responsible for ensuring that all development policies and programmes contribute to GNH and aims to translate theory into practice by using policy review tools to influence the design of policies for health and other cross-cutting domains.

THREE KEY MESSAGES

✔ Views on terminology – intersectoral action, multisectoral action or Health in All Policies – should not impede progress to address health determinants.

✔ Different terminology has pros and cons and can be used purposively. HiAP need not be the name used to describe the approach to actors beyond health. Whichever terminology is adopted in order to be effective policies and processes must be designed with a strong equity focus.

✔ A common understanding of the set of practices, processes and mechanisms needed to progress HiAP will aid in communicating what works.
Experiences from the three regions show how health ministries play a variety of (overlapping) roles across the policy cycle, often simultaneously, in the design, implementation and evaluation of their intersectoral work. Examples highlight both successes and difficulties with assuming important roles in high-level policy processes, and creating space for partnerships with other sectors. Nevertheless, some notable achievements and evidence of challenges regarding intersectoral roles and their relationship with determinants of health are worth mentioning.

**ADVOCATES FOR POPULATION GROUPS**

People who are most disadvantaged depend on the protection provided by policies, legislation and programmes to ensure social determinants support good health and well-being. These people cannot simply move to a healthier neighbourhood or workplace. Reductions in inequities rely on the health sector as advocates for equity. For example in the South African healthy schools case study there was a focus on overcoming barriers to learning including violence, poor health and unhealthy environments to which the more disadvantaged groups are exposed. The reviewers commented, however, that there was evidence about the limitations of education and cognitive inputs in changing behaviour when risk environments are profound or overwhelming. This finding suggests a more systematic policy-driven approach could have included HiAP action on the broader determinants of health inequities.

**DISCOVERERS OF COMMON WIN-WIN AGENDAS**

The South Australia approach of helping other sectors achieve their goals is an important example. This approach focuses on the language and goals of the other sector and expressly aims at health being viewed as less “self-interested” – albeit unintentionally.

**CATALYSTS, FACILITATORS, INNOVATORS AND POLICY SPECIALISTS FOR ACTIONS ADDRESSING DETERMINANTS OF HEALTH DIRECTLY OR INDIRECTLY**

The health sector can run its own initiatives to tackle the determinants of health either as the main focus or as a part of the work of others. Examples of this include Sri Lanka, where community-based approaches to address determinants were carried out in Alawwa, Kurunegala District in the northwest of the country, through home gardening and first-aid training; and in Ghana, where health was involved in broad microfinance initiatives. But overall the review suggests that these types of opportunities are often missed. The microfinance experience in Ghana explicitly targeted the lowest income regions of the country and low-income women within those regions. Further, they specifically built in strategies including provision of health information by mobile phone (e.g. relating to maternal health) to address inequities in health information and access. But overall the review suggests that these types of opportunities are often missed.

**CHAMPIONS OF UNIVERSAL HEALTH COVERAGE**

The health sector’s ability to implement HiAP is important to ensure UHC, as many of the barriers to health and health services lie outside the remit of the health sector. Progress towards UHC will be enhanced by and is dependent on strengthening intersectoral policy action to address the determinants of health equity. Partnerships at all levels and sectors of government can identify and promote policy reforms and other strategies that help address the determinants of health, mitigate demand-side barriers and create an optimal context for health system performance. Ministerial support for and leadership on intersectoral action will thus contribute to achieving UHC outcomes. Examples include, the Western Pacific region where the health sector has supported action on issues such as NCDs and transport, urban development and gender inequalities, which are important convening points for HiAP. Similarly, the health
sector has helped work towards the efficient provision of UHC around nutrition in Nepal, sexually transmitted diseases, and complex problems such as violence against women where often other sectors are involved.

There are complex challenges in delivering UHC especially for low- and middle-income countries. Further, there are pressures on governments that counter a focus on equity including political pressures, expectations from other policy sectors, commercialization and globalization, a focus on curative care and policies that create geographic and financial barriers.

Unfortunately, the health sector often faces opposition both within health and beyond in ensuring a prevention focus prioritizing determinants and equity. A health determinants lens may also provide advice on unintended impacts, for example where roads are built to improve access to health services but the unintended consequence is loss of agricultural land and hence income and food leading to poorer health.

But more nuanced approaches offer the health sector an important role in facilitating joined-up services. For example, in New Zealand, regional environmental health officers working with local community organizations have received community members’ and trade union input that has made primary health care more accessible to people in social housing.

**MANAGERS OF PARTNERS AND INTEREST GROUPS**

Ministries of health are often required to navigate between the concerns of different partners and interest groups both within health and beyond.

The advantages of working with partners include using funding to leverage action on upstream determinants, provision of policy and technical expertise, as well as provision of services, health advocacy, and connections with universities. The UK Government funding for the mental health policy reforms in Kenya, for example, supported the collaboration of a range of non-health sectors including police, prisons, schools, child protection and social welfare whilst an NGO supported community engagement and action at other levels and a local university facilitated a participatory process in a high need community.

Civil society organizations were seen to be very important in supporting intersectoral action on health and there are several examples where civil society has created the necessary weight to push non-health sectors and the government to address health related issues, such as tobacco control, where political support alone might not be strong enough.

Managing the different interests of the private sector can be challenging for health – for example, prioritizing action that is medical and pharmaceutically based, for malaria for example, whilst the social or environmental determinants of health problems go unchallenged. In Viet Nam, however, the private sector worked under government leadership on a road safety agenda. Universal Health Coverage requires action across the continuum and the varying regulatory control and strength of governments of different countries will influence the ability of government to manage potential conflicts.

One of the major challenges is pressure groups and stakeholders within the health sector, often from private providers, whose service models favour a focus on curative care, often for those who are easiest to reach and with the greatest ability to pay. By and large the prevention and promotion agenda is secondary for reasons of market failure. But this makes it all the more important that the government sector develop intersectoral models and use HiAP approaches as well as ensuring a focus on addressing inequity in all interventions. There are also trade-offs that need to be made and it is often politically difficult to make trade-off criteria explicit when there are competing agendas. A good example here is the work on international trade, particularly in the Western Pacific region (and other regions) seeking to have a sugar tax on soft drinks in Fiji; but at the same time the country is required by the World Trade Organization to reduce unnecessary taxes.
And, of course, health needs to support the partnerships with other sectors whose policies are the subject of HiAP. The advocacy for leadership and implementation of Health in All Policies involves ministries of health working in partnership with a variety of organizations.

Communities are also key and health ministries have an important role in galvanizing them. **Thailand** has an impressive system enabling communities to hold governments accountable for health through the HiAP process. The government, professional groups and civil society are involved in health assemblies, health impact assessments and various other strategies and tools to identify required reforms and potential healthy public policies. Nonetheless, responsible agencies need to be sophisticated enough to ensure effective participation.

**SPECIALISTS OF HiAP IMPLEMENTATION**

Less strategic but critical is the role invariably played by the health system in conceptualizing a problem, initiating partnerships to address determinants and inequities, planning, implementing and evaluating the roll-out of an intersectoral initiative.

The case studies show that often the health team provided expert, technical advice and accurate data and information to help partners understand the health aspects of any issue and to measure impacts. An example is in **Viet Nam** where hospital data informed the need for evaluation and components of the road safety approach. Information on epidemic outbreaks of malaria and dengue fever in the **Philippines** at the local government level helped ensure different parts of local government across different responsibilities had a central chain of command with respect to surveillance. It is not clear if equity related data are routinely included in HiAP action – an area for further development – and ministries sometimes had limited understanding of the substantive interlinkages between sectors and their consequent implications. In **Timor-Leste** the national policy support for ISA is not fully matched by cross-disciplinary implementation. In another example, understanding food security as an area for ISA has been hampered by a lack of familiarity among health scientists with evidence relating to sustainability and affordability.

**ONE KEY MESSAGE**

✔ The case studies illustrate that it is important for health to perceive the other sectors’ goals and language, and to have bilateral relations that award equality to partners or members of partnerships among the sectors. Central governments and parts of ministries concerned with medical services need to support ministries of health in this public health work.
EMERGING AGENDA – MAKING INTERSECTORAL ACTION A SYSTEMATIC PART OF PUBLIC HEALTH AND HEALTH SERVICES

There are many examples of high-level commitments to HiAP, addressing health inequities and the social determinants of health as well as seeking to expand UHC including intersectoral governance arrangements. However, there is no doubt that ministries face multiple barriers in implementing HiAP in their countries; this is true for all countries. Some of the key challenges that exist are listed below.

POLICY DESIGN

Given the importance of health inequities there was limited evidence in the case studies of a causal framework or program logic that identified equity as an unambiguous outcome nor did the case studies suggest that social determinants were consistently embedded as inputs and critical outcome measures. One example is the work in South Australia on Aboriginal mobility where there is explicit recognition that the social determinants are not equally distributed and the project aim is to close the health gap, particularly for Aboriginal people through redressing barriers to mobility. This also included a Health Lens Analysis to examine the health impact of a non-health sector policy.

From a determinants perspective there is very good evidence about how action on determinants such as parental rights regarding working conditions, access to child care services and social protection can yield benefits for the health and well-being of the community and the demands on health and other services. The health sector has an interest in seeing non-health outcomes achieved. However, there were very few examples where the health sector proactively sought to achieve outcomes for the non-health sector despite this evidence. This is compounded by a tendency for each sector, including health, to want collaboration on its own terms, insisting on running projects even when other sectors might be more appropriate (e.g. nutrition projects conducted through health rather than agriculture) and creating parallel structures in order to “be in charge”. Joint strategic assessment of issues would enhance policy design.

EVALUATION

Reviewers noted very few of the case studies were evaluated for their impact. This suggests that action on determinants and inequities is still not considered a mainstream responsibility of government or indeed the health sector, hence there is no infrastructure to collect information and report on progress or hold governments accountable for outcomes. This goes hand in hand with the policy design limitations outlined above. However, this reflects a wider practice where within the health system (and potentially the entire system) we have not been very good at evaluating the impact of what we do. This practice is beginning to change as evidenced by work in other regions – such as the European Union, where work has been commissioned to describe actions on determinants in terms of more nuanced approaches to equity impacts (using Hilary Graham’s three-fold typology for reducing health inequities – remediying health disadvantage, closing the gap or tackling social gradient\(^1\)). Evaluation of multifaceted interventions, which often take a long time and involve a range of players, is challenging and HiAP is

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still in its infancy, but lack of evaluation makes it more difficult to argue for investment in HiAP and evaluation must be a focus for the future. International work on core indicators will assist.

ENSURING A COMPREHENSIVE APPROACH

The reviews showed some excellent examples of intersectoral action, many addressing inequities and assisting in progressing UHC. However, there are important agendas to address for countries to achieve a comprehensive system-wide approach as advocated for in Health in All Policies.

› High-level government or regional commitment to addressing the determinants of health inequities and achieving UHC, such as illustrated by the Bhutan, Sri Lanka and Ghana case studies, as well as ensuring intersectoral action is an important, systematic part of public health.

› An explicit rationale for and determination of an integrated and coordinated set of activities at multiple levels and across sectors, such as the commitment to NCDs in the Western Pacific strategies to build capacity of the workforce in health and beyond for intersectoral work, is critical. The South African case on healthy schools programmes commented on the need to plan and invest in the dynamics and challenges, knowledge, skills and institutional mechanisms and guidelines to facilitate change in institutional practices in education and health.

› One perspective that emerged on the capacities needed was that intersectoral goals are achieved where at least some of those involved have a high level of understanding of the pathways through which different determinants (and their differential impact across the population) influence health inequities and barriers to health service use, and the implications for policy reforms for private sector incentives, and for strategic plans as key instruments for administrative accountability in the public sector.

› High-level leadership and multisectoral governance arrangements are important. For example the Fijian Health Minister provided leadership and encouraged the development of intersectoral policies. In Malaysia and Cambodia there are high-level multisectoral committees around NCDs with health ministers or even the prime minister or deputy leading the work. In Palau the Minister for Health has responsibility for addressing NCDs and called on the Ministry for Finance to escalate the level of response to an emergency.

› A commitment to monitoring and evaluating the impact of strategies.

IMPLEMENTATION CHALLENGES

In addition to problems with policy design, barriers were also related to effective policy implementation. Lack of clear governance arrangements caused difficulties and were compounded when (health or other sector) staff were under pressure, demotivated or had competing demands, and where frequent change occurred. Even delivering on the sectoral mandates in these contexts was considered challenging where structures were changing as intersectoral work was perceived as requiring further energy, if not resources. The reviews noted there were limited skills in public policy development and reform and compliance checking. In other cases there were concerns that the state ministry was unable or unwilling to take responsibility for health care delivery or delivery of basic services such as water as it lacked technical and financial capability, despite a supportive policy. A lack of accountability often led to NGOs filling the void. This was compounded by frequent changes in senior ministry personnel and changes in ministry structures.

Often institutional cultures, value bases, success criteria and management cultures vary widely. In the microfinance experience from Ghana, for example, there were no clear lines of accountability across the project team or clear agreements of commitments from each partner, making it difficult to enforce agreements made later at the field level. This led to misunderstandings affecting trust. The pace and style of the NGOs, with a culture of social entrepreneurship and rapid innovation, and the “gradual consensus building”
model typically employed in health systems caused friction between NGOs and the state sector. Different sectors tend to approach programmes from “different worlds”, drawing from distinct vocabulary, ideology and modes of communicating new ideas.

ONE KEY MESSAGE
✔ Health ministries can support effective HiAP by ensuring it is consistently embedded in the strategic directions of the health sector and sending a clear message to the whole health sector to support this work. Embedding encompasses inclusion in health systems performance frameworks, with monitoring and evaluation not just of health outcomes but also inequities in health, trends in determinants of health in partnership with other sectors, and monitoring of policy achievements and progress towards attaining Universal Health Coverage.
BUILDING A HiAP PORTFOLIO

Broadly, the review across regions has deepened understanding of the range of health’s engagement in intersectoral action, and provides a patchwork of ideas for scaling up HiAP approaches. Evidence presented here augments the existing knowledge base on intersectoral action and provides ministries with a range of options to build their HiAP portfolio.

In synthesizing key lessons from the research there are six different approaches to HiAP. They are not mutually exclusive and can be pursued simultaneously subject to capacity and opportunity. There are different starting points and opportunities to scale up HiAP in each of the six areas. The roles of the health ministry will differ and are explored and the policy focus – essential in HiAP – is more dominant in some than others. Different needs will call for different approaches and often complementary approaches are most powerful, with action to address the structural determinants through policy reform as well as working at the regional and local levels for policy adaptation and implementation, changing environments and behaviours and building skills.

BROAD FOCUS ON WHOLE-OF-COUNTRY WELL-BEING FOR DEVELOPMENT INCLUDING HEALTH

In some countries, Thailand, Bhutan and Timor-Leste for example, a high-level, whole-of-country commitment has been made to ensure improved economic, social, health and cultural outcomes as part of strategic development plans. Here, health is seen as a contributor to and benefiter from economic and social development, poverty reduction, happiness etc. They reflect high-level leadership and provide a mandate for intersectoral action and accountability requirements. In some cases countries will not be ready for this but a similar approach can be established at the state or regional level.

The health sector is just one player and the role for health is variable and not always well defined. In Fiji and Palau, while NCD action is being led by the minister for health, the whole-of-government/society action is upheld by the commitment from the Prime Minister or President. In the case of implementation of the Framework Convention for Tobacco Control, health can play an important role in ensuring there are appropriate governance structures and accountability requirements.

The imprimatur is for intersectoral action to address intermediate and upstream determinants of health using multisectoral action, with both a policy and practice focus. Ensuring a focus on inequities is important as is making clear how HiAP seeks synergies and avoids harmful health impacts thus contributing to UHC.

Multiple tools are useful in policies, projects and partnerships. Thailand has a comprehensive sophisticated approach to HiAP through its National Health Assembly, involving the community in decision-making, and developing public policies with the National Health Commission having an important monitoring and evaluation role.

STRUCTURAL DETERMINANTS OF HEALTH

There were relatively few examples of specifically crafted actions on policies related to the first recommendation of the Commission on Social Determinants of Health – addressing the unequal balance in power, money and resources, such as policies affecting discrimination, employment opportunities or land ownership. In this case, the lead role is more likely to be with another sector. The health sector is more likely to be a catalyst or facilitator urging the inclusion of a health and equity perspective (for example, ensuring relative gains in economic development accrue to disadvantaged groups with poorer health).

The health sector may also act as a policy specialist, monitoring and providing technical expertise on the impact of an issue on health outcomes and giving advice on unintended
impacts, e.g. where roads are built to improve access to health services but the unintended consequence is loss of agricultural land and hence income and food leading to poorer health. Here, the health ministry can make an important contribution to examining all potential consequences to get the best solutions. The work in Malaysia on eradicating poverty and restructuring society saw health bring expertise in three areas: specific engagement with the poor and other disadvantaged groups (especially rural communities and the urban poor); knowledge of disease at a population health level (e.g. infectious diseases, malnutrition) but with a focus on sanitation and the health of the mother and child; and finally the inequitable distribution of health resources and facilities.

The entry point is the social determinants of health (SDH) but equity is not always paramount and ministries of health need to be responsible for bringing an equity focus.

**INTERMEDIARY DETERMINANTS OF HEALTH FOCUS**

Examples here are NCDs and tobacco, nutrition and road safety. NCDs are imposing an increasing burden on countries across all income levels and thus are an increasing focus for intersectoral action.

Injuries also continue to unfairly impact many countries and the field of injury prevention has noted that it “…provides a powerful way of illustrating the health impacts of intervening on the social determinants. Intervening in this way can and frequently does yield cross-cutting benefits for health and other outcomes.”

In some cases the health sector is assigned a leadership role in the context of high-level commitments such as occurred on NCDs in Palau, or a whole-of-government approach to addressing determinants and then has the authority to engage other sectors and hand over leadership. In other cases the health sector tends to lead and advocate for change by other sectors. Health’s role includes ensuring an equity focus, prioritizing policy reforms for sustainability and advocating for coverage of programmes to include those who are more disadvantaged, in line with UHC.

The road safety work in Viet Nam was led by the transport sector with health providing data on injury patterns as well as providing a health education role. There can be an advantage in having sectors other than health lead this work; in Viet Nam a separate agency was established to lead the work on tobacco reform and was granted an official mandate for action, fiscal autonomy and the imprimatur to convene ministerial partners.

Action on midstream determinants can also impact on upstream determinants. For example, tobacco policy reforms in India encompassed partnerships with agriculture, labour, rural development and environment to address the implications for business and individuals.

Strategies include education, policies in schools, workplaces and legislation such as for smoking or food advertising etc. Again in India action occurred at the national as well as state, city and village level. Action tends to be universal in approach, especially given the widespread prevalence of chronic disease risk with additional strategies for those most in need. Invariably, partnerships are developed with other sectors such as urban planning, transport, advertising and industry with efforts to change their policies.

**FOCUS ON LIVING AND WORKING CONDITIONS AND SETTINGS**

There is a long history of health promotion action to promote health and well-being, prevent illness and redress inequities through action on living and working conditions through settings, including schools, work places and villages. Arguably equity has often been an implicit, rather than explicit, aim with an assumption that settings based strategies will improve health equity. More can be achieved if sectors share explicit equity concerns about opportunities to improve health through settings, such as in slums.

The health sector may lead but typically works in partnership with other sectors including education, welfare and employment, as well as with private sector health professionals and NGOs. The health sector’s role includes provision of technical expertise, relevant data and policy analysis as well as implementer, ensuring local implementation of national policy.
directions or frameworks. Healthy settings are already multisectoral in nature and thus can be promoted and strengthened and initiatives such as healthy cities can be scaled up towards “health in all urban policies”. Case studies suggest that when health is responsible for working with partners to ensure the “policy” HiAP can be more about the practical application of policies (e.g. a school policy on health or a village policy on tobacco) developed at regional and national levels.

The focus on living and working conditions aims to use practical initiatives to build knowledge and skills, create healthier environments in particular settings and enhance coverage of existing preventive health programmes (e.g. exercise or eating at the workplace). Many of these programmes are universal in approach but can be targeted to high need communities. Taking the SDH into account in the way programmes are delivered, can increase the uptake and can increase effectiveness.

Initiatives of this type typically have strong community participation – which is also a determinant of health. Continued investment in this approach needs to emphasise that appropriate translation of prevention is responding to the needs of the community.

FOCUS ON ENVIRONMENTAL ACTION TO IMPROVE HEALTH, MITIGATE RISKS AND MANAGE DISASTERS

Exposure to risky environmental conditions has had a major impact on health outcomes and over many years work in this area has been responsible for great improvements in health in relation to malaria and other communicable diseases. Examples include action on water supply, sanitation, waste management and disaster prevention and management. The direct impact on health outcomes engenders health sector support for this more traditional area of public health but even here there is typically public sector underinvestment in physical infrastructure or appropriate regulatory standard setting although it is a role that the public sector is uniquely positioned to play.

Health and other sectors frequently work together, with health bringing the expertise around health threats and consequences. There is the potential for programmes designed to achieve one outcome, such as irrigation programmes to improve nutrition, to have a negative impact on health such as malaria (as in Ethiopia) so again the input of health is valuable. As a further example, work undertaken in Colombo, Sri Lanka, on reducing flood risks and improving urban infrastructure, had many positive impacts on health including reduced dengue fever incidence and lower pollution; this was led by the ministries of defence and urban development who took health considerations into account; an example of putting health into their policies and practices. While an initiative with certain positive outcomes for health, more comprehensive scoping of social impacts on health, in particular mental health, that were not considered by the other sectors, could have strengthened the outcomes for health equity.

Policy tools such as health impact assessments have history here and priority can be on policy reform for long-term sustainable change or can be about solving contemporary problems. Action occurs at all levels from local to international, e.g. tsunami preparedness.

FOCUS ON HEALTH SERVICES

Much of the work on communicable diseases, nutrition and child and maternal health is based on engagement by the health sector with other sectors for successful implementation. The delivery of primary health care has a long history of involving partnerships with the community, NGOs, other sectors such as schools, and with a variety of health workers. In South-East Asia, for example, multiple examples were provided of countries taking action to increase the reach and coverage of coordinated accessible, affordable and accountable quality health services which typically play an important role in helping vulnerable populations with poorer health outcomes. Bhutan, India, Nepal and Sri Lanka have all developed strategies to “reach the unreached”, often decentralizing health systems management to achieve changes.
This is the health sector’s core business and health is the instigator, implementer and local informant collaborating with other sectors in the process. Several projects commented that competition within the health sector (between different professions or about the importance of different priorities such as sexual health education versus treatment) can cause problems. It is important to note that while treatments are advancing apace, advances in medical care and treatment will not be enough to solve many of the complex problems of the future and clearer understanding of determinants may help old established treatments to function better or help to identify determinants from which changes for health can be leveraged.

In some cases the focus might be on several entry points simultaneously. For example the work on mental health in Kenya used evidence to feed into a sustained policy dialogue on mental health involving ministries of health, social welfare, education, police, prisons and child protection about the issues raised, including the policy and institutional needs, and the integration of mental health into generic health sector reforms. This was complemented by more project-focused action on service delivery reforms and community engagement resulting in action at national, district and local levels. The district and local level processes linked with economic actors and resources to link health responses and care with economic and production services to strengthen the social inclusion, incomes and well-being of people with mental ill health and that of their households. This constitutes a good example of intersectoral work for UHC in practice.

In terms of service delivery, access to and use of health care is influenced by a variety of social determinants including income, gender, education and transport. Projects are often funded with priority to population groups or locations in greatest need and the opportunity for community empowerment through participation is significant.

The focus of service work is less on high-level policy reforms and more on work practice policies concerning effective collaboration, often addressing the social determinants e.g. gender inequity, low levels of education, poor diet and lack of sanitation, as part of the initiative. In some cases, such as nutrition interventions in Nepal and Kenya, other sectors implemented community-based nutrition strategies with strong collaboration with the health sector and reviewers noted that in Nepal the Multisectoral Nutrition Programme provides a current window of opportunity for institutionalization of Health in All Policies.
CONCLUSION

Ministries of health have a responsibility to support improved health and reduce health inequities and one of the most important ways to do this is through action on the social determinants and on the environmental determinants of health. Addressing health inequities requires attention to the causes of the unequal distribution of health determinants, in addition to the focus on the determinants themselves. Health in All Policies approaches offer a means of achieving sustainable improvements through public policy reforms.

By working in partnership with sectors other than health there are co-benefits for all, including both public health and curative health services. This is not easy and may be seen as of marginal importance by some who prioritize health services, treatments and insurance as the core health business. There is, however, a growing international demand for countries to be accountable for their HiAP actions. There is also growing evidence on the impacts that working intersectorally can have on improved health and effectiveness of health services. Evidence presented here from the review augments the existing knowledge base on intersectoral action and provides ministries with a range of options to build their Health in All Policies portfolios.
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Asterisks (*) indicate that this is being published as a stand-alone publication (details forthcoming). All cases with § are summarized in a joint publication Moving towards Health in All Policies: A compilation of experiences from Africa, South-East Asia and the Western Pacific.
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