Health in All Policies: An EU literature review 2006 – 2011 and interview with key stakeholders.

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Tackling health inequalities – an EU priority: Parliament calls on the Council to promote efforts to tackle health inequalities as a policy priority in all Member States, taking into account the social determinants of health and lifestyle-related risk factors, such as alcohol, tobacco and nutrition, by means of actions in policy areas such as consumer policy, employment, housing, social policy, the environment, agriculture and food, education, living and working conditions and research, in keeping with the 'health in all policies' principle.

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Contents

Executive Summary

The first part of this report is a literature review undertaken during July 2011. It identifies opportunities and barriers for the implementation of HiAP in the countries of the EU. The second part is a report from semi-structured qualitative interviews with key stakeholders conducted during September and October 2011. This combined report was presented to a meeting of the Equity Action Work Package 4 meeting on 14 November 2011. This executive summary highlights the key findings from the literature review and qualitative interviews. It identifies opportunities and barriers for the implementation of HiAP in the countries of the EU. Seven key themes emerged and top tips for implementing HiAP more successfully across the EU were identified.

1. *Leadership*

   Explicit political commitment to HiAP at the highest possible level is a pre-requisite for success. Health systems need to show leadership in advocating for health and the HiAP approach. This is an essential starting point for the whole approach.

2. *Governance and strategy*

   It is advantageous to have an overarching high level strategy that specifically endorses HiAP approach. This can help to overcome divisions when there are apparent conflicting objectives between sectors. It can help to identify common aims across government, and support the use of resources to implement HIAs and a wider HiAP approach.

3. *Partnership and stakeholder engagement*

   Working effectively with a wide range of partners is essential. Including stakeholders by using a community participation approach is a critical factor in a successful HiAP approach. However in practice partnership working is largely seen as a local rather than national priority and there is some concern about working with both private and community sectors.

4. *Capacity and technical skills*

   Building skills and capacity both within and external to the health sector is seen by most as essential to the development of HiAP. Although technical skills were recognised as important capacity and capability issues, stronger emphasis was placed upon the need for the softer skills. These are needed to influence OGDs and other sectors, to resolve conflicts, and to raise awareness of health equity.

5. *Health equity*

   The lack of success in incorporating health equity into both HiAP and HIA is a feature of much of the literature. A greater understanding is needed of the differences between health equality and health equity, and better data are needed to be able to understand health inequalities at a national and local level. There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus.

6. *Tactics*

    Identifying win-win approaches, where there are clear and evidence based co-benefits to health and other policy areas, is a fruitful area for implementation of HiAP. However, the way in which this is done is crucial and there is a danger of health coming across as an 'imperialistic' outsider with vested interests, rather than taking a truly collaborative approach.

7. *Culture and values*

    Whilst being recognised as an important factor in the literature, the role of culture and values to provide a context for HiAP implementation was not widely commented upon by stakeholders. Some did see how the history and tradition of public health could influence the acceptability of an interventionist approach to the SDH.

Top tips for promoting equity focussed HiAP
As well as providing thoughts on how HiAP could be implemented Member States gave their views of the top tips for the implementation of HiAP.

England – Hang on in there! HiAP needs persistence and takes time – even in favourable winds!

Republic of Ireland and Northern Ireland - You need dedicated people and resources to implement both HIAs and the HiAP approach.

The Netherlands – Strengthen links with other agencies and clarify how policies impact on health in a very concrete way. It's also important to support the development of overarching strategies and goals.

Norway – First you need political commitment, then establish facts and evidence, but this can work the other way round! For example it was evidence from international publications which demonstrated that health inequalities within Norway were greater than expected, that raised HiAP higher up the political agenda.

Scotland – Don't use the 'H' word (Health!). Best to describe health in terms of its wider outcomes and how it influences and is influenced by for example education, crime etc so that HiAP is not seen as a parochial concern of the Health sector lobby.

Spain and Basque Country – It's difficult to progress without political commitment and so you need to develop advocacy skills at a political level.

Sweden – Need to establish a political cross party consensus for HiAP to enable effective implementation and to ensure its long term sustainability.

Wales – Emphasise wellbeing rather than health – this is much more meaningful when working with partners.

Conclusions

The following conclusions have been drawn from the evidence reviewed;

- Explicit political commitment to HiAP at the highest possible level is a pre-requisite for success. Health systems need to show leadership in advocating for health and the HiAP approach. This is particularly important given the current economic crisis.
- EU member states, countries and regions should be encouraged to develop overarching strategies and action plans that endorse a HiAP approach.
- Working in partnership, particularly with communities, is a neglected area in the implementation of HiAP.
- Although technical skills (such as data analysis and interpretation) were recognised as important capacity and capability issues, stronger emphasis needs to be placed on the development of softer skills (such as negotiation and relationship building) to influence OGDs and other sectors and to resolve conflicts and raise awareness of health equity.
- There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus. This needs to be addressed as a priority by EU Member States, Countries and Regions.
- A focus on win-win policies is recommended, but Health must take a truly collaborative approach; 'Health for All Policies' as well as 'Health in All Policies'.

1. Background

In 2010 the World Bank (1) stated that the reduction in poverty seen over the last decade in Europe has now been reversed. In September 2010 the interim first report on social determinants of health and the health divide in the WHO European Region (2) confirmed that there are major health inequalities within and between countries in the WHO European Region and that unless urgent action is taken, these gaps will increase.

> *"…action must be both systematic and sustained and is critical in responding to the global economic downturn" (2).*

The 'Health Inequalities in Europe' report in 2005 (3) identified that health inequalities exist in all European Union (EU) countries. The European Commission's Communication 'Solidarity in Health: Reducing Health Inequalities in the EU' in 2009 (4) set out a framework for addressing the social determinants of health across government. Building on this the Council of the EU issued its 'Council conclusions on Equity and Health in All Policies: Solidarity in Health' noted that:

> *"The general framework of public health has changed over the last decades, and now there is a greater understanding of the mechanisms affecting the distribution of health and morbidity in populations and of the potential which exists to promote equity in health, taking into account the social determinants of health in the broadest sense of the term, which means acting on areas as diverse as the environment, education and working conditions."* (5).

The European Parliament adopted a resolution on reducing health inequalities in the EU in March 2011 (2). In response to the framework and a request from the European Commission, Health Action Partnership International (HAPI) on behalf of the Department of Health is leading a health inequalities Joint Action (JA) to assist Member States (MS).

The programme brings partners together from across the EU and aims to:
- Identify what works and why
- Consolidate these lessons into practical guidance and build capacity to improve the effectiveness in the member states of the EU.
- Develop a consensus and make recommendations on how to take forward a Health in All Policies approach (HiAP).

The programme started in February 2011 and the initial process had three phases;
- Undertake a review of evidence and opinion relating to HiAP
- Ask MS to identify the HiAP approach within their countries, the consideration of equity and resources available to them, and
- To present the findings to MS to agree future action.

This will provide methodologies to support MS in HiAP i.e. produce recommendations on how to take forward a HiAP approach within their MS.

1.1 Aims & objectives

The aim of this report is to undertake a review of evidence to identify opportunities and barriers for the implementation of a HiAP approach across the EU, and to assess current opinion on the implementation across a range of member states, countries and regions and in particular to assess how health equity is being incorporated within the HiAP approach. This includes the use of HIA (as a tool to implement HiAP) when applied to national or regional policies.

The first part of this report is a literature review undertaken during July 2011. The second part is a report from semi-structured qualitative interviews with key stakeholders conducted during September and October 2011.

HiAP is a policy strategy, which targets the key social determinants of health through integrated policy response across relevant policy areas with the ultimate goal of supporting health equity. For a definition and brief discussion of the terms 'health inequalities', 'health equity', and 'Health Impact Assessment' see Appendix 4.

2. Literature review.

2.1 Search aim and strategy

The starting point of the literature review was the findings and evidence presented in the Finnish EU Presidency publication on the Health in All Policy approach and its implementation within the European Union (EU) and its member states and countries by Stahl in 2006 (14). The aim therefore was to search for subsequent publications and reports that had addressed this issue since 2006. In addition to explore the extent to which health equity has been taken into account in these approaches. The objectives therefore of the literature review were;

- to summarise the findings of the Stahl 2006 report in relation to these issues, and
- to search and review published evidence that has emerged from 2006 to the present (July 2011).

A literature search was undertaken using a wide variety of search engines and databases. These were NHS Evidence, EMBASE, MEDLINE, PubMed and Google. Search terms were: "Health in All Policies" AND "Healthy Equity" OR "Health inequalities", limiting searches to those published in English from 2006 to the July 2011. All reports and publications were briefly reviewed and those that were relevant to the review were selected. Further publications were reviewed that were cited in the selected publications. In addition then to Stahl et al (2006), a further 16 reports were fully reviewed.

The literature review is divided into two parts; the first (2.3) a summary and review of Stahl 2006, and the second (2.4), a review of the 16 identified subsequent reports. Seven main themes emerged in summarising the papers;

1. Leadership
2. Governance and strategy
3. Partnership and stakeholder engagement
4. Capacity and technical skills
5. Health equity
6. Tactics
7. Culture and values

These themes form the structure for the discussion which draws together the key points from each publication reviewed.

2.2 Review of Health in All Policies: Prospects and potentials. (Stahl et al, 2006 (14)).

The report starts by reviewing emerging European challenges and describes what is meant by the HiAP approach. It suggests that broader societal health determinants, and in particular education, employment and the environment, influence the distribution of risk factors among population groups that result in health inequalities, noting that greater socioeconomic inequalities in society are related to poorer average health. It argues that HiAP should be placed within a human rights framework with core values of equity, solidarity and participation. These three values lie at the heart of both how HiAP can be taken forward and in how equity should be central within this approach.

The report is divided into four main sections – the wider context of HiAP, experiences across different sectors, governance, and the use of HIA; draws some conclusions and suggests the way forward.

The report argues (Chapter 1) that implementation is the most difficult challenge facing a HiAP approach and suggest the utilisation of the three conditions for policy change (based on the Kingdom framework for policy changes). These are:
- the problem (the problem stream) that puts the issue on the agenda
- the alternatives and solutions produced by experts (the policy stream) and
- the politically determined solutions (the politics stream).

During crises all three of these 'windows' can be open at once, allowing the real possibility of policy change. However, many other factors influence the challenge of implementation of policy change including:
- whether health objectives are compatible with other sectors objectives (win-win options)
- whether the health sector can facilitate change alone
- the economic cost of implementing health policy
- the level of compatibility between national and local policy frameworks, and
- the importance of commitment and long term sustainable action.

There is recognition (Chapter 2) at EU level that there are;

> "Specific effects on particular risk groups (determined by age, gender, disability, social group, mobility, region etc)."

The authors suggest that European citizens recognise the fundamental values of equity, universality and solidarity, though no evidence is provided for this assertion. However, in general social and environmental concerns can be subservient to the aim of promoting competitiveness explicit in

strategies such as the Lisbon Treaty. This means that HiAP can be limited if it focuses mainly on finding win-win options with other policy areas. This tension is reflected in the process of stakeholder engagement, which needs to recognise that commercial organisations with vested interests are also stakeholders. They conclude that;

> *"Moving health higher up the European agenda is a necessity… that needs to be driven by health policy priorities and concerns".*

Part 2 of the report focuses on sectoral experiences of HiAP. Examples from Finland (Chapter 3) which examine the HiAP approach to improving heart health shows that a multi-factorial approach is needed which combines legislation, regulation, working with industry, information and mass media, community involvement and education. This approach within the North Karelia project led to a 53% reduction in mortality by reducing cholesterol levels, blood pressure and smoking rates between 1982–1997. The background to this was a focus on health inequalities and the impact of societal factors on health behaviour.

However, the existence of pressure with other policy areas is demonstrated in an examination of policies which have had a negative impact on health. For example the Common Agricultural Policy, which until recently provided subsidies for the production of full fat milk, meat and sugar, and tobacco, but not for fruit and vegetables.

The potential for a negative health impact is illustrated in the world of work (Chapter 4) where polices which focus on the globalisation of the labour market have led to an increase in non-standard work arrangements which *"might result in a widening of socioeconomic differences in health"*. The authors argue that the implementation of the Lisbon Strategy needs a stronger consideration of health and social aspects to balance insecurity and flexibility in the labour market.

Further examples from food and nutrition policy areas highlight this potential, as nutrition is 'hardly ever discussed' in the Agriculture Council or by the DG for Agriculture despite the health sector continuing to point out the negative health impacts in EU policy, *"…so far, there has been little evidence of any improvement".*

A number of ways are proposed to stimulate this process, including greater promotional work by public health to increase the awareness of negative health impacts among decision-makers; greater use of HIA during the policy development processes, and better public-private partnership working, with equivalent weight given to public health and environmental concerns as to agricultural and rural interests.

Similar concerns are expressed in relation to alcohol policies (Chapter 6). Examples from Finland show that compliance with EU policies resulted in substantial increases in both alcohol consumption and alcohol related harm by increasing access and decreasing price. The analysis looked at the impact on health inequalities and demonstrated that the increase in consumption was greatest among men with the least education. Finally Chapter 7 looked at the environmental and health

perspectives. These more positive illustrations show the benefits of working with win-win options where there are clear co-benefits across agendas. However they highlight the advantage of health being integrated at the beginning of the policy development cycle, particularly within the development of transport polices where increasingly stringent standards are based upon robust health impact evidence.

The next section of the report focuses on governance issues, and gets to the heart of the opportunities and challenges for including health in the policy making process (Chapter 8). Here the authors argue that there needs to be an agreed starting point of shared values in reducing health inequity, backed up with a number of examples of work across the EU and at national and local levels. They conclude that there are a number of key mechanisms and processes for developing HiAP. These include:

- a common understanding of shared values to reduce health inequity and to understand the importance of social determinants of health
- raising awareness and strengthening support including using annual reports and mass media
- improved information and research to both improve impact assessment and to evaluate the effect of HiAP approach
- examination of structures and mechanisms for cross sectoral working at European, national regional and local levels
- look for win-win situations to develop new partnerships
- provide training to develop skills – to build capacity in working across sectors
- increase resources – especially designation of staff time to HiAP activities, and finally a suggestion that
- the changes over time in the health status of disadvantaged groups should be used as an indicator of the quality of development in countries.

Part 4 of the report concerns HIA and has been the subject of a recent Equity Action literature review (8). Most professionals argue that health equity and inequality impact should be a core component of a well conducted HIA and so there is no need to develop a separate assessment tool (Chapter 10). Despite this, the mapping exercise (Chapter 11) showed that less than half the 158 HIAs analysed stratified data by either conventional (age, gender, socioeconomic class) or unconventional categories in order to be able to assess the impact on health equity. Recognised limitations of the mapping exercise (including overly large samples from UK and Netherlands, and large proportion of local HIAs) mean this should be viewed with caution. Chapter 12 calls for the systematic integration of HIA into decision making processes.

The final section outlines some conclusions and a way forward. Firstly it reconfirms the policy mandate for HiAP within Article 152 of the treaty of Lisbon establishing the European Community. Secondly it expresses equity as a core value within health. Thirdly it discusses two main pathways for developing HiAP approach depending on whether there is a win-win option with recognisable co-benefits across policy areas, or whether policy objectives are incompatible and how negotiation and compromise is needed to keep health high on the agenda. Finally it states that;

"Increasing emphasis on internal markets, competition and economic policies more generally, pose a challenge to keeping health and health equity aims high on the agenda".

2.3 Literature review HiAP 2006 - 2011

The following literature review reviews papers covering 2006-2011. Wismar et al 2007 (15) looked at the scope and limitations of HIAs applied to policies and how they support decision making in Europe. This is in the context that HIA's is a tool to support the implementation of HiAP. They discuss the advantages of win-win strategies, but recognise that there are often 'conflicting system objectives'. For example, the liberties of a market economy in relation to alcohol or tobacco. They argue that in these cases, HIA can help to bring about compromises that can increase positive health benefits and reduce harm. The key factors that they identify as contributing to the successful influence of policy development are:

- community participation
- timing – early entry into the policy making process, and
- the public health culture of the Member State or organisation developing the policy.

In relation to the impact of HIA on health equity, they find in their review that although the majority of HIAs had been successful in influencing policy, equity was rarely a distinctive issue in the modification of the decision.

Apart from a handful of countries (England, Finland, Netherlands, Wales, and Sweden) they suggest that HIA is still in its infancy in Europe. Whilst acknowledging some of the limitations of their study (in particular the small number of case studies and small geographical representation) they do make a number of suggestions for taking this work forward. These include:

- reviewing the expectations of HIA in light of the scientific evidence
- the need to compromise where win-win situations cannot be found
- better promotion of the benefits and costs of undertaking HIA
- greater promotion in member states that aren't currently using HIA
- the need for: political leadership, public support, early engagement, legal support, and technical support within health systems.

Because of concern with global health inequity the director-general of the World Health Organisation established the Commission on Social Determinants of Health (CSDH) in 2005 (Marmot et al 2008 16). The CSDH produced evidence based recommendations about what could be done to take further action to promote health equity by focussing on the social determinants of health. This hugely influential report places emphasis on the need to use a HiAP approach. The rational is outlined very clearly:

"Economic growth... without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity".

As a result it makes a number of recommendations on building a coherent approach to health equity. These include making health equity a marker of the progress of society, recognising that to do this, requires political leadership at the highest level. It specifically recommends the HiAP approach and places an emphasis on identifying win-win policy solutions. As well as supporting adequate resourcing of cross government actions to tackle health equity, it recommends the use of 'health equity impact assessments' for all government policies (and suggests adapting HIA for this purpose).

The report recognises the barriers to inter-sectoral action for health and that this despite a global evidence base supporting it, is still not systematically translated into policy approaches - even less into 'pro-equity policy'. Part of the problem lies within the structural framework within which governments operate and hence the emphasis on cross government action and infrastructure development. Working outside of government has other challenges, and involving the community in policy making for health can be a 'rallying call' in these difficult areas. In addition they suggest the need to adapt to the specific context and to be flexible – reflecting other papers which identify the need to reach consensus and compromise to achieve the best health gains or smallest health harms possible.

Kickbush 2008 (17) published as part of her work as 'Adelaide Thinker in Residence' Prof. Illona Kickbush's report 'Healthy Societies: Addressing 21st Century Health Challenges" identifies HiAP, along with health sustainability and health equity as three key initiatives to develop a 'radically new mindset' for the 21st century.

Lessons learnt from her time in Adelaide, and in the HiAP work undertaken in Southern Australia led to a number of recommendations for implementing HiAP. These include:
- gaining high level political commitment
- linking strategically into national / regional plans
- identifying adequate resources
- reviewing legislation that has largest impact on health
- establishing governance mechanisms to deliver the work including a high level HiAP committee that can make policy recommendations
- issuing bi-annual 'health lens' report on Sothern Australia's strategic plan and
- developing support mechanisms to build capacity within government to engage in HiAP.

She makes recommendations for developing HiAP at a local level to enable local government to create supportive environments for health and suggests a focus on 'win-win' policies across different sectors. However, it says little about how to progress when policy objectives conflict and 'win-win' approaches are not possible.

Simpson et al 2009 (18) discussion paper reviewed at options for promoting equity within HIAs. It builds on the CSDH report (16) and the 62nd World Health Assembly 2009 resolution that urged member states to:

"take into account health equity in all national policies that address the social determinants of health and the ensure equitable access to health promotion, disease prevention and health care".

The paper suggests three actions for WHO to support this:

- enhance equity focus of HIA
- build capacity to assess health equity impacts including the wider use of HIA, and
- extend member state capacity to integrate findings into programme design and policy making activities.

These conclusions arise from the assertion that although values of health equity are within the Gothenburg consensus on HIA, in practice they are often neglected. The main reasons for this are lack of appropriate data e.g. health outcomes stratified into appropriate sub groups, and the assumption that engaging community participation will in itself be enough to promote equity.

The WHO European Office report on health and health systems (19) discusses the role of stewardship within health, and argues that this involves;

"leadership and advocacy to influence and coordinate action with other branches of government... at the central and regional or local levels... the private sector and other stakeholders".

The main routes to achieving this are:
- collaborating and building coalitions
- promoting initiatives to improve health and its social determinants, and
- advocating the incorporation of HiAP approach.

The achievement of the latter depends on building capacity to gain support from other ministries outside of health, and the extended use of HIAs. Although there is 'ample evidence' to indicate that HIAs have had a substantial influence on policy making decisions, mechanisms that can support this are needed such as the development of inter-sectoral committees, and joint health targets across government departments.

The This WHO report on poverty and social exclusion in Europe (20) argues that 'Equity should be a guiding principle in all health stewardship tasks' and that this involves engaging other sectors that influence health by applying tools such as 'equity oriented health impact assessment'. By analysing and learning lessons from a variety of case studies, the report suggests three main approaches to achieving this:

1. Involving poor populations (and the organisations working with them) in decision making and practices. This can help to overcome cultural and linguistic barriers, improve understanding, build capacity and ensure sustainability.

2. Establish information systems for health inequalities and the social determinants of health. This can help to inform the development of policies as well as to monitor and evaluate their impact.

3. Work across sectors by using a HiAP approach. This can be effective because it can; empower health workers, integrate service points and so increase access, develop working groups for specific populations, increase cooperation between ministries and influence structural funds. The report lists all the potential tools and instruments for applying HiAP in practice:
- inter-ministerial and interdepartmental committees
- community consultations and citizens' juries
- cross-sector action teams
- partnership platforms
- integrated budgets and accounting
- health lens analysis
- cross-cutting information and evaluation systems
- impact assessments
- joined-up workforce development and
- legislative frameworks.

Koivusalo (21) describes three main challenges to the implementation of HiAP. First is the compatibility of sectors with the main interests we wish to influence, second is the issue of which sectors can address improvements of health determinants on their own, and third the costs of taking health into account in other policy areas.

Koivusalo suggests four main strategies to tackling these based on Ollila (22);
1. health strategy – where health objectives are maintained at the core of the exercise
2. the win-win strategy which is geared to finding policies that benefit all parties
3. cooperation strategy which focuses on what health experts can do to help others achieve their goals, and
4. damage limitation strategy, where potential negative health impacts from others' policy areas are identified and addressed.

The main issues resulting from this are:
1. bias toward areas of co-benefits/win-win approaches - because the focus of reviews of HiAP tends to be on what works

2. avoidance of conflict across sectors – mostly for political reasons and a sense of mutual dependency. As they state, "In areas where mutual cooperation is likely to fail, the stakes of political accountability rise".
3. the lower status of health compared to other sectors, and
4. little analysis of how to progress when partners are reluctant or dismissive of the health agenda.

A number of ways forward are suggested, including the need to promote health better to other sectors, yet the Health sector have to have a better understanding of other sectors' priorities. There is a call for realism in recognising that at present *"Health in All Policies, to a large extent, remains more rhetoric than action"*. They point to case studies from the Netherlands which suggest taking opportunities to legislate to make HIA mandatory. However, this does not address the political decision making process, which is why HiAP is a broader concept than HIA alone.

At an EU level, the Koivusalo expresses concern at the lack of commitment of the European Commission to HiAP and;

"concerns and tensions which relate to European Court of Justice judgements as well as the implications of market freedoms, internal market regulations and even Commission proposal concerning directives on cross border care to financial sustainability, organisation and regulatory policy space within national health systems."

This means we should be concerned not only with health within other policies, but health within health policies.

Finally the report considers the role of health impacts within wider impact assessments. The involvement of corporate interests in the process is a concern. For example there is a concern that the tobacco lobby influences impact assessment processes to overemphasis economic impacts with less value given to health impacts.

The report concludes that we need to think about how to proceed with HiAPs when faced with reluctant partners and conflicting objectives. This includes ensuring we protect health within health policies when faced with other policy objectives, i.e. the promotion of competition within health systems and ensure that when we think about HiAP, we consider the political dimensions rather than simply the technical HIA aspects, to preserve policy space for HiAP.

Ollila (22) covers similar ground to Koivusalo, and starts from the point of view of stating that there is little evidence that HiAP has had an impact on the 'hardcore EU-level policies'. The author therefore explores potential avenues to strengthen HiAP as an upstream intervention at EU or national policy level. In focussing at this high level, Ollila stresses the importance and challenge of keeping up to date with all existing and emerging policy areas and organisations that can impact on health. Outlined are four main approaches to HiAP as above. The heart of the report examines how

windows of opportunity can be opened for HiAP. In doing this the report builds on Kingdon's theories of policy development but expands on how they might be applied to HiAP.

> *"Firstly for the 'problem stream' the attempt to raise and sustain health onto the political agenda can be supported through development of governance structures, such as health select committees, educational campaigns, including working with mass media, and through generating debate based up robust data."*

Secondly, 'the policy stream' can be supported by the development of tools that can create and evaluate potential solutions. This includes HIA and how HIA can be built into wider impact assessments, yet expresses the importance of developing tools in collaboration with other key partners.

Finally the 'politics stream' can be developed by creating, identifying or tapping into suitable political movements. Whilst recognising that this requires sustained effort, windows of opportunity can be opened for example when there is a change of government or political leadership.

The European Commission's Open Health Forum (23) brought together over 500 health stakeholders to discuss HiAP and the role of stakeholders. The final report suggests that the key to success is finding areas where health and other policy objectives overlap (win-win options). This is exemplified by the development of the GAVI alliance (see www.gavialliance.org), that created the economic and funding conditions to support the health objectives of vaccinating children from poorer regions across the globe.

In addition, the report suggests that a combined multi-stakeholder approach to HiAP (the cooperation approach) is always the most effective. However, the report does not consider how to influence policies that fall outside of this narrow scope.

The Adelaide Statement on HiAP arose from the international meeting in 2010 (24). It outlined the need for:

> *"a new social contract between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government".*

It suggests that HiAP works best when a number of conditions are in place. These include:
- government mandate for HiAP, with whole government commitment
- it is systematic and embedded into overall government strategies and goals
- it allows space for innovation and experimentation
- it uses mediation skills and cooperation
- it is an accountable transparent and inclusive process with real joint decision making and

- it builds on engagement, partnership and trust.

For the health sector, the statement suggests a number of ways forward. These include;
- a greater understanding of politics
- building robust knowledge and evidence base
- using HIA
- using existing platforms and opportunities
- building capacity, both with health and within other sectors
- a focus on helping others achieve their goals (win-win).

It is hoped that this statement will be built upon in the World Conference on Social Determinants of Health in Brazil 2011, and the 8th Global Conference on Health promotion in Finland 2013 and preparations for the Millennium Development Goals post-2015.

As well as publishing the Adelaide statement, the 'Public Health Bulletin SA: Health in All Polices' (25) was produced that compiled together reports from experts in HiAP from across the globe. These reports outline a number of factors or approaches that they feel are likely to enhance the effectiveness of HiAP.

Kickbucsh's introduction asserts that health is now on the political agenda and that this presents us with a real opportunity to progress HiAP, and Lin's chapter says that the global economic crisis could provide an opportunity to put HiAP into practice.

Stahl and Pettila suggest a number of prerequisites for building structures for health at local level including:
- political will, commitment and leadership
- robust information and management systems, and
- common targets across sectors.

Petterson supports this by emphasising the importance of going for win-win options, whilst recognising that progress takes time. Merkel identifies political will and leadership, as well as shared goals and objectives, but he points out that whilst useful, legal support on its own is not enough; we need appropriate structures, systems and mechanisms to support concrete action.

St-Pierre and Gauvin argue that health should establish intersectoral governance which would include leadership, coordination, collaboration and accountability, but would also recognise the need for cultural change. Mulgan takes a more psychological perspective, expressing the need for an increase in 'cognitive capacity' to enable people to think beyond their particular remit.

Harris and Harris-Roxas take a focussed look at health equity in HiAP. They argue that simply influencing social determinants is not enough in itself to begin to tackle health inequity in society. Their framework sees health and wellbeing as leading from the social determinants of health (the causes of the causes), yet in order to understand the causes of the distribution of the causes, for

example unequal access to education, we need to understand the values, history, norms, power and culture of the society that has created them. Within the value system alone lie the concepts of equity, justice, transparency, sustainability, democracy and fairness, and an understanding of this context is needed if we are to ensure HiAP, alongside HIA is used as a practical solution to effect change and promote health equity.

To support this process, health needs to develop technical solutions, conceptual solutions to develop goals and problem solving strategies, and social learning to advance interaction with all stakeholders.

'Putting our own house in order: examples of health-system action on socially determined health inequalities' (26) is a WHO report that aims to show how case studies can be used to generate evidence informed options for action. It suggests that there are four overarching principles for health systems in promoting health equity. These are:

1. Inter-sectoral action
2. Civic participation
3. Universal coverage, and
4. Comprehensive primary care.

These principles are then used to develop a checklist that can be used to review examples of action and to design one's own policies (Appendix 2).

As part of a series of articles debating the role of HiAP in the Journal of Epidemiology and Community Health, Bacigalupe et al (27) argue that healthy public policy has rarely been systematically adopted by any government in the world. Part of the problem has been the focus of health promotion on downstream disease oriented topics and lifestyles rather than the social determinants of health which, they argue, has led to the *"de-politicisation of the economic and social conditions that are largely beyond an individual's control"*. The three key barriers to a more holistic HiAP approach are:

- conceptual/philosophical – for example the imprecision of terms such as health inequity
- organisational / infrastructural – including government departments working in silos, or commissioning/provider split working against integration of services,
- political – in particular the rise of neo-liberalism and values of individualism and materialism alongside the decrease of 'nanny state' interventions and social welfare.

They argue that those promoting HiAP need to support alternative views, for example 'de-growth' theory and the development of gross national happiness indicators. Action to promote greater health equity is limited unless we question *'the structures of power and the current socioeconomic development model'*.

To support this, they point out that HIA is mostly focussed on local projects that do not challenge the whole economic and political system, and that the challenge is now to re-invigorate the social model of health as put forward by the Ottawa Charter for Health promotion in 1984. This does not mean a paternalistic approach to health, but an approach that makes it easy for individuals and communities to make healthy choices.

The WHO Regional Office for Europe, 2010 (28) report explores how the EU Structural Funds and Cohesion Funds, which amount to 347 billion Euros for the period 2007 – 2013, could contribute to the reduction of health inequalities across the EU. One of the key recommendations is the promotion of a HiAP approach. Health systems can influence this in two ways. Firstly by being involved in the management of the Social Fund from policy initiation to completion they can ensure the social determinants of health are addressed to tackle health inequalities. Secondly by being part of the delivery of Social Fund projects by;

- agreeing priorities, procurement and project implementation through the final audit of the project
- facilitating HIAs or incorporating HIAs into integrated impact assessments
- building capacity of health staff to engage in the Social Fund process
- sharing learning amongst all recent and current EU funded projects to build a knowledge base to inform future research, policy and practice.

Kahlmeier et al 2010 (29) describe an international project to develop guidance and tools for quantifying the health effects of cycling and walking through economic appraisal. The context for this is the recognition that to demonstrate win-win options within HiAP *"Including economic savings from health benefits... is paramount to make the potential co-benefits explicit".* It uses a cost benefit approach where health gains are given monetary values. The tool illustrates the importance of considering health within transport policy and infrastructure planning, and so put 'Health in All Policies into practice'.

Finally, the Robert Johnson Wood Foundation report (30) examines how HIA can be used to promote HiAP. Within this they point out that the definition of HIA should include an analysis of the distribution of health effects within a population and hence should address health inequalities. Their starting point specifies the inclusion of equity as one of the core values for HIA.

Whilst viewing HIA as an essential tool for achieving HiAP, they point out some of the challenges. These include the time lag between upstream measures and health benefits being demonstrated and the existence of confounding factors (and the difficulty of adjusting for these in HIA assessments). As well as HIA therefore, HiAP needs to establish appropriate; governance structures, financial support, and a regulatory and legal framework that facilitates collaboration across sectors. They conclude that the first essential step to HiAP;

> *"may be bringing sectors together to make the case for joint action, to discuss their respective needs and constraints, and to create a shared language for decision-making".*

2.4 Strengths and weaknesses of studies

The majority of the studies reviewed here are 'grey literature', that is, they have not been published in peer reviewed journals (except 21,22,27,and 29). Although this is to be expected for policy papers, it does mean that there are potential weaknesses within these studies that may have been identified had they been subject to a robust peer review process.

The peer review process was established to ensure only those studies of the highest standards achieve publication, and although many of the studies reviewed here are published by respected publishers and institutions, the lack of transparent peer review process does mean the that the quality is not checked in a systematic and transparent way.

The majority of reports reviewed here are opinion pieces based upon the authors' interpretation of case studies and their own experiences, rather than presenting the results of research studies. Again, although this is to be expected for reports of this type, there may be methodological flaws in the collation and interpretation of evidence used to formulate the reports. Where these are apparent they have been discussed in the individual reviews. Otherwise one can only state a general caution as to the level of evidence presented in this literature review.

2.5 Discussion

Several key themes emerge from this review of the reports and publications presented here. These themes relate to both the barriers and potential solutions to implementing HiAP more successfully across the EU, and also in particular to the explicit inclusion of health equity within the HiAP approach. The key themes are as followed and discussed below:

1. Leadership
2. Governance and strategy
3. Partnership and stakeholder engagement
4. Capacity and technical skills
5. Health equity
6. Tactics
7. Culture and values.

Leadership and politics

Many reports argue for an explicit political commitment to HiAP at the highest possible level as a pre-requisite for success (14, 15, 16, 17, 24, 25). The commitment needs to be long-term and explicit (14). Health systems need to show leadership in advocating for health and the HiAP approach (141, 15, 19, 22). The use of annual reports and other publications can help to demonstrate this leadership (14, 19). Some have argued for the need to question the structures of power and the socio-economic model of society (27). This is most apparent when there is conflict between policy areas, for example economic development and health (14, 21, 27).

Governance and strategy

A number of reports suggest that it is advantageous to have an overarching high level strategy that specifically endorses HiAP approach (1, 16, 17, 19, 20, 24). This can help to overcome divisions when there are apparent conflicting objectives between sectors. The departmental structure of governing bodies can act as barriers to cross government working (16, 20, 27). The establishment of inter-departmental committees (16, 19, 20, 22, 26, 27) and shared targets (19, 20, 25) as well as examining the potential for pooled budgets (16, 20) can also contribute to better strategic coordination across government. It can help to identify strategic priorities, and help to achieve cooperation and compromise when needed (22). Systems which make HiAP and HIA systematic can ensure health is embedded within an overarching high level strategy.

The importance of influencing and increasing financial support to undertake HiAP as well as to tackle the social determinants of health is also recognised (1, 16, 20, 30). Some have pointed out the importance of the health sector keeping up to date with wider government policies and developing systematic methods to horizon scan and identify those that may have the largest impact on health (22, 24).

Partnerships and stakeholder engagement

Working effectively with a wide range of partners is essential, and many of the reports recognise the need for a multi-stakeholder and multi-factorial approach (14, 19, 20, 21, 3, 24, 26). It is important to have an understanding of the key drivers and objectives of wider partners and their policy areas (14, 16) and know when to protect health objectives, and ensure they have the policy space necessary to have an influence (14, 8, 11).

Including stakeholders is seen as a critical factor in a successful HiAP approach (15, 16, 20, 21, 27). Community participation, including empowering and training communities to use HIA themselves, can be a rallying call that can take forward HiAP when there is resistance from other sectors (15, 16). Finally, there needs to be high quality information and data presented to stakeholders in clear and appropriate formats to ensure evidence based policy making is a truly collaborative process (14, 20).

Capacity and technical skills

Building skills and capacity both within and external to the health sector is seen by most as essential to the development of HiAP. This ranges from building capacity to undertake HIAs (14, 19, 22) to developing skills around partnership working including mediation and negotiation skills (14, 18, 24). Others discuss the importance of developing specific skills such as fundraising (28), economic analysis (29), evaluation (20) and social learning (25). Building equity into both HIAs and the HiAP process is considered a specific skill that needs developing (16), as well as incorporating HIAs into wider Integrated Impact Assessments (20). Finally, the importance of building cognitive capacity is discussed (25), meaning the ability to think innovatively and beyond ones own policy areas, for both health and other sectors.

Health equity

The lack of success in incorporating health equity into both HiAP and HIA is mentioned by many reports (14, 15, 18, 20, 25). A number refer to the review of HIAs which showed that less than half had stratified data to be able to examine the impact on health inequalities (14, 15). A number of ways forward are suggested including:

- improved information and research to both improve impact assessment and to evaluate the effect of HiAP approach (14)
- improved data collection and information skills (18)
- the promotion of health equity within HIAs (18, 20)
- capacity building to improve HIA skills that have a strong health equity element to them (20)
- involving poor communities in the HIA and HiAP process (20) and
- a better political understanding of the context of health inequalities and the distribution of the social determinants of health in society (25).

Tactics

A number of reports promote the importance of identifying win-win approaches, where there are clear and evidence based co-benefits to health and other policy areas, as being a successful area for implementation of HiAP (14, 15, 16, 21, 25, 29). In addition, developing tools such as economic

analysis that can objectively demonstrate those co-benefits could be productive (29). However, when win-win options are not possible, because there are conflicts between different policy objectives, then a different approach is needed. This requires cooperation, alliance building, negotiation, mediation and compromise (14, 15, 16, 21, 24). Being adaptable and flexible as well as having realistic expectations helps (16). Timing is important too, especially getting involved at the beginning of the policy development cycle (15), and demonstrating the added skills and value that health can bring to the table (15, 22, 29). Using legal expertise is also seen as an important though insufficient tactic to promote HiAP (15, 20).

Culture and values
The values of equity, solidarity and universality embedded within the EU are values that should apply to HiAP (14). Whether HiAP is successful can depend upon the culture of public health across the organisations (15). Others have argued that values of openness and transparency within the HiAP process are essential (24). However, the development of shared values across sectors is seen as an essential starting point for HiAP by a number of reports (15, 19, 20).

The role of cultural change needed for HiAP to be effective has been discussed, in particular in relation to how the distribution of the social determinants of health are embedded within the values, history, norms, power and culture of society. It is argued that only by understanding these can HiAP begin to have a sustainable impact (12).

3. Interviews with key stakeholders

3.1 Aim

The aim of this section is to explore the themes that emerged during the literature review with key stakeholders engaged in HiAP at a Country and Region level. These were:

1. Leadership
2. Governance and strategy
3. Partnership and stakeholder engagement
4. Capacity and technical skills
5. Health equity
6. Tactics
7. Culture and values.

3.2 Methodology

A qualitative research methodology was used in the form of semi-structured interviews with key stakeholders, who were invited to take part in a telephone/skype interview. A pro-forma was developed for the interviews using the above themes, and was used to guide the interviews (Appendix 2). Invitations to take part were sent to 34 individuals comprising members of the Joint Action Work Package 4 'Tools to improve the health equity focus in cross government policy making'.

Full interviews were conducted with 19 people representing 12 countries and one region (see Appendix 3). The interviews lasted approximately one hour each. The interviews explored the above themes and gave interviewees the opportunity to discuss areas they felt were not covered by the themes and to offer advice to others who were just developing a HiAP approach. The interviewer took notes during the interviews and sent them for comment to the interviewees to allow corrections and additions to be made before the production of the final report. For the purposes of this report, the Basque Country which is a Region of Spain, will be referred to as one of the 'Countries' interviewed.

3.3 Results

3.31 General
All interviewees were happy with the range of themes to be explored.

3.32 Leadership

Political commitment to HiAP

A number of Countries felt that they had high level and explicit political commitment to HiAP with a strong focus on tackling the SDH (England, Scotland, The Netherlands, Norway, Wales, Sweden) and that this was crucial in making progress with a HiAP approach. Some however felt that this was

work in progress (Belgium) or was currently being strengthened, for example the new public health act in Norway specifically mentions HiAP. Others such as Sweden expressed some reservations about the current direction of travel whilst Spain and the Basque Country and felt there had been high levels of political commitment from 2008 – 2010 and especially during the Spanish Presidency of the EU during 2010. Hungary said that the current economic crisis was overriding any other political drivers.

Others stated that political commitment alone was not enough if it did not have coordinated mechanisms for implementation (The Netherlands). Part of this problem was identified as the political emphasis on healthcare delivery rather than on prevention. There is still a need to promote the social model of health (Basque Country). Others were more optimistic. In Wales there is significant cross party commitment to the wellbeing agenda and public health plans are becoming more widely embedded into OGDs. The recent Bevan Commission Report 'NHS Wales: Forging a better future' agreed by cabinet and assembly is seen to offer promise for the future of this approach;

> *"The Commission concluded that the NHS could not resolve the health problems of Wales alone: these must be addressed by a broader public health strategy otherwise the NHS will become increasingly strained over the longer term."*

Health leadership

There was a wide range of views on the strength and effectiveness of health leadership for HiAP. England felt leadership was built systematically into the health system with Scotland describing their leadership as 'charismatic'. Some however felt that in comparison to OGDs, health leadership was often not strong enough to really tackle more powerful departments and influence their policies. In addition, the emphasis and priority on health service delivery was a common feature of the majority of Countries interviewed. The use of Annual Reports was a common feature of most Countries to generate awareness. Again it was felt this was not enough on its own to support the implementation of a HiAP approach (The Netherlands).

Several Countries said that their public health systems were currently under reform (England, Hungary) and that clear leadership to tackle the SDH was difficult until the new system was in place (Hungary). Others felt that strong leadership could help in situations where there was conflict with OGD policy areas, though other factors such as political commitment and support also needed to be in place (Scotland).

3.33 Governance and strategy

Cross Government Strategy

Seven of the thirteen countries/region interviewed (England, Scotland, Wales, Northern Ireland, Republic of Ireland, Norway, and Sweden) said that they do have an overarching strategy that endorses a HiAP approach.

One of the main advantages expressed across these countries were that having an overarching strategy gives legitimacy to taking a HiAP, approach and is an important emblem of political support and engagement. For example, in Sweden the 2003 Public Health Bill (renewed in 2008) provides a strong political support for HiAP and a preventative approach to health which focuses on social conditions.

For Norway, it was felt that the advantage of a high level strategy gives legitimacy to HiAP and that this is a distinct advantage. However, in their case the strategy established a systematic reporting system on the progress made to reduce inequalities in health, as well as social determinants of health such as trends in income distribution, education, working environment and social inclusion. In addition the strategy supported the development of a new Public Health Act 2011 (to be implemented January 2012) that has HiAP as one of it's five fundamental principles:

> "*Health in all policies: Equitable health systems are important to public health, but health inequities arise from societal factors beyond health care. Impact on health must be considered when policies and action are developed and implemented in all sectors. Joined up governance and intersectoral action is key to reduce health inequities*".

A number of other Countries were in the process of developing strategies and plans that would support HiAP (Hungary, Spain) or were able to use other existing action plans or strategies that may not specifically endorse HiAP nevertheless provided a useful framework or principles that could be used to legitimise this work. For example, Spain has just approved a new General Act on Public Health, which includes a HiAP approach and makes HIA mandatory to "regulations, plans, activities and projects with a significant impact in health", while the Basque Country is developing a new regional Public Health law with a specifically social model of health mentioning both HIA and HiAP. In France, although there is not overarching strategy, there are specific goals to tackle health inequalities which are helpful in ensuring HiAP has a health equity focus.

Those without a current strategy did feel that this would facilitate cross government working, again by supporting the approach and by giving health a legitimacy it may otherwise lack.

Interdepartmental structures

Three Countries have formalised cross government structures that have responsibility for this HiAP (Scotland, England, and France). Although Health may take a lead in these, there are expectations that other government departments (OGDs) take responsibility for specific targets and work areas. For example in Scotland, a ministerial taskforce convenes every two years to assess progress towards the 'Equally Well' strategy published 2008, which has a strong emphasis on the social determinants of health (SDH).

Other Countries have a range of systems to work across government. For example in The Netherlands there are working groups for specific topics like healthy weight, whereas in Wales, where all departments work in the same building there isn't necessarily the need for formal structures since interdepartmental working occurs organically as a result of individual relationships'

between officers and politicians. Similarly in Sweden, the Social Department with responsibility for health works well with other ministries and there are specific working groups that bring departments together to work on particular issues. For those Countries without a formal cross government structure, some (The Netherlands, Republic Ireland) felt that this could mean Health has little influence on OGDs, or at least that the influence was at the discretion of individuals rather than institutionalised. The Basque Country felt that the organisational split between teams working on HIAs and those working on HiAP created barriers to integrated working on SDH.

One specific area in which Spain has a comprehensive and satisfactory experience on HiAP is dealing with equity and health for the Roma population. Action on relevant areas such as education, health, housing, employment, among others, is being implemented through the Action Plan for the Development of the Roma population of Spain 2010-2012. The different areas were developed with the consensus of the State Council for Roma Population where there are representatives of Roma NGOs.

Financial support for HiAP

None of the Countries interviewed had specific budgets for HiAP. However, funding for this work often came from general public health budgets (Sweden, Hungary). It was felt that the emphasis for HiAP is about influencing other departments spending by developing shared goals (Wales). In addition some felt it could be counter productive to hold a specific HiAP budget, because the aim was to encourage OGDs to take responsibility for the health impacts of their own spending (England).

Keeping up to take with OGDs policy developments

Most Countries did not have a systematic way of doing this, with most relying (often, they felt fairly successfully) on personal relationships with OGDs (Scotland, England, Belgium, Spain, Hungary, Basque Country, Republic of Ireland and Northern Ireland). Problems can occur when staff leave or relationships break down for other reasons.

Some however had more systematic methods. For example in 2011 The Netherlands national Institute for Public Health and Environment undertook a research project to review OGDs policies over the previous four years to identify those with potential health impacts. This was then used to look for a renewed strategy to reduce health inequalities.

In Sweden the Public Health Bill focuses particularly on children, young people and the elderly, with a special focus on initiatives aimed at strengthening and supporting parents in their parenthood, increasing suicide prevention efforts, promoting healthy eating habits and physical activity and reducing the use of tobacco. This provides a way to keep up to date cross a broad range of priorities across government.

3.34 Partnership and stakeholder engagement

Many Countries had limited experience of working with wider stakeholders outside of government but recognised that could be advantageous (Basque Country, Sweden, Spain). Some identified a key factor in engaging stakeholders as improved communications on health with good quality

information well-presented that could be understood by broad range of sectors (Spain). Others felt that there were efforts made to systematically engage with key stakeholders and a strong tradition of engagement largely funded by the state (England, Norway). In Wales, one of the four strands for their approach to HiAP is partnerships, and the definition of partnerships includes a broad range of stakeholders.

Partnerships with the Community sector

Most Countries had some experience of working in partnership with the community sector, though the level of this involvement varied considerably. In Scotland for example a system of 'reverse mentoring' is in place in which senior policy officers are mentored by community representatives. England has a systematic approach to partnering with the 3rd sector. In France, a new Act for the regions means that community participation is mandatory.

However, there is a feeling that consultations tend to be responded to by professional groups and that more work is needed to ensure that the voice of real people is heard (France, Spain). Others felt that although community involvement happened at a local level it was often missing and certainly more difficult at a regional or national level (Basque Country, Sweden). Nevertheless, some have embedded community participation within national strategy documents. For example in Sweden, the 1st Public Health Objective of the National Public Health Policy 2009 is around 'Participation and influence in society, and states;

> *"Societies with low election turn-out, where few people feel there is any point in participating in NGO activity or trying to influence societal development, are those which are characterized by the occurrence of serious health problems. Increasing people's level of participation in society is therefore one of the most important public health objectives."*

There was however caution expressed in being 'too close' to NGOs with a single focus which may conflict with the need to present objective evidence to Government. In working at a local level most Countries mentioned working with local authorities in partnership, and some discussed working with academia. For example the Basque Country works closely with the Andalucían School of Public Health.

Partnerships with the private sector

Most Countries expressed the view that although involving private sector partners could be beneficial and should at times be encouraged (England, Spain, The Netherlands) there were inherent dangers in terms of potential conflicts of interest and there were certainly some private sector partners that most Countries would never work with in partnership – principally the tobacco industry. However, on balance in a democratic society all voices should be heard and a professional approach is needed to this (Sweden). A number of Countries highlighted the food industry as examples where progress could be made in reaching voluntary agreements for example on labelling or reductions in levels of salt, saturated fats and sugars (England, Northern Ireland, Norway, Spain).

3.35 Capacity and technical skills

Some Countries discussed lack of capability and capacity of technical skills, including developing the evidence base, HIA, economic analysis and in particular equity focussed HIA (Scotland, Hungary, Spain and the Basque Country). The majority felt there were more significant gaps in the 'softer' skills. These included influencing and negotiation skills, how to identify win-win options, skills needed to demonstrate the effectiveness of HiAP, and communication and relationship building skills needed to get health onto the political agenda.

Although HIA training was generally seen to be popular there was a perceived lack of capacity for implementation (Republic of Ireland and Northern Ireland). Belgium wanted more specific support in the form of concrete case studies that could clearly demonstrate the benefits of taking a HiAP approach, and expresses a view that existing resources tended to be too abstract or vague.

Many suspected that building equity into HIAs and HiAP was a specific skills gap, although a plea was made for simpler tools and the hope that the Joint Action would help to deliver this. Having good links to academic institution was seen as a potential way to increase capacity for example the Scottish collaboration for public health research.

3.36 Health equity

A few Countries gave concrete example of HiAP that had a strong equity focus. In Norway Health recently contributed to a report on income distribution outlining the health impacts for greater income equality. However, the fact that most countries could not cite specific examples possibly reflects that lack of emphasis that equity has had within HiAP to date. In Northern Ireland OGDs are already undertaking impact assessments on policies, yet the health equity impact tends to be a half page 'add on' rather than an integral part of policy toolkit.

The lack of stratified data, for example socio-economic class, was identified by a number of Countries as barrier to health equity work (The Netherlands, Belgium, Hungary). This was felt to be a necessary but not sufficient factor for successful HIA (Basque Country). Finally, the very language of health equity was felt not to be widely known (Hungary) or misunderstood (Wales) and much more work is needed to raise awareness of this outside of health sectors.

3.37 Tactics

Win-win approach

Most Countries agreed that prioritising areas where there were clear co-benefits between health and OGD objectives was a sensible tactic, and provided many examples of where this had been successful. For example in The Netherlands health worked successfully with the government department responsible for housing and communities to develop programmes for deprived communities. This resulted in work on safe housing, road safety and the social environment. The identification of clear co-benefits made this work possible and highly productive. In the Basque Country, Health worked with four other government departments on a regional transport policy.

This involved screening 16 policies and making suggestion for how they could be improved to reduce negative health impacts and increase positive health.

However, a number of Countries (Basque Country, Norway) expressed caution that Health must not come across as imperialistic when using this tactic i.e. coming in to tell OGDs what to do then disappearing again. Instead, Health must work hard to develop shared goals and objectives and ensure that health incorporates others policy areas as well as vice versa. For example in Wales Health have worked not only to ensure that health aims are embedded in child poverty policies and that NHS plans incorporate child poverty objectives, yet others argued that in the current financial climate across the EU it is more important than ever to argue for economic co-benefits of wider public health policies and proposals.

Conflict and cooperation

Many Countries mentioned economic crisis as a huge barrier to developing win-win approaches when there are potential policy conflicts in particular with OGDs responsible for business and economic development. However, there have nevertheless been notable successes in spite of this, for example in the republic of Ireland a proposal to develop a huge 'super' casino was rejected, in part due to Health providing evidence on the potential negative impact this might have on mental health and poverty.

A common theme emerging from discussions relating to conflict were how political commitment can be hugely influential in resolving these differences and that this sometimes happens at the highest level e.g. in Hungary policy conflicts are generally resolved by the Prime Minister who pushed through smoke free legislation in the face of opposition from OGDs who were worried about the economic impact.

Other approaches to managing this conflict were suggested. Many felt that compromise is often needed and certainly the ability to negotiate and maintain good relationships. Using NGOs and other stakeholders can be a good way of 'selling' the health story (Norway) and suggesting what Health can do for OGDs and well as what OGDs can do for health i.e. 'health for all polices' as well as health in all policies (The Netherlands).

Timing and legal support

Most Countries agreed that it was desirable to get involved at the beginning of the policy development cycle, but in practical terms this could be difficult when policy making is such a fluid process (England). However, in Wales the 'Policy gateway' process requires OGDs to consider health at the outset of policy development, and this may be facilitated by a move toward greater use of Integrated Impact Assessment tools in future.

Legal support was felt to be available when needed for some (Scotland) but Spain found that although legal support is essential it should be accompanied by social support and regulations which promote changes in culture and values.

3.38 Culture and values

The majority of Countries interviewed felt there the values inherent in their countries reflected the EU values of equity, solidarity and universality. Wales however pointed out the potential conflict between universality and health equity, where implicit in the concept of vertical equity is the targeting of resources at those with the greatest need. This is an important point often overlooked and clearly demonstrates the importance of clear definitions of concepts and terms within this policy field.

Some Countries describes a strong tradition of public health, whereas others described this as a fairly new concept (Hungary). Even those with a strong tradition felt that this needed emphasising and renewing. The Netherlands expressed a lack of commitment to collaboration at a high level. However at an officer level, most policy officers of different departments acknowledge that their policy resolutions could contribute to the reduction of health inequalities, and most of them had a positive attitude towards intersectoral collaboration as well. This indicates that among policy officers there is a basis for a HiAP approach.

Wales expressed the need to ensure values of public health are linked to those of sustainable development. Most however recognised the influence culture and values have on the acceptability of a HiAP approach. For example the strong culture of temperance movement in Norway meant that public health interventions such as maintaining very high alcohol pricing were more accepted than perhaps in other Countries where individual choice was more strongly emphasised above 'nanny stateism' (Wales, England). It was recognised that cultures and values change over time and that the current economic situation meant that people's views of what was important could change with the danger that heath could be relegated down the list of priorities.

3.39 Top tips for promoting equity focussed HiAP

As well as providing thoughts on how HiAP could be implemented Member States gave their views of the top tips for the implementation of HiAP.

> **England** – Hang on in there! HiAP needs persistence and takes time – even in favourable winds!

> **Republic of Ireland and Northern Ireland** - You need dedicated people and resources to implement both HIAs and the HiAP approach.

> **The Netherlands** – Strengthen links with other agencies and clarify how policies impact on health in a very concrete way. It's also important to support the development of overarching strategies and goals.

> **Norway** – First you need political commitment, then establish facts and evidence, but this can work the other way round! For example it was evidence from international

publications which demonstrated that health inequalities within Norway were greater than expected, that raised HiAP higher up the political agenda.

Scotland – Don't use the 'H' word (Health!). Best to describe health in terms of its wider outcomes and how it influences and is influenced by for example education, crime etc so that HiAP is not seen as a parochial concern of the Health sector lobby.

Spain and Basque Country – It's difficult to progress without political commitment and so you need to develop advocacy skills at a political level.

Sweden – Need to establish a political cross party consensus for HiAP to enable effective implementation and to ensure its long term sustainability.

Wales – Emphasise wellbeing rather than health – this is much more meaningful when working with partners.

3.4 Discussion

3.41 Themes

In general there was a fairly consistent agreement with the barriers and potential solutions to the successful implementation of HiAP outlines in the literature review. However there were some changes of emphasis and a richer description of how thee operate in practice, as well as some pleas for support and recommendations or tips for progress.

Leadership and politics

Political leadership was consistently cited as a crucial factor in the implementation of a HiAP approach. In addition Health leadership was vital because Health was often seen as a poorer cousin in relation to OGDs, in particular given the current economic crisis across the EU. For some this was seen as a starting point for the whole approach.

Governance and strategy

A strong emphasis was placed on the advantages of working within the context of an overarching strategy, or at least action plan to tackle health inequalities and promote health equity by taking action on the social determinants of health. As well as legitimising a HiAP approach, it can help to identify common aims across government, and support the use of resources to implement HIAs and a wider HiAP.

Less emphasis was placed on the need for interdepartmental structures to facilitate HiAP. In general, although this was ideal, the development of topic specific working groups at which Health had an influence was seen to be a practical alternative.

Most Countries however supported the view that more work was needed to ensure that a systematic approach was taken to ensure Health kept up to date with the myriad of OGD policies

that could influence health. However, a pragmatic approach was needed. It was recognised that in smaller Countries with good cross government relationships this wasn't necessarily an issue.

Partnerships and stakeholder engagement

Although recognised as important, in some cases this was felt to be a local priority rather than a national one, and indeed some caution and concerns were expressed in engaging with both private and community sectors. Those that did feel this was an important area however often felt that national consultations failed to truly engage with communities.

Capacity and technical skills

Although technical skills were recognised as important capacity and capability issues, and stronger emphasis was placed upon the need for softer skills to influence OGDs and other sectors and to resolve conflicts and raise awareness of health equity. Specific pleas were made for case studies to help raise awareness and sell the concept of HiAP, and for simpler tools to support its implementation.

Health equity

A greater understanding is needed of the differences between health equality and health equity, and better data needed to be able to understand health inequalities at a national and local level. There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus.

Tactics

Identifying and focussing on win-win policies was consistently highlighted repeatedly by Countries. However, the way in which this was done was crucial and several pointed out the danger of health coming across as an 'imperialistic' outsider with vested interests rather than taking a truly collaborative approach. This should emphasise how Health can help deliver other policy objectives and aim to reach common goals (a 'health for all polices' as well as 'health in all policies' approach). This is particularly important in resolving potential policy conflicts.

Culture and values

Whilst being recognised as an important factor, the role of culture and values to provide a context for HiAP implementation was not widely commented upon. Some did see how the history and tradition of public health could influence the acceptability of an interventionist approach to the SDH, and that culture and values are not static concepts but change and can be changed in ways which can be positive and negative for health and health equity.

3.42 Limitations

Selection bias

Given only 19/34 partners invited to take part in these interviews were able or willing to take part, and that they represented only 13 of the 18 countries invited, there may be selection bias in the views expressed. For example that those Countries with more positive experiences of implementing HiAP were more likely to take part and that the views of those who have made the

least progress have not been heard. It is particularly noted that only one former Eastern European country (Hungary) took part in the interviews. Sensitivity analysis could be undertaken by using this report to consult with those individuals and Countries who were not represented.

Misclassification Bias

Since the interview process and report is not anonymised, and that interviewees have been given the chance to correct the summarised views expressed in the report, it may be that political sensitivities may prevented individuals were not always able to express there true views.

It is also true that the individuals interviewed may have different views from others within there country, and that the split that often occurs between those undertaking HIAs and those with a HiAP policy mandate meant that there have been areas that interviewees felt they did not have the knowledge to comment on. Again, wider consultation on the content of the report may help to correct some of this misclassification and plug some of the gaps.

4. Conclusions

The following conclusions have been drawn from the evidence reviewed;

- Explicit political commitment to HiAP at the highest possible level is a pre-requisite for success. Health systems need to show leadership in advocating for health and the HiAP approach. This is particularly important given the current economic crisis.

- EU member states, countries and regions should be encouraged to develop overarching strategies and action plans that endorse a HiAP approach.

- Working in partnership, particularly with communities, is a neglected area in the implementation of HiAP.

- Although technical skills (such as data analysis and interpretation) were recognised as important capacity and capability issues, stronger emphasis needs to be placed on the development of softer skills (such as negotiation and relationship building) to influence OGDs and other sectors and to resolve conflicts and raise awareness of health equity.

- There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus. This needs to be addressed as a priority by EU Member States, Countries and Regions.

- A focus on win-win policies is recommended, but Health must take a truly collaborative approach; 'Health for All Policies' as well as 'Health in All Policies'.

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Appendix 1. WHO Regional Office for Europe: A checklist of key principles for reviewing examples of practice.

1. Is it about action on SDH with the objective of reducing health inequalities? Or does it focus only on tackling the SDH without regard to distribution of impact, i.e. health inequalities?

2. Is the equity objective clearly defined?

3. Do the equity objective and actions match the problem or issue they are designed to address?
    - is it easy to see what the problem was including the causal pathways?
    - is there information about how the problem and solution were defined and developed, including who was involved?

4. Has the action been evaluated for its impact on health inequalities?
    - did the evaluation approach have a model of attribution?
    - were the assumptions about the links between the issue or problem and solution made clear?
    - were the indicators or targets and measures for monitoring them relevant or
    - consistent?
    - Was the theory of change that informed the solution made clear?

5. Is the action consistent with the broader policy context? For example, is the social protection system also designed to promote universal coverage? Is there enough information about the broader policy context to be able to assess this?

6. Is there enough information about the health (and/or social) system context to identify essential or fundamental features that need to be in place to support the action?

7. Were additional human, financial and other resources required for implementation of the action, or was it done by redirecting existing resources?
    - how was this done – by introduction of a new funding formula for allocation of resources with an emphasis on equity, for example?
    - is there a system for monitoring progress?
    - is there any evidence that this has made a difference to practices within the
    - health system?

8. What investment was made in building capacity to act and to implement the health-system action? Is there any evidence that this has made a difference to practices within the health system?

Appendix 2. Interview proforma.

Introduce myself as PH Registrar working for Health Action Partnership International (HAPI) and the Department of Health (England).

Following a literature review, this piece of work is a series of semi-structured qualitative interviews with key stakeholders across the EU.

In structuring the interviews I am using the key themes that have emerged from the review:

- Governance and strategy
- Tactics
- Partnership and stakeholder engagement
- Leadership
- Culture and values
- Capacity and technical skills
- Health equity

Your answers will not be recorded – I will be taking notes as we speak. Unless you request anonymity this will be a attributed interview, but I will send you a draft of the report so that you can correct any inaccuracies.

Contact details:

Name

Job title

Org

Email

Phone/Skype

General

1. Firstly, are you happy with this approach? Do you think there are other key themes that are not covered here?

Governance and Strategy

2. Does your member state have an overarching strategy that endorses a HiAP approach e.g. on HIs. *If so* has this been advantageous in implementing HiAP? were you able to influence the development of a high level strategy? How did you do this? What would you recommend to others trying to do this?

3. Does your country have interdepartmental structures with responsibility for this area? e.g. any shared targets, or pooled budgets?

4. If not has this had an impact on implementing HiAP?

5. Have you been able to influence or increase financial support for HiAP? Where from and how did you go about doing this? What were the success factors and barriers?

6. How do you keep up to date with policy development across Government / EU to assess their potential impact on health? How do you do this? Is it systematic?

Tactics

One of the most successful approaches identified by the lit review was win-win situations i.e. targeting policy areas where there are obvious co-benefits between health (including equity) and the other policy area for example physical activity, sustainability and active transport planning.

7. Can you give me some examples of areas where this has been successful for you? Where has it not worked so well?

8. What about when this is not possible i.e. there are conflicts between policy areas (e.g. economic development, alcohol, and health). What approach (if any) have you taken in these situations? (Hint: cooperation, alliance building, negotiation, mediation, compromise)

9. Can you give an example of when you have managed to get involved at the start of the policy development cycle? Was this important? Why?

10. Have you used legal expertise to support HiAP? Did this work?

Partnership and stakeholder engagement

11. Have you taken a multi-stakeholder and/or multi-factorial approach to HiAP implementation? If yes what facilitated this and If not what has prevented this?

12. Have you included stakeholders in the process of HiAP? Does this include private sector, and if so what were the advantages and disadvantages of this?

13. What about including communities? Have you tried to do this? How did you go about it? Have communities been trained and supported to undertake HIAs themselves? Is this important?

14. How do you ensure data and information presented to stakeholders is clear and understood?

Leadership and politics

15. Do you have a political commitment to HiAP? If so is this a long term explicit commitment?

16. How do you from a health perspective show leadership in this area? Do you publish annual reports? Are these useful?

17. How can leadership help when there are strong conflicts between policy areas e.g. economic development and health equity?

Culture and values

18. Are the EU values of equity, solidarity and universality reflected in the values of your country? Do you feel these are shared values that cut across departmental boundaries? Does this help/hinder your work to implement HiAP?

19. Do you think your country has a strong culture/tradition of public health? Is this reflected across departmental boundaries?

20. Do the norms / values of your countries help to promote greater health equity in your country? How/Why not?

Capacity and technical skills

21. What specific skills do you feel are important to HiAP and HIA (technical, epidemiology, CA, health economics, evaluation, partnership working, negotiation, mediations, influencing, fund raising)

23. To what extent does the lack of capacity and/or capability in these areas affect your ability to implement HiAP?

24. Do you consider building equity into HiAP/HIA a specific skill gap?

25. What has been successful in building capacity in your country? What lessons can you pass on to others?

Health Equity

26. Do you have any examples of areas where you have explicitly addressed equity into HiAP or HIA? What were the drivers for this? Were there any barriers? How did you overcome them?

27. Could improved information, data collection and research contribute to developing Health equity within HiAP/HIA? (to improve impact assessment? To evaluate impact of HiAP?) How could this be achieved?

28. Could including communities in the HIA and HiAP approach help to promote health equity within these processes?

29. Does there need to be a better understanding across the system of the impact of policies not only on health but on health inequalities and equity? How could this be done?

General

30. Are there any areas you would like to mention that we haven't managed to cover?

31. What are your top tips for promoting HiAP generally, and health equity in particular?

Appendix 3. Interviewees.

Name	Organisation	Country/Region
Ida Knutsson	Swedish National Institute of Public Health	Sweden
Gila Ginsell	Directorate for Public Health and Health Professions, Welsh Government.	Wales
Andy Bruce	Health Improvement Division, Scottish Government	Scotland
Ray Earwicker	Health Inequalities Unit, Department of Health	England
Dr Pol Gertis	Ministry of Social Affairs and Health	Belgium
Pilar Campos	Ministry of Health, Social Policy and Equality, Spain	Spain
Begona Merino		
Ana Gil		
María Santaolaya		
Elena Aldasora	Health and Consumer Affairs Department, Basque Country	Basque Country
Santiago Esnaola		
Amaia Bacigalupe		
Dr Nicolas Prisse	Secretariat DG Health, French Government	France
StigErik Sorheim	Norwegian Directorate of Health	Norway
Agnes Taller	National Institute for Health Development	Hungary
Eszter Lorik		
Edina Gabor		
Owen Metcalfe	Institute of Public Health	Northern Ireland and the Irish Republic
Ilse Storm	National Institute for Public Health and Environment	The Netherlands

Appendix 4. Definition of Terms

Health inequality and health equity are different but related concepts. They have been discussed (along with Health Impact Assessment) in other documents published as part of this programme (24).

For the purposes of this literature review, the following definitions have been used:

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes (25).

Health Equity refers to differences in health that are not only unnecessary and avoidable, but in addition are unfair and unjust (26).

Health Impact Assessment (HIA) is combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population (29).

The important point to note from this is that not all inequalities are inequitable, not all equalities equitable (27). This relates to the concept of horizontal and vertical equity; horizontal equity occurs when the same resources are used to address the same needs, whereas vertical equity allows different resources to apply to differing needs. For example most people would support the 'rule of rescue' (28) which gives priority of treatment to those with urgent health need.