Getting Started with Health in All Policies:  
A Resource Pack

Health in All Policies: A Snapshot for Ontario

Results of a Realist-Informed Scoping Review of the Literature

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# Table of Contents

One Page Summary ........................................................................................................................................... 3  
Executive Summary ........................................................................................................................................ 3  
1. Introduction .................................................................................................................................................. 8  
   1.1 Objectives ......................................................................................................................................... 8  
   1.2 Additional Resources ....................................................................................................................... 9  
2. Background ............................................................................................................................................... 10  
   2.1 Reducing Health Inequities in Ontario ............................................................................................. 10  
   2.2 What is a Realist Scoping Review? .................................................................................................... 10  
   2.3 Defining “Health in All Policies” ...................................................................................................... 11  
   2.4 Five Stage Scoping Review and the Identification of “Health in All Policies” Cases .................... 12  
3. Scoping Review Results ............................................................................................................................. 13  
   3.1 “Health in All Policies” Jurisdictions Around the World .................................................................. 13  
   3.2 Information Collected and Compiled About “Health in All Policies” Approaches ....................... 13  
   3.3 Case Summaries ................................................................................................................................. 13  
   4.1 Context of Initiation, Implementation Mechanisms, and Intervention Design ............................... 15  
5. Understanding “Health in All Policies” Initiation and Implementation: A Descriptive Comparison of  
   Empirical Cases, Using the Conceptual Framework ............................................................................ 18  
   5.1 Understanding the Context of Initiation: Relevance of Welfare State Profile, Timing, and International Influences ............................................................................................................................................. 18  
   5.2 Understanding Implementation Mechanisms: Patterns of Interaction between Health Care and Other Sectors, Tools, and Government Structures Influencing Interactions, and Health Impact and Health Equity Impact Assessment Tools ................................................................................................................................................................. 22  
   5.3 Understanding Intervention Design: Entry Points, Equity Lens and Management and Control of Interventions .................................................................................................................................................................................... 28  
6. Relevance to Ministry of Health and Long Term Care and Options for Further Study ............... 33  
   6.1 Getting Started with “Health in All Policies: Resources Produced and How they Can be Used....... 33  
   6.2 Further Investigation of “Health in All Policies” that may be Relevant to the Ministry of Health and Long-Term Care ................................................................................................................................................ 33  
   6.3 Conclusion ............................................................................................................................................ 35  
Works Cited ..................................................................................................................................................... 37
One Page Summary

“Health in All Policies” refers to formal, sustained, “whole-of-government” (read: cross-sectoral and coordinated) policy initiatives aimed to improve population health. In some cases, health inequities are targeted specifically in “Health in All Policies” initiatives.

A scoping review identified literature describing international examples of health equity-focused “Health in All Policies”. A total of 4833 scholarly articles and 501 sources of grey literature were gathered based on a keyword search. Following screening and sorting, 163 articles were retained, and intersectoral health activities were described in 43 countries. Further screening identified 16 jurisdictions that have implemented a “Health in All Policies” approach, specifically.

Scoping Review of “Health in All Policies” Literature: Findings

• Whole-of-government, “Health in All Policies“ approaches focused on health equity have been implemented in 16 countries or sub-national areas worldwide: Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales.

• In every case, a formal, whole-of-government “Health in All Policies” approach was preceded by intersectoral initiatives that were less formal and broad-reaching.

• Government-wide Health Impact Assessment (HIA) or a variant thereof to measure health outcomes/health needs was instituted in almost all jurisdictions.

• “Health in All Policies” strategies were usually aimed to improve working/living conditions, or to target individual behavior change. Improving access to health care was also stressed. Fewer than a third of cases involved wealth redistribution to address health inequities.

• By definition, “Health in All Policies“ approaches have a broader focus than vulnerable populations only. Most jurisdictions combined attention to vulnerable populations and universal policy initiatives. The preponderance of policy activity related to vulnerable groups.

• “Health in all Policies” involved a high degree of interaction and interdependence across sectors, and limited individual sectors’ autonomy. “Health in All Policies” was not supported through simple information-sharing.

• Mechanisms for supporting “Health in All Policies” included formal intersectoral committees (e.g. cabinet committees, interdepartmental committees), joint budgets, and evaluation and monitoring tools. In most jurisdictions a mix of horizontal and vertical integration management strategies was used to manage policy implementation.
Executive Summary

“Health in All Policies” is a new but increasingly recognized term to describe “whole-of-government” approaches for reducing population health inequities. A “Health in All Policies” approach makes formal and sustained use of structures, mechanisms, and actions that are managed mainly outside of the health care sector to improve population health and reduce health inequities across social groups.

In 2010 the Ministry launched a broad set of studies and consultations to assess the relevance and feasibility of a government-wide “Health in All Policies” approach to reducing health inequities. This report contributes to the Ministry’s initiative. It summarizes results of a scoping review of the international literature on equity-focused “Health in All Policies” initiatives, conducted by the Centre for Research on Inner City Health. A total of 4833 scholarly articles and 501 sources of grey literature were gathered based on a keyword search. Following screening and sorting, 163 articles were retained, and intersectoral health activities were described in 43 countries. Further screening identified 16 jurisdictions that have implemented a “Health in All Policies” approach, specifically.

This report includes a conceptual framework describing the initiation and implementation stages of “Health in All Policies” approaches, a discussion of comparisons and trends found in the 16 cases of “Health in All Policies” uncovered through the literature search, and a discussion of implications of the scoping review findings for the Province of Ontario.

Scoping Review of Health in All Policies: Findings

Whole-of-government, “Health in All Policies” approaches have been implemented and reported on in 16 countries and regions worldwide: Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales. Most “Health in All Policies” approaches have been launched by governments during the past decade. In every case, the formal, whole-of-government “Health in All Policies” approach was preceded by the emergence of ad hoc intersectoral initiatives to address health equity. The “Health in All Policies” approaches varied considerably across the jurisdictions. Preliminary review of empirical examples suggests that no single configuration of factors leads to successful implementation of this approach. However, some trends were observed.

- Health Impact Assessment (HIA) and Health Equity Impact Assessment Tools were used in over 60% of cases. Where HIA was not used, some other mechanism for auditing health equity needs and/or evaluating interventions related to health equity was implemented in sectors outside health care.

- Every “Health in All Policies” approach included policy initiatives to target health effects of lifestyle/behavioral factors and/or working and living conditions. Initiatives related to work/living conditions were more common than initiatives related to lifestyle.

- In 3 out of 4 of the jurisdictions, interventions to increase access to health care service-related interventions were also implemented. Less than a third initiated “upstream” interventions such as income or power redistribution to redress health inequities.
• By definition, “Health in All Policies” approaches have a broader focus than improving the health of vulnerable communities only. Almost all jurisdictions that adopted a “Health in All Policies” approach combined a focus on vulnerable populations with universal policy initiatives. However, the preponderance of policy activity was related to vulnerable communities.

• The government’s vision of health and society was an important factor driving the implementation of “Health in All Policies.” If the government’s vision of health is broader than health care delivery and emphasizes social determinants as factors affecting health, then a broader palette of action, social policies involving sectors outside of health care, and non-governmental stakeholders can be mobilized for “Health in All Policies”.

• Across almost all cases of “Health in all Policies” there was a high degree of interaction and interdependence across sectors. This had the effect of a loss of individual sectors’ autonomy (for example, through adjustments to policy and programs within various sectors, and sharing of budgets across sectors, to meet health equity goals). “Health in All Policies” cannot be supported through simple information sharing or cooperation.

• Tools and structures used to support coordination for “Health in All Policies” included formal intersectoral committees (e.g. cabinet committees, interdepartmental committees), budget development processes, decision support tools (e.g. health impact and health equity impact assessment frameworks), and equity evaluation and monitoring tools. Pre-existing government structures and new ones were developed for “Health in All Policies”.

• “Health in All Policies” appears feasible in both strong and weak welfare states.

• In most cases, the “Health in All Policies” effort was aimed to reduce health gaps between most and least vulnerable groups, often in concert with a focus on vulnerable groups. Fewer programs focused on flattening the health gradient across the entire population.

• In most jurisdictions a mix of horizontal and vertical integration management strategies was used to manage policy implementation. Approaches were highly heterogeneous, though two trends were noted. “Health in All Policies” was often linked to the management and delivery of primary health care, if objectives for primary health care were more encompassing than simply health care delivery to include, for example, the furthering of social and economic development. In other cases, intersectoral strengthening at the local or regional level was itself was a government goal, that was driven via a “Health in All Policies” approach (e.g. Health Action Zones in UK).
A “Health in All Policies” approach was implemented for different reasons and relied on diverse drivers and mechanisms across the 16 cases. For example, the symbolic and political role of Health Impact Assessment under a Health in All Policies approach varied dramatically. This is evident when comparing the cases of Thailand and Quebec, where mandatory HIA is the centerpiece of both Health in All Policies initiatives.

In Quebec, the Health in All Policies approach is consistent with a longstanding standing integration of health and social services within the provincial government. “Health in All Policies” came to greater prominence when systematic, intersectoral action on social, economic and environmental determinants of health became a public health priority in the mid-1990s. To support this priority, cross-government use of health impact assessments was enshrined in law under a new Public Health Act in 2002. The “Ministry of Health and Social Services” was assigned responsibility for facilitating use of HIA across government, in coordination with a range of other ministries and agencies.

In contrast, in Thailand, the “Health in All Policies” approach, (including mandated use of Health Impact Assessment) was precipitated by a popular movement for political and economic reform, in the 1990s, in response to longstanding social inequalities in the country. In Thailand, HIA has been described as a tool for “reconcile[ing] the conflict from untrustworthy attitude between government and the civil society” (Phoolcharoen, 2003). Under Thailand’s current HIA legislation – which is integrated into the constitution – citizens have the right to request an HIA where they have concerns about the health impacts of government decisions, and to sue the government where HIA regulations are not being followed. The Thai HIA program is managed by an intersectoral network of agencies created for this purpose – not primarily the Ministry of Health.

Additional Resources:

This report is part of the “Getting Started with Health in All Policies” Resource Pack. Other components of the Resource Pack include:

- **Health in All Policies Research Library.** An electronic library of 228 research and grey literature papers describing intersectoral action on health globally, including cases of “Health in All Policies” and other examples of intersectoral action for health equity. The library is accompanied by an electronic index (“scoping table”) containing key case information for most articles.

- **Case Summaries Booklet.** A description of the sixteen cases of “Health in All Policies” uncovered through the literature search. These Case Summaries introduce milestones and key structures, mechanisms and actions related to “Health in All Policies” efforts.

- **Health in All Policies Conceptual Framework Addendum.** The framework described later in this report depicts factors affecting how “Health in All Policies” approaches are introduced and implemented across governments (actors, modes of interaction, internal and external stimuli, etc.). This is a tool analysts can use to bring conceptual clarity to otherwise highly complex and differentiated cases of inter-organizational relationships. It facilitates explanation of how the “Health in All Policies” approach unfolded in a particular jurisdiction, or how two or more jurisdictions compare across a range of factors. The framework is also intended to support “Health in All Policies” scenario-planning for Ontario. This addendum includes a methodology for how the framework was development, and a table that offers a detailed description of the specific components that comprise the three core conceptual domains, including associated typologies, examples and references.

- **Economic Assessment of Health in All Policies: A Discussion Brief.** No full economic analyses of the “Health in All Policies” approach were uncovered during the scoping review. This document outlines key considerations to make when evaluating the economic impacts (costs and benefits) of a “Health in All Policies” approach in Ontario.
1. Introduction

“Health in All Policies” is a new but increasingly recognized term to describe “whole of government” approaches for reducing population health inequities. A “Health in All Policies” approach makes formal and sustained use of structures, mechanisms, and actions that are managed mainly outside of the health care sector to improve population health and reduce health inequities across social groups. In this respect, “Health in All Policies” is one approach for pursuing what the World Health Organization has more generally discussed as the involvement of numerous departments, sectors, and even governments and regions to address social determinants of health problems that are unresolveable by individual actors working on their own (i.e. intersectoral action for health equity). Intersectoral action has been brought to bear on specific determinants of health, diseases, populations (e.g. indigenous peoples, children), geographic communities, health behaviours, and risk factors.

“Health in All Policies” approaches are distinguishable from other intersectoral initiatives to advance health equity in two important ways. First, “Health in All Policies” approaches are coordinated primarily by formal structures and mechanisms of governments – although they may include non-governmental actors, including those from academic, private, and community/civil sectors. Second, interventions adopted under “Health in All Policies” approaches are explicitly linked to supra-governmental policies or agendas, rather than being ad hoc in nature.

Interest in the effectiveness, feasibility, and costs associated with the “Health in All Policies” approach is growing. However limited comparative research has been conducted to assess how, why, and under what circumstances “Health in All Policies” approaches have been adopted in different jurisdictions – and with what effects. A systematic examination of these issues can inform future efforts to ensure the success of “Health in All Policies” initiatives.

This report documents the process and results of a scoping review of the scholarly and grey literature related to “Health in All Policies.” It includes a conceptual framework describing the initiation and implementation stages of “Health in All Policies” approaches, examples of how to use the Conceptual Framework to better understand the “Health in All Policies” approach in different settings, and a discussion of implications of the scoping review findings for Ontario. The scoping review was conducted by the Centre for Research on Inner City Health to support the Ministry of Health and Long-Term Care in Ontario in its work to assess the relevance of a “Health in All Policies” approach for Ontario.

1.1 Objectives

The objectives of this “Health in All Policies” scoping review were:

(1) to develop a conceptual framework of the core factors influencing how and why “Health in All Policies” initiatives have been initiated and implemented;

(2) to compile the available empirical evidence related to “Health in All Policies” across diverse jurisdictions and to describe the range and depth of this evidence, particularly in terms of how well current evidence illuminates factors that have affected the initiation and implementation of “Health in All Policies” approaches; and
(3) to demonstrate, through use of examples, how the conceptual framework can help the Ministry to learn further from the empirical literature and draw inferences about the feasibility of launching a “Health in All Policies” approach in Ontario.

1.2 Additional Resources

This report is part of the “Getting Started with Health in All Policies” Resource Pack. Other components of the Resource Pack include:

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- **Case Summaries Booklet.** A description of the sixteen cases of “Health in All Policies” uncovered through the literature search. These Case Summaries introduce milestones and key structures, mechanisms and action related to “Health in All Policies” efforts.

- **Health in All Policies Conceptual Framework Addendum.** The framework described later in this report depicts factors affecting how “Health in All Policies” approaches are introduced and implemented across governments (actors, modes of interaction, internal and external stimuli, etc.). This is a tool analysts can use to bring conceptual clarity to otherwise highly complex and differentiated cases of inter-organizational relationships. It facilitates explanation of how the “Health in All Policies” approach unfolded in a particular jurisdiction, or how two or more jurisdictions compare across a range of factors. The framework is also intended to support “Health in All Policies” scenario-planning for Ontario. This addendum includes a methodology for how the framework was development, and a table that offers a detailed description of the specific components that comprise the three core conceptual domains, including associated typologies, examples and references.

- **Economic Assessment of Health in All Policies: A Discussion Brief.** No full economic analyses of the “Health in All Policies” approach were uncovered during the scoping review. This document outlines key considerations to make when evaluating the economic impacts (costs and benefits) of a “Health in All Policies” approach in Ontario.
2. Background

2.1 Reducing Health Inequities in Ontario

Low income and socially vulnerable populations in Ontario face higher rates of illness, earlier mortality, and greater unmet need for primary care and prevention services, compared to more affluent, socially supported groups. Systematic differences in health status attributable to social determinants of health (e.g. income, living and working conditions, sociocultural inclusion) are called health inequities. Health inequities have been documented in every country in the world where health and wealth have been compared. Health inequities are most severe in jurisdictions with high levels of social and income inequality, and least severe in jurisdictions that have flatter gradients of social inequality.

Ontario is not unique with respect to the pervasiveness of health inequities that persist here. However, there are unique attributes of the Ontario sociodemographic and economic context that call for innovations involving diverse sectors to redress social determinants of health and respond to growing population health inequities (in particular, Ontario has the highest rates of immigration and ethnoracial diversity in Canada, coupled with escalating levels of family poverty). In light of these challenges, the Ministry of Health and Long-Term Care has adopted the goal of reducing health inequities in its Value Statement on Healthy Communities.

In 2010 the Ministry launched a broad set of studies and consultations to assess the relevance and feasibility of a government-wide “Health in All Policies” approach to reducing health inequities. Through an agreement between the Ministry and the Canadian Institutes of Health Research, a research grant was awarded to the Centre for Research on Inner City Health to undertake a scoping review of the international literature on “Health in All Policies” with a particular focus on factors relevant to launching a “Health in All Policies” approach, and fostering stakeholder engagement in the process. For example, some of the initial guiding questions for the review included: Which stakeholders or groups of stakeholders in the public and private sectors should be consulted or engaged to generate support for a health equity-focused “Health in All Policies” approach? What types of consultation techniques will help to generate productive feedback from these stakeholders about “Health in All Policies”? What types of communication strategies will most effectively generate engagement around “Health in All Policies” with respect to different stakeholders (e.g. the public, community leaders, corporate leaders, etc.)? And, do economic impacts (interpreted as broadly as possible) of “Health in All Policies” approaches have a role to play in promoting engagement in the process, and if so, how?

2.2 What is a Realist Scoping Review?

A scoping review of a body of research evidence is an important first step before undertaking a knowledge synthesis. A scoping review is particularly necessary when the body of literature on a topic is being compiled for the first time, and/or when the phenomena under investigation are especially complex or non-homogeneous. While there is a growing body of literature that describes “Health in All Policies” approaches in selected settings, this evidence has not been systematically compiled, is hard to obtain, and very little comparative analysis has been carried out to date. For example, the World Health
Organization has provided a compilation of case studies where intersectoral action was used to address health equity (PHAC, 2008a); however, the scholarly literature was not consulted and there was no analysis of whether or not these cases were addressing health equity using a “Health in All Policies” approach. Another report by the National Collaborating Center for Health Public Policy began to articulate governmental mechanisms related to cases of “Health in All Policies”, but mainly focused on those settings where Health Impact Assessment was used and did not cover the initiation of “Health in All Policies” (St. Pierre et al., 2009).

The scoping process, as the name suggests, permits analysts to characterize the “extent, range, and nature” of research questions that are addressed in a body of literature (Arksey and O’Malley, 2005, p. 21). The review sheds light on where and in what respects the research literature is robust or thin. This information is useful for determining what types of strategic questions are most likely to be answerable, based on the body of available evidence. Therefore, a high-quality scoping review increases the efficiency and quality of future evidence syntheses and can help guide the direction for future research.

This scoping review was carried out using a realist methodological lens (Pawson, 2006), which implies an explanatory perspective (i.e. unpacking how “x” works and under what circumstances) rather than a judgmental one (how well did “x” work?). This approach is highly suitable for understanding complex processes such as launching a “Health in All Policies” approach to reduce health inequities.

### 2.3 Defining “Health in All Policies”

To identify positive cases of “Health in All Policies” during the screening process, a rigorous working definition was generated that emphasizes the presence of high-potential policy approaches for reducing health inequities:

A single case of “Health in All Policies” reflects an intersectoral initiative toward healthy public policy-making involving the national or state/provincial level of government where sectors collaborate (often through processes of cooperation, coordination or integration) to develop policies and programs that include population health interventions to prevent the clinical manifestation of inequities (i.e. these are interventions that are not limited to increasing access to primary health care; these actions involve impacts on social determinants of health such as education, housing conditions, or poverty reduction). Such action could aim to impact equity by targeting marginalized or otherwise susceptible populations (e.g. using means testing) but should also include a universal approach to preventing inequities (i.e. across the population at-large). “Health in All Policies” requires a mechanism for moving beyond the detection of health equity problems (e.g. mere health equity impact assessment) to foster remedial action involving an intersectoral response. This definition also assumes that health is conceived of in fundamentally multisectoral terms (i.e. that population health is impacted by non-health sectors; e.g. the notion of social determinants of health) by the government. It is recognized that policies related to “Health in All Policies” may foster multiple programs or projects at multiple levels of context (i.e.
multiple entry points for the implementation policies and strategies) – either directly or indirectly related to the policy commitment.

2.4 Five Stage Scoping Review and the Identification of “Health in All Policies” Cases

The scoping review process (Figure 1) included five systematic steps for winnowing down from an initial collection of 5,343 documents describing intersectoral action for health equity to sixteen distinct cases of the “Health in All Policies” approach (i.e. unique jurisdictions where “Health in All Policies” was implemented) and thirty distinct cases of intersectoral action for health equity. A detailed description of the scoping method is included in Appendix 1.

Figure 1. Five-stage scoping review process.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEARCHING</td>
<td>Systematic search for scholarly and grey literature about intersectoral action for health equity (ISAHE) and Health in All Policies (HiAP)</td>
<td>4833 scholarly articles and 510 electronic sources of grey literature searched</td>
</tr>
<tr>
<td>SCREENING</td>
<td>Brief review of scholarly abstracts and grey literature to identify documents describing potential cases of ISAHE based on three criteria</td>
<td>533 articles with potential cases of ISAHE identified via scholarly (122) and grey (381) literature searches, and other methods (30)</td>
</tr>
<tr>
<td>SORTING</td>
<td>Sorting of literature by country/region to identify potential unique cases of ISAHE</td>
<td>533 articles with potential cases of ISAHE sorted across 83 countries</td>
</tr>
<tr>
<td>SCOPING</td>
<td>Full review of literature to confirm ISAHE cases and extraction of information about the explanatory framework for HiAP</td>
<td>163 articles with confirmed cases of ISAHE sorted across 43 countries</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>Cases of HiAP with strong elements of intersectorality and health equity identified based on five criteria and described</td>
<td>16 cases of HiAP identified, with ISAHE occurring in 30 countries (including 3 that appeared to have both HiAP and other ISAHE)</td>
</tr>
</tbody>
</table>
3. Scoping Review Results

3.1 “Health in All Policies” Jurisdictions Around the World

“Health in All Policies” approaches were identified in the following sixteen countries and regions: Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales. The world map in Figure 2 displays the location of sixteen cases of “Health in All Policies”, as well as the thirty cases of intersectoral action for health equity that did not meet our definition of “Health in All Policies”.

3.2 Information Collected and Compiled About “Health in All Policies” Approaches

For each unique case of “Health in All Policies” and for the 30 cases of intersectoral action for health equity, the following information was collected in Scoping Table that accompanies the “Getting Started with Health in All Policies” Research Library

- Case setting, country, and geographic level of intersectoral action (e.g. city, province)
- Year of article
- Problem stream leading to intersectoral action (cf. Kingdon)
- Approximate starting date of intersectoral action
- List of government sectors involved in intersectoral action
- Pattern of relationship between government sectors (e.g. integration, coordination, etc.)
- Private sector involved in intersectoral action? (Y/N)
- Civil sector involved in intersectoral action? (Y/N)
- Academic sector involved in intersectoral action? (Y/N)
- Does intersectoral action target upstream, midstream, or downstream social determinants of health?
- Does intersectoral action address equity in a targeted, universal, or mixed manner?
- Use of impact assessment? (Y/N)
- Type of impact assessment, if used (e.g. HIA, HEIA)
- Information about evaluation, in general? (Y/N)
- Information about economic evaluation? (Y/N)
- Does article contain information about intersectoral engagement leading to intersectoral action? (Y/N)
- Does article contain information about intersectoral engagement (anytime)? (Y/N)

3.3 Case Summaries

The “Getting Started with Health in All Policies” Case Summaries Booklet, describes each of the sixteen unique cases of “Health in All Policies” uncovered through the literature search. The case summaries were created by using information obtained from articles included in the scoping stage, as well as
additional information from articles and websites. Case Summaries focus on core factors that influenced initiation and implementation of the “Health in all Policies” approach: context of initiation, implementation mechanisms, and intervention design. The Case Summaries Booklet also includes two portraits of intersectoral action for health equity (Ticino, Switzerland and British Columbia, Canada). These are included to illustrate important differences between intersectoral action for health equity and “Health in All Policies”.

Figure 2. Map of countries with “Health in All Policies” and intersectoral action for health equity cases.

4.1 Context of Initiation, Implementation Mechanisms, and Intervention Design

“...intersectorality is one of the recurring issues in public health management, however there is very little documentation and systematization of its practice, especially within the health field. Nor is there an explicit theory on which to build a framework for analysis of which types of intersectoral action are more feasible under different scenarios and which type of intersectoral action need to address social determinants of health and reduce health equity.” (Solar et al., 2009, p. 4)

A conceptual framework is a heuristic tool that can help to explain complex processes and relationships such as those at play in intersectoral collaborations. As Judge et al. (1998) comment, such frameworks:

“...provide a language and frame of reference through which reality can be examined and lead theorists to ask questions that might not otherwise occur. The result, if successful, is new and fresh insights that other frameworks or perspectives might not have yielded. Conceptual frameworks can constitute an attempt to establish a paradigm shift.” (p. 3)

The first task undertaken for this project was to develop an explanatory conceptual model of the initiation and implementation of “Health in All Policies” (Figure 3), based on a synthesis of existing literature describing intersectoral and whole-of-government approaches to policymaking in general, and health equity specifically.1 The conceptual framework is a heuristic tool that can help the Ministry of Health and Long-Term Care to better assess the factors in the Ontario environment that may facilitate or hinder the initiation and implementation of a “Health in All Policies” approach. The tool will also aid the Ministry in learning from the empirical experiences of “Health in All Policies” in other jurisdictions, because it provides a theoretically well-supported framework for drawing comparisons.

The framework includes three core conceptual domains, leading to ongoing interventions and policy-making:

1. CONTEXT OF INITIATION. Because health equity is a normative and essentially contestable concept, obtaining the initial commitment for “Health in All Policies” across all relevant parts of government may be challenging. The Context of Initiation includes social, economical, political, historical, and external influences that create policy windows and environment conducive for intersectoral engagement around “Health in All Policies”. This domain is highlighted in red in Figure 3 below.

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1 The framework was based on prior work by Solar et al. (2009) to typologize entry points that governments can take to implement intersectoral action for health equity, and empirical sources. Modifications were made to the original framework (i.e. pieces were added, removed, and re-organized) in light of empirical evidence from “Health in All Policies” cases identified in this review.
The initiation of a government-wide “Health in All Policies” approach occurs in a “policy change window”, based on Kingdon’s notion of “windows of opportunity” for policy change. Initiation is conditioned by three analytically distinct policy-making streams, and a window of opportunity is opened for a major policy change only if these three different streams of policy-making coexist simultaneously in fashion that is conducive to a “Health in All Policies” approach. These streams are: the “problem stream” (i.e. whether a problem is defined and brought to the political agenda in a way that would require a government-wide policy solution like “Health in All Policies”), the “policy stream” (i.e. how and whether a variety of actors influence the design of feasible and sustainable policy options), and the “political stream” (i.e. how and whether politically agreeable policies are adopted). These streams may be coupled with chance political factors such as elections, or chance organizational cycle factors such as staff turnover, or by the actions of individual policy entrepreneurs who facilitate the coupling process by investing their own personal resources (e.g. reputation/status). The policy change window is embedded within a distinct social, economic, and political context, and may be partly determined by international influences. As noted above, these contextual factors continue to influence the implementation of “Health in All Policies” beyond the initiation stage.

2. IMPLEMENTATION MECHANISMS. “Health in All Policies” implies coordination of programs across sectors and has implications for the autonomy of participating government sectors. This domain includes mechanisms of influence, financing, and sustainability that facilitate sharing of power and control over decision making, including participants’ overarching interpretations of the ideas of “health”, “society”, and their interpretation of the relationships between these ideas. This domain is highlighted in orange in Figure 3 below.

3. INTERVENTION DESIGN. “Health in All Policies” approaches are defined by the entry points selected for action to reduce health inequities vis-à-vis previously identified problem streams; the equity lens of action, including the level of health determinants being addressed (i.e. upstream, midstream, downstream), the coverage of populations by action (i.e. focus on horizontal/universal or vertical/targeted approaches to reducing inequities), and implicit or explicit equity goals (i.e. closing gaps, flattening gradients, or improving the health of vulnerable groups); and finally, on options available for managing and controlling interventions. This domain is highlighted in yellow in Figure 3 below, and each of these elements is described in detail in Section 5.3.

4. ONGOING IMPLEMENTATION. Intervention design should not be seen as an endpoint of the “Health in All Policies” approach; the approach is better understood as cyclical and iterative. The design of new interventions to reduce health inequities across diverse sectors may contribute in reshaping the initiation context (e.g. policy windows) and other factors in the framework over time (e.g. mechanisms for decision-making and interpretations of problem/action streams). This iterative character of the process has implications for the sustainability of “Health in All Policies” approaches over the longer term.
Figure 3. Getting Started with “Health in All Policies”: A Conceptual Framework
5. Understanding “Health in All Policies” Initiation and Implementation: A Descriptive Comparison of Empirical Cases, Using the Conceptual Framework

This section provides some preliminary comparative description of the sixteen “Health in All Policies” cases collected through the scoping review. The goals of this section are to flesh out the three core conceptual domains related to the initiation and implementation of “Health in All Policies” and to suggest how the conceptual framework can help to guide future analyses of the empirical evidence that has been compiled and scoped.

The examples that follow illuminate some categories of similarity and difference across cases of “Health in All Policies” but these reflect only a superficial examination of the data. The primary purpose of this project was to compile, rather than carefully analyze the available information. More intensive study of the “Health in all Policies” cases is required, especially to better understand their relevance to the Ontario setting.

5.1 Understanding the Context of Initiation: Relevance of Welfare State Profile, Timing, and International Influences

Figure 4 highlights aspects of the context of initiation that shapes readiness and opportunities to launch a “Health in All Policies” approach. The context of initiation encompasses a broad set of structural, cultural, historical and functional aspects of a social system which exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities and potential inequities in health. To illustrate potential approaches for analyzing the context of initiation, we look at the relevance of welfare state profile, historical timing, and international influences.

Figure 4. Context of Initiation
5.1.1. Relevance of Welfare State Profile: Welfare state is a concept of government where the state plays a primary role in the protection of members of society, the reduction of social inequalities, and the promotion of human capacities for action and self-reliance. At the national level, many countries fit into a welfare state type describing the relationship between public institutions, markets, and civil society. Since countries featuring stronger welfare state profiles may be expected to be more amenable to government action for health equity, we classified (Table 1) the sixteen “Health in All Policies” jurisdictions for their welfare state profile, using a typology recently developed by Chung, Muntaner, & Benach (2010). In this typology, countries are first stratified into three structural zones related to their central importance to the world economy: core, semi-peripheral, peripheral; these zones roughly correspond to high-, middle- and low-income countries, respectively. Within each zone, countries can be sorted into three groups based on the egalitarianism of their labour markets (e.g. bargaining power of employees). Countries with higher position in the world economy and increasing labor market egalitarianism were recently shown to have better health outcomes (Chung, Muntaner, Benach, 2010).

Table 1. Welfare State Regime of “Health in All Policies” Countries

<table>
<thead>
<tr>
<th>Labour Market Egalitarianism</th>
<th>More equal</th>
<th>Less equal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core (High income)</td>
<td>Finland</td>
<td>Canada</td>
</tr>
<tr>
<td></td>
<td>Norway</td>
<td>United Kingdom</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>New Zealand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>South Australia</td>
</tr>
<tr>
<td>Semi-peripheral (Middle income)</td>
<td>Thailand</td>
<td>Brazil</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malaysia</td>
</tr>
<tr>
<td>Peripheral (Low Income)</td>
<td></td>
<td>Sri Lanka</td>
</tr>
</tbody>
</table>

* Cuba was not included in mentioned typology

As shown in Table 1, the “Health in All Policies” approach appears to be feasible across countries with both strong and weak welfare state regimes. Within different types of welfare state regimes, some clustering patterns are observable, related to income and labour market egalitarianism. For example, in the high income country strata, “Health in All Policies” approaches were introduced in contexts with both higher labour market egalitarianism (e.g. Sweden) and lower egalitarianism (e.g. Canada). In contrast, middle income (e.g. Brazil) and lower income countries (e.g. Sri Lanka) using “Health in All Policies” tended to be neutral in terms of labor market egalitarianism. Although it is beyond the scope of this report to provide further analysis on this topic, it may be interesting to examine whether or not
there are commonalities in how and why “Health in All Policies” approaches were initiated within or across these specific clusters, and how other social, political and economic characteristics may have facilitated “Health in All Policies” across these setting. For example, since the initiation of a “Health in All Policies” approach appears to have been timed with the election of social progressive parties in the UK and Norway, the adoption of “Health in All Policies” may be linked to the political orientation of governments.

5.1.2 Timing, Historical Context and Duration of “Health in All Policies”: Figure 5 depicts approximate start dates and duration of “Health in All Policies” approaches in the case countries, based on review of the empirical literature. With the exception of Malaysia and Sri Lanka, all “Health in All Policies” approaches were initiated in the case countries over the last decade. All were preceded by more ad hoc intersectoral projects to address health equity. “Health in All Policies” has been especially durable in Sri Lanka and Malaysia, and there has also been a long legacy of intersectoral action for health equity in Cuba, Finland, and Quebec. It may be particularly valuable to examine factors that have supported the introduction and long term sustainability in these cases, given shifting social, political, and economic contextual factors, and how the types of action and mechanisms related to “Health in All Policies” may have changed as a result over the course of decades.

Figure 5. Start Date, Duration of “Health in All Policies” and Intersectoral Initiatives for Health Equity in Sixteen Settings.
5.1.2 International Influences: Global initiatives that influence national policy agendas and priorities may have effects on readiness to initiate “Health in All Policies” at the national or subnational level, as well as the approaches to implementation and resulting action on healthy equity. Examples include the leadership and technical support of international agencies like the World Health Organization, or other examples of global or regional leadership across groups of countries (e.g. Finnish European Union Presidency in 2006). Such international partnerships facilitate cross-national agenda setting and the exchange of evidence-based policy options and, in this way, may influence local policy change windows, as well as the design and legitimacy of resulting “Health in All Policies” initiatives.

To assess potential relationships between global leadership and country-level “Health in All Policies” approaches, Figure 6 charts international population health milestones against the historical timeline when “Health in All Policies” was introduced in the sixteen case countries. These international milestones are: the Alma Ata Declaration and the emphasis on “Health For All” (Alma Ata Declaration, 1978); the Charter of Ottawa and the emphasis on health promotion (Ottawa Charter, 1986); the WHO Resolution from the 39th World Health Assembly: “Intersectoral cooperation in national strategies for Health For All” in 1986; the publication of the summary report of the WHO/Nordic School of Public Health meeting in Gothenburg on “The role of intersectoral cooperation in combat inequities in health in national strategies for Health For All” in 1987 (Barnard et al., 1987); the publication of the WHO report, “Intersectoral Action for Health: A Cornerstone for Health For All in the Twenty-First Century” (WHO, 1997) and the publication of the WHO European Region Health21 policy framework (WHO, 1998), both which proposed modern versions of the Health For All approach; the Finnish President’s European Union launch of “Health in all Policies” in 2005; and the launch of the WHO Commission on the social determinants of health and the emphasis on health equity (Irwin et al., 2006).

In most but not all cases, “Health in All Policies” was initiated in the period following or contemporaneous with many major international health equity milestones. In Malaysia and Sri Lanka, a “Health in All Policies” approach appears to have been initiated prior to many of these milestones. Closer study is needed to understand the impact, if any, of these international influences on the initiation and implementation of “Health in All Policies” in case settings.
5.2 Understanding Implementation Mechanisms: Patterns of Interaction between Health Care and Other Sectors, Tools, and Government Structures Influencing Interactions, and Health Impact and Health Equity Impact Assessment Tools

The second major conceptual domain in the explanatory framework illuminates implementation mechanisms for facilitating coordination of programs and policies across government. An important element here is the visions of “health and society” held by the health sector and, importantly, by other sectors and by the party in government. The extent to which these visions are complementary, comprehensive, and coherent can help to shape the role of the government in addressing health inequities, including how effectively government sectors can work with each other and with the private sector and civil society. Since policy choices are guided by values (implicit or explicit), the vision of health espoused by a government can shape the orientation and intensity of action for equity that gets implemented through a “Health in All Policies” initiative. The government’s vision of health may also facilitate or limit civil society participation and private sector participation in “Health in All Policies” approaches. For example, if the vision of health that drives equity policy is equated with health care and the uses of health care to remove disease, then the focus of action will likely be oriented toward improving access to services and technologies for marginalized groups. On the other hand, if the vision
of health is broader than health care and emphasizes social determinants as factors affecting health, then a broader palette of action, social policies involving sectors outside of health care, and non-governmental stakeholders may be mobilized. Figure 7 depicts relevant components of this domain.

To illustrate potential approaches for analyzing implementation mechanisms, we review the sixteen empirical case of “Health in All Policies” with a particular focus on the following: Patterns of Interaction between Health Care and other Sectors, Patterns of Interaction between Health Care and Other Sectors, Tools and Government Structures Influencing Interactions, and Health Impact and Health Equity Impact Assessment Tools.

Figure 7. Implementation Mechanisms for “Health in All Policies”, Including Overarching Vision of Health and Society.

5.2.1 Patterns of Interaction between Health Care and Other Sectors: The relationships and patterns of interaction among governmental and non-governmental sectors (and the mechanisms and strategies available for managing these relationships) also help shape the orientation and intensity of actions undertaken for health equity. For example, evidence that governmental sectors have been working together in a highly coordinated manner may indicate a greater capacity to facilitate the design and delivery of interventions; where strategic and operational integration across sectoral portfolios is possible. In turn, these types of highly integrated approaches to HiAP may be able to address determinants of health – particularly those outside of the health sector – in a more holistic and sustainable manner.

Solar et al. (2009) typologized four distinct patterns of relationships that may be observable between sectors of government (and/or between government and non-governmental organizations) as follows:
- **Information Sharing**: A one-way relationship where instructions from one sector are communicated to passive recipient sectors. May be the first step in the intersectoral process of building a common language for dialogue.

- **Cooperation**: Interaction between sectors to achieve greater efficiency in their actions. Aims to optimize resources while establishing formalities in the work relationship; results in a loss of autonomy for each sector.

- **Coordination**: Adjusting the policies and programs of each sector to improve efficiency and effectiveness. Leads to increased horizontal networking among sectors. Usually uses a shared financing source which creates synergies within administration but leads to a greater dependence between sectors and loss of autonomy.

- **Integration**: A political process where a new policy or program (representing the work of multiple sectors) is defined in conjunction with other sectors. This “trans-sectoral” approach entails the integration of objectives and administrative processes and the sharing of resources, responsibilities and actions. This ultimately results in the collapsing of “closed fiefdoms”.

Figure 8 compares the pattern of relationships in implementing action for equity between health and non-health sectors across the sixteen “Health in All Policies” cases using the typology above. Based on our definition of “Health in All Policies,” jurisdictions were excluded from the set if simple information sharing was the sole mode of interaction between health and other sectors. In most of the jurisdictions where “Health in All Policies” approaches have been adopted, policies and programs controlled by the respective sectors were adjusted, via increased horizontal and vertical engagement with one another, in order to improve efficiency and effectiveness. In other words, the most common pattern of intersectoral relationship was coordination. Coordination implies increased interdependence between or among sectors and loss of sector autonomy (for example, through the sharing of budgets). The most intensive modes of interaction between sectors (i.e. integration) were seen in the “Health in All Policies” approaches developed in Iran and Norway. As we note later in this report, these were also among the few cases where equity interventions were implemented across all levels of health determinants (i.e. upstream, midstream, and downstream; see Figure 11 below), which suggests that closer relationships across sectors may facilitate more comprehensive approaches to “Health in All Policies”.

24
5.2.2 Tools and Government Structures that Influence Patterns of Intersectoral Interaction: What tools and structures of government facilitate patterns of interaction conducive to “Health in All Policies”? As shown in Figure 9, the tools and structures used in the empirical cases included formal intersectoral committees (e.g. cabinet committees, interdepartmental committees), budget development processes, decision support tools such as health impact and health equity impact assessment frameworks, and equity evaluation and monitoring tools. These can facilitate a variety of functions related to “Health in All Policies”, such as the coordination of strategies across sectors, assessment of health and equity needs, the design or implementation of action for equity, monitoring and evaluation, and administration. For example, since government funds are usually earmarked to specific sectors, budgets can act as a catalyst for intersectoral action by facilitating the pooling of resources and providing fiscal incentives for the collaboration of ministries. In Figure 9, the tools and structures for influencing interaction are shown spanning both the domain of implementation mechanisms and the domain of action streams/interventions design. This is because they may be artifacts of pre-existing structures and/or be created new for the purposes of facilitating a “Health in All Policies” approach.
Table 2 lists the respective tools and structures used to join up government sectors in the sixteen empirical cases of “Health in All Policies”. In some cases, pre-existing structures were used, while in other cases new formal and informal structures were established, such as committees (or networks of committees) dedicated to implementing “Health in All Policies”. The Case Summaries Booklet contains more information about the use of specific structures across case settings.

<table>
<thead>
<tr>
<th>Structure(s) utilized*</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabinet committee</td>
<td>Cuba, Brazil, Malaysia, Scotland, Iran</td>
</tr>
<tr>
<td>Steering committee (e.g. within Cabinet)</td>
<td>Finland, Northern Ireland, Sweden, Thailand, Sri Lanka</td>
</tr>
<tr>
<td>Formal committees or authorities at the local level</td>
<td>Cuba, Northern Ireland, Scotland, Wales</td>
</tr>
<tr>
<td>Network of committees</td>
<td>Iran, Malaysia</td>
</tr>
<tr>
<td>Independent organization/unit</td>
<td>New Zealand, Quebec</td>
</tr>
</tbody>
</table>
5.2.3 Decision-Support Mechanisms – Health and Health Equity Impact Assessment Tools: Interest is growing in the use of Health and Health Equity Impact Assessment (HIA and HIEA) to anticipate how policies, plans and projects across health and non-health sectors might affect health and health equity using a variety of techniques and tools (St. Pierre, et al., 2009). Table 3 indicates the use and type of decision-making support tools across the sixteen empirical cases of “Health in All Policies”. In more than 60% of the cases, HIA for decision support was used, including countries in the United Kingdom that specifically target impacts on health equity (i.e. HIEA). For example, in Thailand, HIA was originally used on an ad hoc basis to assess the environmental health impacts of industrial projects; however its use has recently been legislated across a wider range of programs, policies, and projects. In the six cases where HIA was not used, some other mechanism for monitoring health equity and/or evaluating interventions related to health equity was implemented. For example, in Iran, the development of a National Coordination Council for Healthy Cities and Healthy Villages (NCCHCHV) in 1996 to assess and respond to issues of health and health equity intersectorally appears to have led to the development of the Supreme Council for Health and Food Security (SCHFS) in 2006. SCHFS is headed by the President and aims to further promote the goals of intersectoral collaboration and health equity. These tools may be seen as complementary in design, where the Supreme Council provides high-level guidance to the more practical work of the National Coordination Council.

Table 3. Use of Health Impact Assessment and other Monitoring Tools in “Health In all Policies” Jurisdictions.

<table>
<thead>
<tr>
<th>Utilization of HIA</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>England*</td>
</tr>
<tr>
<td></td>
<td>New Zealand</td>
</tr>
<tr>
<td></td>
<td>Northern Ireland*</td>
</tr>
<tr>
<td></td>
<td>Norway</td>
</tr>
<tr>
<td></td>
<td>Quebec</td>
</tr>
<tr>
<td></td>
<td>Scotland*</td>
</tr>
<tr>
<td></td>
<td>South Australia</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
</tr>
<tr>
<td></td>
<td>Thailand</td>
</tr>
<tr>
<td></td>
<td>Wales*</td>
</tr>
<tr>
<td></td>
<td>Brazil</td>
</tr>
<tr>
<td></td>
<td>Cuba†</td>
</tr>
<tr>
<td></td>
<td>Finland</td>
</tr>
<tr>
<td></td>
<td>Iran†</td>
</tr>
<tr>
<td></td>
<td>Malaysia†</td>
</tr>
<tr>
<td></td>
<td>Sri Lanka</td>
</tr>
</tbody>
</table>
5.3 Understanding Intervention Design: Entry Points, Equity Lens and Management and Control of Interventions

The third major conceptual domain in the explanatory framework relates to the design of interventions for improving health equity through a “Health in All Policies” approach. Intervention design is strongly influenced by the context of initiation and implementation mechanisms, including the prevailing vision of health in health and other sectors. Within the intervention design domain itself, three conceptual categories are particularly important (1) the “entry point” for interventions; (2) the “equity lens” that defines the approach to taking action on health equity, and (3) strategies for the management of implementation. These elements are depicted in Figure 10. In this section, each is described in some detail, with reference to the sixteen empirical cases of “Health in All Policies”.

![Figure 10. Core Elements Affecting Intervention Design for “Health in all Policies”.](image)

5.3.1 “Entry Point” – The Identification of Problems and the Design of Interventions: “Entry point” refers to the particular inequity problem/health determinant that that ends up being identified and acted on through one or more interventions (cf. Kingdon’s notion of the problem stream). Over the course of utilizing a “Health in All Policies” approach, multiple entry points may be identified and acted on. “Entry points” selected for action will help define the specific sectors involved in dealing with these problems and the role (if any) that will be played by the health care sector. For example, health care could be involved as the leader, negotiator or partner for specific actions, depending on how the
problem and solution are defined, and depending on the level of relevant knowledge and control over relevant resources that are available through health care.

5.3.2 “Equity Lens” – The Types of Health Determinants Addressed Through “Health in All Policies”:

Intersectoral action under “Health in All Policies” can be described by the way in which it, theoretically, aims to address equity (i.e. the “equity lens”). In particular, interventions may aim to reduce inequities in health by addressing “upstream”, “midstream”, or “downstream” determinants of health, with implications for which sectors are involved, and in what types of capacities. There are three options.

Upstream interventions are aimed at fundamental social and economic reform and involve mechanisms for the redistribution of wealth, power, opportunities, decision-making capacities, and other resources. Midstream interventions aim to reduce risky behaviors or exposures to hazards and may include strategies to affect lifestyle or psychosocial factors, and/or to improve material working and living conditions. Finally, downstream interventions aim to mitigate the inequitable impacts of upstream and midstream determinants of health and disease through efforts to increase equitable access to health care services.

Figure 11 reflects the spectrum of health determinants that have been addressed in the sixteen empirical cases of “Health in All Policies”. Based on our definition of “Health in All Policies”, empirical cases were excluded from the set if they focused exclusively on health care services-related (i.e. downstream) interventions. All of the empirical “Health in All Policies” cases involved problems and interventions related to improving lifestyle/behavioral factors and/or working and living conditions (i.e. midstream determinants of health). Work/life conditions were tackled in ten out of the sixteen cases, compared to just six cases that addressed “lifestyle/behavior” issues. Nearly three-quarters of all the cases also included health care service-related interventions (i.e. downstream interventions); however less than a third of the empirical cases of “Health in All Policies” also emphasized upstream interventions such as income or power redistribution.
5.3.3. “Equity Lens” - The Coverage of Populations in Addressing Population Health Inequities: Health equity interventions can also be defined by whether the approach to responding to population health differences will be universal (i.e. a horizontal approach to equity, addressing the entire population, and providing equal treatment for equal need) or targeted (i.e. a vertical approach to equity, involving means-testing and provision of preferential treatment for greater needs).

Based on our definition of “Health in All Policies” we excluded from our set of empirical cases any initiatives that designed only targeted coverage. Across the sixteen cases almost all used a mixed universal/targeted approach to addressing health equity (Figure 11). To better understand what was included in a mixed approach, cases were further classified according to whether the predominant approach was universal or targeted. Most of the cases with mixed universal/targeted approaches to addressing health inequities emphasized interventions that were targeted to marginalized populations (see Figure 12).
Figure 12. “Health in All Policies” Countries Using Universal vs. Targeted Approaches to Tackle Population Health Inequities

5.3.4 “Equity Lens” – Closing Gaps, Flattening Gradients, or Improving Health of Vulnerable Groups:
The design of “Health in All Policies” interventions is also informed by the implicit or explicit equity goals of the government and participating sectors. There are three options here (based on Whitehead and Dahlgren, 2006 – see Box 1), which need not be mutually exclusive. The equity goal may be: (1) to improve the health of a vulnerable group – often targeting those in poverty – irrespective of whether the health divide changes between vulnerable and other groups; (2) to reduce health gaps between most and least vulnerable groups; or (3) to flatten the social gradient in health across the entire population (Box 6). Figure 13 reflects the diversity of equity goals among the sixteen “Health in All Policies” cases. Only two cases focused exclusively on improving the health of vulnerable groups and in only one case did all three equity goals drive the design of interventions. The majority of countries focused on reducing health gaps between most and least vulnerable groups, often in concert with a focus on vulnerable groups.

Figure 13. Equity Goals in “Health in All Policies” Cases
Box 1. Three main approaches to reducing social inequities in health (Adapted from Whitehead and Dahlgren, 2006).

1) Improving the health of vulnerable groups: This approach focuses on specific marginalized populations (e.g. those in poverty) and measures progress in terms of an improvement in health for the targeted group only, without any reference to improvements in health taking place in the population as a whole or among the most privileged group. From this perspective, any improvement in the health status of disadvantaged groups can be considered a success, even if the health divide between rich and poor is increasing.

2) Closing gaps: This approach aims to narrow health divides taking as its starting point the health of disadvantaged groups relative to the rest of the population. The focus of action in this category is to reduce the gap between the worst off in society and the best off – the disparity in health status between the extremes of the social scale.

3) Flattening gradients: This approach recognizes that morbidity and premature mortality tend to increase with declining socioeconomic status, and that they are not just an issue of a gap in health between rich and poor. In turn, this approach aims to reduce social inequities throughout the whole population, including middle-income groups, by seeking to reduce the differences in health between high-, middle- and low-income groups, by equalizing health opportunities across the socioeconomic spectrum.

5.3.5 Management and Control of “Health in All Policies” Interventions: The “Health in All Policies” approach may require the involvement and interaction of one or more specific orders of government (e.g. national, local), as well as the participation of civil society and the private sector. Within and among governments, decision-making may be shared, such as horizontal integration (i.e. relationships form across departments inside each sector as well as across different sectors, within the same level of government) and vertical integration (i.e. different levels of government are coordinated, intra-sectoral approaches). In the sixteen empirical “Health in All Policies” cases, implementation and management of interventions utilized a top-down or bottom-up process, depending on the presence and type of community and private sector involvement. Most jurisdictions used a mix of horizontal and vertical integration management styles, albeit in very unique ways. The Case Summaries Booklet describes management approaches in each jurisdiction. A few trends were notable. First, “Health in All Policies” was often linked with the management and delivery of primary health care, where objectives for primary health care were more encompassing than simply health care delivery, and included, for example, the furthering of social and economic development (e.g. Malaysia, Cuba, Sri Lanka, Brazil). In a related set of examples, the management strategy defined in large part by the problem stream that led to the initiation of the “Health in All Policies” approach in the first place. For example, in the case of Health Action Zones in the United Kingdom, the objective of strengthening of intersectorality at the local or regional level shaped the management approach by placing social service delivery within the health sector.
6. Relevance to Ministry of Health and Long Term Care and Options for Further Study

6.1 Getting Started with “Health in All Policies: Resources Produced and How they Can be Used

Initiating and implementing “Health in All Policies” approaches are complex processes, and the literature describing “Health in All Policies” is by and large neither analytically nor conceptually-driven. Even across multiple sources of information, cases of “Health in All Policies” to date have not been rigorously documented nor evaluated. This project was aimed to produce resources that the Ministry of Health and Long-Term Care and its partners can use to investigate the “Health in All Policies” process with greater precision.

Four important resources were produced through this expedited scoping review.

First, an explanatory Conceptual Model of the initiation and implementation of “Health in All Policies” was developed based on a synthesis of existing literature describing intersectoral and whole-of-government approaches to policymaking in general, and health equity specifically. The conceptual framework is a heuristic tool that can assist the Ministry of Health and Long-Term Care to better assess factors in the Ontario environment that may facilitate or hinder the initiation and implementation of a “Health in All Policies” approach. The tool will also aid the Ministry in learning from the empirical experiences of “Health in All Policies” in other jurisdictions, because it provides a theoretically well-supported framework for drawing comparisons.

Second, an indexed, electronic Health in All Policies Research Library of 228 research and grey literature reports describing formal “Health in All Policies” approaches and more ad hoc intersectoral initiatives to advance health equity has been developed. This was produced after screening and sorting over 5,300 sources of information. Using this library, the MOHLTC can undertake focused investigations of “Health in All Policies” start up experiences in 43 different countries.

Third, a Case Summaries Booklet details the sixteen global cases of “Health in All Policies” uncovered through the literature search. These Case Summaries introduce milestones and key structures, mechanisms and action related to “Health in All Policies” efforts.

Fourth, a discussion brief entitled “Economic Assessment of Health in All Policies” outlines key considerations to make when evaluating the economic impacts (costs and benefits) of a “Health in All Policies” approach in Ontario. No full economic analyses of the “Health in All Policies” approach were uncovered during the scoping review.

6.2 Further Investigation of “Health in All Policies” that may be Relevant to the Ministry of Health and Long-Term Care

The Ministry can use the compiled literature to investigate how intersectoral engagement facilitated the use of a “Health in All Policies” to reduce health inequities in different settings, and to what extent engagement succeeded or failed. Questions that need to be addressed include: Was there a key policy entrepreneur that drove the initiation of “Health in All Policies”? What was the role of the health sector?
What were the incentives that attracted different stakeholders to participate? And were there any missed opportunities to develop stronger intersectoral action on health equity? In particular, since addressing health equity may not have been the primary motivation for collaboration for all stakeholders – for example, some may have been motivated by budgetary efficiency or social equity – it is important to consider such questions from the perspective of multiple stakeholders.

The current literature is sparse and largely descriptive on the topic of how the initiation and implementation of “Health in All Policies” was negotiated across sectors, and does not generally account for multiple perspectives. While others have noted the important role for strong leadership in attaining population health improvement (Manuel DG, et al., 2009), it was also not always clear if there was a “leader” – an individual or a sector – driving “Health in All Policies”. Yet, information about the context of initiation does suggest that the role of various sectors and the type and importance of leadership varies across cases of “Health in All Policies”. For example, in Malaysia, the desire for health equity appears to have been inextricably linked to a broader response to political turmoil in the late 1960s that led to a clear mandate for national development that was socially equitable. In Sri Lanka, “Health in All Policies” appears to be rooted in a long tradition of cross-sectoral approaches to development and democratic socialism. The leadership role of the health sector at large can also be very different across settings. For example, in UK countries, a “Health in All Policies” approach appears to have been adopted as part of a drive for state efficiency, not any specific health equity rationale.

For this reason, empirical examples of “Health in All Policies” approaches need to be further investigated using intensive methods that are capable of uncovering tacit knowledge on this topic, such as interviews and case study approaches. While the explanatory framework does not explicitly situate the role of leadership or intersectoral engagement, it identifies conceptual domains and factors that should be considered by policy entrepreneurs and indicates at what points in the initiation and implementation processes leadership in policymaking and implementation may require more attention. It also describes key components that may act as barriers or facilitators for “Health in All Policies” that could be addressed through strategic intersectoral engagement. In this way, future work examining the types of relationships and mechanisms that have supported “Health in All Policies” in case settings can inform the development of a basket of organizational needs appropriate for initiating and implementing “Health in All Policies” in Ontario.

6.2.1 The Limitation to “Potentially Strong” Cases of “Health in All Policies”: The definition of “Health in All Policies” that we developed to identify cases for description makes some assumptions in order to emphasize potentially strong approaches to health equity (see Section 2.3). In using this definition, we may have classified some cases that would self-identify as “Health in All Policies” into the category of ad hoc intersectoral action for health equity. For example, this might include the case of Act Now BC and the short-lived Ministry of Healthy Living and Sport in British Columbia in Canada. This case largely met our definition of “Health in All Policies” except that action to address health equity appeared to be limited to an objective targeted at Aboriginal Peoples. Our decision not to include the British Columbia experience into the final set of “Health in All Policies” study cases is no reflection on the importance of reducing the health gaps between Aboriginal Peoples and other populations in British Columbia; rather, we wanted to identify cases that of “Health in All Policies” that pertain to whole populations over time.
Literature describing the case of British Columbia, and all other cases of intersectoral action for health equity, has been characterized according to the categories in section 3.2.

**6.2.2 Local Efforts:** Our definition of “Health in All Policies” also excluded cases that operated solely at a local level (i.e. without the apparent participation of governments at the state/provincial or national levels). Local cases were excluded primarily in order to identify cases of “Health in All Policies” that would resemble the approach that might be developed in the Ontario setting. To be clear, while “Health in All Policies” in Ontario may include very strong community and local government involvement, the province will ostensibly be a partner in this endeavor. In turn, there may be mechanisms of influence, financing, and sustainability (e.g. the network of committees linking higher and lower levels of government and community in Iran), as well as entry points for implementation (e.g. income tax redistribution in Norway), that are specific to “Health in All Policies” involving higher levels of government.

For a variety of reasons, examining local cases of intersectoral action for health equity may be useful for the Ministry. For example, local health equity initiatives may be effectively integrated into higher order “Health in All Policies” approaches and “Health in All Policies” at higher levels of government may scale-up from more local action. While we were not able to identify such a bottom-up approach to “Health in All Policies” among the 16 cases, we were able to identify local cases of intersectoral action for health equity that emerged as a result of more grassroots action, including in Cotacachi, Ecuador and in San Francisco, USA. Other cases of intersectoral work at the local level that may be of particular interest to the Ministry include those located in the municipalities of Porto Alegre and Rio Grande in Brazil, the cities of London and Shedfield in England, Valencia in Spain, and Ticino in Switzerland.

Finally, it should also be noted that the purpose of this scoping review was to identify literature that could be used to study the early stages of “Health in All Policies”. Cases of “Health in All Policies” should not be interpreted as necessarily successful at addressing health or social equity, and more recent cases may not even be sustainable in the long-term. In this regard, future work interested in better understanding the early stages of “Health in All Policies” should also aim to clarify the content of approaches to implementation, including the specific policies, projects, and programs used to address health equity, as well as the success that these interventions had with addressing health equity in the long term.

**6.3 Conclusion**

Examination of the sixteen empirical cases of “Health in All Policies” indicates great variation in the reasons why (i.e. the “problem stream”) this approach has been initiated in different settings. For example, in Quebec and Thailand, the roots of a “Health in All Policies” approach appear to be related to concerns for negative environmental health impacts; whereas in Finland, the impetus for an intersectoral work on health and health equity was the need to address high rates of cardiovascular disease in North Karelia in the early 1970s. The case summaries also reflect differences in the specific approaches that have been used by governments to address health equity. For example, in some settings, there has been a strong role for local governance and community involvement (e.g. in Iran and Thailand). Within these cases, however the role of the community and local public institutions differs
greatly. Overall, our preliminary review of the literature supports the understanding that there is no single configuration of factors that leads to “Health in all Policies”. Many options and pathways are available for government leadership to reduce health inequities.
Works Cited


