HiAP

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity

Health in All Policies

FROM THE GLOBAL TO THE LOCAL

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

HiAP

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Washington, D.C.
2017

Health in All Policies: from the local to the global
ISBN 978-92-75-11930-3

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Suggested citation. Pan American Health Organization. Health in All Policies: from the local to the global. Washington, D.C.: PAHO; 2017.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://iris.paho.org.

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SUMMARY AND READING GUIDE

This white paper presents options and opportunities for local governments to explore in developing and implementing their Health in All Policies (HiAP) initiatives. These options and opportunities have emerged from a series of recent global developments and are firmly grounded in a growing base of evidence. The specific developments that have given rise to them include the following:

- The recognition that the complex issues around health, equity, and development must be addressed through integrated policy responses;
- An accumulation of insights that have underscored the multilevel nature (social, political, and commercial) of the determinants of health and the evidence of "what works";
- A fuller appreciation of the connections between economics and health at every level of society;
- Ongoing support for comprehensive action in primary health care, universal health coverage, and fulfillment of the Sustainable Development Goals; and
- Perhaps most important and most interesting in an age of globalization, the growing strength and empowerment of local governments acting in concert with civil society.

This paper outlines the core parameters of HiAP. While different countries and communities have varying operational views, the overarching perspective is that it is an innovative view of collaboration between the public policy-making sectors undertaken in good partnership. It can also involve action toward achieving greater health equity, synergy, accountability, and integration. In the Americas, there is overwhelming evidence that intersectoral action drives HiAP and that the current social, cultural, economic, and political context is fertile ground for local government to embrace integrated action and policies on health and health equity. The PAHO strategy to promote an HiAP plan of action at each level of governance is timely and appropriate.

The main purpose of this paper is to discuss and make recommendations on the following topics:

1. Framing the need and priorities for HiAP at the local level;
2. Planning actions to connect, integrate, and expand the scope of the integrated policy agenda;
3. Identifying existing supportive structures and processes and agendas for their development;
4. Facilitating the assessment and engagement of civil society assets;
5. Ensuring that progress is monitored, evaluated, and reported; and
6. Building permanent capacity.

For each of these topics, it is argued that deliberate and planned action in concert with, and with respect for, civil society is both important and feasible. Vision and leadership for HiAP at the local level will be inspired by transparent needs assessments, priority-setting, monitoring and evaluation, inclusive reporting, and responsive operational action.

ACKNOWLEDGMENTS

The original idea for the white paper was conceptualized by Francisco Becerra, Luiz Augusto Galvão, Gina Watson, Kira Fortune, and Alfonso Contreras. Dr. Evelyne de Leeuw wrote the White Paper, which was shared and reviewed by members of the Health in All Policies Expert Group.

The Pan American Health Organization gratefully acknowledge the following individuals for their contributions: Marco Akerman, Hirám Arroyo-Acevedo, John Balbus, Craig Beatty, Ana Boischio, Paulo Buss, Raúl Castellanos, Ivan Dario Chahin, Anna Coates, Paloma Cuchi, Cathy Cuellar, Gerry Eijkemans, Stephen Fawcett, José Fernández, James Fitzgerald, Cristina Franceschinni, Patricia Frenz, Robert García, Diego Gonzalez, Anselm Hennis, Mana Herel, Franz Herrera, Marcia Hills, Suzanne Jackson, Marcelo Korc, Barbara Krimgold, Isobel Ludford, Blanca Mantilla, Michael Marmot, Adolfo Martínez, Matthew McConnell, David McQueen, Helia Molina, Joaquin Molina, Rebecca Morley, Oscar Mujica, Matthew Murphy, Maria Neira, Cristina Nogueira, Sebastian Peña, César Johan Pereira, Vivian Pérez, Cristina Rabadán-Diehl, Lucero Rodriguez, Julietta Rodriguez-Guzman, Linda Rudolph, Nelly Salgado, Carlos Santos-Burgoa, Agnes Soares, Orielle Solar, Timo Stahl, KC Tang, Karin Troncoso, Guillermo Troya, Agis Tsouros, Manuel Urbina, Nicole Valentine, Javier Vasquez, and Jeanette Vega.

Special thanks are due to the editor Muriel Vasconcellos and designer Miki Fernández from Ultradesigns, under the supervision of Janet Khoddami, for their ideas and efficiency in supporting the publishing of the white paper.

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1. INTRODUCTION: SCOPE AND PURPOSE OF THE PAPER

With the adoption of the Plan of Action on Health in All Policies (HiAP) at the 53rd meeting of the Pan American Health Organization (PAHO) Directing Council in September 2014 (CD53.R2), the Americas became the first World Health Organization (WHO) region to embrace a formal commitment to HiAP. The plan is based on a body of sound evidence and best practices drawn from extensive consultations with stakeholders both within and beyond the health sector. This initiative is a major step toward strengthening the HiAP agenda and application of this approach in the Region of the Americas, and it also sets an example for the rest of the global community.

The following year, a meeting of key experts was convened on 31 March to 1 April 2015 to consider approaches to implementing the plan. The specific objectives of the consultation were to:

- Develop a road map for implementation of the Plan of Action, including the definition of roles and responsibilities;
- Validate the document *Benchmarking of HiAP Indicators* prepared by the HiAP Working Group in collaboration with the HiAP Reference Group; and
- Provide input to the present white paper.

This exercise laid the groundwork for developing concrete recommendations on how the Plan of Action can best be operationalized in the Region of the Americas over the next five years, 2014-2019. It also set the stage for a dialogue on what kinds of interventions have worked in the Region, what steps can be taken to better achieve Health in All Policies, and what can be done to narrow the inequity gap more effectively using the HiAP approach. The consultation also considered the role of the Healthy Municipalities Network in implementing the Regional Plan of Action on HiAP at the local level.

In this same spirit, Health in All Policies was chosen as the central theme of the Regional Forum on Urban Health, convened by the city of Medellín, Colombia, and the PAHO/WHO Representative Office in Colombia for December 2015. It will be the fourth Regional Forum on Urban Health in the series initiated by PAHO in 2007 to foster dialogue on urban health with both internal and external partners. The Regional Forum has proved to be an innovative platform for sharing cutting-edge knowledge, experiences, and lessons learned and for strengthening South-South and North-South networking and collaboration. The meeting in Medellin will showcase successful

examples of Health in All Policies implemented at the local level. Also, marking the establishment of the Healthy Municipalities Network 25 years ago in response to the Ottawa Charter for Health Promotion (WHO, 1986), the Regional Forum will take stock of the Network's progress and explore ways to further strengthen it over the next decade.

Other activities in the Region of the Americas have included preparations for the 22nd World Conference on Health Promotion under the aegis of the International Union for Health Promotion and Education (IUHPE), to take place in Curitiba, Brazil, on 24-27 May 2016, and the 9th WHO Global Conference on Health Promotion, to be held in Shanghai at the end of 2016. The Region of the Americas is actively participating in the preparations for these events, and the evidence, recommendations, and outcomes of meetings at the regional level will be featured in these two global events.

This white paper is not a formal policy document issued by PAHO. Rather, in the tradition of public policy white papers, it is intended to provide a concise summary of the complex issue of policy development for use by stakeholders and to present the Organization's general philosophy on the matter. White papers are seen as important tools in participatory and deliberative democracy (Doern & Aucoin, 1971).

It starts by reviewing developments over the last two centuries in the evolution of public health interventions and the policies and politics that govern them. From there, it proceeds to the more recent global and local contexts that have shaped opportunities for and barriers to achieving health and health equity for all. Finally, it concludes with an overview of the current situation and the unique prospects for a paradigm shift in the area of health action.

These developments have complex cognitive, temporal, and spatial dimensions. Much research has been done, and many stakeholders are communicating their passionate concern for health-related issues in increasingly diverse forums, including social media. Incidents which in the not-so-distant past might have ended up as isolated events can now, in our globalized world, become benchmarks that can be retrieved through the Internet long into the future. Natural and man-made disasters, for instance, are no longer temporally isolated events; they are now seen as phenomena with lasting and wide-ranging consequences in a complex world. The "global village" foreshadowed by futurist Marshall McLuhan (1962) has become a reality: everything and everyone is connected, and even in our lived realities, where "local" is geographically distinct from "global," the two are inextricably intertwined.

A key term that will be encountered throughout this paper is *glocal. Glocal* health (Kickbusch, 1999; de Leeuw, 2001; de Leeuw, Tang, & Beaglehole, 2006) is a term that is used to recognize and appreciate the intricate and inseparable interface between global developments (e.g., climate change or trade) and local responses (e.g., councils that are adopting building codes to address the increased risks of flooding and heat islands, or offering favorable opportunities for local entrepreneurs to engage in international forums). The *glocalization* dynamic is reciprocal: less desirable global developments may be mitigated—or exacerbated—by local action. For instance, the increasing number of local governments around the world adopting zero carbon emission policies (e.g., Koehn, 2008) not only contributes to possible reductions in climate change risks, but also sends the message to their colleagues at both local and higher levels that such actions

are feasible and effective. These local policies impact global change through policy diffusion. In fact, it was analyses of local government effectiveness in the late 1980s and early 1990s that led to introduction of the terms *glocal* and *glocalization* into our vocabularies (Swyngedouw, 1992). Virtually every development and phenomenon described in this paper has glocal dimensions.

Indeed, the main purpose of the paper is to review the global developments that have contributed to the formation and implementation of Health in All Policies at the local level. At the global level, the past decade has seen numerous statements and declarations on HiAP, followed by successful experimentation across the world. A benchmark for these developments was the designation of HiAP as the key theme of the 8th Global Conference on Health Promotion, held in Helsinki in 2013. Furthermore, the conclusions of the Conference were reinforced by a resolution of the World Health Assembly (WHA67.12) in 2014. Bearing in mind that the terms *local* and *local government* may have different connotations in different contexts, the time has come to harvest the benefits to be gained from local initiatives in HiAP.

The Region of the Americas itself offers an example of the complexity that arises when trying to separate *local* from *global*. While many of the political entities in the Hemisphere are nation-states with multiple tiers of government, some have the status of local or regional government (e.g., *constituent country*, *commonwealth*, or *overseas collectivity*) and others are autonomous nation-states with just one tier of government where local and national completely merge, as with a number of countries in the Caribbean. The particular characteristics of small island states (Briguglio, 1995) were acknowledged, for instance, in the Barbados Programme of Action for the Sustainable Development of Small Island Developing States (UNGA, 1994). Similarly, recognition of the special situation of SIDS prompted the Ministers of Health of the Pacific Islands, also mindful of the settings approach advocated in the Ottawa Charter, to issue the Yanuca Island Declaration the following year (WHO/WPRO, 1995). These issues have been taken into account in our description of the consequences and opportunities for the glocalization of HiAP at the local level.

2. HEALTH IS A SOCIAL RESOURCE: BROAD ACTION IS REQUIRED

Healthy people are an important resource for society. Healthy communities are thriving communities, not just in economic terms, because they are more likely to contribute to the building of common resources, but also in terms of social development and resilience to cope with changes and challenges in their social and natural environment. Societies and communities with high levels of positive health are resilient. They are better equipped to face adversity.

A firm expression of this understanding of health has been enshrined in the Constitution of the World Health Organization (1948):

> *Health is a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or infirmity.*

However, despite the position that WHO has taken in its broad interpretation of health, in many countries the health services (or "sick care") sector has not fully embraced this view and all that it implies. Most health care establishments still focus on individual treatment and disease prevention; they have not yet accepted the challenge to adopt a full social model of health. Around the world, the health delivery industry has become a dominant economic sector in its own right and efforts to involve it in actions to promote community health, as opposed to the cure and prevention of disease, face strong individual-based beliefs.

The fact that the health delivery industry has become a powerful economic force also means that the need for its involvement in the development of policies for health (beyond programs to deal with disease or infirmity) is almost beyond argument and that it is an often untapped resource for policy development.

The World Health Organization has consistently advocated this view since the adoption of the Alma-Ata Declaration on Primary Health Care in 1978, and it has been regularly reaffirmed in the face of global political shifts ever since.

Microbiologist-philosopher René Dubos (1962) recognized the profound interface between individual and social health when he defined health as:

> *…the expression of the extent to which the individual and the social body maintain in readiness the resources required to meet the exigencies of the future (pp. 102-3).*

The key to appreciating this definition is the notion of the *social body*, which encompasses the concept of community as well as society and its institutions. Its institutions may be seen not only as the tangible "hardware" (hospitals, transportation services, government bodies) but also in a more sociological sense. The formidable Hannah Ahrendt (1970) defined an institution as "a body of people and thought that endeavors to make good on common expressions of human purpose." This idea of the institution—like "the institution of marriage," as opposed to "a hospital institution"—is strongly tied to the concepts of *government* and *governance*, as we will discuss below.

Local governments are shaped by both the philosophical and the structural views of institutions. In democratic traditions, it is assumed that local government can directly represent its constituents and respond to individual, family, community, and neighborhood needs. But that assumption is based, in turn, on other assumptions about representation and the eligibility of people to take part in the communal and political processes leading to formation of the values that pervade governance, and ultimately to the shape itself of government.

For the purpose of this paper, we assert that local government is both an expression and an instrument in the process of setting the priorities that create the resources for health that Dubos describes. This happens through the development of policy and the management of social and environmental assets. The body of evidence that has accumulated over recent decades on the social, political, and commercial determinants of health may well enable local government to take decisive action more readily than other levels of government and governance. Local government is presumably in closer contact with its constituents and in a position to respond more rapidly and effectively when needs are expressed. Clearly, this is an ideal description. Not all local governments are transparent and accountable, and not all people may be, or may feel, represented. This is particularly true for people living in shantytowns: they are often unregistered and therefore not a political force. However, modern technology may help to bring them into the political process (e.g., Corburn & Karanja, 2014).

Local government also has the potential to address the wider determinants of health and health equity. The determinants of health extend far beyond the workings of the health care system; they include the opportunity for education and levels of schooling, the availability of employment and standards for workplace safety, the quality of the built and natural environment, the general social gradients between those at the highest and the lowest ends of the socioeconomic spectrum, and intangibles such as sense of community and solidarity—all of which are ultimately expressed as *social capital*.

Families and communities, and their elected representatives in local governments, are the ones who suffer most directly and experience both the negative and positive consequences of decisions on how their lives are shaped in all of these domains. Complex and interconnected issues require complex and integral responses. Local government does not stand alone in this. While it is able to respond more swiftly to the needs of its people (and has responded through such initiatives as the Healthy Communities and Healthy Cities networks), at the same time it is also bound by regional (provincial, state) and (inter)national contexts. Horizontal and vertical collaboration and synergy can and should be sought.

In the next section, we will explore where these insights might lead us.

The Local HiAP Message

Health is a resource. Communities and their local governments can and must work together so that it is tapped to its fullest potential. This mandate transcends traditional boundaries of disciplines and sectors. Local government is uniquely well placed to take action.

3. PROGRESS TOWARD THE DEVELOPMENT OF COMPLEX AND INTEGRATED POLICY AND ACTION

Studies of the workings of modern society and its institutional structures (governance, democracy, leadership, etc.) have shown that traditional sectoral (sometimes called siloed) and vertical (top-down) responses, while they may yield short-term results, often fail to address the complex systemic causes that underlie problems. This observation has led to a call for greater integration in the areas of problem formulation, policy development, and comprehensive action, among others.

Integration of this kind implies equitable access by highly heterogeneous stakeholders to all of the elements in an enormously multifaceted system. It is no wonder that achieving this goal has eluded politicians, scholars, practitioners, and communities for a long time.

At an abstract level, the solution is found in concepts like systems thinking and complexity science, and problems are characterized as "fuzzy," "messy," or "wicked." For policy-making, these terms have translated into perspectives like *whole of government, joined-up government, integral government,* and *horizontal government*. There is a strong argument to be made that these perspectives play out best at the local level because it is there that cooperation between state, market, and civil society actors is considered most likely to produce coordinated planning and action (Christensen & Lægreid, 2007). The search for whole, joined-up, integral, and/or horizontal local government approaches gained momentum, according to some scholars and politicians, with the (perhaps overly zealous) adoption of the principles of *new public management* (NPM) in the 1980s. In NPM, citizens are viewed as customers, while public servants and administrators are considered managers of product and service delivery.

The assumption was that the marketization of public goods would yield greater efficiencies. However, there was often no place in this pseudo-economic discourse for the people who are vulnerable, socially excluded, marginal, and underrepresented. Governments have tried to repair the gaps in the system by applying tools that go by cunningly rhetorical names like "new social partnerships," "the empowered client," etc. In many cases, the right balance between complete state control and full transfer of services to commercial sectors has yet to be struck.

In the health field, the recognition that health issues extend across many social and government sectors has led to the emergence of policy perspectives such as Healthy Public Policy and Health in All Policies. When it comes to specific interventions, we are hearing terms like *strategic*, *comprehensive*, *multisectoral*, and *intersectoral*.

In the scientific literature we see serious efforts to distinguish between these terms. Analysts also suggest ways in which they interrelate. An Australian publication (IPAA, 2002:1) starts the discussion with thoughts on the meaning of *integrated governance*:

> *[Integrated governance is understood to be] the structure of formal and informal relations to manage affairs through collaborative (joined-up) approaches, which may be between government agencies or across levels of government (local, state, and Commonwealth) and/or the nongovernment sector.*

This description summarizes the overarching principles that drive both policy and interventions in response to the complexity of the issues in health development: the management of health, health development, and health equity through collaborative approaches. The current perspective on Health in All Policies finds its basis in the call to develop healthy public policies in the Ottawa Charter.

Around the world, governments at all levels have experimented with integrated health policies. Some of these endeavors actually inspired the tenets of the Ottawa Charter—for example, Norway's farm-food-nutrition policy, the Barefoot Doctors program in China, and women's health initiatives in the Americas. But it was two experiences on opposite sides of the world that started the process we now call HiAP. During the time when Finland held the presidency of the Council of the European Union, that country, building on its experience with the long-running North Karelia project, which is considered a horizontal health policy, urged other members of the Union to engage in HiAP, defined as:

> *…a horizontal, complementary policy-related strategy with a high potential for contributing to improved population health. The core of HiAP is to examine determinants of health, which can be influenced to improve health but are mainly controlled by the policies of sectors other than health* (Ståhl et al., 2006:270).

Almost simultaneously, the government of the state of South Australia identified opportunities for a broad policy-based program to invest in the health of its people:

> *Health in All Policies aims to improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors' core goals* (cited in South Australia, 2011:4).

These two developments informed the agenda of the 8th Global Conference on Health Promotion, held in Helsinki in June 2013, where a conceptual framework for HiAP was defined as follows:

> *Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being* (WHO, 2013:2).

Emphasis on the different dimensions of HiAP varies from country to country and jurisdiction to jurisdiction. In all cases, however, the values associated with the concept remain unchanged: they are consistently centered around the importance of collaboration between public policy-making sectors working in good partnership. Other aspects in which there is less uniformity include health equity, the attainment of synergy, whether HiAP leads to or is driven by accountability, the nature of innovation, forms of integration, and the very nature of HiAP itself, as exemplified in the following definitions:

> *Health in All Policies is a collaborative approach that integrates and articulates health considerations into policy making across sectors, and at all levels, to improve the health of all communities and people.* –"Health in All Policies: Strategies to Promote Innovative Leadership," U.S. Association of State and Territorial Health Officers (ASTHO), 2013.
>
> *Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.* –"Health in All Policies: A Guide for State and Local Governments," California Health in All Policies Task Force, 2013.
>
> *Health in All Policies is the policy practice of including, integrating or internalizing health in other policies that shape or influence the [Social Determinants of Health (SDoH)]…Health in All Policies is a policy practice adopted by leaders and policy makers to integrate consideration of health, well-being and equity during the development, implementation and evaluation of policies.* –"Intersectoral Governance for Health in All Policies," European Observatory on Health Systems and Policies, 2012.
>
> *Health in All Policies is an innovative, systems change approach to the processes through which policies are created and implemented.* –Introduction to web-based fact sheet on Health in All Policies, National Association of County and City Health Officials (NACCHO), 2015.

The adoption of World Health Assembly Resolution 67.12 in 2014, *Contributing to Social and Economic Development: Sustainable Action across Sectors to Improve Health and Health Equity*, initiated a global process of consultation and deliberation that should lead to further consistency and priority-setting. The Americas have already contributed significantly to the development of profound insights in HiAP development and implementation. Extensive experiences at the local and national levels in the Region culminated in a compilation of evidence (PAHO, 2013) prepared for the 8th Global Conference on Health Promotion and a regional Plan of Action on Health in All Policies adopted by the 53rd Meeting of the PAHO Directing Council in September 2014 (CD53.R2). The Plan of Action mandates the Director to do the following:

a. *support national efforts to improve health and well-being and ensure health equity, including action across sectors on determinants of health and risk factors for diseases, by strengthening knowledge and evidence to promote health in all policies;*

b. *provide guidance and technical assistance, upon request, to Member States in their efforts to implement Health in All Policies, including building necessary capacities, structures, mechanisms, and processes for measuring and tracking determinants of health and health disparities;*

c. *strengthen PAHO's role, capacities, and knowledge resources for giving guidance and technical assistance to support implementation of policies across sectors at the various levels of governance, and ensure coherence and collaboration with PAHO's own initiatives requiring actions across sectors, including in the regional response to the challenges posed by noncommunicable diseases;*

d. *strengthen the exchange of experiences between countries and the work among United Nations System and Inter-American System agencies.*

HiAP Is Value-Based

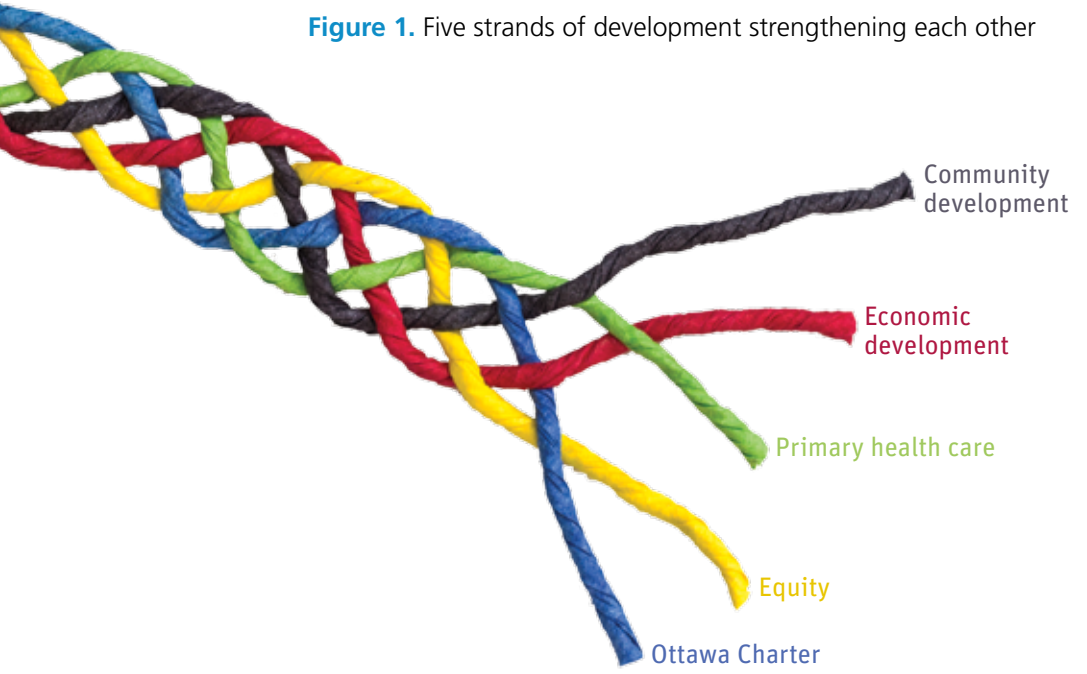
Health in All Policies has a long developmental tradition. These integrated policies have been tried and tested around the world at national and local levels. Their flavor may be different in different contexts, but all HiAP-based policies share a strong foundation in values such as innovation, good governance, equity, and participation. Local politicians, connected to their constituent communities, can embrace and be held accountable to these values.

4. HiAP AS A GLOBAL AND LOCAL (GLOCAL) CULMINATION OF DEVELOPMENT

HiAP is firmly grounded in several decades of evolution of thinking around health development and health promotion—decades that have seen increased sophistication in discerning the "causes of the causes" of health and disease, growing attention to considerations around sustainability and resilience as they relate to human development, and greater prominence of the issues of health inequality on local, national, and global agendas and across diverse populations, including lesbian, gay, bisexual, and transgender (LGBT), and indigenous minorities. The discussions around these issues often take a rights-based and value-driven orientation, as consistently affirmed by United Nations and WHO resolutions at the global and regional levels.

These evolutionary developments have taken place at both the global and local level, and the two levels have each influenced the other. They are truly glocal. We will describe five strands of development.

Figure 1. Five strands of development strengthening each other



4.1 Primary Health Care and Integrated Local Health Systems

The drive toward primary health care (PHC) has played a fundamental role in our thinking about Health in All Policies. At the WHO/UNICEF International Conference on Primary Health Care held in Alma-Ata in 1978, this concept was defined as:

> *...essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain...* (WHO, 1978).

As the concept evolved, PHC became more fine-grained and two perspectives emerged: a horizontal (comprehensive, systems-driven) approach aligned with a set of strong values around equity, participation, and community-driven, bottom-up action for health and well-being, and a vertical (disease- and health care-driven) approach based on the need to address specific disease burdens in many of the countries, grounded in existing institutions and patterns of delivering clinical interventions. Ideology-inspired debates have raged over the relative superiority of one or the other approach. Reviews of the outcomes (e.g., Magnussen et al., 2004) show that vertical programs, particularly those that have focused on morbidity from infectious diseases, can yield short-term targeted gains, but these selective approaches have not been shown to be unequivocally beneficial for the long-term development of population health. In particular, addressing health equity and noncommunicable diseases (NCDs) does not align well with a selective, vertical approach. Evidence has emerged that, depending on the existing health profile and management of the social determinants of health in different communities and countries, a rough balance between the two should be struck. Building on a mix between vertical and horizontal PHC, the aspiration should be to engage in the development of comprehensive health strategies accessible to all.

In the Americas, operational versions of the call for PHC led to the development, implementation, and management of a strong movement of local integrated health delivery (*Sistemas Integrales/ Integrados Locales de Salud* – SILOS), and the initiation of Healthy Communities and Healthy Cities (*Municipios Saludables*) networks in many countries can be traced back to PHC and SILOS. At the same time, a somewhat different developmental pattern has evolved in other WHO regions. In Europe, for example, the Healthy Cities movement was initiated in an effort to demonstrate the legitimacy and viability of the principles set forth in the Ottawa Charter. The success of SILOS may explain why health services delivery has remained an important benchmark in local health strategies and policies throughout the Americas.

Taking a comprehensive approach to health requires national as well as local governments to transcend a managerial and reactive approach to health and disease. They should, and can, take a more strategic and proactive stance. This is an investment that will pay health and economic dividends, as we will argue below. However, if governments are to shift from the management and maintenance of health care delivery toward strategic and social health planning, they must connect with all of the sectors that contribute to the determinants of health.

HiAP: A Seamless Fit

HiAP is a seamless fit with the existing knowledge and practice base of primary health care (PHC) and the concept of Healthy Communities. However, the development of HiAP is a process of gradual stepwise change. Local governments must use local successes in PHC to build momentum for reaching out. Broad policy investment in community-based health systems, not just the delivery of care, is not only an appropriate political strategy but also an investment in the sustainability of local government.

4.2 Community Development and Community Assets

The Americas have a long history of participatory community development. Several traditions have contributed to significant insights and progress in this area.

In North America, planning emerged as a discipline in the early twentieth century. Initially, the planning professional focused on urban development, but soon social planning and other areas such as health and environmental planning were added to the planners' repertoire. As they considered the "best" ways to go about planning, experts soon discovered that it was very important for the people affected to fully participate in the planning process. What was (and perhaps continues to be) involved in this "full participation" has been a matter of debate. In the meantime, Arnstein's Ladder of Citizen Participation (1969) and Davidson's Wheel of Participation (1998) have helped to clarify our understanding of the circumstances and degrees of public participation in the planning endeavor, as well as the practice of public health and health promotion around the world (Wallerstein, 2006), in the Americas (Wallerstein & Duran, 2006), and in the Healthy Cities movement in Europe (Green & Tsouros, 2008; Boulos et al., 2015).

A second tradition in this regard, which has been critically important in Central and South America, has been driven by Paulo Freire's work (1970) in community development based on new approaches in education, famously called "the pedagogy of the oppressed." The views espoused by Freire and others in this tradition stem from the belief that everyone in society should be able to engage equitably in personal and social development through open forms of democracy and decision-making. A key strategy for achieving this goal in local health development has been, and continues to be, empowerment.

Others have taken this important work as a starting point for such initiatives as asset-based community development (recognizing that people in their social contexts are an important resource for change), deliberative democracy, and a particular form of the latter, participatory budgeting. Experiments in this area, especially some initiated in Brazil (Porto Alegre in particular), have won the endorsement of the global community following an evidence-based assessment by the World Bank.

Effectively mobilizing and empowering communities to act in the interest of their own health, health equity, wealth, and well-being is an inherently political enterprise and one that can upset the status quo. Not all governments, local or national, can be expected to see the full benefit of participation and empowerment. Sometimes their level of maturity and their governance styles, as well as their patterns of accountability, transparency, and responsiveness to need, may preclude full mobilization of community assets.

Integrated Policy Must Be Grounded in Communities

Health is a resource that is essential for everyday life, and hence a critical asset for communities. The Americas have a long and successful tradition in asset-based community development. This potential can be mobilized for the development of HiAP.

The history and traditions of participatory and deliberative community engagement must be taken into account in the planning of HiAP actions.

4.3 The Ottawa Charter: A Lasting Foundation for the New Local Public Health

In the wake of growing recognition that lifestyle changes through traditional behavioral interventions (e.g., health education) have had limited efficacy and need to be embedded in broader social change, the World Health Organization, Health Canada, and the Canadian Public Health Association convened the First International Conference on Health Promotion in Ottawa in 1986 to advance "the move toward a new public health." The Conference culminated in adoption of the Ottawa Charter, in which health promotion is seen as the process of enabling individuals, groups, and communities to improve their health by increasing control over its determinants.

The Charter declared that it is the responsibility of health services to enable, mediate, and advocate for a broad view of health and health action in five areas:

- *Building healthy public policy*—bearing in mind that health is created across many sectors in society, all of which have the potential to promote enhanced institutional, community, and personal health;
- *Creating supportive environments*—recognizing the need for social, economic, natural, and built environments that will create and sustain health promotion and address the determinants of health with equity;
- *Strengthening community action*—in the belief that empowered communities will take ownership and control over their own endeavors and destinies;
- *Developing personal skills*—mindful that increasing the options available to people will enable them to exercise greater control over their health and their environments; and
- *Reorienting health services*—with the goal of moving the health sector toward a broader, participatory, and health-promoting position in society at any and all levels.

The Region of the Americas was among the first to adopt these approaches in the promotion of health. Following on the Ottawa Charter, the Declaration of the International Conference on Health Promotion (WHO, 1992), held in Bogota, Colombia, wholly embraced inclusive and policy-driven health development. Similarly, in 1993 the Caribbean Charter for Health Promotion (HCC, 1993) also recognized the importance of this process.

Reviews of accomplishments under the Ottawa Charter (*The Ottawa Charter 25 Years On*, 2011), including concerted efforts at the follow-up conferences, have found that substantial progress has been made in our understanding of the drivers of success in each of these areas. Our awareness of the complex nature of the natural, social, political, and commercial determinants of health has increased, as has our appreciation of the impact of policies on all of these. Great progress has been documented in linking (i.e., "enabling, mediating, and advocating") individual and community health potential to systematic action on environments that affect health. The only area in which success has been lagging is the reorientation of health services (Ziglio, et. al., 2011).

The global community of health promoters continues to work on the basis of these principles and to implement them, especially in the context of healthy settings—a concept introduced the Charter:

> *Health is created and lived by people within the settings of their everyday life, where they learn, work, play, and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.*

Healthy settings are of particular interest and importance in the Americas, as seen in the large networks of health-promoting schools across the Region, the thriving national and international networks of healthy municipalities and communities, and the range of other efforts that continue to accumulate evidence on the importance, and efficacy, of addressing the determinants of health through comprehensive integrated action and policy.

Health Promotion, the New Public Health, and HiAP

An important foundation for Health in All Policies has been the pivotal Ottawa Charter for Health Promotion. The Charter connected action to policy and recognized the impact of all public policy on health (healthy public policy). Health promotion works in synergy with integrated policy processes for health and development. The Ottawa Charter has been confirmed and validated through a series of global conferences on health promotion that consistently embrace the importance of a systems approach to health, including, but certainly not limited to, the promotion of a healthy lifestyle.

4.4 Economic Development and the Role of the World Bank

Health and economic development go hand in hand, although the interface between the two can best be described as "fuzzy," or in the terminology of policy development for complex systems, "wicked." For instance, poverty contributes to ill health, and ill health contributes to poverty. Economic livelihood, however, is not generally a concern of the health system and health policy environment, and health may be a peripheral concern of the institutions that drive the global financial system and economic development.

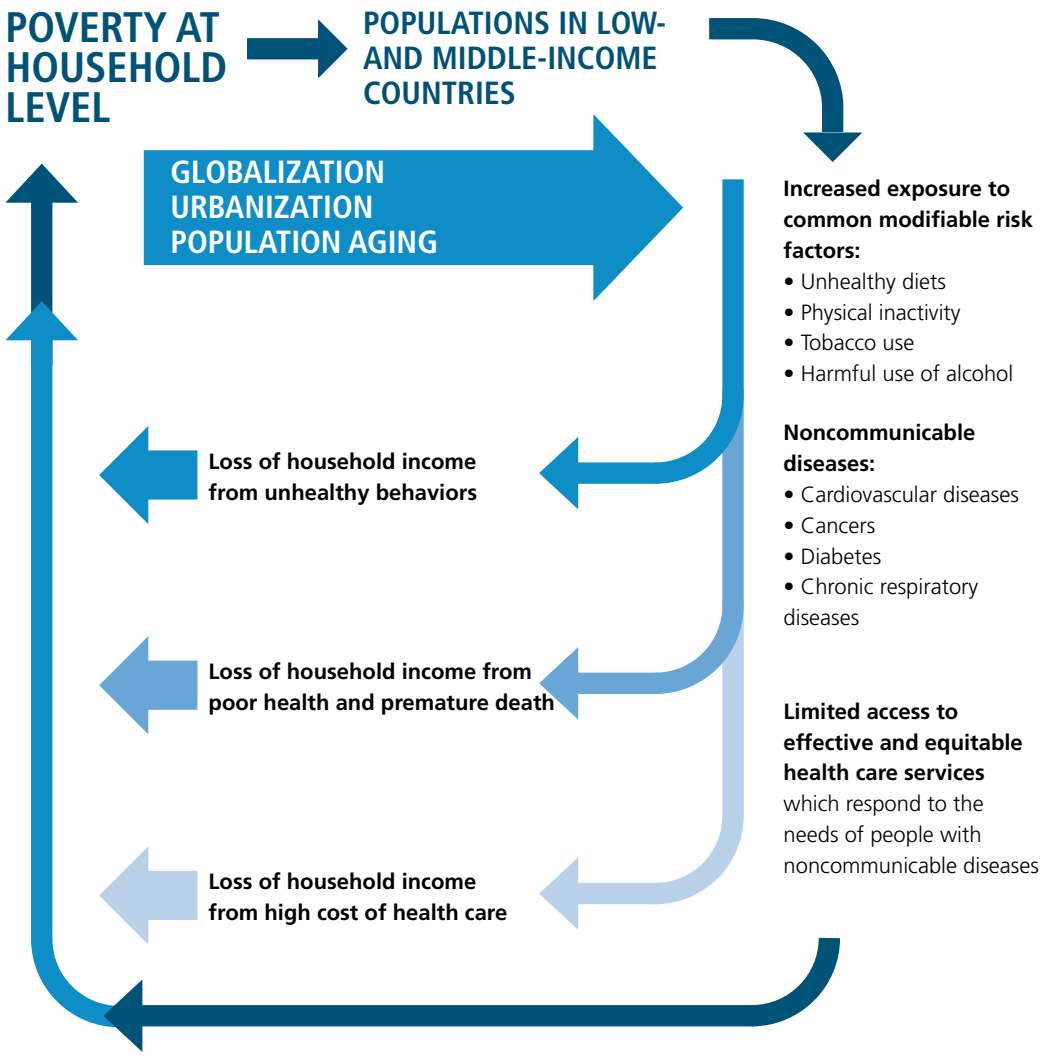
The Region of the Americas has an unfortunate record in inequitable development between and within countries. By any economic indicator, the Region is home to some of the highest- and lowest-performing countries. Within countries, there are also unsettling patterns of increasing inequity that impact social stability, well-being, and health. At the same time, other countries, even under economic duress, manage their social development and health resources equitably, yielding significant advances in both health and human development.

The realization that investment in health is a sound economic strategy started to gain traction in the late 1980s and for the first time achieved prominence in the World Bank's *World Development Report 1993: Investing in Health* (World Bank, 1993). A strong case was made that national economies and local communities stand to benefit from addressing the health and disease factors that impede full development. The report was criticized for espousing the new public management and neoliberal principles of outsourcing and privatizing health as a public good—including, for example, the supply of safe drinking water—and quantifying the impact of disability on economic development through a measure called the *disability-adjusted life year* (DALY). However, it succeeded in placing health promotion and public health management on global and local agendas as legitimate strategies for development. Similarly, the argument for Health in All Policies has also evolved in institutional bodies at the global level over the past 20 years, and today the family of United Nations agencies, including the World Bank, United Nations Development Programme (UNDP), and WHO, is prepared to mobilize for action.

The argument has been developed and refined over the years. One example was the work of the WHO Commission on Macroeconomics and Health. More recently, the WHO Commission on Social Determinants of Health concluded that unequal economic conditions and pervasive poverty were among the most critical drivers of health inequity throughout the world. The Commission's report has been followed by a series of more localized studies, covering Europe at the regional level, Brazil and England, for example, at the national level, and the city of Malmö in Sweden at the local level. Each of them has highlighted the opportunities for political action and the beneficial impact it can have on the social determinants of health. In recent years there has also been a move to take the discourse further, with some initiatives starting to address the commercial and political determinants of health as well. Recently, WHO and UNDP issued a joint report *Guidance Note on the Integration of Noncommunicable Diseases into the United Nations Development Assistance Framework* (2015), which reflects on the outcome of the 2011 High-Level Meeting on Noncommunicable Disease Prevention and Control and examines the vicious cycle of poverty and health (Figure 2) with great insight into the consequences of this perspective for local government action.

In an era of globalization, local governments and small nation-states may feel that international forces, particularly in the areas of trade and commercial development, are beyond their own policy grasp. Around the world, however, communities and local governments have taken effective action either to counter unfavorable conditions, through such approaches as partnering with civil society to alert media and other governments, or to exploit possibly favorable conditions—for example, by creating conditions to attract global players in the market.

Figure 2. The vicious cycle between poverty and health (WHO and UNDP, 2015)



Local, National, and Global Development: Challenges and Opportunities for Integrated HiAP

Economic development is health development, and health development is economic development. The economic benefits of health and well-being can and must be identified and strengthened if individuals, groups, and communities at the local level are to reach their full potential. There is a key opportunity and responsibility for local government to act at the interface between development and health.

4.5 Health Equity

The recognition that health is unequally distributed across populations is not new to the twenty-first century. Already in the nineteenth century French epidemiologist Louis-René Villermé (1840) demonstrated the adverse health effects of certain types of work and occupations. He called for action to reduce these risks, as did Rudolph Virchow, who recognized the critical importance of the health sector and its professionals in addressing social injustice:

> *Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution... Science for its own sake usually means nothing more than science for the sake of the people who happen to be pursuing it. Knowledge which is unable to support action is not genuine – and how unsure is activity without understanding... If medicine is to fulfil her great task, then she must enter the political and social life... The physicians are the natural attorneys of the poor, and the social problems should largely be solved by them.* –Dr. Rudolph Virchow, Die Medizinische Reform, 1848.

Since Virchow's time, many physicians have entered the political realm; famous examples are Che Guevara and Salvador Allende. Medical and health care groups actively engage in local and national policy development even outside the realm of health services delivery (Browne, 1998), and they are in a position to play a role in the development of more equitable societies.

The terminology used to describe the uneven distribution of health across populations is possibly as political as the causes and consequences of the phenomenon itself. Various terms are pertinent to this discourse—for example, *health disparities*, *health differences*, and *social gradient*, referring to the statistical slope between those at the top of the socioeconomic spectrum and those at the bottom. Scholars of the unfair distribution of resources and its consequences in society claim that these relatively value-free functional descriptors have been chosen deliberately to obscure the political nature of the issue. *Equality-inequality* is seen as simply a social gradient, whereas *equity-inequity* conveys a view of the moral and social injustice of such differences in society. Wilkinson and Pickett (2010) describe how equitable societies provide and create better opportunities for health for all, including enhanced economic development, sustainability, and education. Striving for equity is not the job of national government alone; achieving and securing it depends on a vibrant civil society and its political representation, extending from local action to global policy and the other way around.

Equity has entered the global discourse not just in health but in other sectors of development as well. It is a driving concept behind various global strategies, including those that address climate change, sustainable development, and gender. In the health domain, the work of the Commission on Social Determinants of Health has set the stage for change. After reviewing the causes and consequences of inequity in health, the Commission's report demonstrates that it is possible to close the gap within a generation. Policy and action are required at every level to mitigate the potentially negative effects of globalization on equity. On the other hand, global connectedness through the new social media can have a positive impact on the equity agenda.

Equity as a Driver of HiAP

Concerns for health and social equity are political concerns. Although globalization drives the determinants of equity, action and policy at the local level can mitigate their negative effects and help to lay the groundwork for change. Integration between local, national, and global public policy is important.

4.6 Globalization: The Rise of the Local and Governance for Health

The idea that we live in a globalized world has become a mainstream perspective in the twenty-first century. Goods, capital, and knowledge sometimes travel around the world at the speed of light. Globalization goes beyond the role of the traditional nation-state. Indeed, although national governments continue to collaborate and expand their vision in an increasingly globalized world, the phenomenon is driven in no small measure by commercial interests (especially trade) and yet at the same time by a new global civil society represented in such organizations as Greenpeace, Doctors Without Borders, Amnesty International, Human Rights Watch, the People's Health Movement, and many others.

The work of these varied actors on the global scene has made the traditional borders of sovereign states more permeable. No country can thrive without interaction, not just with its neighbors but across the globe, and not just with other countries but also with so-called "non-state actors." In discussions about global health governance, experts agree that it will be important to have a new architecture for managing health and health systems in this context. At the same time, new technologies and social media offer opportunities for knowledge development and community mobilization.

Local governments around the world see the weakening authority of the nation-state as an opportunity to take action. The challenges to the sovereign nature of the nation-state were evident, for example, during the 2002-2004 SARS epidemic, when the efforts of central national authorities to control the spread of SARS were broadly judged as inadequate. Authors such as Fidler argue for a new architecture of global health governance (de Leeuw, 2013). Control of NCDs, Ebola, HIV/AIDS, and other health challenges has become a global health concern, and new options for policy development at the interface between global and local need to be developed. Change has started to take place with the creation of networks of cities focused on such themes as climate change and sustainability, age-friendly environments, and knowledge and creativity. Assessments of these initiatives show that they enhance the quality of policy development and actions to improve the quality of life of citizens.

Geidne et al. (2012) undertook a comprehensive review of the concept of *governance* as it relates to local health development, and came to the conclusion that the new focus on governance has its origins in a more refined understanding of the scope and nature of the welfare state. This understanding has contributed, in turn, to a growing consensus that "government directed by sovereign politicians is not necessarily the most rational arrangement" (Geidne et al., 2012: 307). Stoker (1998) argues that, even though experts have not yet arrived at a final definition of governance, they do agree that it refers to the development of governing styles that blur the boundaries between, and within, the public and private sectors. Thus governance, in its current meaning, is both multidimensional and contextually relevant to local arrangements for health development. Still, from the research perspective it is viewed as a "messy" problem (e.g., Sinkovics & Alfoldi, 2012), since "evidence" for it must be generated in ways that go beyond the epidemiological paradigm of (quasi-)experimental studies.

Global and Local: Glocal HiAP

Globalization offers new opportunities for local governments and their communities to take action. The use of new technologies makes world knowledge and connections available to local governments and communities. This requires new, networked forms of governance for health.

There is a strong connection between governance and health (e.g., Marmot et al., 2008; Plochg et al., 2006; Vlahov et al., 2007). In a foundation report contributing to development of the Health 2020 strategy for the WHO European Region, Kickbusch and Gleicher (2012) examine this connection and go on to argue that there is a difference between *health governance* and *governance for health*: (1) *health governance* has to do with the governance and strengthening of health systems, whereas (2) *governance for health* is the joint action of health and non-health sectors, public and private sectors, and citizens, all working together in the common interest—or in the words of these authors:

> *[T]he attempts of governments or other actors to steer communities, countries, or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches* (p. vii).

4.7 Wrap-up: Six Interrelated Streams Flow into the HiAP Basin

We now have a much clearer understanding of the key issues that drive global patterns of health development. The global community has argued repeatedly that a business-as-usual approach will not allow us to work constructively toward achieving better health for all and closing the gap between the better and the worse off. Whether in relation to community development and community participation, primary health care, social and economic development, health promotion, or equity, it has been stated many times—often in the form of charters, declarations, or goals—that the world deserves better in order to become better.

However, global statements are not enough, as local governments have already recognized. Following the maxim "think globally, act locally," it is time for local authorities to take charge and make change happen. This is not an empty call. In the following sections we will demonstrate that local government is exquisitely well positioned to take charge of positive global change.

Think globally, act locally

Integrate glocally

Think locally, act globally

Glocal HiAP

Health in All Policies at the local level is the combined expression of opportunities offered by global developments and local innovation.

5. FIVE THEMES THAT PREPARE LOCAL GOVERNMENT FOR HiAP DEVELOPMENT AND IMPLEMENTATION

The developments mentioned so far have created a strong historical basis for the development of Health in All Policies. Unfortunately, they are often seen as abstract global aspirations rather than operational local inspirations. In this second decade of the third millennium, there are many reasons why local governments and their communities should be inspired to make a real difference. We propose five themes for driving further action.

5.1 The Evidence Base for Health Promotion

It is important for society and its communities to spend their resources where they matter. However, it can easily be argued that the meaning of "where they matter" will differ depending on the context. For instance, a national re-election campaign of a politician based in a megacity would probably not recognize the needs of rural and remote communities to their fullest magnitude. The fact that needs differ has given rise to the development of evidence-based policy, especially in the area of health. The evidence-based mantra in medicine has its foundation in the work of Archibald Cochrane (1971), who found that many medical practices were not firmly rooted in evidence of their effectiveness (whether something produces the intended result) or their efficiency (how well it produces that result). Consequently, decision-makers, both in their policies and in practice, have begun to invest in demonstrating the effectiveness of medical procedures.

The result of this effort can be seen both globally and locally in policies that espouse a broad social model of health and health promotion. Naturally, the methods for generating evidence of effectiveness are different from the controlled circumstances under which clinical procedures are typically tested. Whereas in clinical environments there is an assumption that an experimental group can be matched with a control group, it is much harder to find the perfect experimental match—for example, for a barrio in Medellin, Colombia—to test the effectiveness of social investment.

Yet, despite this limitation, very good progress is being made in demonstrating the effectiveness and efficiency of health policy and health promotion. Evaluation efforts around the Healthy Cities initiative show that it is easier to achieve public participation and good governance for health at the

local level. Equity is a concept close to the heart of many local politicians. Assessments of impacts on health and health equity are not just highly effective tools for measuring the consequences of broader social, environmental, and economic changes for population health; they also have a significant influence on the quality and sustainability of policy development and implementation. For example, concepts like healthy urban planning, which embrace a wider view of transportation and mobility, have contributed not just to health but also to broad social improvement.

The Ottawa Charter also launched the idea of settings for health—i.e., "where people live, love, work, and play"—as a critical aspect of health development. Significant evidence has been accumulated on the efficacy and health impacts of initiatives beyond Healthy Cities—for example: Health-promoting Schools (a network of tens of thousands of participating primary and secondary schools, soon to include kindergartens), Healthy Marketplaces, Healthy Islands (notably in the Pacific, under the Yanuca Declaration and the Barbados Programme of Action), Health Promoting Universities, Health Promoting Prisons, and Healthy Transport.

The evidence continues to be compiled by international organizations like WHO, UNDP, IUHPE, and other global agencies, as well as networks in civil society (e.g., international city networks like C40 Cities and Healthy Cities) and academia. Networking to generate evidence enhances the quality, relevance, and responsiveness of glocal (global and local) action.

5.2 Universal Health Coverage

The enthusiasm and vigor that originally infused the Alma-Ata Declaration on Primary Health Care was rekindled a few years ago when the World Health Assembly formally re-endorsed the broad social nature of the concept. It was further sustained by a global campaign to work toward universal health coverage (UHC) at all levels of governance and health system operation, defined by WHO (2014) as:

> *... ensuring that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.*

In some instances, UHC is conceived as an exclusively financial issue that requires fiscal programs and discipline to redistribute key social resources. In fact, the monetary dimension is perhaps the least problematic to address. Moving from divisive health delivery services toward inclusive ones requires much more than the reallocation of resources.

UHC has many benefits and creates ample win-win situations apart from the obvious health gain. It secures a human rights-based perspective on population health; it can be a focus for organizing and rallying communities for social and economic development; and it has the strong potential to facilitate the collection and management of high-quality health information, thus improving the evidence base for local health policy.

Local governments may not always have control over fiscal opportunities and the management of health facilities and professionals. Often these arrangements are organized and financed at higher levels of governance, and partly for good reason: not every town needs highly specialized neurosurgeons and expensive fMRI scanners. But the essential population-based "first point of contact" with the health system, i.e., primary care, is by its very nature integrated into local communities. Community health workers and local health posts play critical roles in maintaining and integrating universally accessible and appropriate health and social support. They are also the natural champions of local community development. Even when there are no formal governance arrangements for local government institutions (for example, in shantytowns), these workers and their operational bases are very much part of the social and political fabric of local government.

UHC at the point of delivery is therefore a concern for local action, even if it has not been formally recognized as a local government responsibility. Experiences from the Americas—for example, people-centered programs in Mexico and Brazil—show that UHC is possible and yields significant dividends, not just for population health but also more broadly for social development (Quick, et al., 2014). PAHO is providing strong support for such approaches. Evidence suggests that the success of UHC initiatives depends on: (a) the presence of strong, organized progressive groups in local communities; (b) the potential to mobilize adequate economic resources; (c) the absence of significant societal divisions; (d) weak opposition from institutions that might oppose UHC, such as for-profit hospital enterprises; and (e) the ability of local policy entrepreneurs to identify and open up windows of opportunity (McKee et al., 2013).

5.3 Determinants of Health

The notion of the social gradient in health—that is, the reflection of the distribution of wealth, prestige, social status, and education in health parameters like mortality, morbidity, and life expectancy—is no longer a mere epidemiological curiosity; it is now a major political issue. More and more governments around the world are striving to place health equity and its causes high on their political agendas, with varying degrees of success.

There have been arenas of governance in which the belief in its equitable nature was so strong that a debate around the sheer existence of health inequity in those societies and communities was unimaginable. On the other hand, there have also been cases in which existing inequity is attributed to personal lifestyle choices rather than broader determinants of health. This so-called "lifestyle drift" can be inspired either by uninformed behaviorist thinking, in which all human behavior is assumed to be entirely within the control of the individual, or by political ideologies like conservative liberalism, which attributes the fate of societies entirely to the resourcefulness of their individual members.

The evidence, however, demonstrates that individual choice is determined by a combination of social, environmental, cultural, economic, natural, and built environments. Clearly, these forces interact at extremely intricate levels. It is also shaped by political preference and commercial interest.

Figure 3. Conceptual model for the work of the WHO Commission on Social Determinants of Health (WHO, 2008)

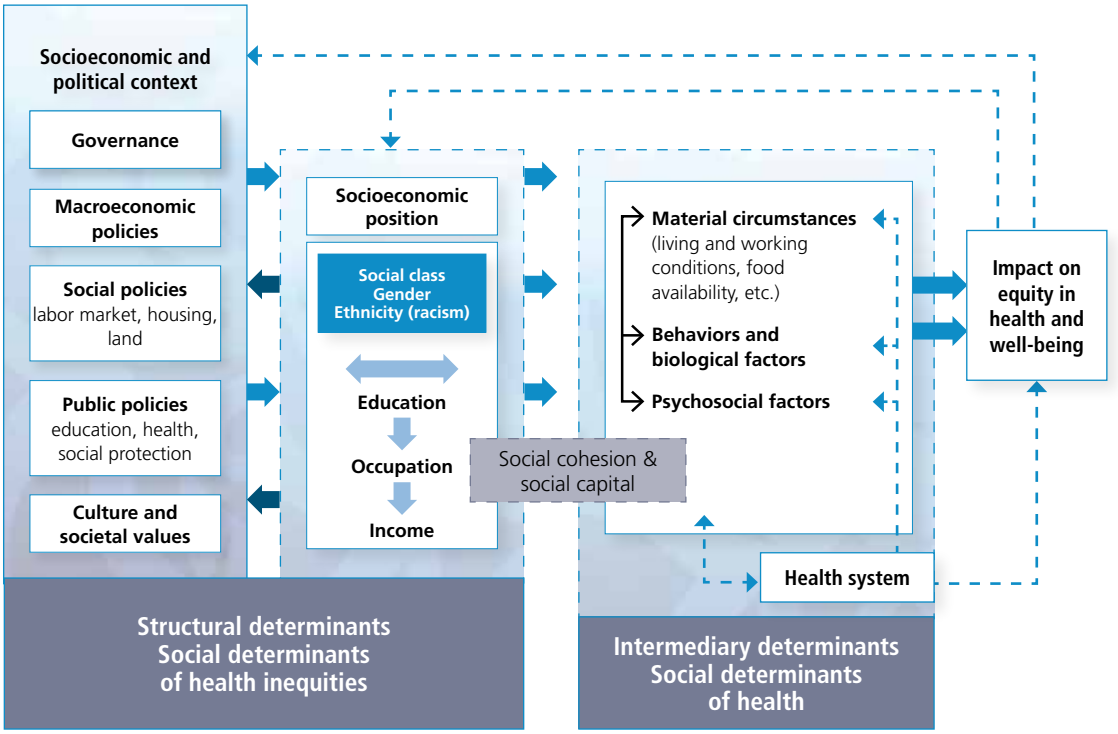


Figure 3 shows the conceptual model used by the Commission on Social Determinants to map the impact of social determinants on health and health equity. This model has been applied at the global, regional, national, and local levels. In particular, the Marmot reviews for England and the city of Malmö in Sweden provide a wealth of insight into the potential and opportunities for local government to take comprehensive and integrated action to address complex health challenges.

Both the review undertaken for England (Marmot Review Team, 2010) and the study done in Malmö (Commission for a Socially Sustainable Malmö, 2013) stress the interrelationships between the policies that aim to achieve the following six objectives:

- Give every child the best start in life;
- Enable all children, young people, and adults to maximize their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of prevention programs.

5.4 Some Reflections on Silos: How did we get into them, and how to move beyond them?

One of the main challenges in establishing cross-cutting policies and actions is moving beyond the traditional disciplinary and sectoral boundaries that keep policy-makers confined in what we call silos. How did we end up with these silos?

Up until the Age of Enlightenment, also known as the Age of Reason, the classic wise man knew something about everything. The most famous example is Leonardo da Vinci (1452–1519), Italian polymath, painter, sculptor, architect, musician, mathematician, engineer, inventor, anatomist, geologist, cartographer, botanist, and writer, but Leonardo was certainly not unique. Over the centuries other men and women have drawn on multiple areas of knowledge and the arts to give us many of the advances that we enjoy today in modern society.

This comprehensive integration of the sciences and the arts, embodied not just in one person but in the prevailing world view, was to be challenged during the Enlightenment in the seventeenth and eighteenth centuries, when knowledge evolved toward a separation into distinctly different disciplines. It was argued that the observed world was best understood by breaking it down into its unique components. Scholars began to focus on particular bodies of knowledge and developed strong theories for each. Thus separate disciplines emerged, including medicine. In the nineteenth century, influenced in part by the Industrial Revolution and a growing upwardly mobile middle class, these disciplines started to specialize even further and become highly professionalized. The process is sometimes called *hyperspecialization* and can still be witnessed in the proliferation of academic journals focusing on highly specific areas of interest.

Hyperspecialization is one of the factors that causes modern societies to operate in management and policy silos. Professionalization—the process of establishing acceptable qualifications, a professional body or association to oversee the conduct of members of the profession, and a means of distinguishing between qualified professionals and unqualified amateurs—is another. This process creates a hierarchical divide between the knowledge authorities in the professions and a deferential citizenry, and it creates strong patterns of inclusion and exclusion: to build a bridge, you need to hire an engineer; to take someone to court, you need to retain a lawyer; and to get treatment for a physical problem, you need to see a doctor.

The boundaries of specialties and professions are constantly being challenged. In the early twentieth century, for example, a debate raged in North America over whether public health was within the scope of the medical profession. The question was resolved with publication of the Flexner Report in 1910, urging a proper "scientific" approach to the teaching of clinical medicine, thus excluding public health. In Europe, however, as well as countries that followed a European model of

health professionalization, medical education continued to include public health matters under the banner of "social medicine."

Specialization and professionalization have mobilized formidable commercial and political forces to maintain and protect the status quo. Even when the evidence base on the social determinants of health rationally dictates collaboration and integration of efforts, these forces often prevent successful and effective action and policy development.

Moving Forward

There is a growing body of rhetorical and evidence-based knowledge that addresses these issues. Effective partnering for health starts by recognizing that the capacities of a given discipline or specialty in isolation are insufficient to make a difference. The process that promotes this recognition requires leadership, communication, analytical skills, and something that could be called social entrepreneurship—in other words, the capacity to advocate, to manage opportunities, and to mediate differences between diverse communities of policy and practice. This process must be backed by firm pronouncements from a high-ranking executive such as a mayor, CEO, or spiritual leader to encourage reaching out to other sectors. Reliable and sustainable grounding of this position in community action helps to maintain the momentum.

The foregoing approaches to breaking down the silos play out at a relatively high level of abstraction. It is also vital to have a workforce that is receptive to interdisciplinary work and has been trained to reach out to others. We are beginning to see education programs and curricula at the primary, secondary, and tertiary levels that embrace these values.

5.5 From the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs)

Global development goes hand in hand with local development, and the other way around. The year 2015 saw the "expiration" of the Millennium Development Goals (MDGs) that had been driving development agendas around the world since 2000. Although some have criticized the MDGs for being too abstract or overly ambitious, there is insurmountable evidence that their adoption and review have shaped the direction of glocal development.

Building on the findings from the MDG experience, the United Nations and its partner organizations have embarked on an inclusive consultative process to develop a new set of goals for the post-2015 agenda. These new objectives are called Sustainable Development Goals (SDGs). A final set of SDGs will be adopted near the end of 2015. The currently proposed SDGs are shown in Table 1.

Although the process of crafting these goals and their nearly 200 associated operational targets has included global civil society, and the goals and targets have been validated glocally in preparation for the eventual adoption of a set of SDGs by the United Nations Member States, some countries do not appear to be ready to adopt the entire list and others are asking for greater specificity. United Nations Secretary-General Ban Ki-moon, in his synthesis report on the SDGs presented to the General Assembly in December 2014 (UNGA, 2014), did not seem open to reducing or expanding the number of SDGs. However, in a bid to help governments frame their goals, Ban grouped them into six "essential elements": dignity, prosperity, justice, partnership, planet, and people. It is no coincidence that these are also the social determinants of health and the core values of all those who are committed to health development.

The SDGs serve as a potential entry point and uniting force for HiAP action. Health may be considered a precursor, indicator, or outcome of development. Each Sustainable Development Goal is a statement on the determinants of health, and it will therefore impact health and health equity. Governments and the health sector have an opportunity to utilize the final set of SDGs as powerful key drivers of not just their own actions and policies but also their initiatives to engage with others.

Table 1. Proposed Sustainable Development Goals

1	*End poverty in all its forms everywhere*
2	*End hunger, achieve food security and improved nutrition, and promote sustainable agriculture*
3	*Ensure healthy lives and promote well-being for all at all ages*
4	*Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*
5	*Achieve gender equality and empower all women and girls*
6	*Ensure availability and sustainable management of water and sanitation for all*
7	*Ensure access to affordable, reliable, sustainable, and modern energy for all*
8	*Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all*
9	*Build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation*
10	*Reduce inequality within and among countries*
11	*Make cities and human settlements inclusive, safe, resilient, and sustainable*
12	*Ensure sustainable consumption and production patterns*
13	*Take urgent action to combat climate change and its impacts**
14	*Conserve and sustainably use the oceans, seas, and marine resources for sustainable development*
15	*Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss*
16	*Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels*
17	*Strengthen the means of implementation and revitalize the global partnership for sustainable development*

* Acknowledging that the United Nations Framework Convention on Climate Change is the primary international, intergovernmental forum for negotiating the global response to climate change.

6. HEALTH IN ALL POLICIES: STATE OF THE ART AND LOCAL OPPORTUNITY

6.1 The Pan American Health Organization/Americas Region (PAHO/AMRO) Advantage

As we have already noted, the Region of the Americas and the Pan American Health Organization have consistently taken the lead in local and integrated responses to complex health problems. In preparation for the 8th Global Conference on Health Promotion in 2013, the PAHO Member States compiled and analyzed a series of case studies that demonstrate the Region's clear commitment to HiAP and its leadership in developing and implementing it at both the international and national level. These case studies more often than not included local and community perspectives on the successful engagement of thriving Healthy Communities networks and creative and proactive approaches to community development and participation.

There is clear and urgent momentum in the Region to move forward with HiAP at all levels of government and governance. At the national level, many governments have established structures and processes for assessing HiAP potential, and many of their public health and health promotion agencies have developed manuals and checklists that will help to drive national and state-level policy development.

PAHO is committed to boosting this potential even further through its Plan of Action on Health in All Policies. Comprehensive sets of evidence, both practical and research-based, have already been made available to local governments in such areas as policy development and action on the social determinants of health, the commitment to health equity, and the inclusion of health and well-being in local and national development plans. Following up on these initiatives, in 2014 the PAHO Directing Council adopted the Plan of Action on Health in All Policies, which is in full alignment with the global impetus to develop a framework for HiAP implementation and with global capacity-building efforts. Through implementation of the Plan of Action, it is hoped to:

a. Generate and document evidence on HiAP for high-level advocacy to further strengthen collaboration between different sectors;
b. Utilize case studies in HiAP to demonstrate its applicability in the Region;
c. Build capacity in HiAP using the course on HiAP developed by WHO, which will be rolled out by two of the PAHO collaborating centers;

d. Scale up the use of health impact assessment methodology, following up on the pilot HiAP initiatives carried out in Argentina, Colombia, and Suriname as the outcome of a regional training initiative conducted by PAHO and the University of New South Wales in Australia;
e. Work with the Healthy Municipalities and Healthy Schools networks to expand the scope of the Plan of Action;
f. Monitor the countries' progress in implementing Health in All Policies;
g. Strengthen South-South collaboration by showcasing achievements in the application of HiAP, as well as South-North collaboration, especially with the WHO Regional Office for Europe, which has made significant progress in this area.

6.2 Policy and Action

The terms *intersectoral action* and *multisectoral action* have been part of the public health and health promotion lexicon since the mid-1970s. They have gained currency through the Ottawa Charter and a series of other pronouncements by global bodies, including WHO and PAHO. The international discourse has also considered ideas on working together for health along the spectrum of *networking-coordinating-cooperating-collaborating*. Although there may be different nuances in the interpretation of these terms, public health and health promotion are clearly focused on the noun *action*.

While agencies, individuals, groups, and communities may come together to act jointly on health concerns or determinants of health, this does not necessarily mean that their actions are driven by policy or that they will result in policy. In the meantime, a series of case studies are starting to build an evidence base demonstrating that successful intersectoral action can inspire the need for HiAP. However, HiAP may not always have to lead to intersectoral action. For instance, policies to limit lead content in paint and gasoline are singularly industrial-economic in nature, and, apart from commitments required by industry, they do not require the deep involvement of other government sectors.

Considering the importance of successful intersectoral action for the development of HiAP, it is appropriate to quote from a study commissioned by WHO (Irwin & Scali, 2010) following the launch of the report of the Commission on Social Determinants of Health:

> *[T]he track record of actual results from national implementation of IAH [intersectoral action for health] was feeble. Indeed, despite the high profile accorded to intersectoral action in the Alma-Ata Declaration, WHA technical discussions, the health promotion movement, and Good Health at Low Cost [GHLC], IAH to address social and environmental health determinants generally proved, in practice, to be the weakest component of the strategies associated with Health for All.*
>
> *Why? In part, precisely because many countries attempted to implement IAH in isolation from the other relevant social and political factors pointed out in the above list. These contributing factors are to an important degree interdependent and mutually reinforcing. Thus, the chances of success in IAH vary with the strength of the other pillars: broad commitment to health as a collective social and political goal; the crafting of economic development policies*

The Region of the Americas Continues to Lead

The potential for HiAP in the Americas is convincingly documented. PAHO Member States and civil society are committed to integrated policies for health and well-being. The successes to date in the Healthy Municipalities strategy, primary care, and universal health coverage are fertile ground for decisive local policy action.

to promote social welfare; community empowerment and participation; and equity in health services coverage. Where these objectives were not seriously pursued, IAH also faltered.

Later analysts identified further reasons why IAH failed to "take off" in many countries in the wake of Alma-Ata and GHLC. One problem concerned evidence and measurement. Decision-makers in other sectors complained that health experts were often unable to provide quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy, or industrial policy. At a deeper level, beyond the inability to furnish data in specific cases, profound methodological uncertainty persisted about how to measure social conditions and processes and accurately evaluate their health effects. The problem was complicated both by the inherent complexity of such processes and by the frequent time-lag between the introduction of social policies and the observation of effects in population health. Measurement experts reached no clear resolution on the methodological challenges of evaluation and attribution in social contexts where by definition the conditions of controlled clinical trials could not be approximated.

During the 1980s, IAH also ran up against government structures and budgeting processes poorly adapted to intersectoral approaches. One review identified the following difficulties:

- *Vertical boundaries between sections in government;*
- *Integrated programmes often seen as threatening to sector-specific budgets, to the direct access of sectors to donors, and to the sectors' functional autonomy;*
- *Weak position of health and environment sectors within many governments;*
- *Few economic incentives to support intersectorality and integrated initiatives;*
- *Government priorities often defined by political expediency, rather than rational analysis.*

Uncertainties about evidence and intragovernmental dynamics were only part of the problem, however. Wider trends in the global health and development policy environment contributed to derailing efforts to implement intersectoral health policies. A decisive factor was the rapid shift on the part of many donor agencies, international health authorities, and countries from the ambitious Alma-Ata vision of primary health care, which had included intersectoral action on social determinants of health [SDH] as a core focus, to a narrower model of "selective primary health care" (Irwin & Scali, 2010:12).

It appears that, with the resurgence of primary health care, the strengthening of universal health care, and an increasing commitment to equity around the world, the tide toward neoliberalism and free market principles has become balanced again, and that the political climate for successful intersectoral initiatives is more positive. This momentum is reflected in the commitment to formulate and implement HiAP, but the limitations and challenges involved in the comprehensive embrace of integral action will remain, and they will need to be addressed.

This discussion on the critical connection between action and policy raises at least two questions: What is involved in the process of attaining and sustaining Health in All Policies? And: Who are the actors that need to be engaged? McQueen et al. (2012) have described several governance models for HiAP and have mapped them onto the different elements of the policy process (Figure 4) based on seven best-practice models for HiAP implementation. Different groups of government and nongovernmental agencies can play different roles during the HiAP process. Figure 4 indicates some of the governance parameters for positioning HiAP development within government structures. In addition, Figure 5 identifies eight different structural patterns that characterize the linkages between the health care system and its public policy agencies (e.g., a Ministry of Health at the

Figure 4. Actors engaged in governance for HiAP

	Agenda setting			Policy formation			Policy implementation		Policy review		
	Identity problem	Research	Set agenda	Develop options and strategies	Negotiate	Formulate policy/guidance	Implement policy	Enforce policy	Monitor	Evaluate	Report
1. Cabinet committees and secretariats			■	■	■	■	■				
2. Parliamentary committees		■	■						■	■	
3. Interdepartmental committees and units	■	■	■	■	■	■	■	■	■	■	■
4. Mega-ministries and merges				■	■	■	■		■	■	■
5. Joint budgeting							■	■			
6. Intersectoral policy-making procedures				■	■	■					
7. Nongovernment stakeholder engagement	■			■	■	■	■				

Source: WHO (2015), based on McQueen et al. (2012).

national or provincial level, or a public servant within a local government agency with public health responsibilities) or other public sector agencies and executives (office of the president or mayor, for instance), with a graphic image that suggests the resulting shape of the intersectoral action for health and health equity.

That said, it would be an illusion to think that interagency integration or collaboration would automatically lead to integrated action. There are many cases in which collaboration still leads to a multitude of singular projects without a lot of systemic or synergistic consequences. An example might be interagency collaboration on road safety: although there is agreement on the nature of the problem, improvements in road design, trauma response, and safety messages (e.g., on the need to use seatbelts or bike helmets) do not align to create truly interlocking and effective programs.

On the other hand, there are many examples of the health sector successfully driving systemic and sustainable intersectoral action when the sector is given the opportunity to engage with local communities. One of them would be the integration of health checkups, child care, and health literacy training at *casas de cultura* across the Region.

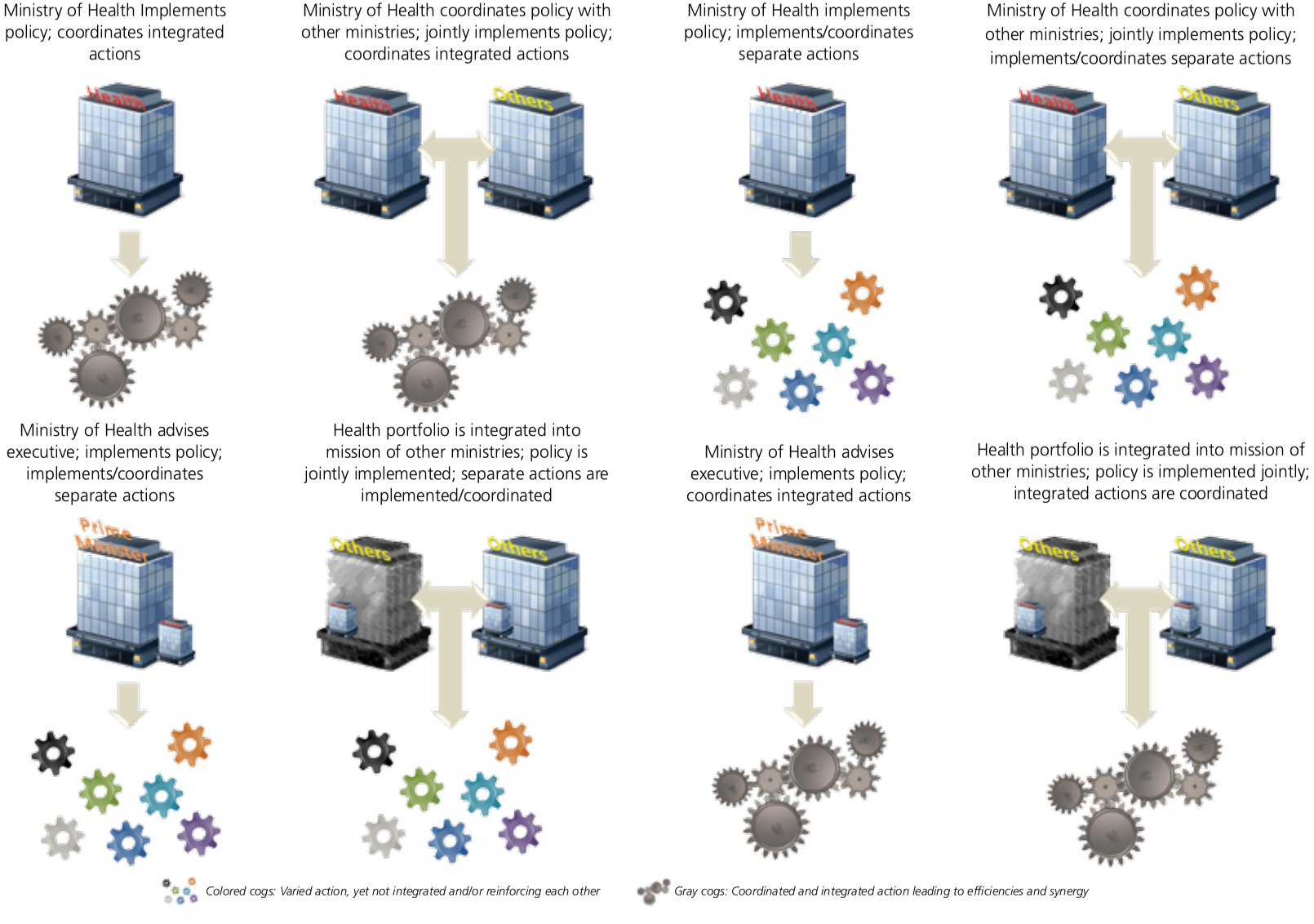
Key to the success of any approach is identifying win-win opportunities, playing to the strengths of each sector and community, "going with the flow" rather than against it, demonstrating co-benefits to those involved (even beyond government sectors), and avoiding turf wars. It is also essential to promote a more comprehensive appreciation of the different forms of evidence that are generated and applied beyond the health system alone and to exploit successful inter- and multisectoral action driven by stakeholders outside the health and public sectors.

The Differences and Connections between Policy and Action

Intersectoral action is a precursor to HiAP, and HiAP can lead to intersectoral action. A vision for integrated approaches to health is once again taking center stage.

Appropriate and insightful strategic analyses of different stakeholder positions while building on experiences elsewhere would strengthen both policy and action.

Figure 5. Eight ways to coordinate between sectors and implement HiAP in integrated or separate action



6.3 Framing the Need and Priorities for HiAP at the Local Level

Local governments are supremely situated to gauge community health priorities, put processes in place to address these priorities, and work with local stakeholders (including government departments, civil society, and industry) to develop lasting processes that will address concerns. We make this assertion under the assumption that local stakeholders can be adequately represented in such processes, but in many cases—e.g., residents of shantytowns and itinerant populations—hearing their voice is a challenging proposition. It is important for local government and its branches in neighborhoods and communities to be fully aware of the potential roadblocks to full participation and to put processes and structures in place that will allow for consultative and participatory action.

Earlier we noted that the Americas have a rich tradition in participation and empowerment practice, even though in some political environments the full potential of these processes has been stifled. Apart from political barriers, local governments may have the perception that participatory and deliberative action is structurally and organizationally hard to accomplish. Also, some local administrations are facing tight deadlines and urgent problems, and they may feel that consultative processes and networking efforts between stakeholders would take too much time—time that might be better spent on immediate action.

The evidence, however, is clear. Consultation and participation are the bedrock of systemic policy approaches that draw upon the broad assets available in local communities and at the same time reward them with lasting, sustainable solutions. When it comes to health challenges, health professionals such as epidemiologists, biostatisticians, public health doctors, and community health workers can make a very important contribution to inventories of needs and priorities. However, their often quantitative efforts at monitoring, reviewing, and evaluating health issues and the broad determinants they use must be supplemented and benchmarked by qualitative community surveys, broad stakeholder input, and respect for legitimate expressions of concern by the population.

In many initiatives under the Healthy Communities program, local health leaders start the process of needs assessment and priority-setting by developing health profiles and health development plans. In the most successful examples of such initiatives, working documents and briefings are shared with communities in local forums, thus extending policy development beyond City Hall and into the heart of the community. This approach builds trust in the process and strengthens community commitment.

An important component of needs assessment and priority-setting is mutual respect between the community and the local government apparatus. Respect can be demonstrated through ongoing dialogue and engagement, even when some of the issues may seem too hard to tackle. Examples of issues that might easily be dismissed as too challenging might be poverty and sanitation in shantytowns, or obesity and diabetes in areas of urban sprawl. Recognizing their complexity is an important first step in coming up with possible solutions.

HiAP Needs and Priorities

Complex health issues require complex solutions and interventions driven by policy that is both multilevel and integral. Inclusive needs assessment and priority-setting will establish a solid and lasting agenda for intersectoral action and integrated policy development.

6.4 Planning Action to Connect, Integrate, and Define the Shape of the Policy Agenda

Collaboration and partnerships are key tools for the establishment and maintenance of an integrated health policy agenda. Again, the evidence is clear: complex health problems require complex solutions in which many sectors and stakeholders collaborate. But collaboration and partnering are not phenomena that happen automatically or spontaneously. They require careful cultivation, governance, and vision by credible local leadership. While these leaders are often elected officials in local government, others may assume such roles as well. These others have been given names like boundary workers, social entrepreneurs, issue initiators, policy brokers, strategists, or caretakers. They are critically important in planning action tied to policy initiatives and the work they do deserves to be celebrated.

It is crucial to understand that intersectoral action and HiAP cannot just happen by themselves. Collaboration without joint ownership and shared outcomes, without integrated policy that addresses all issues, is senseless. Many lessons have been learned from experience with integrated partnerships in health promotion, especially as part of the Healthy Cities initiative (e.g., Lipp et al., 2013). Planned action to connect, integrate, and define the shape of the integral policy agenda needs to go through the following steps, each of which requires an evidence base:

- Define the organizational mission and assess available resource capacity while at the same time acknowledging the boundaries of the traditional organizational footprint;
- Describe the challenges that the organization faces in addressing issues and reaching out to populations that both permeate and extend beyond its legitimate area of concern;
- Identify and include organizations that cover the same, similar, or different issues and populations and that share the same, similar, or different approaches and interventions for dealing with them;
- Recognize the legitimate potential for other stakeholders to be involved in intersectoral action or integrated policy development and strive for transparency in sharing all views;
- Estimate the dimensions of possible collaboration and the factors that may stand in the way of respectful joint action;
- Engage real authorities and decision-makers, including both organizational executives and street-level bureaucrats (frontline implementation personnel who deal with the challenges of intersectoral action on an everyday basis), in shaping the joint agenda; and
- Formalize and celebrate the completion of each of these steps, making sure to include, insofar as possible, individuals, communities, and neighborhoods that will be at the "receiving end" of the policy-based actions and outputs.

Make all stakeholders in these processes accountable for their actions to the extent that it is culturally and organizationally feasible for them to do so, while requiring full confidentiality in the case of sensitive and strategic issues, following the terms of the Chatham House Rule whenever necessary.

6.5 Identifying Existing Supportive Structures and Processes and Agendas for Their Development

So far we have seen that many local government areas already have effective structures and processes in place that would further facilitate the development of intersectoral action for health, along with the potential for integrated policy development. These structures and processes may include the following characteristics:

- An engaged and empowered community;
- Successful experience in deliberative democratic and participatory processes;
- Successful experience in partnerships and collaboration for health and well-being;
- Recognition of the urgency of NCD strategies, supported at executive and council levels;
- Recognition of the "causes of the causes" of ill health, also supported at executive and council levels;
- An existing agenda to strengthen or move toward universal health coverage;
- Interest in benefiting from other existing local-level role models and examples of intersectoral action and HiAP elsewhere in the country through connections like Healthy Communities networks;
- Vertical integration of governance models for intersectoral action and HiAP at higher levels of government; and
- Awareness of existing evidence of social, economic, and sustainable win-win situations and ongoing connections with local and national agencies and structures that would support the creation and maintenance of such evidence (e.g., local and national universities and NGOs).

It is important role for local councils and executives, mayors in particular, as well as engaged individuals, to formally and explicitly embrace these strong foundations for action and policy development. Their commitment will be strengthened through open and transparent mechanisms to engage civil society in the development, formalization, and maintenance of these processes and structures.

Critically, the evidence base for the formulation and implementation of Health in All Policies shows that HiAP should not be left to haphazard circumstance. It is a process that needs to be managed with clear vision and leadership. At the national level, this leadership is likely to be assumed by the Ministry of Health, though the "clinical gaze" sometimes stands in the way of novel whole-of-government approaches. At the local level, there is more diversity across the Region in terms of governance arrangements for public health and health service delivery. In some countries, the local government is fully responsible for the development of health policy and the delivery of services; in other countries these functions are decentralized but not entirely under the control of local government; and in still other cases they are structured and managed from the center.

Chatham House Rule

When a meeting, or a part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.

Hence, local leadership for intersectoral action and HiAP development and implementation may not necessarily have a direct connection with local health providers. The lead may be taken by social work organizations, community enterprises, the municipal apparatus, or other stakeholders. Since HiAP is an expression of local public policy, the role of local government is essential. Furthermore, the leadership of a given public sector is a precondition for integrated policy.

6.6 Facilitating the Assessment and Engagement of Civil Society Assets

The open and transparent engagement of civil society assets depends on a strong commitment to review and assess the existing potential of local communities, professionals, NGOs, and industry to contribute and sustain action and policy for health. Facilitating asset-based community development is an ongoing process that includes the following:

- Identifying and giving visibility to the health-enhancing assets in a community;
- Seeing citizens and communities as co-producers of health and well-being, rather than recipients of services;
- Promoting community networks, relationships, and friendships that can provide caring, mutual help, and empowerment;
- Recognizing the value of what works well in a given area;
- Identifying resources that have the potential to improve health and well-being;
- Supporting individuals in fostering their own health and well-being through the development of self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge, and personal resourcefulness; and
- Empowering communities to control their future and create tangible resources such as services, funds, and buildings.

Effective tools for mapping community assets have already been developed and validated, and they are freely available to local governments, particularly in the Americas—for example, in Canada (OHCC, 2008), the United States (University of Kansas, 2014), Brazil, and Chile.

However, asset mapping—that is, assessing and mobilizing community assets—should not be seen as just an academic exercise. Overwhelming local communities with seemingly esoteric evaluation tools without appropriate respect and follow-up action is not only unethical but also a waste of precious resources. It is therefore critical to identify the ongoing and developmental aspects of this process.

Furthermore, follow-up action should be framed in terms of civil society's potential to engage in broad intersectoral action for health and well-being. It calls for building a strong policy agenda that foreshadows lasting, systemic, and integrated decision-making with appropriate allocation of resources. Such a policy agenda must also allow for the ongoing involvement of civil society and its assets in integrated approaches to health.

Local HiAP Vision and Leadership

Broad engagement by all local stakeholders is essential for the successful development of integrated health policy. Within this context, leadership and the identification of a lead actor are important. Different lead actors will be identified in different local contexts.

6.7 Monitoring, Evaluating, and Reporting

In order for the action-policy-action vortex to succeed, it is critical to have systems in place for monitoring, evaluating, and reporting on the following elements:

- The contribution of intersectoral action to the HiAP agenda;
- The HiAP development process and engagement of the broadest possible array of stakeholders;
- The actual implementation of HiAP in terms of policy products, interventions, and intersectoral engagement;
- The mutual and reciprocal benefits resulting from this integrated policy agenda;
- The impact of HiAP implementation on the determinants of health and well-being; and
- Ultimately, the health consequences of the policy and its actions.

Having up-to-date information in these areas reassures and empowers all stakeholders in the process, demonstrates the efficacy of the allocation of resources, and sets the stage for managerial processes that stay focused on core deliverables. Also, monitoring, evaluation, and reporting allow for transferability of success within and beyond local government areas, create systems of accountability toward the stakeholders involved, and help to secure their commitment to intersectoral action and HiAP development.

Many local governments may feel challenged to establish such an all-encompassing evaluation agenda. They may not have the local capacity to design and implement comprehensive research strategies. However, since it is imperative for governments to allocate and spend resources wisely, putting mechanisms in place to review the inputs and outputs of government processes is critical for their survival.

When local government engages in intersectoral action and HiAP development, even at its most basic level, it also has the capacity for monitoring and evaluation. This capacity is derived from the existing local assets and the cumulative documentation of steps along the way. More often than not, engaged communities are happy and proud to contribute to assessment and monitoring and they should be involved in the various stages of reporting. Government and community workers who deliver and facilitate action for health "in the trenches" also have a responsibility to keep track of what they do, and they should be encouraged to keep journals and record their work regularly.

It is also important for institutions of higher education and research to engage in these processes. Students can be a powerful community resource. Local governments should encourage institutions of higher learning to promote research on the social and political aspects of health. This may work best using individuals or institutions that are sometimes called knowledge brokers, research entrepreneurs, or development facilitators. Local governments may want to establish collaborative networks to mobilize these resources when they are not available locally, while national governments and the international community have an obligation to facilitate working across the nexus of research, policy, and practice.

Asset Mapping Drives HiAP

An understanding of the assets available to local government, coupled with a full appreciation of its potential for intersectoral action and HiAP, is critical in order to have lasting action and policy.

A deliberate process of monitoring and evaluation is essential for providing the information needed in order to assess progress and pitfalls. Within such a process, the job of local government is to establish monitoring and evaluation milestones (e.g., What is to be accomplished? By whom? In what time frame?), baseline measurements, and an agreement on what constitutes progress or failure.

6.8 Building Lasting Capacity

Addressing the complex issues of modern health and health equity is a long, ongoing process. Establishment and implementation of a single Health in All Policy is not the end point of this process. It is a stage in an evolutionary practice. The policy needs to be reviewed, adapted, and constantly updated to meet the requirements it has created. The context in which this happens, and the local stakeholders involved, will constantly change. Political shifts may require a renewal of executive commitment; evolving community concerns may call for ongoing participatory action; and technological advances may inspire new solutions.

The local government apparatus will need to have a flexible understanding of the foundations of intersectoral action and HiAP as well as the processes required in order to maintain and grow its potential and impact. The steps laid out above, when documented and conscientiously applied, will form a local basis for sustained capacity to address complex new health issues through HiAP and intersectoral action. Some kind of corporate memory, backed by a virtual or physical public repository, is needed in order to keep such lessons on the radar.

Expert advice and benchmarking are also available and can be applied at the local level. The recently published HiAP Training Manual (WHO, 2015) offers significant opportunities to build lasting capacity, as does a guide on HiAP for state and local governments prepared in the United States (University of Kansas, 2014).

Experience with the Healthy Cities initiative, especially in Europe, suggests that networking among cities, local politicians, and committed communities around building capacity is a process that stimulates and enhances second-order learning—in other words, the application of practical lessons not just to promote operational action but also to develop strategic insight at the systemic level.

Monitoring, Evaluation, and Reporting: Integral Aspects of HiAP

An explicit strategy and operational tools for monitoring and evaluation depend on respectful and relevant reporting based on local governance parameters. Partnerships for evaluation can be forged between government, civil society, and academia.

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8. APPENDIX
GLOSSARY OF HiAP-RELATED TERMS

Determinants of health: the factors found to have the most significant influence—for better or worse—on health. Determinants of health include the social and economic environment and the physical environment, as well as the individual's particular characteristics and behaviors.

Social and economic conditions: conditions such as poverty, social exclusion, unemployment, and poor housing that are strongly correlated with health status. They contribute to inequalities in health, explaining why people living in poverty die sooner and become sick more often than those living in more privileged conditions.

Social determinants of health: the social conditions in which people live and work. These determinants point to specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts.

Within the context of health promotion, health is seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities.

Health promotion: the process of enabling individuals and communities to increase control over the determinants of health and therefore improve their health. It represents a strategy within the health and social fields which can be seen on the one hand as a political strategy and on the other hand as an enabling approach to health directed at lifestyles.

Health sector: government ministries and departments, social security and health insurance schemes, voluntary organizations, and private individuals and groups that provide health services.

Intersectoral action for health: a coordinated action that explicitly aims to improve people's health or influence determinants of health. Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors. The term "intersectoral" was originally used to refer to the collaboration of the various public sectors, but more recently it has been used to refer to the collaboration between the public and private sectors. The term multisectoral action has been used to refer to health action carried out simultaneously by a number of sectors within and outside the health system, but according to the WHO Glossary of Terms it can be used as a synonym for intersectoral action.

Healthy public policy: policy that is "characterized by an explicit concern for health and equity an all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible and easier for citizens. It makes social and physical environments health-enhancing" (WHO, 1988, Adelaide Recommendations).

Public policy: policy at any level of government, which may be set by heads of government, legislatures, and regulatory agencies. The policies of supranational institutions may overrule the policies of governments.

Source: Adapted from Ståhl et al. (2006).

HiAP

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Pan American Health Organization

World Health Organization

REGIONAL OFFICE FOR THE Americas

525 Twenty-third Street, NW
Washington, DC 20037
Tel: +1 (202) 974-3000
www.paho.org

ISBN: 978-92-75-11930-3