White Paper

Health in All Policies: From the Local to the Global

Draft 1

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Health in All Local Policies:
Antecedents and Options for Action

Summary and reading guide

This White Paper provides options and opportunities for local governments to develop and implement Health in All Policies (HiAPs).

These options and opportunities are first firmly grounded in a series of global developments and the evidence-base that supported them:

- The recognition of the need to address complex issues around health, equity and development through integrated policy responses
- The accumulation of insights in the multi-level nature of (social, political and commercial) determinants of health and evidence on 'what works'
- The fuller appreciation of the connections between economics and health at every level of society
- The lasting support for comprehensive action in the field of Primary Health Care, Universal Health Coverage and the Sustainable Development Goals
- Perhaps most importantly and interestingly, in an age of globalisation it appears that local government has been strengthened and empowered to act in concert with civil society.

The paper proceeds by outlining core parameters of HiAPs. In different countries and communities varying operational views exist. Overarching is the perspective that it is an *innovative* view of *collaboration between sectors* of *public policy-making* in *good partnership*. This may involve action on *health equity*, the attainment of *synergy*, *accountability*, and new ways of *integration*. In the Americas there is overwhelming contributory evidence that intersectoral action drives HiAP, and that the current social, cultural, economic and political context is fertile ground for local government embracing integral action and policy for health and health equity. The PAHO strategy to drive a HiAP Plan of Action at each level of governance is timely and appropriate.

This long introduction leads to the core argument of the White Paper. It discusses and recommends to:

1. Frame the need and priorities for HiAP at the local level
2. Plan action to connect, integrate and scope the integral policy agenda
3. Identify existing supportive structures and processes and agendas for their development
4. Facilitate assessment and engagement of civil society assets
5. Ensure monitoring, evaluation, and reporting
6. Build lasting capacity

For each of these we argue that deliberate and planned action, in concert with and respect for civil society are 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.

Contents

1. 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 may more comprehensively contribute to building their common resources) but certainly also in terms of social development and resilience to cope with shifts and challenges in their social and natural environments. Societies and communities with high levels of positive health are resilient. They can face adversity better.

A firm expression of the nature of such a health perspective is often found in its definition as engrained 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.*

In spite of this broad framing of health, in many countries the health service delivery (or 'sick care') sector is not fully embracing these views and their consequences. Most healthcare establishments focus on individual treatment and disease prevention, and are challenged 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 them in actions to promote community health (rather than cure and prevention of disease) face strong individual-based beliefs.

The importance of the healthcare delivery industry also means that its involvement in the development of policies for health (beyond programmes to deal with disease or infirmity) is almost beyond argument, and an often untapped resource for policy development.

Such a view has consistently been advocated by the World Health Organization since the adoption of the Alma Ata Declaration on Primary Health Care in 1978 – and regularly reaffirmed in the face of global political shifts ever since.

The microbiologist-philosopher René Dubos recognised the profound interface between individual and social health and 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.*

Local government is an expression and instrument of priority setting for shaping those resources. This happens through policy development and management of social and environmental assets. The growing body of evidence, over recent decades, on the social, political and commercial determinants of health may well enable local government better than other levels of government and governance to take decisive action.

The determinants of health extend far beyond the workings of the healthcare system and include the provision and levels of education, work and employment availability and standards, quality of the built and natural environment, 'intangible' things as sense of community and sol-

idarity expressed in ‘social capital’, and general social gradients between those at the highest and lowest ends of the socio-economic spectrum.

Families and communities, and their elected representations in local governments, most directly suffer and enjoy the negative and positive consequences of their decisions on how their lives are shaped in all these domains. Complex and connected issues require complex and integral responses. In the following we will review, analyse and argue where these insights could lead us.

LOCAL HIAP MESSAGE

Health is a resource. Communities and their local governments can and must work together to enable that resource to reach its fullest potential. This transcends traditional disciplinary and sectoral boundaries. Local government is uniquely well-placed to take action.

2. The advance of complex integral policy and action

Analyses of the workings of modern society and its institutional structures (governance, democracy, leadership, etc.) since the 1960s have shown that traditional sectoral (sometimes called 'silo-ed') and vertical (top-down) responses may yield short-term success, but may not address the systemic nature of the causes of problems. The consequence of such analyses has been a call for better integration in the fields of, among others, problem formulation, policy development, and more comprehensive action.

At an *abstract* level, the solution has been found in things such as 'systems thinking', 'complexity science' and the identification of problems as being 'wicked', 'messy' or 'fuzzy'. For *policy-making*, those terms have translated into perspectives on 'Whole of Government', 'Joined-Up Government', 'Integral Government', 'Horizontal Government' and for health, 'Healthy Public Policy' and 'Health in All Policies'. In *action* terms (that is, for specific intervention development) we have seen the emergence of terms like 'strategic', 'comprehensive', 'multi-sectoral' or 'intersectoral' action.

In the scientific literature we see important efforts to distinguish between all these terms. Analysts also suggest ways in which they interrelate. A Canadian publication starts this discussion with a description (stemming from Australia) of 'Integrated Governance':

> *Integrated governance describes 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 describes overarching principles driving both policy and intervention responses to complex systems issues in health development: managing health, health development and health equity through collaborative approaches. The current perspective on Health in All Policies (HiAPs) finds a basis in the call to develop Healthy Public Policies in the Ottawa Charter (1986).

Around the world governments at all levels have experimented with integrated health policies. Some of these actually inspired the pronouncements of the Ottawa Charter, e.g., the Norwegian Farm-Food-Nutrition policy, the Chinese 'barefoot doctors' programme, and women's health initiatives in the Americas. Two initiatives, on opposite ends of the world started the developmental process of what now is called HiAP. During the Presidency of Finland of the European Union the country, building on its effective experience in the long-running North Karelia project (labelled a 'horizontal health policy'), urged other members of the Union to engage in

> *…a horizontal, complementary policy-related strategy contributing to improved population health. The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health.*

Almost simultaneously, the government of the state of South Australia identified opportunities for a broad policy programme 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."*

These two developments provided impetus for the organization of the Eight Global Conference on Health Promotion (Helsinki, June 2013) where a statement and framework (Appendix #) were adopted that expressed HiAP 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.*

In different countries and jurisdictions the emphases of the different dimensions of HiAP vary. Consistently, values associated with the concept centre around the importance of **collaboration** between sectors of **public policy**-making in good **partnership**. Other aspects where less coherence exist between the different jurisdictions include **health equity**, the attainment of **synergy**, HiAP leading to or driven by **accountability**, the character of **innovation**, ways of **integration** and the very **nature of policy**, e.g.:

> *"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."* – US Association of State and Territorial Health Officers (ASTHO).

> *"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."* –California Health in All Policies Task Force.

> *"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."* – European Observatory on Health Systems and Policies.

> *"Health in All Policies is an innovative, systems change approach to the processes through which policies are created and implemented."* – National Association of County and City Health Officials (NACCHO).

As a consequence of the adoption, in 2014, of World Health Assembly Resolution 67.12 (*"Contributing to social and economic development: sustainable action across sectors to improve health and health equity"*) a global process of consultation and deliberation has been initiated 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 local and national levels culminated in a compilation of evidence prepared for the Eighth Global Conference on Health Promotion and a Regional Plan of Action on HiAP adopted by the PAHO Directing Council. The Plan of Action mandates the organization to:

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.

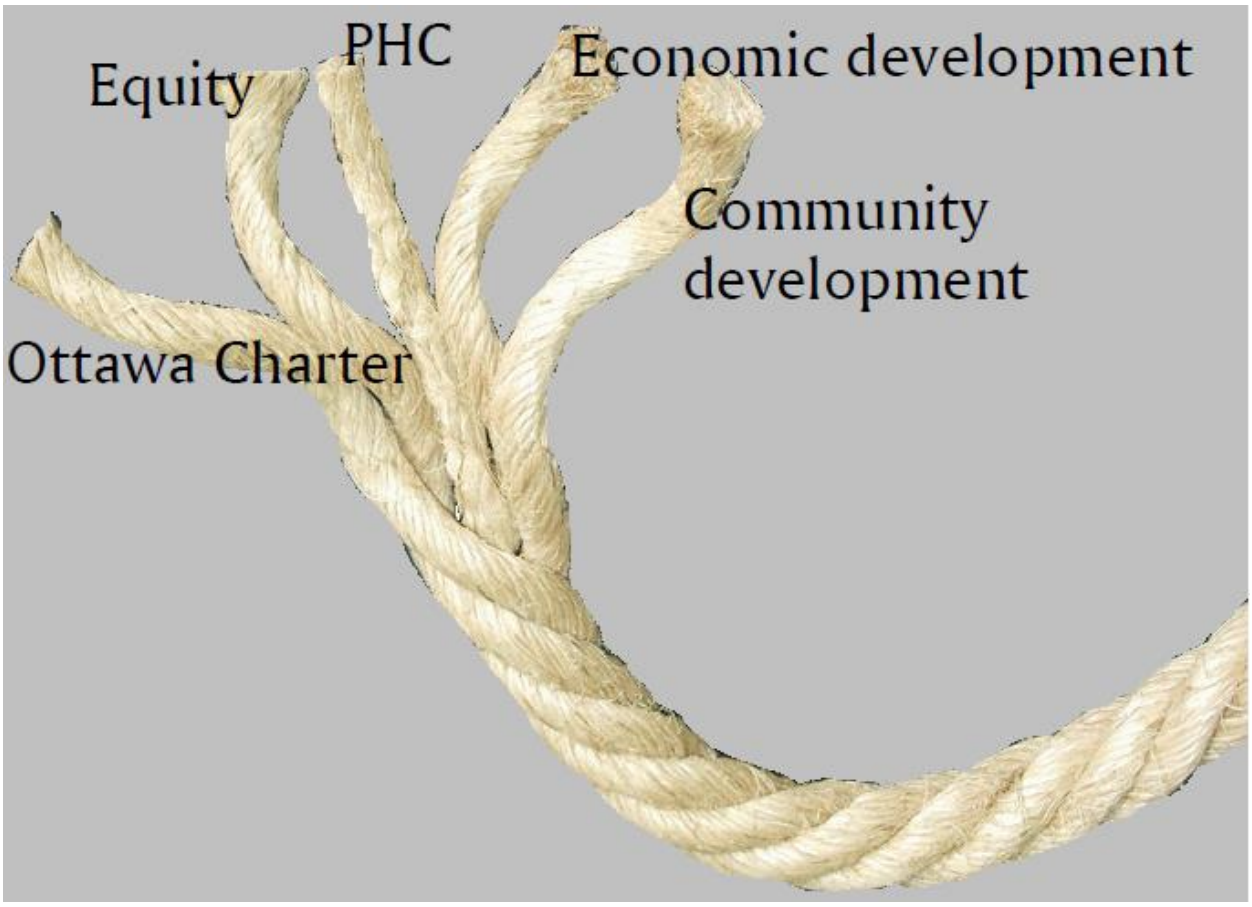
HiAP is Value-Based

Health in All Policies have a long developmental tradition. These complex and integrated, novel types of policies have been tried and tested around the world, at national and local levels. Their flavour may be different in different contexts, but all HiAPs 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.

3. HiAP as a global and local ('glocal') culmination of development

As stated above, HiAP is firmly grounded in several decades of evolution of thinking around health development and health promotion, increased sophistication in discerning the causes (of the causes) of health and disease, a further prominence of considerations around sustainability and resilience for human development, and a firmer position of health (in)equ(al)ity issues on local, national and global agendas.

These evolutionary developments have taken place both at the global and the local level – they are truly glocal. We will describe five strands of development.



3.1 Primary Health Care and Integrated Local Health Systems

At the WHO/UNICEF conference on Primary Health Care in Alma Ata in 1978, the concept was defined as

> *…essential health care based on practical, scientific and socially acceptable methods and technology. It is made universally accessible to individuals and families in the community through their full participation and at an affordable cost to the community and country.*

In its further development, PHC became more fine-grained and two perspectives were proposed. A horizontal (comprehensive, systems-driven) approach aligned with a set of strong val-

ues around equity, participation, and community driven bottom-up action for health and well-being. A vertical (disease and health care driven) approach aligned with the need to address specific (burdens of) disease in many countries, and was grounded in existing institutions and patterns in the delivery of clinical interventions. Ideology-inspired debates have raged contrasting the superiority of either approach. Reviews show that vertical programmes, particularly targeting infectious disease morbidity, may yield short-term and targeted health gains, but that long-term population health development does not unequivocally benefit from such selective approaches (e.g., Magnussen, Ehiri & Jolly, 2004). In particular addressing health equity and NCDs does not align well with a selective, vertical approach. Evidence has emerged that, depending on the existing health profile and management of (social) determinants of health in different communities and countries, an appropriate 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 (SILOS - Sistemas Integrales/Integrados Locales de Salud), and the initiation of the Healthy Communities and Municipios Saludables networks in many countries can be traced back to both PHC and SILOS. The developmental pattern has been different in other regions of WHO, e.g., in Europe where the Healthy Cities movement was initiated as an effort to demonstrate the legitimacy and viability of principles as laid down in the Ottawa Charter (below). This 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 government 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 dividend, as we will argue below. However, moving from management and maintenance of health care delivery into strategic and social health planning demands of governments to connect to all sectors that contribute to determinants of health.

HiAP: A SEAMLESS FIT

HiAPs seamlessly fit with the existing knowledge and practice base around Primary Health Care and Healthy Communities. The development of HiAPs, however, requires a step change. Local governments must use local successes in PHC to build momentum for reaching out.

3.2 Community development and its assets

The Americas are the heartland of traditions in participatory community development. Several traditions have contributed to significant insights and progress in this field.

In North America, planning emerged as a discipline early in the 20th 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 repertoire of the planner. Considering the 'best' ways of planning, experts before long found that the full participation of people in planning considerations was important. What 'full participation' entailed was (and perhaps continues to be) a matter of debate, and Arnstein's 'Ladder of Participation' as well as Davidson's 'Wheel of Participation' have contributed significantly to insights in the circumstances and degrees of public participation in the planning endeavour. These views have also made a significant contribution to public health and health promotion practice around the world.

A second tradition in this arena – and a critical one in Central and South America – was driven by Paulo Freire's work in the area of community development through new forms of education, famously called 'the pedagogy of the oppressed'. The views espoused by Freire and others in this tradition hinged on a philosophy that all in society should be able to engage with personal and social development equitably through open forms of democracy and decision-making. In order to attain such a capacity, empowerment was, and maintains, a key strategy in (local) (health) development.

Others have taken this important work as a starting point for, for instance, Asset-Based Community Development (recognising the people in their social contexts are an important resources for change), deliberative democracy and a particular form of the latter, participatory budgeting. Experiments in this field, particularly initiated in Brazil (and notably Porto Alegre) have won the endorsement of the global community through an evidence-based assessment by the World Bank.

INTEGRAL POLICY MUST BE GROUNDED IN COMMUNITIES

Health is a resource 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 mobilised for HiAP development.

3.3 The Ottawa Charter – a lasting foundation of the new local public health

Due to a growing recognition that health lifestyle change through traditional behavioural (health education) interventions had limited efficacy, and needed to be embedded in broader social change, the World Health Organization with Health Canada and the Canadian Public Health Association organised the first international conference on 'the move toward a new public health' in Ottawa, in 1986. The conference, followed by a series of global health promotion conferences, culminated in the adoption of the Ottawa Charter. The Charter defined health promotion as

> *…the process to enable individuals, groups and communities to increase control over the determinants of health and thereby improve their health.*

The conference and its Charter saw a responsibility to enable, mediate and advocate for a broad view of health and health action in four areas:

- To reorient health services toward such a broader, participatory and health promoting position in society at any level;
- To create supportive social, economic, natural and built environments to create and sustain health promotion and to address the determinants of health equitably;
- To invest in personal skills and community action to drive and complement these actions; and
- To build Healthy Public Policy, recognising that health is created across many sectors in society that would all have the potential to enhanced institutional, community and personal health.

Again, the Region of the Americas was early to adopt these approaches to the promotion of health. In 1992, the Santa Fe de Bogota Declaration on Health Promotion wholly embraced inclusive and policy driven health development. In 1993 a Caribbean Charter for Health Promotion was adopted, recognising the particular assets of the area.

Reviews of the accomplishments of the Ottawa Charter, including through concerted efforts at the follow-up conferences, have found that substantial progress has been made in our understanding of the drivers of success for each of these fields. Our understanding of the complex nature of natural, social, political and commercial determinants of health has increased, as has our appreciation of the impact of policies on all of these. Great advance has been documented in linking ('enabling, mediating and advocating') individual and community health potential with systemic action on environments for health. The only area where success has been lagging is reorientation of health services (Ziglio, Simpson & Tsouros, 2011).

The global community of health promoters continues to work on the basis of these principles and advances, and implements these especially in the context of 'Healthy Settings' – a concept that the Charter launched:

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.

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 and policy areas and recognised the impact of all public policy on health ('Healthy Public Policy'). Health promotion works in synergy with integral policy processes for health and development.

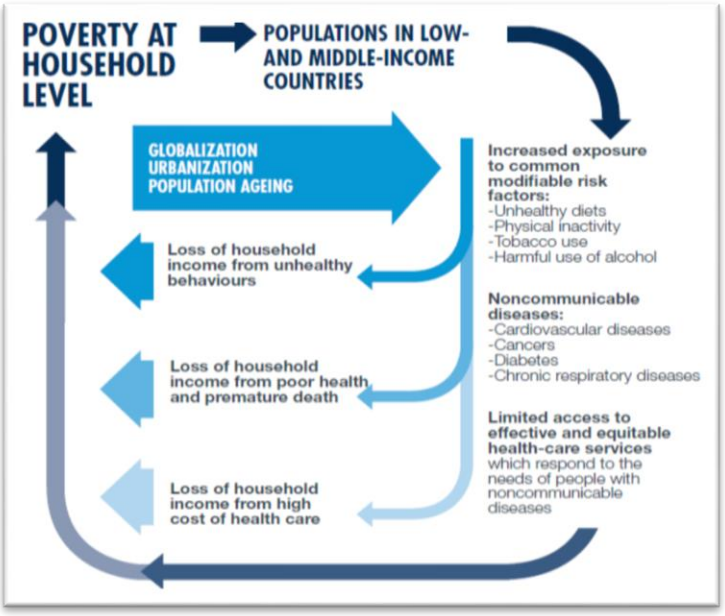
Healthy settings are of particular interest and importance in the Americas, from large networks of Health Promoting Schools across the region, the thriving national and international networks of Healthy Municipalities and Communities, and the range of other efforts that continue to accumulate evidence on the importance – and efficacy – of addressing determinants of health through comprehensive integrated action and policy.

3.4 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 terms of complex systems policy development, 'wicked'. For instance, poverty leads to ill health, and ill health leads to poverty. Economic livelihoods, however, are not generally a concern of the health system and its 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 countries and within countries. No matter what the economic indicator, the region is home to some of the highest and lowest performing countries (e.g, the USA and Haiti). Within countries there are also unsettling patterns of increasing inequity that impact on social stability, wellbeing and health (e.g., Brazil and the USA). At the same time, some countries, even under economic duress, manage their social development and health resources equitably and this yields significant advances in health and human development (e.g., Cuba and Costa Rica).

The fact that investment in health is a sound economic strategy started to gain traction from the late 1980s and for the first time achieved prominence in the 1993 World Bank's World Development Report 'Investing in Health'. A strong case was made for the importance to national economies and local communities to address health and disease factors that impeded full development. The Report was criticised for espousing New Public Management and neoliberal principles of outsourcing and privatising health as a public good (including, e.g., 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. The argument for Health in All Policies, also at the global level between international bodies, has evolved in the past 20 years with the family of UN agencies, including World Bank, UNDP and WHO, now mobilised for NCD action.

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

The argument has been developed and refined over the years, for instance in the Jeffrey Sachs led WHO Commission on macro-economics and health. More recently the WHO Commission on Social Determinants of Health ('Marmot Commission') forcefully indicted unequal economic conditions and pervasive poverty as one of the most critical drivers of health inequity around the world. Impressively, the global Marmot Report has had a number of regional (Europe), national (e.g., Brazil, England) and local (Malmø) reincarnations, highlighting the opportunities and benefits of political action on the social determinants of health. In recent years there has also been a move to take the discourse further, with some starting to address commercial and political determinants of health.

Recently, WHO and UNDP issued a 'Guidance note on the integration of noncommunicable diseases into the United Nations Development Assistance Framework' (2015). This was an expression of the joint-agency work that was an outcome of the high-level meeting at the UN in which NCDs were given utmost priority. In the Guidance Note the vicious cycle of poverty and health is described – with great insight into the consequences of this perspective for local government action.

3.5 Health equity

The recognition that health is unequally distributed across populations is not new to the 21st century. Already in the 19th century French epidemiologist Louis-René Villermé demonstrated the adverse health effects of certain types of work. He called for action to reduce these risks, as

LOCAL, NATIONAL AND GLOBAL DEVELOPMENT: INTEGRAL HIAP CHALLENGES AND OPPORTUNITIES

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

did Rudolph Virchow who recognised 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.*

Many doctors have subsequently entered the political realm (including, for instance, Che Guevara and Salvador Allende). Medical and healthcare groups actively engage in local and national policy development, even outside the health services delivery realm (Browne, 1998), and have a role to play 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, including 'health disparities' and 'health differences' (deliberately 'value-free' functional descriptors) and 'the social gradient' (the statistical slope between those at the top of the socio-economic spectrum in society and those at the bottom) upon which most health and disease expressions can be mapped. (In)equality, some say, is purely a description of that social health gradient, where (in)equity conveys a view of the moral and social injustice of such differences in society. Wilkinson & Picket (2010) describe how equitable societies provide and create better opportunities for health for all, including enhanced economic development, sustainability and educational attainment. Striving for equity is not necessarily a requirement or prerogative of national government alone – it depends and thrives on a vibrant civil society and its political representation, extending from local action to global policy and the other way around.

Equity has entered particularly the global discourse, not just in health, but also in other sectors of development. It is a driving concept in various global strategies, including those on climate

EQUITY AS A DRIVER OF HIAP

Concerns for health and social equity are political concerns. Although globalisation drives determinants of equity, action and policy at the local level can mitigate and exacerbate equity and its consequences. Integration between local, national and global public policy is important.

change, sustainable development, and gender. Particularly in the health domain the work by the Marmot Commission has been instrumental. The report reviews the causes and consequences of health inequity, and demonstrates that it is possible to close the gap within a generation. Policy and action at every level are required to mitigate the possibly negative influences of globalisation on equity; some authors, however, also allude to the significant potential that global connectedness through new social media may have on an equity agenda.

3.6 Globalisation and the rise of the local

The idea that we live in a globalised world has become a mainstream perspective in the 21st century. Goods, capital and knowledge travel, sometimes with the speed of light, around the world. Globalisation goes beyond the role of the traditional nation-state. Indeed, although countries continue to collaborate and expand their vision in the globalised world, the phenomenon to no small extent is driven by commercial (trade) interests, but also by a new global civil society. The latter includes NGOs like Greenpeace, Médecins Sans Frontières, Amnesty International, Human Rights Watch, and the Peoples' Health Movement.

The actions of this variety of 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 neighbours, 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 a new architecture for managing health and health systems in this context is very important. At the same time new technologies and social media offer opportunities for knowledge development and community mobilisation.

Local governments around the world see the dissolving integrity of the nation-state as an opportunity to take action. The challenges to the sovereign nature of the nation-state have become prominent during (and in the aftermath of) the SARS epidemic; authors such as Fidler argue for a new architecture of global health governance (De Leeuw, 2013). NCD control, Ebola, HIV/AIDS and other health issues have become a global health concern, and new options for policy development at the interface between global and local need to be developed. This has happened through the creation of networks of cities around themes such as climate change and

sustainability, age-friendly cities, and knowledge and creativity. Assessments of these networks show that such contacts benefit the quality of policy development and actions to improve the quality of life of their citizens.

GLOBAL AND LOCAL: GLOCAL HIAP

Globalisation offers new opportunities to local governments and their communities to take action. The use of new technologies makes world knowledge and connections available to local governments and communi-

3.7 Wrap-up: six interrelated streams flow into a HiAP basin

It will be clear from the above that there is increased sophisticated understanding of key issues that drive global patterns of health development. Repeatedly the global community, both symbolically as well as in scholarly circles, has argued that business-as-usual will not allow us to work constructively toward better health for all while closing the gap between the better and worse off. Whether it is in community development and participation, primary health care, social and economic development, health promotion, or in terms of equity, pronouncements (often in the form of Charters, Declarations, Statements, Compacts, or Goals) have been made that the world deserves better to become better.

Global statements are, however, not enough. Local governments have already recognised this. Following the maxim (interestingly enough attributed to the same René Dubos that – above – viewed health as a social resource) ***'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 we will demonstrate that local government is exquisitely well-positioned to take charge of positive global change.

THINK GLOBAL, ACT LOCAL

THINK LOCAL, ACT GLOBAL

INTEGRATE GLOCAL

GLOCAL HIAP

Health in All Policies at the local level are an expression of the opportunities offered by global developments and local innovation

4. Five themes that enable local government to do HiAP

The above developments have created a strong historical footing for the development of Health in All Policies. They are, however, often seen as abstract global concepts and aspirations rather than operational local inspirations. In this second decade of the third millennium there are, nevertheless, many reasons why in particular local governments and their communities should be inspired to make a real difference. We compile five themes that drive further action.

4.1 The health promotion evidence base

It is important for society and its communities to spend its resources where it matters. Although it can be easily contested what 'where it matters' actually means in different contexts (for instance, a national re-election campaign of a politician based in a megacity would probably not recognise the needs of rural and remote communities to their fullest magnitude), this idea has driven the development of evidence-based (health) policy. Substantial impact on this broader aspiration was made by the Evidence-Based Medicine mantra that has its foundation in the work of Archibald Cochrane. He found that many medical practices were not firmly rooted in evidence on effectiveness (whether something produces the intended result) or efficiency (how well it produces that result). The consequence of this position was that decision-makers, both in policy as well as in practice, invested in approaches to demonstrate the effectiveness of medical procedures.

This effort has had its influence on policies that espouse a broad social model of health and health promotion, both globally and locally. The methods to generate evidence of effectiveness on this arenas are, naturally, different from the often controlled circumstances under which clinical procedures can be tried and tested. Where in clinical environments an assumption is that an experimental group can be matched with a control group, is it much harder to find the perfect experimental match, for example, for a barrio in Medellin in order to test the effectiveness of social investment.

Yet, very good progress is being made in demonstrating the effectiveness and efficiency of health policy and health promotion. Evaluation efforts around Healthy Cities 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. International research shows that health and health equity impact assessments are not just highly effective tools for measuring the consequences for population health of broader social, environmental and economic change, but also impact significantly on the quality and sustainability of policy development and implementation. Concepts like Healthy Urban Planning that embrace a wider view of transport and mobility show not just health, but broad social improvement.

The Ottawa Charter for Health Promotion also launched the ideas of settings for health ('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 instance in Health Promoting Schools (globally the most significant network of set-

tings for health with tens of thousands of participating primary and secondary schools, currently expanding into kindergarten environments), Health Promoting Market Places, Healthy Islands (notably in the Pacific through the Yanuca Declaration, linked to the Barbados Programme of Action), Health Promoting Universities, Health Promoting Prisons, and Healthy Transport.

This evidence continues to be compiled by international organizations like WHO, UNDP, IUHPE and other global agencies, but also through networks of civil society like international city networks (e.g., C40 and Healthy Cities) and academia. There is, in fact, 'meta-evidence' that networking for evidence generation enhances the quality, relevance and responsiveness for glocal (global and local) action.

4.2 Universal health coverage

The enthusiasm and vigour that was originally part of 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 idea. It was further sustained by a global campaign to work toward universal health coverage (UHC) at all levels of governance and health system operation. It is defined 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 programmes and discipline to redistribute key social resources. The evidence shows that, in fact, the monetary dimension is maybe 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. They secure a (human) rights-based perspective on population health, have the potential to organise and rally communities for social and economic development, and have the strong potential for higher quality health information collection and management, thus adding to more bespoke evidence-based local health policy.

Local governments may not always have control over fiscal opportunities and the management of health facilities and professionals. Often these are organised and financed at higher levels of governance, and partly for good reason: not every town needs highly specialised neurosurgeons and expensive f_MRI scanners. But the essential population-based 'first point of contact' with the health system, i.e., primary care, is by its very nature integrated in local communities – even where there may be no doctor. 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 (and in

slum areas may even have an informal nature), these professionals and their operational bases are very much part of the social and political landscape of local government.

UHC at point-of-delivery is therefore a concern for local action, whether it has been formalised or not. Experiences from the Americas, e.g., for people-centered programmes in Mexico and Brazil, show that UHC is possible and yields significant dividend, not just for population health but more broadly for social development (Quick, Canavan & Jay, 2014). PAHO is strongly supporting such approaches. Evidence suggests that success of UHC schemes depends on the presence of (a) the strength of organized progressive groups in local communities; (b) the potential of mobilising adequate economic resources; (c) absence of significant societal divisions (d) a weakness of institutions that might oppose it (such as, e.g., for-profit hospital enterprises), and (d) a skilful identification and opening up of windows of opportunity by – local – policy entrepreneurs (McKee et al., 2013).

4.3 Determinants of health

The description of the social gradient in health (that is, the fact that health parameters like mortality, morbidity and life expectancy follow patterns of the distribution of wealth, prestige, status and education in society) has moved from a mere epidemiological curiosity to a political issue. Increasing numbers of governments around the world endeavour to place health equity and its causes high on their political agendas. This happens with varying degrees of success.

There have been arenas of governance with such a strong belief in their equitable nature that a debate around the sheer existence of health inequity in those societies and communities was unimaginable. There are also cases where existing inequity is attributed to personal lifestyle choice, rather than broader determinants of health. This so-called ‘lifestyle drift’ can be inspired either by uninformed behaviourist tendencies (assuming that all human behaviour is entirely within the control of the individual), or by political ideologies like conservative liberalism (assuming that the fate of societies can be entirely attributed to the resourcefulness of its individual members).

The evidence, however, demonstrates that individual choice is determined by social, environmental, cultural, economic, natural and built environments. Clearly these interact at extremely intricate levels. They are also the result of political preference, and commercial interest.

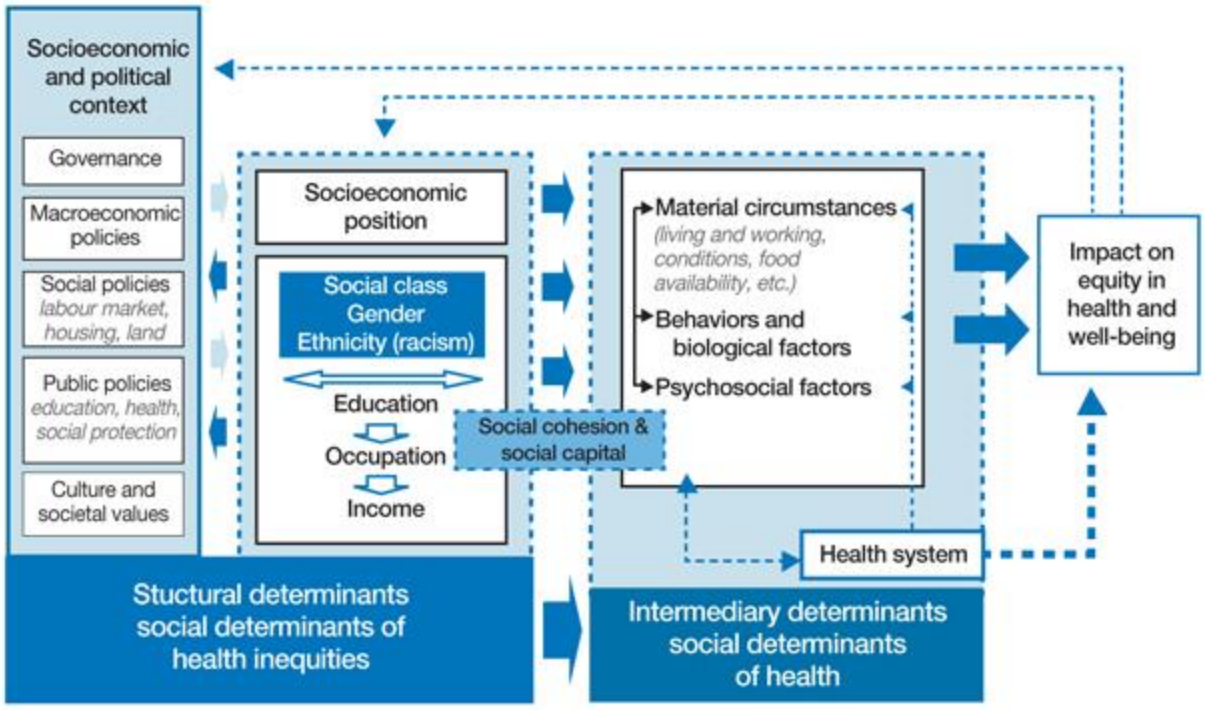


Figure. Conceptual model for the work of the WHO Commission on Social Determinants of Health, 2008 ('Marmot Commission')

The figure above shows the conceptual model that the Commission applied to map determinants of health and their impacts on health and health equity. This model has been applied at the global, regional, national and local levels. In particular the 'Marmot Commissions' for England and Malmø (Sweden) provide a wealth of insight into the potential and opportunities for local government to take comprehensive and integral action on complex health challenges.

Both the England report ('Fair Society Healthy Lives') and the Swedish work ('Socially Sustainable Malmö') stress the interrelation between policies that aim to

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

A reflection on silos – and moving beyond them

One of the most prominent challenges in establishing cross-cutting policies and actions is to move outside traditional disciplinary and sectoral boundaries – silos. How did we end up with those silos?

The classic ideal of a good citizen was that of the 'Renaissance Man' – perhaps the best example of such a person is Leonardo da Vinci (1452 – 1519), the Italian polymath, painter, sculptor, architect, musician, mathematician, engineer, inventor, anatomist, geologist, cartographer, botanist, and writer. He was certainly not unique – many advances to modern society have been made by men and women that branched out across scientific disciplines and the arts.

This comprehensive integration of the sciences and the arts, not just in one person but in a worldview, was challenged in the period of Enlightenment, in the 16th and 17th centuries, when the worldview evolved toward one of a separation of body and mind, and of distinctly different disciplines arguing that the observed world could be understood mainly through rigorous analysis, that is, taking it apart into its unique parts. Scholars started to focus on particular bodies of knowledge and developed strong theories for each. When in the 19th century medicine, as one of these disciplines, became highly professionalised (influenced by the industrial revolution and a growing upwardly mobile middle class) these disciplines started to specialise even further. The process is sometimes called 'hyperspecialization' and can still be witnessed in the proliferation of academic journals focusing on quite particular areas of interest.

Hyperspecialization is one reason that modern societies operate in management and policy silos. Professionalization is another. Professionalization (the process of establishing acceptable qualifications, a professional body or association to oversee the conduct of members of the profession and some degree of demarcation of the qualified from unqualified amateurs. The process creates a hierarchical divide between the knowledge-authorities in the professions and a deferential citizenry) creates strong patterns of inclusion and exclusion: building a bridge requires an engineering professional, taking someone to court needs legal professionals, and treating disease must involve qualified medical professionals.

Specialist and professional segregation are continuously challenged. In the early 20th century, for instance, a debate raged in North America whether public health was within the remit of the medical profession. The matter was resolved with the publication of the Flexner Report in 1910, urging a proper 'scientific' approach to clinical medicine teaching, thus excluding public health. In Europe – and in countries that followed a European model of health professionalization – medical education continued to include public health matters under the banner of 'social medicine'.

Specialisation and professionalization created formidable commercial and political forces to maintain and protect their status quo. Even when the evidence-base around 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 problems. Effective partnering for health starts with the recognition that the capacities of the discipline or specialty in isolation are insufficient to make a difference. The process that enables such a recognition requires the presence of leadership, communication and analytical skills, and something that can be called 'social entrepreneurship' (the capacity to advocate, mediate and manage opportunities and differences in diverse communities of policy and practice). Firm pronouncements by executive offices (e.g., a Mayor, CEO, or spiritual leader) in support of reaching out to other sectors are indispensable. Reliable and sustainable grounding of such positions in community action helps maintain momentum.

The above approaches to removing the walls of silos play out at a relatively high level of abstraction; a workforce that is receptive to interdisciplinary work and has been trained to reach out to others is of course vital, too. Increasingly we see programmes and curricula across primary, secondary and tertiary education that do in fact embrace such values.

4.4 From MDGs to SDGs

Global development goes hand in hand with local development – and the other way around. This year witnesses the 'expiry' of the Millennium Development Goals that have been driving development agendas around the world. Although the MDGs have been criticised for being too abstract or ambitious, there is insurmountable evidence that their adoption and review have shaped the direction of the glocal development discourse.

Building on these findings, the United Nations and its partners embarked on a consultative and inclusive process to develop a new set of goals for the 'post-2015 agenda'. These are called Sustainable Development Goals (SDGs), and a final set of SDGs will be adopted toward the end of 2015. The currently proposed SDGs are in below table.

	Proposed Sustainable Development Goals (the 'Post-2015 global agenda')
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 wellbeing 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 industrialisation, 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 (taking note of agreements made by the UNFCCC forum)
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, 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 revitalise the global partnership for sustaina-

ble development

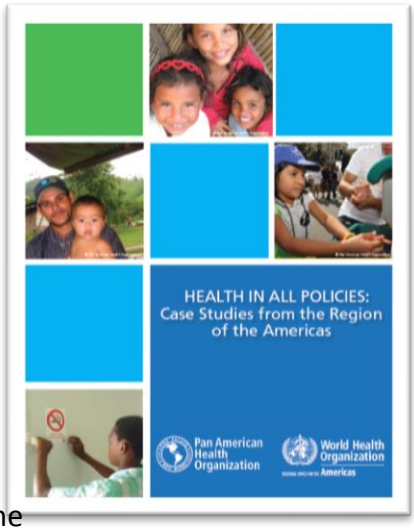
Table. Proposed Sustainable Development Goals

Although the process of creating these goals, and their nearly 200 associated operational targets, has been inclusive of global civil society and validated across glocal for a, the ultimate adoption of a set of SDGs in in the hand of UN member states. It appears that some countries are not yet ready to adopt a longer list, whereas others require more specificity. In his synthesis report on the SDGs in December, UN secretary general Ban Ki-moon did not suggest that the number of SDGs could be reduced or expanded. In a bid to help governments to frame the goals, Ban clustered them into six "essential elements": dignity, prosperity, justice, partnership, planet, and people. It is no surprise that these are social determinants of health, and constitute core values of all those committed to health development.

5. Health in All Policies: state of the art and local opportunity

5.1 The PAHO/AMRO advantage

The region of the Americas and its Pan-American Health Organization have, as we have seen above, always taken a lead in local and integral responses to complex health problems. In the lead-up to the Eighth Global Conference on Health Promotion (Helsinki, 2013) member states compiled and analysed series of case studies that demonstrate the clear commitment and leadership at the international and national levels to HiAP development and implementation. These case studies more often than not included local and community perspectives, exploiting successfully the thriving networks of Healthy Communities and creative and proactive approaches to community development and participation in the region.



There is a clear and urgent momentum in the region to take the commitment to HiAP forward at all levels of government and governance. At the national levels, many governments have established structures and processes to appraise HiAP potential, and - in collaboration with public health and health promotion agencies – manuals and checklists have been developed that can drive national and state-level policy development.

PAHO is committed to further boost this potential through its HiAP Plan of Action. Comprehensive sets of practical and research evidence have already been available to local government on, for instance, 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. PAHO member states in 2014 adopted the Plan of Action that aligns with the global efforts to develop a framework for HiAP implementation and capacity-building efforts through the global HiAP training course. Specifically, the Plan of Action aims to:

a. Generate and document evidence on HiAP for high-level advocacy to further strengthen collaboration between different sectors;
b. Utilize case studies on HiAP to further scaling up HiAP in the Region;
c. Build capacity on HiAP using the course on HiAP developed by WHO, which will be rolled out by two of PAHO's collaborating centers;
d. Scale up the use of Health Impact Assessment methodology, following up on the pilot initiatives on HiAP that was carried in Argentina, Colombia and Suriname as

a result of a regional training conducted by PAHO and University of New South Wales, Australia;

e. Work with the Healthy Municipalities Network and Healthy School networks to further roll out the HiAP Regional Plan of Action;
f. Monitor countries' progress on implementing Health in All Policies;
g. Strengthen South-South collaboration through show-casing progress made on HiAP as well as South-North collaboration in particular with the EURO WHO Office which has progressed significantly on this agenda.

PAHO/AMRO CONTINUES TO LEAD

The HiAP potential in the Region is convincingly documented. Members States and civil society are committed to integral policy for health and well-being. The successes in Healthy Municipalities, primary care, and commitments to Universal Health Coverage are fertile ground for decisive local policy action.

5.2 Policy and action

The terms *Intersectoral Action* (sometimes *Intersectorial Action*) and *Multisectoral Action* have been part of the rhetorical repertoire of public health and health promotion since the mid-1970s. The terms achieved credence through the Alma Ata Declaration, the Ottawa Charter, and series of other pronouncements by global bodies, including WHO and PAHO. The international discourse has also included arguments and evidence around variations of ideas about working together for health on the spectrum *networking-coordinating-cooperating-collaborating*. Although there may be conceptual shades of grey around the interpretation of these terms this focus of public health and health promotion clearly hinges on the noun *action*.

Agencies, individuals, groups and communities may come together to jointly *act* on health concerns or determinants of health – but this does not necessarily mean that these actions are either *driven by policy* or *result in policy*. Series of case studies, however, are starting to build an evidence base that demonstrates that successful intersectoral action may inspire the need for HiAP. HiAP, in turn, may not necessarily have to lead to intersectoral action: for instance, policies to limit lead (Pb) content in paints and gasoline are singularly industrial-economic in nature, and – apart from commitments required by industry – do not necessitate the deep involvement of other government sectors.

Considering the importance of successful intersectoral action for the development of HiAP it is worthwhile to quote at length from a study commissioned by WHO in celebration of the launch of the report of the Marmot Commission (Irwin & Scali E, 2010):

(…) the track record of actual results from national implementation of Intersectoral Action for Health (IAH) 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, 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 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 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 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 SDH as a core focus, to a narrower model of "selective primary health care".

It appears that, with the resurgence of Primary Health Care, the strengthening of UHC, 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 action initiatives is more positive. This is expressed in the commitment to HiAP formation and implementation, but the limitations and challenges in the comprehensive embrace of integral action will remain and need to be addressed.

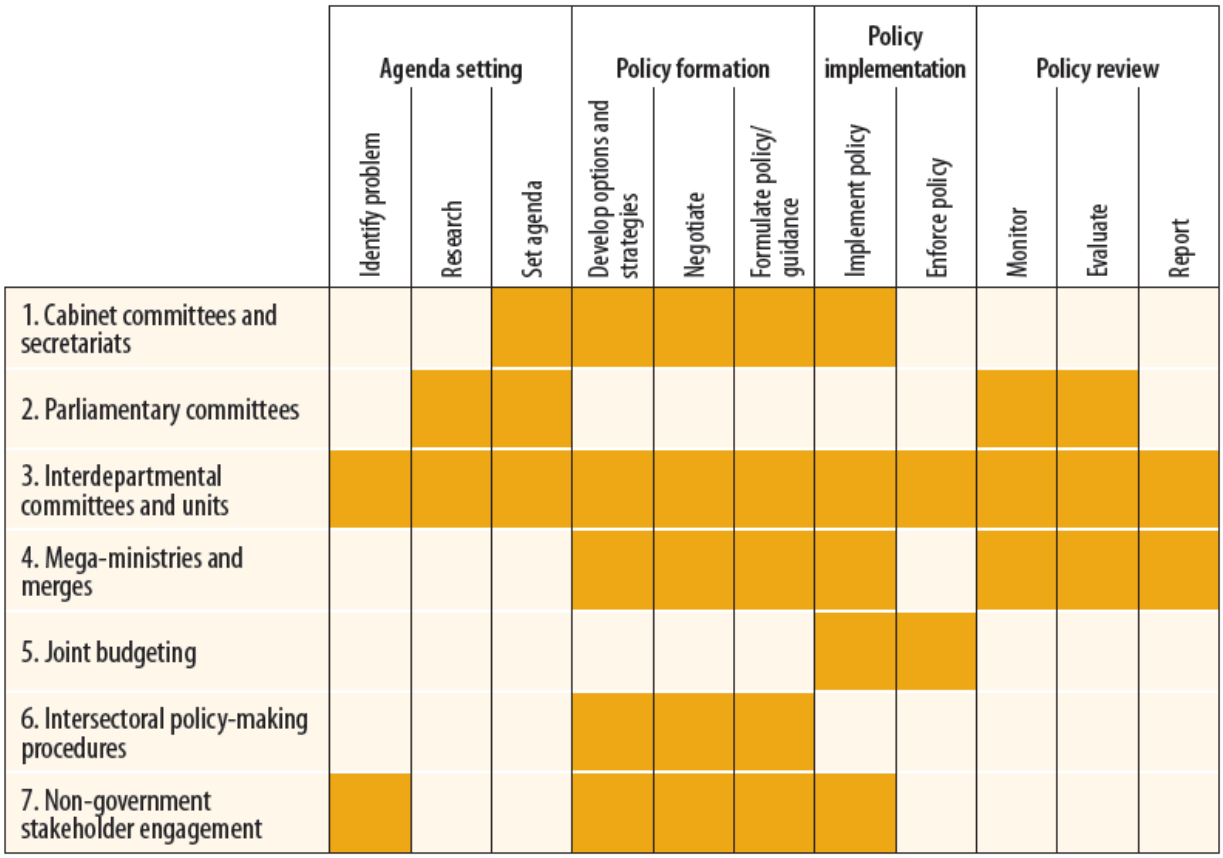


Figure. Actors engaged in governance for HiAP. WHO (2015) based on McQueen et al. (2012)

This discussion on the critical connection between action and policy raises the question what the process to attain and sustain Health in All Policies would entail, and which actors need to be engaged. McQueen et al. (2012) describe various governance models for HiAP. These have been mapped onto the different elements of the policy process (figure above) and hinge on seven best practice models for HiAP implementation. Different (groups of) government and non-

government agencies can play different roles during the HiAP process. In another graph (next page) we further describe the roles of the health sector and other government sectors in steering integrated or separate actions for health.

THE DIFFERENCE AND CONNECTION BETWEEN POLICY AND ACTION

Intersectoral action is a precursor to HiAP. HiAP may lead to intersectoral action. A vision for integral approaches to health is taking centre stage again.

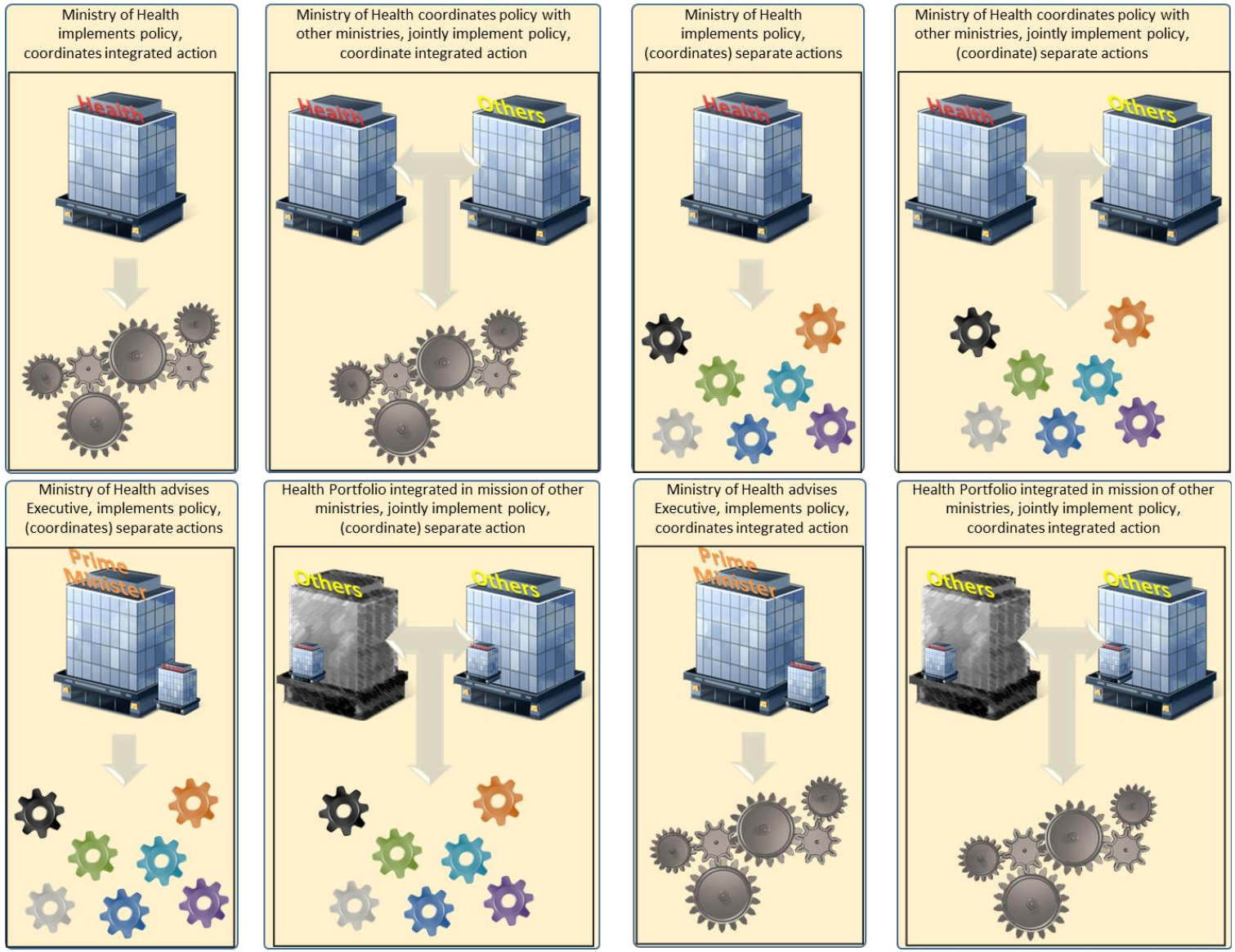


Figure: Eight ways to coordinate between sectors, and implement HiAP in integrated or separate action

5.3 Frame the need and priorities for HiAP at the local level

Local governments are supremely placed 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 to 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., for slum dwellers and itinerant populations) this is a challenging proposition. It is important for local government and its branches in neighbourhoods and communities to be fully aware of the potential limitations to full participation, and put processes and structures in place that would allow for consultative and participatory action.

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

The evidence, however, is clear. Consultation and participation are the bedrock for lasting, sustainable, and systemic policy solutions that embrace and reward the broad assets available in local communities. When it comes to health challenges, there is a very important contribution to be made to inventories of needs and priorities by appropriate health professionals such as epidemiologists, biostatisticians, public health doctors, and community health workers. However, their – often quantitative - efforts at monitoring, review and evaluation of health issues and their (broad) determinants must be supplemented and benchmarked by – often qualitative – community surveys, wide stakeholder input, and respect for legitimate perceptions of concern in the population.

In many Healthy Communities local health leaders start the process of needs assessment and policy 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 health forums. Such meetings take policy development out of City Hall and right into the community. This strengthens credibility and commitment of health policy development considerably.

An important aspect of needs assessment and priority setting is having mutual respect between the community and the local government apparatus. Such respect can be demonstrated through on-going dialogue and engagement, even when some health issues seem too hard to handle – for instance, issues around poverty and sanitation in slum areas, or obesity and diabe-

HiAP Needs and Priorities

Complex health issues require complex solutions and interventions that should be driven by multi-level integral policy. Inclusive needs assessment and priority setting will establish a solid and lasting agenda for intersectoral action and integral policy development.

tes in areas of urban sprawl might easily be dismissed to the 'too hard' basket. A recognition of their complex (the literature refers to 'messy' or 'wicked') nature is an important first step in structuring possible solutions.

5.4 Plan action to connect, integrate and scope the integral policy agenda

Collaboration and partnerships are key tools for the establishment and maintenance of the integral 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 autonomously. They require careful crafting, governance and vision by credible local leadership. These leaders may be elected officials in local government, but it must be recognised that others may well assume such roles, too. Individuals that do this have been described as 'boundary workers', 'social entrepreneurs', 'issue initiators', 'policy brokers', 'strategists' or 'caretakers'. They are critically important in planning action to connect policy initiatives and they need to be celebrated.

It is crucial to recognise that intersectoral action and HiAP must not happen for their own sake. Collaboration without joint ownership and outcomes, and integrated policy addressing one-dimensional issues, are senseless. Many lessons have been learned from the integrated partnerships agenda in health promotion, particularly in Healthy Cities (e.g., Lipp, Winters & de Leeuw, 2013). Planned action to connect, integrate and scope the integral policy agenda needs to address the following evidence-based stages:

- Map and recognise organisational mission and resource capacities and acknowledge the boundaries of the traditional organisational footprint;
- Describe organisational challenges in addressing issues and populations that permeate and move beyond the organisation's legitimate area of concern;
- Map and include organisations that cover the same, similar, or different issues and populations, and/or share the same, similar or different approaches and interventions to deal with these;
- Recognise the legitimate potential of other stakeholders to be involved in intersectoral action or integral policy development and strive for transparency in sharing these views;
- Scope the dimensions of probable and possible collaboration and factors that may stand in the way of respectful joint action;
- Involve real authorities and decision-makers, including organisation executives as well as street-level bureaucrats (frontline implementation personnel that deals with intersectoral action challenges on an everyday basis), in shaping the joint agenda;
- Formalise and celebrate each of these stages, as far as possible including individuals, communities and neighbourhoods that are at the 'pointy end' of the implementation of action and policy outputs;

- Make all stakeholders in these processes as far as is culturally and organisationally possible accountable for their actions, but apply the 'Chatham House Rule' (full confidentiality of sensitive and strategic considerations) wherever necessary.

CHATHAM HOUSE RULE

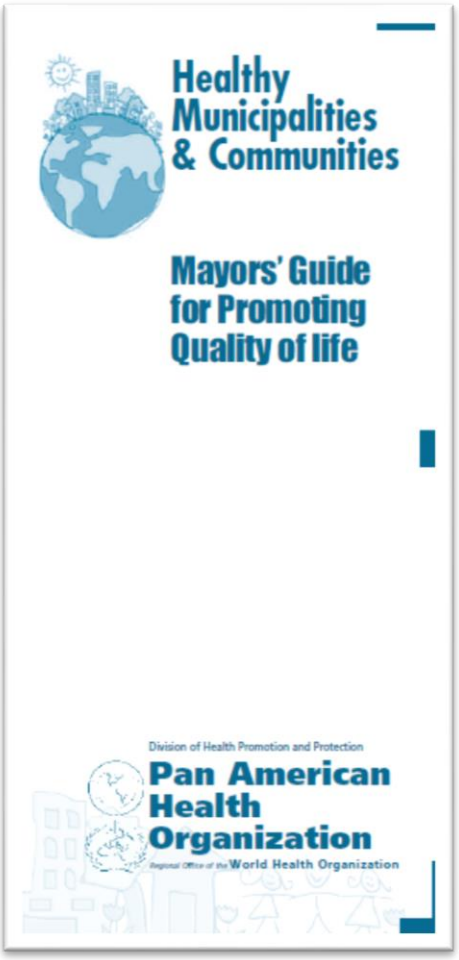
When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed

5.5 Identify existing supportive structures and processes and agendas for their development

Above we have seen that in many local government areas there are already effective structures and processes to would further facilitate the development of intersectoral action for health and a strongly associated integral policy development potential. Such structures and processes may include

- An engaged and empowered community
- Successful experience in deliberative democratic and participatory processes
- Successful experience in partnerships and collaboration for health and well-being
- A broad recognition of the urgency of NCD strategies, supported at executive and council levels
- A broad recognition of the 'causes of the causes' of ill health, supported at executive and council levels
- An existing agenda to strengthen or move toward Universal Health Coverage
- Existing role models and examples of intersectoral action and HiAPs in other local governments in the countries, e.g., connected through 'Healthy Communities' networks
- Vertical integration of governance models for intersectoral action and HiAP between different levels of government
- Existing evidence of social, economic and sustainability win-win situations, and on-going 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)

There is an important role for local Councils and executives, and in particular Mayors 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, formalisation and sustenance of these processes and structures.



Critically, the evidence base around formulation and implementation of Health in All Policies shows that HiAP should not be left to haphazard circumstance – it is a process that should be managed with clear vision and leadership. At the national level this leadership may be assumed by a Ministry of Health, although the 'clinical gaze' sometimes stands in the way of novel whole-of-government approaches. At the local level, however, governance arrangements for public health and health service delivery are highly diverse across the region. In some countries, health service policy development and delivery are fully within the remit of local government. In other countries, these are decentralised, but not under the control of local government. It also possible, in some countries, that the delivery and policy development for health services and public health are structured and managed from the centre.

Hence, local leadership for intersectoral action and HiAP development and implementation may not necessarily connect with local health providers. The lead may be taken by social work organisations, community enterprises, the municipal apparatus, etc. Considering HiAP is an expression of local public policy, the role of local government is essential, and a clear expression of emphasis and priority for a particular public sector taking the lead is a precondition for integral policy.

LOCAL HIAP VISION AND LEADERSHIP

Broad engagement by all local stakeholders is essential for the successful development of integral health policy. However, leadership and the identification of a lead actor are important. In different local contexts different leads will be identified.

5.6 Facilitate assessment and engagement of civil society assets

The above 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 requires a continuous process of mapping assets that

- identify and make visible the health-enhancing assets in a community
- see citizens and communities as the co-producers of health and wellbeing, rather than the recipients of services
- promote community networks, relationships and friendships that can provide caring, mutual help and empowerment
- value what works well in an area
- identify what has the potential to improve health and wellbeing
- support individuals' health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empower communities to control their futures and create tangible resources such as services, funds and buildings

Strong and validated tools for community asset mapping exist and are freely available to local governments, particularly in the Americas, e.g., in Canada, the USA (also in Spanish), Brazil and Chile.

Mapping, assessing and mobilising community assets should, however, not be seen as (merely) an academic exercise. It is critical to determine in this process that it is on-going and developmental: overwhelming local communities with seemingly esoteric evaluation tools without appropriate respect and follow-up action is not only unethical, but a waste of precious resources.

Follow-up action, furthermore, would need to be framed not only in terms of the potential of civil society to engage in broad intersectoral action for health and well-being. It would build a strong policy agenda that foreshadows lasting, systemic and integral decision-making with an appropriate allocation of resources. Such a policy agenda needs to allow for the continuous involvement of civil society and its assets in integral approaches to health.

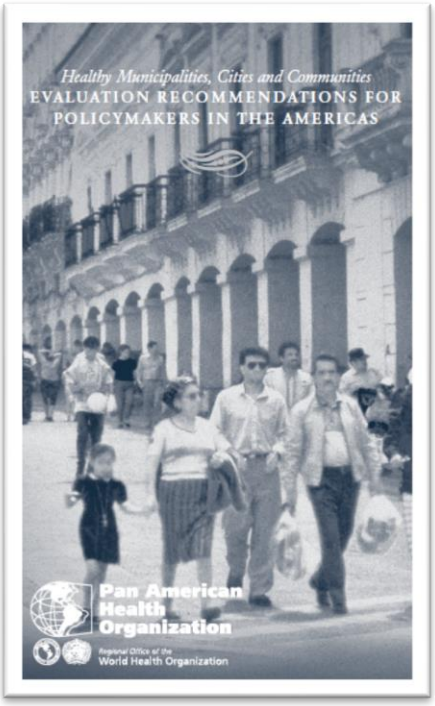
ASSET MAPPING DRIVES HIAP

An appropriate view of the assets available to local government and a full appreciation of its potential for intersectoral action and HiAP is quintessential for lasting action and policy.

5.7 Ensure monitoring, evaluation, and reporting

Monitoring, evaluation and reporting of

- the contribution of intersectoral action to a HiAP agenda;
- the development process of HiAP and the engagement of the broadest possible suite of stakeholders;
- the actual implementation of HiAP in terms of policy products, interventions and intersectoral engagement;
- the mutual and reciprocal efficacies and benefits brought about by this integral policy agenda;
- the impacts of HiAP implementation on determinants of health and well-being; and
- ultimately the health consequences of the policy and its actions



are critical to the success of the action-policy-action vortex. It reassures and empowers all stakeholders in the process, it demonstrates efficacy of the allocation of resources, and allows 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. They also create systems of accountability toward involved stakeholders, and have the potential to keep them involved in intersectoral action and HiAP development.

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

At its most basic level, local government engaging in intersectoral action and HiAP development and implementation *does*, however, have capacity for monitoring and evaluation. The resources for this capacity are (a) existing local assets; and (b) documenting steps along the way. More often than not, engaged communities will be happy and proud to contribute to assessment and monitoring, and should be involved in the various stages of reporting. Community workers and government staff 'at the coal-face' in delivering and facilitating action for health also has a responsibility to keep track of their actions, and should be facilitated in keeping journals and records in responsible manners.

There is, nevertheless, also an important responsibility for institutions of higher education and research to engage in these processes. A resource that in many cases is not recognised and rewarded enough exists of students, either in processes of service-learning, participatory action and evaluation placements, or as a powerful existing community resource. Institutions of higher education and research should be constructively engaged by local governments in enabling social and political health research. This may work best through the facilitation of individuals or institutions that have sometimes be called 'knowledge brokers', 'research entrepreneurs' or 'development facilitators'. Local governments may want to establish collaborative networks to mobilise these resources where they are not readily available locally, and national governments and the international community have an obligation to facilitate working across the nexus of research, policy and practice.

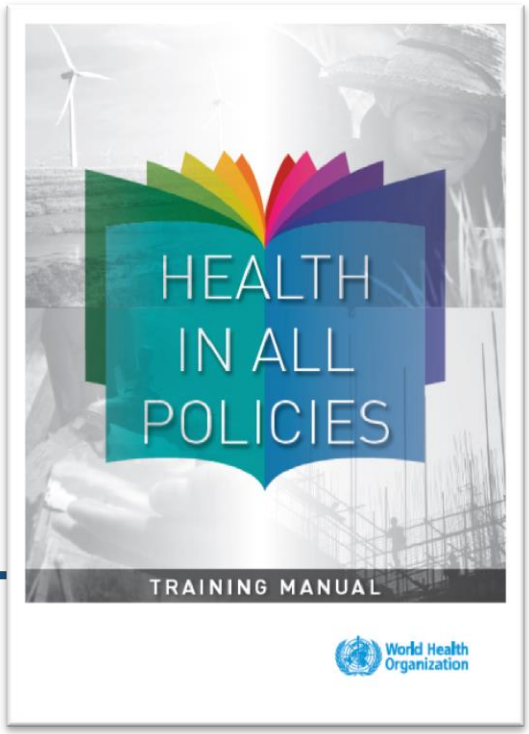
A deliberate process to monitoring and evaluation is essential in providing the information that is required to assess progress and pitfalls. In this deliberate process local government is to establish monitoring and evaluation milestones (*what is to be accomplished by whom at what time?*), baseline measures and an agreement on what constitutes progress or failure.

MONITORING, EVALUATION AND REPORTING: INTEGRAL TO HIAP

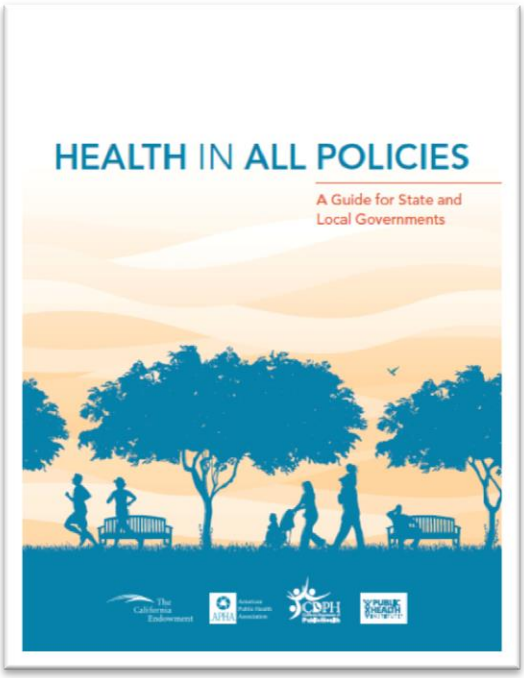
An explicit strategy and operational tools for monitoring and evaluation must connect to respectful and relevant reporting. This needs to be integrated throughout local governance parameters. Partnerships for evaluation can be forged between government, civil society, and academia.

5.8 Build lasting capacity

Addressing the complexity of modern health and health equity issues requires a lasting, continuous process. The establishment and implementation of one Health in All Policy cannot be considered the end point of this process. It is a stage in an evolutionary practice: the policy needs to be reviewed, adapted, and renewed to meet the exigencies that it has created. The context, and local stakeholders, in which this happens will constantly change. Political shifts may require a renewal of executive commitment, evolving community concerns will dictate on-going participatory consultative action, and technological advances may inspire new solutions.



The local government apparatus will require a firm grounding in flexible understanding of the foundations of intersectoral action and HiAP and the processes required to maintain and grow its potential and impact. The above steps, when documented and conscientiously applied, form a local basis for sustained capacity to address new complex health issues through HiAP and intersectoral action. A form of 'corporate memory' is required to keep such lessons on the radar, and a public repository (virtual or real) can be such a resource.



However, expert advice and benchmarking is also available and can be applied at the local level. The recently published WHO HiAP Training Manual offers significant opportunities to build lasting capacity, as does a HiAP Guide for State and local governments prepared in the USA.

Experience from Healthy Cities, particularly in Europe, suggests that networking around capacity building between cities, local politicians, and committed communities, is a process that stimulates and enhances 'second order learning', that is, the ability to apply practical lessons not just to operational action, but to strategic and systemic levels of insight.

6. The journey ahead

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Appendices

Appendix: Terms used in the Finnish European Union HiAP publication

Determinants of health *refers to 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 behaviours.*
Social and economic conditions *– such as poverty, social exclusion, unemployment and poor housing – 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 *can be understood as 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 *is 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 *includes government ministries and departments, social security and health insurance schemes, voluntary organizations and private individuals, and groups providing health services.*
Intersectoral action for health *could be defined as 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 pulbic 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 *is, according to the Adelaide recommendations, "characterized by an explicit concern for health and equity an all areas of policy, and by an accountability for health impact. The main aim for healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible and easier for citizens. It makes social and physical environment enhancing."*
Public policy *is policy at any level of government and may be set by heads of government, legislatures and regulatory agencies. Supranational institutions' policies may overrule government policies.*