KNOWLEDGE EXCHANGE

SEMINAR SERIES

Health in All Policies (HiAP)

Anne-Marie Doherty, Queen's University Belfast

adoherty44@qub.ac.uk

This briefing paper concerns Health in All Policies (HiAP), which is becoming increasingly recognised as a way for governments to tackle the social determinants of health. The paper highlights the origins and description of HiAP and makes suggestions how it could be progressed in this region.

1. The origin of Health in all Policies

- During the twentieth century there was a growing awareness that 'health' was not simply a function of hygiene, nor the absence of disease, but incorporated a wide range of social, psychological and economic factors (1,2,3).

- One of the first to understand the relationship between sanitation and social hygiene was Rudolf Virchow. Virchow was a social activist who linked the health of people to social and economic conditions and he advocated the need for political solutions (4,5). Virchow believed that human health and disease are the embodiment of the successes and failures of society as a whole and the only way to improve health is by changing society and therefore by political action (5).

- Geoffrey Rose is considered to be the modern champion of the idea that whole populations can be sick and political action may be needed to improve population health (6).

- There was a growing recognition in the UK that social organisation can impact on health as reported in the 1980 Black Report (7) and later Acheson Inquiry (8). Sir Michael Marmot suggested (9) that the Black Report had enormous influence. Although the short-term policy implications were negligible because of its dismissal by the conservative Government, the long-term policy implications were substantial because it led to the setting up of the Acheson Inquiry. Marmot reported that in contrast to the Black report, the Inquiry Acheson was welcomed by the Labour Government which reported: "we are committed to tackling the underlying problems, such as poverty, neighbourhood deprivation and lack of education and employment opportunity"(10).

Internationally:

- Canada was host of the first international conference on health promotion in 1986, held in Ottawa. The World Health Organisation endorsed the resulting 'Ottawa Charter for Health Promotion' (11). This charter declared that 'Health promotion goes beyond health care and puts health on the agenda of policy makers in all sectors at all levels, directing them to aware of the health consequences of their decisions and to accept their responsibilities for health.

- As a result of the Ottawa Charter, many countries began to look at the determinants of health and the way public policy can contribute to this agenda. However, many countries focused their efforts on lifestyle issues and developed programmes to address concerns such as tobacco use, healthy eating and physical activity.

- The rapidly changing nature of society has added new dimensions in which we need to consider the creation of health (12). The publication of the WHO Global Commission on the Social Determinants of Health report in 2008 (13) and the subsequent commissioning of the Review of Health Inequalities Post 2010 in England (14) has raised the profile of the social determinants of health and of the importance of addressing the conditions of everyday life that lead to health inequities.

1.1 The cost ….

- Sir Derek Wanless (15) provided a report to the UK Treasury and described a 'fully engaged' scenario that advocated a population that if 'fully engaged' in maintaining and improving its health and wellbeing would result in significant savings for the

health sector. Achieving a fully engaged population will lead to a long term reduction in demand for health services with a subsequent reduction for competing scarce resources (16).

- Regionally, the Appleby review in Northern Ireland (17) reported that the health of the population is a complex function of many economic, social, cultural, lifestyle, educational and other factors and health status in Northern Ireland (NI) was worse than in the rest of the UK. Sir Derek Wanless in his 2005 report to the UK Treasury suggested that failure to prevent illness over the next 20 years could cost somewhere in the region of £30 billion (18).

- In Northern Ireland, health expenditure accounts for approximately half of the total Programme for Government budget. Clearly this will be challenging to sustain in the future and a major shift in improving the health and wellbeing of the population will be required.

- Ham (19) reports that although the health of the population in Northern Ireland is worse than England, despite higher expenditure, it reinforces the need for action outside the health sector to improve health.

- In relation to the economy it is commonly perceived that health is a drain on the public purse (12). However, the economic case for Investment in health has been made (20,21,22) and increasing recognition that investment in health is good for the economy in rich nations (23).

- There are strong economic arguments for investing in health at population level (22). Public Service Agreement number 8 in the Northern Ireland Programme for Government states that: "A healthy population is desirable in itself; it is also an essential element in helping to deliver a strong economy"

- A report prepared for the Marmot review (20) estimated that health inequalities would give rise to economic losses of £31 - £33 billion pounds. Other estimates imply an enormous economic benefit associated with improving mortality in lower socioeconomic groups. It has been reported that for the considered adult population the economic gains would be on average between about £98 and £118 billion pounds in 2002 prices. However they do not suggest the effect of any policies that might help achieve the reduction in health inequality they do highlight the extent of the benefits and illustrate what is at stake (24).

1.2 What is Health in All Policies (HiAP)?

- Finland held the presidency of the EU in 2006 and introduced HiAP as the lead theme.

- A conference was held at the end of the 6 months to highlight how and why the health dimension can and should be taken into account across all government sectors.

- The council of Health Ministers of the EU approved the conclusions on HiAP with recommendations to the commission of member states. In addition, the European Commission adopted a new health strategy 'Together for Health: A strategic approach for the EU 2008-2013 in which HiAP is incorporated as the 3rd Principle in the strategy (23).

- HiAP is an innovative policy strategy that responds to the critical role that health plays in the economies and social life of contemporary societies. It allows governments to address the key determinants of health in a more systematic manner as well as taking into account the benefit of improved population health for other sectors (12).

- If societies are to prepare adequately for the 21st century they must completely rethink their approach to health policy. A health policy for the 21st century must address the classic determinants of health such as education, work, housing, transport and equity (12,27).

- Countries such as Sweden and South Australia have now based their health policies on a health determinants approach. The 'health' needs of a population require consideration across a broad range of policy arenas and government portfolios (12,14,24,25,26,27).

- The second of four principles in the EU health strategy "Together for Health" (23) states that health is a prerequisite for economic productivity and prosperity. The health sector is an important part of the economy. Some perceive it as a drain on resources others as a driver of the economy through innovation and investment in biomedical technologies, production and sales of pharmaceuticals or through

ensuring a healthy population, which is economically productive (Buse et al; 2005).

- Sir Derek Wanless gave an unexpected prominence to the importance of public health. He argued that health and wealth went together: good health relies on good economics. In addition to health benefits a focus on public health was seen to bring wider benefits including increasing productivity and reducing inactivity in the working age population (26).

- It has been suggested that strong policy coordination across government departments will require greater understanding of health and wellbeing and that the Department of Health has a leadership role across government with specific responsibilities of other departments needing to be made clear - especially where action is the collective responsibility of several departments. However, they consider that ministers and senior officials within the Department of health will have a better view of what will work (28).

- Ministries of Health cannot transform social conditions in isolation but they can provide leadership to progress an approach to health policy that incorporates actions on tackling social determinants of health across government departments (29).

1.3 The 'Marmot' Review

- Sir Michael Marmot (14) led a Strategic Review of health inequalities in England and found that while there have been significant improvements in the health of disadvantaged groups and areas, the gap between these groups and the population average has widened. A number of barriers that have hindered progress with the reduction of health inequalities in England have been identified in this review. A Departmental Official, in a personal communication with the author of this briefing, reported that although these barriers are specific to England they are also relevant to Northern Ireland.

On a national level they include:

- Responsibility for health inequalities and health improvement resting with the Department of Health even though the main determinants of health inequalities require action by a variety of other government Departments

- Policy delivery processes are fragmented and result in disconnected action

- A succession of policy changes and organisational structures

- Pursuit of short term objectives and targets based on a ‘quick win’ ethos, instead of allowing existing initiatives to mature and limited commitment to longer time cycles.

- A preoccupation with NHS acute services, access and waiting times and NHS financial balance

- An emphasis on the need for new money and;

- Lack of attention to building workforce capacity and creating a context within which action on the determinants of health can be delivered.

On a local level progress has been hindered by:

- Inadequate understanding of the key drivers of health inequalities and the key drivers of social determinants

- Partnership working has been a key feature of health inequalities policy approaches but there is little evidence that this has produced better health outcomes

- Reliance on small scale health improvement projects and programmes

- Lack of understanding about the need for evidence, what constitutes good evidence and a lack of agreed protocols for systematic sharing of information between agencies to underpin evidence based strategic action

- Significant variation in engaging the senior personnel necessary to deliver effective partnerships and strategic change; and

- Overemphasis on targets and pressure to demonstrate quick short term wins to the detriment of the long-term strategic progress.

- A perspective on social determinants makes clear the role of government sectors other than health that are responsible for many of the policy decisions that shape the health of the population (12). This can only be resolved through political commitment, social action and willingness to innovate including policy innovation (30). Our understanding of the determinants of health makes it obvious that every policy decision a government makes also impacts on health (31).

- It has been recognised that HiAP is an innovative policy strategy that responds to the critical role that health plays in the economies and social life of contemporary societies (27). It introduces better health and closing the health gap as shared goals across all parts of government and allows the key determinants of health to be addressed in a more systematic manner as well as taking into account the benefit of improved population health for the goals of other sectors (31).

1.4 Investing for Health

- In 2002, the first regional Public Health Strategy for Northern Ireland 'Investing for Health' (IfH) (32) was produced. Investing for Health was unique because it had ministerial and cross-departmental support across Government. It has a preface by the then First Minister and Deputy First Minister with a comment that: "all Ministers are committed to it".

- The vision of IfH is about the prevention of ill health and reducing health inequalities in society rather than a strategy for treatment and care.

- Since 2002 Northern Ireland has embraced a 'Health in All Policies' approach although this has not been recognised locally. This region was ahead of its time.

2.0 Anne-Marie Doherty - Doctoral Research

We know little about how health policy is adopted and how evidence informed decisions are made in Northern Ireland. This study aims to fill these gaps in knowledge.

Kingdon (33) has contributed to the debate around what determines whether alternatives to existing policy regimes get serious attention and whether new policies actually get adopted.

The Kingdon model diverges from the traditional model of phases with his identification of streams (problem, policy and political) that explain how an issue goes from the public agenda to the government agenda and finally to the government decision agenda. He describes these three independent streams of policy making and activities that must come together at some point to progress from the public agenda to the government agenda.

Kingdon claims that none of these streams or their related activities necessarily follows in a logical fashion. He differentiates between the government agenda, a list of subjects getting serious attention, and the decision agenda, a list of subjects within governmental agenda that are up for an active decision. Problems are accompanied by a set of alternatives from which the government can choose. Issues can come from many sources inside or outside government. According to Kingdon, a single stream rarely moves an issue to the top of the policy agenda and result in a decision. The main factor that influences whether or not an issue is on the agenda is the 'climate' in government regardless of the source of the issue.

It has been argued that those in public health need to pay far more attention to the policy environment, and especially the process of policy making (34). It has also been argued that politics and health is a neglected area of research (35,36).

As part of this doctoral research, a total of 34 qualitative interviews have been carried out with a range of 'elite' policy makers\decision makers in Northern Ireland. This includes Members of the Legislative Assembly, Departmental officials and Advisors.

Preliminary findings:

- Government Departments are working in silos.
- Recognition that Departments should be working together to tackle the social determinants of health but this is often challenging.

- Terminology can be confusing - Health in All Policies, Health Impact Assessment, Investing for Health.
- Investing for Health was easily understood - but not progressed.
- The 'voice of the people' is important in influencing policy – media and lobbyists are also considerations along with evidence presented by various Departments/officials.
- Assembly research used to provide evidence that shapes a course of action but also used to authenticate evidence provided by departments.
- Health in All policies should be included within Programme for Government.
- Health in All Policies should 'logically' be taken forward by OFMDFM but recognition that currently there are limitations to this.

3. Conclusions

With the continuing stability of a devolved Government, there is every reason to be optimistic that this region - could and should - become the European leader in fully embracing and adopting a 'whole of Government' approach to tackling the social determinants of health and implementing Health in All Policies.

The key to this is:

1. Having the political will
2. Mobilising 'champions' at all levels
3. Embedding Health in All Policies within Programme for Government.
4. Reconsider how budgets are administered
5. Consider how the Public Health Agency could further support this approach.

Biography: Anne-Marie Doherty is a PhD Candidate in the School of Sociology, Social Policy and Social Work and is an affiliated student with the Centre of Excellence in Public Health at QUB. She was awarded a Health and Social Care (HSC) Doctoral Fellowship Award, from the Public Health Agency and anticipates completing her research in September. Anne-Marie is a Registered Nurse and Health Promotion Specialist.

Bibliography

1. Baggott, R. (2000) *Public Health Policy and Politics* Palgrave, Basingstoke.
2. Parish, R. (2007) "Foreword" in *Public health: social context and action*, eds. A. Scriven & S. Garman, Open University Press, London, pp. xv-xvi.
3. Dow, W.H., Schoeni, R.F., Adler, N.E. & Stewart, J. (2010) "Evaluating the evidence base: Policies and interventions to address socioeconomic status gradients in health", *Annals of the New York Academy of Sciences,* vol. 1186, no. The Biology of Disadvantage Socioeconomic Status and Health, pp. 240-251.
4. Tulchinsky, T.H. & Varavikova, E.A. (2000) *The new public health: an introduction for the 21st century,* Academic Press, New York.
5. Mackenbach, J.P. (2006) *Health Inequalities: Europe in profile,* produced the Department of Health for the EU, London.
6. Mackenbach, J.P. (2009) "Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea", *J of epidemiology & community health,* vol. 63, no. 3, pp. 181-184.
7. Department of Health and Social Security (1980) *Inequalities in Health: Report of a Research Working Party,* DHSS, London.
8. Acheson, D. (1998) *Independent inquiry into health inequalities report.* DHSS, London.
9. Marmot, M. (2001) "From Black to Acheson: two decades of concern with inequalities in health. A celebration of the 90th birthday of Professor Jerry Morris". *International Journal of Epidemiolgy*. Vol. 30, no. 5, pp. 1165-1171.
10. Department of Health. (1999) *Saving Lives: Our Healthier Nation*. The Stationery Office, London.
11. World Health Organisation (1986) "Ottawa Charter for health promotion", *First International Conference on Health Promotion* World Health Organisation, Geneva , pp. 21.
12. Kickbusch, I., McCann, W. & Sherbon, T. (2008) "Adelaide revisited: from healthy public policy to Health in All Policies", *Health promotion international,* vol. 23, no. 1, pp. 1.
13. World Health Organisation (2008) *Closing the gap in a generation. Health equity through action on the social determinants of health*. Final report of the Commission on Social determinants of Health. WHO, Geneva.
14. Marmot, M. (2010) *Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post 2010.* The Marmot Review, London.
15. Wanless, D. (2004) "Securing good health for the whole population", *HM Treasury, London*
16. Office of the First Minister and Deputy First Minister (2008) *Programme For Government*, OFMDFM, Belfast.
17. Appleby, J. (2005) *Independent review of health and social care services in N. Ireland*, DHSSPS, Belfast.
18. Wanless, D (2005) *Securing our future health: taking a long term view*. HM Treasury, London.
19. Ham, C. (1999) *Health Policy in Britain,* Fourth Edition edn, Palgrave, Basingstoke.
20. Frontier Economics (2010) *Estimating the costs of health inequalities. A report prepared for the Marmot review,* Frontier Economics
21. Henke, K.D. & Martin, K. (2009) "Health as a Driving Economic Force" in *Policy Innovation for Health*, ed. I. Kickbusch, Springer
22. Institute of Public Health (2009) *Economic Arguments for addressing social determinants of health inequalities*, Institute of Public Health in Ireland, Dublin.
23. European Commission (2007) *Together for Heath "A Strategic Approach for the EU 2008-2013*, European Commission, Brussels
24. Mazzuco, S., Meggiolaro, S. & and Suhrcke, M. (2010) *The economic benefits of reducing health inequalities in England and Wales. Background study to the Strategic Review of Health Inequalities in England post 2010*, University of East Anglia, Norwich.
25. Puska, P. (2007) "Health in all policies", *European Journal of public health,* vol. 17, no. 4, pp. 328.
26. Hunter, D.J. (2008) "Health needs more than health care: the need for a new paradigm", *The European Journal of Public Health* vol. 18, no. 3, pp. 217.
27. Government of South Australia Department of Health (2008) *Health in All Policies*, 5 (1), Government of South Australia, Adelaide.
28. Bernstein, H., Cosford, P. & Williams, A. (2010) *Enabling effective delivery of health and wellbeing. An independent report,* Department of Health, London.
29. Irwin, A., Valentine, N., Brown, C., Loewenson, R., Solar, O., Brown, H., Koller, T. & Vega, J. (2006) "The Commission on Social Determinants of Health: Tackling the social roots of health inequities", *PLoS Med,* vol. 3, no. 6, pp. 0749-0751.
30. Kickbusch, I. (ed) 2009, *Policy innovations for health*, Springer, New York.
31. Kickbusch, I. (2007) "Responding to the health society", *Health promotion international,* vol. 22, no. 2, pp. 89.
32. Department of Health Social Services & Public Safety (2002) *Investing for Health,* DHSSPS, Belfast.
33. Kingdon, J.W. (2003) *Agendas, Alternatives and Public Policies,* 2nd edn, Longman, New York.
34. Walt, G. (1994) "How far does research influence policy?", *The European Journal of Public Health,* vol. 4, no. 4, pp. 233.
35. Bambra, C., Fox, D. & Scott-Samuel, A. (2005) "Towards a politics of health", *Health promotion international,* vol. 20, no. 2, pp. 187-193.
36. Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, Á., Rodríguez-Sanz, M., Vergés, N. & Pasarín, M.I. (2006) "Politics and health outcomes", *The Lancet,* vol. 368, no. 9540, pp. 1033-1037