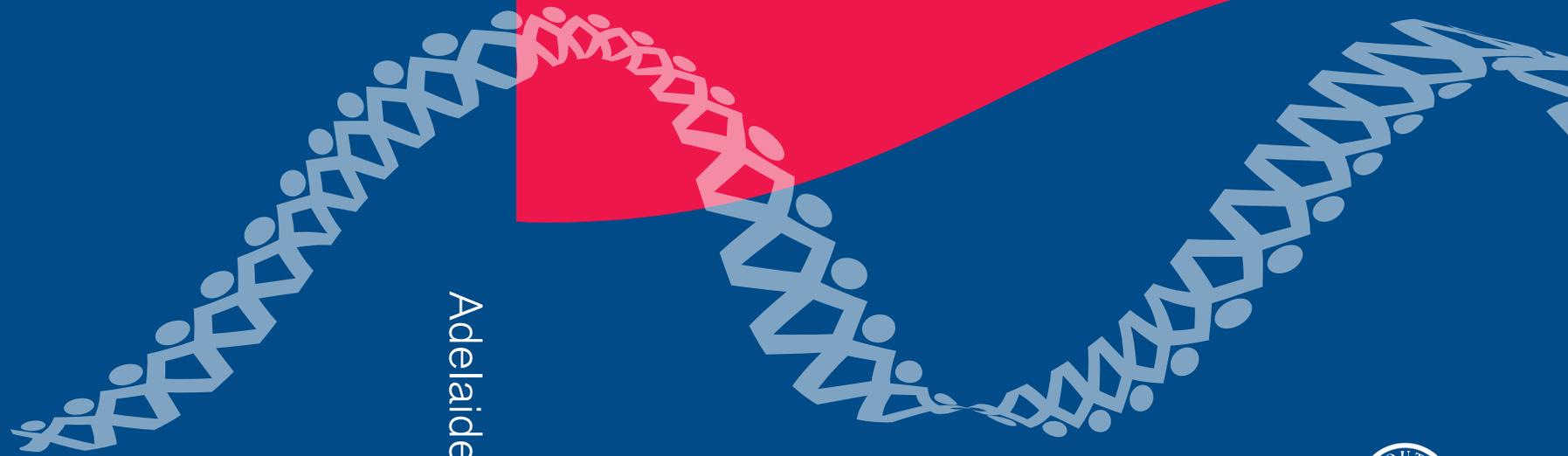Implementing
Health in
All Policies
Adelaide 2010

Edited by
Professor Ilona Kickbusch and Dr Kevin Buckett

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Edited by

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Foreword

The report of the Commission on Social Determinants of Health, published in 2008, challenged conventional public health thinking on several fronts. The report responded to a situation in which the gaps, within and between countries, in income levels, opportunities, health status, life expectancy and access to care are greater than at any time in recent history. As the report argued, improving the health of populations, in genuine and lasting ways, ultimately depends on understanding the causes of these inequities and addressing them.

The Commission found abundant evidence that the true upstream drivers of health inequities reside in social, economic and political environments. These environments are shaped by policies, which make them amenable to change. The new challenge for the health sector is to study the logic of the decisions of other sectors. Then it is our responsibility to take what we know about equity and the social determinants of health and apply it to their frameworks, using their language, based on their desired outcomes. This is the 'different logic' referred to in the World Health Organization's *2008 World Health Report on Primary Health Care*.

The World Health Assembly Resolution, *Reducing Health Inequities through Action on the Social Determinants of Health* (2009), challenges governments to improve their efficacy in tackling the determinants of health inequities through a Health in All Policies approach, and for WHO to provide the necessary assistance and guidance to enable this action. Moving towards intersectoral action for health and beyond the health sector were core recommendations of the Declaration of Alma Ata (1978) and the Ottawa Charter (1986). Yet we know that the health sector has struggled with this very approach.

This volume addresses a number of important implementation challenges for Health in All Policies. History is analysed, different contexts are explored, concepts and methods are elaborated and case studies are described. National and sub-national country case studies shed light on how nations as diverse as Australia, Canada, Finland, France, Norway and Thailand are incrementally working towards better policy integration and governance for social wellbeing and equity. The concepts, examples and practical experiences documented in this volume provide essential learning for moving towards a clearer conceptual framework for Health in All Policies.

Dr Timothy Evans

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March 2010

Introduction

Health in All Policies: the evolution

Ilona Kickbusch and Kevin Buckett

We are becoming increasingly familiar with the notion of 'wicked problems'—those problems on the public policy agenda that are wicked, not in the sense of being evil but of being highly resistant to resolution. They are problems that: are difficult to define, may be socially complex, are often multi-causal with many interdependencies, have no clear solution and are not the responsibility of any one organisation or government department.[1]

These wicked problems are exemplified by the crises facing health systems worldwide, in both the developed and developing world. In the developed world the predominant focus of the health system is in treating ill health, where the escalating costs associated with technological advances, community expectations and an ageing population are putting unsustainable pressure on the health system—dealing with illness or 'illth' rather than health.

A major contributor to this crisis is the epidemic of chronic disease, the causative factors of which are outside the control of the health system. The health system ends up 'owning' the problems that result from the chronic disease epidemic and must deal with these. However, it does not own the ways of addressing the causes of the problems, as the answers are not medical or clinical but environmental and social. A wicked problem indeed.

Wicked problems need innovative solutions. They are not amenable to the linear process traditionally adopted in policy development. Their resolution requires new and innovative ways of thinking and working.

This need has led to new insights in public policy development and implementation, and has forced a growing interest in how governments can redesign their structures, budgets, data information systems etc. to, as Mulgan puts it, '...make collaboration more natural'.[2] Referring to this, Mulgan coined the phrase 'joined-up government' in a landmark speech written for Tony Blair in 1997 to launch the Social Exclusion Unit in the UK.[3]

This notion of joined-up government did not emerge fully fledged in the 1990s—its genesis was much earlier and evolved over the preceding 30 years or so. One of the first iterations of the concepts that began this evolution in the health domain—intersectoral action for health—was a key strategy of the Alma Ata Declaration in 1978, which encouraged the health sector to look beyond its role of acute medical care and consider how to deal with the actual causes of people's ill health.

Moving beyond intersectoral action for health, the next major evolutionary step—the Ottawa Charter for Health Promotion—talked about developing healthy *public* policy, not just health policy; considering a range of approaches across all policy environments to bring about improvements in health and wellbeing.

Health in all Policies (HiAP) is a further innovation on these earlier joined-up approaches to public policy, taking as a starting point the crucial role that health plays in the economic life of a society. Health has become a major economic and social driving force. The sustainability of the health of the population is as critical as the sustainability of the environment to achieving sustained prosperity and quality of life. A healthy and skilled population is critical to workforce participation, productivity and a healthy economy—and, hence, to future living standards. People in good health are more productive and can participate more effectively in the labour market and education. Improving population health then becomes a shared goal across all sectors. HiAP has, as a central concern, the health impacts of policy across all sectors, and provides a lever for governments to address the key determinants of health through a systematic approach.

Implementing HiAP in South Australia

HiAP is gaining currency in many jurisdictions. The impetus for its implementation in South Australia (SA) came through one of the authors of this paper (Kickbusch) accepting the offer to participate in the Premier of South Australia's Thinker in Residence Program. Through the work undertaken as part of this Residency, South Australia's Strategic Plan (SASP) was identified as the key structural vehicle that would enable joined-up government for tackling health determinants to become a reality. SASP is explicit about being a plan for the whole community and not for the government alone.

> '...it is a whole of state plan with ambitious targets that can only be achieved through the cooperation within and between government, industry and the community. Partnerships will be critical to its success. The plan throws down a challenge to all South Australians to take action that will achieve a better future for the state.' [4]

The objectives of SASP—growing prosperity, improving wellbeing, attaining sustainability, fostering creativity, building communities and expanding opportunity—relate very well to the determinants of health. They provide an opportunity to incorporate health outcomes in policies and programs aimed at meeting targets under each objective.

Issues for HiAP

Understanding and dealing with the socioeconomic determinants of health is difficult because issues such as income, employment, education and environment are complex and multi-factorial. The time between cause and effect is generally long (especially compared to the political cycle), evidence is often incomplete or weak, and associations are often difficult to explain.

Working across government sectors is also difficult—'ownership', funding, reporting arrangements, departmental or agency culture, and language all present challenges for joined-up government. Government departments are often said to operate as 'silos', which need to be bridged to achieve joined-up government. In reality, government departments often work more like castles and keeps than silos, being actively defended to resist distraction from 'core business' and sectoral interests.

Combining these two issues compounds the difficulties and accentuates the 'wickedness' of the problem for HiAP.

In implementing HiAP, a number of questions are raised and need to be considered:

- It is one thing for the health sector to be interested in trying to solve its wicked problems, but why would other sectors want to work in a joined-up way with Health in an HiAP approach—what's in it for them?

- Health often makes up the greatest single expenditure of governments, so why should other agencies be asked to spend their funds on health outcomes? Again, what's in it for them?

- How should the power dynamics and relationships between health and other sectors be managed so that a fruitful relationship can be developed—who leads (and, therefore, who follows)? This is a vital question as relationship-building and partnerships are key aspects of successful across-sector work.

- How do you develop a common goal given the current institutional arrangements where each sector is striving to achieve its own goals? Without shared goals, at some level HiAP will fail.

- How do you develop a culture of cooperation given that sectors, and their leaders, are in competition for resources and 'their time in the sun'?

- What is Health's role in HiAP? How can it be inclusive and not dominant in partnerships given that health issues are generally seen as Health's responsibilities?

These questions and others are dealt with to varying degrees by the authors in this volume.

The structure of this book

While this book considers the implementation of HiAP in a number of jurisdictions, it does however have as a major focus its implementation in SA, given that it has been produced to coincide with the Health in all Policies Adelaide 2010 Meeting.

The book is divided into four sections. The first section sets the scene of HiAP, beginning with a chapter by Kickbusch on the evolution of the concept through the three intellectual policy waves that have supported the emergence of a 21st century model of joined-up health governance. Providing context, Baum and Laris discuss the links between equity, healthy public policy and the work of the Commission on the Social Determinants of Health. A key recommendation of the commission concerns the need for governments to be aware of, and ensure accountability for, the health and equity impacts of their policies, and for an HiAP approach to be adopted by governments and international agencies.

The second section looks at the implementation of HiAP in several jurisdictions. Wismar and Ernst consider the European context, presenting case studies from Finland, Norway, France and Wales. These studies show different whole-of government approaches to healthy public policy and use varying combinations of governance tools. Sukkumnoed and Reukpornpipat provide an overview of developments in Thailand that have led to the institutionalisation of health impact assessment (HIA) as a key tool for achieving healthy public policy at all levels of society.

The third section looks at, in the main, aspects of implementation of HiAP in one jurisdiction—SA—offering theoretical and methodological discussions. Williams and Broderick present the SA model of HiAP from the perspective of the Department of Health, outlining the underlying values, governance structure, model adopted and implementation to date. Pitcher, Jordan and Buckett complete this governance picture by discussing the central agency's (the Department of the Premier and Cabinet's) perspective on implementing HiAP and highlighting the key role that SASP has in providing the mechanisms for HiAP.

Druet et al. present a comparison between Quebec and SA in the adoption of healthy public policy. In Quebec HIA is a legislative requirement for bills and regulations that have a significant impact on population health, and Health has developed an intragovernmental HIA mechanism by which this happens. The authors compare Quebec's strategy for joined-up government with that of SA, indicating that there are possibly more similarities than differences.

Quigley, who provided extensive consultative advice and support to the SA implementation of HiAP, discusses HIA from two perspectives—the theoretical, including its relationship to HiAP; and the practical, explaining its role in the HiAP approach in SA.

The final section of the book presents specific examples of HiAP in practice in SA, telling the story of three health lens projects from the perspectives of the partner agencies and researchers. The health lens is an emerging methodology used by the South Australian Government to translate the HiAP concept beyond rhetoric into action. It works to identify key interactions and synergies between SASP targets, government policies and strategies to implement these policies, and the health and wellbeing of the population, relying heavily on the well-established methods and structures of HIA.

Conclusion

To arrive where we are today with the HiAP approach has been an evolutionary process. It will continue to evolve over time as its potential for improving health gain becomes a reality. Such an approach is also vital, as we are clearly reaching an untenable, unsustainable situation within health systems worldwide. The problems facing health are wicked. Solutions must be innovative and revolutionary. That is Health in All Policies.

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Section 1

Health in All Policies: setting the scene
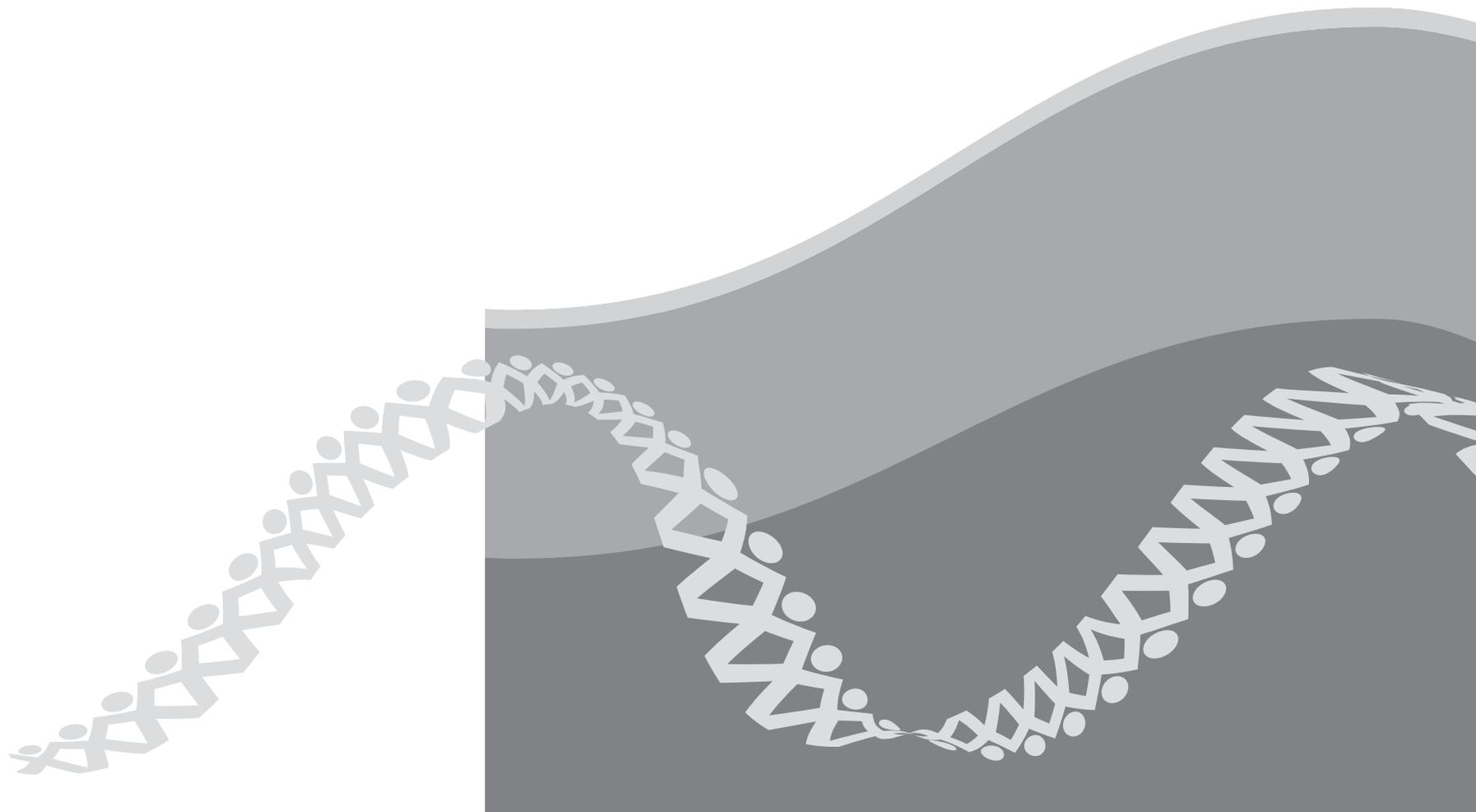
Chapter 1

Health in All Policies: the evolution of the concept of horizontal health governance

Ilona Kickbusch

Introduction

As South Australia's 2007 Thinker in Residence, I was appointed by the South Australian Government to assist in formulating new approaches to health, wellbeing and health governance in the state. My residency provided a catalyst for action that enabled the health sector and the government to explore how best to develop Health in All Policies (HiAP) in South Australia (SA). During my time in this position, SA developed its own unique approach to HiAP. A key element of this approach has been the development of the health lens process which is described in more detail throughout this publication. The first 2 years of experience with the health lens reinforced what actors in the field of horizontal governance know so well—it is a process of mutual learning between stakeholders that requires both time and trust in order to achieve results. The decisive innovation of the SA health lens process has been to tie it to the long-term commitments of South Australia's Strategic Plan (SASP). This relationship provides a continuous and formalised, yet flexible, mechanism to engage departments across government. It has changed the way health cooperates with other sectors and how other sectors view health.

Re-emphasising the social, political and economic factors in public health

George Rosen, the great historian of public health, has defined 'the medical and technical development' and 'the social, political and economic factors' as the two major strands of public health that constantly need to be woven together to ensure impact. We are presently in a period where the second strand is again becoming more prominent, as medical and technical development provide only limited results for resolving some of the key challenges facing public health today. It is well known, based on both historical

and scientific evidence, that the major determinants of health need to be addressed in order to achieve better health outcomes. These include not only clean air, water and sanitation; housing, tobacco control, healthy food, essential medicines, vaccines and functioning health systems but also factors such as employment, social status and participation in society. Innumerable studies have shown the link between poverty, economic development and health. The World Health Organization (WHO) Commission on the Social Determinants of Health has presented the scientific evidence once again. And it has stated unequivocally that governments need to refocus their public health policies to ensure action by all sectors of government to address 'the causes of the causes' in order to improve population health.[1]

However, it is only under specific conditions that governments act. The political response by governments to public health challenges has always been subject to mixed motivations, including economic utility, demographic concerns, political ideology, a fear of contagion, humanitarian commitment, medical discovery, and a dedication to social reform and social justice—to name but a few. These are not only developed within government but are part of overall processes of social change and social conflict. It is usually a blend of, or trade-off between, the instrumental and intrinsic dimensions of health that creates the backdrop for governmental action. This was the case in the 19th century, when health was a critical dimension of the 'social question' and a key element in maintaining social order. Again, today, health has moved up in the political agenda in developed welfare states and in development policies precisely because of its relevance both to the economy and to the social rights and expectations of citizens. This also means that it is of high interest to many different stakeholders in society, albeit for different reasons. This blend and its inherent contradictions have initiated an important political debate on health inequalities and determinants of health, and have again moved the focus of 21st century public health *beyond health care*.

Horizontal governance

'Whole-of-government' denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal or informal, and can focus on policy development, program management and service delivery. 'Joined-up government' is generally focused on improving outcomes.[2]

Developments in the health arena have run parallel to larger shifts in the approach to governance. The increasingly complex problems have made governments aware that horizontal policy-making and implementation is necessary—the policy documents produced around the world use terms such as horizontal governance, joined-up government or whole-of-government. Recognising this need to improve governance, some governments—like SA—have produced a strategic plan that sets out common goals, integrated responses and increased accountability across government departments. In the same vein many governments around the world have introduced health objectives and targets, some of which (e.g. the Swedish Public Health Policy[3]) reach far beyond the health sector.

Health is an exemplar of the interconnected policy-making required in the 21st century, not only because of the need to address the health determinants but also because it is clearly a so-called 'wicked problem'. This term is applied to problems that are difficult or impossible to solve because of incomplete, contradictory and changing requirements. Moreover, because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems. In the case of any major health problem such as the AIDS epidemic, pandemic influenza, international drug trafficking or obesity, it will be characterised by the following:

1. The solution will depend on how the problem is framed and vice versa (i.e. the problem definition depends on the solution).

2. Stakeholders have radically different world views and different frames for understanding the problem.

3. The constraints that the problem is subject to and the resources needed to solve it change over time.

4. The problem is never solved definitively, and its solution can lead to problems in other arenas.[4]

Wicked problems cannot be tackled by the traditional approach in which problems are defined, analysed and solved in sequential steps, as proposed in many of the models of the strategic planning cycle.[5] One of the most effective ways to address them is through engaging stakeholders. The goal is '…to make those people who are being affected into participants of the planning process. They are not merely asked but actively involved in the planning process…'.[6] Typically, these approaches involve many meetings in which issues and ideas are discussed and a common, agreed approach is formulated—but government departments are not usually set up for these kinds of processes.

A typical example of a wicked problem in the health arena is obesity: both the problem *and* the solution are systemic. It is not only a disease but a complex system of determinants, and involves a plethora of actors who fulfil many different functions in society. Risk patterns are local (e.g. the absence of playgrounds or lack of bicycle lanes) as well as national (e.g. the lack of food labelling requirements) and global.[7] Obesity will be a test case for 21st century health policy because such systemic challenges can only be resolved through great political commitment at all levels of government and in many sectors of society.[7]

The clustering of wicked problems in the health arena is one of the reasons why the concept of HiAP has gained such prominence as an innovative approach to health governance. Of course, many policy-makers in the health sector are very aware of the need to reach out 'beyond health care'—but it is very difficult to move forward. It implies challenging nearly every societal actor, sector and institution at all levels of governance to 'think health' and contribute to the circumstances in which people can be healthy.[8]

The ideal conditions for effective intersectoral action have been summarised as follows:

- The parties have identified a **need** to work together in order to achieve their goals. This requires clarity on both individual organisational goals and joint goals.

- In the broader operating environment there are **opportunities** that promote intersectoral collaboration, for example community understanding and supportive.

- Organisations have the **capacity**—the required resources, skills and knowledge —to take action.

- The parties have developed a **relationship** on which to base cooperative, planned action. The relationship is clearly defined and is based on trust and respect.

- The **planned action** is well conceived and can be implemented and evaluated. The action is clear and there is agreement to undertake it. Roles and responsibilities are clear.

- There are plans to **monitor** and **sustain outcomes**.

Source: adapted from Harris et al. [9]

These ideal conditions rarely apply in real life health policy formulation. They also neglect two essential conditions that determine a successful HiAP process.

First, in order to achieve results, the health sector itself must be willing to cooperate with other sectors. But the health sector is a particularly vertical configuration, driven by a strong 'functional imperative', with a concentration of specialist medical knowledge and very well organised professional special interests. Consequently, it is not well equipped (and often not willing) to deal with many of the contemporary public health challenges, both from its own attitude and from the incentive structure of government. It must 're'-configure itself or reboot to support an understanding of public health as a dynamic network that constantly creates nodes and synergies for health.

Second, the health sector needs to be supported by whole-of-government approaches that provide an environment conducive to such cooperation. In order to respond, it needs dependable yet flexible mechanisms of horizontal governance—indeed, they often provide the only chance for success. But in most governments the incentives continue to be aligned with outputs for individual departments rather than shared across agencies. This reduces the effectiveness of the public sector in areas such as health, because it reduces the opportunity to act on the determinants of health and on interdependent problems that are considered to be (to use a term from social planning) a 'social mess'.[10]

Looking back on three intellectual policy waves of horizontal health governance

Since the late 1970s three intellectual policy waves have contributed to the emergence of a 21st century model of horizontal health governance: intersectoral action for health, healthy public policy and HiAP. All three have been heavily promoted at the international level but have faced serious difficulties in implementation within countries. It is also not always easy to evaluate the impact of those approaches that have been implemented, due to many confounding factors. In general they seem to work better as a 'project' or at the local level. While the three terms are often used nearly interchangeably in the literature and in policy debates, there has been a gradual shift in perspective from a one-directional health-centred focus to a multi-directional dynamic model based on wellbeing. To some extent these three waves also respectively reflect rational, incremental and network-based models of policy-making.[11]

It must also be noted that the focus of the three approaches is presently being expanded to include policy arenas that transcend national boundaries, e.g. security, trade and foreign policy.[12] Horizontal health governance is also reaching out beyond government to include civil society and the private sector. This could well be considered the fourth wave of horizontal health governance. It was expressed to some extent in both the Jakarta Declaration (1998) and the Bangkok Charter (2005).[13,14]

First wave: intersectoral action—Alma Ata and primary health care

Intersectoral action: efforts by the health sector to work collaboratively with other sectors of society to achieve improved health outcomes.

Intersectoral action for health was a key component in the WHO's seminal Alma Ata Declaration 1978, which called for 'a comprehensive health strategy that not only provided health services but also addressed the underlying social economic and political causes of poor health'.[15] The declaration stated that: 'PHC [primary health care] involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors'.[15] This call to engage in coordination for health can be considered the first wave of systematic attempts by modern health policy to highlight the relevance of other sectors for improved population health outcomes.

Alma Ata was written with the knowledge that the extraordinary advances in healthy life expectancy achieved since the late 19th century in developed countries had largely been due to improved social, environmental and economic living and working conditions. These improvements were part of the shaping of modern industrialised societies and the European welfare state, by which the state and its role in health were redefined. By the 1960s and 1970s there was a growing recognition that similar investments in health through social and economic development and action by government were needed in developing nations in order to improve health.

The WHO stated that the role of governments in health in the late 20th century needed to be redefined and strengthened for all countries, both developing and developed, and that intersectoral action was a key to better health. The discussions at the WHO influenced some governments to move in this direction, but for many reasons the major focus remained on developing countries. Here (because many governments were weak) Alma Ata was understood as a program of action at the local level that combined social and economic development with access to health services and active community engagement in planning and decision-making.[15] While Alma Ata was misunderstood by many to apply to developing countries, only a few countries (such as Canada and Finland) in the developed world stand out as examples of early adapters.

On the whole one can say that this first wave of horizontal health governance was based on a model of rational policy-making initiated by the health sector. By following an ends–means rationality, the health sector would show that action in other sectors (e.g. education) would improve health, and this in turn would contribute towards economic and social development.

Second wave: healthy public policy

'Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact.' [16]

The call to engage other sectors for health was reinforced in the next decade by the health promotion movement. In 1986 the WHO's Ottawa Charter for Health Promotion introduced 'build healthy public policy' as one of the five key action areas for health promotion, the others being 'create supportive environments, strengthen community action, develop personal skills and reorient health services'. Healthy public policy was to be implemented in concert with the other four strategies of the charter in order to be fully effective.[17]

The Ottawa Charter stated unequivocally that health is created in the context of everyday life where people live, love, work and play. It expanded the concept of health determinants to include environmental challenges and people's empowerment. It not only included the basic classical determinants but broadened the strategic thinking to the need to combine diverse but complementary approaches in order to promote lifestyles conducive to health.[14] These now included, in particular, legislation, fiscal measures, taxation and organisational change. Healthy public policy further highlighted the need for accountability for health, and laid the base for the development of health impact and health equity statements. It called for investment in health by other sectors.

The innovations contributed through the health promotion approach were threefold:

1. The focus on new lifestyle and environmental challenges to health called for regulation in sectors other than health (both nationally and internationally) in order to ensure health.

2. The focus on supportive environments introduced implementation of a common health purpose through 'settings' approaches such as the Healthy Cities Project, health-promoting schools and healthy workplaces.

3. The health promotion approach engaged in the interface between different levels of governance, key stakeholders and organisations in other sectors. Health promotion professionals were considered brokers for health rather than implementers.

The 1988 Healthy Public Policy Conference in Adelaide, Australia, focused on select issues of policy that required concerted action across government, such as women's health, food and nutrition, tobacco and alcohol, and creating supportive environments for health. The Adelaide recommendations stressed the need to act on the underlying elements of a healthy society—what is now referred to as 'the causes of the causes'. It referred to the high relevance of equity as a determinant of health; for example, it drew attention to the health disparities of the Australian Aboriginal populations. It also introduced the notion of being accountable for health impact.[13] This thinking led to the development of health impact statements as a policy tool to measure impact.

By the time of the Adelaide conference an increasing number of wicked problems had begun to crowd the health arena and three facts were becoming increasingly clear: the territory of health was expanding into many areas of everyday life; action was needed by governments but government intervention in the areas of priority was highly controversial; and the challenges could not be resolved by the health sector alone. Healthy public policy was needed in order to cope with rising rates of obesity, childhood diabetes, binge drinking, motor accidents, demographic changes and health inequalities—but nearly every one of these issues required challenging other stakeholders and their interests, in particular major industries. However, one can still conclude that, after two decades of focusing on individual behavioural change, a consensus was beginning to emerge (as in other areas of policy such as the environment) that the problems needed to be addressed at the causal level, and that joined-up policy approaches were necessary.

Healthy public policy can be situated closer to an incrementalist rather than a rational policy model. More than the first wave of intersectoral action, it recognised that policy-making is a complex process that needs to acknowledge interests, values, established positions within institutions, and personal ambitions. Because of the great power discrepancies involved (e.g. between health advocates and major industries such as the tobacco industry), it has a greater focus on process, making use of windows of opportunity and a multitude of strategies and tactics. It also recognises that many parts of the health sector have no interest whatsoever in engaging in horizontal health governance.[18] Because of the nature of wicked problems, and of opposition both within and outside the health sector, there is a significant amount of 'muddling through' in the policy process. The settings approaches are typical of what has been termed 'disjointed incrementalism' in policy theory, implying that joint agenda setting, policy-making debates and small steps undertaken for health in the settings will lead to a learning process and thus to policy change over time.

Third wave: Health in All Policies

'Health in All Policies is a horizontal, complementary policy-related strategy with a high potential to contributing to population health. The core of Health in All Policies is to examine determinants of health, which can be influenced to improve health but are mainly controlled by policies of sectors other than health.' [19]

A Canadian analysis shows that intersectoral action usually took on the shape of projects.[20] These projects, including the many-settings projects, provided opportunities to test some of the key elements of horizontal health governance. In Europe large-scale health promotion intervention projects such as HEARTBEAT WALES [21] and the North Karelia Project [22] provided further impetus and experience. However, there are fewer examples of what is needed to move beyond the project approach to a systematic approach at the level of government policies.

Finland is perhaps a major exception and an exemplar of a paradigm shift. At the national level the Finnish approach to horizontal health governance has, from the start, been more focused on redefining health within government overall, eventually leading to the third wave model of HiAP.[23] Even in 1972 the Finnish Government's Economic Council included health in its deliberations, and optimal population health and its fair distribution were integrated as priority targets of Finnish public policy. Finland began to see health as a basic contributor to the welfare of the country, and it developed many policy initiatives in this direction and became an international leader in the field.[15]

The third wave of horizontal health governance was launched during the Finnish Presidency of the European Union (EU) in 2006. Finland had continued to develop various approaches to horizontal health policy since the 1970s, particularly in its response to very high levels of cardiovascular disease. It had adopted a national health program based on intersectoral action in 1986, providing one of the models for healthy public policy in the Ottawa Charter. National policy action was undertaken, particularly in areas such as agriculture and commerce. A key factor was the reduction of agricultural subsidies for products with high fat content, such as the percentage of fat in milk, and subsidies were moved to promote domestic berry and vegetable products.

Based on these experiences, Finland had introduced a resolution on health protection in all policies during the Finnish Presidency of the EU in 1999. This led to a number of subsequent actions within the European Community, one of the most important being the launch of sector-specific health impact assessments throughout EU policies launched in 2000. Finland built on these developments and proceeded to make HiAP a major theme of the Finnish Presidency of the EU in 2006. It engaged senior government bureaucrats and academics alike from throughout Europe in a stimulating discussion about how to deliver joined-up policies that promote the health of the peoples of the EU. At the close of the presidency a council conclusion was adopted that invited the EU to:

- apply parliamentary mechanisms to ensure effective cross-sectoral cooperation for a high level of health protection in all policy sectors
- take into account and carry out health impact assessments of legislative and non-legislative proposals

- consider the health impacts, with particular emphasis on equity in health, of decision-making across all policy sectors.[24]

The EU Presidency called upon governments across Europe to ensure that health considerations were included in all government policies. The phrase 'Health in All Policies' is now official EU policy and a key principle of the new health strategy of the EU adopted in 2007. HiAP clearly builds on the first two waves of collaborative approaches highlighted in primary health care and health promotion, drawing on their strengths and learning from their shortcomings. It is an innovative policy strategy that responds to the critical role that health plays in the economies and social life of 21st century societies in ways that take it beyond intersectoral action and healthy public policy.

HiAP represents a network approach of policy-making that accepts that there are different interests in the policy arena and considers the importance of building relationships between policy-makers in order to ensure policy outcomes. In 1997 the WHO Conference on Intersectoral Action for Health expressed this by calling for 'a new vision for health that establishes the health sector as one of a number of intersectoral players in a 'web' that makes use of new kinds of leadership, skills, information and intelligence'.[25]

Some characteristics of the third wave of horizontal health governance can be summarised as follows:

1. It introduces better health (improved population health outcomes) as a key dimension of wellbeing and defines the closing of the health gap as a shared goal across all parts of government.

2. It addresses complex health challenges through an integrated and dynamic policy response across portfolio boundaries. Health is no longer in the centre but, by incorporating a concern with health impacts into the policy development process of all sectors and agencies, it raises the importance of health issues.

3. It allows government 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 the goals of other sectors.

Horizontal health governance has become a dynamic and partnership-based policy process that is no longer driven only by the health sector but by a larger agenda that includes the contribution by health to other sectors. Recognition of what other sectors contribute to health and wellbeing is more differentiated, in terms of both explicit policy goals and indirect impact. Increasingly, the policy networks that emerge within government expand beyond government to include other societal actors, particularly in consideration of wicked problems such as obesity. We therefore see an increasing number of platforms and alliances being created in the search for solutions.

The analysis 'Crossing sectors' by the Public Health Agency of Canada confirms that the balance appears to be shifting from 'intersectoral action for health to intersectoral action for shared societal goals'.[20] This report contends that 'equity, with health as one important indicator, offers an entry point that may hold promise in many political contexts'.[20]

South Australia's HiAP approach

Recognition of a need for horizontal health governance has clearly been growing. The key concerns of many policy-makers today are questions that relate to the implementation of horizontal health governance. Those questions that need to be answered include:

- how to formulate a policy that focuses on the determinants of health
- who should be involved in formulating it
- what mechanisms are needed for implementation
- how to ensure accountability and transparency
- how to measure progress
- how to assign budgets.

SA has begun to explore how best to answer a number of these questions, for example the difficulty in how to have health issues placed on the agendas of other policy-makers who do not consider health or the determinants of health as part of their core business. Fortunately, SASP, a broad-based governance framework for the state, became part of the solution. It provided the opportunity to establish HiAP as a whole-of-government concern, which has been a missing link in previous attempts at joined-up policy. Linking HiAP to SASP became an essential element of my recommendations and final report as Thinker in Residence.

To assist in the successful delivery of SASP, the SA government set up strong monitoring and accountability mechanisms. For example, individual chief executives of government departments are held directly accountable to the Premier for the achievement of the targets allocated to their department. One of my key recommendations as Thinker in Residence was that HiAP must be driven and be seen to be driven by the key central government agency. In SA this is the Department of the Premier and Cabinet. Tying HiAP to SASP and the leadership and governance structures established to implement SASP ensured that HiAP obtained commitment from the highest decision-makers within government. HiAP is now being progressively integrated into policy and planning processes arising out of the implementation of SASP.

An important element of the SA HiAP model is the health lens concept. It is a collaborative process combining the expertise of key health personnel with skilled staff from other government agencies. It investigates the potential health impacts of particular plans and proposals, and examines the contribution of a healthier population to achieve the other agency's goal or target. A critical feature of the health lens is the two-way dynamic— how can better health support the achievement of the target and how does this target impact on health? Wherever possible, actions are identified that provide mutual benefit—both improved population health and realisation of the other agency's targets. This is one of the unusual features of the SA HiAP model—**it places equal emphasis on achieving the goals of other agencies at the same time as achieving health goals.**

Although it is still early days, the SA approach to HiAP has begun to progress in line with Ling's five critical features for success:

- working towards shared goals that are clearly defined and mutually agreed
- measuring and evaluating progress towards the goals
- having sufficient and appropriate resources available
- having strong leadership directing the team and initiative towards the goal
- working well together with a sense of shared responsibility.[26,27]

However, despite this strong start, there is much work still to be done in SA and across other international and national jurisdictions. This is especially true when trying to develop sound and effective evaluation methodology that captures the HiAP's need to be flexible, sensitive and responsive.

Final thoughts

'The landscape of public health is crowded with health problems', says Dr Chan, the Director-General of the WHO. Most countries are not well prepared for this 'crowding' of new challenges, with complex determinants and the multi-actor responses that are necessary to combat both infectious and chronic diseases.[28] In order to implement and innovate, the traditional public health system needs to move to new forms of governance and management that include and bind an increasing number of other players, such as other government sectors, the private sector, foundations, academia, the non-government sector and civil society movements.

Public health actors now include other ministries (e.g. trade, agriculture, finance, foreign affairs, education) as well as parliamentarians, non-government organisations (NGOs), private companies, research institutions and, in developing countries, foreign aid donors, regional and multilateral development banks, UN organisations, consultancy firms and philanthropy. 'From this emerges a radically new vision of public health where the "organized effort of society" is based on network governance, complexity management, relationship building and open communications. The "crowding" of health challenges, their interface and the need for rapid response also imply new forms of learning and knowledge management.' [28]

With great simplification, we could say that for a significant period in the 19th century the focus of public health was national and political, then for a large part of the 20th century it moved to being national and technical, and later to being global and predominantly technical. It is now being challenged to strengthen the political strand together with the global dimension of managing interdependence. This political action also has a new dimension: while, in the 19th century, the role of NGOs was an important feature of public health action, a new aspect today is the role of the global industry of health-related products and services, which has catapulted the health agenda into discussion of trade regimes, industry approaches to innovation and corporate responsibility.

It is imperative to underline the significance of the fact that health is now discussed in so many places at so many levels. The multitude of activities and players also constitutes a process of learning and trial and error. The goal is to find a new balance between national and global, collective and individual, state and market responsibilities for health, and to address the role and accountability of the many actors in the health arena and beyond.

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Chapter 2

Improving health equity: action on the social determinants of health through Health in All Policies

Fran Baum and Paul Laris

Introduction

This chapter is concerned with examining the links between health equity, healthy public policy and the work of the World Health Organization's Commission on the Social Determinants of Health (CSDH). Our basic starting point is that, despite significant improvements in health status over the course of the last century, health inequities persist, reflecting a failure of society to determine a means of reducing these differences between groups in the community. We are concerned with the question of how health is best promoted within a population, and how this can be done in a way that reduces the differences in health status between different groups in the community. The CSDH has presented a synthesis of the global evidence on the social determinants of health and their impact on health equity, and made a series of recommendations for how health equity can be promoted.[1] A key aspect of its recommendations concerns the need for governments to ensure that all agencies are accountable for, and aware of, their health and health equity impacts, and for a Health in All Policies (HiAP) approach to be adopted by governments and international agencies. This chapter provides a review of the persistence of health inequity; a very brief history of healthy public policy; and a description of the work of the CSDH and its applications to Australia and South Australia in particular. This latter discussion is based on the three major areas of recommendation made by the CSDH: improving daily living conditions; tackling the inequitable distribution of power, wealth and resources; and improving the ways in which we understand and measure social progress and health equity.

The persistence of health inequities

'Although some of the inequities in health outcomes are due to differences in access to health services, the majority are attributable to the conditions in which people are born, grow, live, work, and age. In turn, poor and unequal living conditions are largely the result of poor social policies and programmes, unfair economic arrangements, and politics driven by narrow interests.' [2]

A remarkable persistence in health inequalities within and between countries has been evident over the past century. Australia is no exception—while, overall, it enjoys one of the longest life expectancies in the world, Indigenous peoples and those in lower socioeconomic groups experience a lower life expectancy than other groups.[3] Thus, Indigenous peoples record a life expectancy some 17 years less than other Australians. Over the last two decades increased inequities in wealth and income have accompanied increased inequities in health outcomes,[4,5] so there is little sign that the intransigent health inequities are reducing.

Much of the excess mortality accounting for health inequities in developed countries reflects persistent chronic disease.[6,7] Evidence has been accumulating that action on the social determinants of health has the greatest potential to contribute to reducing these inequities.[1,8-11] The above quote from the United Nations Secretary-General (which directly reflects insights from the CSDH) indicates a growing international awareness of the importance of social determinants in driving health inequities. Wilkinson and Marmot demonstrated that powerful social determinants of health such as housing, education, income and access to safe meaningful work are distributed across populations on a gradient that corresponds closely to, and strongly influences, longevity and health status.[12]

Improving population health: more than effective and efficient health systems

Like other developed countries, Australia faces questions about the sustainability of current health systems. All states and territories in the last 10 years have undertaken health system reviews to address common issues: the need to constrain health spending, service fragmentation, the increasing cost of intervention technologies, the increasing incidence of chronic disease, the ageing population and a weak primary health care system. Despite the evidence on social determinants, most public policy responses have been limited to the health sector, focusing on more efficient or effective medical care. This is in spite of the fact that an emphasis on selective, vertical and disease-centred approaches has led to an unsustainable, uncoordinated patchwork of health interventions.[13-15]

The health of a society's population is at once: a public good and economic resource; a human right; and an indicator of social equity and wellbeing. Health is determined by the social, economic and physical environments in which people live and work, as well as by individuals' particular characteristics and behaviours. However, despite the obvious power of the social determinants of health, it is common for action to reduce health inequities to focus on the provision of health care services. The health care sector is largely restricted to dealing with the *consequences* of illness[16] and, despite accumulating evidence, it is still rare for health sectors to pay much attention to ways in which population health (as opposed to the health of individuals) can be promoted. Rose has demonstrated how the implementation of healthy public policy reduces the mean level of risk and thus improves the health of the population as a whole;[17] and, while it can also reduce inequities in health outcomes within the population, it may make little difference to individuals and is clinically insignificant—a phenomenon he dubbed the 'prevention paradox'.

It is clear then that a health sector committed to improving population health has to do more than provide services to treat sick individuals. Health sectors also need to adopt a stewardship role in order to promote the health of the populations they serve.[18] A re-oriented health sector with a strong focus on research, education, policy development, primary health care, community participation and Ottawa Charter-driven health, including advocating health-promoting policies to other sectors, is vital to fulfilling this stewardship role. However, as Baum et al. have pointed out, the health sector legitimacy in enabling the progress of HiAP must be exercised with care and in partnership, lest it be seen (and rebuffed) as health imperialism by other sectors.[18] Encouraging and sponsoring an HiAP response is one way in which this responsibility can be promoted.

Healthy public policy and HiAP

The World Health Organization (WHO) has defined healthy public policy thus:[1]

'Healthy public policy is characterised by an explicit concern for health and equity in all areas of policy and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives.' [19]

Thus, healthy public policy covers a broad range of activities involving most sectors of society, and aims to alter the socioeconomic and physical environments in which we live, work and play. It is based on an understanding that while the behaviours of individuals need to change in order to improve health, these behaviours are most likely to change when the sociocultural, economic and political environments are supportive of the healthy behaviours.[3] Healthy public policy has a long history, built on epidemiological evidence, social science and historical analysis. HiAP can be seen as the latest expression of this long tradition. In the 19th century Engels described the appalling living conditions of the working class in Manchester in 1844 and made the explicit link between these conditions and health.[20] McKeown demonstrated that the great reductions in mortality in industrialised countries in the first half of the 20th century had *preceded* most effective medical interventions, and argued that the causes were actually improved living standards, especially nutrition.[21] Szreter noted that improvements (largely initiated

by governments as a result of pressure from social movements) in working conditions, housing, education and other social determinants of health played a major role in the substantial gains in mortality and morbidity in the 19th century.[22]

The WHO/UNICEF *Alma-Ata Declaration* of 1978 acknowledged the importance of intersectoral action for health. The 1986 WHO *Ottawa Charter for Health Promotion* identified healthy public policy and supportive environments as the key to effective health promotion. The 1988 WHO Healthy Public Policy Conference in Adelaide concentrated on public policy impacts on population health, and built awareness of the fundamental importance of policy action beyond the health care sector. In 2006 HiAP was endorsed as a key principle of the European Union's new health strategy. Thus, South Australia's endorsement of HiAP should be seen as part of a continuing and broader trend calling for cross-government action to promote health and sustainability.

The South Australian Rann Labor Government accepted the recommendations from the 2007 Adelaide Thinker in Residence, Professor Ilona Kickbusch,[23] and is committed to the application of HiAP to South Australia's Strategic Plan (SASP). That plan calls for 'joined-up' government to work across traditional departmental silos to achieve specified targets and objectives. The development and implementation of an HiAP approach is based on mutual and complementary advantage for all sectors. It has the potential to simultaneously limit health care costs; improve economic and environmental conditions; and build social wellbeing, equity and sustainability. Thus, HiAP is a particularly well suited and timely approach for the South Australian Government. Baum concluded that ensuring action on the social determinants of health is emphatically a whole-of-government issue.[24] The geopolitical context at an international level is conducive to implementation and research and development in HiAP. This is signified by the report of the CSDH to WHO.

The WHO Commission on the Social Determinants of Health

The CSDH was set up by former WHO Director-General, JW Lee, in 2005. Its task was to collect, collate and synthesise global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity. The 19 Commissioners led a global collaboration of policy-makers, researchers and civil society organisations. They were able to combine political, academic and advocacy knowledge, skills and experience. Central to their brief was the requirement to encompass all nations at all levels of income and development, acknowledging that health equity is an issue within all countries and that it is affected significantly by the global economic and political system.

Knowledge networks spanning the globe were established to gather information on early child development, employment conditions, urban settings, social exclusion, women and gender equity, globalisation, health systems, priority public health conditions, and measurement and evidence. Other issues including food and nutrition, rural factors,

violence and crime, and climate change were considered across the nine knowledge networks. The evidence emerging from the networks was assessed by the CSDH on the basis of its scope and completeness, and its potential for enabling action to improve global health equity. Key to the question of feasibility for action was the need for implementation to be effective across different population groups and countries at different stages of development. The CSDH conceptual framework appears in Figure 2.1.
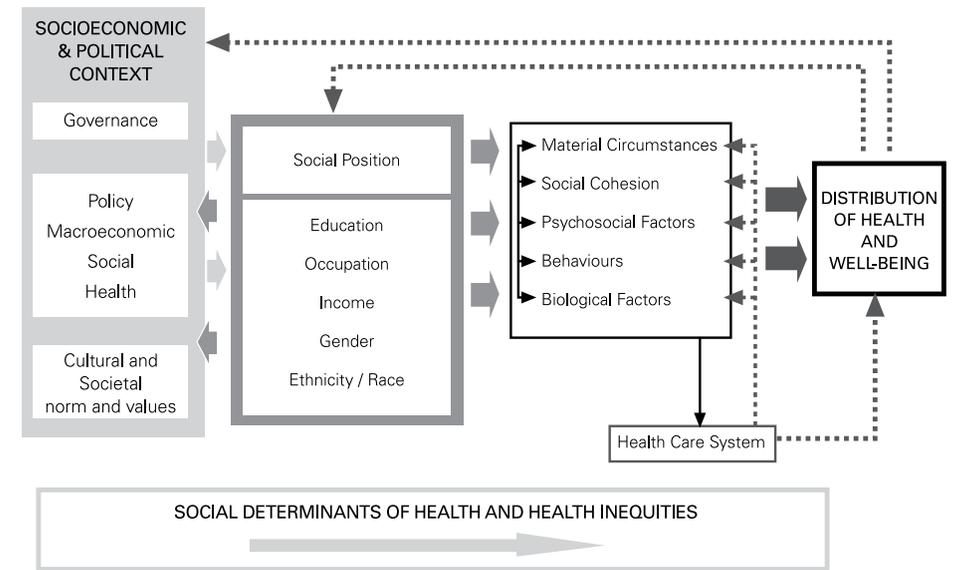
Figure 2.1: Conceptual framework of social determinants of health

Source: Adapted from WHO (2008), p.43.[1]

The model illustrates why UN Secretary-General, Ban Ki Moon, has commented so concisely '…we must remember health is an outcome of all policies'.[2] Policies in education, industrial affairs, taxation and welfare can improve access to whole-of-life education and to a more equitable labour market, and can lead to a distribution of wealth that reduces inequity. Healthy public policies in occupational health and safety, alcohol and tobacco use, and housing can reduce unhealthy exposures. Policies that give strong support to early childhood education, build families and communities, and create social capital, build resilience and reduce susceptibility to threats to health. Universal health insurance, labour market flexibility and access to transport protect against differential and adverse consequences of illness and injury. Policies that ensure access to sick care services on the basis of need; access to housing, sick leave and supportive labour markets for those with disabilities and income; and support for those excluded from labour reduce adverse impacts on the lives of individuals, families and communities.

The Commission made three overarching recommendations (Box 1).

Box 1: Key recommendations from the Commission on the Social Determinants of Health

- **Improve daily living conditions**

   Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

- **Tackle the inequitable distribution of power, money and resources**

   In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities—such as those between men and women—in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government—it requires strengthened governance: legitimacy, space and support for civil society, for an accountable private sector, and for people across society to agree on public interests and reinvest in the value of collective action. In a globalised world, the need for governance dedicated to equity applies equally from the community level to global institutions.

- **Measure and understand the problem and assess the impact of action**

   Acknowledging that there is a problem, and ensuring that health inequity is measured—within countries and globally—is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

Source: WHO (2008), pp. 202–206 [1]

What the Commission on the Social Determinants of Health has to offer South Australia's HiAP approach

The CSDH's overarching recommendations translate readily into the national and South Australian contexts. SASP provides a major resource for South Australia in addressing the social determinants of health and sets the stage for the HiAP approach. The plan's

approach has been used to direct government activity across sectors, and most of the areas of activity have direct implications for health. It includes health equity and social inclusion targets. The Office of the Department of the Premier and Cabinet (DPC) has been a strong supporter of the HiAP approach, describing SASP and HiAP as perfect partners, and arguing that HiAP provides a model for ensuring that decisions made in any one arena are done with the full knowledge of likely impacts across a range of considerations.[25] HiAP is relevant to each of the six objectives of the plan: Growing Prosperity, Improving Wellbeing, Attaining Sustainability, Fostering Creativity and Innovation, Building Communities, and Expanding Opportunity.[24] The Department of Health website states, 'A series of equity actions have been identified to enable the SA health system to address the social gradient affecting the health targets of South Australia's Strategic Plan (SASP)'.[26]

The Social Inclusion Initiative (SA Department of the Premier and Cabinet 2009) gave legitimacy to community work that focuses on including people in disadvantaged circumstances in service provision or community activity as pathways to education or employment.[27] The initiative works by identifying population groups at risk and facilitating 'joined-up responses that cut across and through government departments'.[28] This approach is being replicated nationally with the establishment of the Australian Social Inclusion Board. The social inclusion agenda is ideally suited to implementing key areas of the CSDH's recommendations, particularly those relating to improving the settings of daily life for disadvantaged groups.

HiAP adds the third leg to the policy tripod by providing a health outcomes dimension to SASP that extends beyond the health care sector, and a health equity dimension to the work of the Social Inclusion Initiative with disadvantaged population groups. It adds weight and rigor to the process of implementing, monitoring and evaluating SASP by highlighting the health gains of good policy.

The following section looks at each of the CSDH's recommendations and provides some ideas about how they might be applied in Australia and South Australia.

Application of the CSDH recommendations to Australia and South Australia

Key recommendation 1: improve daily living conditions

This set of recommendations builds directly on the various healthy settings movements that have been implemented over the past two decades, including Healthy Cities, Healthy Schools and Healthy Workplaces. The HiAP approach provides an umbrella for a range of initiatives in various sectors that can build on and complement past experience with healthy settings programs. Table 2.1 provides a range of examples of the policies that we consider would improve daily living conditions across the populations and particularly work to improve health equity. Some of these suggestions will receive more widespread support than others. Like all policy suggestions, they are based on a set of

values concerning how society should operate and there is unlikely to be consensus on the suggestions or the values underpinning them. Thus, we call for universality as a condition of social protection policies. Yet recently in Australia this principle has been undermined in the Northern Territory Intervention,[29] whereby welfare payments in certain Indigenous communities have been conditional on the school attendance of children. Each example of HiAP is likely to give rise to debate about preferred policy options.

Table 2.1: Improving daily living conditions

Target areas	Example of application to Australia
Equity from the start (including physical, social/emotional, and language and cognitive domains) to ensure that all children reach their potential	• Ensure coherent policies between sectors for early childhood and through the school years. • Implement generous parenting leave. • Develop policies to support parents. • Focus on public health perspectives on child support and protection
Healthy places—healthy people	• Introduce major initiatives to change urban planning to encourage physical exercise, and use planning regulations to control fast food and alcohol outlets. • Put health equity at the heart of urban governance and planning. • Develop a range of healthy settings initiatives including healthy and sustainable communities based on local government, state government and NGO cooperation.
Fair employment and decent work	• Introduce policies to reduce health impacts of precarious employment. • Safeguard occupational health including exposure to material hazards and psychosocial impacts. • Encourage healthy work-life balance.
Social protection across the life course	• Aim for universality, rather than targeting and conditionalities, in social protection payments. • Increase generosity of family policy. • Maintain and extend Medicare (including to dental services). • Create citizen debate about how health service spending can be curtailed. • Achieve a demonstrated shift of health dollars to primary health care and health promotion.

Source: adapted from Baum (2009)[24]

Key recommendation 2: tackle the inequitable distribution of power, money and resources

Table 2.2: Tackling the inequitable distribution of power, money and resources

Target areas	Example of application to Australia
Health equity in all policies, systems and programs	• Adopt an across-government Health in All Policies initiative led by the state Premier's Departments or the Prime Minister's Department. • Adopt a social determinants function across policies and programs by health departments, and a stewardship role to support this approach across government.
Fair financing	• Adopt the Henry Review of taxation, which leads to more progressive taxation. • Advocate for global financial mechanisms to ensure funding for global action on the social determinants of health. • Increase expenditure on overseas aid to 0.7% of GDP.
Market accountability	• Ensure that basic services essential to health (water, sanitation, power supply, health services) are publicly run and accountable. • Encourage citizen debate about public ownership of assets and the need for regulation to control private sector activity.
Gender equity—tackling gender bias in institutions	• Increase female representation in parliaments, governments and boards of management. • Assess broader family and work policies to ensure they encourage gender equity. • Continue work to reduce gender-based violence.
Political empowerment, inclusion and voice	• Work to improve operation of parliamentary democracy. • Encourage genuine rather than token participation in government decision-making. • Fund independent bodies to support citizen participation.
Good global governance	• Australia to support the development of a global architecture of regulation. • Australia, as a Member State, to strongly encourage WHO to adopt a social determinants of health approach in all its policies and programs.

Source: adapted from Baum (2009)[24]

This section of the recommendations from the CSDH reflects the recognition of the Commission that the health status enjoyed by a country or groups within countries very significantly reflects economic and political factors. This point was emphasised by the WHO Director-General, Dr Margaret Chan, in a speech to the General Assembly of the United Nations when she said:[1]

'Political decisions ultimately determine how economies are managed, how societies are structured, and whether vulnerable and deprived groups receive social protection… with the global financial system on the verge of collapse, is it not right for health and multiple other sectors to ask for some changes in the functioning of the global economy?'

Her comments support the view that if an HiAP approach is to be successful in promoting health, and especially in promoting a more equitable distribution of health, it will principally be a result of political decisions that are made explicitly in favour of health. This recognition brings into very sharp relief the fact that healthy public policy and HiAP must be concerned with issues of power and the interests of a wide range of players. Policy-making is complex, and policy agendas are shaped and change in response to ideas, different interests and institutions.[30] Healthy public policies can threaten established interests and so usually require advocacy from interest groups and political sponsorship to be successful. Thus, tobacco reduction schemes are opposed by tobacco manufacturers, gun control by a powerful gun lobby, and restriction on the advertising of fast food to children by the manufacturers and retailers of that food. In almost every instance in which healthy public policy is relevant there will be a myriad of voices, vested interests and perspectives that interact to produce policy options. If a government is committed to an HiAP approach, as the South Australian government is, it increases the likelihood that population health considerations will receive crucial political and bureaucratic sponsorship. The case studies elsewhere in this volume provide examples of the complexity of implementing an HiAP approach.

Key recommendation 3: measure and understand the problem and assess the impact of action

Measuring for change is not merely an issue of using the right measurement tools but, more fundamentally, of reconsidering what it is we should usefully be measuring. Measures of health have tended to focus either on outcome indicators such as mortality and morbidity, or on outcomes for sick care services such as waiting times for elective surgery and comparative outcomes of treatments. Baum et al. have referred to this as 'the dominant biomedical imagination of health';[18] by contrast, positive measures of health (the salutogenic model) have received little attention.[31]

Similarly, while economic growth has been widely seen as necessary to social wellbeing, purely economic measures such as gross national product (GNP) merely plot market activity and are inadequate in acknowledging or valuing the health of the population, the quality of education, the vibrancy of culture, the sustainability of human life or multiple

other aspects of human wellbeing. The CSDH suggests that health equity is a good measure of the social and health progress of a society and should be adopted alongside economic measures of wellbeing. In Australia equity is not often set as a target of government. However, SASP does include equity targets in relation to Indigenous health, and the federal government has established closing the life expectancy gap between Indigenous and non-Indigenous Australians as a goal of the Council of Australian Governments.

Few nations have adopted measures that integrate economic, social and health indicators and acknowledge their fundamental connections. Indeed, an unquestioning dedication to economic growth per se by governments and mass media has been critiqued as part of the problem, contributing to widening equity gaps, dangerous climate change, and mental and social health problems.[3,5] In response to these challenges, a number of broader measures of national progress have been developed. These are characterised by combining a range of indicators that span various sectors and are well suited to monitoring the progress of an HiAP approach. Already, in South Australia, SASP provides an example of the sort of development agenda that could dovetail effectively with such alternative indicators.

France has recently released a report commissioned by President Nicholas Sarkozy that reviewed a wide range of progress indicators.[32] The report's authors noted the inadequacy of traditional, narrow economic indicators in predicting the impact of the global financial crisis or in developing responses to its impacts. They propose a model that includes a much broader range of social and life satisfaction measures. A range of alternative means of measuring the overall progress of a society that offers much more than a reductionist and crude economic measure are being developed around the world. One such example is the Happy Planet Index, which combines life satisfaction, life expectancy and ecological footprint (Marks et al. 2006).[33] South Australia is in a good position to be a world leader on alternative measures of societal progress using SASP as a basis for the development of measures.

Conclusion

An HiAP approach provides an additional level of legitimacy for policy-makers working to improve population health. It enables further recognition of the social determinants of health and a pathway for governments to take action to make positive changes in them. There is scope for the HiAP approach to incorporate a more explicit equity agenda and to define the ways in which each area of action under the initiative can aim to make a contribution to health equity and population health overall. It has the potential to challenge the predominance of neo-liberal policies that privilege growth in economic activity above all else and dominate public and political arenas. Recognition by leaders such as Kevin Rudd[34] of the failings of such policies opens the agenda for greater acceptance of the importance of the social determinants of health and the opportunities represented by an HiAP approach.

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Chapter 3

Health is not just the absence of illness: Health in All Policies and 'all in health policies'

Geoff Mulgan

Introduction

This paper provides an overview of the links between health and other policy fields. It draws on experience within several governments of attempts to design and implement various tools for 'joined-up government'; and on recent work on service innovation relating to issues affecting health where health services play a relatively marginal role. It focuses on the ways in which public policy can promote positive health as well as dealing with disease. It also discusses the many ways in which health can become part of the agendas of other parts of government, and how their perspectives can become part of health thinking.

The idea of seeing health care in the round is not a new one. The 1930s, for example, saw many bold experiments in holistic health care. One, in London—known as the Peckham experiment—`started when two radical doctors set up a Pioneer Health Centre in a poor neighbourhood, designed not just to treat the sick but also to promote health.[1] They started from the idea that health was, like a disease, something that could become contagious. The doctors were convinced that they needed to make the whole environment healthy, and so the centre included a pool, a gym, a creche, a library, a café with local food, and a remarkable range of activities. Unfortunately, the experiment, never popular with the medical establishment, was closed in 1950, soon after the creation of the National Health Service. Although there was no formal evaluation, the babies born to Peckham mothers proved to be remarkably healthy, and the experiment continues to be remembered as a beacon of creative thinking about how a whole environment could be made to enhance health.

The tools for horizontal government

My own interest in 'health in all policies' comes in part from being involved in many experiments with new structures, processes and cultures to mitigate the vertical silos into which modern government is typically organised. It has long been evident that many of the factors that most powerfully shape health are well beyond the reach of health services, including everything from regulations governing air quality to the availability of addictive substances.

During most of the 20th century, governments were founded on ever more complex divisions of labour, with specialist departments and agencies. They were largely organised vertically, connecting ministers at the top to professionals delivering services to a largely passive public. However, the later years of the century brought a return to interest in alternative models of organisation of government—for example around client groups (children or the elderly), tasks (such as reducing regional inequalities) or places (e.g. with a single representative of national government having wide-ranging powers in an area, as in the model of the French 'prefet').

Holism of this kind was encouraged by rising attention to issues that clearly affected many different departments. These included the environment, climate change, social policy, competitiveness and equality, as well as health. Many tools have been used to mobilise the many arms of the state in horizontal ways, including cross cutting budgets, teams and networks, as well as the more traditional mechanisms of interdepartmental committees. The UK has experimented with:

- cross-cutting policy teams—on social exclusion, teenage pregnancy and health inequalities
- implementation teams—on rough sleeping, with a significant component for issues of mental health and alcohol
- budgets—on post-conflict reconstruction and drugs
- roles—e.g. giving a head of e-government a double key to ensure that all IT projects are interoperable
- training programs—e.g. encouraging police officers to train alongside other professionals
- data systems—e.g. for children at risk.

Around the world there has been no shortage of experiments in joined-up policy initiative. In Scandinavia many governments (e.g. the Swedish) have pioneered new ways to connect budgets to outcomes, and cross-cutting programs with strong political leadership to force government to behave in more holistic ways (as in Finland in the 2000s). Singapore has pioneered integrated accounts for citizens, while the US has arguably gone as far as any in trying to integrate diverse agencies into mega structures (e.g. the Department for Homeland Security). Impact statements have been a preferred tool in some countries for health, the environment or equality, alongside legal requirements to consider the impacts of decisions on particular issues.

With all tools of this kind there are both gains and risks. The gains are greater sophistication, systems thinking and, hopefully, a reduction of unintended consequences. The risks are those of excessive bureaucracy and transaction costs, and the danger that any agency that tries to do too many things ends up doing none of them well. Hence, there is a need in any system to be highly selective in setting cross-cutting goals, and economical in the use of tools.

The evolution of health care: new knowledge, rising demands and more open systems

Tools of this kind are almost bound to become more important to health care. It is hard to envisage any scenarios for health care over the next two to three decades that do not involve, alongside a steady stream of clinical discovery, new understandings of genetic dispositions and new treatments, and a growing attention to self-care and mutual care. Needs and demands for care look likely to rise faster than the capacity of taxpayers to pay and professions to provide. This is primarily the result of ageing and the rising incidence of long-term conditions. In some countries the economic pressures will be intense—the Congressional Budget office predicts a rise in US health care costs from 16% of GDP in 2007 to 25% in 2025 and 37% in 2050.[2]

Simply expanding existing models of care in response to rising demand looks implausible. Instead, many governments will have no choice but to shift their attention to alternative tools for enhancing health. They will need to mobilise the resources of the community and the environment; and complement the knowledge of the professions with other sources of guidance in an environment in which there may be fewer clear boundaries between experts and non-experts. Certainly, the World Health Organization (WHO) believes that, because of demographic and lifestyle changes, chronic conditions will be the leading cause of disability by 2020, and that 'any 21st century health and social care service will have to make greater use of technology; deliver care closer to, and sometimes in, the home; and make increasing use of people's capacity to care for themselves whilst offering them appropriate support'.[3]

These triple trends that are reshaping health—new knowledge, rising demands and more open systems—are not absolute certainties but high probabilities. They imply, as many have argued for decades, the unavoidable need for a parallel increase in both the quality of health care provision and the responsibility taken by citizens themselves and their friends and family.

Good health—holistic perspectives and policies

These three trends will have many effects, but one is already very present—how most people now think about health. In most health systems good health means not being sick. But in daily life being well is not just the absence of illness. Instead, health exists on a continuum from being very sick to very well. This is a very old idea, certainly

found in ancient Greece and Rome and also in China. Most writers about health were concerned with the habits that would make people thrive. Dietetics was concerned with how to shape ourselves through exercise and eating habits so as to achieve the greatest possible wellness of both mind and body. It was assumed that inner health —confidence, optimism and a positive outlook—would protect the physical body from illness and help it recover fast.

These ways of thinking about health have a very long lineage but were rather marginalised as modern health systems took shape to cure illness or prevent it. And, of course, dietetics was not much help if you were suffering from TB or a malignant tumour. Yet, perhaps as a consequence of success in dealing with so many other aspects of disease, these issues are returning. Science is exploring what it means to be very healthy as well as what it is that helps people bounce back from disease, shock and trauma. In some hands this is a purely physical question (see, for example, Ray Kurzweil's influential writings on how to greatly extend longevity[4]), while in others the mental and physical are seen as closely intertwined.

A mounting body of evidence is showing the importance of optimism for recovery.[5–8] There is also strong evidence that, for example, negative emotions such as anger, anxiety and depression significantly increase the risk for cardiac events, and that exercise is often more effective and cheaper than drugs for conditions as varied as diabetes and depression.

We can expect more data and more insights, including fresh analysis of the long time series data sets on health, for example, to help understand the dynamics of positive health. This work is likely to point in similar directions to the vast range of evidence on the importance of social networks for longevity and recovery (e.g. the Framingham study's evidence on the ways in which conditions such as obesity spread along social networks),[9] and the very suggestive evidence on the importance of status and self-worth explored so imaginatively in Michael Marmot's WHO Commission on the Social Determinants of Health.[10]

This research confirms that health and illness are related but different, just as mental health is not just the absence of mental illness. The correlation between 'happiness' and depression is not minus 1.0—rather, it is closer to minus 0.35. Mental illnesses damage, but do not exclude, positive engagement, relationships and meanings.

Looking to the future, we may find that interventions that encourage mental health and an optimistic and positive outlook on life may achieve impacts not just on physical and mental health, but also on the economy (through higher productivity and lower absenteeism) and on crime (through reducing violence). For now, the evidence is tentative, but this should be a priority for research.

Resilience—personal, networked and structural

For anyone concerned with the design and delivery of health care, these are fascinating but also challenging findings. They force us to pay attention not just to care and cure,

but also to what might be termed inner health—the ability to withstand threats. This involves action on at least three levels:

- self: strengthening personal resilience, the dispositions and contexts that help patients to recover from setbacks and disease, and modes of diagnosis that attend to these

- support: mobilising all the resources that surround a patient—friends, family, support networks—that may be decisive in supporting recovery. Recent research on isolation and loneliness has shown that their absence can be decisive in accelerating both psychological and physical decline

- structures and systems: improving the structural conditions that influence resilience — the existence of rights to care, economies providing opportunities and recognition, and salutogenic environments. These conditions include overall levels of equality and the fundamental political settlements that different countries have struck.

Health systems are very familiar with delivering services to individuals and, to a lesser extent, with whole population strategies. It is the space in the middle which is arguably least familiar—how to mobilise networks of support or influence.

Ageing and Health in All Policies

The continuing evolution of policies for ageing reinforces the importance of a Health in All Policies (HiAP) approach and the interaction of the above three levels of action. On the one hand there are the medical interventions—to arrest dementia, tackle physical disabilities and shift the balance of morbidity and mortality to achieve more disability-free years of life. On the other hand there is the growing raft of policies to promote active ageing—easier options for employment, volunteering, age-friendly cities, intergenerational programs and befriending services. Many emphasise increasing activity in the earlier stages of old age in order to improve resilience and health.

Some are very much focused on individuals, for example brain exercises, physiotherapies and treatments. Some are about structures and environments, for example legal requirements for public buildings or transport networks to be used by people with disabilities. But many fall in the middle space, and research on the daily life of older people confirms the importance of these intermediate spaces, for example the critical role played in some communities by cafés, bars or grocery stores in providing both services and companionship.

Examples of interventions in these spaces include:

- projects using social network technologies to integrate formal and informal care, with shared scheduling of visits, reminders on prescriptions etc.

- proliferating technologies for the home—from monitoring devices and alarms to fingerprint readers—that also involve friends, family and neighbours

- trust devices to ensure that more people coming in and out of homes, whether for maintenance or meals, are trustworthy

- transport models that aggregate public and private vehicles to help with mobility
- uses of the web to aggregate cooking facilities and link food provision to older people's health needs.

Most of these have arisen from voluntary organisations and social enterprises rather than out of clinical practice, but they are increasingly being integrated into care pathways and the work of primary care deliverers.

Salutogenic environments

The other great shift is towards thinking about how whole environments shape health—as in the Peckham experiment.[1] Salutogenic environments (a concept promoted by the International Academy of Health Design), as well as various WHO initiatives, have many dimensions. They include physical design (e.g. achieving the right designs to encourage 'eyes on public spaces' and easy social interaction, but also spaces for privacy and separation); the nature of transport provision (e.g. ensuring that it is easy to bicycle or walk, with cities as diverse as Copenhagen and Bogota pointing the way forward); the media environment and the implicit messages of advertising and products themselves; and the environment in the traditional sense of clean air and safe water. We could also add to these environmental issues others such as the relative prices of healthy and unhealthy products or services, as shaped by taxes and regulations.

At each of these levels of action—self, supports and structures, or systems—agencies other than health services can play decisive roles. At the personal level schools and welfare services arguably play a bigger role in shaping individual resilience than health care institutions, as well as playing direct roles in relation to such things as school food. At the social level many parts of the public sector provide some kind of one-to-one support, which in some cases is consciously linked into family and other networks (e.g. the Harlem Children's Zone in education[11] or the Reggio Emilio model of childcare).[12] At the structural level departments for planning, transport, education, security and welfare all have obvious roles to play.

Behaviours for health

These new health lenses have encouraged ever greater interest in how behaviour can be influenced beyond the provision of health as a service. I commissioned and co-authored an overview of the state of the field at the UK Prime Minister's Strategy Unit in 2002, but at the time was struck by how uncomfortable most of government was with this way of thinking.[13] The award of the 2002 Nobel Prize for Economics to Daniel Kahneman significantly raised the profile of behavioural economics[14] and, more recently, Cass Sunstein and Richard Thaler's *Nudge* became a best-seller.[15]

There are several main insights from this body of work that are now widely accepted, even if the experts differ on the precise mechanisms. They have obvious implications for the HiAP movement, at least in the most prosperous societies. This evidence confirms

that people tend to over-discount the future, for example putting too much weight on the pleasures of excessive drinking now, against the risk of the potential health problems that could result later in life (or even the risk of being injured in a fight or accident on the way home from the pub). We pay more attention to potential losses than gains. We make decisions using both our rational conscious brain and our 'automatic processing system', the parts of the brain that make decisions unconsciously or subconsciously. The most powerful interventions address both.

How we behave is influenced by contexts and 'choice architectures'. A teenager may know about contraception but may push that knowledge to one side when drunk. When trying to change habits, such as smoking or excessive drinking, people often need personalised plans that help them think through how to deal with difficult situations, such as social occasions where they are used to smoking or drinking excessively. Similarly, the precise context in which choices are made can be important—people can be 'nudged' towards better choices through everything from portion sizes in cafeterias to making particular kinds of pension the default option. Incentives can play a part in shaping behaviour, as has been shown by many experiments with smoking cessation and diet, albeit with questions about sustainability.

If there is one lesson from the research, however, it is that changing the environment in which people live and work is often the most powerful way of influencing their behaviours. Information campaigns, by contrast, rarely have much impact, at least on deep-rooted behaviours. At one extreme, banning smoking is bound to have more impact than any number of taxes or public health campaigns. Reducing the presence of fast-food outlets near schools is a less extreme example, as are regulations that require parents to drop off their children at least 500 m from the school to encourage walking. However, changing environments tends to be the most controversial of the available options for governments, requiring the longest build-up of scientific evidence and at least some consensus that the absence of restraints will cause harm to third parties.

Innovation and HiAP

The contribution of other departments and agencies to health remains at an early stage. There are relatively few strongly evidenced policies, which is an inevitable consequence of the fact that the samples are small. As a result, this is a classic field requiring systematic innovation, experiment and assessment. Unfortunately, there is a strong bias against adequate investment in pilots of this kind. The great majority of spending for health innovation is controlled by clinicians or big business, the former being most interested in new procedures (such as surgical procedures) that can take place within health care settings, and the latter being most interested in replicable and scalable models for individualised interventions (such as new drugs). In the UK, for example, barely 2% of health R&D is invested in prevention. The traditional types of R&D will undoubtedly continue to achieve advances, but any examination of living health systems confirms that many different types of innovation are contributing to health gain. Innovations in policy, service, behaviour change and environments may be just

as important in achieving outcomes. Which channels get the most private investment is strongly shaped by the particular conditions of markets (e.g. which drugs meet the needs of rich people, with highly repetitive uses, and with strong intellectual property control), whereas which channels get the most public money is more easily explained in terms of power, tradition and access rather than science or evaluation.

That other kinds of innovation are cost effective should not be a surprise. The greatest success of health in the last half century—the elimination of smallpox—was described by the WHO's Dr Mahler as a triumph of management, not medicine. The greatest single step forward of the last decade—bans on smoking—was helped by clinical evidence but was a political innovation, not a clinical one.

It follows that we need a more pluralistic approach to innovation that deliberately works on many fronts simultaneously while building up a more solid evidence-base on which innovations deliver the most 'bang for the buck'. These will include science-driven, university-based R&D; professional practice and professionally led continuous improvement; and formal pilots and randomised controlled trials. But they will also include experimental service innovation, social entrepreneurship, the use of open innovation methods of the kind increasingly common in other fields, and innovation in which patients and the public play a leading role. And they will require the right mix of support for these very different types of innovation—from pure grants for speculative research, through convertible grants and loans, to equity.

Some of these patterns are being developed in innovation funds such as Tekes and Sitra in Finland[16,17] and the UK National Health Service.[18] They generally require more systematic and open ideation phases in which ideas from many sources are gathered and developed; new roles to develop ideas, such as 'social entrepreneurs in residence' located within commissioning bodies; and then stage-gate processes that take them through trials and pilots to large-scale projects.

Holistic approaches to holistic policies

How can HiAP be advanced? One perspective sees HiAP primarily in top-down terms —integrating health into formal strategies and budgets of governments at all tiers, reinforced by impact statements and monitoring mechanisms (units, committees etc.). These can all play their part, but the goal of HiAP cannot be met by policy-makers and governments alone. As the previous examples have shown, the next stages of health care will involve much more collaboration with NGOs, the media, business, social movements and citizens themselves, which will require governments to help create the conditions in which it is easier for them to act. And it will also require new institutions that straddle sectors, for example connecting social enterprises into strategic planning processes, or patient groups into service design.

In other words, HiAP cannot simply be a means for health knowledge and principles to be applied elsewhere in public policy. It also requires 'all in health policies' which may be an even more challenging concept. It implies models of care that are more about 'with' —doing things with other providers and with citizens, rather than to them or for them.

As with HiAP, there are both costs and benefits in new kinds of collaboration. Specialisation brings huge gains, and in some areas of health care there may be a need for further specialisation (e.g. specialist teams focused on particular conditions providing advice over large geographical areas in place of support from generalist primary care providers or hospitals). But in some of the fields offering the greatest potential for advance, including public health, the gains from HiAP and 'all in health policies' look likely to outweigh the costs.

Wellness and holism

Martin Luther King said that 'peace is not the absence of war but the presence of justice'.[19] Health is not just the absence of disease, but the presence of vitality and thriving. Fortunately, we now have ways to make these more than mere words. We know more about the interaction of mental and physical health; more about how to be very well, not just well; and more about wellbeing, including the evidence that happy nations seem to have higher life expectancy when other variables are stripped away (and, even more intriguingly, that blood pressure and wellbeing are inversely correlated). We are also learning ever more about the interactions of individual health and the health of whole populations, as well as the environments in which we live, even if many profound uncertainties remain (e.g. on the causal links between inequality and poor health outcomes). Policy and delivery have lagged behind this new knowledge. But it's now time to catch up.

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Section 2

Health in All Policies: international perspectives
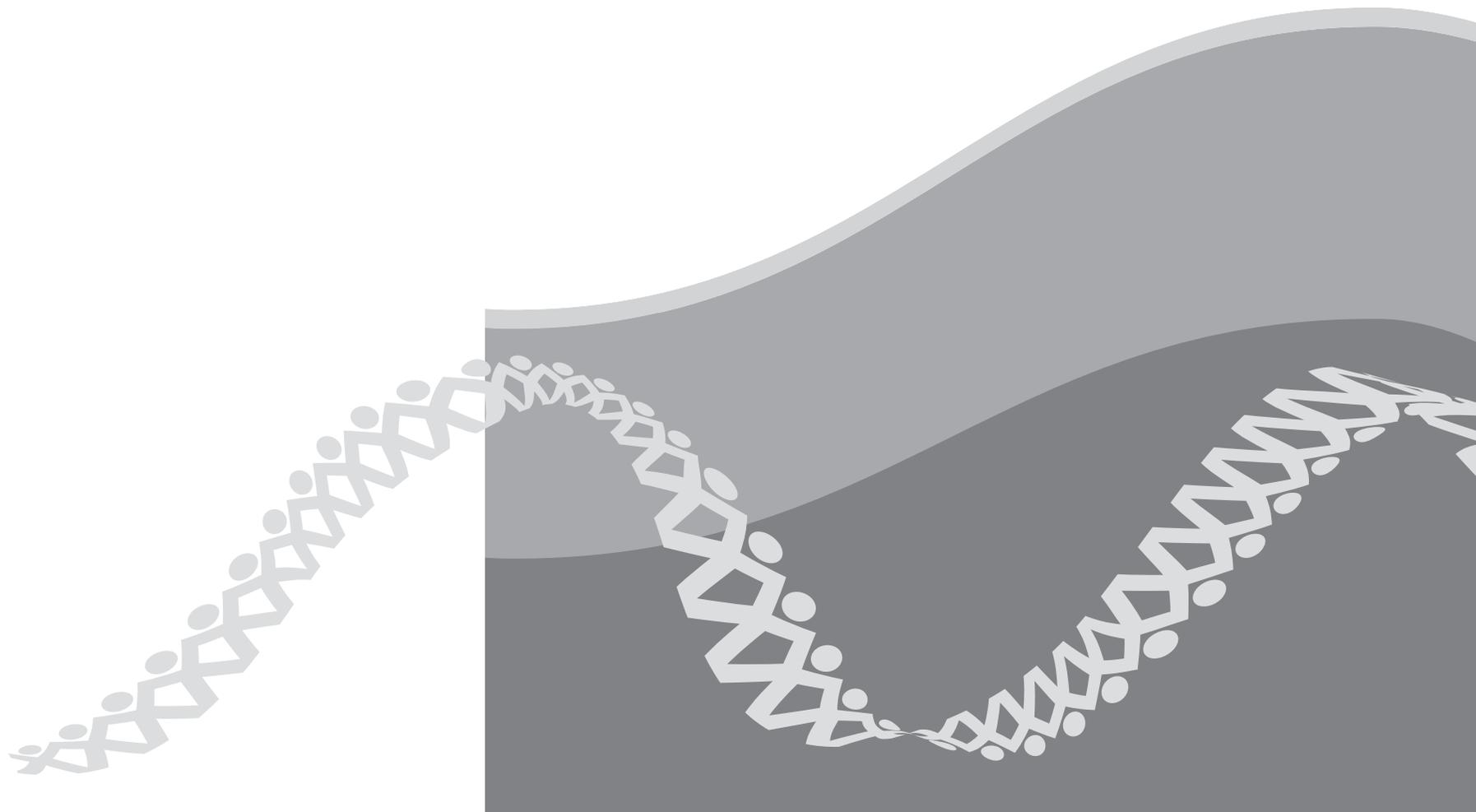
Chapter 4

Health in All Policies in Europe

Matthias Wismar and Kelly Ernst

Introduction

South Australia (SA) has embarked on a 'proof of concept' trial of a Health in All Policies (HiAP) model that aims to integrate health concerns into other areas of public policies. The SA model is based on a whole-of-government approach that includes several elements:

- a comprehensive across-government and community strategic plan[a] featuring 6 objectives and 98 targets

- an overarching mandate for the application of HiAP to this state plan at cabinet level

- coordination between the Department of the Premier and Cabinet (Cabinet Office) and the Department of Health

- the flexible application of various governance tools

- dedicated resources for a small team acting as a reference point for HiAP activities.

While the SA model for HiAP is still under development, it is at the same time subject to continuous evaluation (the SA model is discussed in more detail in other chapters in this book).

Recent developments in SA have been followed with great interest in Europe, both with regards to scientific debate and policy-making. The developments in SA are paralleled by a resurgence of interest in the concepts and practice of intersectoral policy-making in Europe.[1] Member States of the European Union (EU) have adopted Council conclusions on HiAP at the EU level,[2] and, as stipulated in the Rome Declaration, have pledged to emphasise HiAP at the country level.[3] The Member States of the WHO European Region have also included HiAP in the existing European Health for All Policy.[4]

This chapter is aimed at the exchanges between countries of experiences on the application of different models and approaches in HiAP. A brief insight is provided into the continuities, novelties, contexts and drivers for HiAP in Europe, followed by an overview on the governance tools and frameworks for HiAP used in Europe.

[a] *http://saplan.org.au/component/option,com_frontpage/Itemid,1/*

Health in All Policies in Europe: continuity, governance, context and demography

Europe has a long history in addressing the social determinants of health. The more recent part of this history has been in close communication with global developments. The Health for All (HFA) policy of the WHO Regional Office for Europe is an important milestone of this continuity. In 1980 the Regional Committee for Europe approved a European strategy for attaining health for all by the year 2000. The first HFA policy and targets in support of the regional strategy were adopted in 1984, and in 1998 a revised European HFA policy framework, entitled Health21, was adopted.[4] The European policy was developed in parallel with the global HFA policy, which was inspired by the Canadian health policy developed under the Minister of Health, Marc Lalonde.[5] Moreover, Europe has a close exchange with other regions based on the international health promotion conferences that were instrumental in propagating key concepts such as healthy public policy and the whole-of-government approach.[6] And, of course, the recent report of the WHO Commission on the Social Determinants of Health[7] has also been very stimulating in Europe.

The HFA policy is built on the long tradition of stressing the linkages between social determinants, inequities and health. Important milestones were set in the mid 19th century. Fredrick Engels's analysis of 'the condition of the working class in England', first published in 1845, counts as an early example. While the described conditions no longer exist in England, the approach is still deemed valid.[8] Not much later, Rudolf Virchow founded the field of 'social medicine', with the aim of understanding how social and economic conditions impact health, disease and the practice of medicine, and how to foster conditions in which this understanding leads to a healthier society. He fought for improving the health of the population both by means of science and in the political arena. Similar developments around the time were observed in other European countries.

Following this long history of addressing the social determinants of health comes HiAP, with a new emphasis on governance. The aim is to reach out to other ministries and sectors to develop and sustain dialogue on the health-related aspects of all policies, as they are the entry point for changing the determinants of health. Policies on agriculture, education, housing, labour markets, transport, taxation and other areas shape the social determinants of health, and changes in these policies may therefore impact on the health of a given population. Many polices relevant to health are outside the remit of the ministry responsible for health, and most social determinants are found in other sectors. In this regard it is not so much the ministry of health that is presenting an intersectoral health policy but, rather, the integration of health in the policies of other ministries. In order to do so, HiAP emphasises the governance tools and frameworks that can help to establish dialogue with other ministries.[9–11]

Europe has a rather unique governance context that is set by European integration.[12] Today, the reach of Europe continues to grow, with 27 EU Member States and a population of 494 million. Many policies are decided or co-decided at the European institution level, for example heart health,[13] health in the world of work,[14] working conditions,[15] food and agricultural policies,[16] alcohol control,[17] and environment and health.[18] This implies that HiAP as a governance tool does not only need to reach out to other ministries and sectors, but also needs to operate effectively in multilevel governance systems.

In this European governance context the term Health in All Policies has been coined. It was first introduced in the course of the revisions of the treaties on which European integration is based. In 1993 public health as a policy was added to the competencies of the EU. The mandate was, and still is, limited, but it does provide leverage for intersectoral activities at the EU level. As Article 152 of the European Community Treaty states: '[a] high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'.[19]

Another Europe-specific aspect—the demographic change and related concerns about the future of Europe—is the main driver for HiAP[20] Europe has reached unprecedented levels of health and wealth, but this success cannot be taken for granted. There are worries about a new, emerging scourge, but in particular the debate is focusing on the demographic change in European societies, which are ageing and shrinking. If unaddressed, these changes will result in severe consequences for health and wealth in Europe. Labour market participation may dwindle, productivity may decline, tax revenues may contract, the ageing population may be in need of more health services, and chronic diseases will be on the increase. It is this agenda, as stipulated in the Tallinn Charter and acclaimed by the Member States of the WHO European Region, to which HiAP intends to make a contribution.[21]

The health and wealth agenda is based on the scientific evidence that health is an investment and not just expenditure. Healthier populations are more productive, they participate in the labour market better and they gain higher income.[22–24] In fact, there is also evidence that social inequities in health are expensive and detrimental to economic aims.[25] In this respect a healthier population can contribute towards maintaining the high levels of wealth and compensate for some of the effects of demographic change. It is hoped that the economic argument functions as the lingua franca of HiAP, a language that can be heard and understood across all ministries and sectors, and that lends itself to joined-up government action on health and equity.

Governance tools and frameworks for HiAP

Whole-of-government approach

Important recent examples of the whole-of-government approach for HiAP in Europe can be found in England,[26–28] Finland,[26,29,30] France,[31] the Netherlands,[32] Norway,[26,33] and Sweden.[26,34–37] These countries use combinations of governance tools such as policy formulation, target setting, public health laws, cabinet level coordination, interdepartmental committees, horizontal and vertical coordination mechanisms, public hearings, cross-departmental spending reviews and new forms of intelligence provision in a relatively coherent government framework. They use these tools in order to reach

out to other ministries and sectors to integrate health in other policies. This may happen at the government or cabinet level, between ministries or in partnership with regional and local authorities.[26,38]

The Finnish model

Finland has formulated intersectoral health policies that address the social determinants of health since 1986. The current policy, Health 2015, is seen as a cooperation program that provides a broad framework for health promotion in various areas of society, reaching across different sectors of administration. Financing for this public health policy is ensured by a special budget specified through intersectoral action plans such as the National Action Plan to Reduce Health Inequalities, produced in 2008.

One of its most important coordination mechanisms is the Advisory Board of Public Health. There are about 17 members on this council from all sectors of government and non-government organisations, research institutes and municipalities. A permanent secretariat with experts supports the committee's work.

Collaboration in health is also fostered by intersectoral policy programs that are overseen by the Prime Minister's office. The policy program for health promotion, launched in 2007, is one of three intersectoral programs making up this initiative that aim to foster, among other things, the implantation of subnational health programs.

The 2006 revised Public Health Act also requires intersectoral action in health promotion at the local level, and the use of health impact assessment is encouraged.

The Ministry of Social Affairs and Health entrusted research institutes such as the National Public Health Institute (KTL), the National Research and Development Centre for Welfare and Health (STAKES)[b] and the Finnish Institute for Occupational Health with the task of developing the tools needed for implementing and monitoring actions defined by the public health policies and programs. Among them are an internet portal, pilot projects, curricula development in diverse sectors, a database on innovative practices, and indicator development for monitoring health at the local level.

Finland also attaches great attention to evaluating its health policies and programs, and all ministries are legally required to provide the necessary information for evaluation.[26]

Norway

Norway started to formulate its first intersectoral policy in 1987. In 2003 the white paper 'Prescription for a healthier Norway' presented a 10-year plan that, while promoting a balance between individual and social responsibilities, also looked at the social gradient of health. This paper presented an action plan to reduce inequalities and create partnerships between the national government, the counties, the municipalities and other civil society organisations. In 2007 *The National Strategy to Reduce Social Inequalities in Health* was published. It called for the linkage of policies and strategies across multiple sectors, with the aim of establishing guidelines for the government's and ministries' work on the annual budget, management dialogues with subordinate agencies and regional

[b] *These two research institutes were merged on 1 January 2009 to create the National Institute for Health and Welfare (THL).*

health enterprises, legislation, regulations, interministerial collaboration, organisational measures and other available policy instruments.

Two policy instruments were put forward to promote intersectoral action: health impact assessment and, at the municipal level, social and land use planning.

The Directorate for Health plays a central role in supporting this strategy through coordinating the development of new indicators, producing reports, providing an internet portal with information on how to include inequality concerns in planning, developing the skills of local public health actors, fostering collaboration between municipal and local public health authorities, and developing new knowledge that supports the practice of collaboration between different ministries (HiAP) and between the municipalities and the local health authorities.

Annual policy reviews are expected from the Ministry of Health and Care Services to discuss strategies at the national level and budgetary requirements.[26]

Intersectoral policies and health targets approach

Other countries in Europe have focused on using certain governance tools for HiAP. The use of intersectoral policies and health targets is widespread in Europe and there is continuous interest in these tools.[39–41] A study showed that 40 out of the 52 WHO European Region Member States had formulated HFA-style policies by 2004.[4] Countries are constantly renewing their policies, and intersectoral policies have been formulated by successive governments, even in the case of changing governments. Intersectoral policy formulation can be found at the national, regional and local level, and there are even attempts to coordinate these policies between different levels.

Target setting across all sectors—the French Cancer Plan[31]

The French Cancer Plan was launched in 2003 in response to a report showing that France had the highest rate of cancer-related mortality in the EU. Its main objective was to reduce cancer by 20% within 5 years using a series of 70 operational goals that cut across all sectors. The Mission Interministérielle pour la Lutte contre le Cancer (MILC) ensured participation of stakeholders at different levels, cooperation between state institutions, and strategic planning that involved several ministries. Overlapping national health plans allowed stakeholders to define operational goals and, more specifically, ensured cooperation between government services.

Initiatives were introduced to reduce cancer from within the health remit, such as the promotion of screening (e.g. access for all French women to screening for breast cancer, which should enable a 20% reduction in mortality) and better medical care (e.g. targets for installation of modernised equipment for diagnosis and treatment). In addition, targets were set beyond the health remit to reduce the number of cancer mortalities. To meet the targets, financial incentives were used to reduce tobacco consumption by increasing the price of cigarettes by 45% in the first 2 years, resulting in 1.8 million less smokers.[42] Legislation was enacted to forbid the sale of tobacco products to anyone under the age of 16 years. Food and drink packaging was required to show a warning of health risks, and schools banned all vending machines for food and drink.

The National Health in the Workplace Plan had eight objectives to reduce occupational risks, including the reduction of exposure thresholds to carcinogenic agents and the development of new methods to assess environmental and societal determinants of health. The Cancer Plan also formally acknowledged the link between cancer (health) and environmental factors.

Public education was a major focus of the plan, and the Ministries of Health and Education collaborated to implement public health programs to raise awareness of risky behaviours associated with cancer in schools and the public domain.

The French Cancer Plan will continue for an additional 5 years, with new funding announced in November 2009.[43]

Health impact assessment approach

In Europe much attention has been drawn to the use of health impact assessment (HIA), which is intended to support decision-makers in choosing between different options and predicting their future consequences.[44] It is by definition intersectoral and prospective,[45,46] and it has been shown in Europe that it can work under different institutional settings and at different institutional levels.[45,47] Qualitative case studies have demonstrated the effectiveness of HIA and the value it can add both to the decision-making process and to organisational and community development.[48] Economic evaluation has also underscored its effectiveness.[49]

However, only a few countries have institutionalised[50] HIA and it is more often used at the regional, and particularly the local, level.[51] Reasons for the reluctance to institutionalise on the national level are not entirely clear, since impact assessment is a standard administrative procedure in many countries that can help to strengthen the consistency and effectiveness of decision-making. In some countries, however, the institutional setting may impose restraints to include health in existing impact assessments. Germany, for example, introduced a mandatory impact assessment (Gesetzesfolgenabschätzung) for all federal legislative acts in 2000,[54] stipulated in the common ministerial by-laws.[55] The impact assessment, however, is indifferent with regards to health and does not provide any screening instruments to identify potential health-related impacts. It is difficult to find, at the federal level, a legal basis and a true advocate for including health in the impact assessment because there is no federal public health law and the public health competencies (with some notable exceptions) are in the remit of the regional states (Länder). At the regional level the situation is different—some states have included a mandate in their public health laws for the public health administrations to be involved in all planning procedures. North Rhine–Westphalia, a state with a population of 19 million, is a good example.[56]

In contrast, thanks to the aforementioned Article 152, the European Commission has used this mandate to include health in their impact assessment procedure, which is applied to all major initiatives and legal proposals. However, the potential to identify health impacts using the Commission's impact assessment has not yet been fully realised.[52,53]

Using health impact assessment to reduce inequalities in Wales

Reducing health inequalities is one of the priorities of the Welsh Assembly Government. HIAs that focus on the health equity impact of specific measures are an important way of achieving this. An HIA was conducted to analyse the impact of a road construction project that would link with the motorway between Cardiff and London. The road would be located very close to a housing area that consisted primarily of rental units leased out on the basis of social criteria. The area suffered from high levels of unemployment and very low incomes. A rapid HIA, initiated by the local residents' association, was carried out. One of its main tasks was to discuss and document health impacts on the already vulnerable population as a result of the impending road construction.

The HIA took into account issues such as the health impacts of pollution, noise and physical activity levels. The evidence collected led to the conclusion that the road construction project would have negative health impacts on the local population. The outcome of the HIA was positive in that it empowered a vulnerable group to raise their concerns, while making planners in various sectors aware of the health impact of their activities. The eventual outcome was that the road was never constructed. While it is uncertain to what extent the results of the HIA influenced this decision, it was influential in raising awareness and providing a linkage between outside influences on health.[51]

Other governance tools and frameworks

Many additional governance tools and frameworks for HiAP are being used in Europe, addressing organisational structures, processes, finance or regulation. They include cabinet committees, interdepartmental committees, steering committees, networks, dedicated organisations/units, planning and priority-setting processes, policy formulation, health targets, joined-up evaluation, grant or financial support mechanisms, joint agreements on financing, laws, agreement protocols and accountability frameworks. Most of them, however, have not been studied in detail and context.[26,39,41,57]

The evidence presented has to be interpreted with caution. There are only a handful of recent studies that have comparatively analysed what governments in Europe are doing to integrate HiAP. These studies approached the issue from different angles and with different intentions. One recently published study on the whole-of-government approach[20] briefly reviewed country experiences and individual tools. It was part of a compilation by the Dutch Council for Health and Healthcare informing the government on governance options for tackling the determinants of health. It outlined the abundance of governance tools available to establish dialogue between ministries and sectors, and demonstrated that the whole-of-government approach has been implemented in some countries and regions.

Another study focused on HiAP,[9] with an intention to put health and health determinants higher on the political agenda in Europe. Being part of the Finnish Council Presidency in 2007, it supported policy dialogues with Member States and a ministerial conference. The study put HiAP in the wider socioeconomic context, reviewed sectoral experiences and governance tools, and summarised experiences with HIA. It concluded that, although

achievements have been made, some positive developments are under threat of being reversed, such as the alcohol control policy of some Member States. In many sectors there was plenty of scope for improvement, and a lack of exploiting win–win situations was identified. The study also recommended a more systematic implementation of governance tools for dialogue, as well as cooperation between different sectors.

A third important study provided a critical analysis of public health policies in eight European countries, with a specific focus on mainstreaming equity. Among the conclusions, the study states that, at present, most national public health policies concentrate on lifestyle factors, but there is good evidence for an increase in attention to the underlining of distal, social determinants.[58]

A study that focused on governance aspects of health policy by analysing experiences with targets for health[41] concluded that the effectiveness of the targets depends on the form of implementation. It showed that health targets can contribute to a rapid change of organisational and individual behaviour when embedded in appropriate accountability frameworks. Although there was evidence that targets for health can contribute to improved health outcomes, the study also addressed the side effects of improper target setting and the attempts of organisations and individuals to fiddle with data.

Conclusion

Despite these important scientific contributions, Europe is still lacking a comprehensive and methodologically sound pan-European study on the whole-of-government approach and governance tools and frameworks for HiAP. It also has to be acknowledged that many developments take place at the regional and local level,[59] but remain unreported. This has become even more important over the last decades as federalisation, devolution and decentralisation in health and health care[60] have assigned more responsibilities to regional and local governments. Examples include the recent devolution in Denmark,[61] the strengthening of regional governance as part of the French Public Health Act of 2004,[62] devolution in the United Kingdom,[63] and the federalisation of Belgium.

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Chapter 5

Health impact assessment in Thailand: a learning tool for addressing Health in All Policies

Decharut Sukkumnoed and Kuametha Reukpornpipat

Introduction: we have rights, we have solutions

The issues of healthy public policy and health impact assessment (HIA) were first raised in Thailand in 2000 at the national seminar 'The desirable health system in Thailand', and subsequently echoed during provincial public hearings in 2001. These issues have recently become more important to Thai society, mainly because of the increasing occurrence of health problems caused by environmental hazards such as air pollution, pesticide contamination, improper waste treatment etc.; as well as evidence of and concerns about the health impacts of development projects such as large dams, coal-fired power plants, and transnational gas pipelines and highways.

After the issues had been raised in the reform process, the Health Systems Research Institute set up an academic review process in 2001, which reinforced the concept of healthy public policy as promoted by the Ottawa Charter for Health Promotion. The notion of healthy public policy received good public response in combating the problems faced by Thai society and was incorporated into the national health system reform framework.[1]

Following the public hearing, including special hearings for those who had been affected by development projects, a special session on healthy public policy and health hazards was organised within the second National Health Assembly to scrutinise and later endorse the draft of the National Health Act in August 2002.

From 2002, HIA guidelines were implemented and capacity-strengthening activities were carried out for both the academic community and active citizens in general. More than 50 HIA case studies were conducted on several policy issues at both the national and local level. Although all the cases were aimed at implementing desirable policy changes, only some will be able to reach their expected policy outcomes. To foster desirable changes,

five policy networks were set up, with the role of seeking opportunities and formulating strategies for healthier policy changes. The lessons from these policy networks were later summed up and further developed into an operational framework for healthy public policy formulation in Thailand.[2]

All these actions have paved the way for not only broadening the concept of healthy public policy in Thai society, but also embedding it into the culture of public decision-making and uplifting it into the process of public policy-making throughout the country.

In March 2007 the National Health Act BE.2550 (2007) (the Act) was approved by the Parliament and came into force. The Act stipulates that:

'An individual or group of people has the right to request an assessment and to participate in the assessment of **health impact resulting from a public policy**.

An individual or group of people shall have the right to acquire information and an explanation of the underlying rationale from state agencies prior to a permission or performance of a program or activity which may affect someone's health or that of their community, and shall also have the right to express their opinions on such matters.' [3]

Moreover, in August 2007 HIA was acknowledged in the national Constitution of the Kingdom of Thailand BE.2550 (2007); section 67 stipulates that:

'Any project or activity which may seriously affect a community's environmental quality, its natural resources **or its people's health, is prohibited unless (a) these environmental and health impacts are studied and assessed** *(b) a public hearing process is undertaken to obtain the opinions of people and stakeholders and (c) an independent organization formed by representatives of non-governmental organizations and higher education institutes provides opinions and comments, prior to the implementation of such a project or activity…'* [4]

What is HIA?

HIA is a new tool that provides an opportunity to everyone, be they project owners, villagers fearing harm, researchers or other concerned parties, to take part in a process to study and evaluate the possible health and environmental impacts of a project or activity. It also enables the study of methods to prevent such impacts, so as to allow economic development to proceed hand in hand with public health protection.

HIA is not limited to improving only those policies and projects with negative health impacts. The tool is also recommended for health advancement policies and projects that directly promote health and improvement in quality of life. For example, HIA can help a public park project better accommodate the needs of different people by making sure that paths and pavements are designed for jogging, running and biking, and are suitable for young and old alike. HIA may also be used to identify measures to address air pollution in the park's neighborhood, such as providing a green buffer zone and public transportation, as was done in the HIA case study in Yala province, the southern

part of Thailand, in 2006.[5] The outcome of the HIA in Yala province encouraged local governments to invest in green areas in the country's emerging cities and towns.

How to create an HIA participatory process

The people's rights

HIA must emanate from people's awareness of health problems that may result from development policies and projects. People must learn to ask the right questions and exercise their legal rights to request studies on health impacts, and to actively participate in the assessment process. The National Health Commission Office and Department of Health provides both introductory and advanced documents and training,[4] and case studies to support the learning process of local people. In Thailand the rights of local people to demand HIAs have been asserted both in the Constitution and the National Health Act. Public scoping is an essential step for local people to use their rights effectively to seek knowledge, raise questions and frame an HIA plan. Recently (2009) the National Health Commission set up the National Principles and Criteria for HIA public scoping to ensure the quality of public participation in the process.[6]

The project owners' responsibilities

Project owners must recognise that their projects may cause unanticipated health impacts. They should take into consideration local concerns and take steps to address possible impacts on the health and livelihoods of people living near their project site.

Government agencies and project owners must also support individual and community rights to demand the preparation of HIAs, and must provide assistance throughout the process, ensuring accurate gathering of information to support the best possible decision-making process. Based on the National Principles and Criteria for HIA public scoping, government agencies and project owners must provide essential information about the project, especially the possible positive and negative impacts on local determinants of health, 15 days before public scoping, and also allow another 15 days for public consultation.

Moreover, if necessary, both government agencies and the National Health Commission Office must provide technical support and resources for local people to conduct their own parallel HIA study, called community HIA, to provide different viewpoints and ensure that all relevant evidence will be used in the decision-making process.

The review process

Individuals and the community must take part in reviewing the studies to ensure that the decision-making process is fair and encompasses all concerns. In the case of projects that may have possible harmful effects, the public review requires that the government agencies and project owners present and provide an HIA draft 15 days before the review, and allow another 15 days for the public to scrutinise it to ensure the quality of

the report. After the public review the HIA report and public comments will be sent to an environmental impact assessment (EIA) and HIA technical expert for approval. If the project passes the technical approval process, it still has to receive an additional opinion from an independent organisation before a decision is made.

When and for what can we use HIA?

As stipulated by the Constitution, whenever a new project or activity is proposed that may cause public health impacts, HIA should be implemented along with EIA.

In Thailand, after the completion of a project or activity where health impacts have occurred, people can still request HIA for such a project or activity, as stipulated by the National Health Act. Although, in principle, HIA should be used prospectively, a retrospective HIA can also be very useful for policy evaluation. Owners of the project or activity may have to undertake measures to eliminate the impact, such as changing an industrial production technology. An example of this is the HIA conducted for the Mab Ta Put industrial zone development in Rayong province in 2007–08, which was undertaken with the cooperation of local residents and the National Health Commission Office of Thailand and led to proposed policy changes at both the provincial and national policy level.[7]

An HIA can be called for before or during implementation of government policies that may cause, or have already caused, health impacts. For example, a policy to increase exports of agricultural products that necessitate an increase in the use of dangerous chemicals could encourage farmers and consumers to request an HIA. Following a request, the National Health Commission Office will consult with relevant organisations, local people and stakeholders, and suggest the most appropriate ways of conducting HIA as a social learning process.

Local administrative agencies such as municipalities, sub-district administrative organisations and provincial administrative organisations can undertake HIA for their development policies, projects or activities to ensure there are no health impacts associated with local developments.

Present HIA mechanisms in Thailand

Based on the National Principles and Criteria for HIA Process for Public Policy,[6] HIA has been applied in four main ways in Thailand. First, as accorded by the Constitution, all projects with possible harmful effects are required to conduct HIA in their decision-making processes. Local people and the public generally can participate meaningfully in public scoping and public review, and reviewers are appointed to ensure the quality of the HIA process and report.

Second, any governmental organisations may apply HIA at the policy and planning development stage, such as for a power development plan, a mining development strategy or a regional development policy. The National Health Commission Office must coordinate with and support the relevant organisation to conduct the HIA in their planning process, and facilitate public participation in the process.

Third, local people who have concerns about the impacts of a specific policy on their health also have the right to request an HIA to ensure that the policy would not lead to negative health impacts. In this case the National Health Commission Office will facilitate the HIA process, especially the liaison between local people, policy-makers and relevant organisations in conducting the HIA and applying it to the policy-making process.

Fourth, local governments, the people and other organisations can apply HIA as a social learning process to solve their own problems or to plan for better health in the future. In this case the assessment can be done locally without any law requirement, with communication with the National Health Commission Office for technical support and exchange of ideas and information.

The National Health Commission has established the National HIA Commission, which is composed of key organisations involved in the development of HIA in Thailand, to take care of overall HIA development in the country. Moreover, in order to facilitate the four HIA channels described above, the HIA Coordination Centre has been set up to work with other organisations, local people and the National HIA Commission in the ongoing continuous development of HIA in Thailand.

HIA for a better choice of health

'We believe that if the good opportunity of learning process is opened to local community, the healthy river as well as the well-being of the community will be ensured.' [8]

Everybody has the right to live a healthy life, both physically and mentally, and to live in a good and safe environment. This is achievable by fulfilling our own spirituality and gaining wisdom in the benefits of health protection.

Almost 10 years since their introduction, the concepts of healthy public policy and HIA have been further elaborated and developed by several actors and in several sectors in Thai society. Several HIAs have been conducted by grassroots organisations and were crucial to policy development, especially agricultural policy. Moreover, several local administrative organisations and civil groups have applied these concepts to change their own policy direction towards, for example, healthier agricultural production, a healthier river and better energy solutions (such as biogas for organic waste management and an efficient charcoal stove). These experiences confirm that healthy public policy is not only a matter of governmental authority, but also a challenge of social responsibility.

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For more information about HIA in Thailand and the Asia–Pacific region, see the website of HIA2008, the Asia-Pacific Regional Conference on Health Impact Assessment, http://www.hia2008chiangmai.com/home.php

Section 3

Health in All Policies in SA: theoretical and methodological perspectives
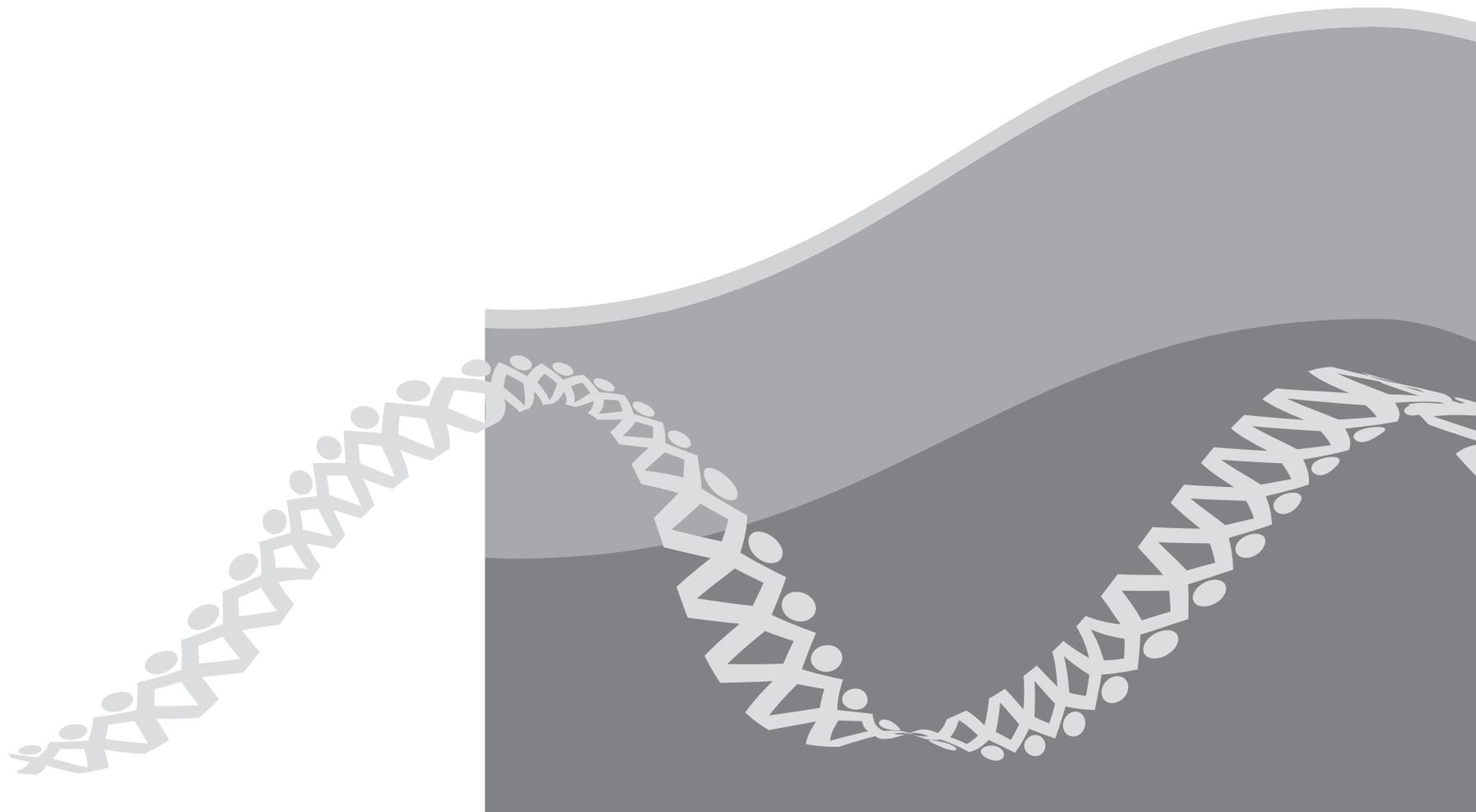
Chapter 6

Navigating through the policy territory of other sectors: South Australia's Health in All Policies approach

Carmel Williams and Danny Broderick

Introduction

The concept of the social determinants of health (SDOH) is now firmly in place as a driver of contemporary public health policy. This concept has long been championed by the new public health movement and health promotion advocates. Internationally, the work arising out of the Alma Ata Declaration on Primary Health Care and the Ottawa Charter for Health Promotion has provided a bedrock policy framework for action. At the national level, the Lalonde report in Canada[1], and the Black report[2] and Acheson report in the UK[3], are all examples of attempts to turn a determinants approach into policy imperatives and strategies. At the international level, the recent World Health Organization (WHO) Commission on the Social Determinants of Health, chaired by Sir Michael Marmot, is the latest and most compelling example of a call to strategic action.[4]

However, there is a paradox in this approach. It has long been understood by those working in the health sector that the primary levers for affecting change in the SDOH are outside the ambit and control of the health sector. Therefore, the key issue in the development of strategies designed to have impact on the SDOH is not whether health advocates and practitioners understand, accept and work through this approach, but whether other policy domains, sectors of government and the community do so as well. These other agencies, however, do not generally have the SDOH or population health agendas as part of their mandate. It is not, and never will be, their core business.

There have been many efforts over the last 30 years to engage other policy domains through intersectoral action on health. While there are good examples of practice, much of that effort has been either at a program-specific level or applied within a focused geographic region. The task of developing comprehensive and strategic engagement on an SDOH agenda across all policy domains of government remains a relatively untested and underdeveloped area of public health practice.

Significant impediments to the SDOH that are comprehensively placed on a whole-of-government policy agenda include perceptions of the health sector and how it engages or does not engage across government. International health care budgets are growing and this growth is showing no signs of abating, despite attempts at tight fiscal control and budget management practices. Whatever the causes (and there are many), one clear result is that, as more funds are allocated to the health care sector to provide for individual health care needs, there is less for other areas of government. Therefore, there is less capacity in those sectors to take action on the SDOH or improve population health. Similarly, approaches by health advocates to other sectors can, at times, be perceived as an exercise in 'health imperialism'—the health sector places such a focus on attaining the best possible health outcomes that it ignores or seeks to dominate the policy priorities and concerns of other sectors. This can lead to health advocates being frustrated in their pursuit for a 'perfect solution' to a health issue because they have failed to effectively acknowledge or respond to the legitimate imperatives of other areas of public policy. The health sector often fails to recognise that substantial health benefit is possible when working with other sectors to help them achieve their core goals. As stated by Voltaire, '…don't let the quest for the perfect become the enemy of the good'.

A recent initiative emerging from the European context has promoted the Health in All Policies (HiAP) approach. HiAP attempts to embed health issues and concerns within other policy areas. As with previous efforts, there may be a danger that this again will be seen as primarily the health sector's concern and not have direct relevance to the core business of other sectors. Mindful of these potential pitfalls, South Australia (SA) has embarked on a developmental process to adapt an HiAP approach and position it more strategically as a central process of government, rather than an approach run by and for the health sector and imposed on other sectors. SA's HiAP initiative was sparked by the internationally renowned expert in health promotion and development, Professor Ilona Kickbusch. Professor Kickbusch was a Thinker in Residence in South Australia in 2007 and produced a comprehensive report on health in the 21st century. A central recommendation of her report was the adoption of HiAP across government.[5]

Implementing Health in All Policies in South Australia

The development of HiAP in South Australia has progressed in two distinct developmental phases—a *preparatory and awareness raising phase and a proof of concept phase*. HiAP is now moving into the next the phase—*implementation*—where strategies are being put into place to ensure its ongoing sustainability. The rest of this paper will discuss how the first two phases were conducted and what lessons have been learnt.

Preparatory and awareness raising phase

Following the first part of her 2007 Residency, Professor Kickbusch called on the Department of Health (DH) and the Department of the Premier and Cabinet (DPC) to jointly investigate the feasibility of SA implementing an HiAP approach. She challenged

the SA Government to convene a conference at the end of her residency, in November 2007, where senior executives from across government would come together to map out how to implement HiAP in SA. The conference was one of three interconnected strategies designed to build interest and understanding of the key HiAP concepts. The conference proved to be a great success, with Chief Executives and senior executives representing all departments actively participating. One of the important success factors was that DH did not lead the process, but instead took on the facilitation role, an approach clearly recognised and valued by other government departments. Even at this early stage of development, the 'yin and yang' or win–win concept was a key platform upon which the HiAP approach was built—that outcomes arising out of the approach must benefit all partners, not just the health sector.

In preparation for the 2007 conference, DPC, in line with another recommendation from Professor Kickbusch, completed a rapid desktop analysis of South Australia's Strategic Plan (SASP) targets and their potential impacts on health and wellbeing. SASP is the principal strategic document for the state and has the strong backing of the Premier and Cabinet. DPC's analysis, once completed, provided a mechanism for the integration of health considerations across a wide range of policy areas that affect the SDOH, such as the environment, education, child development, social capital, housing, transportation and employment. With DPC rather than DH taking the lead, this exercise was itself an example of an HiAP approach.

To provide other government departments with the opportunity to experience HiAP in action, a more in-depth analysis was undertaken on SASP targets. Stakeholders from across government participated in workshops that sought to identify win–win solutions, where both improved population health outcomes and progress towards the other agencies' core goals could be achieved. This process identified relationships between sectors and stimulated further work, thus capturing the spirit of HiAP. It also aided policy-makers and decision-makers outside the health sector to recognise the connections between health and their core businesses, and appreciate the important role that non-health policies play in promoting health.

These strategies provided the opportunity to actively engage with other sectors about HiAP, and to begin to frame discussions and tailor documents directly linking individual agencies' core businesses with health outcomes through a SDOH pathway. There is a strong imperative across the SA government sector to support the Thinkers, and thereby the Premier, and this was an important factor in preliminary consultations with other sectors. It ensured initial high-level commitment. However, this support needed to be backed up with substance, which was provided through the desktop analysis of SASP and conference and, ultimately, through the adoption of HiAP across government.

Successful completion of the preparatory and awareness raising phase was instrumental in gaining support from central government for the next critical step in the development of HiAP in SA, namely establishing an overarching governance structure and implementing the first health lens analysis of a particular target area. These two elements comprised the proof of concept phase.

Proof of concept phase

The SA HiAP model rests on the twin pillars of i) central governance and accountability, and ii) a health lens analysis process, which seeks agreement on the policy focus, and builds on and develops methods that can be found in Health Impact Assessments (HIAs), as well as within broader public health investigative techniques (Figure 6.1). The following sections describe these twin pillars in more detail.
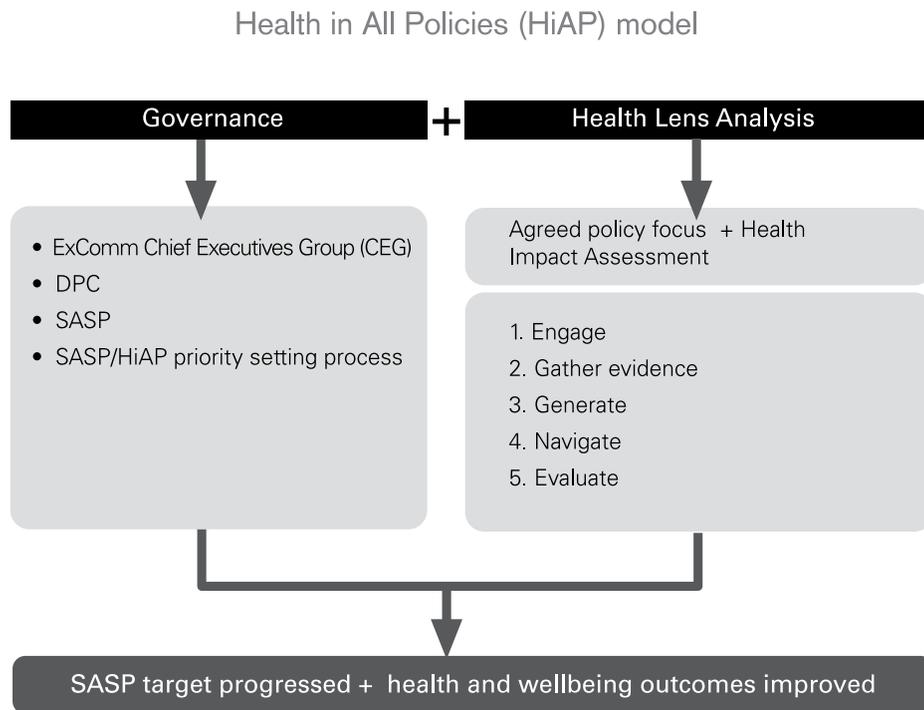
Health in All Policies (HiAP) model

Governance	+	Health Lens Analysis
• ExComm Chief Executives Group (CEG) • DPC • SASP • SASP/HiAP priority setting process		Agreed policy focus + Health Impact Assessment 1. Engage 2. Gather evidence 3. Generate 4. Navigate 5. Evaluate

SASP target progressed + health and wellbeing outcomes improved

Figure 6.1: South Australian model of HiAP

Governance

The central issue facing HiAP is how to place health criteria on the agendas of policy-makers who have not previously considered health as part of their agendas, or who may not see the value of such an approach. Professor Kickbusch identified SA as being well placed to manage this through the application of HiAP to the targets contained in SASP. The advantage of this process is the strategic importance of SASP to all government agencies. As a more detailed discussion of the HiAP central governance structure and the role of SASP is covered in Chapter 7, they will only be briefly touched on in this section.

Following the 2007 HiAP conference and its associated strategies, there emerged a whole-of-government consensus supporting the application of HiAP to SASP, and calling for the leadership of this new initiative to sit with central government and not with the health sector. The consensus provided a valuable cross-government mandate for

HiAP. DH, in partnership with DPC, worked to translate this mandate into an effective governance structure where the final decision-making responsibility and oversight for HiAP was placed under the auspices of the committee responsible for overseeing the implementation of SASP, namely the Executive Committee of Cabinet's Chief Executive Group (CEG). Obtaining central government leadership for the HiAP process has been an essential step in the transition from the preparatory and awareness raising phase to the proof of concept phase. It provided a clear statement of commitment that HiAP will be supported by all of government, not just the health sector, which has given other sectors the impetus to engage in HiAP.

A clear priority-setting process has been established where the CEG determines which SASP targets are included in the HiAP health lens work plan. The process also seeks the views of each government department, including DH and DPC.

Health lens analysis

The health lens is a key feature of the HiAP model. It outlines a series of steps that can be practically applied to SASP targets by a range of government agencies. It aims to identify key interactions and synergies between targets, policies and strategies, and population health and wellbeing. A range of well-established methodologies and tools are used to examine these connections in a rigorous and systematic manner.

Health lens analysis is a collaborative approach combining the skill and expertise of key health personnel with staff from participating agencies, jointly assessing options and posing solutions. It is a process that investigates the potential health impacts of particular plans and proposals, and examines the contribution of a healthier population to achieving the SASP target. An overview of the health lens process is provided below, and the process is described in more detail in Chapter 10.

Health lens analysis process

There are five essential elements included in the health lens analysis process that underpin its effectiveness and ability to deliver mutually beneficial outcomes:

- Engage: establishing and maintaining strong collaborative relationships with other sectors

- Gather evidence: establishing impacts between health and the policy area under focus, and identifying evidence-based solutions or policy options

- Generate: producing a set of policy recommendations and a final report that are jointly owned by all partner agencies

- Navigate: helping to steer the recommendations through the decision-making process

- Evaluate: determining the effectiveness of the health lens.

Engagement formally commences with the agreement between the lead agency and DH on the policy areas to be considered, and is followed up with the convening of a joint expert working group (JEWG) to determine the specific policy focus of the health lens analysis. This process can take time as individual SASP targets, having a wide policy scope, tend to be ambitious, so it is important to consider which aspects

have the best potential. This time also offers an important **engagement** opportunity, strengthening relationships and building understanding between the partner agencies. It provides a means by which goals and objectives can be agreed upon and a work plan collaboratively developed. Once the focus of the health lens analysis has been agreed and a project plan developed, the most suitable research and analysis tools are identified for the **evidence gathering** step.

The health lens methodology relies heavily on the well-established methods and structures of HIA. The systematic approach recommended by HIA models is helpful in structuring the discussion between the health agency and the other government departments. However, there are some fundamental differences between traditional HIA approaches and health lens analysis. For example, traditional HIA is most effective when applied to an existing policy or project proposal, which are often from the planning and development field, or are specific projects with clear plans and proposals. On the other hand, the HiAP health lens operates within a policy development environment, where the general policy intent is known but existing draft policies frequently don't exist. An important early task within the analysis is to determine the exact policy issue to address, and this tends to be an iterative process. Additionally, health lens analysis that relies solely on traditional HIA restricts the opportunities to consider the health implications of policies at every stage of the policy development cycle.

The health lens projects use a range of other tools and methods that are designed to provide the most useful information. The methods are largely dependent on the stage of development of the SASP target—whether it is still at the information-gathering or problem-identification phase, or the implementation or evaluation phase.

Once the evidence gathering has been completed, the JEWG considers the evidence in line with the original policy proposal and **generates** a series of recommendations designed to both improve population health and wellbeing and support the achievement of the lead government agency's SASP target. The recommendations and associated final report are provided to the each of the partner agencies' Chief Executives for approval prior to being sent to the CEG. An informal consultation plan is mapped out for each of the partner agencies, where key stakeholders are briefed on the findings and recommendations. The health lens process **navigates** the final recommendations through the government bureaucratic structures required as part of the approval process. This ensures that health factors and priorities remain in focus through further processes of consultation and decision-making.

Department of Health commitment

In addition to obtaining cross-government commitment for HiAP through SASP and DPC, it has also been important to obtain internal commitment from DH. A high-level DH governance structure has been established to support the HiAP Unit and prioritise access to the technical resources required. DH has committed staff and financial resources to support the development of HiAP and, in particular, consolidate the technical expertise required to support other government agencies in applying HiAP to their targets.

The implementation of HiAP in SA has not been heavily resource intensive. A small unit has been established within DH to support the central governance structures in partnership with DPC, and apply the health lens to agreed SASP targets alongside other government departments. It is not expected that the adoption of HiAP across government will require any significant new investment of resources. It is anticipated that the HiAP approach will bring about slow but progressive cultural change within agencies, where they adopt HiAP as part of their own core business as they recognise its potential to help them achieve their goals.

An emerging challenge for SA's HiAP model is to maintain its relevance with the broader health sector. The very premise upon which it is based, namely preventing disease and illness through improving the SDOH, minimises the downstream role of the health sector, particularly the part of the sector involved in planning and delivering health services. The immediate issues facing health services appear to have little to do with the determinants, and they realise no immediate benefit from the model. Fortunately, there is a strong recognition across the health system that the determinants underpin health and that efforts must be made to strengthen them. This support is unlikely to last without evidence that the model is effective. Furthermore, the model needs to demonstrate that it can directly support the important issues confronting health, such as chronic disease and obesity. The HiAP Unit is actively working to ensure that the model works effectively with SASP targets of both other government departments and the health sector.

Evaluation

As the methodology is still developmental, it is important that each SASP health lens be evaluated to determine it success. Has the health lens analysis influenced the policy decisions of the other government agencies? Did their goals benefit from the process? What determinants were influenced through this work? The evaluation will also ensure that the analysis process can be refined to be flexible and adaptable to all government agencies' needs as well as deliver policy options that contribute to improved health outcomes.

Built into the HiAP model is a commitment to undertake joint evaluation by both DH and the other agency. This is agreed to from the outset. The three dimensions for evaluation are:

- process evaluation—did the process sufficiently meet the needs of all agencies involved and did it help establish and maintain the appropriate collaborative climate

- impact evaluation—is there documentary or other evidence that health issues have been incorporated/addressed adequately in final policy proposals

- outcome evaluation—what measures or proxy measures can be observed that indicate the likelihood over the medium to long term that the other agencies' policy goals have been enhanced and that health impacts have been positive.

In addition, DH and DPC have recognised the need to evaluate the entire HiAP model. Plans are underway to identify how best to effectively conduct an evaluation of policy changes that will necessarily be wide ranging, with significant health impacts only emerging in the longer term.

Underlying values of Health in All Policies

The focus on working in partnership with other government agencies to assist them achieve their targets demonstrates the health sector's commitment to joined-up government, and the need for it to support the work of other sectors if the SDOH are to be effectively addressed. In bureaucratic systems the health sector has often been seen as 'imperialist' in its approach to other agencies, consuming large amounts of the state's budget, and expecting other agencies to change their policies and work practices to enhance health outcomes with little consideration for their core businesses. For HiAP to have traction with other government agencies, it has been essential that DH, with support from DPC, be seen to work differently. This has occurred through the upfront recognition that other sectors' targets and core businesses are critically important and need not be sacrificed to meet the population health goals—the aim is to optimise both the agencies' and Health's outcomes.

The value orientation of health professionals engaged in HiAP work is of critical importance to successful engagement with other sectors. The following value positions have had significant positive impacts on the acceptance of HiAP in the SA context.

Respect

When engaged in HiAP work it is important to remember that it is occurring on the policy territory of another agency or sector. That agency knows more about its own sector and the policy factors and imperatives it faces than do staff from the health sector. Having specialised health knowledge, while important to the process, does not confer expertise about another agency's situation.

A willingness to listen and respond

Respect is best demonstrated by starting off and continuing from a position of listening and responding to what is found. The first task in any HiAP process is to understand the world and the policy issue from the other sector's point of view. This sends a clear and direct message that health is genuinely committed to working with the other sector on their issues. It provides the basis for their receptiveness to factoring in health considerations through the process. Basically, if Health wants other sectors to listen to its views, it first has to listen to theirs.

A commitment to a two-way street

Mutuality is something that must be clearly demonstrated from the outset. It is important that Health shows that they are entering this process not to push a health agenda above all other considerations, but to help that sector or agency advance their progress towards their policy goals in ways that are health promoting or health protecting.

Humility

Health needs to see itself as a facilitator rather than a (self-appointed) leader. Humility is important in demonstrating the necessary credentials to provide assistance and support for the work of the other sector. Public health is both a science and an art—it is inexact. While the evidence for many aspects of the SDOH is strong and growing stronger, it is not definitively conclusive in all areas. Similarly, the evidence on strategies, or measures to take in order to effectively address them, in particular areas of policy, is also far from complete and definitive. Many such strategies are also quite context specific—what works in one setting may not work in another. Engaging from a position of expressed humility accurately reflects this uncertainty and can also blunt resistance, which might become more evident if too many assertive claims are made too early in the process.

Building

When engaging with another sector of government through an HiAP approach, the primary purpose of Health's involvement is to build rather than to change. No one likes being the target of change. Health's role is to work with other sectors to look for ways to help them achieve their goals in a way that widens and improves their options and proposals. HiAP aims to add value from a health perspective in ways that enhance the policy or proposal under consideration. Taking this stance of building from the outset and sticking to it strengthens the capacity to introduce health factors into another sector's work, but in ways that they will find acceptable.

A note on conflict

There may come a time in an engagement with another sector Health is confronted with an option or a position that, if adopted, would be seriously counter to health and wellbeing outcomes. Having laid a foundation based on: respect, listening and responding, a commitment to a two-way street, humility and a stance committed to building, Health will be in a much stronger position to assert health factors (irrespective of the certainty or strength of the evidence).

It is neither possible nor desirable to eliminate conflict from any process. But, by consistently basing behaviour and engagement with another sector on these five related value positions, the potential to positively engage with that sector when conflict does emerge is strengthened.

Health in All Policies: the South Australian foundations

Even at this early stage of development, the SA experience in applying an HiAP approach is identifying some valuable lessons in how to ensure sustainable cross-government policy focus on the SDOH. Table 6.1 identifies some of the foundations that have allowed HiAP to progressive with the speed it has across the state government system.

Table 6.1: The foundations of Health in All Policies in South Australia

Foundation areas	Example of application to South Australia
Strong cross-government focus	The existence of SASP means that there are pre-existing requirements, expectations and structures for working across portfolios. Aligning HiAP with SASP meant that health lens work was quickly seen as a legitimate part of the way government goes about its business.
Central government mandate and coordination	Ensuring that HiAP was not seen as being owned by the health sector was critical to its acceptance across government. Ensuring a clear mandate from government, together with continuing support, leadership and coordination from central government agencies, secured a strong base for HiAP and enhanced credibility for the process of health lenses.
Flexible and adaptable methods of enquiry	Health lens work requires rigorous and robust critical thinking within a collaborative framework. It is not captured nor does it work through any one particular methodology of investigation; rather, it adapts to fit the circumstances. This enhances its acceptability to other agencies, whose unique contextual circumstances and time and resource constraints can be visibly incorporated into the process.
Mutual gain and collaboration	A value orientation that is committed to joint work and joint outcomes is essential to successful HiAP work. It stands firmly with the reality that the potential for changing the SDOH lies substantially outside the control of the health sector. The only way to work effectively on the SDOH is to cooperatively engage with other organisations in a process of partnership and mutual gain.
Dedicated health resources	While this has not been a resource-intensive process, HiAP requires clearly identified health resources dedicated to it. Health must resource the process, not lead it; rather, it must facilitate the elements of a health lens as well as provide expert advice where needed.
Joint decision-making and joint accountability	The 'product' of a health lens process must be jointly owned. While it is seen as essentially the responsibility of the other agency, Health needs to be satisfied that its issues have been addressed. Also, both agencies hold themselves responsible to central government for delivery and implementation of the recommendations. This promotes mutual accountability and provides a secure basis for ensuring that potential differences can be reconciled before they run the risk of seriously impacting on the process.

Conclusion

The SA model for HiAP is still under development and is the subject of rigorous and continuous evaluation. However, even at this early stage, results are proving encouraging—it has been shown that successful engagement with other agencies across government around the SDOH can occur at a high strategic level in ways that bring mutual gain. The transferability of this emerging model is yet to be tested; however, there is nothing particularly unique about the SA context. The elements described above can be adapted and developed in many different circumstances and cultures, such as where there is:

- a strong cross-government strategic focus

- a central government mandate coupled with central coordination

- the application of robust methods of inquiry and assessment in ways that are flexible and adaptable to individual contextual circumstances

- a clear value orientation that places health gain within the context of mutual gain and collaboration

- a guarantee of specific resources from the Health portfolio for the process

- joint decision-making and accountability, and

- greatly enhanced prospects for integrating a focus on the SDOH.

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5.   http://www.thinkers.sa.gov.au/images/Kickbusch_Final_Report.pdf

For more information

South Australian Health in all Policies website.

http://www.dh.sa.gov.au/pehs/health-in-all-policies.htm

South Australia's Strategic Plan (SASP): a PDF version of the updated SASP.

http://www.saplan.org.au/content/view/62/106/

The Public Health Bulletin South Australia: The March 2007 Bulletin was dedicated to HiAP.

http://www.health.sa.gov.au/pehs/publications/0803-PHB-HIAP-vol5-no1.pdf

Public Health Information Development Unit

The Public Health Information Development Unit (PHIDU), located at The University of Adelaide, was established by the Australian Government Department of Health and Ageing in 1999 to assist in the development of public health data, data systems and indicators. PHIDU is committed to the development of an integrated health information system in Australia that can provide information on a broad range of health determinants across the life course. A major emphasis is on the development and publication of small area statistics for monitoring inequality in health and wellbeing.

http://www.publichealth.gov.au/

Chapter 7

South Australia's Strategic Plan and Health in All Policies

Sandy Pitcher, Dan Jordan and Kevin Buckett

Introduction

Governments have a responsibility for maintaining the health of people, thereby enabling them to live a socially and economically fulfilled life. Good health is something we all want and expect, and we tend to take it for granted. Conversely, poor health imposes a huge cost on the population, in terms of quality and length of life for those affected, pressures on carers and families, and a significant financial burden on the health system.

Although major developments have been made in managing and preventing acute illnesses, chronic health conditions are emerging as a significant and ongoing cost to the community. As the population ages, these chronic health conditions and costs will only become greater.

Many chronic conditions are preventable. They are closely linked to living conditions and lifestyle factors (hence the term 'determinants of health'), many of which are influenced by policies outside the health sector. This puts health on the agenda of policy-makers in all sectors and at all levels, requiring them to be aware of the health consequences of their decisions and to accept responsibility for health.

This paper looks at the Health in All Policies (HiAP) approach that has been adopted by the South Australian Government to support achievement of the targets in South Australia's Strategic Plan (SASP). In conjunction with the Department of Health (DH), the Department of the Premier and Cabinet (DPC) has encouraged agencies to apply a 'health lens' over a range of SASP targets to improve our understanding of how the determinants of health influence wellbeing at the individual, family and community levels.

The case for a Health in All Policies approach

There are a number of compelling reasons to adopt an HiAP approach across government to focus policy away from illness treatment and towards illness prevention.

Issues facing the health system are significant, with costs escalating at a faster rate than the projected economic growth of the state. At the same time changes in the age profile of the population are putting pressure on the capacity of the economy to grow.[1] In this context there is an imperative to keep existing workers healthy and in the workforce. As the workforce ages and the prevalence of chronic diseases increases, South Australia (SA) has the potential to experience significant workforce shortages over the longer term. One way to meet these challenges is to reduce the impact of chronic disease across all age groups within the population.

Policies, interventions and actions outside the health sector can address the underlying causes of chronic disease and illness more directly than health policy. There is a need, therefore, to integrate health considerations into other policies and sectors beyond the health sector.

South Australia's Strategic Plan

Given the compelling arguments for an HiAP approach, how can SASP's framework assist?

SASP was launched by the SA Government in March 2004, and updated in January 2007 after a comprehensive statewide community engagement process. It expresses the values, priorities and actions for the future direction of the state. It is a key organising document and reference point for the activities of the government through each of its agencies.[3] However, it is also a whole-of-state plan with ambitious targets that can be achieved only through cooperation within and between government, industry and the community. Premier Rann has described it as a 'goad to action for all South Australians' and 'a plan for everyone—for business, for the community and for government—not a plan for government alone'.[2] Partnerships are therefore critical to the success of SASP.

SASP contains 98 targets across the following six objectives:

- growing prosperity
- improving wellbeing (which contains a number of health-specific targets)
- attaining sustainability
- fostering creativity and innovation
- building communities
- expanding opportunity.

An important feature of SASP is that neither the objectives nor any individual targets stand alone—they are all part of a larger, interrelated framework and achieving one target does not come at the expense of another. Smart thinking about how we do things can neutralise negative effects on other targets or even turn them into positives. The aim is to encourage collaborative behaviour and innovative thinking to address some of the most complex issues facing SA.

In adopting an HiAP approach to SASP, policy officers are encouraged to think beyond the immediate concerns of their own portfolio areas and consider the implications for population health in any decisions they may take.

Overseeing implementation of SASP

Implementation of SASP is overseen by the Executive Committee of Cabinet (ExComm), which is chaired by the Premier and includes the Treasurer, three other Ministers and the chairs of the government's two most powerful advisory bodies—the Economic Development Board and Social Inclusion Board. ExComm serves as a strategic policy committee of Cabinet and, among other things, undertakes annual appraisals of chief executives' performances against SASP and other whole-of-government objectives.

Government agencies are nominated as 'leads' for individual targets. They are asked to prepare and monitor implementation plans that identify strategies, key performance indicators and milestones to meet the target within the time frame. In doing so they are expected to involve other agencies and stakeholders.

From the beginning, implementation of SASP has been underpinned by a strong commitment to transparent reporting. This is reflected in the work of an independent Audit Committee, which reports on SA's overall progress towards SASP targets every 2 years. According to the committee's 2008 report, the state is tracking well against the 98 targets, with almost 70 per cent within reach, on track or already achieved.[3]

Another foundation for SASP's success has been a strong sense of community ownership. The government embarked on a detailed community consultation process as part of the 2006 SASP update, and has continued to engage the community on implementation under the guidance of the Community Engagement Board.

In 2010 there will be another statewide update to review the objectives, targets and priorities in SASP. Once again, members of the community will have an opportunity to influence the future directions of the state.

Governance and HiAP

Professor Kickbusch was SA's catalyst for action on HiAP. She was contracted by the SA Government to assist in formulating new approaches to health, wellbeing and health governance in the state as part of the Premier's Thinkers in Residence Program.

Early in her residency, Professor Kickbusch identified the opportunity to apply an HiAP approach to the targets contained in SASP. She recognised how closely SASP and its targets aligned to the factors commonly described as the determinants of health—factors such as work, employment, education, food, transport, housing environment, early life and social support.

In other words, Professor Kickbusch saw SASP as a blueprint for action to improve health through addressing its determinants. It is for this reason that the HiAP approach has such potential in SA. It is the foremost expression of the government's objectives and vision for the state, and spans the range of factors that contribute to the health and wellbeing of populations.

The adoption of HiAP became the principal recommendation arising out of Professor Kickbusch's residency, in which she argued that the uptake of HiAP across government would be more successful if the leadership for this work sat with the central government department rather than the health department. This view implicitly recognises the difficulty that a line agency, such as the health department, has in trying to instigate a whole-of-government approach to its own policy agenda. In response, the state government gave responsibility for overseeing HiAP to a high-level group of chief executives with responsibility for reporting to ExComm on the implementation of SASP, namely the ExComm Chief Executives Group.

The Office of the Executive Committee of Cabinet in DPC works with DH to support the ExComm Chief Executives Group in identifying opportunities to apply the health lens methodology to particular targets within SASP.

To date, the ExComm Chief Executives Group has overseen the following health lens projects:

Health lens project	Lead agency/agencies
Water sustainability	Office for Water Security
Digital technology	Department of Further Education, Employment, Science and Technology
Regional migration	Department of Trade and Economic
Transit-oriented developments	Department of Planning and Local Government; and Department for Transport, Energy and Infrastructure
Literacy and parental engagement	Department of Education and Children's Services
Aboriginal road safety	Department of Correctional Services; Attorney-General's Department; Police; Department for Transport, Energy and Infrastructure; and Department of Health (Aboriginal Health)
Healthy weight	Department of Health

In encouraging agencies to look at SASP targets through a health lens, the HiAP approach focuses on breaking down the traditional misconception that health problems are issues only for the health portfolio.

What this means in practice is that health policy-makers work with representatives from central and line agencies to develop policy proposals that deliver better health outcomes for the population and contribute to progress against the broader objectives set out in SASP. For example, the work on transit-oriented developments (TODs) supports pedestrian-friendly environments that, in turn, contribute to greater physical activity and reduced obesity, both of which are important objectives in SASP. The work on regional migration aims to achieve better health outcomes for migrants settling in regional SA, which, in turn, will support achievement of the state's population targets. Similarly, the work on Aboriginal road safety is aimed at addressing a significant cause of lower life expectancy among Aboriginal people.

Conclusion

HiAP is a methodology as much as an outcome. This article has advanced some of the reasons why SA has chosen to adopt HiAP. SASP is proving to be an ideal framework within which to progress this methodology because it offers examples of linkages between health and non-health sectors, and encourages joint action to address the inter-relationships between SASP targets.

DPC and DH will continue to work with government agencies to incorporate HiAP thinking into the internal processes of government and engagement with the community.

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Chapter 8

Towards the integration of Health in All Policies: a Québec – South Australia comparison

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Introduction

Since the adoption of the Ottawa Charter for Health Promotion (1986), several states recognise that policies developed in different sectors have a significant impact on population health. Therefore, better coordination between the health sector and other government sectors appears essential. The best collaborative approaches spark interest among states that wish to increase the consideration of health issues in all their policies. This concern is shared by the governments of Québec and South Australia (SA), which are both committed to adopting healthy public policies. This chapter, which results from a collaboration initiated in 2008,[1] compares their respective approaches in order to draw useful lessons for the international community.

In each case we briefly describe the political and institutional context that has fostered the emergence of a broad vision of health and its determinants. We then examine the collaborative approach adopted, the support offered, and the evaluation and accountability processes established. A comparative table specifies features of the two cases. We finally discuss the relevance of both approaches, the development priorities and the common challenges when working towards the integration of Health in All Policies.

Québec's approach: health impact assessment

Québec is the largest Canadian province in area and has the second largest population —7.8 million—around 23% of the total Canadian population.[2] It is part of a federation where health is a shared jurisdiction between the provinces and the federal government.

The management of health systems is a provincial jurisdiction, but provinces and territories must comply with national standards.[3] The Québec welfare state, characterised as social democratic, is set apart by an integrated health and social services system, including public health services. It is a publicly-funded three-level system (central, regional and local) that benefits from the expertise of a public health institute, the Institut national de santé publique du Québec (INSPQ) (Québec National Public Health Institute).

In agreement with the Ottawa Charter for Health Promotion, the Québec Government recognises the importance of acting on the individual as well as the social, economic and environmental determinants of health. This vision is manifest both in the Public Health Act (2001) and the Québec Public Health Program 2003–2012, and was reaffirmed in the revised Act, Respecting Health Services and Social Services (2005). This program specifies the strategies and public health activities to be undertaken in all local territories in Québec. As many health and welfare problems require concerted action, the program relies on close collaboration between professionals in health and their partners in other sectors, such as education, employment, environment, agriculture and food industry, and urban planning. Different public health thematic plans, such as the Government Action Plan to Promote Healthy Lifestyles and Prevent Weight-related Problems 2006–2012 —Investing for the Future, have also mobilised several ministries and agencies around specific health issues. Finally, the Ministère de la Santé et des Services sociaux (MSSS) (Ministry of Health and Social Services) is involved in many policies developed in other sectors that can positively influence the determinants of health, such as the Government Action Plan to Combat Poverty and Social Exclusion 2004–2009 and the Government Sustainable Development Strategy 2008–2013. In fact, the horizontal management of policies is progressively generalised in government, fostering a culture of collaboration conducive to the adoption of healthy public policies.

Section 54 of the Québec Public Health Act, in force since 2002, legitimises consideration of health issues in other government sectors. This section stipulates that the Minister of Health and Social Services is the government's advisor on any public health issue, and shall be consulted during the development of measures provided for in Bills and Regulations that could have significant impact on population health. To meet this requirement, the MSSS has developed an implementation strategy in two parts: the establishment of an intragovernmental health impact assessment (HIA) mechanism and a knowledge development and transfer program on public policies and health.

The HIA mechanism builds on the global vision of health determinants underlying public health, as well as on previous work on strategic environmental assessment underway at the time, led by the Ministère de l'Environnement (Ministry of Environment). As promoted by the MSSS, HIA must support policy development in other government sectors. In this context, HIA has been integrated in the Ministère du Conseil exécutif (MCE) (Ministry of Executive Council)-governed process of inter-ministerial consultation already in place, but may occur at different policy development stages. The MSSS also relies on a network of ministerial respondents to further the implementation of HIA across government. The HIA process is structured in five stages: screening; scoping; summary or in-depth analysis; adjustment and decision-making; and evaluation and monitoring. While it

is the responsibility of each ministry or agency sponsoring a legislative or regulatory proposal to conduct an HIA,[4] the MSSS and its network facilitates access to knowledge and offers technical support throughout the process. To this end, an HIA guide and an awareness-raising tool on determinants of health have been distributed in ministries and agencies, and training sessions will soon be offered to professionals involved in policy-making. Lastly, the MSSS relies on a network of ministerial respondents to support the implementation of HIA across government.

Regarding knowledge development and transfer on public policies and health, the MSSS closely collaborates with the INSPQ and two research funds.[5] Since 2003 an MSSS–INSPQ service agreement has covered the production of scientific reports documenting the impact of public policies on health, and the development of tools and activities to increase access to scientific knowledge and expertise.[6] The MSSS also financially supports, in collaboration with research funds, the the Groupe d'étude sur les politiques publiques et la santé (Healthy Public Policy Research Group)[7] and various healthy public policy-related research projects. Meanwhile, the National Collaborating Centre for Healthy Public Policy (NCCHPP), an organisation funded by the Public Health Agency of Canada, but managed and hosted by the INSPQ, also helps public health actors to improve their knowledge and skills in HIA.[8]

With respect to evaluation and accountability mechanisms, a systematic monitoring of requests for advice transmitted to the MSSS by ministries and agencies gathers information on the origin and number of requests, the history of consultation and the analysis process. Global results are presented and discussed in a periodic report on the implementation of Section 54 of the Québec Public Health Act, published by the MSSS. Furthermore, under the Public Administration Act (2000), the MSSS has to adopt a 5-year strategic plan. Subsequently, an annual management report, which covers the activities undertaken and objectives achieved, is tabled in the National Assembly. This accountability process could be another possible avenue to better assess progress towards the integration of HIA into policy development in other government sectors.

South Australia's approach: Health in All Policies

SA is the central southern state on the Australian mainland. Its population is approximately 1.6 million, around 8% of the total Australian population. Most South Australians (73%) live in Adelaide, the capital city. SA is part of the Australian federal system of government, and is a sovereign government with responsibility for a wide range of public services and infrastructure. In the area of health the state government is principally responsible for the management and delivery of public health care services such as hospitals, and some community health and primary health care services. Public health and health protection services are principally a state responsibility under state legislation. Public health legislation identifies a partnership between the state government, through the Department of Health (DH), and the 68 local governments, which are recognised at law as public health authorities in their respective areas. Primary medical care is largely provided by general practitioners on a fee-for-service basis, principally funded by the federal government and by patient co-payments.

SA is currently reviewing and modernising its public health legislation. One particular aspect has been to propose the adoption of clauses similar to the Québec Public Health Act (particularly section 54). This will provide the legislative basis for institutionalising a Health in All Policies (HiAP) approach. In 2008 SA and Québec signed a Public Health Partnership Agreement1 that established the basis for ongoing collaboration and exchange in areas of mutual interest, including exchange about approaches to healthy public policy.

SA has been developing and refining its HiAP approach since 2007. Prior to this, HIAs were conducted on an ad hoc basis with no clear mandate. DH also provides comments on proposals and initiatives from other sectors as part of the Cabinet process. However, there is no guarantee that the views of the health sector or the identification of potential impacts on health will be incorporated earlier in the planning processes.

An HiAP approach (together with the proposed new legislation) provides a more systematic and proactive framework for early engagement between the health sector and other sectors of government. HiAP has been mandated by the government to undertake health lens analyses over several areas of policy and proposals. At this time health lenses are largely conducted by a specific unit within DH working in close collaboration with other public sector agencies on their policy priorities. Health lenses are chiefly focused on proposals developed under South Australia's Strategic Plan (SASP), which was originally adopted by the SA Government in 2004. SASP is a cross-cutting document designed to bring together the combined efforts of government agencies, local government and the community in achieving strategic objectives for the state. It was the strategic insight of Professor Ilona Kickbusch (the world renowned expert in health promotion) to identify SASP as a health determinants document. As the Adelaide Thinker in Residence in 2007, she recommended to the Premier that the way to unlock the health potential of SASP was to place a health lens over its objectives and targets. After a preparatory and awareness raising phase, this recommendation was accepted and implemented by the state government in 2008.

Health lens analysis is the operational process in SA's approach to HiAP. It applies a wide range of investigative and analytical techniques and aims to identify the health potential of other sectors' plans and proposals. As part of its toolkit, health lens analysis can apply elements of traditional HIA methods; however, the process is highly context specific and the elements are not applied rigidly. While collaboration can be a key feature in the conduct of HIAs, the methodology employed in health lens analyses **requires** close collaboration, with the full participation of other agencies as the cornerstone of the work. They also occur early (or as early as possible) in the planning and development cycle, which ensures that health lens analyses maximise their potential for impacting the proposals of other agencies throughout their development. It also allows for recommendations to be tested and refined with the other agency's to ensure their practicality and acceptability. Reports generated from the process must be agreed to by the chief executives of both the health department and the lead agency. This ensures that any final product from the process is the result of genuine agreement rather than the incorporation of positions that may substantially compromise the health potential of the proposal.

The health lens analysis is a joint collaboration between agencies, with the overall process being facilitated by the HiAP Unit within DH. This unit is also able to draw on the resources and expertise of other areas within the health sector (e.g. epidemiology and population health monitoring, environmental health and policy analysis) as well as the involvement of independent health experts as required.

Discussion

Below is a comparative table of the approach taken by these two jurisdictions; it analyses aspects of their models, structure and context for action.

Table 8.1: Comparative analysis of Québec and South Australia

Dimension	Québec HIA	South Australian HiAP
Mandate	S. 54 of the Québec Public Health Act (2001) provides the legislative basis for this approach.	Decision by the Executive Committee of Cabinet in 2008 to systematically apply an HiAP health lens across SASP targets. Moving towards a similar legislative mandate as contained in the draft South Australian *Public Health Bill 2009*.
Governance	Both the Minister of Health and Social Services and the National Public Health Director /Assistant Deputy Minister are ultimately responsible for the implementation of s. 54.	Overseen by a group of chief executives of other government departments (not Health) who have responsibility for implementing SASP.
Central agency engagement	Close collaboration between the MSSS and the MCE. The MCE fosters the development of an inter-ministerial consultation culture. Helpful in the identification of projects that may have a significant impact on population health.	Memorandum of Understanding between DH and DPC. DPC has lead role in overall coordination, and DH provides resources to undertake health lens work.

Dimension	Québec HIA	South Australian HiAP
Structure/actors involved	Small team within the MSSS undertakes HIA work and advice in collaboration with other ministries and agencies. Engagement of other MSSS teams and support of the INSPQ.	Small team within DH undertakes health lens work in collaboration with other government agencies.
Process and methods	HIA may occur at different policy development stages, e.g. early on in the process; when the MSSS is directly involved in the project; when advice is sought on the preliminary version of a proposal; when advice is requested at the MCE's analysis stage. Collaboration pursued with other ministries and agencies (acceptability and practicality of recommendations). Flexible use of HIA methods and access to multidisciplinary research results.	DH undertakes health lenses on early stage policy and plans in collaboration with other agencies; uses aspects of HIA in its methods, along with a range of other policy investigation and analysis tools. Seeks to engage in the policy formation process as early as possible to ensure incorporation of health factors in the decision-making process.
Links with other government departments	Network of ministerial respondents to further the implementation of HIA across government. Capacity development.	Works collaboratively with other agencies on jointly analysing proposals and plans that aim to maximise health gain.
Links with local government	Interest in implementing HIA at regional and local decision-making levels: pilot experiment and links with the Healthy Cities movement.	Exploring possibility for the application of HiAP to the local government sector.
Policy focus	Based on a determinants approach to health, with a focus on the health impacts of particular proposals.	Based on a determinants approach to health.

Both jurisdictions:

- base their approaches on an understanding that the levers for change for improving the determinants of health mainly lie outside the policy domain of the health care sector

- have developed an integrated governance approach to achieve healthy public policies. This requires developing a capacity to engage effectively with other policy sectors, understand their policy parameters and imperatives, and work collaboratively with them to identify and resolve health issues that may be amenable to change

- have developed a strong relationship with their central government agency and seek to place their healthy public policy actions within the broader framework of governmental decision-making processes

- understand the need to work 'upstream' and as early as possible in the policy formation/ development process. Québec has made particular efforts to integrate HIA into the Cabinet decision-making process. Even if this strategy has some limits, since there may be some rigidities in terms of timing of advice to other agencies, it has the merit to formally embed health concerns in public decisions. However, on a functional basis, both agencies endeavour to work (both formally and informally) with other sectors as early as possible.

A clear and shared value stance present in both the Québec and South Australian models is the need to build effective relationships with other non-health agencies on a win–win basis, i.e. an approach based on respect for the policy goals of the other agency and a clear determination to work collaboratively, which implies voluntary involvement of other sectors. This orientation has implications for how this work is evaluated. Both jurisdictions are developing approaches to evaluation that, while focusing on health impacts and outcomes, place those results within the broader context of the policy goals of other agencies. However, some challenges remain, since effective relationships and trust building takes time and win-win solutions are not always directly at hand.

It is well recognised in both jurisdictions that the work they are engaged in is both innovative and still in its developmental stages. Areas for further work include:

- workforce capacity development both within the health sector and other sectors, and at different decision-making levels

- aligning and engaging with the mainstream health sector to build policy coherence around health-specific priorities

- development of sensitive and sophisticated evaluation models that can monitor process, policy impacts and policy outcomes in the long term

- the continued incorporation and integration of these approaches into government decision-making processes, based on their demonstrated utility to both achieve a health goal and contribute to other policy goals.

Conclusion

The development of systems for the creation of healthy public policies can be highly context specific depending on the political, cultural and institutional formation of government structures. However, early results from both Québec and SA indicate that

there may be a broad set of values, principles and approaches that can have extensive application across a range of government and country contexts.

These experiments show that a whole-of-government approach for health is feasible and can have a positive long-term effect by changing the political and institutional culture underlying the management of cross-cutting issues such as health.

The Québec – South Australian Public Health Partnership Agreement[1] provides a strong basis for continued exchange and mutual learning between these two related approaches. Both Québec and SA are committed to this ongoing exploration and rigorous evaluation of their work.

Acknowledgements

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Chapter 9

Role of Health Impact Assessment in Health in All Policies

Robert Quigley

Introduction

Internationally, Health Impact Assessment (HIA) continues to receive prominence in global health promotion literature, the most recent being *Closing the gap in a generation* by the World Health Organization's Commission on Social Determinants of Health (CSDH).[1] This report recommends 'routine consideration of health and health equity impacts in policy development' as one way to achieve a reduction in health inequalities. HIA practice continues apace and its wide international use is best demonstrated by the number of practitioners from a variety of countries attending the many HIA conferences that occur around the world each year.

The definition of HIA by the World Health Organization in 1999[2] was reworked by the International Association of Impact Assessment to be:

> *'A combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, program or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects'.*[3]

For clarity, the reader should be aware of several similar terms used in this chapter:

- Health in All Policies (HiAP) is an overarching conceptual framework for systematic engagement with other sectors.

- The operational conduct of HiAP is done through a health lens analysis (as named in South Australia (SA)), which is a form of HIA that uses several components of HIA and, like HIA, draws on general public health methods of investigation and analysis.

  ○ By definition, HIA needs to be undertaken on a draft policy or program. In comparison, health lens analysis can begin earlier in the development process, allowing government departments to work together when the policy or program is not yet developed—starting with a so-called 'blank piece of paper'.

○ When a health lens analysis is undertaken on a draft policy or program outside SA, it would commonly be known as HIA.

○ Health lens analysis does not rigidly apply the steps of HIA and their application is highly context specific (as is also the case in HIA practice). The HIA steps and frameworks provide a 'mental map' for health personnel engaged in an health lens analysis process.

○ Throughout this chapter the term HIA has been used, although in most cases health lens analysis could be substituted, as the two approaches are similar— only their starting point is different.

There are a number of ways to support HiAP practice within SA. One approach is to 'build the capacity of all sectors to consider the health impacts of their policies'.[4] HIA is one mechanism for this; it is being used to provide additional structure for the development of individual policies, and in turn assist the HiAP work that is already occurring at an institutional level. HIA has proved particularly useful at providing a systematic process for continued engagement on a specific issue once the government departments in SA have agreed to work together on HiAP. HIA provides a tangible course of *action* for government departments to work together along the policy development process, which is critical for moving beyond verbal and written commitments to work together. The use of HIA within HiAP is being discussed and recommended around the world,[5] and in SA it is being practised.

This paper is about how HIA fits into the HiAP approach in SA.

The groundwork for HIA

Because HIA within SA is being used to engage government departments in the HiAP approach, it is critical that the process of undertaking HIAs is supportive of existing processes, and that the outcomes are useful to all concerned. Poor process in undertaking HIAs or failure in achieving a useful outcome would undermine the HiAP approach. The continuous nature of the HiAP approach provides the perfect overarching context for a single policy or program-level HIA to be undertaken between government departments. Under the HiAP approach in SA, relationships have further developed, political structures have been developed, an understanding of the determinants of health has been achieved, and a willingness to work together to meet joint goals has been set. In these conditions HIA is likely to thrive.

Senior officials in the Department of the Premier and Cabinet acknowledge that health is central to achieving the objectives of South Australia's Strategic Plan (SASP), for which government departments have responsibility. This allows useful discussions to occur such as 'How can working together help meet each government agency's SASP targets, and how might reaching these targets improve health?' This is a two-way conversation where it is acknowledged that: (1) HiAP is there to support the government department in meeting their targets; and (2) by supporting the meeting of these targets, good health

is likely to be maximised. While not all SA civil servants fully understand the relationships between their work and health (and vice versa), the important point is that many are open for the conversation. Similarly, HiAP provides an avenue for Department of Health (DH) officials to engage in a conversation about how they can better understand the needs of other government departments, and how they might be able to help.

In SA the above groundwork has all occurred due to strong leadership from the Premier, the Cabinet and the Minister for Health, all the way through to the HiAP team leading the approach within DH. Leadership at these different levels has been invaluable for making each individual policy or program-level HIA work well. The leaders have taken great pains to 'not scare the horses' by outlining the positive and helpful nature of HIA within the HiAP approach. Political structures have been meticulously developed to support these leaders and the HIA approach. Internationally, lack of leadership and inadequate political structures at one or more of the levels described above has stymied HIA efforts.[6] In Sweden the link between why HiAP was important in the national strategy and how it would be undertaken within action plans (such as via HIA) was not clearly laid out, such that HiAP is still to reach its full potential in Sweden.[7]

A different approach for the Department of Health

HIA practice within an HiAP framework is a substantial and welcome movement away from the regulatory role of DH. In the past the department has had the unenviable role of having to undertake HIAs on strategic developments at a late stage in the process, with an often prescribed narrow discussion around air, water, noise and contaminants. It is a substantial change when government departments work collaboratively with DH about what topics to focus on, and when a full determinants of health approach is available for HIA practice rather than a narrow band of environmental health determinants.

HIA as practised in SA under HiAP should not be confused with risk assessments or cost–benefit analyses, which are typically based around a single metric, reducing the discussions among stakeholders to dollars and/or disability-adjusted-life-years rather than the inherent values of humanity and wellbeing. Such methods have the potential to provide decision-makers with a false sense of security about precision. HIA as practised in most of the world, and in SA, seldom predicts the magnitude of impact and/or the number of people affected due to the participatory nature of HIA and a lack of quantitative modelling, and this may be an area for further work.[8] HIA practice in SA is, however, very good at outlining likely causal pathways from potential policy options, and being clear about any assumptions made. In turn, this additional information allows decision-makers the freedom to make decisions knowing they have the best, albeit not perfect, information available.

Health lens analysis allows government departments to work together when the policy or program is not yet developed—starting with a so-called 'blank piece of paper'— whereas HIA requires a draft policy or program. This is the substantial difference between health lens analysis and HIA, although this difference is often masked, as the

way of thinking and approach between the two is very similar, making them excellent partners. When government departments work closely together, health lens analysis and/or HIA 'has the potential to improve future policy-making through an enlightenment process',[9] rather than HIA just influencing the individual policy or program at the time.

Making HIA work

There are several basic concepts that have been well practised within SA, allowing the HIAs undertaken to be well received by the stakeholders involved.

1. Preparatory groundwork undertaken (as discussed above).

2. HIA mentoring and training was provided for government staff.

3. Because HiAP is described as 'the perfect match for SASP… to examine the connections between health outcomes and achievement of SASP targets',[10,11] it was therefore logical to screen SASP to determine the best possible points of application for HIA across government departments. With a short list identified from the screening, the HIA work began with 'natural partners'—for example, combining departments involved in water and transport decisions was considered a useful route. Undertaking the HIA on a tangible project/policy within each government department was important.

4. Scoping was carried out: to outline a clear HIA work program—who is doing what, when, how and where, and with what resources; to be clear that the HIA must fit into the commissioning government department's policy process and timeframe; and to be clear about what could and could not be achieved with the resources and skills available.

5. Two types of information—written and verbal—were collected, covering the context of the issues and policy, literature reviews, and information from community and experts. From this information, clear descriptions of potential positive and negative impacts were developed via causal pathways. Working closely with the policy-makers was needed at all points so that everyone could see the information developing in a 'no surprises' manner.

6. For development of the recommendations, the policy-makers participating in the HIAs were key contributors as they were often in a better position to describe potential recommendations to alter the policy because of their familiarity with the policy area. The recommendations were based on the information gathered in the HIA—the context, the literature and the community/expert information. Any recommendations supported by all three types of information and developed in conjunction with the policy-makers increased the likelihood of recommendations being useful and being agreed to by the decision-makers. All participants in SA were aware of competing demands by decision-makers on such issues as economics, environment and cultural factors, just as other HIA practitioners have elsewhere.[12]

The role of the South Australian Department of Health in undertaking HIA

'Health agencies are the catalyst for HiAP…by providing resources, support and advice'.[13] This is the same for HIA and has been a key role of DH. Additionally, health agencies bring and add their knowledge of causal pathways about how an intervention (the policy) might affect health determinants and subsequent potential impacts on health. The relationships are well understood and described for some areas, but for many policy HIAs where evidence is less, literature can help signpost possible causal relationships. A blend of expertise from different disciplines is required to understand the full causal pathway. Health agencies have access to medical and social literature databases that other agencies do not, as well as staff who can use such databases and write literature reviews. This largely observational data from the literature about causal relationships is used in the HIA to aid the prediction of impacts. This, of course, is a substantial future challenge for HIA, when embedding HIA practice requires certain DH resources. An example is a finding from New South Wales (in a local government setting) in which evaluators of HIAs found that 'council staff would not have had the time or research skills to find or review relevant evidence'.[14]

Lay knowledge, such as from people likely to be affected by a proposal, and expert knowledge from key individuals, often complement knowledge from the literature. People in the community are often well placed to discuss how they believe a draft policy or program may impact on them, as they are the intended target audience and it is their reactions to the policy that will lead to change. Their suggestions for ways to positively change the policy and to reduce potential negative impacts are often enlightening.

DH has a small amount of funding to assist HIA information collection, and this is matched (or bettered) by other government departments. For example, 11 community focus groups were commissioned to assist an HIA on refugee and skilled migrants. Such focus group work is useful for three reasons.

1. The obvious reason is providing information about the potential positive and negative impacts, and ways to move forward.

2. A less obvious reason is helping the policy-maker write down the policy in such a way that a community group can understand it; and for the HIA practitioner to write questions in a simple manner for a community group to answer in a short time frame. Clarity of expression and getting rid of jargon has proved to be continually useful, as these documents can also be used to help draft media releases, and deal with Ministers and CEs and any other information requests. It also greatly assists the health sector staff understand the policy.

3. An important reason is asking a small number of community members for their opinions to input directly into a decision-making process. Community members enjoy participation, knowing that their information is going into an HIA process that is directly linked to decision-makers.

DH also has a strong role in quality assurance in HIA, including constant refinement of the approach so as to ensure that HIA maintains simplicity in administration, and avoiding a 'one-size fits all' mentality.

Conclusion

HIA is an important and useful tool within HiAP—it provides a tangible way for government departments to actually work together rather than just talking about working together. This is also true in the SA experience. As a springboard from the excellent groundwork of the HiAP approach, HIA practice has provided DH with a new way to work. HIA practice in SA reiterates the importance of multidisciplinary approaches, where teams of people from the different departments share their skills and openly acknowledge the expertise of the community and established experts. The usual steps of HIA practice have been well applied and have set the scene for effective use of HIA. As with all HIA practice, SA practitioners will need to remain vigilant to further enhance their practice and continue to contribute to the international understanding of HIA within HiAP.

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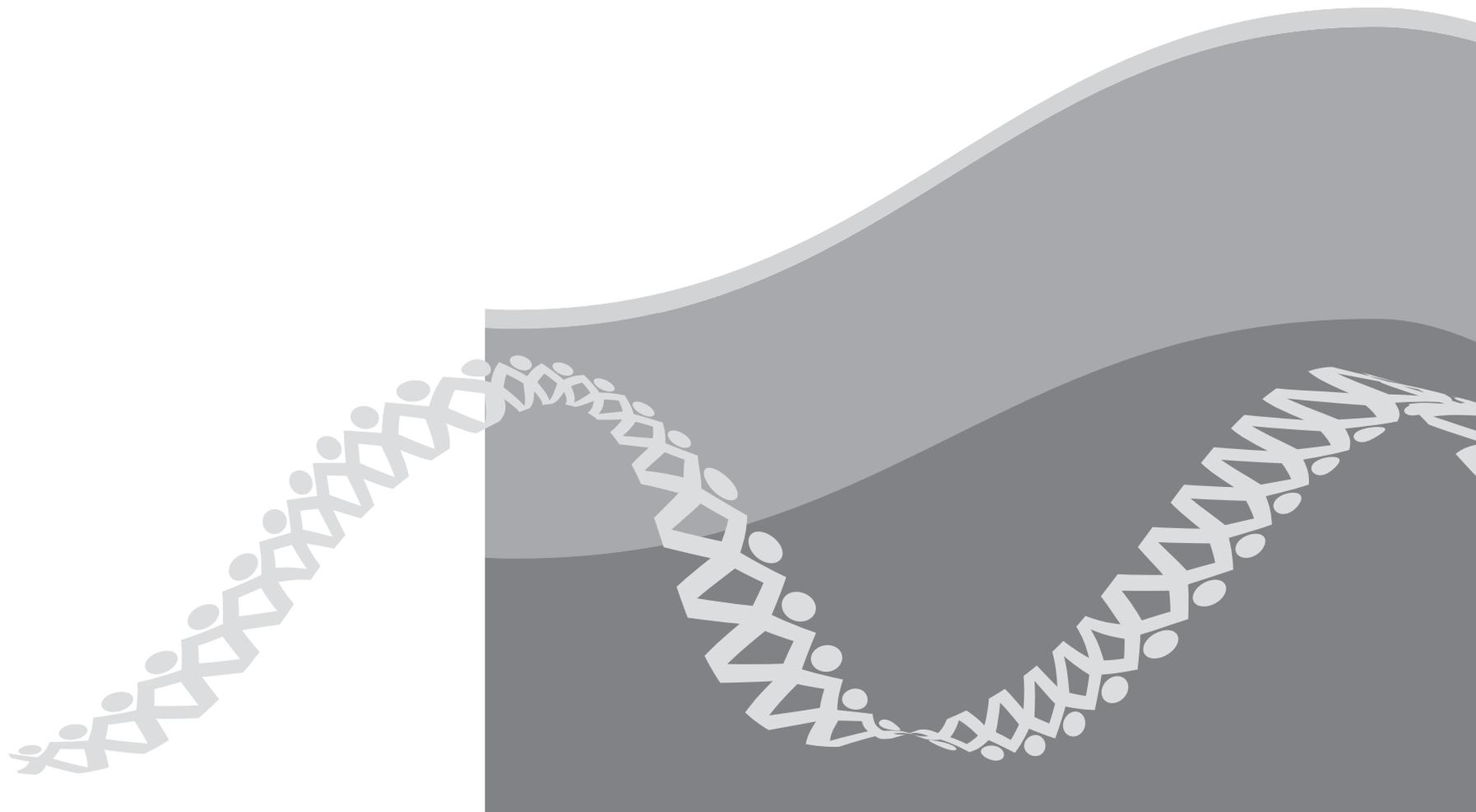
Chapter 10

An introduction to the health lens analysis

Carmel Williams, Deb Wildgoose, Amy Sawford and Lauren Williams

Introduction

The health lens is a key feature of the Health in All Policies (HiAP) approach adopted in South Australia (SA). The application of a health lens aims to identify key interactions and synergies between South Australia's Strategic Plan (SASP) targets, policies and strategies, and population health and wellbeing. The health lens, based on an internationally recognised approach, uses a range of methodologies and tools to examine these connections in a rigorous and systematic manner.

A health lens aims to deliver evidence-based recommendations to inform the decision-making process, to maximise gains in health and wellbeing, and to reduce or remove negative impacts or inequalities of programs or policies. It aims to support the development of sound policy outcomes for all agencies involved, in particular the partner agencies. To this end, a win–win outcome is sought in all cases.

The health lens analysis is a collaborative process that staff from the Department of Health (DH) enter into with a clear understanding that they are resources, providing support and advice related to the health lens process and health-related subject matter as required. Both the proposal under review and the outcomes of the process are owned by the partner agencies. DH staff work with the partner agencies to identify opportunities for mutual gain. This is an iterative process that seeks to explore, identify and maximise health and wellbeing benefits, while simultaneously identifying how improved health can contribute to better outcomes for each partner agency's priorities and policy goals. Above all, there is recognition by DH staff that they are on another agency's policy terrain and therefore must understand and respect their policy drivers. It is important that they maintain this understanding throughout the process to ensure that the partner agencies are comfortable in owning the outcomes at the completion of the project. This is not to say that fundamental health concerns are ignored or compromised; rather, it is about making a genuine attempt to understand and work within the policy parameters of the other agencies.

Flexible methodologies are used to ensure that the approach fits with the proposal in question, the resources available and the local populations affected. Importantly, equal emphasis is placed on both achieving the goals and objectives of the partner agencies and improving health and wellbeing outcomes.

Health lens methodology

In the early stages of implementing HiAP in SA a clear methodology for the health lens process did not exist. In part this was due to a number of uncertainties: how would partner agencies respond to the concept; what resources (including staff and financial) would be available and be required; and would the projects be a priority for the partner agencies. However, it was also partly due to the fact that, despite HiAP strategy being developed in various other countries around the world, SA was a pioneer in implementing HiAP and developing a process for putting its rhetoric into action through across-government partnerships.

A strong 'learning by doing' approach was adopted for the first health lens projects. There has been a clear evolution of understanding by DH staff as the methodology has developed, and the process has evolved accordingly. While a more robust and well-understood process now exists, it is still important that a strong emphasis remains on flexibility.

In part, the health lens methodology draws on the well-established methods and structures of health impact assessment (HIA). The systematic approach provided by traditional HIA models is helpful in structuring the discussion between DH and the other government agencies. However, a limitation of the traditional HIA approach is that it is most effective when applied to an existing policy or project proposal. Relying solely on HIA may therefore restrict the opportunities to consider the health implications of policies at every stage of the policy development cycle. The health lens uses a range of other tools and methods that are designed to provide the most useful information.

Other more traditional public health methods are used to examine the health impacts at different stages of the policy development cycle, including qualitative research, literature synthesis, data and policy analysis, and the adoption of analysis methods used by other sectors (e.g. scenario development and economic modelling).

An overview of the five-step process

There are five steps that are a recognised part of every health lens project, as outlined in Figure 10.1.

1. Engage

2. Gather evidence

3. Generate

4. Navigate

5. Evaluate

It is important to acknowledge that, while these five processes are clearly different from each other, there will be significant overlap between them.
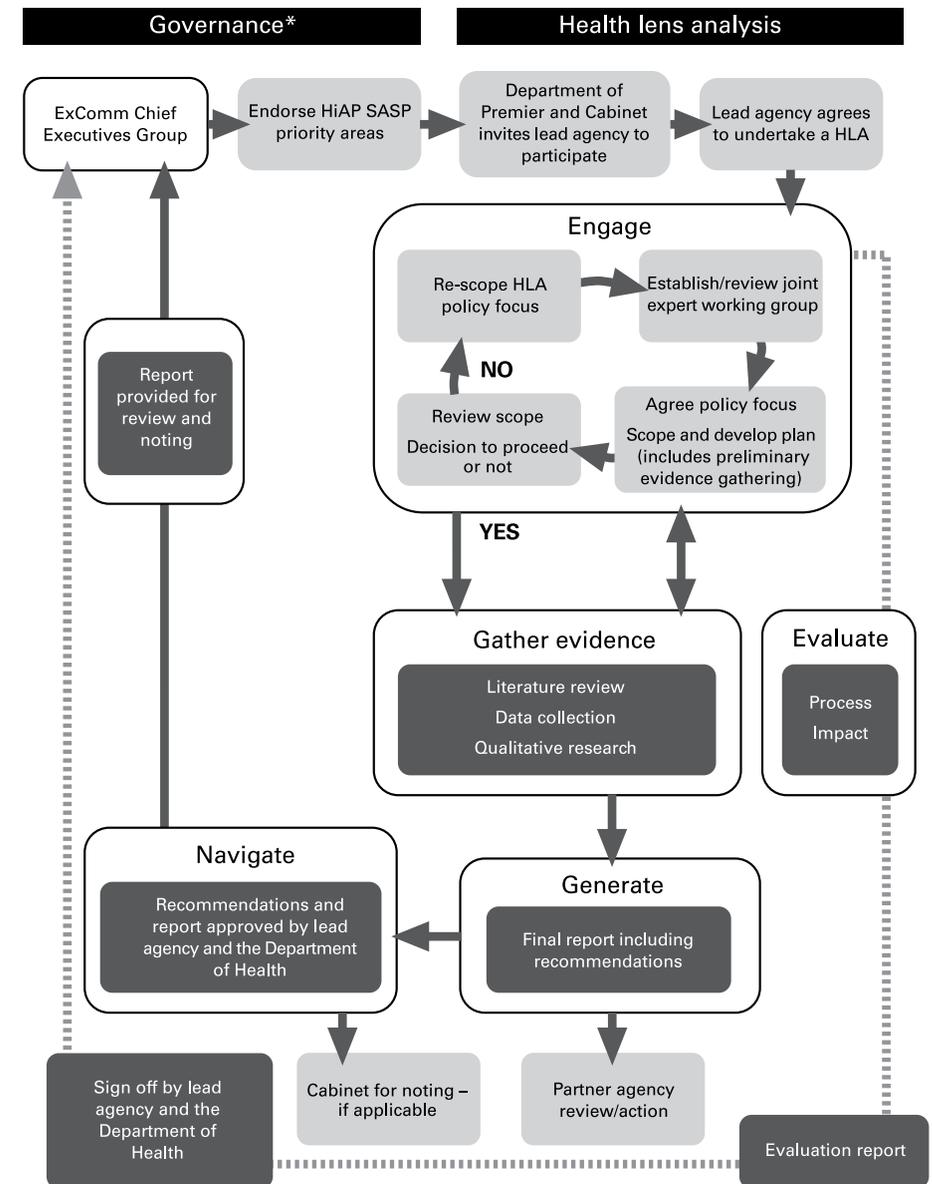

Figure 10.1: South Australian health lens process

*The governance arrangements are discussed in more detail in Chapter 7

1. Engage

A joint expert working group (JEWG) is established early in the development of each health lens project. Members are drawn together by the lead agency (the agency with responsibility for the SASP target under investigation) following preliminary discussions with DH. The initial role of the JEWG is to determine a specific policy focus for the health lens analysis within the boundaries of the SASP target. The JEWG oversees the project, providing expert information and advice throughout the process (in particular, relevant and up-to-date evidence where available) and also formulating the final recommendations.

The JEWG agrees on a policy focus for the project, scopes the breadth of the project and develops a project proposal, with the aim of optimising outcomes for the SASP target under investigation and for improved health and wellbeing outcomes. This scoping process is often quite lengthy, particularly where the lead agency does not already have a specific policy focus in mind before coming to the table. However, this can also be beneficial—without prior investment in a particular topic, there is more space for a joint decision to be made about where to focus the efforts of the health lens and where there is most opportunity to achieve a win–win outcome.

It is important that the members of the JEWG are in a position to make decisions relating to policy change or development on behalf of their agency, as well as playing a role in implementing the recommendations where applicable. Where it is not possible to have all relevant agencies around the table at the commencement of a project, other agencies may be invited to join later in the process if it is determined that their input is necessary or that it is possible that the anticipated recommendations may impact their core work.

Once the project proposal has been agreed upon by members of the JEWG and approved by the Chief Executives (CEs) of the lead agency and DH, the most suitable research and analysis tools are identified.

In many ways the engagement phase is the most important, as relationships are established or strengthened, forming a firm basis for the conduct of the project. Strong engagement with the right agencies and members at this stage is critical in the smooth running and success of the project.

2. Gather evidence

An important aspect of the health lens analysis is its strong evidence-based approach to policy development, in particular understanding the potential health and wellbeing implications of a policy, plan, program or initiative.

The collation and development of an evidence base is generally conducted by a subgroup of the JEWG, comprising members of all agencies involved where possible. Where it is not possible for a representative from each agency to be part of this group, it is strongly encouraged that they provide advice on sources of evidence. Their detailed review of the evidence is critical before moving forward.

As the links between health impacts and the area of the partner agency's core work can sometimes be unclear, it is important that this is made evident through providing clear descriptions or pathways supported by good evidence. It is also important to note that the links between the health impacts and the area under investigation may need to be tied to their impact on the determinants of health where there is no obvious direct link otherwise. Time may need to be invested by DH staff to explain the relevance of the determinants of health to members of the partner agencies.

Evidence can come from a range of sources and can be either qualitative or quantitative in nature; generally, a combination of each of these is used. Qualitative evidence is used in all health lens projects, and generally includes literature reviews and analysis as well as some form of social research such as focus groups or interviews. Quantitative evidence may include existing data, or a survey may be conducted as part of the project design.

As a general guide, a first step has been to conduct a literature scan of all available evidence, paying particular attention to Australian and SA content where available. In many cases, however, local evidence has not been available, making it necessary to draw on national or international literature. Sourcing literature from locations with similar demographic characteristics enables rigorous comparisons to be made between SA and the national or international evidence. Analysis of existing data sources may also be required and can generally be carried out in conjunction with the literature scan.

The JEWG then reviews the results of this preliminary evidence collection and determines a way to move forward. This process assists in narrowing the scope (e.g. the selection of a more specific population group or region for investigation) and identifying areas where more research needs to be undertaken. If advised by the JEWG, a more detailed literature review will be completed. In some SA cases this has been undertaken by researchers, and in other instances members of the JEWG have conducted the reviews.

From our experience in SA, in most cases gaps will be identified in the literature, making it necessary to undertake some qualitative research to provide more detailed and contextual evidence relevant to the local population and policy setting. This would generally include a series of focus groups and/or interviews with key stakeholders.

The evidence-gathering phase is intensive and is also generally the longest. While the JEWG has not generally been involved in the intensive evidence gathering, it is important to keep all members engaged to ensure they have a clear understanding of where the evidence has come from and its implications.

3. Generate

The evidence is collated and analysed, and then compiled into either a draft report or a series of reports where appropriate. The reports are then reviewed by the JEWG. Input from members of the JEWG at this stage is critical to ensure that all aspects of the relevant, available evidence have been included, as this evidence will be used to inform the development of a series of recommendations. The JEWG provides comments and edits on the draft reports and if there are any contentious issues or points that require clarification or debate, the JEWG will reconvene to negotiate these issues. A final report is then generated based on the joint feedback of the JEWG.

This phase can be highly intensive. It is important that the entire JEWG remains engaged and actively involved during this stage, particularly those members from the lead agency who will own the final project outcomes.

4. Navigate

Once recommendations have been drafted and agreed on by the JEWG, they are sent to the CE of the relevant agencies for approval. A summary of the evidence and a brief description of the process is also provided to demonstrate the development of the recommendations and to show that they are supported by a strong evidence base. The recommendations are approved firstly by each partner and then by the Executive Committee of Cabinet's Chief Executives Group, who manage the SASP process.

To ensure the smooth transition of the recommendations through the approval process, attention is given to supporting the partner agencies in moving the documents through their relevant processes and engaging relevant partners along the way to ensure that the recommendations are not blocked.

Where applicable, an informal consultation plan is mapped out for each of the partner agencies, in which key stakeholders are briefed on the health lens findings and recommendations. This is particularly important where the recommendations may impact on the work of these key stakeholders, who may not be government agencies.

5. Evaluate

As the health lens methodology is still developmental, it is important that each health lens project is evaluated to determine whether it has influenced policy decisions, whether it has assisted the agencies to achieve their goals, and what determinants of health were influenced. It is also important to gauge whether the process has resulted in a strengthening of existing relationships between the partners or the development of new relationships. Ongoing evaluations will also ensure that the health lens process can be refined so that it is flexible and adaptable to all government agencies, as well as being able to deliver policy options that contribute to improved health outcomes.

For each of the health lens projects there are three dimensions which are considered during evaluation.

- Process evaluation—did the process sufficiently meet the needs of all agencies involved and did it help to establish an appropriate, collaborative climate?

- Impact evaluation—is there documentary or other evidence to demonstrate that health issues have been addressed in final policy proposals?

- Outcome evaluation—what measures or proxy measures can be observed which indicate the likelihood over the medium to long-term that the partner agencies policy goals have been enhanced and that health impacts have been positive.

In addition to evaluating the individual health lens projects, the need to evaluate the entire HiAP model is acknowledged. This work has not yet begun but at the time of writing is in the planning stages.

Case studies

To date a number of health lens projects have been conducted, three of which have been completed in full. The following chapters provide a series of case studies demonstrating the perspectives of the partner agencies and researchers involved in these completed projects.

Chapter 11

Water security health lens project: alternative water sources

Linda Carruthers and Angela Lawless

Introduction

The Office for Water Security (OWS) was established in March 2008 in recognition of the complex and considerable water issues facing South Australia (SA), and was charged with the responsibility of developing a long-term water security plan for the state. This plan would contribute significantly to the achievement of South Australia's Strategic Plan Target 3.9: *Sustainable water supply—South Australia's water resources are managed within sustainable limits by 2018.* OWS sits administratively within the Department of Water, Land and Biodiversity Conservation, which is the lead agency for this target.

The Health in All Policies (HiAP) concept, which was showcased at a conference attended by members of SA government agencies, was viewed by OWS as an opportunity to participate in a cross-sectoral strategy that could assist in the development of a sustainable water security plan. It also provided an opportunity for a health perspective to directly inform the plan, although it would clearly be only one of many perspectives seeking influence in shaping the plan.

Discussions between members of the Department of Health (DH) and OWS resulted in an agreement that the agencies would undertake a collaborative health lens project that would inform the development of the SA water security plan.

The project was based on the premise that HiAP provides joined-up solutions to complex problems, with the end result providing outcomes that benefit the work of both agencies. Therefore, an important aspect of the project was that it considered health outcomes in a very broad context, including both the positive and negative implications relating to physical, psychological and social wellbeing of increasing the use of alternative water sources.

As the first health lens initiative to be undertaken, this project was very much a 'learning by doing' exercise. The process was facilitated by having a clear purpose for the project —that the recommendations would be used to inform the development of the SA water security plan.

Undertaking a health lens project: the process

A joint expert working group (JEWG) was formed that included members of both DH and OWS who were experts in areas of water security and policy, water quality and wastewater management; as well as members of the DH's HiAP unit, who would facilitate the health lens process.

International experts in health impact assessment (HIA) were commissioned to facilitate a screening and scoping exercise with the JEWG to construct a more specific focus for the project, as it was recognised early on that it would not be possible to conduct the HIA exercise in relation to all elements of water security with the available time and resources.

The use of alternative water supplies was identified as an appropriate focus for the health lens project given the likelihood that a future increase in the use of climate-independent resources will be necessary in SA. It was also recognised that public opinion and perception would play an important role in this being achieved. Thus, the use of alternative water supplies—rainwater, greywater and stormwater for non-potable purposes (i.e. for uses other than drinking and bathing)—became the focus of the project. The health lens project would explore affordability and cultural acceptability, as well as concerns relating to the potential health risks associated with the use of these alternative water supplies.

Another important part of the screening and scoping process was recognising that specific resources would be required to conduct the health lens. Consequently, both agencies agreed to jointly fund a position to assist in evidence gathering and administrative tasks associated with the project.

A detailed review of the available literature was undertaken, including international and national papers, with SA evidence being considered wherever possible. The literature was summarised in three reports covering the following themes: 'Health risks associated with an increased use of greywater, stormwater and rainwater', 'Positive health impacts of increasing the use of alterative water sources' and 'Consumer compliance and behaviour change'. Both negative and positive health impacts were identified, and a particular focus was placed on the potential for alternative water sources to maintain both public and private greenspace areas.

Significant gaps were identified in the literature, particularly in terms of SA-based evidence and issues relating to public acceptability of using alternative water supplies. In an attempt to fill these gaps, the project commissioned a social science researcher from Flinders University to undertake focus group research with members of three distinct population groups identified as potentially being at higher risk from the adverse health

impacts associated with alternative water supplies. These groups were the elderly, parents of young children, and young adults (aged 16–24 years). From the available evidence and using the expertise of members of the JEWG, hypothetical scenarios were developed around potential reuse options, and these scenarios were then explored in each of the focus groups.

The results of the focus group research were of great interest to the JEWG. There was overwhelming support from participants across the groups for increased capture and reuse of stormwater, but little support for increasing greywater reuse at either the household or community level. Many participants were already actively involved in recycling water or using alternative supplies, particularly through the installation of rainwater tanks either plumbed into the home or for use in the garden, as well as reusing washing water in the garden. While this finding reflected what was identified in the literature, the strong support for stormwater reuse was of interest to both agencies.

There was ongoing review of evidence and community and stakeholder feedback by the project team. The team then drafted a project report with recommendations crafted to inform the development of the water security policy. A presentation of the analysis and the draft recommendations was made to the SA Water Customer Council (representatives of industry and business) and was well received. The final report, including strategic recommendations, was provided to the Independent Commissioner for Water Security and OWS for consideration in the creation of future water security policy.

The state's water security plan, *Water for Good*, was released in June 2009, with the vision of ensuring that SA's water supplies are secure, safe, reliable and able to sustain continued growth to 2050.

Evaluation of the process and outcomes

On completion of the health lens project, the South Australian Community Health Research Unit, Flinders University, was commissioned to undertake an evaluation of the project. The process consisted of a focus group discussion with members of the project team, as well as key informant interviews with a senior policy manager within OWS and the Commissioner for Water Security. The results of the evaluation process are summarised in the following section.

Overall, the health lens was seen as a constructive initiative, building capacity and adding value to the work of both OWS and DH. Perhaps one of the most important outcomes of the project was a strengthening of the relationship between the partner agencies, both with the HiAP team and members of the Water Quality and Wastewater Management teams within DH. These relationships will play a critical role in the further development and achievement of actions within *Water for Good* and in other work involving both agencies. The development of a joint understanding of each agency's core business, processes and language was central to the development of new relationships and the strengthening of existing ones. Having members of DH involved in the project who already had a solid understanding of issues around water security and quality assisted in joining the two agendas in an almost seamless manner.

Key reflections

Reflections on the process identified a number of key factors that contributed to the constructive nature of this health lens. These are outlined below.

A broad conception of health, and a commitment that the priorities of *both* agencies would inform the process, underpinned the development of the collaboration. Finding common ground was perhaps a relatively easy process given the obvious and strong historical connection between health and water supply. As one senior decision-maker from OWS noted, health considerations are integral to determining the safety and quality of water supply. The health lens process did, however, highlight other ways in which water influences health, for example the importance of green spaces, which are dependent on a secure water supply, to both community and individual health.

One informant suggested that modern policy development was about human adaptation and behaviour rather than simply resource management. This perspective clearly broadens the knowledge base and range of strategies considered in policy development. It frames the issue in a way that encourages an intersectoral rather than a siloed approach.

Commitment to the process by senior staff within both OWS and DH was seen as critical. Senior executives from both agencies were provided with briefings regarding the process and project outcomes on a regular basis. Process leadership was provided by the HiAP Manager in DH in a manner that was seen to encourage inclusion rather than the dominance of any one agency. People with relevant expertise regarding water quality were readily identified within DH and were regarded as credible experts within the field. Some members were described as being 'more open' to the health lens approach than others, but generally all approached the project with goodwill. Participants felt the project team worked well together, and regular team meetings were held and were well attended.

Participants reported that the team composition and the process undertaken resulted in new perspectives being brought to bear on the issue, and this was seen as very positive.

The scoping process was particularly important in defining the boundaries of the health lens and ensuring that the core business and constraints of the agencies were well understood by all parties. A sense of shared ownership was developed.

A junior staff member from each agency supported the health lens initiative and this was seen as a key factor in achieving the aims within a reasonable time frame. They undertook literature searches, facilitated communication between agencies and were responsible for the organisation of focus groups. Participants noted the importance of having people with dedicated time to ensure that momentum was not lost and timelines were adhered to.

This health lens project was undertaken during a period of policy development in what is a highly visible and politically sensitive policy area, and participants were constantly mindful of this. This provided momentum, a focus and a sense of authenticity to the process.

The development of *Water for Good* was seen as a 'policy opportunity', but it also meant that there were significant and sometimes competing demands on OWS staff. Timelines and milestones needed to be responsive to the dynamic policy environment. It is worth noting that the health lens process was able to adapt to significant organisational changes, including the appointment of an Independent Commissioner for Water Security. Updates on the process, the final report and recommendations were brought to her attention upon completion.

Using focus groups to test reaction to policy options was new to some members of the project group and was seen as a useful and powerful means of capturing community feedback. The JEWG considered it important that the focus groups were independently facilitated, which ensured a professional approach to the conduct and reporting of the sessions. In particular, the JEWG noted that there was considerable public debate regarding water issues at the time. It was therefore important that the purpose of the focus groups was made clear to all participants, and the possibility of miscommunication or misinformation was carefully managed.

Suggestions for improvement in the process

During the evaluation session conducted with members of the JEWG, a number of suggestions were made to improve or strengthen the health lens process. A summary of the suggestions is given below.

In order to ensure a shared understanding of the process and its purposes, more investment should be made at the beginning of projects to ensure that all participants have an understanding of the broad determinants of health and wellbeing. This should include how determinants operate to influence the health of individuals and populations, and how determinants act to produce health inequities.

It is important that all participants understand the nature of the commitment and expectations regarding participation. As a long-term process (this health lens was undertaken over a 6-month period), it is inevitable that there may be some changes in membership or that participants may not be able to attend all meetings. Alternative arrangements (e.g. proxy representatives) should be in place to ensure that progress is not compromised.

It may be useful to include some participants from related but not necessarily core agencies in the process on an 'as needs' or 'just-in-time' basis, to provide specific advice or feedback. In this instance only members of the two partner agencies were involved in the project work; however, there may be instances where it would be useful to draw on the experiences or seek advice from members of other agencies who deal in the issue under investigation.

Given that cost is clearly a critical factor in the adoption of any policy recommendations, it may be seen as beneficial to include someone in the JEWG with expertise in this area (e.g. an economist).

Health lens recommendations informing policy

The key policy document regarding water security for SA, *Water for Good*, was released in June 2009. As noted above, this health lens analysis was undertaken in the active development phase of this policy. The scope of the project was clearly focused on use of alternative water sources—stormwater, rainwater and greywater. This represents only one aspect of the territory covered in water security policy, which focuses on sustainably securing water supply for the whole state. Nevertheless, by interviewing senior decision-makers within OWS and analysing the recently released report in light of the project recommendations, we gained some indication of the extent to which the health lens approach may have been incorporated into this report.

Key decision-makers in the policy development process reported that the health lens project report did have influence in the policy process. In particular, it influenced the narrative of the *Water for Good* report—how the issues were framed and the language used. An important component of *Water for Good* is the section on stormwater reuse, a concept that was broadly accepted and encouraged by the community members consulted through the focus groups. Broad community support for increased stormwater reuse was documented through the qualitative research process. This was important in providing evidence to confirm that this option would be supported by community members. In this way, the outcomes of the health lens project were important in influencing future policy development and informing the *Water for Good* plan.

The project report also confirmed the relevance of information from other jurisdictions to the SA community through the input of the focus groups. The analysis was viewed as a positive contribution to the policy development process.

Testament to the success of the health lens project and the ongoing relationship is OWS's interest in conducting a second analysis relating to potable water supplies in regional communities. Initial discussions have commenced and are continuing.

Chapter 12

Regional migrant settlement: a health lens approach

Tyson Miller, Italia Mignone and Louise Thornley

Introduction

The Regional Migrant Settlement Health Lens Project was a collaborative initiative led by the Department of Trade and Economic Development (DTED) in partnership with Multicultural SA and the South Australian Department of Health (DH). The main aim of the project was to identify the factors that influence settlement outcomes for migrants and explore the relationship between settlement experiences, policies and programs and the health and wellbeing of migrants in regional areas of South Australia (SA).

A further aim of the project was to develop evidence-based recommendations that could inform decision-making processes to maximise gains in health and wellbeing and reduce or remove negative impacts or inequalities. The project also sought to support the development of sound policy outcomes for all agencies involved.

Background

In late 2007 DTED began preliminary discussions with DH to be part of the Health in All Policies (HiAP) program, and expressed an interest in applying this approach to migrant settlement. In January 2009 Multicultural SA was invited to be a project partner as the state government agency responsible for advising the government on all matters relating to multicultural and ethnic affairs in SA.

Migrant settlement is a key objective of the state's Population Policy and contributes to a number of South Australia's Strategic Plan (SASP) Targets, including Target 1.24 *Overseas Migration: Increase net migration gain to 8500 per annum by 2014*. The role of the state government in migrant settlement is to coordinate and support access to the delivery of effective settlement services for all new settlers in SA. The government has committed to promoting population growth in regional areas of SA, which includes overseas migration programs (SASP Target 5.9 *Regional population levels: Maintain*

regional South Australia's share of the state's population (18%)). Regional SA faces challenges of lower population growth than the metropolitan area of Adelaide, a rapidly ageing population, and young people leaving their local areas to pursue career paths in Adelaide, interstate and overseas.

Migration to SA, and increasingly to regional areas, has grown significantly in recent years, with a particular focus on skilled migration to address persistent skill shortages. At the same time the Commonwealth Department for Immigration and Citizenship has promoted a policy of regional settlement for humanitarian migrants. Successful settlement has important implications for the health and wellbeing of migrants, and plays a significant role in their willingness to move to regional areas and remain there for the long term. However, relatively little is known about the settlement experiences of migrants in regional areas.

Process

The project was overseen by a team comprising the key partners—DTED, Multicultural SA and DH—which was advised by a joint expert working group (JEWG). The JEWG included representatives from the Department of Further Education, Employment, Science and Technology (DFEEST), the Department of Education and Children's Services (DECS) and academics from the University of Adelaide and University of South Australia.

The project involved four stages.

- Stage 1 Project Development: explored common issues in migrant settlement through a preliminary review of national and international literature and the development of a migrant settlement wellbeing framework. The framework was used to provide guidance for data and evidence collection on key issues that impact on settlement outcomes and the wellbeing of migrants and their communities.

- Stage 2 Preliminary Investigation: included baseline data collection, mapping of the settlement service pathways for skilled and humanitarian migrants, and the development of selected regional profiles. Baseline data was collected to identify the location of migrant groups across SA to inform the most appropriate locations to use as case studies for the project. Workshops were conducted with migrant service providers, who identified a number of issues with the provision of adequate services for migrants. During the preliminary investigation it became clear that there was a lack of evidence relating to migrant settlement experiences, and the JEWG concluded that in-depth qualitative research would need to be conducted.

- Stage 3 Qualitative Regional Evidence Gathering: involved gathering information about the settlement experiences of migrants in the two selected regions. This consisted of focus group discussions with migrants and community members, and interviews with employers of migrants. A social researcher with expertise in qualitative research and knowledge of the SA HiAP approach was commissioned to conduct this research, and DH and DTED staff provided assistance.

- Stage 4 Recommendations, Final Report and Approval: the JEWG drafted a series of recommendations for each of the three partner agencies based on the project findings. These were approved by the Chief Executives of DTED, DH and Multicultural SA, and included in the final project report.

Regional research

Building on the findings from the preliminary investigation, the qualitative research explored the settlement experiences from the perspectives of migrants, employers of migrants and community members, to identify the factors that influence settlement outcomes in regional areas of SA. The study also aimed to determine whether the services, programs and policies available to migrants settling in regional SA are delivering the outcomes desired by government, migrants and the broader community. The research aims were to:

- identify facilitators and barriers to positive settlement experiences and outcomes

- describe how settlement experiences impact on the wellbeing of migrants

- identify strategies for positive settlement of migrants in the future.

The existing relationship of the regional service providers and community leaders with DTED and Multicultural SA was integral to the success of the focus groups and interviews.

Reflections on the research process by the researcher

- The project team played a key role in facilitating the researcher's learning about migrant settlement policy issues in SA, especially by providing comprehensive and relevant background material prior to the research. As the researcher was unfamiliar with the regional locations, it was important to have research assistants with prior experience and understanding of the regions. The need to spend time becoming familiar with the policy context and the regions was recognised prior to the research, and specific time for this was included in the project.

- On reflection, it was vital to include all three perspectives—migrants, employers of migrants and community members—in the qualitative research. Views from the various perspectives were able to be compared in the different regions, and this was more useful than if the research had only included migrants. The partnership between the project team, local service providers and community leaders played a major role in setting up a workable research schedule and in ensuring that appropriate research participants were involved. Despite the variety of people involved, the research participant recruitment process ran relatively smoothly, mainly due to good communication and regular liaison between the project team and the local contacts.

Findings

The literature review revealed that all migrant groups face challenges when settling in a new location, including language barriers, cultural differences, unfamiliarity with a new service environment and the loss of familiar support structures. This was supported by the research fieldwork.

The key issues identified through the research included:

- Limited access to English language courses made it difficult for migrants to develop adequate language proficiency, impacting on their ability to obtain appropriate employment and to access services (including health services).

- Securing employment, particularly securing work appropriate to their qualifications was a major issue.

- Temporary visas caused significant stress for migrants, creating uncertainty about their ongoing employment status and making it difficult for them to access services that are available to the general population, e.g. health care and tertiary education.

- Migrant support services were identified by participants from all groups as playing a key role in facilitating positive settlement outcomes.

- Access to services (including health services) is limited in regional SA for both the general and migrant population and access to culturally appropriate services was even more limited.

- Migrants, community members and employers reported that the local communities were becoming increasingly open to new migrants. They acknowledged that while it took time for new migrants to settle and integrate, migrants played an important role in the sustainability of their community.

Analysis of impacts of findings on health and wellbeing

The findings from the project demonstrated a number of factors associated with migration and settlement that may impact on the health outcomes for migrants. Factors such as low socioeconomic status; poor English language proficiency; lack of recognition of qualifications; discrimination and racism; lack of job satisfaction; social isolation; and traumatic experiences before or during migration increase the likelihood of poorer settlement and health outcomes.[1] Poor settlement outcomes can lead to feelings of isolation and discrimination, which research shows have a major impact on both physical and mental health.[2]

Recommendations

A key outcome of this project was a series of recommendations for policies and programs for each of the agencies involved, in order to improve settlement outcomes for migrants and the communities they settle in. The recommendations have been developed in order to minimise the negative impacts of settlement on health and wellbeing and to ensure that settlement is a positive experience for all migrants.

The recommendations include an integrated settlement strategy that supports all aspects of settlement: from finding employment and adequate housing to navigating transport systems and accessing services. Reducing the stress of settlement will improve health and wellbeing significantly as evidence has established that stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health.[3] While stress can impact on many aspects of health and wellbeing, it is the cardiovascular and immune systems which are most affected, diseases of which place a significant burden on the health system.

Improving the social integration of recently arrived migrants into communities is also a key aim of the recommendations. Evidence shows that social inclusion and social support improve both psychological and physical health. Social support acts as a protective factor against many negative health outcomes. Social support is also related to beneficial effects on aspects of the cardiovascular, endocrine and immune systems.[4] People with less social and emotional support from others are more likely to experience less wellbeing, more depression, a greater risk of pregnancy complications and higher levels of chronic disease.[3]

The recommendations also reflect a need to support migrants to gain meaningful employment as it is well recognised that unemployment has a significant impact on health. A review of literature found that unemployed men and their families have increased mortality, particularly from suicide and lung cancer. Unemployed men are also more likely to use general practitioner and hospital services more frequently, and receive more prescribed medicines. Smoking and alcohol consumption are often increased after the onset of unemployment.[5]

The recommendations have been approved by the Chief Executives of DTED, DH and Multicultural SA. They will inform future decisions in DTED and relevant government departments in improving policies and programs to achieve successful settlement outcomes for migrants and the regional communities that they settle in.

Learning and reflections

In reflecting on the health lens process and its outcomes, DTED and Multicultural SA identified a number of key learnings. These are described below.

Process

The development of the health lens project proposal took place over a number of months. Scoping the project was an iterative process and, while deliberations over the scope perhaps caused some delay in the project's timing, it provided an opportunity for uncovering issues relating to knowledge, process and methodology. This helped to create a shared understanding of the project's aims and what it would deliver.

Migrant settlement has a broad policy scope that encompasses numerous policy areas such as education, employment and training, health, housing, transport, and economic and community development. Narrowing the scope of the project was only possible

following the preliminary literature review and once the development of a migrant settlement framework had been completed.

The initial interest for DTED was in the focus of their policies and programs, principally skilled migration. The scope of the project brief was therefore originally designed to include only skilled migrants. After discussion with the JEWG and reflection by DTED, this was not considered practical, as any research at a community or migrant level would discuss issues more generic in nature for migrants.

HiAP is a unique approach to policy and program administration. It has a broad scope of application, from the time that a program or policy is implemented through to its review and evaluation. Program or policy proposals, particularly involving funding, are often subject to consultation or impact assessments but they generally do not touch on areas such as health and wellbeing. The health and wellbeing impacts may only become apparent later and may be an unintended consequence or benefit of the original intent. The strength of the HiAP approach is that it has the potential to be broad in its application and fluid in its timelines. The application of a broad lens to government policy and programs could be explored by DTED in the future in areas such as economic development, regional community building, and infrastructure and planning.

Project team

Initially the project team consisted only of staff from DTED and DH; however, the inclusion of all migrants in the project scope necessitated an approach by DTED to Multicultural SA. The involvement of Multicultural SA was critical in accessing existing relationships with settlement service providers in regions, as well as knowledge relating to migration issues. Gaining this active participation of Multicultural SA was an important part of the process.

Decisions about who had responsibility for key aspects of the project—how the reporting would occur and who would do the work—proceeded slowly, in hindsight. This period of uncertainty, although initially perceived as a weakness of the HiAP approach, was eventually resolved and, in fairness, coincided with a period of indecision about the goals of the project.

Research

The original aim was to conduct research fieldwork across four regions of SA. Due to resource limitations and competing priorities across the agencies, this was not possible. Nevertheless, the project team was still able to undertake a comprehensive project across the two selected regions. While the settlement issues that arose from the research fieldwork were generally consistent across the two selected regions, there were site-specific variations. This was to be expected as site characteristics will influence settlement outcomes for migrants. However, as a result of the more limited scope of the research, the data collection and variations in approaches to supporting migration settlement were not able to be fully tested. The preliminary research and data collection processes were a long time in development but, once implemented, proved to be highly valuable in terms of the information provided.

Direct engagement with migrants, employers and community groups through the research phase enabled a different and perhaps clearer perspective of the impact of existing policies. It also meant that the project can be seen to support citizen-centred engagement—the research participants not only engaged in an evaluation of existing policy settings but are assisting in shaping future policy work.

Additionally, the direct involvement of DTED and DH staff in the research was particularly valuable as it provided them with a deeper understanding of the issues raised by the participants and of the research process, which in turn helped with development of the recommendations. It also provided opportunity for building the capacity of staff to undertake and understand the research.

Evaluation

One of the original project goals was to provide action-oriented recommendations for DTED and, potentially, other agencies for future consideration of migration settlement policies and programs. While a process evaluation has been undertaken, an enhancement to the HiAP approach may include longer term evaluation or monitoring of project outcomes.

Conclusion

While this project took longer than initially anticipated and was a steep learning curve for staff from DTED and Multicultural SA, both the project outcomes and experience of the process were considered valuable to all agencies involved. Working in a way to achieve successful intersectoral collaboration is a skill in itself, and the JEWG appreciated the opportunity to further develop their skills in this area. The success of this project is indicated by the prompt approval of the recommendations and the commitment by each agency to action the recommendations. For example, work will commence early in 2010 on an integrated regional settlement strategy. The recognition by one agency that this project was about the need for 'migration in all policies' indicates the value of encouraging other agencies to consider the implications of their policies on the determinants of health.

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Chapter 13

Digital technology access and use as 21st century determinants of health: impact of social and economic disadvantage

Wendy Golder, Lareen Newman, Kate Biedrzycki and Fran Baum

Introduction

In 2008 the Department of Further Education, Employment, Science and Technology (DFEEST) indicated an interest in collaborating with the Department of Health (DH) on a health lens project. Initial discussions revealed digital technology access and use in low socioeconomic status populations to be an area of particular interest to both agencies. Researchers from Flinders University of South Australia (FUSA) were commissioned to undertake a series of focus group discussions investigating the use of digital technology by members of this population group.

This paper presents the perspectives of both the lead agency (DFEEST) and the researchers involved in the project (FUSA) on their experiences in working with DH on the Digital Technology Health Lens project.

Connecting our future

Linking health with digital technology

The linking of health and wellbeing with the use of digital technology is a challenging concept. Digital technology (the use of online tools such as computers, the internet and mobile 3G technology) can have a direct impact on health in various ways, including providing access to online health information and support groups, and as a means of efficiency and transportability for patient records. For practitioners high-end digital technology can provide ready access and input into current research. As videoconferencing technologies improve, so too do opportunities for tele-medicine, online consultation

and access to clinical services. These opportunities address practitioner shortages and overcome restricted access to services, particularly for people in remote or isolated environments.

However, establishing a causal link between digital technology and general population wellbeing is not so straightforward. This Health in All Policies (HiAP) investigation explored the concept that 'connectedness' is a key component of good health and general wellbeing—that those with good access to other people, services and support are more likely to be empowered to meet health and wellbeing challenges. Being connected can take many forms. A small village community, for example, may provide strong support networks through direct proximity and daily contact, no matter how economically disadvantaged such a community may be. On the other hand, in our urbanised Western communities, isolation and inequity of access to resources is increasing. In response, digital technology is increasingly providing a means of being connected, across global as well as local barriers, and significantly replicating other traditional community links in today's society.

As the penetration and capacity of digital technology increases, service providers and the community increasingly rely on it as a tool to communicate and deliver services. Banking, shopping, education, entertainment, information and communication are just some aspects of life for which online channels are now accepted and encouraged. E-government and e-learning, tele-work and even e-reading are today generating much interest and increasingly being regarded as methodologies for the future.

In our communities socioeconomic status can be directly linked to the health divide, the social divide and the digital divide. Evidence supports the concept that people of lower socioeconomic status are more likely to have lower health status and least likely to access and use digital technology. Thus, the use of this technology can be seen both as an indicator of socioeconomic wellbeing and an enabler that will assist populations and individuals to better health outcomes. The World Health Organization (WHO) Commission on the Social Determinants of Health reported on the dramatic differences in health outcomes observed to be linked to degrees of social disadvantage.[1]

South Australia's Strategic Plan (SASP) includes a target to increase the uptake of broadband[a] in South Australia (SASP Target 4.8 *Broadband usage in South Australia to exceed the Australian national average by 2010, and be maintained thereafter*). The SA Information Economy Agenda further explores this concept, emphasising that making broadband infrastructure available will not succeed alone in improving uptake, without concurrent and interrelated improvements in '…digital capability and technology-based productivity growth'.[2] It is these factors that will support each individual, business and industry to effectively engage with the technology to generate social and economic benefits. Effective engagement of all community members with online technology will, in turn, generate increased demand for broadband and gain improved health outcomes in our society.

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[a] *'Broadband' is a general term for telecommunications services that transmit digital information at high speed over extended distances, either through the air or along a physical carriage medium.*[3]

The project

The Digital Technology Health Lens project examined the health and wellbeing impacts of inadequate access to digital technology. As traditional communication methods are replaced by digital technology, people who do not use this technology will be left behind, therefore placing their health and wellbeing at risk.

In 2008 the Australian Health Inequities Program at Flinders University was commissioned, under the HiAP Health Lens Initiative, to explore the impact of social and economic disadvantage on the use of digital technology. Focus groups were conducted with participants drawn from identified socially and economically disadvantaged groups.

Key findings from these focus groups linked the use of technology to other socioeconomic indicators such as level of education and literacy, employment status, home ownership and income. It is significant that, even when there was access to digital technology, its use was limited by individual capability, digital literacy and confidence, and insufficient financial resources.

This research also identified negative health impacts associated with the use of digital technology, including the pressure of not understanding the technology or distrusting the claims of providers, addiction to its use (e.g. with chat rooms or online games), and previous or assumed threats to personal security and safety. There was some acknowledgment that people withdrew from using the technology even when it was available to them, rather than risk embarrassment at their lack of digital skill or access to the latest version or model.

While the focus groups indicated that face-to-face communication was often their preferred option, it is also true that, as online services increase, people on the wrong side of the digital divide will be increasingly disadvantaged and dysfunctional, with obvious impacts on their wellbeing.

Phase 2 of this study explored how people's interaction with digital technology may be encouraged and supported, and how the barriers identified in the initial study may be addressed. This study focused on the use of mobile phone access to broadband, acknowledging the wide penetration of this technology in our community, the development of mobile applications and services, and the predictions that mobile devices will be the preferred technology platform of the future. As cited in the Digital Britain Report, 'Given time, low cost broadband mobile phones connected to the mobile broadband network have the best long term potential to ensure complete inclusion of all in the UK to the broadband internet'.[4]

In considering how the use of mobile phones can be seen as a vehicle to increase internet use across the board and improve health and wellbeing in South Australia, focus groups again considered the implications for people whose low socioeconomic status predicted lower digital engagement. As anticipated, within these groups there was limited access to broadband through mobile phones. Reasons included real and perceived costs, lack of awareness about online content and access mechanisms, lack of skill and confidence in using this technology, and complexities inherent in the technology and in available

contract options. However, these groups also explored the possibilities offered by this technology and how these opportunities may be defined to meet the needs of their lifestyles and circumstances.

Recommendations from this research recognise that digital technology is a core enabler in our community and that it should be equitably available across all social groupings. It is imperative that a digital inclusion policy and agenda be developed and resourced, so that existing divides in our community are ameliorated and the benefits of the digital economy can be the foundation of a progressive and healthy society. As the WHO report highlights, '…health and health equity may not be the aim of all social policies, but they will be a fundamental result.'[1]

Success factors

Digital technology is the 'new black'

The adoption rates for digital technology in Australia are among the highest in the world. Even for those people marginalised by the social and digital divides, the appeal of this technology is compelling. The community recognises the universal impact that digital technology has. As evidenced by the input from the focus groups, most people have considered their response to the online environment and the impact that it has, or may have, on their lives. As research subjects, the focus group members were a willing and enthusiastic cohort, able to provide data on an issue that has direct and significant impact on the conduct of their lives and, by strong implication, on their health and wellbeing.

Recognising the value of 'joined-up' government

Consider that today, for example, driving licence tests and renewals are available on line, applications for study and employment are often only accessible through the internet, and local members keep their constituency informed through their social networking sites. Within this context, the responsibility of making the digital environment accessible to all citizens falls to the government as a whole. For example, digital literacy is the focus of vocational and community education, as well as schools and the higher education sector. Digital engagement programs for Aboriginal communities require the input of Aboriginal and social inclusion authorities; education and information economy programs; and health, family services and industry resources. If government is to access the myriad opportunities presented by the online world for community consultation, it must ensure that this is equitably available to all.

The relevance of the information economy in ensuring that connectivity and digital capability meet the needs of current trends in government communication policy and service delivery means that the findings of this research project have significance across government. The project offers various pathways to a single goal that will support a healthy and viable society through the universal application of digital technology.

Innovation and opportunity

If exploring the linkage between health and wellbeing and the use of digital technology presents a challenge, it is also a prime example of an innovative approach to policy development. The health lens approach explores previously uncharted territory, and frames policy development in specific interest areas with broad social goals and a whole-of-government impact.

The findings of this research complement the work of 2009 Thinker in Residence, Genevieve Bell, who explored strategic directions and opportunities for the future of digital technology in South Australia.

Sensitivity and respect

This research was characterised by the thoughtful and sensitive approach of the researchers in interacting with the working group, government and research subjects. Content and methodology for this research was continually refined, and every effort was made to ensure that the needs of all parties were respected and coordinated. The responsiveness of community participants is testament to the sensitivity of this approach.

Collaboration

A strong collaboration between key agencies was fundamental to the success of this project. As previously described, the strength of HiAP is its relevance across government, and this has been demonstrated by the collaboration between members of the joint expert working group.

Hurdles to be overcome

Health by computer?

Establishing the link between health and digital technology is difficult to quantify. Literature and data searches clearly support the link, and the HiAP team continue to evaluate the efficacy of the health lens analysis. Without a longitudinal case study process incorporating clinical and psychosocial analysis, it is necessary to rely on the juxtaposition of social wellbeing indexes, analysis of population trends, understanding of the social condition, and awareness of the rationale and conduct of current engagement programs to illuminate this trend in our society. There are multiple social determinants of health, and isolating just one indicator needs to be carefully defined. However, the overwhelming evidence of the interrelation of socioeconomic status, digital engagement, and health and wellbeing validates this study.

Predicting the future

Just as the rate of change in digital technology increases exponentially, so too does the need to forecast the direction of technological innovation as part of policy frameworks.

Will voice recognition technology, for example, remove the need for written literacy skills, which for many citizens is impeding their use of digital technology? Will downward cost trends make technology increasingly accessible for those in low socioeconomic groups? Will free 'wifi' (wireless digital technology) replace the need to lock into service provider contracts? Innovation in digital technology will impact on the way it is used in our society, but the intrinsic value of current trends in digital engagement remains at the core of this study.

How do you know what you do not know

While the focus group members were aware of digital technology and used it to varying degrees, they were unaware of many features, applications and resources that may have influenced their responses to the focus group questions. Individuals were unaware, for example, of community training and cyber safety resources available to them, or of free wifi hotspots or simplified phone handset models. Lack of information and awareness continues to be a major stumbling block for both the research participants and the wider community. This has a flow-on effect for any government policy that encourages the use of broadband.

It's a corporate world

For most areas of digital technology, and in examining the use of mobile phone technology in particular, these research outcomes are impacted by the commercial environment, its market drivers and the existing regulatory environment. It is necessary to recognise the limits of influence of government policy-makers. The findings, however, are a timely recognition of changes in communication and interaction today that should be addressed to ensure the social and economic benefit of a healthy society.

'An ideal information economy requires all our citizens to participate collectively and embrace digital technologies.' [2]

The future is now…

The rate of change in digital technology is increasing exponentially. As advances in technology and the delivery of information and services online increasingly shape society, so too does the possibility that the digital divide will deepen. We need to ensure that all people have the opportunity to participate in all aspects of society and the option to contribute to it. Digital inclusiveness, accessing and effectively using new technologies, and having access to all service and information channels, is mandatory for the continued health and wellbeing of our community and the individuals in it.

Researcher reflections on the HiAP process

In 2008 researchers from Flinders University of South Australia (FUSA) were commissioned to conduct qualitative research into the uptake and use of digital technology (digital technology; including computers, broadband internet and mobile phones) in low socioeconomic status populations.

In this section we, as the researchers involved in this health lens project, present our perspective on the process, with a view to identifying some of the challenges we faced, how we overcame them and what we have learned. A secondary theme of the paper is to assist in informing researchers who may be involved in a future health lens project of factors they may need to consider, particularly in terms of working in a policy environment—something that many researchers will not be familiar with.

The Digital Technology Health Lens project developed in a partially organic way, primarily as it was only the second such project to be implemented in South Australia. This meant that, as researchers, we needed to be flexible with the process and directions, and see the lack of an existing process as an opportunity rather than a frustration. The literature highlights some key elements in successful researcher–policy-maker partnerships,[5-11] and we have used these to structure our reflections below.

Building mutually committed trusting relationships

The most crucial element identified in the literature for a successful research–policy joint project is allowing sufficient time and regular face-to-face interactive meetings to build a trusting and mutually committed relationship. Trust already existed with the HiAP staff from having worked together on other projects, but time was required to build a new relationship with the DFEEST staff. This developed during subsequent face-to-face meetings, phone calls, email contact and information sharing.

Some project members were unable to attend all meetings and this may have slowed progress. However, the project was able to move forward if a representative from each of the three parties (i.e. DFEEST, DH and FUSA) was present at each meeting. This did not perhaps provide for development of a perfect understanding, but did allow for important dialogue that supported the process. Furthermore, attendees were invariably enthusiastic and engaged during meetings. The project also benefited from the committed drive of someone in a management position within the HiAP project team to drive the process and keep people coming together. We recognised that HiAP projects are not the core business of the non-health sector, and that even scheduled meetings could come up against competing priorities for some partners. In hindsight we think it is also important to clarify early on which parties' presence is absolutely vital at which meetings, and to have everyone present at an initial meeting.

Working to a common purpose that has timely relevance to both sides

As researchers interested in how academic evidence on health inequities and social determinants is taken up in policy, we found the HiAP process particularly satisfying. We were directly involved in seeing how the policy question of two government departments shaped our empirical research, and, in turn, how the voices of the research participants informed potential policy actions and recommendations. This meant we experienced first-hand the context-dependent process of 'evidence-based policy-making', as identified by Nutbeam.[12]

From our perspective, HiAP worked well for this project because all parties had interests that overlapped to a considerable extent to provide a common purpose. For DH, HiAP was clearly a priority; and for DFEEST it offered a new way to meet their SASP target as well as possibly to increase digital inclusion, an area for which they had already established a Digital Bridge Unit.

Working with clear boundaries, roles and responsibilities

Some boundaries, roles and responsibilities seemed clear from the start: DH led the HiAP process and was the liaison point for ourselves as researchers and for DFEEST (together constituting 'the project team'). Our expectations were that DFEEST and DH would provide expert knowledge in their respective fields. Our role would be understanding the HiAP aims sufficiently to design research to: collect the required evidence; lead the instrument design with subject input from HiAP and DFEEST staff; conduct and analyse the fieldwork; and present the research findings to the project team and joint expert working group (JEWG). We expected that all three parties in the project team would then discuss the research findings in light of the HiAP questions and their implications for potential government action. Having more discussions about how the research linked to the current and future policy context could also have been useful. However, we accepted that the HiAP implementation process was inherently organic and that some negotiation would be needed.

Building a joint understanding of the issues

Joint understanding of the issues was primarily developed in an ad hoc way, in that key concepts and terms were mainly defined informally at meetings, and therefore some had to be repeatedly defined and clarified. This was particularly the case for key terms and concepts such as 'HiAP', 'social determinants of health', and the difference between improving average health and reducing inequities. We felt it required a good deal of work to convey an understanding of social determinants of health to a non-health audience in ways that were relevant to the culture and understandings of other organisations. Eventually, the potential step-by-step links were written down to clearly show how digital technology access and use could be expected to influence health and wellbeing, as shown in Figure 13.1.

In contrast, it was easy to develop some common understanding of disadvantage because staff from DFEEST's Digital Bridge Unit had a mandate on increasing broadband uptake among specific disadvantaged population groups. We needed to explain our focus on the lower half of the population, and to emphasise our finding that not everyone uses, or wants to use, digital technology—despite this being a common assumption. Similarly, it took us, as social researchers, considerable time to understand technological concepts, particularly as digital technology is advancing rapidly. We had to develop an understanding of concepts such as the difference between broadband, wifi and WAP, so that we could hold meaningful and up-to-date discussions with the focus group participants.
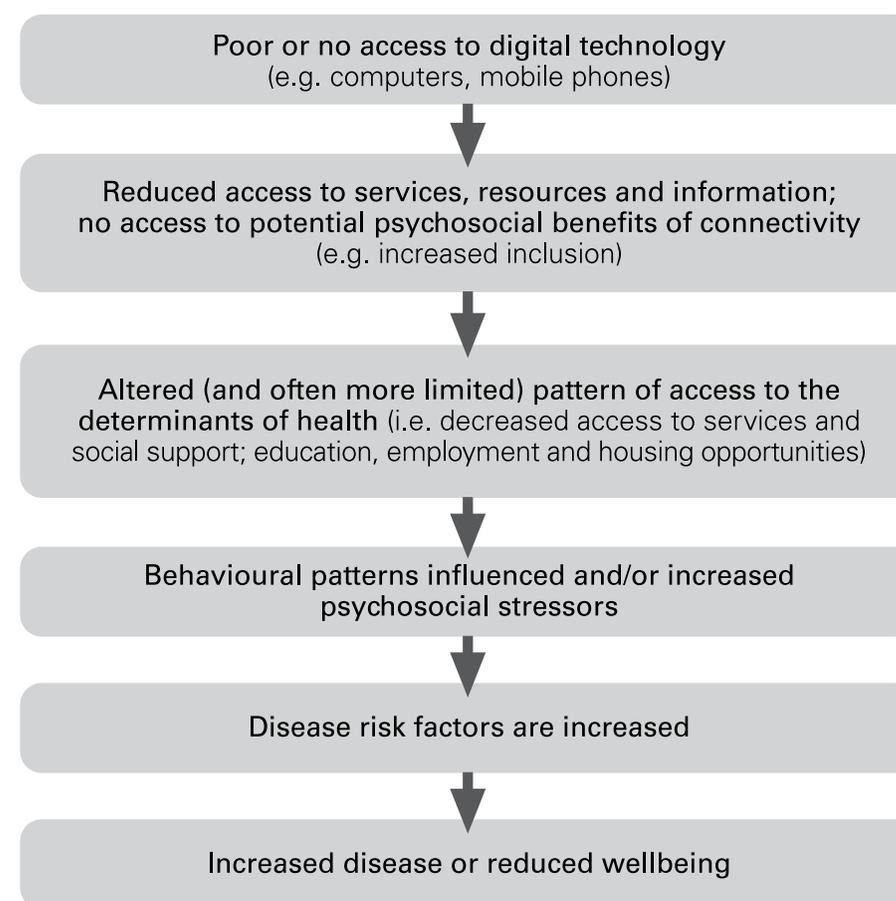
Figure 13.1: Links between use of digital technology and health and wellbeing outcomes

Summarising the research with key recommendations and forums where the key players discuss the implications

Throughout the project we felt the need to reiterate key concepts and our research findings, particularly because the concepts had not been clearly understood from the start (as explained previously). The research findings were disseminated on paper during meetings and as a final report with key recommendations, which, in retrospect, may have been a more academic way of information sharing. We also came to realise that members of the JEWG had significant time commitment on other projects, which probably precluded detailed readings of lengthy reports. For this reason it was important to provide summary documents or, in the case of the final report, a clear and concise executive summary, to draw attention to the key findings.

As previously mentioned, we observed significant progress during debates at the meetings, which highlights the importance of verbal presentation of ideas from all parties. We have also come to think that verbal/visual presentation may be a more common way of sharing information within government, and presenting the key research findings in a more culturally appropriate way may have enabled faster or deeper understanding. However, there are few incentives or rewards within academia for spending time engaging with policy-makers in this more time-consuming way.

Building a joint understanding of each other's culture

From our perspective, the Digital Technology Health Lens process was aided because we work in an academic department which, for 20 years, has developed a policy-relevant culture and worked with various departments of the South Australian government, in particular the public health area of DH. However, this HiAP project provided us, as individuals, with the opportunity to work with a department with which we have previously had no contact. It allowed us to learn about different assumptions, language, processes and ways of working. At the same time it hopefully provided the department staff with some insight into the ways of working with a research group with which they have not previously had contact. We felt that the cross-cultural work between researchers and policy-makers was also aided because DH staff have considerable experience in a research-attuned culture. They regularly commission academic research and work with the researchers to inform local health policy.

As researchers with some previous experience of working with policy-makers, we also had some awareness of the policy process, and the fact that academic research is often only one of many types of input to government decision-making and policy-making. Hence, we expected that not all our research findings would lead to recommendations to government, and only those most in line with the current policy context were likely to be taken up.

Researchers involved in HiAP projects need to be aware that there are fundamental differences between the policy-making process and the research process, and that academic research is only one type of evidence used by policy-makers. They also need to understand that policy operates to different timelines, and possibly to changing political imperatives and contexts. Conversely, it is beneficial for policy-makers to also come to the project willing to learn about the way research is conducted, so that they can understand what the researchers can offer them and can consider the best ways to work together.

Conclusion

From the researchers' perspective, the Digital Technology Health Lens project demonstrated that it is possible for health and wellbeing implications to be considered within the core business of a non-health government department. In particular, we felt that it encouraged the technological side of achieving greater broadband uptake to be balanced with consideration of the related social and equity issues, and for broadband to be seen as a broader social determinant of health. This would have been unlikely without HiAP involvement. Our involvement as researchers was not straightforward, partly because the health lens approach is still in its early stages. We were helping to shape the process at the same time as the project itself progressed.

Having, or developing, skills in cross-cultural understanding and relationship-building is particularly important for the success of such projects. There is perhaps a need for clearer reward structures and encouragement from within academia and grant-funding bodies if researchers are to be more involved in this kind of policy-related research. We hope our reflections will be useful to others considering undertaking HiAP health lens projects or researcher–policy-maker collaboration in other areas.

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Chapter 14

Reflections on the health lens process

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South Australia

Introduction

Professor Kickbusch had set an ambitious agenda for South Australia (SA) to adopt a Health in All Policies (HiAP) approach. Even with the clear support of the Department of the Premier and Cabinet (DPC), the responsibility to deliver on the HiAP agenda sat firmly with the Department of Health (DH). Here was a rare opportunity to progress an approach that was cutting-edge and, at the same time, had the potential to make a significant contribution to the determinants of health.

It was clear from the start that cooperation between DH and DPC was essential to the successful operation of HiAP. Therefore, both agencies worked to build a healthy and productive partnership, which has provided the foundation to build relationships with other sectors and facilitate the engagement of senior decision-makers. As the governance surrounding the implementation of HiAP has been covered elsewhere in this book, it will not be revisited here. Rather, the focus of this chapter is on what has been learned through the process of developing and applying the health lens.

Building and maintaining strong relationships

As is the case for all work at an intersectoral level, strong relationships are a critical part of the health lens. Significant energy is put into establishing them, building mutual respect and developing a clear understanding about each agency's roles and responsibilities. This is fundamental to completing each health lens, building capacity and delivering effective policy outcomes. In these projects, capacity building contributes an important element for the long-term implementation of HiAP, as it supports the partner agency to assimilate aspects of the health lens process that they are able to apply to future policy work.

The role of the Department of Health

The core tenet of the health lens approach is that DH facilitates the work and does not assume the lead role. Instead, that role is reserved for the agency with primary responsibility for achieving the South Australia's Strategic Plan (SASP) target under investigation—the lead agency. In principle this idea appears simple and relatively easy to achieve; however, in practice it has proved more problematic, especially at the beginning of the process when the other agency was still gaining an understanding of the purpose of the health lens and how it would operate. Staff from DH have found that they occasionally slipped into a leadership role, which assisted in keeping momentum but created confusion about the role of other agencies and compromised the relationship. Conversely, because the health lens work focuses on the determinants of health, other agencies often assumed that DH would lead the process.

Health needs to resist the inclination to lead—support for the lead agency's ownership of the final product and the recommendations is critical.

Developing a shared understanding

It is not surprising that people from different professional backgrounds and organisational cultures have different views and perspectives, and that this can sometimes create significant barriers. During the developmental phase of HiAP, the establishment of a joint expert working group (JEWG) was built into the health lens methodology in an effort to prevent or minimise the chance of these problems occurring. The JEWG enables members to engage in intensive and regular dialogue, and provides a mechanism to build a shared understanding between the partners. While the JEWG may at first appear to be similar to the standard interdepartmental committee, it operates differently. The governance structure and approach underpinning HiAP work responds to incentives for the partner agencies. This enables the JEWG to operate effectively and maintains the active engagement of senior decision-makers throughout the process. These incentives have included support for mandated SASP targets as well as a clear offer of assistance from DH in achieving their policy priorities. Despite this, there have been occasional instances where the JEWG failed to build a shared understanding. It has then been necessary to revisit the original purpose and anticipated outcomes of the health lens process to see if they still met the policy needs of the agencies involved. If not, the health lens proposal was re-scoped. To date there has not been a time when the agencies involved have not been able to be reframe the health lens and continue the work, although there may be some potential for this to occur.

Each JEWG undertakes intensive discussions as part of the engagement phase to help all members develop a shared understanding of the relevant aspects of each other's business and language. It has been important to recognise that this is a two-way process, where DH staff become familiar with aspects of the business of the other agencies. At the same time the other agencies are familiarising themselves with key health concepts, in particular the determinants of health, which is generally a concept that they are not familiar with. The process of jointly developing the project proposal and the literature review contributes significantly to this shared understanding, as it requires discussions about the use of terminology and the policy context of the work. Revisiting and clarifying the understanding and use of language as it relates to the policy focus has been very important. The emphasis on mutuality and partnership helps to create a culture of open exchange that allows frank discussions about progress, process and purpose. The most successful projects have been able to create a project culture that crosses traditional departmental boundaries and overcomes interdepartmental battles that otherwise can occur.

Interestingly, developing a shared understanding between agencies has proved somewhat easier in projects where the lead agency's business is quite different from that of DH. It is not clear why this has been the case, although internal discussions within DH have suggested that agencies with stronger connections to and interest in health are likely to share some common language, and that this may lead to *assumptions* that the shared terminology equals a shared understanding, which has not always been the case. While the process of developing a shared understanding of language, purpose and policy focus proved to be time consuming and at times complex, it has been invaluable for developing strong partnerships and helping to achieve project outcomes.

Getting the balance right

Perhaps SA's significant contribution to the HiAP field has been to draw attention to the need to focus on achieving the goals of partner agencies at the same time as improving health. In other words, the policy outcome must deliver win–win results wherever possible. Not surprisingly, this approach has been strongly supported by other agencies and has led them to invest considerable time, resources and energy in conducting the health lens projects. The challenge in each case has been to get the balance right, so that the other agency and the health sector can both clearly see the benefits.

In several cases the connection between the health outcomes and the agency's outcomes are direct, and therefore more obvious and easily identified and described. In other cases the relationship between health and the policy area under investigation is not immediately obvious or is less direct. Despite this, the policy may be a significant contributor to health outcomes. In these circumstances it became essential to document a more explicit pathway between the policy issue of interest and the related determinants of health, together with their consequences for health and wellbeing outcomes. For instance, during the regional migrant settlement health lens it became important to map the health and wellbeing indicators for migrants and their families, employers and the local community, and to draw the links between these indicators and regional settlement outcomes. These pathways are supported by the best available evidence. The benefits of this more explicit approach are two-fold: for the other agencies it clarifies how their policy area interacts with health issues; and for the health sector it enables other health personnel and senior decision-makers within DH to see the value of both the health lens and the HiAP approach in advancing health priorities.

Implementing HiAP in SA has not been resource intensive. On the contrary, most of the work has been conducted using existing resources by adjusting work priorities. DH has established a small dedicated team, the HiAP Unit, and partner agencies provide some resources for each of the health lens projects, usually in the form of staff time or funding for specific parts of the work.

In striving for a win–win outcome, the health lens recommendations can appear to have little to do with health policy, as they focus on the policies of the lead agency's work. Of course, this is largely what the health lens process strives for and, in a number of cases, has successfully achieved—where the partner agency can see the policy benefits of the recommendations and acts on them. However, the risk of this approach is that the health benefits become so integrated within the recommendations that it is difficult for someone not involved in the project to easily identify them. It is a challenge to balance out the need to focus on the other agency's business and, at the same time, make the health agenda very clear. It is a challenge that is being worked through by putting a range of strategies in place (e.g. focusing on evidence, identifying all agencies' policy imperatives, drawing the links between health and other policy goals) to help get the balance right.

Evidence-informed policy development

Evidence-informed policy development is a key aim of all policy-makers, and HiAP provides the vehicle to develop such policy. All health lens projects include a substantial focus on identifying, synthesising and analysing the best available evidence and determining the weight of evidence.

As with similar fields of work, this phase of the health lens is the most time intensive and involves a combination of quantitative and qualitative methods. Familiarity with the use of qualitative evidence across different government departments has been variable. The results produced have sometimes been unexpected and have provided a level of additional insight for both the partner agencies and DH. Partners have indicated that they value and respect the experience and knowledge that DH brings to the evidence-gathering phase, and that it has emphasised the value of the HiAP process.

This phase has also proved to be one of the most stimulating for HiAP Unit staff, as it has regularly taken them outside the normal realm of 'health'. Staff have been able to explore issues with significant implications for health but where the links have not yet been well researched—such as access to mobile broadband internet and digital technology, and transit-oriented developments. It has been rewarding to collaborate with agencies to research these issues and their implications for health, and to consider the best possible policy options.

While evidence gathering was the most resource- and time-intensive phase, it was also very valuable. The joint funding of the research by the lead agency and DH supported greater ownership of the evidence. Emphasis on a comprehensive evidence-gathering stage as part of the health lens process has resulted in strong high-level support for the recommendations within each of the agencies involved.

Working with intangibles

A common response from those involved in the health lens projects is that it is the intangible benefits that arise out of the process that make it so valuable. The strong relationships established throughout the project continue after the health lens has been completed, and are tapped into at other times to help progress work outside the health lens process. The exposure to other agencies' broad policy environments and their work culture enables contacts to be made across departments in new content areas that would normally not occur through traditional bureaucratic processes. In other words, the health lens process actually assists government departments to work together, increasing the capacity for agencies to actively participate in joined-up government approaches. This has been confirmed by (unpublished) qualitative research conducted by independent researchers commissioned by DH. For example, as stated by one interviewee, *'We've not engaged a lot with Health in the past so it has given us an entrée into the Health Department which has been very useful… We have wanted to engage with Health and this is probably the best way of doing it.'* Importantly for DH, it has opened up other policy doors, and agencies have begun to invite DH to work with them on issues not contained within the SASP framework. This is a significant shift from some of the early across-government experiences that DH had with other departments.

It is difficult to adequately document all the intangible benefits that arise from this type of work. Some aspects are captured in the process evaluation conducted at the conclusion of each health lens, although this is an area that requires more attention. It is also essential to focus on documenting the tangible benefits, namely the policy outcomes and the health improvements. Evaluation plans are in place for each health lens but they only aim to capture the process and the impact outcomes associated with the analysis. The next step is to develop indicators that enable links to be made between the uptake of health lens recommendations, the policy changes implemented by partner agencies, the improvements in achievement of the SASP target and, ultimately, the improved health outcomes. This is an area of significant discussion within DH and is emerging as both a challenge and a major priority for future work.

Conclusion

While the application of HiAP has now been mandated across government as an integral part of SASP planning processes, it has been important for HiAP Unit staff to continue to regard their processes and approaches as developmental. This means that there is a continuing emphasis on evaluation (both formal and informal) of the process and outcomes of each health lens. Taking a somewhat sceptical, self-critical and reflective approach to this work has meant that the SA model of HiAP is open to continuous improvement, remains flexible and is able to take account of differing agency circumstances and policy contexts. This outlook adds to the capacity to be responsive to the needs of other agencies, keeping the focus on how health factors can contribute to their aims in ways that also advance the health agenda. Humility and a non-defensive stance are key to ensuring ongoing engagement and commitment from other agencies. The more they can identify the utility of the HiAP process in terms of advancing their policy agenda, the more likely it will be that HiAP becomes a stronger and more systematised part of government decision-making. That is our ultimate goal.

Appendices
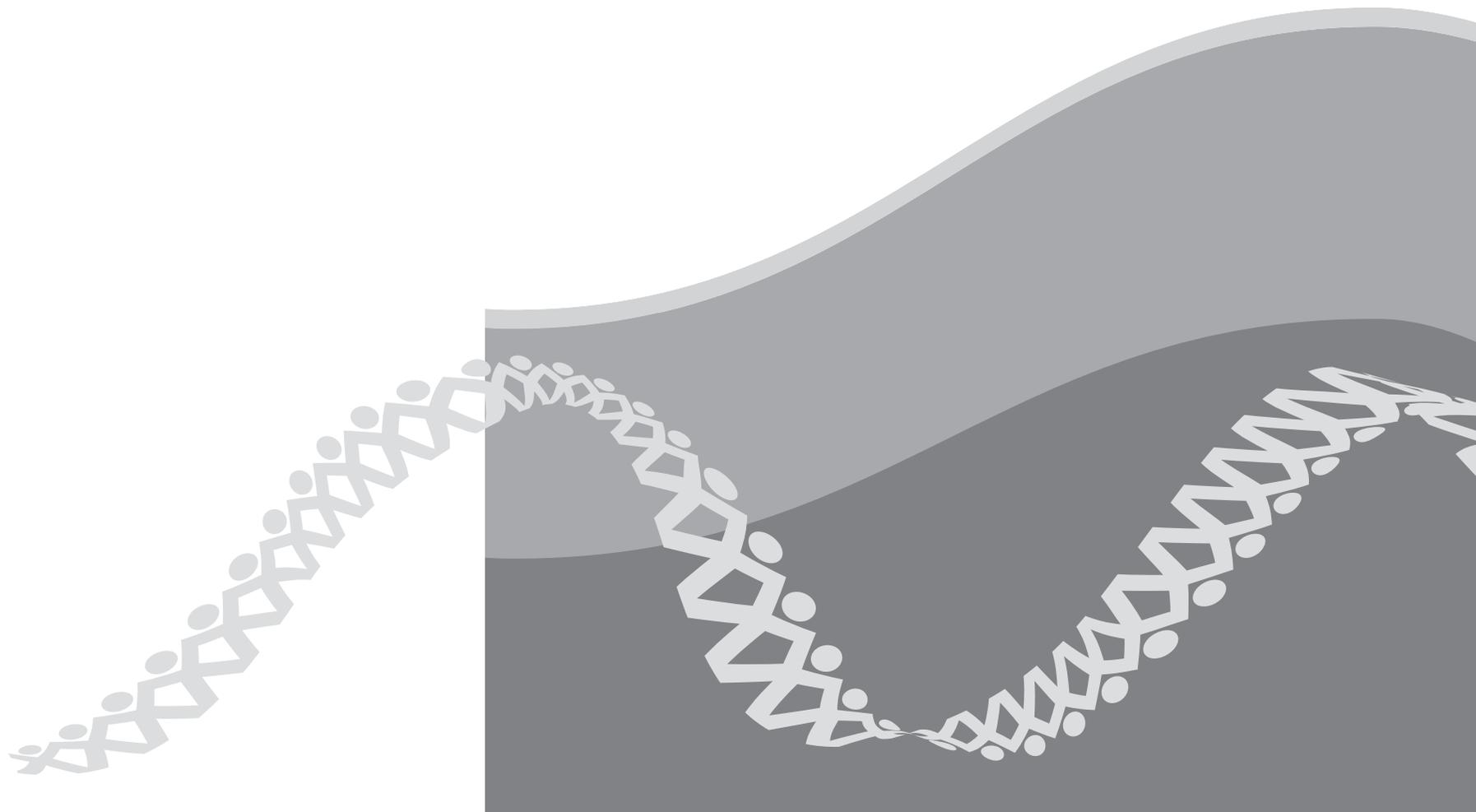
Appendix 1

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on

primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the

whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Appendix 2

Ottawa Charter for Health Promotion
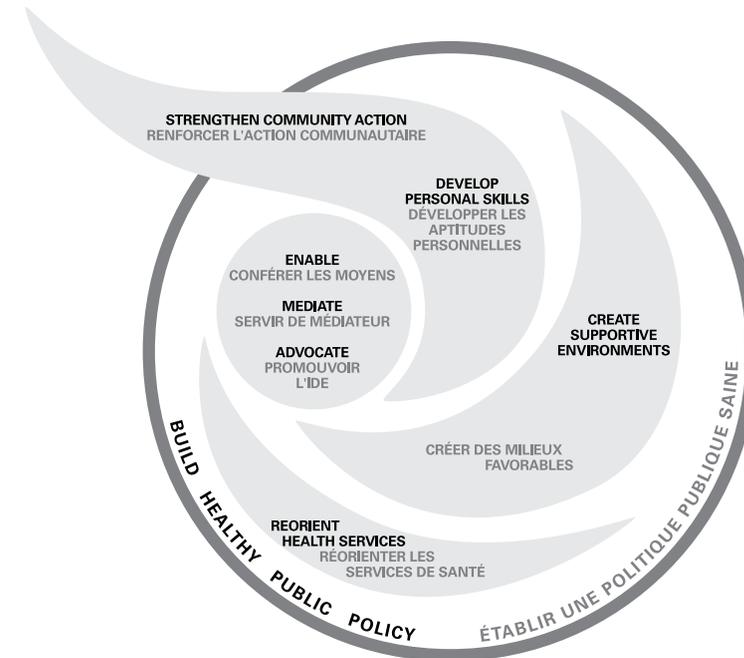
The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond. This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Healthy Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health

The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:

Build Healthy Public Policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio¬ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance—to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment—particularly in areas of technology, work, energy production and urbanization—is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen Community Actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities—their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems

for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop Personal Skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

Moving into the Future

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.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to Health Promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;

- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;

- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;

- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;

- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;

- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

Appendix 3

Adelaide Recommendations on Healthy Public Policy

Second International Conference on Health Promotion, Adelaide, South Australia, 5–9 April 1988

The adoption of the Declaration of Alma-Ata a decade ago was a major milestone in the Health for All movement which the World Health Assembly launched in 1977. Building on the recognition of health as a fundamental social goal, the Declaration set a new direction for health policy by emphasizing people's involvement, cooperation between sectors of society. and primary health care as its foundation.

The Spirit of Alma-Ata

The spirit of Alma-Ata was carried forward in the Charter for Health Promotion which was adopted in Ottawa in 1986. The Charter set the challenge for a move towards the new public health by reaffirming social justice and equity as prerequisites for health, and advocacy and mediation as the processes for their achievement.

The Charter identified five health promotion action areas:

- build Healthy Public Policy
- create supportive environments
- develop personal skills
- strengthen community action, and
- reorient health services.

These actions are interdependent, but healthy public policy establishes the environment that makes the other four possible.

The Adelaide Conference on Healthy Public Policy continued in the direction set at Alma-Ata and Ottawa, and built on their momentum. Two hundred and twenty participants from forty-two countries shared experiences in formulating and implementing healthy public policy. The following recommended strategies for healthy public policy action reflect the consensus achieved at the Conference.

Healthy public policy

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. It makes social and physical environments health-enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations.

The value of health

Health is both a fundamental human right and a sound social investment. Governments need to invest resources in healthy public policy and health promotion in order to raise the health status of all their citizens. A basic principle of social justice is to ensure that people have access to the essentials for a healthy and satisfying life. At the same time, this raises overall societal productivity in both social and economic terms. Healthy public policy in the short term will lead to long-term economic benefits as shown by the case studies presented at this Conference. New efforts must be made to link economic, social, and health policies into integrated action.

Equity, access and development

Inequalities in health are rooted in inequities in society. Closing the health gap between socially and educationally disadvantaged people and more advantaged people requires a policy that will improve access to health-enhancing goods and services, and create supportive environments. Such a policy would assign high priority to underprivileged and vulnerable groups. Furthermore, a healthy public policy recognizes the unique culture of indigenous peoples, ethnic minorities, and immigrants. Equal access to health services, particularly community health care, is a vital aspect of equity in health.

New inequalities in health may follow rapid structural change caused by emerging technologies. The first target of the European Region of the World Health Organization, in moving towards Health for All is that:

by the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups.

In view of the large health gaps between countries, which this Conference has examined, the developed countries have an obligation to ensure that their own policies have a positive health impact on developing nations. The Conference recommends that all countries develop healthy public policies that explicitly address this issue.

Accountability for health

The recommendations of this Conference will be realized only if governments at national, regional and local levels take action. The development of healthy public policy is as important at the local levels of government as it is nationally. Governments should set explicit health goals that emphasize health promotion.

Public accountability for health is an essential nutrient for the growth of healthy public policy. Governments and all other controllers of resources are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policy means that governments must measure and report the health impact of their policies in language that all groups in society readily understand. Community action is central to the fostering of healthy public policy. Taking education and literacy into account, special efforts must be made to communicate with those groups most affected by the policy concerned.

The Conference emphasizes the need to evaluate the impact of policy. Health information systems that support this process need to be developed. This will encourage informed decision-making over the future allocation of resources for the implementation of healthy public policy.

Moving beyond health care

Healthy public policy responds to the challenges in health set by an increasingly dynamic and technologically changing world, with is complex ecological interactions and growing international interdependencies. Many of the health consequences of these challenges cannot be remedied by present and foreseeable health care. Health promotion efforts are essential, and these require an integrated approach to social and economic development which will re¬establish the links between health and social reform, which the World Health Organization policies of the past decade have addressed as a basic principle.

Partners in the policy process

Government plays an important role in health, but health is also influenced greatly by corporate and business interests, nongovernmental bodies and community organizations. Their potential for preserving and promoting people's health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community. New alliances must be forged to provide the impetus for health action.

Action areas

The Conference identified four key areas as priorities for health public policy for immediate action.

Supporting the health of women

Women are the primary health promoters all over the world, and most of their work is performed without pay or for a minimal wage. Women's networks and organizations are models for the process of health promotion organization, planning and implementation. Women's networks should receive more recognition and support from policy-makers and established institutions. Otherwise, this investment of women's labour increases inequity. For their effective participation in health promotion women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy to ensure its cultural relevance.

This Conference proposes that countries start developing a national women's healthy public policy in which women's own health agendas are central and which includes proposals for:

* equal sharing of caring work performed in society;
* birthing practices based on women's preferences and needs;
* supportive mechanisms for caring work, such as support for mothers with children, parental leave, and dependent health-care leave.

Food and nutrition

The elimination of hunger and malnutrition is a fundamental objective of healthy public policy. Such policy should guarantee universal access to adequate amounts of healthy food in culturally acceptable ways. Food and nutrition policies need to integrate methods of food production and distribution, both private and public, to achieve equitable prices.

A food and nutrition policy that integrates agricultural, economic, and environmental factors to ensure a positive national and international health impact should be a priority for all governments. The first stage of such a policy would be the establishment of goals for nutrition and diet. Taxation and subsidies should discriminate in favour of easy access for all to healthy food and an improved diet.

The Conference recommends that governments take immediate and direct action at all levels to use their purchasing power in the food market to ensure that the food-supply under their specific control (such as catering in hospitals, schools, day-care centres, welfare services and workplaces) gives consumers ready access to nutritious food.

Tobacco and alcohol

The use of tobacco and the abuse of alcohol are two major health hazards that deserve immediate action through the development of healthy public policies. Not only is tobacco directly injurious to the health of the smoker but the health consequences of passive smoking, especially in infants, are now more clearly recognized than in the past. Alcohol contributes to social discord, and physical and mental trauma. Additionally, the serious ecological consequences of the use of tobacco as a cash crop in impoverished economies have contributed to the current world crises in food production and distribution.

The production and marketing of tobacco and alcohol are highly profitable activities— especially to governments through taxation. Governments often consider that the economic consequences of reducing the production and consumption of tobacco and alcohol by altering policy would be too heavy a price to pay for the health gains involved.

This Conference calls on all governments to consider the price they are paying in lost human potential by abetting the loss of life and illness that tobacco smoking and alcohol abuse cause. Governments should commit themselves to the development of healthy public policy by setting nationally-determined targets to reduce tobacco growing and alcohol production, marketing and consumption significantly by the year 2000.

Creating supportive environments

Many people live and work in conditions that are hazardous to their health and are exposed to potentially hazardous products. Such problems often transcend national frontiers. Environmental management must protect human health from the direct and indirect adverse effects of biological, chemical, and physical factors, and should recognize that women and men are part of a complex ecosystem. The extremely diverse but limited natural resources that enrich life are essential to the human race. Policies promoting health can be achieved only in an environment that conserves resources through global, regional, and local ecological strategies.

A commitment by all levels of government is required. Coordinated intersectoral efforts are needed to ensure that health considerations are regarded as integral prerequisites for industrial and agricultural development. At an international level, the World Health Organization should play a major role in achieving acceptance of such principles and should support the concept of sustainable development.

This Conference advocates that, as a priority, the public health and ecological movements join together to develop strategies in pursuit of socioeconomic development and the conservation of our planet's limited resources.

Developing new health alliances

The commitment to healthy public policy demands an approach that emphasizes consultation and negotiation. Healthy public policy requires strong advocates who put health high on the agenda of policy-makers. This means fostering the work of advocacy groups and helping the media to interpret complex policy issues.

Educational institutions must respond to the emerging needs of the new public health by reorienting existing curricula to include enabling, mediating, and advocating skills. There must be a power shift from control to technical support in policy development. In addition, forums for the exchange of experiences at local, national and international levels are needed.

The Conference recommends that local, national and international bodies:

- establish clearing-houses to promote good practice in developing healthy public policy;

- develop networks of research workers, training personnel, and programme managers to help analyse and implement healthy public policy.

Commitment to global public health

Prerequisites for health and social development are peace and social justice; nutritious food and clean water; education and decent housing; a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem. The vision of healthy public policy is the achievement of these fundamental conditions for healthy living. The achievement of global health rests on recognizing and accepting interdependence both within and between countries. Commitment to global public health will depend on finding strong means of international cooperation to act on the issues that cross national boundaries.

Future challenges

1. Ensuring an equitable distribution of resources even in adverse economic circumstances is a challenge for all nations.

2. Health for All will be achieved only if the creation and preservation of healthy living and working conditions become a central concern in all public policy decisions. Work in all its dimensions—caring work, opportunities for employment, quality of working life dramatically affects people's health and happiness. The impact of work on health and equity needs to be explored.

3. The most fundamental challenge for individual nations and international agencies in achieving healthy public policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology, and sustainable development around the globe.

4. In most countries, health is the responsibility of bodies at different political levels. In the pursuit of better health it is desirable to find new ways for collaboration within and between these levels.

5. Healthy public policy must ensure that advances in health-care technology help, rather than hinder, the process of achieving improvements in equity.

The Conference strongly recommends that the World Health Organization continue the dynamic development of health promotion through the five strategies described in the Ottawa Charter. It urges the World Health Organization to expand this initiative throughout all its regions as an integrated part of its work. Support for developing countries is at the heart of this process.

Renewal of commitment

In the interests of global health, the participants at the Adelaide Conference urge all concerned to reaffirm the commitment to a strong public health alliance that the Ottawa Charter called for.

EXTRACT FROM THE REPORT ON THE ADELAIDE CONFERENCE *

HEALTHY PUBLIC POLICY, 2nd International Conference on Health Promotion April 5-9, 1988 Adelaide South Australia

* Co-sponsored by the Department of Community Services & Health, Canberra, Australia and the World Health Organization Regional Office for Europe, Copenhagen, Denmark

Appendix 4

South Australia's Strategic Plan Summary of Targets, 2007

South Australia's Strategic Plan is a commitment to making this state the best it can be—prosperous, environmentally rich, culturally stimulating, offering its citizens every opportunity to live well and succeed. Our plan expresses our values; its targets reflect our priorities. We will achieve a better future for South Australia by keeping our communities strong, maintaining an international outlook, and promoting knowledge, inquiry and innovation. By aspiring to be the best, we can better secure a good quality of life for South Australians of all ages and backgrounds Reading the Plan SA's Strategic Plan is organised around six broad, strategic objectives which overarch 98 specific targets. But neither the objectives nor any individual target stand alone. They are all part of a larger inter-related framework. Ten important relationships between targets—the 'key interactions'—are identified in the plan to encourage the collaborative behaviour and innovative thinking required to address some of the most complex issues South Australia faces but there are also many more unstated relationships and connections across the breadth of the plan. The reader should consider any individual part in the context of the whole plan.

The 98 targets are set out below with plan reference numbers (T1.1 etc.) in brackets.

Objective 1 Growing Prosperity

Economic Environment

T1.1   Economic Growth:

Exceed the national economic growth rate by 2014

T1.2   Competitive business climate:

Maintain Adelaide's rating as the least costly place to set up and do business in Australia and continue to improve our position internationally.

T1.3   Credit Rating:

Maintain AAA credit rating.

T1.4   Industrial Relations:

Achieve the lowest number of working days lost per thousand employees of any state in Australia by 2014.

T1.5   Business Investment:

Exceed Australia's ratio of business investment as a percentage of the economy by 2014.

T1.6   Labour Productivity:

Exceed Australia's average labour productivity growth rate in trend terms by 2014

T1.7   Performance in the public sector - customer and client satisfaction with government services:

Increase the satisfaction of South Australians with government services by 10% by 2010, maintaining or exceeding that level of satisfaction thereafter.

T1.8   Performance in the public sector - government decision-making:

Become, by 2010, the best-performing jurisdiction in Australia in timeliness and transparency of decisions which impact the business community (and maintain that rating).

T1.9   Performance in the public sector - administrative efficiency:

Increase the ratio of operational to administrative expenditure in state government by 2010, and maintain or better that ratio thereafter

Employment

T1.10   Jobs:

Better the Australian average employment growth rate by 2014

T1.11   Unemployment:

Maintain equal or lower than the Australian average through to 2014.

T1.12   Employment participation:

Increase the employment to population ratio, standardised for age differences, to the Australian average.

T1.13   Defence employment:

Increase defence industry employment from 16,000 to 28,000 by 2014.

Exports

T1.14   Total Exports:

Treble the value of South Australia's export income to $25 billion by 2014.

T1.15   Tourism industry:

Increase visitor expenditure in South Australia's tourism industry from $3.7 billion in 2002 to $6.3 billion by 2014.

T1.16   Share of overseas students:

Double South Australia's share of overseas students by 2014.

T1.17   Minerals exploration:

Exploration expenditure in South Australia to be maintained in excess of $100 million per annum until 2010.

T1.18   Minerals production:

Increase the value of minerals production to $3 billion by 2014. (T1.18)

T1.19   Minerals processing:

Increase the value of minerals processing to $1 billion by 2014. (T1.19)

T1.20   Defence industry:

Double the defence industry contribution to our economy from $1 billion to $2 billion annually. (T1.20)

Infrastructure

T1.21   Strategic Infrastructure:

Match the national average in terms of investment in key economic and social infrastructure.

Population

T1.22   Total Population:

Increase South Australia's population to 2 million by 2050, with an interim target of 1.64 million by 2014.

T1.23   Interstate migration:

Reduce annual net interstate migration loss to zero by 2010, with a net inflow thereafter to be sustained through to 2014.

T1.24   Overseas migration:

Increase net overseas migration gain to 8500 per annum by 2014

T1.25   Population fertility rate:

Maintain a rate of at least 1.7 births per woman.

Aboriginal Unemployment

T1.26   Aboriginal unemployment:

Reduce the gap between Aboriginal and non-Aboriginal unemployment rates each year.

Objective 2 Improving Wellbeing

Preventative Health

T2.1   Smoking:

Reduce the percentage of young cigarette smokers by 10 percentage points between 2004 and 2014.

T2.2   Healthy Weight:

Increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014.

T2.3   Sport and Recreation:

Exceed the Australian average for participation in sport and physical activity by 2014

Healthy Life Expectancy

T2.4   Healthy South Australians:

Increase the healthy life expectancy of South Australians by 5% for males and 3% for females by 2014.

T2.5   Aboriginal healthy life expectancy:

Lower the morbidity and mortality rates of Aboriginal South Australians.

T2.6   Chronic diseases:

Increase, by 5 percentage points, the proportion of people living with a chronic disease whose self-assessed health status is good or better.

Psychological Wellbeing

T2.7   Psychological wellbeing:

Equal or lower than the Australian average for psychological distress by 2014.

Public Safety

T2.8   Statewide crime rates:

Reduce victim reported crime by 12% by 2014.

T2.9   Road safety – fatalities:

By 2010, reduce road fatalities to less than 90 persons per year.

T2.10 Road safety – serious injuries:

By 2010 reduce serious injuries to less than 1000 per year.

T2.11 Greater safety at work:

Achieve the nationally agreed target of 40% reduction in injury by 2012.

Work-Life Balance

T2.12   Work-life balance:

Improve the quality of life of all South Australians through maintenance of a healthy work-life balance.

Objective 3 Attaining Sustainability

Biodiversity

T3.1   Lose no species*:

Lose no known native species as a result of human impacts.

T3.2   Land biodiversity:

By 2010 have five well-established biodiversity corridors aimed at maximising ecological outcomes particularly in the face of climate change.

T3.3   Soil protection:

By 2014, achieve a 20% increase in South Australia's agricultural cropping land that is adequately protected from erosion.

T3.4   Marine biodiversity:

By 2010 create 19 marine parks aimed at maximising ecological outcomes.

Climate Change

T3.5   Greenhouse gas emissions reduction*:

Achieve the Kyoto target by limiting the state's greenhouse gas emissions to 108% of 1990 levels during 2008-2012, as a first step towards reducing emissions by 60% (to 40% of 1990 levels) by 2050.

T3.6   Use of public transport:

Increase the use of public transport to 10% of metropolitan weekday passenger vehicle kilometres travelled by 2018.

Ecological Footprint

T3.7   Ecological footprint*:

Reduce South Australia's ecological footprint by 30% by 2050.

T3.8   Zero waste:

Reduce waste to landfill by 25% by 2014.

Water

T3.9   Sustainable water supply:

South Australia's water resources are managed within sustainable limits by 2018.

T3.10 River Murray – flows:

Increase environmental flows by 500GL in the River Murray by 2009 as a first step towards improving sustainability in the Murray-Darling Basin, with a longer-term target of 1500 GL by 2018.

T3.11 River Murray – salinity:

South Australia maintains a positive balance on the Murray-Darling Basin Commission salinity register.

Energy

T3.12   Renewable Energy:

Support the development of renewable energy so that it comprises 20% of the state's electricity production and consumption by 2014.

T3.13   Energy efficiency – government buildings:

Improve the energy efficiency of government buildings by 25% from 2000-01 levels by 2014.

T3.14   Energy efficiency – dwellings:

Increase the energy efficiency of dwellings by 10% by 2014.

Aboriginal Lands

T3.15 Aboriginal lands – access and management:

Resolve 75% of all native title claims by 2014.

* Lose no species, greenhouse gas emissions reductions and ecological footprint are the three high order targets under this Objective. The remaining targets may contribute to more than one of these.

Objective 4 Fostering Creativity

Creativity

T4.1   Creative industries:

Increase the number of South Australians undertaking work in the creative industries by 20% by 2014.

T4.2   Film industry:

Double the number of feature films produced in South Australia by 2014.

T4.3   Cultural engagement – institutions:

Increase the number of attendances at South Australia's cultural institutions by 20% by 2014.

T4.4   Cultural engagement – arts activities:

Increase the number of attendances at selected arts activities by 40% by 2014.

T4.5   Understanding of Aboriginal culture:

Aboriginal cultural studies included in school curriculum by 2014 with involvement of Aboriginal people in design and delivery.

Innovation

T4.6   Commercialisation of research:

Increase gross revenues received by South Australian-based research institutions from licences, options, royalty agreements, assignments, licensed technology and patents by 2010.

T4.7   Business innovation:

The proportion of South Australian businesses innovating to exceed 50% in 2010 and 60% in 2014.

T4.8   Broadband usage:

Broadband usage in South Australia to exceed the Australian national average by 2010, and be maintained thereafter.

Investment in Science, Research and Innovation

T4.9   Public expenditure:

By 2010, public expenditure on research and development, as a proportion of GSP, to match or exceed average investment compared to other Australian states.

T4.10 Australian Government resources:

Secure Australian Government research and development resources to 10% above South Australia's per capita share by 2010 and increase this share to 25% by 2014, for both public and private spheres.

T4.11 Business expenditure:

Increase business expenditure on research and development to 1.5% of GSP in 2010 and increase to 1.9% by 2014.

Venture Capital

T4.12 Venture capital:

South Australia's share of Australian Government-administered venture capital program funds to reach 7% by 2010, and be maintained thereafter.

Objective 5 Building Communities

Women in Leadership

T5.1   Boards and Committees:

Increase the number of women on all State Government boards and committees to 50% on average by 2008, and maintain thereafter by ensuring that 50% of women are appointed, on average, each quarter.

T5.2   Chairs of boards and committees:

Increase the number of women chairing state government boards and committees to 50% by 2010.

T5.3   Members of Parliament:

Increase the number of women in Parliament to 50% by 2014.

Political Participation

T5.4   Enrolment to vote:

Increase the proportion of eligible young South Australians (18-19 years) enrolled to vote to better the Australian average by 2014.

T5.5   Local government elections:

Increase voter participation in local government elections in South Australia to 50% by 2014.

Volunteering

T5.6   Volunteering:

Maintain the high level of volunteering in South Australia at 50% participation rate or higher.

Aboriginal Leadership

T5.7   Aboriginal leadership:

Increase the number of Aboriginal South Australians participating in community leadership and in community leadership development programs

Multiculturalism

T5.8   Multiculturalism:

Increase the percentage of South Australians who accept cultural diversity as a positive influence in the community.

Regional Population Levels

T5.9   Regional population levels:

Maintain regional South Australia's share of the state's population (18%).

Objective 6 Expanding Opportunity

Aboriginal Wellbeing

T6.1   Aboriginal wellbeing:

Improve the overall wellbeing of Aboriginal South Australians.

Early Childhood

T6.2   Early childhood – Year 1 literacy:

By 2014 achieve a 10% improvement in the number of children reading at an age appropriate level by the end of Year 1.

T6.3   Early childhood – Birthweight:

Reduce the proportion of low birthweight babies.

T6.4   Early childhood – AEDI:

Improve South Australia's performance on the Australian Early Development Index.

Economic Disadvantage

T6.5   Economic disadvantage:

Reduce the percentage of South Australians receiving government benefits (excluding age pensions) as their major income source to below the Australian average by 2014.

Housing

T6.6   Homelessness:

Halve the number of 'rough sleepers' in South Australia by 2010 and maintain thereafter.

T6.7   Affordable housing:

Increase affordable home purchase and rental opportunities by 5 percentage points by 2014.

T6.8   Housing stress:

Halve the number of South Australians experiencing housing stress by 2014.

T6.9   Aboriginal housing:

Reduce overcrowding in Aboriginal households by 10% by 2014.

Disability

T6.10 Housing for people with disabilities:

Double the number of people with disabilities appropriately housed and supported in community based accommodation by 2014.

T6.11 Participation by people with disabilities:

Increase by 400 the number of people with disability involved in day options program by 2014.

Education

T6.12 Year 3:

By 2010, 93% of students in Year 3 to achieve the national benchmarks in reading, writing and numeracy.

T6.13 Year 5:

By 2010, 93% of students in Year 5 to achieve the national benchmarks in reading, writing and numeracy.

T6.14 Year 7:

By 2010, 93% of students in Year 7 to achieve the national benchmarks in reading, writing and numeracy.

T6.15 Learning or earning:

By 2010 increase the number of 15-19 year olds engaged fulltime in school, work or further education/training (or combination thereof) to 90%.

T6.16 SACE or equivalent:

Increase yearly the proportion of 15-19 year olds who achieve the SACE or comparable senior secondary qualification.

T6.17 Science and maths:

By 2010 increase by 15 percent the proportion of students receiving a Tertiary Entrance Rank (TER) or equivalent with at least one of the follow subjects: mathematics, physics or chemistry.

Aboriginal Education

T6.18 Aboriginal education – early years:

Increase yearly the proportion of Aboriginal children reading at age appropriate levels at the end of Year 1.

Workforce Development and Training

T6.19 Non-school qualifications:

By 2014, equal or better the national average for the proportion of the labour force with non-school qualifications.

T6.20 Higher education:

Increase South Australia's proportion of higher education students to 7.5% of the national total by 2014.

T6.21 VET participation:

Exceed the national average for VET participation by 2010.

Diversity in the Public Sector

T6.22 People with disabilities:

Double the number of people with disabilities employed by 2014.

T6.23 Women:

Have women comprising half of the public sector employees in the executive levels (including chief executives) by 2014.

T6.24 Aboriginal employees:

Increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2% by 2010 and maintain or better those levels through to 2014.

Key Interactions Across the Plan

- Economic growth (T1.1) and greenhouse gas emissions reductions (T3.5)
- Economic growth (T1.1) and ecological footprint (T3.7)
- Economic growth (T1.1) and investment in science, research and innovation (T4.9, T4.10, T4.11)
- Jobs (T1.10) and non-school qualifications (T6.19)
- Exports (T1.14) and sustainable water supply (T3.9)
- Population (T1.122) and greenhouse gas emissions reductions (T3.5)
- Overseas migration (T1.24) and multiculturalism (T5.8)
- Healthy South Australians (T2.4) and early childhood (birthweight) (T6.3)
- Greenhouse gas emissions reductions (T3.5) and investment in science, research and innovation (T4.9, T4.10, T4.11)
- Ecological footprint (T3.7) and investment in science, research and innovation (T4.9, T4.10, T4.11)

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Appendix 5

Health in All Policies: the 10 principles

In November 2007, following the second part of Professor Ilona Kickbusch's Residency, an across-government Health in All Policies (HIAP) Conference was held to discuss the opportunity to apply an HiAP approach in South Australia. During this conference Professor Kickbusch led the development of a series of principles which emphasised the importance of across-government work in addressing the determinants of health. These principles have played a pivotal role in underpinning the South Australian approach to HiAP.

An HiAP approach reflects health as a shared goal of all government. In particular it:

1. Recognises the value of health for the wellbeing of all citizens and for the overall social and economic development of South Australia—health is a human right, a vital resource for everyday life and a key factor of sustainability.

2. Recognises that health is an outcome of a wide range of factors—such as changes to the natural and built environments and to social and work environments—many of which lie outside the activities of the health sector and require a shared responsibility and an integrated and sustained policy response across Government.

3. Acknowledges that all Government policies can have positive or negative impacts on the determinants of health and such impacts are reflected both in the health status of the South Australian population today and in the health prospects of future generations.

4. Recognises that the impacts of health determinants are not equally distributed among population groups in South Australia and aims at closing the health gap, in particular for the Aboriginal peoples.

5. Recognises that health is central to achieving the objectives of the South Australian Strategic Plan (SASP)—it requires both the identification of potential health impacts and the recognition that good health can contribute to achieving SASP targets.

6. Acknowledges that efforts to improve the health of all South Australians will require sustainable mechanisms that support Government agencies to work collaboratively to develop integrated solutions to both current and future policy challenges.

7. Acknowledges that many of the most pressing health problems of the population require long-term policy and budgetary commitment as well as innovative budgetary approaches.

8. Recognises that indicators of success will be equally long-term and that regular monitoring and intermediate measure of progress will need to be established and reported back to South Australian citizens.

9. Recognises the need to regularly consult with citizens to link policy changes with wider social and cultural changes around health and wellbeing.

10. Recognises the potential of partnerships for policy implementation between Government levels, science and academia, business, professional organisations and non-governmental organisations to bring about sustained change.