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The Royal Australasian College of Physicians

Health in All Policies

Position Statement

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Executive Summary

The Royal Australasian College of Physicians (RACP) recognises that the role of health professionals includes addressing the social determinants of health (SDoH) which can influence the prevention, treatment and trajectory of illness (both physical and mental). Many diseases are prevented, mitigated, precipitated or exacerbated by the conditions under which people are born, grow, live, work and age. These factors – which include social, economic, political, cultural and physical circumstances – are referred to as SDoH.¹

Health professionals can influence these social determinants at macro-, meso- and micro-levels, and play a particularly important role in influencing behavioural and psychosocial risk factors across the life course. One strategy to tackle the SDoH is a governance approach called Health in All Policies (HiAP) which, increasingly, is being adopted internationally. HiAP has its roots in the early history of public health and later in one of the Ottawa Strategies: 'Building healthy public policy'. HiAP was first coined as a term in the late 1980s.²

*HiAP is an approach to policy-making that places 'health' as a key decision-making factor in all areas of policy, by systematically taking into account the health and health-system implications of policy decisions, by seeking synergies between policy portfolios, and by avoiding harmful health impacts, in order to improve population health and health equity.*³

The development of the *RACP Health in All Policies Position Statement* has been driven by two fundamental ideas for addressing the SDoH through the implementation of HiAP, both of which are relevant to physicians and to governments:

- Diseases and illness are exacerbated and disparately distributed in direct relationship to inequities in society.⁴ SDoH are often responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries; and
- Addressing the SDoH will reduce the burden of avoidable disease, resulting in savings to the health system and economic growth and development.

The position statement has been built upon a comprehensive collection of evidence which demonstrates the link between one's health status and their socioeconomic circumstances. However, those seeking evidence for the effectiveness of the HiAP approach will be as disappointed as, for example, physicians looking for evidence of the effectiveness of the stethoscope. Like the stethoscope, HiAP is an instrument to assist in achieving health outcomes, is dependent on the skills, knowledge and experience of the operator, and also requires political will.⁵

The overarching aims of the position statement are to raise RACP Fellows and trainees' awareness of SDoH, and to provide an introduction to HiAP.

The RACP is a leading medical body that advocates for its patients by contributing to local, national and international health policy, with the aim of improving the health and wellbeing of all people and communities. RACP Fellows and trainees have an opportunity to promote and support HiAP-based policies to improve population health and health equity.

However, beyond advocacy in the policy realm, the RACP believes that all physicians have a responsibility to identify the SDoH by taking a social history of patients and identifying risk factors, and to make use of health resources to address inequities. The RACP is currently reviewing the Basic Training curricula in Adult and Internal Medicine and Paediatric and Child Health, including consideration of the SDoH. A review of the 36 curricula in Advanced Training is also commencing. The RACP Supporting Physicians' Professionalism and Performance (SPPP) tool⁶ assists physicians to reflect on their own practice and to think about patients in the context of the patient's own life, and

of the wider health system. Health professionals are encouraged to be 'stewards' both of patients and of the health system itself. The tool outlines 8 domains of professional practice that support medical expertise in delivering the best possible outcomes for our patients and our profession. These professional domains are:

- Quality and safety
- Cultural competency
- Communications
- Collaboration and teamwork
- Leadership and management
- Decision making
- Health advocacy
- The broader context of health.

Recommendations

This position statement provides two sets of recommendations which offer:

- *Practical strategies* to influence the social determinants of health. SDoH operate at the individual, local community and national levels, and at all of these within a global context. Notably, health professionals can have influence at each of these levels, and are increasingly expected to incorporate these elements into their practice.
- *Advocacy strategies* which the RACP and its Fellows and trainees can adopt in supporting the development and implementation of policies and initiatives that use the HiAP approach.

Practical strategies to influence the social determinants of health

The following are some recommendations on how RACP Fellows and trainees can influence social determinants in clinical settings and can play a particularly important role in influencing behavioural and psychosocial risk factors across the life course of their patients.⁷

In clinical settings, RACP Fellows and trainees should consider how to acknowledge and address the SDoH for individual patients where possible. This can include:

- Ensuring your practice is accessible to all patients, especially marginalised and vulnerable groups. This can be achieved by increasing the acceptability, approachability and appropriateness of health services, to encourage patients' ability to seek and obtain care.⁸ This also requires efforts to enhance the quality of care and to raise patient awareness of these health services so they can make an informed choice to access them or not.
- Screening patients for social and economic disadvantage may be assisted by using tools such as the Upstream Risks Screening Tool & Guide, developed by HealthBegins.⁹ It is important, however, to consider the unintended consequences such as the detection of adverse exposures and conditions that typically require resources well beyond the scope of clinical care. To avoid such unintended consequences, Garg et al. recommend that social determinants screening should (1) be patient- and family-centred and involve shared decision making; (2) be conducted within a comprehensive process and system that supports early detection, referral and linkage to a wide array of community-based services; (3) engage the entire practice population rather than targeted subgroups; and (4) acknowledge and build on the strengths of patients, families and communities. By following these suggestions, Garg et al. suggest that screening for social determinants of health has the potential to significantly improve the health and wellbeing of all patients.¹⁰

- In collaboration with other health professionals, developing comprehensive care plans for patients, which acknowledge and, where possible, address the impact of SDoH on the patient.
- Building up an awareness of services provided in your local area (e.g. through hospitals, community health services, government departments, welfare agencies, private practices) so you are able to provide referrals to local social services which may assist your patients more directly with SDoH for issues such as child and family welfare, homelessness, substance abuse, poverty, unemployment, disability, family violence and gambling.
- Offering social prescriptions, such as self-help groups, day clubs, fitness groups, art groups and memory loss services, alongside existing medical treatments. The goal of these integrated health and social supports is to link patients with different sources of support within the community.¹¹ One reason why patients appear not to be motivated to respond to lifestyle suggestions is often because they are not referred to services which can assist them to make the necessary changes.¹²

Advocacy strategies to support the development and implementation of policies and initiatives that use the HiAP approach

What physicians can do to promote HiAP processes within the health sector and communities

RACP Fellows and trainees can act as health advocates on behalf of their patients in the broader community, and support actions to improve living conditions for better health outcomes. These actions may include:

- Instilling the principle of ‘proportionate universalism’ – providing more health care to patients who need it most – in the clinical environment.
- Supporting partnerships between local government and non-government organisations, which aim to implement programs to impact positively on communities’ SDoH. For example, initiatives in urban design, community safety and transport planning that encourage walking, cycling and the use of public transport.¹³

What physicians and the RACP can do to advocate to governments

As health advocates, the RACP and individual RACP members can advocate for the implementation of healthy public policies to improve the SDoH at the population health level. This may involve:

- Supporting national implementation of whole-population interventions
- Engaging with medical and health organisations
- Enabling physicians to advocate on behalf of communities
- Continuing demonstration of leadership by both the RACP and its members on various health issues, such as action on climate change, quality end of life care, Indigenous health, obesity, and the health of children in detention
- Endorsing and promoting prospective health policies that act to limit exposure to risk factors (defined in terms of individual behaviour) in an effort to reduce health inequalities across populations.¹⁴

What the RACP can do to support physicians and trainees

- Provide training and learning on the SDoH and on the influence that it has on health status at different levels of training, including Basic and Advanced Training, and Continuing Professional Development.

1. What do we mean by Social Determinants of Health?

An individual's health is shaped by socioeconomic factors, which can be broadly defined as the conditions in which people are born, grow, live, work and age. These social characteristics are influenced by political and economic systems, social and economic policies, and development agendas which shape the conditions of daily life.¹⁵ These influences are collectively known as the social determinants of health (SDoH). The key domains of life in which the SDoH have an impact are broad and include (but are not limited to):

- Intrauterine development
- Early life and childhood development
- Educational attainment
- Access to health care
- Health literacy
- Socioeconomic status
- Family and relationship stability
- Gender
- Social security
- Housing
- Food security
- Tobacco, alcohol and illicit drug use
- Contact with the criminal justice system
- Natural, built and physical environments
- Social exclusion.¹⁶

Health inequities occur when there is failure to avoid inequalities or differences in health between groups of people.¹⁷ As a result, a social gradient is created whereby poorer, disadvantaged populations experience worse health outcomes.

An individual's self-perceived low locus of control, compared with that of others, is also a significant determinant of poor health. The impact of social and economic conditions on people's lives determines two outcomes: 1) their risk of disease, and 2) the actions taken to prevent them becoming ill or treat illness when it occurs. These outcomes highlight the need for physicians and paediatricians to prevent and treat disease in a holistic manner, by having both a biological understanding of disease and an understanding of how social and psychological factors influence biology.

A healthy community can be defined as one that meets its citizens' basic needs, is committed to the quality and sustainability of the environment, has adequate levels of economic and social development, health and social equity, and facilitates social relationships that are supportive and respectful.¹⁸ Intersectoral collaboration can play an instrumental role in town planning, to support active transport, urban greening, improving access to healthy food, and affordable, safe housing. Reducing urban air pollution and enhancing opportunities for high-quality and accessible education can assist in facilitating healthier lifestyles.

Approaches like HiAP that define intersectoral collaboration as a core business can be useful in generating co-benefits for sectors working together to address societal issues. For example, addressing climate change does not only have environmental and financial benefits: climate change has both direct and indirect impacts on human health. Mitigation strategies to address climate change have significant health co-benefits¹⁹, which include reduced levels of chronic disease, respiratory and cardiovascular illness and diabetes, and increased life expectancy.²⁰

The SDoH are often described as using the upstream, midstream and downstream approach to addressing illness. This concept illustrates three interrelated levels at which social and economic factors influence health outcomes. The downstream level describes risk factors immediate to the disease. These are influenced by drivers which operate at the midstream (psychosocial factors, health-related behaviours and role of healthcare system) and upstream levels (government policies, and other underlying determinants of health, which include social, physical, economic and environmental factors).²¹

Progress in the development of a healthy society can be assessed by the quality of its population's health, how fairly health and wealth are distributed across the social continuum, and the scale of protection provided against disadvantage as a result of poor health or poor social conditions.²² Communities flourish when health equity exists – that is, the absence of avoidable differences in health between groups of people, whether defined socially, economically, demographically, or geographically.²³

2. The cost of inaction on SDoH

Health is a fundamental component of quality of life, and a healthy population is a critical building block for a thriving economy.²⁴ There is an economic imperative for governments to adopt a HiAP approach, because threats to both physical and mental health pose significant funding and workforce challenges to healthcare systems and society more broadly.²⁵

Likewise, demographic changes call for an appropriate response to maintain good health in ageing populations.²⁶ The opportunity to reduce the burden of disease and to save on hospital and pharmaceutical costs requires action outside the healthcare system. Adopting a HiAP approach provides a mechanism to tackle this challenge. It allows stakeholders to contribute to collaborative action to address the determinants of health, which will improve health outcomes and achieve healthy public policy objectives.

Lack of action on the determinants of health has a threefold effect on society including:

1. An increase in health inequity – disadvantaged groups continue to be at risk of experiencing poorer health and premature death. A meta-analysis of multilevel studies of income inequality, mortality, and self-rated health in the US demonstrated that inequity results in more deaths than smoking, motor vehicle accidents and guns combined cause.²⁷
2. Rising hospital and pharmaceutical costs – 'high cost users' are accessing the healthcare system for the management of their preventable chronic diseases and for avoidable hospitalisation for acute illnesses, which is on the increase.
3. Reduced participation rate in the workforce – lack of work productivity leads to economic disadvantage and to less active participation in society. Workforce participation, productivity and better economic health are critical factors that influence living standards.²⁸ Increased investment in preventive measures such as skills training, support programs and tailored employment services is needed to support active, engaged and participatory lives.

The cost-benefits of action on SDoH

It is well established that good physical and mental health influences the participation of individuals in social and economic life. An individual's household income, work status, access to and level of education, quality of housing and social connectedness influence health outcomes. If the health gap between the most and least disadvantaged groups was narrowed, then it is estimated that an additional 370,000–400,000 disadvantaged Australians in the 25–64 year demographic group would rate their health as 'good'.²⁹ In this way, it is possible for policy makers to counteract the effects of

health inequity by mobilising action which uses HiAP processes to (1) create a sustainable and holistic health system and (2) increase workforce participation.

1. Create a sustainable and holistic health system

The 2015 Intergenerational Report states that the Commonwealth Government health expenditure is projected to rise from 4.2% of GDP in 2014–15 to 5.7% of GDP in 2054–55.³⁰ With increasing rates of chronic illness in the community, the health budget will continue to be challenged to fund hospital admissions, Pharmaceutical Benefit Scheme drugs and Medicare services. If action was taken to address the determinants of health at all levels of government, it is estimated that 500,000 Australians could avoid incurring a chronic disease.³¹ A 2012 report by the National Centre for Social and Economic Modelling (NATSEM) has estimated that addressing SDoH, as recommended by the World Health Organization (WHO), would result in annual savings to the Commonwealth Government of:

- \$273 million and \$184.7 million less spending on the Medicare Benefits Schedule and on pharmaceutical benefits, respectively, and
- \$4 billion less spending in welfare support payments.³²

This calls for a change in the way that public administrations address mounting health costs. The Sustainable Health Systems Report advocates that governments work towards shifting from *healthcare* to *health system* to provide better health services and to alleviate the demand for health care.³³ The 2013 Report encourages governments to design more sustainable health systems, by broadening the boundaries of responsibility and developing solutions outside health care. Through this strategy, health systems – as opposed to healthcare systems (described as the institutions, facilities and professionals involved in delivering healthcare services) – become diverse and inclusive, and begin to include a range of actors and institutions beyond the traditional health sector. A shift in thinking, from healthcare to health system, broadens the definition of ‘health’ to include a wide range of policies and services targeted at the SDoH, and has the potential to prevent and/or mitigate both physical and mental health problems. These services include, for example, the provision of affordable housing, accessible and fit for purpose mental health services, and high quality and accessible primary health care focused on prevention, all of which would ease the demand for care and improve the system more broadly. This shift in thinking has underpinned, amongst others, the international commitment to primary health care within the healthcare sector and the focus on preventive and integrated care.

2. Increase workforce participation

Social inequalities, due to changes to labour market structures and employment status, represent a considerable social and public health concern.³⁴ Work, in general, is good for health and wellbeing.³⁵ Therefore, employment (or return to work following injury/sickness absence) and working conditions are powerful drivers of health equity, and have a direct impact on health.³⁶ There is established evidence demonstrating that unemployment, work disability and long-term absence from work adversely affect one’s physical and mental health.³⁷ Moreover, the current literature highlighting the emergence of ‘presenteeism’ (the act of attending work despite illness and/or injury resulting in reduced productivity) in the workplace also demonstrates the growing effect which the lack of ‘good’ work has on mental health.³⁸

The application of HiAP is relevant in developing workforce participation policies. While current workforce participation policies will see Australians working into older age, this will not be enough to prevent a reduction in the participation rate to 62.4% in 2054–55 for Australians aged 15 years and over, in comparison with 64.6% in 2014–15.³⁹

To support Australians to remain in the workplace, a different approach to managing the care of multiple diseases may be required, as Australians with long-term health conditions are staying longer in the workforce. This may involve implementing health, safety and wellbeing management strategies,

such as modified duties and recovery-at-work processes, in the workplace. If this approach was taken, an additional 170,000 Australians could re-enter the workforce, which would generate \$8 billion in extra earnings.

The RACP is a strong supporter of HiAP policies. An example of this is the Health Benefits of Good Work policy platform led by the RACP's Australasian Faculty of Occupational and Environmental Medicine (AFOEM). The Health Benefits of Good Work policy work is a great example of how collaboration amongst health and non-health professionals such as physicians, General Practitioners, employers, trade unions, government and the insurance industry can lead to the delivery of 'healthy' workplace policies to improve employees' physical and mental health.

AFOEM has developed the following position statements and policy documents to encourage actions amongst key stakeholders to enhance workplace conditions⁴⁰:

- *Realising the Health Benefits of Work* (2011) and its two accompanying statements published in 2013, *What is Good Work?* and *Workplace Health and Productivity*
- *Realising the Health Benefits of Work: An Evidence Update* (2015)
- *Health Benefits of Good Work Charter of Principles* to supplement the Australian Consensus Statement of the AFOEM on the Health Benefits of Work (2015).

3. A government imperative: addressing the determinants of health through a Health in All Policies approach

Socioeconomic inequalities can be amenable to policy action, and a society that reduces them is likely to achieve strong health gains.⁴¹ As explained earlier, the determinants of health are complex, and operate at many levels from within and outside the health sector and, therefore, so too must the solutions.

This requires more collaborative approaches to managing the determinants and solutions, which will increasingly see physicians working more broadly with government and the private sector to take a more health-focused, joined-up approach to policy-making. This is where Health in All Policies (HiAP) strategies can be useful.

*HiAP is an approach to promoting healthy public policies across sectors, which systematically takes into account the health effects of decisions, seeks synergies, and avoids harmful health impacts, to enhance population health and health equity.*⁴²

Simultaneously, it explores how a healthier population can contribute to achieving other sectoral goals.

Policy interventions that adopt a population-wide approach can be more effective in decreasing risk factors across populations (and would disproportionately benefit disadvantaged groups), because they offer government the opportunity to act directly on population exposure to risk factors, and to address the key drivers of health and health inequalities.⁴³ National regulatory and fiscal policies such as increases in the cost of cigarettes, promoting smoke-free spaces, reducing dietary salt in processed food and banning industrial trans-fats, have contributed to levelling health across socioeconomic groups, as seen in some Scandinavian and European nations.⁴⁴

The ethos underpinning HiAP recognises that the provision of medical care is a comparatively minor determinant of health – rather, it recognises that health is influenced by a broad range of determinants that exist outside the healthcare remit, which include social, economic, political, cultural and environmental determinants, as demonstrated in Figure 1 below.

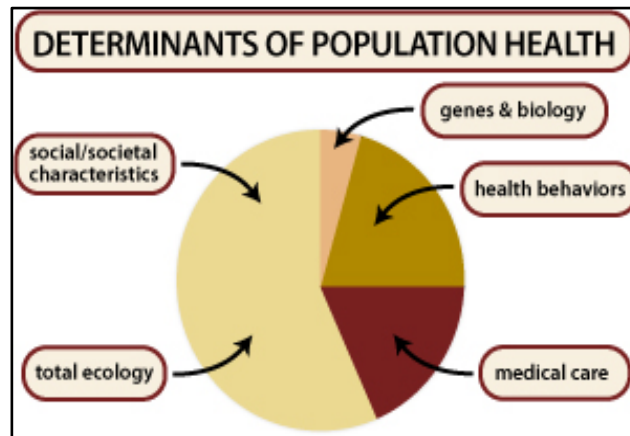


Figure 1: Medical care is a relatively minor determinant of health in comparison to socioeconomic characteristics. Reproduced from Tarlov 1999⁴⁵ with permission of John Wiley and Sons.

Australia's domestic response to the WHO's Commission on Social Determinants of Health report, *Closing the Gap within a Generation*, by the Senate Community Affairs Committee, recommends that the Commonwealth Government adopt a HiAP approach to policy making, by centralising administrative responsibility for addressing the SDoH and establishing reporting mechanisms for tracking progress in tackling the SDoH.⁴⁶ HiAP has the potential to reconfigure the way governments operate to facilitate policy development, implementation and delivery. However, evidence demonstrating successful implementation of joined-up approaches like HiAP is still being developed.⁴⁷

The *Well-being of Future Generations (Wales) Act 2015* is a recent example of a HiAP approach being embedded in national legislation.⁴⁸ The Act requires national and local public services (regardless of their specified responsibility) to increase their contribution to the communities' economic, social, environmental and cultural wellbeing.⁴⁹

The Act is an instrument for moving towards a preventive, ecological approach to health and wellbeing, and a step towards creating a primary care system based on strong collaboration amongst health and non-health sectors.⁵⁰

With a focus on policy-making, HiAP is concerned with the development and implementation of legislation, norms, standards, major strategies, programs and decisions on resource collection and allocation. HiAP activities can be divided into two parts:

1. Strategic – involves new forms of governance and leadership, shared budgets, key relationships, a new understanding of decision-making and processes of diverse organisations, identifying and working with allies and blockers, and reframing of issues for shared understanding.
2. Technical – screening skills, Health Impact Assessments, sustainability assessments, training in and application of SDoH, operating within the Resource Management Act and Local Government Act planning and application processes, and negotiation skills.⁵¹

HiAP is aimed at transforming the current model of government departments, as individual 'silos', into a more hybrid system of policy-making. This will require, among other things, new accountability arrangements which acknowledge that health issues are everyone's business. However, it will also require cultural change in the healthcare sector's attitude to public health, and changes in human resource development which will encourage greater collaboration between schools of public health, medicine, nursing, allied health sciences and public administration as critical partners.⁵²

Housing, early childhood experience, education, transport, economic status, built and social environments, and access to resources are all examples of the SDoH that shape individual and group differences in health status – which may be outside the direct remit of health departments. Thus,

developing healthy public policy requires health ministries to encourage other government agencies which possess the relevant policy levers and programs to influence action in these areas.⁵³ Health is a matter that calls for a whole-of-government and community response.

Ollila (2011) outlines four distinct strategies for integrating HiAP in different areas of policy-making:⁵⁴

1. Health at the core: this is a proactive approach employed most often in health policy where health objectives are the core focus and other sectors are encouraged to adopt policies and measures to enable the fulfilment of these objectives. This is the case in tobacco regulation measures for example. The aim of reducing tobacco use is at the core of the policy and other sectors such as industry/business, customs, etc. are key to the success of the strategy.
2. Win-win: this strategy is employed where policies and actions put in place benefit all parties, i.e. both health objectives and other sectors' objectives are being achieved. This is traditionally found in policies related to education, the environment and sanitation.
3. Co-operation: here the focus is on the health sector making its expertise available to other sectors. This is the focus of occupational and environmental medicine, for example, where the objective is to ensure a safe, healthy and therefore more productive workforce.
4. Damage limitation: this is likely to be the most commonly used strategy, where the aim is to identify potential negative health impacts in policy proposals and ensure these potential risks are addressed/mitigated. For example, this would be the case in planning laws limiting the number of licensed premises in one given area.

HiAP strategies are implemented at the 'upstream' level to address the 'causes of the causes'⁵⁵ of disease. However, looking upstream to treat disease in clinical settings is just one part of the solution, as is evident from Figure 2. Truly looking upstream requires a collaborative effort amongst health and non-health professionals.

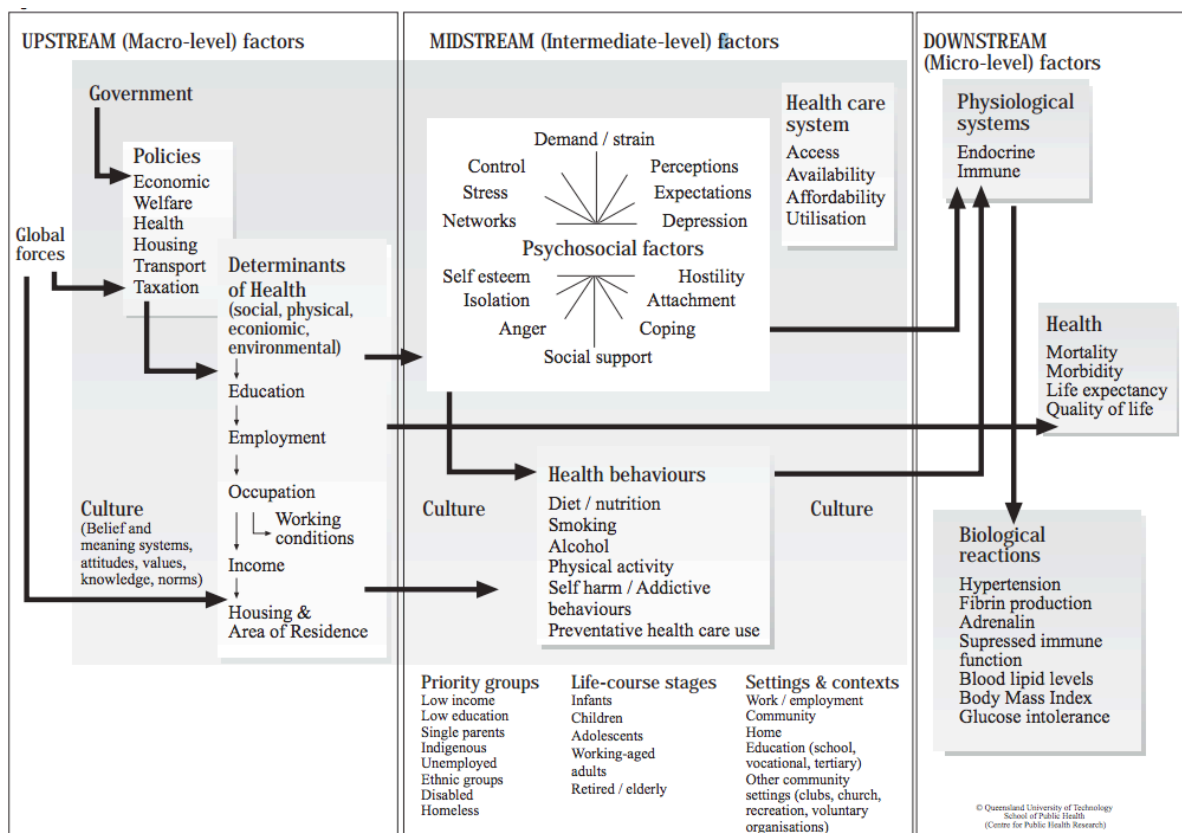


Figure 2: The social and economic determinants of health. Reproduced from Turrell et al. (1999)⁵⁶ with permission of Queensland University of Technology, School of Public Health (Centre for Public Health Research).

The World Health Assembly (WHA) Framework for Action Across Sectors 2015 recommends implementing the following steps to facilitate action on health and health inequity:

1. *Establish the need and priorities for action across sectors* by securing high-level political will and commitment. This requires advocacy to increase awareness that achieving health and health equity is a responsibility of all governments, because health is an outcome of all public policies.
2. *Identify supportive structures and processes* to enable stakeholders from different sectors to interact through a committee, interagency network or public health institute, and communicate effectively by recognising the power and dynamics and influences between stakeholders.
3. *Frame planned actions* by developing action plans which can be stand-alone document plans or incorporated into existing plans.
4. *Facilitate assessment and engagement* to identify unmet gaps in policy formulation or service provision. These data can assist in determining the priorities for action across sectors, and in planning specific policy or service improvements to fill these gaps.
5. *Establish a monitoring, evaluation and reporting mechanism* to provide evidence of best practices regarding intersectoral coordination, intervention and implementation.
6. *Build capacity*, which entails acquiring new knowledge and skills through institutional capacity (for example, expertise of individual practitioners, existing policy commitments, availability of funding, databases for planning, monitoring and evaluation, and organisational structure), and fostering capacity-building for all sectors involved.⁵⁷

The WHO has developed two HiAP Training Manuals⁵⁸, and is actively disseminating the Training in HiAP to complement the WHA Framework for Action.

The following are examples of HiAP inspired community-based interventions led by medical professionals. In 2015, Dr Rishi Manchanda, alongside public health physicians, founded the ‘think-and-do tank’ online platform, HealthBegins, which aims to steer a “*high-cost sick-care system into a smart health care system [to] improve health where it begins – where we live, work, eat, learn and play*”.⁵⁹ HealthBegins develops resources and activities to help health care look ‘upstream’ by addressing and preventing the unhealthy social conditions that cause disease. Similarly, St John of God Health Care in Western Australia provides community-based social outreach services to address the underlying causes of poor health. These outreach services are targeted at building capacity and providing early intervention amongst infants and young people.⁶⁰

Consider this case analysis.⁶¹

A paediatrician based in Port Macquarie was concerned with the prospect of a fast food outlet being developed 500 metres from a school complex, and the detrimental health impact this outlet could have on 1700 students attending the school. In particular, there is substantial evidence that children whose schools are in close proximity to fast food restaurants are more likely to be obese.

In strong opposition, the paediatrician was actively involved in a public campaign with local residents committed to preventing the outlet from being developed.

At the local council level, the fast food outlet’s proposal was rejected. Local planning laws strictly prohibit commercial development within residential zones. However, the food chain giant initiated an appeal to the Land and Environment Court. The current planning laws for communities rarely include any provision specifically to improve the community’s health, particularly child health.

This case example begs the question: could a HiAP approach have prevented any fast food restaurant from submitting a planning application in the first instance?

Certainly, if local planning laws were developed using HiAP measures, they would include provisions to enhance

healthy living and hence consider the health impacts of proposed commercial developments. It is possible that with such laws in place, fast food outlets would not be permitted to build their large complexes to sell unhealthy food to children that would impinge on children's health.

4. Tools for implementing Health in All Policies

A variety of tools are used to address health equity and to ensure that policies and programs are health-protecting and health-promoting.

The main types of assessment tools used to support HiAP goals are:

1. Health Impact Assessments (HIAs)

HIAs are decision support tools to assess the positive and negative health effects of proposed policies, plans, or programs on social and environmental determinants.⁶² HIAs are conducted in a step-wise process with clearly defined phases:

- Screen projects and policies appropriate for assessment
- Scope the assessment
- Assess the impacts
- Report with recommendations
- Ongoing monitoring and evaluation.⁶³

2. Health Equity Impact Assessments (HEIAs)

HEIA follows health impact assessment processes to determine:

- the potential differential and distributional effects of a policy, project or plan on population health, as well as specific groups within that population, and
- to evaluate whether the differential effects are inequitable.⁶⁴

3. Environmental and Social Impact Assessments with a health component

The purpose of an environmental and social impact statement is to assess and report on a project's social, economic and environmental impacts, and the measures proposed to avoid, manage, mitigate or offset the predicted impacts of the project. Impacts can be either positive (i.e. benefits and opportunities to capitalise on) or negative (i.e. adverse impacts to be managed).⁶⁵

4. General Impact Assessments

General Impact assessments are gaining ground as part of policy-making. Usually these assessments are done by persons who are not health professionals and the weight that health gets in such an assessment varies; sometimes health may not be captured.⁶⁶

Case studies and anecdotes provide some support for the claim that tools such as health impact assessments (HIAs) effectively support the decision-making process.

A thorough cost-benefit analysis of 15 HIAs was conducted in 2006 and showed that the benefits derived from the HIAs outweighed the cost of undertaking them. This finding has strengthened the argument that HIAs are effective.⁶⁷ However, the term 'effectiveness' is not a static concept in this complex context and a number of elements can make its assessment problematic: goals can evolve during the process, targeted populations may change in composition, there may be difficulties in controlling and adjusting for confounders. In addition, health effects tend to have long latency and are therefore difficult to measure/assess in the short and medium term. HIAs may also prove problematic if effectiveness is based on achieving intended outcomes – a HIA may be effective in terms of achieving one stakeholder's goals but no other stakeholder's.⁶⁸

The South Australian (SA) HiAP approach

The SA HiAP approach can be described as a flexible methodology which allows cross-departmental or joined-up processes of government to improve and influence the conditions that promote health. The South Australian HiAP model includes two critical enablers: horizontal and vertical governance structures, and a focus on public policy and health and wellbeing outcomes (Figure 3).

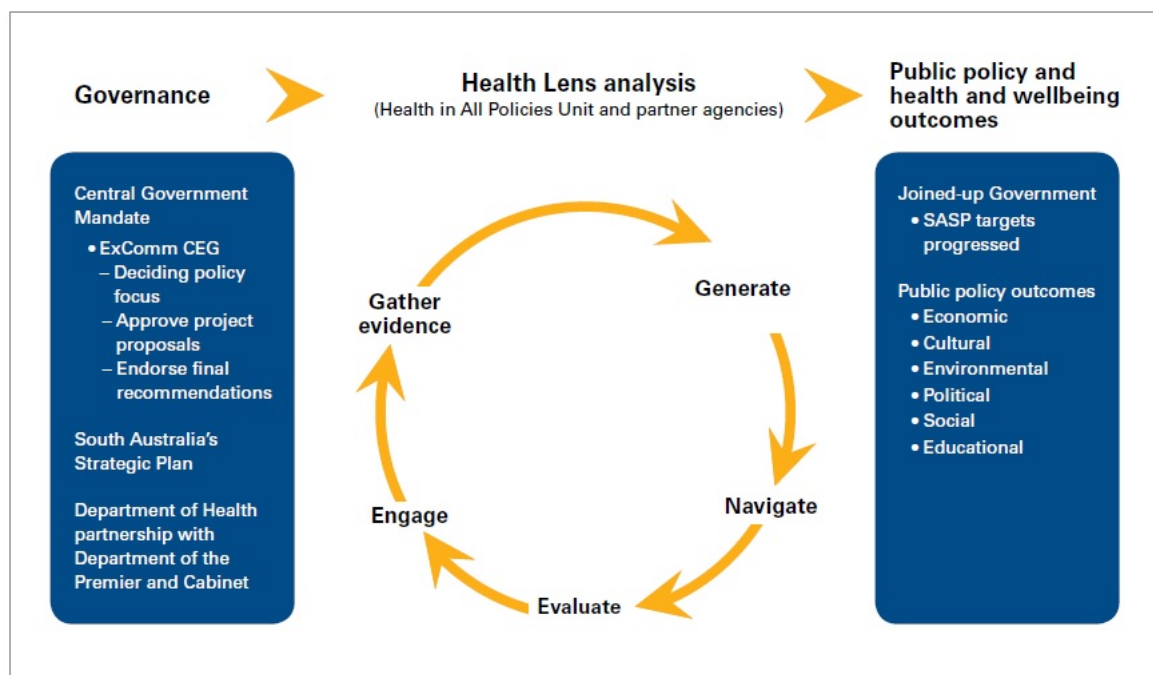


Figure 3: South Australia's Health in All Policies model.⁶⁹ Reproduced with permission of the Department of Health, Government of South Australia.

Health Lens Analysis

The Health Lens Analysis (HLA) is another type of assessment tool to support HiAP. It is an internationally recognised approach that aims to deliver evidence-based recommendations to inform the development of public policy, to maximise gains in health and wellbeing, and to minimise or prevent negative effects or inequalities of policies or programs.⁷⁰ A HLA process involves five stages:

1. **Engage** – establishing and maintaining strong collaborative relationships with partner agencies, including understanding of organisational culture.
2. **Gather evidence** – exploring impacts between health and the policy area under focus, and identifying evidence-based solutions or policy options.
3. **Generate** – producing a set of policy recommendations and a final report that are jointly owned by all agencies with responsibility for the policy area.
4. **Navigate** – helping to steer the recommendations through the decision-making process.
5. **Evaluate** – determining the effectiveness of the HLA through conducting evaluations of process, impact and outcome.

In South Australia, HLA has been applied with partnering government agencies to complete a range of projects including:

- Water Security – Alternative Water Supplies, Office for Water Security

- Regional Migrant Settlement – Department of Trade and Economic Development; Multicultural SA
- Transit-oriented Development (TODs) – Department for Transport, Energy and Infrastructure; Department of Planning and Local Government; Land Management Corporation
- Education – Improving Educational Outcomes in Low SES School Communities, Department of Education and Children's Services; Department for Transport, Energy and Infrastructure; Attorney-General's Department; SA Police; Department of Correctional Services; Department of Further Education, Employment, Science and Technology.

Four critical success factors have enabled South Australia's HiAP approach to be sustainable over time. These include:

1. Political and strategic relevance, which makes the strategy adaptive and responsive to change. In South Australia, this included adapting to the South Australian Strategic Plan, Strategic Priorities of Government, and the *South Australian Public Health Act 2011*.
2. Shared governance between the Department for Health and Ageing and the Department of the Premier and Cabinet. A central government mandate was a critical enabler, providing a clear memorandum of understanding to facilitate working across government departments.
3. An operational focus on co-benefits/mutual gains.
4. A flexible methodology, working with dedicated resources, and working with other departments on their priorities to assist them to achieve their policy goals in ways that protect and promote health.

The South Australian approach of HiAP implementation clearly illustrates the importance of establishing clear governance and accountability structures that cut across all sectors of government, and create joint responsibility. South Australia's approach to HiAP uses a horizontal and vertical process of governance, which breaks away from the traditional departmental boundaries to establish joint responsibility.

Recently, a memorandum of understanding (MoU) has been updated between the State Government and the SA Health Department, with the aim of systematising HiAP across government. The HiAP Unit works across government to formulate strong collaborative relationships with State Government agencies and local governments to create improved public policy and health outcomes. In addition, the SA Public Health Act 2011 provides a legislative framework to explore Public Health Partner Authority relationships between the Department of Health and Ageing and other agencies and/or sectors.

Conclusion

The evidence on the determinants of health and its impact on communities is compelling enough to warrant a whole-of-government and community response. This includes health professionals taking leadership in challenging the SDoH of their patients at micro-, meso- and macro-levels.

HiAP is one such strategy which recognises the idea of health as multidimensional and encompassing more than just the treatment of illness and disease. This strategy considers the wider factors that shape health, and encourages decision-makers to work across policy silos to address the SDoH and health professionals to widen their diagnoses to include all factors that contribute (i.e. social, environmental and economic factors) before overt illness occurs, and timely treatment is required.⁷¹ The HiAP approach may assist in the achievement of one of the Sustainable Development Goals, *Ensure healthy lives and promote well-being for all at all ages*, as defined in the United Nations' Transforming Our World – the 2030 Agenda for Sustainable Development.⁷²

Appendix 1: International implementation of HiAP

The World Health Assembly (WHA) – Action Across Sectors Framework 2015

The WHA has developed the *Action Across Sectors Framework* (the Framework), which acts as a resource for Member States in taking country-level action across sectors to improve health and health equity.⁷³ This approach is a revived application of the HiAP process.

Action across sectors can take the form of:

- The health authority initiating action, with engagement from one or more departments or agencies, focusing on improving health and health equity (the most common form of action)
- The head of government (or central government) initiating action in response to an outbreak or emergency, with all partnering departments participating in combating and managing health emergencies
- Establishing a new government entity to oversee and promote collaboration amongst different ministries and agencies to tackle a public health issue
- Authorities outside the health remit assuming the lead agency role
- Initiating action at the local government level, where various sectors collaborate to address public health and health equity issues by implementing community-based or setting-based health promotion activities.

‘Action Across Sectors’ describes the development and implementation of policies, programs and projects undertaken by two or more government departments or agencies. Through these partnerships, health sectors provide support to non-health sectors in developing policies within their remit, which will achieve co-benefits. This involves both horizontal action between departments and agencies, and action across different levels of government.

Like HiAP, the Framework is based on the fact that many factors which are key to achieving good health outcomes lie beyond the jurisdiction of the health sector. Moreover, action across sectors is necessary to ensure health protection and health system function, both of which are important for improving health and health equity.

Finland – The Helsinki statement on Health in All Policies

The Helsinki statement, followed by the *Health in All Policies (HiAP) Framework for Country Action*, was created as a result of the 8th Global Conference on Health Promotion in Finland. The core theme of the conference was HiAP, and its focus was on its implementation. Participants identified intersectoral action and healthy public policy as crucial factors for promoting health, achieving health equity, and recognising health as a basic human right.

The *Health in All Policies (HiAP) Framework for Country Action*⁷⁴ points out six key elements that need to be addressed to implement the HiAP approach:

- Establish the need and priorities for HiAP
- Frame planned action
- Identify supportive structures and processes
- Facilitate assessment and engagement
- Ensure monitoring, evaluation, and reporting
- Build capacity.

The California Health in All Policies Task Force (Task Force)

The Task Force⁷⁵ was established by the California Executive Order 2010 and affirmed by the California Legislature through Senate Concurrent Resolution 47 in 2012.⁷⁶ The California Department of Public Health is responsible for facilitating and staffing this Task Force. It was formed under the auspices of a cabinet-level body, the Strategic Growth Council (SGC), and is tasked with coordinating multi-agency collaborative projects at the state level to weave health and equity into government decision-making. It aims to improve air and water quality, protect natural resources and agriculture lands, increase the availability of affordable housing, promote public health, improve transport, and assist state and local agencies in planning sustainable communities.⁷⁷ Box 1 highlights the six aspirational goals that guide the Task Force.

Box 1: The Task Force's six aspirational goals which are used to guide its work

1. **Active transportation** – all residents have the option to safely walk, bicycle, or take public transit to school, work, and essential destinations
2. **Healthy housing and indoor spaces** – all residents live in safe, healthy, and affordable housing
3. **Parks, urban greening, and places to be active** – all residents have access to places to be active, such as parks, green space, and healthy tree canopy
4. **Community safety through violence prevention** – all residents are able to live and be active in their communities without fear of violence or crime
5. **Healthy food** – all residents have access to healthy, affordable foods at school, at work, and in their neighbourhoods
6. **Healthy public policy** – California's decision-makers are informed about the health impacts of various policy options during the policy development process.

To date, the Task Force has achieved the following milestones:

- Developed the 2014 Task Force Action Plan in Active Transportation, which highlights the commitments from over 20 state departments to promote safe walking, biking and public transport as a cross- government goal.
- Established the California Farm to Fork Office which is jointly funded by the State Departments of Education, Food and Agriculture, and Public Health. This Office promotes policies and strategies to improve access to healthy, affordable food.
- Created an interagency Food Procurement Working Group, and integrated health criteria into state food-purchasing contracts.
- Developed a multi-agency workgroup to promote healthy environments through school facilities and land use decisions.
- Secured commitment from the Governor's Office of Planning and Research to embed health considerations into the State's General Plan Guidelines, which provide guidance to local jurisdictions for developing comprehensive plans for future development.⁷⁸

Since its inception, HiAP initiatives have been implemented across California on a local community level, with several jurisdictions expanding intersectoral collaboration and engagement as part of their regular business practices. These examples include:

- Local health departments in California agreed to incorporate HiAP as a multi-agency approach in their Community Transformation Grants implementation plans.
- Los Angeles County initiated a multi-agency Healthy Design Workgroup after the Board of Supervisors passed a Healthy Design Ordinance.

- The City of Richmond adopted a HiAP strategy which entailed appointing a HiAP coordinator to execute it across city departments.
- Rural Del Norte County appointed a staff member to focus on HiAP.
- Sonoma County's Health Action Council, a multi-sectoral initiative, engages with government, private and non-government organisations to implement its 2013–2016 action plan, which is focused on education, income and health systems.⁷⁹

Appendix 2: Health inequities in Australia and New Zealand

Health inequities persist in Australia and New Zealand, particularly in Aboriginal and Torres Strait Islander communities, Māori communities, and other vulnerable populations, including disadvantaged socioeconomic groups, the elderly, people with disability and their carers, people with mental illness, new refugees and asylum seekers, and incarcerated people. There is a 10.6 year gap in life expectancy between Aboriginal and Torres Strait Islander men and non-Indigenous men, and a 9.5 year gap in life expectancy between Aboriginal and Torres Strait Islander women and non-Indigenous women.⁸⁰ Likewise, there is a 7.3 year gap between Māori men and non-Māori men, and a 6.8 year gap between Māori women and non-Māori women.⁸¹

In addition, health disparities exist between those in the top and bottom socioeconomic status quintiles of the Australian adult population for a number of chronic diseases and their associated behavioural risk factors (outlined in Figure 4).⁸² However, the most crucial message from Figure 4 is that a clear socioeconomic gradient – i.e. the lower a person’s socioeconomic status, the worse his or her health – is apparent in our society

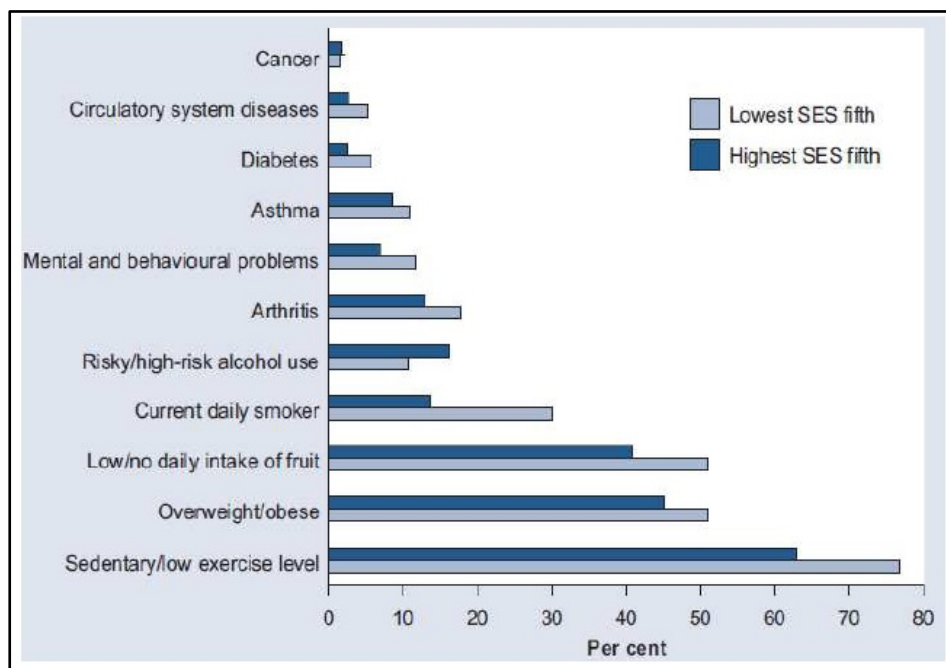


Figure 4: Proportion of people aged 18 years and over reporting selected health risk factors and chronic disease by socioeconomic status, 2004–05 (per cent).⁸³ Reproduced with permission of the Australian Institute of Health and Welfare (AIHW).

Poverty plays a considerable role in driving health disparities in society, particularly in minority populations. New Zealand’s Deprivation Index demonstrates that 75 per cent of Māori people were found in the poorer half of the population in 2006, and 24 per cent were in the lowest decile.⁸⁴ People of Māori descent are afflicted by higher rates of disease, receive delayed treatment which is of lower quality, and have poorer health outcomes. For example, the incidences of various types of cancer are three to four times higher, whilst survival rates are lower, and the incidence of rheumatic fever in children is 20 times greater than in non-Māori populations.⁸⁵

In economically developed countries like Australia and New Zealand, low economic position is associated with low educational attainment, lack of amenities, unemployment and job insecurity, poor

working conditions, and unsafe neighbourhoods.⁸⁶ In Australia and New Zealand, tobacco smoking is a behaviour with a strong social gradient.⁸⁷ In 2010, the prevalence of people living in the lowest socioeconomic areas who smoked was 25 per cent. This is twice the rate amongst people living in the highest socioeconomic areas (Figure 5).⁸⁸

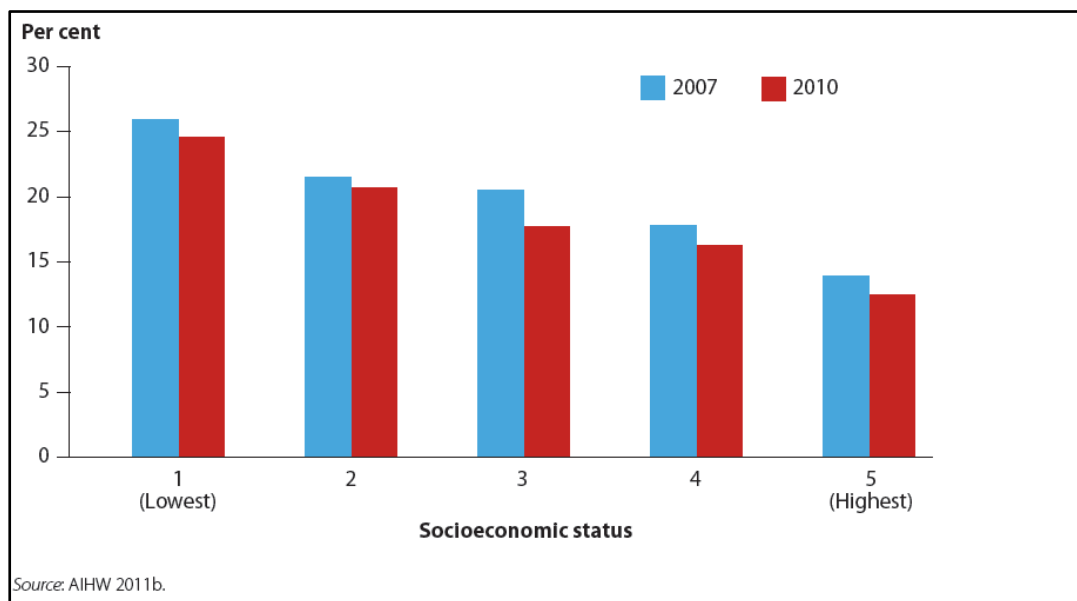


Figure 5: Prevalence of smoking by people in Australia aged 14 and over by socioeconomic status, in 2007 and 2010. Reproduced with permission of the Australian Institute of Health and Welfare (AIHW) from AIHW's Australia's Health 2012 Report.⁸⁹

A range of poor health outcomes can be traced to a person's socioeconomic characteristics as the underlying cause.⁹⁰ For example, income and level of education are two key socioeconomic indicators which have a direct association with health outcomes. A report published by the Queensland University of Technology and the Australian Institute of Health and Welfare showed that respondents from low income families reported experiencing poorer general health, and suffering from chronic illness. This group was also more likely to engage in risky behaviours (i.e. higher rates of smoking); less likely to consume and/or have easy access to a healthy diet, and more likely to report food insecurity; and made greater use of general practitioner services, but were unlikely to use healthcare services for preventive purposes (e.g. dental consultations, mammograms and pap smears).⁹¹

An individual's education level is a key determinant of health, in part because of its link with future occupational opportunities and income. Also, healthy behaviours, such as accessing health information and services, occur more often in those of higher educational attainment.⁹²

Individual-level health promotion activities, targeted at changing risk profiles of high risk populations, can potentially widen health inequalities.⁹³ Such inequalities have been shown in screening, healthy diet consultation, smoking cessation, and statin and anti-hypertensive prescribing.⁹⁴ This is because those interventions which require the use of an individual's material or psychological resources potentially favour populations with more resources, who are in a better position to respond to educational material, services or facilities aimed at improving their health.⁹⁵

Appendix 3: Early Childhood Development and Equity

Child development is characterised by acquiring the physical, cognitive, psychological and socio-emotional skills that contribute to children's increasing competence, autonomy and independence.⁹⁶ The concept of the first 1000 days – from conception through to two years of age – has attracted much attention as the “*blueprint for lifespan trajectories*”.⁹⁷

Antenatal care, to influence social determinants, is a key intervention which can impact on foetal development. The social determinants of maternal health (including the mother's health status and health behaviours) and intrauterine development impact on the cognitive and physical development of infants and children during pregnancy and in early life.

Child development is shaped by the interaction between genes and the environment, and experiences in early childhood have a major influence on future health and wellbeing. Therefore, when adverse experiences (such as under-nutrition, spread of infectious disease, highly chaotic home environments and exposure to violence) threaten early childhood health, lifespan trajectories can be disrupted, which may result in low educational attainment, economic dependency, and poor physical and mental health.⁹⁸

Continual exposure to risk factors without the safeguards of protective factors, especially during the delicate periods of neural development, can result in changes in neurobiology and neurochemistry that limit future developmental capability over a child's life course. A universal primary healthcare system that adopts the principles of ‘proportionate universalism’, which is providing universal care and support, but at a scale and intensity that is proportionate to the level of disadvantage, best addresses the health inequities that exist in society.⁹⁹

This can be achieved through the implementation of pro-child policies, increasing the availability of early detection and intervention for developmentally vulnerable children. Allocation of resources to respond to the growing needs of disadvantaged children will also have a positive effect on a child's developmental trajectory (Figure 6).

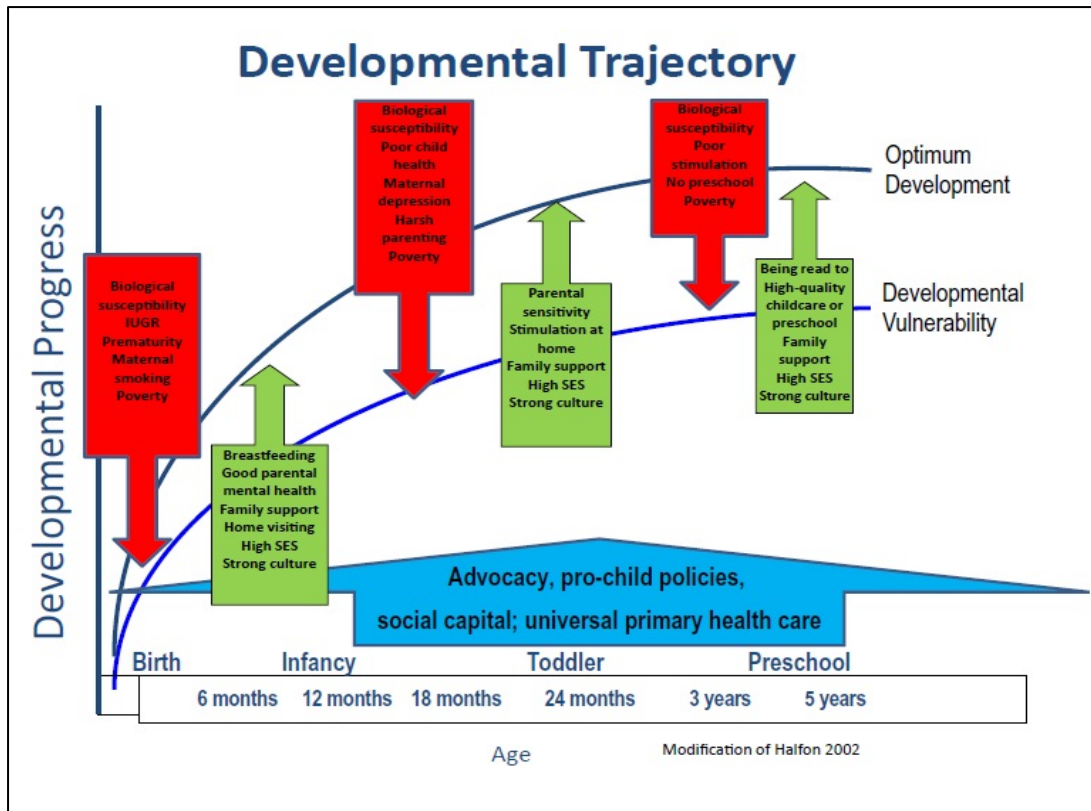
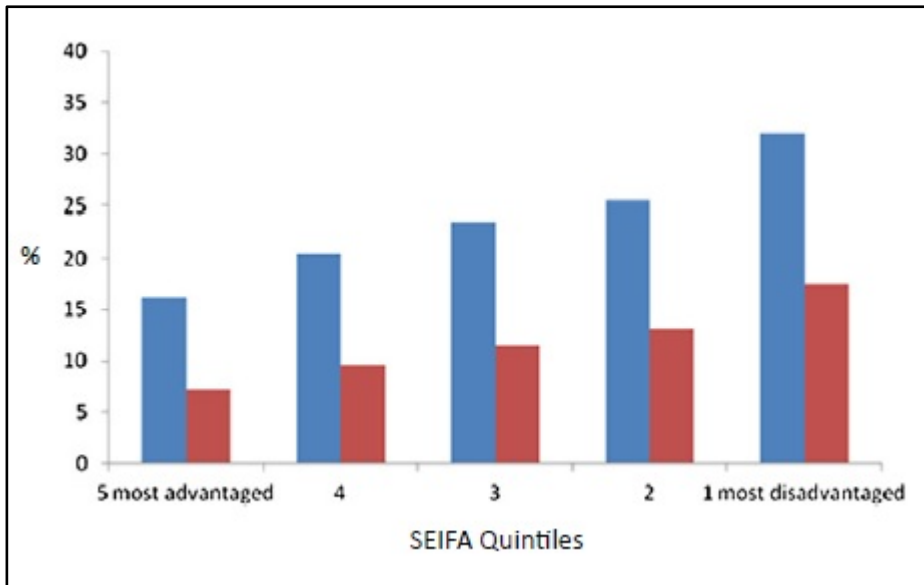


Figure 6: Developmental trajectory. Reproduced from Woolfenden et al. 2013¹⁰⁰ with permission of John Wiley and Sons.

Continued advocacy for breastfeeding and increased emphasis on maternal education are effective prevention strategies, because these protective factors have shown to mitigate the adverse effects of risk factors. Breastfeeding is beneficial for healthy brain and behavioural development. Likewise, maternal education is associated with better nutritional status of the child, as well as a positive child-rearing environment: women who participate in maternal education initiatives are more likely to access and benefit from intervention programs.¹⁰¹

There is emerging evidence showing that children who have a suboptimal start in life become developmentally vulnerable. As a consequence, children may underperform in one or more areas of childhood development such as motor, language, self-help, socio-emotional, cognitive, psychological adjustment and aggression. Nutritional threats, family dynamics and types of family forms and experiences of domestic or political violence are examples of risk which can potentially contribute to a child's suboptimal start in life.¹⁰²

The Australian Early Development Census states that 20 to 25 per cent of Australian children commencing their first year of school are 'developmentally vulnerable', with a higher prevalence associated with lower socio-economic status, with being an Aboriginal or Torres Strait Islander person, and with living in a remote area.¹⁰³ The differences in developmental vulnerability between groups of children are associated with the SDoH, including poor parental mental health and education, low family income, lack of stimulating early childhood experiences and social capital (Figure 7).¹⁰⁴



■ Refers to developmental vulnerabilities in one or more Australian Early Development Index (AEDI) domains
 ■ Refers to developmental vulnerabilities in two or more domains

Figure 7: Comparisons of developmental vulnerabilities by Socio-Economic Indexes for Area (SEIFA).
 Reproduced from Woolfenden et al. 2013¹⁰⁵ with permission of John Wiley and Sons.

Any deficits found in one or more areas of childhood development become increasingly challenging to rectify beyond the early childhood years.¹⁰⁶ Instead, developmental vulnerabilities appear in the reproductive years and adulthood, which in turn perpetuate the cycle of disadvantage and health disparities into the next generation.

Children from preconception to school age are potentially accessible by various government departments and agencies including education, family and social services, violence protection, and transport. Thus, investing in child development *earlier* may help to reduce the impact of health inequity as a means to building human capital.¹⁰⁷

Investments in early childhood services for vulnerable children is socially justifiable, and is a wise economic investment which may result in considerable savings in health, education and welfare budgets, and gains in work productivity.¹⁰⁸ It has been estimated that if all children had the same level of health as children who are socioeconomically advantaged, there would be a 30 to 70 per cent drop in the population-attributable proportion of chronic illnesses such as cerebral palsy, intellectual disabilities and mental health issues.¹⁰⁹ Consequently, action (by means of early intervention for healthy childhood development), or inaction, will have long-term consequences for adult functioning, for the care of the next generation, and for the wellbeing of communities.^{110,111,112}

The RACP Paediatric Policy & Advocacy Committee has published the following policies in support of improving the determinants of health amongst children:

- Physical Punishment of Children Position Statement – July 2013¹¹³
- Protecting Children is Everybody's Business: Paediatricians Responding to the Challenge of Child Protection Position Statement – March 2015¹¹⁴
- Sexual and Reproductive Health Care for Young People Position Statement – November 2015.¹¹⁵

Medical care is only one measure of sickness or injury. Undoubtedly, medical intervention is important for improving health outcomes. However, evidence suggests that health is strongly socially

determined and the problems arising from social, political, economic and environmental factors cannot be appropriately addressed by medical intervention alone. To serve the community better, we need a more sophisticated approach, which considers the SDoH in our patients, especially in preventing early morbidity and mortality.

Appendix 4: Definitions and Abbreviations

Definitions

Causes of the causes: a concept introduced by epidemiologist Geoffrey Rose which explains the need to identify the underlying cause of incidence.¹¹⁶

Developmental vulnerability: refers to a child who is significantly underperforming in an area of child development such as motor, language, self-help, socio-emotional, cognitive and behavioural, as measured by the Australian Early Development Census.

Health: we have adopted the World Health Organization (WHO) definition of health which refers to a “state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity”.¹¹⁷ As such, when health is mentioned throughout the document, it implicitly refers to all three components (i.e. physical, mental and social wellbeing).

Health inequality: refers to systematic differences (i.e. the social determinants of health) in health between social groups.

Health inequity: differences in health which are unfair, unjust, systematic, avoidable and/or unnecessary.

Healthy public policy: a policy that is ‘characterised by an explicit concern for health and equity in all areas of policy and an accountability for health impact’.¹¹⁸ Its aim is to favourably influence the determinants of health at higher levels (these levels include general socio-economic, cultural and environmental conditions, living and working conditions, and social and community influences).

Intersectoral collaboration: joint action among the health sector and non-health sectors to improve population health outcomes.

Joined-up approach: a way of working in partnership across sectors to improve health and health equity.

Proportionate universalism: Universal actions aimed at reducing the steepness of the social gradient in health, but with a scale and intensity that is proportionate to the level of disadvantage. Marmot et al. argue that focusing solely on the most disadvantaged will not decrease health inequalities.¹¹⁹

Abbreviations

HiAP	Health in All Policies
NATSEM	National Centre for Social and Economic Modelling
SDoH	Social determinants of health
SGC	Strategic Growth Council
WHO	World Health Organization

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