1. **What does using a Health in All Policies approach look like in practice? Can you give us some examples?**

“Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity”. This is the definition that was adopted by the World Health Assembly Resolution on *Contributing to Social and Economic Development: Sustainable Action Across Sectors to Improve Health and Health Equity* (WHA 67.12) in 2014. This definition provides a broad scope for what implementation could look like in practice, but given that intersectoral action for health is an old concept, let us examine perhaps some defining features. These perhaps distinguish it from intersectoral action.

The first feature is the issue of sustainability that is not explicitly stated but implied in the word “systematically”; the implication is that a “once-off” approach is not sufficient. Many approaches to intersectoral action have tried to work on a single issue for short space of time, without trying to embed the actions within an existing on-going system. For example, one can think of promotion campaigns between health and education to change eating behaviours through special cooperation between nurses and educators. Very often these types of initiatives have experienced short-lives because the level of cooperation lends the activity to being cut if there are unfavourable budgetary conditions in economic downswings. Typically, these approaches have not embedded a vision of health as part of education in the thinking of other sectors. However, this is not to say that sustained approaches do not involve incremental use of projects as a specific strategy. For example, in South Australia, the government uses project to prospectively evaluate joint policy proposals with a health lens as a part of a package of sustained cross-sectoral dialogue. It means that short projects need to be part of a sustained strategy aimed at embedded policy interlinkages with health.

The second issue is that is implied by the term “systematic” is that of the extent of the vision of intersectorality. Even it at the policy level, two ministries may work together to create a more integrated response to address social determinants of health on their policies (for example, in several countries, sectoral ministries of health and welfare or social protection, are combined), but a
Health in All Policies approach requires them not to stop there but rather to increase the extent of intersectoral scope of work across additional sectors. This may mean reaching even the traditionally harder to reach sectors such as planning and trade. Much of the earlier health promotion literature on intersectoral action, and even the early examples of Good Health at Low Cost (e.g. in Sri Lanka in 70s, 80s) describe the coming together of health and education services, and then health and basic water and sanitation management. But the challenge is to keep going further.

The third and final issue I would like to highlight is the issue of accountability for health. Part of the Health in All Policies approach requires the establishment of formal accountability mechanisms and reporting procedures with regard to the health implications of decisions made in different sectors. These are of course implemented in different ways in different settings. However, legal requirements for reporting and accountability involving civil society have emerged as two strong elements that contribute to the effectiveness of accountability measures. Several examples of this accountability measures are characteristics of recent efforts on Health in All Policies but they have been implemented differently. In Norway, the emphasis is on the establishment of health-related targets by different sectors, and sectoral responsibility as part of an inter-departmental committee for addressing health determinants. This activity is underpinned by a legal mandate. In Quebec, accountability is more at the level of knowledge translation with regard the provision of proposed laws for scrutiny and potential impact assessment by the health sector. This role is also underpinned by a legal mandate. Both of these processes are more bureaucratic. However, in Thailand, health impact assessments are run through the “triangle-that-move-the-mountain” approach, where civil society, representing the affected communities, academia, and different sectors of government are convened by health to assess potential health implications of new policies or development projects.
2. A new training manual on Health in All Policies has been published by WHO. Your unit at WHO has a pivotal role in this. Why did you think that such a manual is necessary?

As implied earlier, a Health in All Policies approach is an approach to intersectoral work, also called by other labels such as working across sectors. The point about WHO producing a manual on this topic at this juncture is important from two perspectives.

First, looking back to previous work on intersectoral action, one sees that WHO has produced training materials before on working across sectors, but this material was more focussed on specific sectors or issues. I am thinking in particular on the work done with regard to health working with water and sanitation sectors, and with regard to nutrition. For establishing a generic public health practice, it is important that the manual is able to refer to a broader range of sectors, and associated health conditions. For example, water and sanitation is traditionally associated with communicable diseases. Nowadays, the rise of noncommunicable diseases is much stronger on people’s agenda and intersectoral work needs to address this too. In this context, other issues emerge as important such as global trade. Another point to note regarding previous material is that much of it was scientific, and more was being asked by Member States with respect to supporting the ways of working. Working intersectorally crosses silos and this can be challenging. Silos won’t go away so working across sectors while having silos requires an emphasis on different skills, different ways of thinking, not always starting from the health perspective, but also thinking of other disciplines and their paradigms and goals.

Second, for the social determinants of health work, this manual is important because it shows a practical way of dealing with health inequities. In our unit, as you will have heard already, our focus is on understanding the causes of health inequities and what can be done to address these. Health inequities refer to health inequalities that are avoidable, unfair and amenable to change. The causes of inequities can be characterised by answering the question:

“why do disadvantaged populations in any society experience higher exposures to poor housing, water and sanitation, poorer quality education, and other conditions that are detrimental to their health?”

Interviews of WHO experts – 10 March 2015

The reasons why this clustering of negative determinants of health occur are numerous, but the responses can be systematized and targeted around ensuring health implications of public policies are taken into consideration, that synergies in policy coherence are actively sought, and that negative impacts are given greater ethical weight and deliberation in decision-making. In the end, without health, people’s lives are short and potentially very painful. The need for a systematic approach was highlighted in the final recommendations of the Commission on the Social Determinants of Health. The Commission on Social Determinants was a global commission appointed by WHO to find a response to the problem of growing health inequities. They concluded in their report of 2008 that WHO needed to pay more attention to working across sectors to make them sensitive to their impacts on health equity. By the same token, the health sector also needs to understand the implications of its actions in health systems contribute on the social development. As of 2014, there is a specific World Health Assembly resolution devoted to this topic: *Contributing to social and economic development: action across sectors to improve health and health equity*, which I referred to earlier. Using the training manual to increase skills in working across sectors and to promote intersectoral dialogue and understanding, is a very practical way for Member States to implement this resolution. In the end, having a Training Manual on Health in All Policies is a very practical entry point for working across sectors, that allows dialogue on health inequities, among other priorities, to take place.
Looking to the future, how will the training on Health in All Policies be used? How will it help addressing the social determinants of health?

WHO is planning to roll out the training manual through a series of training of trainers’ meeting, convening a network of trainers and coordinating routine updates to the manual and relevant material being used by trainers. Some of these additional relevant materials include case studies that are used as discussion points and for role plays during the training, and policy briefings to inform participants on the latest evidence from the literature on the evaluation of policies. We hope by the end of 2016 to have had regional training of trainers’ meeting in all six regions, and to have had national training in up to 20 countries, with a focus on low and lower-middle income countries. Using this manual will give governments and civil society a stronger entry point for discussions of the health implications of public policies across sectors. These discussions may will provide an opening to address the question of health equity. But health equity does not have to be the stated entry point, either position-wise or with respect to the terminology used. Without these cross-sectoral discussions, it is hard to start sustain efforts to address health inequities. The vision of health as human right, and of population health being shaped by structural factors affecting individual behaviours, is lost. Also, disadvantaged groups are at the receiving end of the clustering of too many determinants to make providing health care sufficient to address health gaps. All sectors need to be share a common vision of health in society, and actively contributing to ensuring policy trends in different sectors and changes to social norms do not lead to increasing trends in health gaps.

We thank HIFA-EVIPNET for the opportunity to discuss this with their network and encourage network participants to look at launch background and download the Health in All Policies Training Manual at the WHO sites:

Launch:

Directly access the Manual from the WHO manual repository:
http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf?ua=1