HEALTH IN ALL POLICIES

A Guide for State and Local Governments

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PREFACE

The health of our nation is in crisis: chronic disease is on the rise, health care costs are spiraling up, and inequities are growing. More and more children are facing illnesses that have historically been associated with adults, and current trends suggest that today's young people may be the first generation of children in the United States with shorter life expectancies than their parents. At the same time, we face urgent environmental problems—such as climate change, water shortages, the loss of habitat and other natural resources—which will pose additional health challenges.

There is an increasing recognition that the environments in which people live, work, learn, and play have a tremendous impact on their health. Re-shaping people's economic, physical, social, and service environments can help ensure opportunities for health and support healthy behaviors. But health and public health agencies rarely have the mandate, authority, or organizational capacity to make these changes. Responsibility for the social determinants of health falls to many non-traditional health partners, such as housing, transportation, education, air quality, parks, criminal justice, energy, and employment agencies. Solutions to our complex and urgent problems will require collaborative efforts across many sectors and all levels, including government agencies, businesses, and community-based organizations.

Public health agencies and organizations will need to work with those who are best positioned to create policies and practices that promote healthy communities and environments and secure the many co-benefits that can be attained through healthy public policy. This approach is called "Health in All Policies," and is described in the World Health Organization's Adelaide Statement on Health in All Policies as assisting "leaders and policymakers to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services." The Health in All Policies approach builds on previous collaborative public health work and is spreading rapidly and dynamically in the United States and around the world.

We are very proud of the American Public Health Association's long history of working with colleagues in many sectors to improve the health of communities across the United States. This guide follows in that tradition, and will be of great value as the implementation of Health in All Policies expands and evolves to transform the practice of public health for the benefit of all.

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ABOUT THIS GUIDE

"Health in All Policies: A Guide for State and Local Governments" was written by the public health facilitators of the California Health in All Policies Task Force and is geared toward state and local government leaders who want to use intersectoral collaboration to promote healthy environments. There are many different ways to support intersectoral collaboration for health, and the guide provides a broad range of perspectives and examples.

In developing the guide, the authors reviewed the published peer-reviewed and gray literature and interviewed people working in formal and informal intersectoral collaborative government processes to promote health at local, state, and national levels across the United States and in other countries. While the guide reflects a wide variety of approaches to Health in All Policies, and provides local, state, and national case examples from across the United States and around the world, it draws heavily on the authors' experiences in California and from documents produced by the California Health in All Policies Task Force. More information about the California experience is available in Part III.

Much of the information in this guide may appear intuitive or self-evident. However, the authors' experiences suggest that careful consideration of basic concepts, such as relationship building and decision-making, is very helpful in pursuing the broad range of activities that fall within Health in All Policies.

Health in All Policies is a growing field and the authors expect that new approaches to Health in All Policies will continue to emerge after the publication of this guide.

A NOTE ABOUT THE ORGANIZATION OF THE GUIDE

The order of information in this guide is not intended to imply that the practice of Health in All Policies will necessarily follow any one sequence. For example, some Health in All Policies initiatives will emerge from existing relationships, while others will be created through a top-down directive and necessitate the building of new relationships.

Part I of this guide is a discussion of the concept of Health in All Policies, including its key elements, history, and links to other public health and equity initiatives. Part II covers the "nuts and bolts" of this work and discusses an array of considerations including structure, relationship building, leadership, and messaging. Part III of the guide is a case study of the California Health in All Policies Task Force. Those less familiar with Health in All Policies approaches may find it useful to read the guide in order, while others may be more interested in starting with the California case study or another section.

The guide includes a glossary of commonly used terms, as well as a list of annotated resources, organized by section. You will also find *Food for Thought* sections throughout the guide. These are lists of critical thinking questions you may wish to consider as you apply a Health in All Policies approach.

LANGUAGE USE IN THIS GUIDE

Several of the authors' choices of language merit comment.

The term "policy" deserves special attention. While policy is often seen as synonymous with legislation, it actually describes a broad range of activities, and can be defined much more broadly as an agreement on issues, goals, or a course of action by the people with power to carry it out and enforce it.[1,2] In this guide, "policy" refers to *public* policy, which can be defined as the "sum of government activities, whether acting directly or through agents,"[3] that have an influence on residents and communities. Public policy has also been defined as "the actions of government and the intentions that determine those actions,"[4] "political decisions for implementing programs to achieve societal goals,"[5] or simply "whatever governments choose to do or not to do."[6]

Another term that deserves attention is "equity," which is used frequently in the phrase "health equity," and sometimes by itself. Promoting equity is a key strategy for addressing major population health issues rooted in socioeconomic inequalities facing the United States. Health inequities are differences in health "that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity."[7] In this guide "sustainability" refers to the need of society to create and maintain conditions so that humans can fulfill social, economic, and other requirements of the present without compromising the ability of future generations to meet their own needs.[8] This can be thought of in terms of environmental, economic, and social impacts, and encompasses the concept of stewardship and the responsible management of resources. The authors believe that equity and sustainability are core components of a healthy community.

The term "agency" is generally used to indicate any government entity including an agency, department, office, or board.

The terms "partners" or "partner agencies" generally refer to government agencies, while "stakeholders" generally refers to those outside of government, including members of local communities, representatives of community groups and nonprofit organizations, academics, and representatives of businesses. However, note that for *state* government agencies, the term "stakeholder" may also refer to a representative of a *local* government agency.

PART I. WHAT IS HEALTH IN ALL POLICIES AND WHY DO WE NEED IT?

Health in All Policies: A Guide for State and Local Governments starts with background information on the concept of Health in All Policies in order to ground the reader in key concepts and definitions. Part I includes an overview of the social determinants of health and describes Health in All Policies as an approach to address these key drivers of health outcomes and health inequities. The authors discuss the connections between health, equity, and sustainability and describe the importance of addressing equity and sustainability in order to build healthy communities. Part I also includes an overview of the key principles of Health in All Policies, a description of a healthy community as a goal for Health in All Policies work, and an international history of Health in All Policies.

SECTION 1: Background

KEY POINTS

- Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

- Health is influenced by the social, physical, and economic environments, collectively referred to as the "social determinants of health."

- Health in All Policies, at its core, is an approach to addressing the social determinants of health that are the key drivers of health outcomes and health inequities.

- Health in All Policies supports improved health outcomes and health equity through collaboration between public health practitioners and those nontraditional partners who have influence over the social determinants of health.

- Health in All Policies approaches include five key elements: promoting health and equity, supporting intersectoral collaboration, creating co-benefits for multiple partners, engaging stakeholders, and creating structural or process change.

- Health in All Policies encompasses a wide spectrum of activities and can be implemented in many different ways.

- Health in All Policies initiatives build on an international and historical body of collaborative work.

1.1 What is Health in All Policies?

Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. (See Appendix II for other definitions of Health in All Policies.) The goal of Health in All Policies is to ensure that all decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process.[9] A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health, and how better health can support the achievement of goals from multiple sectors. It engages diverse governmental partners and stakeholders to work together to improve health and simultaneously advance other goals, such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, environmental sustainability, and educational attainment.[10]

> Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

Health in All Policies builds on a long public health tradition of successful intersectoral collaboration, such as efforts to implement water fluoridation, reduce lead exposure, restrict tobacco use in workplaces and public spaces, improve sanitation and drinking water quality, reduce domestic violence and drunk driving, and require the use of seatbelts and child car seats.

Health in All Policies encompasses a wide spectrum of activities, with one-time collaborative efforts with a single partner at one end, and whole-of-government approaches involving on-going collaboration across many agencies at the other. While all parts of the spectrum can help further a Health in All Policies approach, Health in All Policies is most effective when it goes beyond one-time or one-issue collaborations. Ultimately the Health in All Policies approach seeks to institutionalize considerations of health, equity, and sustainability as a standard part of decision-making processes across a broad array of sectors.

"I think it's clear that if we are going to be successful as a state in advancing improvements in individual health [and] in closing health disparities we need to be thinking across silos and across sectors."

—Kimberly Belshé, *former Secretary, California Health and Human Services Agency, November 2010*

1.2 Why We Need Health in All Policies

Health in All Policies is a response to a variety of complex and often inextricably linked problems such as the chronic illness epidemic, growing inequality and health inequities, rising healthcare costs, an aging population, climate change and related threats to our natural resources, and the lack of efficient strategies for achieving governmental goals with shrinking resources. These "wicked problems"[11] or "social messes"[12] are extremely challenging. Addressing them requires innovative solutions, a new policy paradigm, and structures that break down the siloed nature of government to advance trans-disciplinary and intersectoral thinking.[13] Health in All Policies provides such an approach.

Governments, at all levels, are challenged by declining revenues and shrinking budgets while also facing increasingly complex problems. Collaboration across sectors—such as through a Health in All Policies approach—can promote efficiency by identifying issues being addressed by multiple agencies and fostering discussion of how agencies can share resources and reduce redundancies, thus potentially decreasing costs and improving performance and outcomes.

"A Social Mess is a set of interrelated problems …resistant to analysis and, more importantly, to resolution…[It is characterized by] uncertainty and risk, complexity, systems interacting with other systems, competing points of view and values, different people knowing different parts of the problem (and possible solutions), and intra- and inter-organizational politics."

—Robert Horn, *Strategy Kinetics*[14]

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

At its core, Health in All Policies represents an approach to addressing the social determinants of health, which are the key drivers of health outcomes and health inequities. It is founded in the recognition that public health practitioners must work with partners in the many realms that influence the social determinants of health, which are largely outside the purview of public health agencies.

The Upstream Parable

Irving Zola, in a widely cited article by John McKinlay, offered this metaphor for our current sickness-based health system and the need for upstream, preventative approaches for health: "Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore, and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have *no* time to see who the hell is upstream pushing them all in."[15]

Health is influenced by the interaction of many factors including:

- genetics, biology, individual behavior;

- access and barriers to health care; and

- social, economic, service, and physical (natural and built) environments.[16]

While clinical care is vitally important, only a small portion (15–20%) of overall health and longevity can be attributed to clinical care.[17] Social, physical, and economic environments and conditions, collectively referred to as the "social determinants of health," have a far greater impact on how long and how well people live than medical care.[18,19,20] The interaction between health, social factors, and environmental factors is complex. The "Policy Rainbow" below is one model that shows the layers of influence on an individual's potential for health. See the Annotated Resources (Appendix IV, page 140) for additional models that demonstrate the relationship between health and the built and social environment, such as the Spectrum of Prevention and the Health Impact Pyramid.

FIGURE 1. THE BROAD DETERMINANTS OF HEALTH
Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies. Used with permission.
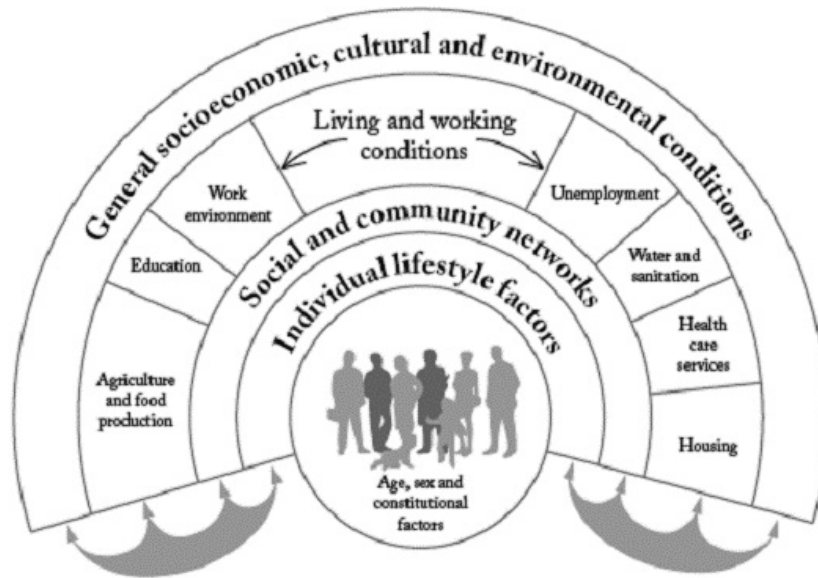
The social determinants of health are key drivers of health inequities, which are persistent in the United States.[21] Health inequities are differences in health "that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity." These are distinct from health disparities, which are "differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities."[22] For example, health disparities include the increased risk of sickle cell disease in African Americans or the increased risk of breast cancer in women, whereas health inequities include the increased rates of asthma hospitalization in children living near freeways or the lower life expectancies for African Americans living in low-income neighborhoods.

Several studies suggest that addressing social and economic inequalities like inadequate education, which contributes to inequitable mortality rates, would contribute substantially more to overall population health than the emergence of new medical advances.[23,24,25] Economic inequality is increasing in the United States, and is likely to lead to worsening health inequities.[26]

Economic well-being is one of the most critical determinants of health; living in poverty is associated with significantly worse health outcomes across all races and ethnicities and in every state and community.[27] Furthermore, unemployment is associated with poor physical and mental health outcomes.[28] A report from the Robert Wood Johnson Foundation states that:

> The means by which poverty damages health over the life course are many, but key elements involve limits on opportunity and participation that come directly from inadequate financial resources, diminished early life environments and poor educational opportunities, physical environments that are dangerous and under-resourced, poor working conditions, absence of benefits, job insecurity, lack of health insurance and access to quality medical care, and acute and chronic stress.[29]

Education is another key determinant of health; education and health correspond closely and impact each other in both directions. People with higher levels of educational attainment consistently experience lower risks for a wide array of illnesses and increased life expectancy.[31] They also experience improved future economic well-being.[32] In turn, educational attainment itself is shaped by health. For example, the health of students significantly impacts school dropout rates,[33] attendance,[34] and academic performance.[35,36,37]

Structural racism contributes to persistent inequities. People of color have consistently lower incomes, less household wealth, and lower educational achievement levels than Whites. Children living in poverty are more likely to be Hispanic or African American.[38] Even at equivalent income levels, people of color in the United States consistently experience significantly higher rates of illness and injury than their White counterparts.[39]

"The first wealth is health."

—Ralph Waldo Emerson[30]

The Gardener's Tale

The following parable, paraphrased here, illustrates how structural racism impacts outcomes and perpetuates inequities over time. Imagine a gardener who has two packets of seeds, one for red flowers and one for pink flowers, and two flower boxes, one with poor soil and one with rich soil. The gardener, who loves red flowers, plants the red flower seeds in the box with the rich, fertile soil, and plants seeds for pink flowers in the box with poor, rocky soil. The seeds in the rich soil grow into big and beautiful flowers; the pink seeds in the poor soil fare poorly, becoming straggly, anemic-looking plants. As the seeds self-sow in the boxes, the progeny of the red flowers in the rich soil continue to thrive, while the pink flowers in the poor soil struggle to survive. The gardener concludes, "I was right to prefer the red flowers."[40]

Neighborhood characteristics have significant impacts on health outcomes because they influence an individual's ability to adopt behaviors that promote health.[41] Efforts to change behaviors that impact health are most effective when they also address the environments in which people make their daily choices.[42] For example:

- People whose neighborhoods lack parks, green open spaces, or trees and whose neighborhoods have high crime rates, have less access to safe places to play or walk.[43]

- People in low-income neighborhoods often have less access to affordable, healthy food retail options, and have more access to cheap fast-food outlets.[44]

- Rates of violent crime and interpersonal violence are higher in neighborhoods with a high density of alcohol outlets.[45]

In almost all urban areas, serious health problems are highly concentrated in a fairly small number of distressed neighborhoods,[46] and the health problems of high-poverty neighborhoods remain substantially more serious than those of middle-class and affluent neighborhoods. People living in neighborhoods with high rates of poverty can have life expectancies up to 14 years shorter than those who live in neighborhoods with less poverty.[47]

These inequities, in part, reflect differences in characteristics between neighborhoods with high levels of poverty where many people of color live and those with less poverty where more white people reside. Many studies suggest that residents of low-income and minority neighborhoods are the most likely to lack access to supermarkets and healthful food, have fewer parks, and are more likely to be located near sources of air pollution.[48,49] Fast-food restaurants and foods with high caloric density and little nutritional value are also more available in lower-income and minority neighborhoods.[50] Liquor stores are disproportionately located in predominantly African American census tracts, even after controlling for census tract socioeconomic status.[51] Residents of rural areas are also more likely to lack access to supermarkets and healthful food.[52]

Furthermore, research shows that racial segregation itself negatively impacts health, regardless of individual income level.[53] For example, cities with the highest degrees of residential racial segregation also show the greatest gaps in African American and white infant mortality rates.[54] This is especially important because rates of residential segregation by race remain high[55] and rates of residential segregation by income are actually increasing across the United States.[56]

The Bay Area Regional Health Inequities Initiative, a collaboration of 11 local health departments in the San Francisco Bay Area, developed the following framework to illustrate how the social determinants of health are linked with poor health outcomes. This framework builds on the Dahlgreen and Whitehead model shown earlier (Figure 1, page 9), to convey how social inequities and institutional power can affect living conditions, risk behaviors, disease, injury, and ultimately mortality.

FIGURE 2. A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
Bay Area Regional Health Inequities Initiative. (2010, June). Used with permission.
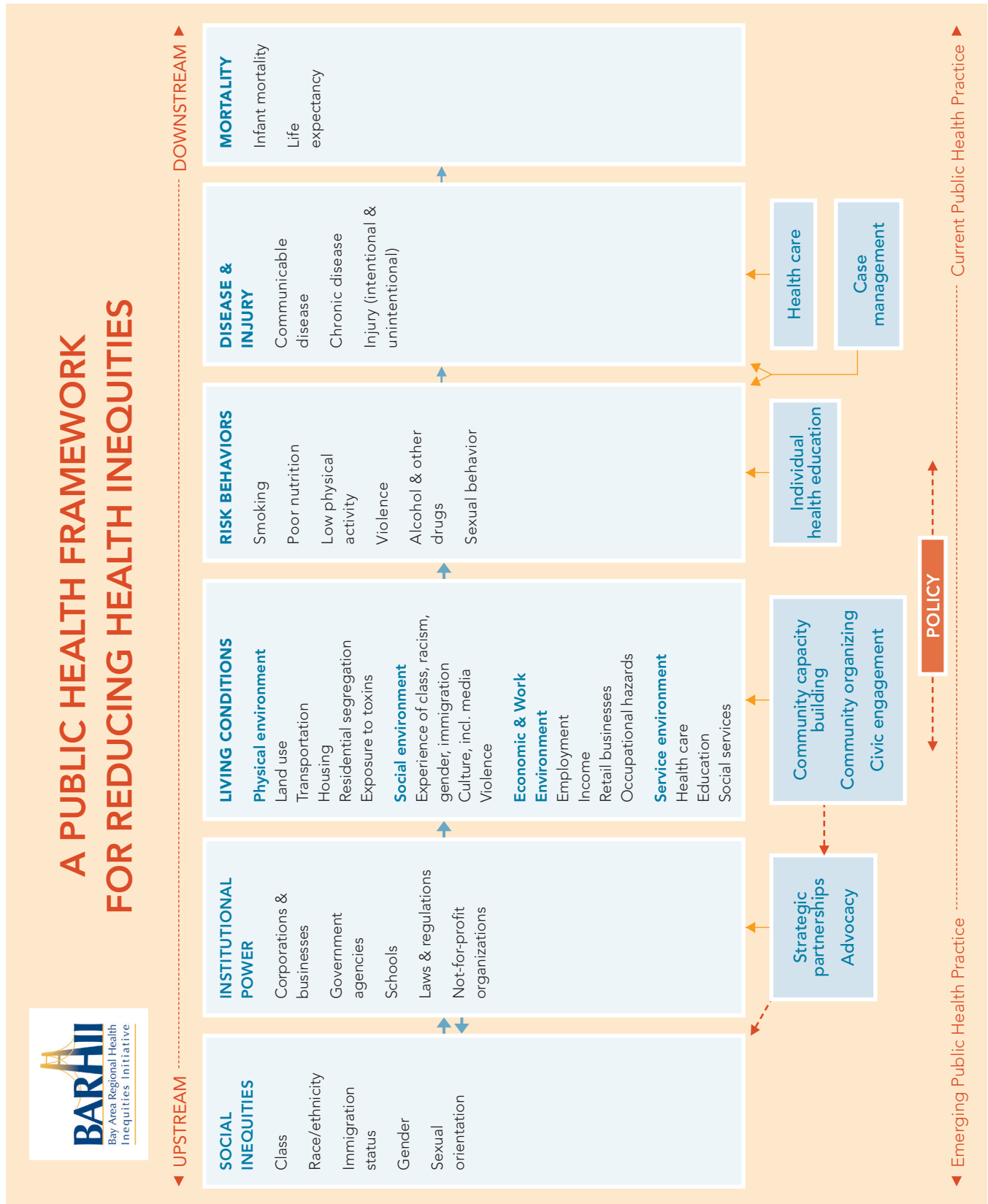
While inequity hurts those at the bottom of the socioeconomic ladder, it is also associated with poorer health outcomes for all members of a community—not just those with fewer financial resources. Wilkinson and Pickett analyzed the relationship between income inequality and health outcomes, using data from industrialized nations and states in the United States, and found that higher overall inequality is consistently associated with worse health outcomes at all rungs of the socioeconomic ladder.[57]

HEALTH AND SUSTAINABILITY

Environmental sustainability is inextricably linked to health and equity,[58] and has an important place in Health in All Policies work. Global environmental challenges not only directly impact health (e.g., flooding and extreme heat events), but also threaten the supporting systems on which human life depends—air, food, shelter, and water. For example, the health effects of air pollution, crop loss, stratospheric ozone depletion, sea level rise, and collapse of fisheries all suggest that environmental sustainability must itself be a key health goal. Luckily, many strategies to address health and equity also address environmental challenges (more information about co-benefits is available in Section 4.2).

It is incumbent upon those engaged in Health in All Policies to incorporate sustainability into the work. In California, for example, the nexus between health, equity, and sustainability was embedded in the structural placement of the Health in All Policies Task Force within the Strategic Growth Council, given the Council's core function as a cabinet-level body created to ensure coordination across agencies on issues related to sustainability.[59] In other jurisdictions, Health in All Policies initiatives may need to intentionally consider sustainability throughout their work.

HEALTH AND THE ECONOMY

The population's health impacts, and is impacted by, the economy in the United States in multiple ways. The rising costs of health care—now roughly 18% of United States gross domestic product (GDP)[60]—are sapping the government's ability to invest in other critical areas like education, renewable energy, or deficit reduction. Of the $2 trillion spent on health care each year, 75% is attributed to chronic conditions,[61] and nearly 10% of all national medical costs are obesity-related.[62] Cardiovascular disease alone costs society nearly $400 billion each year,[63] and it is estimated that an excess of $180 billion is spent annually to treat uncomplicated diabetes and hypertension.[64]

"[E]cosystems are the planet's life-support systems—for the human species and all other forms of life… Nature's goods and services are the ultimate foundations of life and health, even though in modern societies this fundamental dependency may be indirect, displaced in space and time, and therefore poorly recognized.

—World Health Organization, Millennium Ecosystem Assessment[65]

Prevention of chronic illness alone could yield very significant savings. For example, the Trust for America's Health estimates that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years—a return of $5.60 for every $1 spent.[66] In California, a potential reduction of 1% in common chronic conditions among the 2.6 million current members of the California Public Employees Retirement System is projected to yield a savings of $3.6 million per year.[67] Good health allows increased workforce participation and productivity, while illness and injury negatively impact the productivity not only of the individual, but also of family members who provide care for their loved ones. Labor time lost due to health reasons represents $260 billion per year in lost economic output.[68] For example, full-time workers in the United States who are overweight or obese and have chronic health conditions miss an estimated 450 million additional days of work each year compared with healthy workers, resulting in an estimated annual cost of more than $153 billion in lost productivity.[69,70]

Furthermore, people across the political spectrum agree that spending money to improve the health of communities makes sense. Over 75% of voters in small, conservative counties in California "agree that public investments aimed at keeping people healthy, like building parks and promoting neighborhood safety, pay for themselves in the long run by preventing disease and reducing health care costs."[71]

OBESITY: AN EXAMPLE OF THE NEED FOR HEALTH IN ALL POLICIES

The causes of the obesity epidemic are complex, including the food, physical activity, social, and economic environments that shape individuals' opportunities to make healthy food and beverage choices and incorporate exercise into daily routines. More than one-third of adults and almost one-fifth of children in the United States are obese, and obesity rates have more than doubled for adults and tripled for children since 1980.[72] Obesity increases the risk of many health conditions including coronary heart disease, stroke, high blood pressure, Type 2 diabetes, some cancers, osteoarthritis, and infertility. It may also shorten population life expectancies for future generations.[73,74]

The increased prevalence of sedentary lifestyles, which contributes to rising obesity rates, is related to changes in patterns of land use and transportation, increased distances from homes to school and work, parental fears about children's safety, shifts in the nature of work, and cultural changes. Increased consumption of foods and beverages with high caloric density and little nutritional value is encouraged by the proliferation of time-saving, processed convenience foods, pressures on working parents, intensive marketing, and government subsidies for commodity products such as corn and soy.

Reducing the prevalence of obesity and chronic disease will require that public health practitioners address people's environments, which will in turn require working across multiple sectors. Transportation, planning, agriculture, labor, economic development, education, entertainment, and other partners will all need to be involved in order to advance a comprehensive approach to obesity and chronic disease prevention. It will also require exploring the links between these sectors and environmental sustainability, as well as addressing inequities in how communities are impacted.

1.3 What is a Healthy Community?

Because community and social factors drive health outcomes and health equity, it is important to ask, "What is a healthy community?" The framework below provides an answer to this question. The framework was developed by the California Health in All Policies Task Force, and was an important step in developing a shared vision for the group. The California Health in All Policies Task Force case study at the end of this guide gives more information about how the framework was developed as well as other details about implementation of Health in All Policies in California.

"Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

—World Health Organization[75]

What is a Healthy Community?

A Healthy Community provides for the following through all stages of life:

MEETS BASIC NEEDS OF ALL

· Safe, sustainable, accessible, and affordable transportation options

· Affordable, accessible and nutritious foods, and safe drinkable water

· Affordable, high quality, socially integrated, and location-efficient housing

· Affordable, accessible and high quality health care

· Complete and livable communities including quality schools, parks and recreational facilities, child care, libraries, financial services and other daily needs

· Access to affordable and safe opportunities for physical activity

· Able to adapt to changing environments, resilient, and prepared for emergencies

· Opportunities for engagement with arts, music and culture

QUALITY AND SUSTAINABILITY OF ENVIRONMENT

· Clean air, soil and water, and environments free of excessive noise

· Tobacco- and smoke-free

· Green and open spaces, including healthy tree canopy and agricultural lands

· Minimized toxics, green house gas emissions, and waste

· Affordable and sustainable energy use

· Aesthetically pleasing

ADEQUATE LEVELS OF ECONOMIC AND SOCIAL DEVELOPMENT

· Living wage, safe and healthy job opportunities for all, and a thriving economy

· Support for healthy development of children and adolescents

· Opportunities for high quality and accessible education

HEALTH AND SOCIAL EQUITY

SOCIAL RELATIONSHIPS THAT ARE SUPPORTIVE AND RESPECTFUL

· Robust social and civic engagement

· Socially cohesive and supportive relationships, families, homes and neighborhoods

· Safe communities, free of crime and violence

California Health in All Policies Task Force. (2010, December 3). *Health in All Policies Task Force Report to the Strategic Growth Council.* Retrieved from: http://sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf Used with permission.

1.4 The Five Key Elements of Health in All Policies

There is no one "right" way to implement a Health in All Policies approach. While all Health in All Policies initiatives are based on the concept that population health and equity depend upon collaborative, intersectoral action, there is substantial variation in process, structure, scope, and participation in the initiatives. These variations depend upon many factors, including the needs of a particular community, available resources, and relationships with key partners.

Regardless of how a Health in All Policies initiative is structured, there is a wide range of activities that governments can use to promote consideration of health in decision-making. These activities can be seen as falling along a spectrum, ranging from one-time opportunities for stakeholder input to activities that fully embed health considerations into all aspects of government decision-making. Where an activity falls on this spectrum will depend on how much the activity incorporates the five key elements described below. Organizers of initiatives will choose activities depending on capacity, resources, and support from decision-makers, and they may engage in a variety of different activities at the same time or over time. These activities can include jointly sponsored conferences or trainings, providing input on documents or rules, joint research projects, sharing data or new data metrics, health impact assessments, the organization of interagency offices, collaborative decision-making, and many more.

Based on experiences in California, and through a review of Health in All Policies work around the nation and globe, five key elements of Health in All Policies have emerged as vital to the success of this work:

1. **Promote health, equity, and sustainability.** Health in All Policies promotes health, equity, and sustainability through two avenues: (1) incorporating health, equity, and sustainability into specific policies, programs, and processes, and (2) embedding health, equity, and sustainability considerations into government decision-making processes so that healthy public policy becomes the normal way of doing business. Promoting equity is an essential part of Health in All Policies, given the strong ties between inequity and poor health outcomes for all members of society.

2. **Support intersectoral collaboration.** Health in All Policies brings together partners from many sectors to recognize the links between health and other issue and policy areas, break down silos, and build new partnerships to promote health and equity and increase government efficiency. Agencies that are not typically considered as health agencies play a major role in shaping the economic, physical, social, and service environments in which people live, and therefore have an important role to play in promoting health and equity. A Health in All Policies approach focuses on deep and ongoing collaboration, rather than taking a superficial or one-off approach.

3. **Benefit multiple partners.** Health in All Policies is built upon the idea of "co-benefits" and "win-wins." Health in All Polices work should benefit multiple partners, simultaneously addressing the goals of public health agencies and other agencies to benefit more than one end (achieve co-benefits) and create efficiencies across agencies (find win-wins). This concept is essential for securing support from partners and can reduce redundancies and ensure more effective use of scarce government resources. Finding a balance between multiple goals will sometimes be difficult, and requires negotiation, patience, and learning about and valuing others' priorities.

4. **Engage stakeholders.** Health in All Policies engages a variety of stakeholders, such as community members, policy experts, advocates, members of the private sector, and funders. Robust stakeholder engagement is essential for ensuring that work is responsive to community needs and for garnering valuable information necessary to create meaningful and impactful change.

5. **Create structural or procedural change.** Over time, Health in All Policies creates permanent changes in how agencies relate to each other and how government decisions are made. This requires maintenance of both structures which can sustain intersectoral collaboration and mechanisms which can ensure a health and equity lens in decision-making processes across the whole of government. This can be thought of as "embedding" or "institutionalizing" Health in All Policies within existing or new structures and processes of government.

The State of South Australia, an international leader on this approach, has also developed ten principles for Health in All Policies, which can be viewed in Appendix III, on page 139.

1.5 A Brief History of Health in All Policies

While Health in All Policies has gained significant traction in the last few years, its origins go back 35 years to the World Health Organization Declaration of Alma-Ata in 1978. The timeline below shows the history of this innovative approach to intersectoral collaboration for health, including its global spread.

See the Annotated Resources (Appendix IV, page 140) for more details on the events below.

Year	Event
1978	World Health Organization Declaration of Alma-Ata
1986	World Health Organization Ottawa Charter for Health Promotion
1987	Health Policy Towards the Year 2000, Norway
1988	World Health Organization International Conference on Health Promotion, Adelaide, Australia
2000	National Health Strategy, New Zealand
2001	Public Health Act, Quebec, Canada
2003	National Public Health Policy, Sweden
2005	World Health Organization Commission on Social Determinants of Health
2006	Finnish Presidency Health Theme, European Union
2007	State Strategic Plan, South Australia
2007	Thai National Health Act, Thailand
2009	Partnership for Sustainable Communities, United States
2010	California Health in All Policies Task Force, United States
2010	European Union Council Conclusion Statement on Health in All Policies
2010	National Prevention, Health Promotion, and Public Health Council, United States
2010	Adelaide Statement on Health in All Policies, South Australia
2011	For the Public's Health: Revitalizing Law and Policy to Meet New Challenges, Institute of Medicine, United States
2011	Rio Political Declaration on Social Determinants of Health, Brazil

PART II. THE NUTS AND BOLTS OF HEALTH IN ALL POLICIES

While understanding the five key elements of Health in All Policies is essential for doing Health in All Policies work, there are many details involved in putting the approach into action. Part II of this guide discusses the "nuts and bolts" of Health in All Policies. As stated in Part I, there is no "right" way to do this work. All Health in All Policies initiatives will require that people across different sectors work together as a group, but the membership, level of formality, and activities of the group will vary. While the tips and guidance included in Part II draw heavily on the experiences of the California Health in All Policies Task Force, the authors provide numerous examples of efforts from other states in the United States, including local efforts by cities and counties, to illustrate key points. The authors also reference pertinent examples from Australia, Canada, and Thailand.

SECTION 2: Getting Started

KEY POINTS

- If you have a broad vision, windows of opportunity for Health in All Policies are everywhere.

- The activities in which governments already engage and the roles they take on can provide opportunities for Health in All Policies.

- Health in All Policies can be used across the whole of government and can also be applied to specific policies, programs, and strategies.

2.1 Finding Opportunities for Change

Any Health in All Policies initiative will require significant visioning, planning, and decision-making. Unless you have been explicitly mandated to start a Health in All Polices initiative, your initial step may be to find an opportunity to introduce a Health in All Policies approach, whether in the form of a willing partner from outside the public health field, a mobilization around a specific community need, or a great idea for how to embed health into a process or program in another agency not focused on public health. Even if you are directed by a piece of legislation, an executive order, or another mandate to carry out a Health in All Policies initiative, there will inevitably be room for a creative process to discover opportunities, invite partners, and select priorities while implementing this approach.

SHARE YOUR VISION

If you have a vision of healthy communities and value intersectoral collaboration, you will continually come across opportunities for positive change. It is important to talk about your vision in order to help others see the potential that could be achieved. Much of the work of Health in All Policies is about having an idea and sharing it. As people become more aware of the importance of this approach and of the opportunities that it provides to strengthen their own work, it will be easier to develop intersectoral partnerships to promote health.

WINDOWS OF OPPORTUNITY

At any given moment, most governments are discussing or implementing literally hundreds of issues, processes, or initiatives in all kinds of policy areas, many of which offer opportunities to promote health. These create windows of opportunity—or "policy windows"—that may only be open for a short time. For example, you may find policy windows at the beginning of a strategic planning process, when a key leader becomes interested in a topic, when an unexpected crisis or natural disaster hits, or when a community demands action on an issue. You rarely have control over the timing or content of policy windows, but if you look for them, they can provide you with opportunities to engage in intersectoral collaboration for health.[76] John Kingdon suggests that policy agendas are influenced by 1) what issues are considered "significant problems," 2) what solutions are considered sound at any given moment, 3) the electoral process, and 4) public opinion. Any of these can shift unexpectedly, opening an opportunity for a new collaborative approach, such as Health in All Policies.[77]

Three approaches: opportunistic, issue, and sector. The World Health Organization (WHO) describes three approaches to intersectoral action on health.[78] An "opportunistic approach" focuses on identifying issues, policies, or relationships that can potentially provide *early* success for all partners. An "issue approach" starts with identifying policies that have a major impact on specific public health priorities, such as violence prevention, hunger alleviation, or reduction of poverty. A "sector approach" focuses on one specific policy area that has a large health impact, such as transportation or agriculture. In fact, both the issue and sector approaches can be enhanced by an exploration of windows of opportunity.

An Opportunity to Think About Health

The Safe Routes to School National Partnership saw an opportunity to embed Health in All Policies into the Safe Routes to School Local Policy Guide that was already under development. "Using a Health in All Policies approach is a smart prevention strategy which enables policymakers to be leaders in building healthy communities, which leads to healthier, happier people."[79] The Safe Routes to School Local Policy Guide describes many ways that transportation policy and school policies can support health, physical activity, and safety.[80]

🍎 **FOOD FOR THOUGHT.* Here are some questions you may ask yourself as you look for opportunities to apply Health in All Policies approaches:**

- ☐ Are there any existing or newly forming interagency initiatives that have potential health implications?

- ☐ What single-agency initiatives would benefit from partnership with additional agencies?

- ☐ Is your agency, or is another agency, going through a strategic planning process?

- ☐ Is there a new or ongoing process where health metrics or data could be added?

- ☐ What partners have you worked with successfully in the past?

- ☐ Is there a particular health issue of significant concern to community groups? Are they asking for something to be done about it?

The following examples illustrate a variety of windows of opportunity that led to intersectoral, health-promoting projects:

- **Health care crisis.** In 2007 in Sonoma County, California, health system leaders convened a broad group of stakeholders (including hospital and clinic executives, leaders of nonprofit, labor, and business organizations, policymakers, and city council representatives) to discuss the possibility that a major hospital would leave the county. As conversations progressed, the group began to broaden its focus to address not just health care, but also community health. In the end, the hospital stayed open, and as a result of the process, the county developed a Health Action Council, with 10 goals and 22 measures that include educational attainment, economic security, access to healthy food and places to be active, and other health determinants. The Health Action Council has spawned several community-based initiatives, and is moving forward with a 2013–2016 action plan focusing on education, health systems, and income. The initiative is staffed by the Sonoma County Department of Health Services.[81]

*"Food for Thought" is an American idiom that describes intellectually stimulating concepts. In this guide *Food for Thought* sections are lists of critical thinking questions you may wish to consider as you apply a Health in All Policies approach.

- **Natural disaster response.** In 2008, after Hurricane Ike devastated the coastal island city of Galveston, Texas, the local government needed to decide how to rebuild. Local leaders saw an opportunity to provide health input into the planning process, and as a result, the University of Texas Medical Branch partnered with a spectrum of government agencies, engaged with community stakeholders, and used the San Francisco Department of Public Health's Healthy Development Measurement Tool to integrate health into new city plans, including the community's housing plan.[82] See the Annotated Resources for more information on the Sustainable Communities Index, which is an update of the Healthy Development Measurement Tool.

- **Strategic planning process.** South Australia's 2007 "Thinker in Residence," Professor Ilona Kickbusch, recommended that the state government use a Health in All Policies approach to improve health outcomes and achieve targets in the South Australia Strategic Plan.[83] A desktop analysis of the strategic plan documented potential health impacts of its targets. As part of the plan's implementation, agencies were encouraged to look at targets through a health lens, with agency executives accountable for overseeing Health in All Policies and reporting on the plan's progress.[84]

- **City zoning process.** In Baltimore, Maryland, the comprehensive revision of the city's zoning code provided an opportunity to discuss how zoning and the built environment impact residents' health. This discussion led to a 2010 health impact assessment of the first draft of the code. The health impact assessment recommended limiting the concentration of alcohol outlets and instituting land use and design elements to reduce crime (e.g., lighting standards), which is also important for promoting walkability. The subsequent drafts of the municipal zoning code have reflected the input received as a result of the health impact assessment.[85,86]

- **Outreach through existing public health programs.** Public health programs already provide important opportunities to link with other agencies to address the social determinants of health. For example, California's Contra Costa County Public Health Department launched a program to help Women, Infants, & Children (WIC) recipients understand the income tax process and apply for the Earned Income Tax Credit. Agency leaders understood that poverty is a major determinant of poor health, and that by helping support asset development and economic sustainability, the health department can advance the health of women and children in their community. So far, over 6,000 women have participated, and participants report feeling more confident about handling money and have an improved understanding of the impact of money on health.[87]

One possible launching point for interagency partnership is to start with a single agency whose work greatly impacts health, or where there is an opportunity for your public health agency to support an important priority of that agency. Agencies outside the public health field can often benefit from partnerships with public health departments by using health messaging to promote their work, and by building relationships with partners who can help them achieve their goals. For example, many parks and recreation departments use messaging about physical activity, benefits of green space, and other health benefits to promote use of their facilities and funding for their work.

GOVERNMENT MECHANISMS AS OPPORTUNITIES FOR CHANGE

Government agencies continuously engage in processes that offer opportunities to incorporate a health lens, foster new intersectional relationships, make recommendations for intersectoral action, or embark on a more structured Health in All Policies approach. For example, agencies develop reports, sponsor conferences and educational events, develop grant programs, write proposals to obtain new funding, engage in strategic planning and accreditation processes, respond to natural disasters, and in some cases develop and propose regulations and legislation. The table below describes government functions[88,89] and provides examples of how each of these may offer "windows of opportunity" for embarking on new partnerships to support specific healthy policies or programs, or for launching a Health in All Policies initiative.

GOVERNMENT MECHANISM	OPPORTUNITY	POSSIBLE ACTION
DATA	Government agencies collect, standardize, and disseminate information and data. Sharing data or standardizing data elements across agencies can ensure more effective collaboration.	• Improve data sharing and collaborate on data collection between schools and social service agencies to improve access to nutrition assistance programs. • Include indicators related to the social determinants of health (e.g., income and employment, housing, and transportation) in health department reports.
DIRECT SERVICE PROVISION	States, counties, and cities provide direct services to communities and individuals. Departments can expand or create new services, better customize services, link services, and reduce barriers to access.	• Include healthy homes assessments in weatherization programs. • Incorporate health screening into intake processes at youth detention facilities.
EDUCATION AND INFORMATION	Agencies educate and inform the population on topics relevant to individuals, organizations, communities, and businesses.	• Incorporate messages around the importance of physical activity in promotional materials for a park. • Require that nutrition information be either posted or appear on the food labels of all food sold on school grounds or at school-sponsored events.
EMPLOYER	Governments employ staff in offices, parks, schools, and throughout cities, counties, and states. Employee policies can encourage healthy behaviors and also set a positive example for private businesses.	• Provide transit subsidies to encourage employees to use public transportation. • Provide lactation accommodations, including specially designated rooms and refrigerators, to support breastfeeding.
FUNDING	Grants provide funds to support specific projects or activities. Subsidies are assistance (monetary or otherwise) that reduces the need for monetary expenditures. Grants and subsidies can be used to encourage health-promoting actions. This includes payment for health-promoting services (e.g., Medicaid or Medicare).	• Offer childcare subsidies to support workers with children. • Incorporate health and health equity criteria into requests for proposals from agencies outside the public health field.

GUIDANCE AND BEST PRACTICES	Guidelines can be used to encourage communities to implement best practices or proven methodologies.	• Incorporate strategies that promote community health into comprehensive land use and transportation plans or community climate action plans. • Share evidence to inform the adoption of evidence-based and evidence-informed strategies to address crime prevention.
PERMITTING AND LICENSING	Permits and licenses provided by government bodies authorize particular types of activities or development.[90] Zoning, for example, is used to divide land into areas for allowable uses.	• Streamline permitting processes for farmers' markets to provide healthy food in underserved residential neighborhoods. • In the housing element of a comprehensive plan, outline a method for encouraging housing development near public transit hubs.
PURCHASING: PROCUREMENT AND CONTRACTS	Agencies spend significant money purchasing goods like food, supplies, and equipment, and contracting for services like construction and janitorial services. Procurement and contracting policies can promote other desired outcomes such as economic resiliency, and are a way to model behavior for other agencies or private businesses.	• Establish procurement policies that require vending machines on agency property to provide a minimum number of healthy options. • Establish policies supporting contracting with veteran-, minority-, or women-owned businesses.
REGULATION	Agencies can add, abolish, or change regulations, close or open loopholes, improve enforcement, or change complaint mechanisms for the public. Regulation is often useful in situations where consumers lack essential information.	• Improve enforcement of smoking bans in multi-unit housing structures. • Develop a regulation to apply a health analysis to budgetary and legislative decisions.
RESEARCH AND EVALUATION	Agencies may initiate research, or partner on projects with universities, research institutions, and communities. Evaluation can promote best practices and support model programs.	• Conduct economic research on the expected return on investment in terms of health outcomes from specific policies or types of policies. • Research new fuel technologies to identify strategies to improve air quality.
LEGISLATION AND ORDINANCES	State legislation and local ordinances provide funding or authorize new programs, regulations, or restrictions. Government agencies vary in their legal ability to support the passage of legislation and ordinances.	• Amend a local ordinance to allow mobile produce vending in a residential area. • Pass legislation to support access to safe, clean, and affordable water.
TAXES AND FEES	Governments can add new taxes, change or abolish existing taxes, or change the tax base to finance needed services.	• Increase vehicle licensing fees to raise revenue for supporting transit projects. • Raise cigarette taxes and use the revenue to pay for health care services and discourage tobacco use.
TRAINING AND TECHNICAL ASSISTANCE	Agencies provide training and technical assistance to support local programs in working toward ongoing goals, and as programs and policies change. Both interagency and intra-agency training are essential to support collaboration.	• Educate non-health staff on how their work relates to health outcomes. • Provide technical assistance to regional transportation agencies on how to incorporate health considerations and outcomes into transportation modeling.

🍎 **FOOD FOR THOUGHT. Below are a number of questions you may want to ask yourself as you begin to move forward with a particular policy, project, or strategy:**

☐ Why is it important for health to become a part of the process or discussion, and how will you explain this to others?

☐ Who are the key leaders and how will you reach them?

  ○ *How do your interests align with their concerns and priorities?*

  ○ *Who is the best person to reach out to them?*

☐ What do you want others to do?

  ○ *Do you want others to invite health representatives to the table?*

  ○ *Do you want to establish a new group (e.g., a Health in All Policies workgroup or task force)?*

  ○ *Do you want others to incorporate health considerations into an existing government process, such as the development of data or metrics, legislative analysis, or the allocation of grants?*

☐ Are there human or financial resources that can help get work started or can help sustain a project?

☐ What information do you need?

  ○ *Do you need more information to forcefully articulate why intersectoral collaboration might be relevant to partners from outside the public health field?*

  ○ *Do you know your potential new partners' priorities, goals, and challenges?*

☐ Do you know who your stakeholders are and their views on the issue?

2.2 Exploring the Benefits of Collaboration

As you identify opportunities for Health in All Policies work, it may be helpful to explore an issue (within your own group or with your prospective partners) to see why collaboration may be beneficial. See Part III for a discussion of how California developed a Healthy Communities Framework, which is one method for building shared goals and identifying opportunities to integrate a Health in All Policies approach. Below are two other exercises for such exploration.

ROOT CAUSE MAPPING EXERCISE

Root cause mapping is a structured process for identifying key factors contributing to community health problems, and can help you identify methods for correcting or eliminating these underlying factors and promoting improved outcomes. This method involves repeatedly asking "why?" to help people identify the "causes of causes," or the social determinants of the issues they seek to address. It can illustrate the many opportunities for change, and the overlapping roles that various sectors may play in contributing to healthy environments. This can be useful in the beginning of a collaborative process because it can help people see the mutual benefits that could arise from working together.

The following story about "Jason," a hypothetical child in a hospital, conveys the kind of causal chain that a root cause map would show:

- Why is Jason in the hospital? *Because he has a bad infection in his leg.*

- But why does he have an infection? *Because he has a cut on his leg and it got infected.*

- But why does he have a cut on his leg? *Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.*

- But why was he playing in a junkyard? *Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.*

- But why does he live in that neighborhood? *Because his parents can't afford a nicer place to live.*

- But why can't his parents afford a nicer place to live? *Because his dad is unemployed and his mom is sick.*

- But why is his dad unemployed? *Because he doesn't have much education and he can't find a job.*

- But why ...?[91]

Drawing an initial root cause map may be a first step in a more comprehensive process that can include a structured assessment of which root causes appear frequently, which have a higher or lower impact, which agencies or stakeholders might address each identified cause, and which root causes seem feasible to address given resource and political constraints. Figure 3 below shows a basic root cause map model.

FIGURE 3. SIMPLE ROOT CAUSE MAP
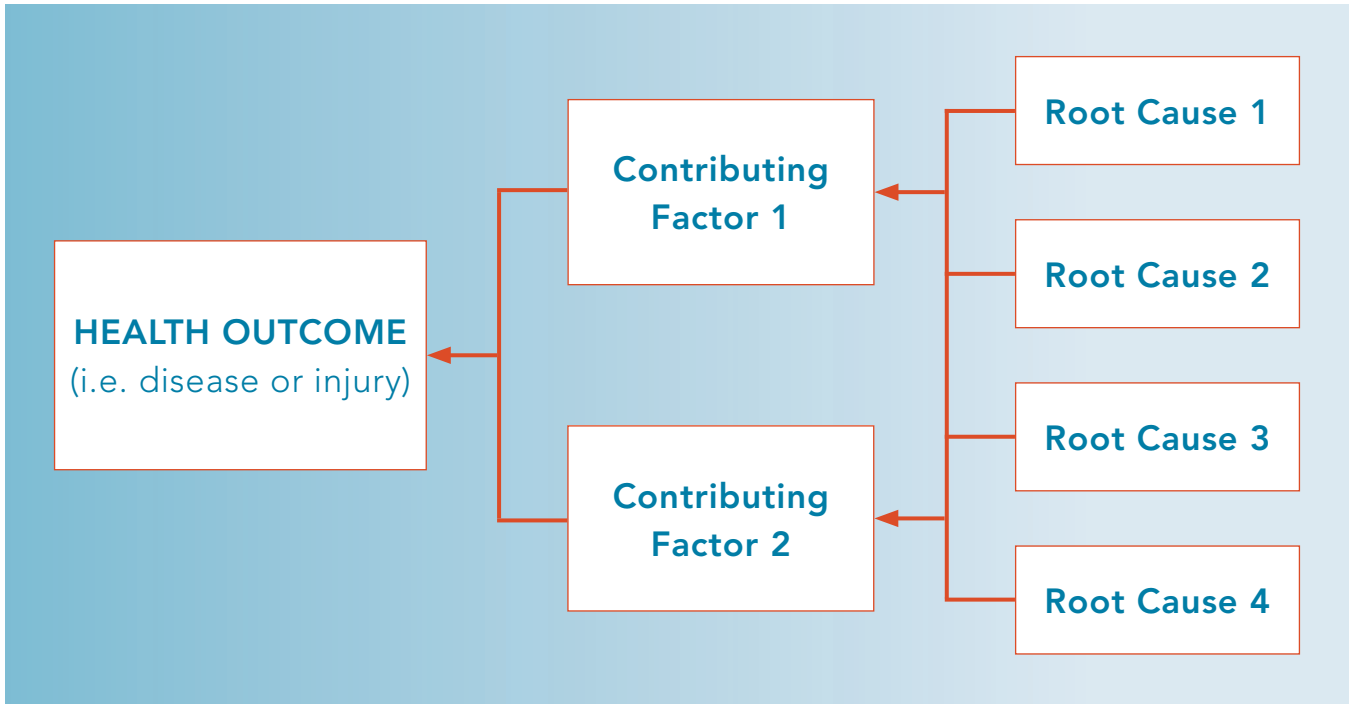
A more detailed example of a root cause map is included in Section 6.1.

COLLABORATION MULTIPLIER

The Collaboration Multiplier is an interactive framework created by the Prevention Institute to help build effective interdisciplinary collaboration between different groups and sectors. The tool can be used to help select partners, or can be used by those already working together to help identify missing partners, better clarify the goals of partners and the group, and leverage the expertise and resources at the table. This is based on the idea that each party in a partnership brings a unique perspective and potential contribution to the table, and that each partner's expertise and resources can be leveraged to help identify and accomplish a common goal. Phase I, Information Gathering, is an opportunity to determine the key sectors that play a role in a problem or solution. Phase II, or Multiplier Analysis, shown in Figure 4, can help partners analyze information they have collected in Phase I.

FIGURE 4. COLLABORATION MULTIPLIER
Prevention Institute. Collaboration Multiplier Analysis Worksheet. (2011, July). Used with permission.

COLLABORATION MULTIPLIER ANALYSIS

Goals: _____

COLLABORATOR

Expertise/Resources:

Desired Outcomes:

Key Strategies:

COLLABORATOR

Expertise/Resources:

Desired Outcomes:

Key Strategies:

WHAT RESULTS OUTCOMES CAN BE ACHIEVED TOGETHER?

WHAT PARTNER STRENGTHS CAN THE COLLABORATIVE UTILIZE?

WHAT STRATEGIES ACTIVITIES CAN 2+ PARTNERS WORK TOGETHER ON?

COLLABORATOR

Expertise/Resources:

Desired Outcomes:

Key Strategies:

COLLABORATOR

Expertise/Resources:

Desired Outcomes:

Key Strategies:

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SECTION 3: Partners and Roles

KEY POINTS

- Governmental partners are an essential part of Health in All Policies initiatives, and it is important to think strategically about which agencies to work with and who to include from those agencies.

- Health in All Policies initiatives depend on champions who use their relationships, visibility, and organizational power to enlist the support of other key players. These initiatives also depend on governmental leaders to guide the development of a shared vision, help build and negotiate consensus, identify opportunities and priorities, and build support among higher-level decision-makers.

- Collaborative processes cannot work in the long term without "backbone" staff to help plan, manage, and support the initiative.

- Stakeholders are those outside of government who are impacted by your work but are not already partners in your Health in All Policies government initiative. They can help ensure that your Health in All Policies work is responsive and accountable to community needs.

- Approaches to stakeholder engagement will vary based on the level of government involved, governmental resources and goals, and the initiative's timeline.

3.1 Governmental Partners, Facilitators, and Backbone Staff

By definition, a Health in All Policies approach involves a wide variety of people and organizations across government. Agency partners are absolutely essential to carrying out the work of Health in All Policies, as well as individual leaders in government who will spearhead the effort and lend vocal and visible support. Staffing is also critical and often referred to as the "backbone" team—people who help facilitate the core operations of a group. Section 3.1 focuses on government partners and discusses key roles necessary for carrying Health in All Policies work forward.

GOVERNMENT AGENCY PARTNERS: WHO SHOULD WE INCLUDE?

In many instances, a health department will initiate collaboration with others, or serve as a convener of an intersectoral work group. Whom you partner with will depend on your programmatic or policy focus (if you have one), how your Health in All Policies effort is defined, under what auspices and authority it is convened, available resources, and more. Keep an open mind about who should be involved, no matter what the issue—there may be important connections to health that have not yet occurred to you. While larger groups may require more work to manage, having more agencies at the table can allow for a more in-depth and nuanced understanding of complex issues, generate a fuller complement of policy alternatives, engage more sectors in discussions about health, and create momentum for Health in All Policies. For example, New York City's Obesity Task Force includes representatives from health and human services, parks, hospitals, city planning, human resources, food, housing, transportation, education, and environmental protection.[92] This allows for a very broad and inclusive approach to obesity prevention, and also creates a venue for discussion with many sectors about their role in health—even beyond obesity prevention.

Partners and Stakeholders

This guide uses the terms "partners" and "stakeholders" to describe the many individuals and organizations that participate in most Health in All Policies initiatives. "Partner" generally refers to a government agency or representative (or other organization that is part of a Health in All Policies group), while "stakeholder" generally refers to those outside of government, including members of local communities, representatives of community groups and nonprofit organizations, academics, and business sector representatives. As a reminder, for *state* government agencies, the term "stakeholder" may also refer to a *local* government agency.

Even if you take a single-sector approach, virtually every issue that you touch will provide an opportunity to branch out and bring in additional partners. For example, if you start by working with a city planning office on pedestrian safety, you may soon find yourself thinking about street lighting, shade trees, violence prevention, siting paths near housing and schools, and broader land use decisions. You may also choose to invite an agency to participate because of an individual leader there who is enthusiastic about Health in All Policies, even if you have not yet identified a clear policy link to that agency. Your job as a Health in All Policies practitioner is to think broadly and across sectors, make connections to policy areas that have a big impact on health even though they may not seem like obvious collaborators, and bring new partners to the table.

You should also consider specifically whom you wish to invite from each agency. Technical staff have more intimate knowledge of the specific programs and policies in their agency and may have ideas about where it may be feasible to incorporate a health lens or health-improving component; management staff have more breadth and greater access to executive-level decision-makers; and senior executives have more power and decision-making authority, and may have broader networks. A Health in All Policies approach benefits from having agency representatives who are able to speak for their organizations, make decisions, and bring ideas and strategies back to their colleagues—either based on their position, or because they are well-connected with agency decision-makers. This will allow them to both impact the agencies' programs and policies and to provide robust feedback to the Health in All policies process. In addition, collaboration takes time, so it is important to think about who will have sufficient time to participate.

If you represent a public health agency and are invited to join an intersectoral group convened by another agency it is important to be sensitive to the reasons the group was convened and the goals of the convening agency, even as you find opportunities to introduce the concept of Health in All Policies.

🍎 **FOOD FOR THOUGHT. Below are some questions you may ask yourself as you consider which agencies to include:**

- ☐ With what agencies do you have existing partnerships?

- ☐ Whose work has strong links to health outcomes?

- ☐ How receptive to working on health issues is a partner agency likely to be?

- ☐ Who has the authority to make the change you want to see?

- ☐ Are there other strategic reasons to include an agency?

Agencies each have their own culture, and this can impact membership and participation in your initiative. For example, some agencies delegate significant authority to their staff, and others keep much tighter controls. Some agencies oversee other agencies. It will be useful for you to understand lines of reporting and accountability, and know who is represented by the partners at your table and their scope of authority. The simplest way to understand these issues is to acknowledge when you don't know how another agency works and ask your initial contacts for information and guidance.

🍎 **FOOD FOR THOUGHT. Below are some questions you may ask representatives of partner agencies as you think about reporting and authority:**

☐ Are there others in their agency who should be included in meetings, or be briefed periodically? Or are there others who should be copied on emails and receive materials and notifications?

☐ How would they like you to communicate with their colleagues? Do they want to initiate introductions? If not, how do they prefer that you form independent relationships with others in their agency?

☐ What materials or information would help them keep their supervisors informed of activities?

You will inevitably lose and gain individual and agency partners on an ongoing basis because of administration changes, people leaving jobs, and identification of other agencies or sectors with potentially valuable information, viewpoints, or roles. Even with eighteen agencies and departments participating, the California Health in All Policies Task Force has reached out to more than ten additional agencies that are not formal members of the group. Adding new members or agencies to an existing group requires orientation to the group process, understanding of shared goals, and attentiveness to group dynamics. It also requires openness to new ideas and perspectives that could alter a prior consensus or provide the creative spark for progress in a sticky area.

HEALTH IN ALL POLICIES REQUIRES MANY ROLES

Some of the key roles that must be filled to facilitate a successful Health in All Policies approach are described in this section. Individuals or organizational representatives are likely to fill multiple roles, and roles will shift over time as the work evolves.

Champions and leaders. A *champion* is someone with key relationships, high visibility, or organizational influence (such as a county supervisor, mayor, governor, agency director, or well-known community leader), who uses their power to promote a Health in All Policies approach and enlist the support of other important players. Champions need not be involved in the day-to-day operations of the effort, but should be kept informed and engaged as advisors and navigators.

A *leader* guides the development of a shared vision, helps build and negotiate consensus, identifies opportunities and priorities, and builds support among higher-level decision-makers. Leaders require a combination of visionary ideas, authority, and pragmatic skills as well as an ability to manage risk. Unlike champions, leaders need to be involved in day-to-day operations. Health in All Policies requires three kinds of leadership:

- **Administrative leadership.** This includes an understanding of how partner agencies work, their particular sensitivities, how to build consensus, and planning tools;

- **Scientific leadership.** This includes an ability to make the case for addressing particular problems or issues and what policies are likely to have the best health outcomes; and

- **Political leadership.** This includes authority, credibility, and decision-making capacity.[93]

The importance of backbone staff. Collaboration requires significant time and resources, possibly beyond what your partner agencies will be able to contribute. To be successful, a collaborative process requires a supporting backbone team of staff, who may take on any or all of the following functions:

- Meeting facilitation and consensus building

- Technology and communications support

- Data collection and reporting

- Synthesizing research

- Drafting and management of documents

- Overseeing implementation of projects

- Seeking funding

- Organizing and summarizing expert and public input

- Building and maintaining relationships with stakeholders

- Handling logistical and administrative details[94]

> "The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails."
>
> —John Kania and Mark Kramer, *Stanford Social Innovation Review*[95]

Staffing for these critical functions can be provided by a single agency or shared by multiple agencies, and could include educators, data managers, research and policy analysts, administrative staff, project managers, experts, and others. While staffing can be provided by non-governmental organizations, the staff must have access to and work closely with the involved government agencies. In addition to a structured process and dedicated staff, Health in All Policies initiatives will benefit from having a backbone organization which can provide centralized infrastructure, adding consistent material and logistical support to coordination efforts. While it may be difficult to find funding for this infrastructure, it is essential to success.

Facilitation. All Health in All Policies groups bring together people with diverse perspectives, and depend upon strong facilitation that keeps discussions focused, inclusive, honest, and moving toward achievement of the group's objectives. A good facilitator can help the whole group generate ideas, identify areas of agreement and disagreement, and mediate conflicts. Facilitation skills are also important for individual meetings with agencies and stakeholders, small meetings with just a few partners, and public engagement opportunities. If the public health agency provides the facilitator, it is important for that person to convey a sense of neutrality and, when neutrality cannot be maintained, acknowledge biases or positions. In some settings it may be useful to bring in an outside facilitator—such as for a discussion on a particularly sensitive issue where all of the participating agencies have a strong opinion or stake, or for a meeting with stakeholders who have expressed distrust of the participating agencies or of government as a whole.

The following examples illustrate the many roles that different people play as champions, leaders, backbone staff, and facilitators in Health in All Policies initiatives:

- **Mayoral council.** The Healthy Chicago Interagency Implementation Council has been championed by the mayor, who conducted outreach to 15 city department heads for the first meeting, and has encouraged continued departmental participation since. It is facilitated and staffed by the Chicago Department of Public Health.[96]

- **City public/private partnership.** Galveston's Health in All Policies work was initiated by the University of Texas Medical Branch, which continues to staff the effort. The initiative has been championed by a politically influential community member who has brought funders, community groups, decision-makers, and university staff to the table.[97]

- **State level task force.** In California, the Health in All Policies Task Force was initially championed by the secretary of the California Health and Human Services Agency, who elicited the support of the governor and colleagues in his cabinet. The Task Force is facilitated by the California Department of Public Health and staffed by the Public Health Institute.

- **Federal council.** The National Prevention Council is chaired by the United States Surgeon General, and includes 17 federal departments, agencies, and offices represented by chief executives (secretaries or comparable). This scientific and technical support is coordinated and supported by a team at the Centers for Disease Control and Prevention with input from a Department of Health and Human Services intradepartmental working group.[98]

Don't forget about your public health colleagues. Staffing an intersectoral collaboration can become the assignment of a small group within a public health agency, and it is easy for that group to become the "voice" of public health. Public health, however, is a very broad field, with many areas of specialized expertise and skills. In addition, public health has a long history of intersectoral collaboration, and it is highly likely that your public health colleagues already have formal or informal relationships with other agencies.

If you work for a public health agency, make sure to ask your colleagues about their intersectoral relationships early in the Health in All Policies process, so that you 1) build on colleagues' existing work and benefit from their knowledge of partners' interests and concerns, 2) avoid confusing other agencies who may not understand why you are reaching out to them when they already work with someone in public health, and 3) ensure coordinated outreach to external agencies, eliminate duplication of projects, and identify areas of synergy.

Internal partnerships within your health agency can lead to shared funding across programs, additional staff time to support Health in All Policies projects, and contributions from public health experts on Health in All Policies projects that require specific technical expertise.

"The public health sector has a preponderant role to play with respect to building capacity among government actors so that they become accustomed to taking into consideration the health implications of their policies. To do so, the public health sector must develop and share knowledge on the links between sectoral policies and health determinants, but also develop its capacities in influencing the policy process and conducting intersectoral dialogues."

—Louise St-Pierre and François-Pierre Gauvin, *National Collaborating Centre for Healthy Public Policy, Quebec, Canada*[99]

3.2 Engaging Stakeholders

Soliciting input from stakeholders is a key strategy for ensuring that your Health in All Policies work is responsive and accountable to community needs. While there are many existing handbooks and other support materials to facilitate stakeholder and community engagement strategies, this section highlights information that is particularly relevant for engaging stakeholders in Health in All Policies efforts.

WHO ARE YOUR STAKEHOLDERS?

Stakeholders are those who are impacted by your work but are not already partners in your process, particularly those who are outside of government, or who represent more localized interests than your partners do. For local Health in All Policies efforts, stakeholders include residents and local organizations that are impacted by or have an interest in your work. For state-level efforts, local governments are important stakeholders with a very important perspective to share. In each of the sectors with which you are working, there are likely to be stakeholders in the categories below who have interests and information relevant to your efforts:

"[At the California Health in All Policies Task Force Stakeholder Input Workshop] I finally felt like I had a voice in public policy and health. I really hope all of the suggestions…will change many of the policies already set. I enjoyed meeting leaders in other issue areas and hope there can be a unified voice."

—Stakeholder Input Workshop Participant, *California Health in All Policies Task Force*

- **Policy and issue experts.** Experts in academia, non-governmental organizations, and the private sector can help identify emerging and innovative solutions, may be aware of others who are also working on the problem, are often familiar with prior efforts to address the issues you may be tackling, and can help research areas where new information is needed.

- **Community members and community-based/non-governmental organizations.** Community residents and community-based organizations can share important information about assets and needs in their communities, the history of prior efforts to address problems, resources and challenges that may impact the effectiveness of proposed strategies, and specific ideas for ways in which government agencies at all levels can support and facilitate community efforts to promote health.

- **Private sector.** Companies in the private sector may be able to contribute resources to your efforts, particularly in support of their own local communities. They also perform many of the same functions as government (e.g. procurers, employers, etc.) and may be willing to practice some of the principles of Health in All Policies.

- **Funders.** Funders are often engaged in public policy work, can help with outreach to their networks, and may be able to provide funds to support robust stakeholder engagement strategies.

WHY ENGAGE STAKEHOLDERS?

Stakeholders engagement in Health in All Policies initiatives can help you:

- Create better solutions by providing information about barriers and opportunities for health at the community level and insight into the ways in which government agencies and policies may impede or promote health;

- Foster better understanding of the roles of different government agencies at the local, regional, state, and federal levels, and the impacts of their policies and programs on community health and well-being;

- Catalyze community action by promoting community participation in government processes;

- Garner support for the concept of Health in All Policies and for more consideration of health concerns in the policies of other sectors;

- Facilitate development of intersectoral relationships among new partners;

- Bring new resources and skills to the table;

- Increase outreach to and information sharing with policymakers;

- Increase understanding of the social determinants of health within non-governmental sectors.

Remember that the stakeholders for a Health in All Policies initiative will include those whose interests are not explicitly health-focused—for example, housing advocates, local farmers, or community development experts.

WAYS TO ENGAGE STAKEHOLDERS

While the literature suggests that partnership and stakeholder engagement are key components of successful Health in All Policies efforts, the nature of that engagement varies widely.[100] Some Health in All Policies initiatives are formally composed solely of government agencies, such as the California Health in All Policies Task Force, the National Prevention, Health Promotion and Public Health Council (National Prevention Council), and the Executive Committee of the Cabinet in South Australia. Others include community stakeholders at the table, such as initiatives in Sonoma County, California and Galveston, Texas. Regardless of the formal makeup of a Health in All Policies group, all Health in All Policies initiatives of which the authors are aware have found ways to engage stakeholders. It is important to design a stakeholder engagement process that helps you get the information you need, secure buy-in, and build credibility in the community where you hope to improve health outcomes.

State and local governments sometimes have "sunshine laws" mandating that certain activities or meetings be open to the public. Formal meetings and hearings can be intimidating or inaccessible to the stakeholders you want to engage, so you may want to identify additional means to engage stakeholders in robust dialogue and collaborative problem-solving that go beyond the minimum legal requirements.

Agency perspectives on stakeholder engagement vary widely. Some may consider posting information on a website or sending a note to an e-mail listserv as adequate, while others routinely conduct public meetings and hearings. Some agencies are reluctant to engage with stakeholders because of the required time commitment, fear of being exposed to "government-bashing," or because previous engagement attempts have not produced practical solutions. Public health agencies tend to be more familiar with community engagement than some other agencies, and Health in All Policies may provide an opportunity to model effective and innovative stakeholder engagement strategies and help support government accountability to the public.

APPROACHES TO STAKEHOLDER ENGAGEMENT

Health in All Policies stakeholders can provide input in many different ways and the approach will vary depending upon the decisions you are trying to inform, the timing of the decisions, the availability of resources, and whether you are seeking one-time or ongoing input. Outreach is critical so that interested parties are aware of opportunities for input and engagement. It is important to work with colleagues and organizations in sectors outside the public health field to reach out to diverse stakeholders that address the broad array of issues your Health in All Policies collaboration may touch. Targeted outreach may be necessary to involve those who work with and represent vulnerable and disenfranchised populations, such as low-income residents and immigrants. In addition, it is essential to consider the particular perspectives, needs, and concerns of rural communities. Think about language accessibility and creative approaches such as social media or online tools. Think about how you can increase accessibility for youth, people with disabilities, seniors, and people in geographically distant areas.

Stakeholder engagement may include:

- One-on-one discussions

- Community workshops, meetings, forums, listening sessions, or focus groups

- Webinars with a discussion feature

- Teleconferences

- Formal or informal advisory groups

- Public input periods at government meetings or hearings

- Invitations for written input

- Social media or other uses of online communications

"I was skeptical about the public workshops, because I thought they would just be opportunities for people to whine about the state. But to my surprise they turned out to be great. The staff and facilitator had an agenda that kept people focused on being constructive and positive. There was a great exchange of information, and a lot of terrific suggestions that came out of each of the workshops."

—Member, *California Health in All Policies Task Force*

Local Governments as Key Stakeholders

Stakeholder engagement will look different for state and local governments. For example, a local government can have direct involvement with community residents whose lives and living environments are impacted by policy decisions; this is much more difficult for a state government. State agencies often seek input from representatives of communities, including state-level organizations that garner input from local organizations and local government. They also seek input from governmental and non-governmental organizations with their own local public input processes. If you are working at a state level, local agencies can have critical insight into the feasibility or challenges of various proposals, as they are often the ones implementing decisions made by your state-level partners. Local government representatives can help remind state-level partners of local needs and the diversity of their communities, and help identify specific ways in which state or federal policies and programs can support (or impede) local efforts to promote healthy communities.

The following examples illustrate a number of ways that Health in All Policies approaches have engaged stakeholders:

- **Engaging people "where they are."** The strategic planning process at the health department in Monterey County, California, included significant engagement with the community. The health department used this engagement process to help boost support for a Health in All Policies approach. Staff identified community groups of churchgoers, college students, elected officials, parent groups, and others, and arranged to meet with those groups during their regular meeting times. To ensure county-wide representation, staff also tried to meet with at least two groups in each county district. In all, 21 meetings were held over five months. To garner sufficient input, the health department took a flexible approach to the input process, arranging additional meetings when more information was needed. Meetings were arranged around stakeholders' holiday schedules and some were arranged to ensure contact with migrant workers. Each meeting was formatted for length and content to fit the needs and interests of the particular group attending. This process ultimately led to the Monterey County Board of Supervisors approving a strategic plan for the health department that includes Health in All Policies approaches.[101]

- **Online community engagement.** In 2011, the State of Queensland, Australia, launched the GetInvolved online community engagement toolkit, which is a suite of community consultation tools freely available to government agencies. The toolkit includes online forums, polls, surveys, and a "consultation dashboard" to help schedule and promote engagement opportunities. These tools can allow communities to discuss issues with government agencies in real time, provide a venue to which residents can subscribe to be kept informed on topics, and allow the government to poll community members to quickly assess their opinions.[102]

- **Tenant survey to support change.** Although a tobacco ban prohibited smoking in many public environments in Boston, there was no way of guaranteeing a smoke-free environment in multifamily housing units. The Boston Housing Authority (BHA), along with residents and advocates, were concerned about health impacts from second-hand smoke, and the BHA received continual requests from tenants wanting to move units in order to avoid smoke drifting in from neighbors' apartments. BHA conducted a community engagement process in order to address this problem in partnership with the Boston Public Health Commission, the Committee for Boston Public Housing, the City of Boston, and the nonprofit Health Resources in Action. BHA administered a tenant survey and found that 80-90% of the residents wanted a smoke-free environment, a finding which was instrumental in building a case for enacting BHA's 2011 Smoke-Free Public Housing policy.[103]

- **Visioning process.** In 2008 and 2009, the Atlanta Regional Commission (ARC) embarked on the Fifty Forward initiative, a community visioning process to plan for the next 50 years for Metro Atlanta. Through this effort, the ARC asked, "How might our economic future be impacted if we adopt a Health in All Policies approach?" and, "How would the look and functions of our communities change if we took a Health in All Policies approach to planning and development?" The ARC explored ideas to ensure livability, prosperity, and sustainability through neighborhood forums on topics such as energy, health, and transportation in neighborhood forums. By partnering with the Civic League for Regional Atlanta, a nonprofit organization whose mission is to empower and engage citizens, ARC was able to gather public input on a wide array of topics at the neighborhood level.[104]

"Community engagement looks different at the local and state levels. We wanted input about how state agencies could best help organizations at the local level create healthier community environments, so we invited local health departments, other local agencies, and many community-based organizations to our public workshops. But local Health in All Policies groups often need the kind of input that can be provided only by people who live in the community."

—Member, *California Health in All Policies Task Force*

Social Media

The internet provides avenues for stakeholder engagement such as allowing e-mailed comments to be submitted in real-time during webcast meetings. It is important to stay updated on emerging technologies and social media innovations that can provide opportunities to engage constituencies that cannot easily get to physical meetings, such as youth, people who are disabled or elderly, those in rural areas, and those facing transportation challenges.[105]

FOOD FOR THOUGHT. Constructive stakeholder engagement requires preparation. Below are some questions you may want to ask yourself as you consider your goals, structure, resources, and support network:

What do you want to achieve?

☐ What information are you seeking? Do you want to collect feedback on existing government programs, identify opportunities and barriers in the community to promote health or create healthy environments, or identify best or promising practices?

☐ What connections do you want to make or strengthen? Are you hoping to form partnerships to address specific issues, or to catalyze new collaborations or community action?

☐ Do your goals align with those of your community members (e.g. community empowerment, information sharing, or participation in a decision-making or problem-solving process)?

How can you ensure that the process is meaningful for your work and for your stakeholders?

☐ How will you use the information gathered?

    ○ *How will the information contribute to solutions or to knowledge gaps?*

    ○ *How will the information be passed on to your government partners and used to make decisions?*

☐ How will you provide optimal opportunities for stakeholder input?

    ○ *Will you pursue multiple avenues for input?*

☐ How will you ensure that stakeholders understand the value of their input, including how their input will affect your initiative's direction?

☐ If you are organizing a forum or workshop, does the agenda and time allotted allow space both to make sure participants understand the goals and context of the forum, and allow them to provide input?

Who can help you achieve your goals?

☐ Who can best provide the input and information you desire?

    ○ *How can you reach and engage the right people and organizations?*

    ○ *Are these people part of your current networks, or will they be new to your work?*

☐ Who will coordinate the process?

    ○ *For state agencies, is there a local or regional agency that is well-respected and trusted in the community that could serve as a host or convener?*

    ○ *What (if any) roles will your Health in All Policies partners have?*

☐ How can you encourage stakeholders to attend?

    ○ *What kinds of outreach will you do?*

    ○ *Will you need language translation or other services to ensure accessibility?*

    ○ *If you are holding an event or meeting, is the meeting space physically and geographically accessible?*

☐ If this is a live process, who will facilitate?

    ○ *Is the facilitator someone who participants are likely to trust?*

    ○ *Is the facilitator prepared to hear complaints about local and state government and skilled enough to redirect the discussion toward constructive recommendations?*

FRAMEWORKS FOR ENGAGEMENT

Two of the many different perspectives on the spectrum of community engagement and participation are illustrated below.

The Ladder of Community Participation. This conceptual framework (shown in Figure 5 below)[106,107,108] is often used by local health agencies to guide planning around stakeholder engagement. Because the Ladder of Community Participation describes a range of strategies, organized by degree of community and government involvement, decision-making, and control, it can catalyze discussions and decisions around strategies, roles, and responsibilities of all participants. The framework shows seven strategies arranged according to level of involvement and control by the health agency or community. At all levels of the ladder, communication between the health department and the community is critical in order to foster the trust and information-sharing necessary to develop solutions that address everyone's needs. Communities can use this framework to identify where their engagement efforts currently fall and develop goals for future input and engagement processes.

FIGURE 5. THE LADDER OF COMMUNITY PARTICIPATION
Morgan, M.A., & Lifshay, J. (2006, March). Community engagement in public health. Martinez, CA: Contra Costa Health Services, Public Health Division. Used with permission.

THE LADDER OF COMMUNITY PARTICIPATION

1 HEALTH DEPARTMENT INITIATES AND DIRECTS ACTION
Local health department takes the lead and directs the community to act.

2 HEALTH DEPARTMENT INFORMS AND EDUCATES COMMUNITY
Local health department shares information with the community.

3 LIMITED COMMUNITY INPUT/CONSULTATION
Local health department solicits specific, periodic community input.

4 COMPREHENSIVE COMMUNITY CONSULTATION
Local health department solicits ongoing, in-depth community input.

5 BRIDGING
Community members serve as conduits of information and feedback to and from the local health department.

6 POWER-SHARING
Community and local health department define and solve problems together.

7 COMMUNITY INITIATES AND DIRECTS ACTION
Community makes decisions, acts, and shares information with the local health department.

The Wheel of Participation. This framework was developed to support participatory community planning processes and allows practitioners to choose from a menu of approaches based upon the constraints and opportunities faced by their community.[109,110] The wheel (shown in Figure 6 below) is centered around four objectives—information, consultation, participation, and empowerment—which direct community partners and practitioners to relevant guidance and techniques. While the Wheel of Participation uses the term "council," it can be applied to any government agency.

FIGURE 6. WHEEL OF PARTICIPATION
© Haymarket Media Group. Davidson, S. (1998, April). Spinning the wheel of empowerment. Planning, 1262(3), 14-15. Used with permission.

EMPOWERMENT

ENTRUSTED CONTROL
Devolving substantial decision-making powers to communities, such as tenant management organizations. Example technique: application of participation techniques with political support to delegate power.

INDEPENDENT CONTROL
Council obliged to provide a service but chooses to do so by facilitating community groups and/or other agencies to provide that service on their behalf, such as the delivery of care service contracts by the voluntary care sector. Example technique: application of participation techniques with political support to delegate power.

DELGATED CONTROL
Delegating limited decision-making powers in a particular area or project, such as tenant management organizations and school boards. Example technique: application of participation techniques with political support to delegate power.

INFORMATION

MINIMAL COMMUNICATION
Council deciding on all matters itself, without community consultation (except when legally required to do so), such as via the minutes of committee meetings. Example technique: public notices.

LIMITED INFORMATION
Telling the public only what you want to tell them, not what the public wants to know. Example techiques: press releases, newsletters, and campaigns.

HIGH-QUALITY INFORMATION
Providing information the community wants and/or needs, such as discussion papers or exhibitions for development plans, or guidance notes for conservation area development. Example technique: leaflet.

WHEEL OF PARTICIPATION

LIMITED DECENTRALIZED DECISION-MAKING
Allowing communities to make their own decisions on some issues, such as management of community halls. Example techniques: application of participation techniques with political support to delegate power.

PARTNERSHIP
Solving problems in partnership with communities, such as a formal partnership. Example techniques: co-option, stakeholder groups and design game.

EFFECTIVE ADVISORY BODY
Inviting communities to draw up proposals for council consideration. Example techniques: citizens' juries, community councils.

LIMITED CONSULTATION
Providing information in a limited manner with the onus often placed on the community to respond, such as posters and leaflets. Example techniques: public meetings and surveys.

CUSTOMER CARE
Having a customer-oriented service, such as introducing a customer care policy or providing a scheme for complaints or comments. Example techniques: comment cards, one-on-one interviews.

GENUINE CONSULTATION
The Council actively discussing issues with communities regarding what it is thinking of doing prior to taking action; for example, liaising with tenants' groups or customer satisfaction surveys. Example techniques: citizens' panels, district circles, focus groups, user panels, and stakeholder groups.

PARTICIPATION

CONSULTATION

SECTION 4: Working Together Across Sectors

KEY POINTS

- Working together across sectors can take many forms, ranging from simply sharing information all the way to collaborating on new projects or adopting shared goals that are integrated throughout each other's work.

- Interagency collaboration requires strong relationships that are built on a foundation of trust, mutuality, and reciprocity.

- Interagency partnerships will benefit from reaching agreement about an overall approach to collaborative decision-making.

4.1 The Spectrum of Collaboration

Health in All Policies is rooted in the concept of partnership or collaboration. Working together with partners can take many forms ranging from simply sharing information all the way to co-creating new projects or adopting shared goals that are integrated throughout each other's work. Much has been written about organizational partnerships, using language such as information-sharing, consultation, cooperation, coordination, collaboration, and integration. Collaboration is one point on a continuum of joint working relationships (shown in Figure 7 below),[111] which can vary in power and communication structure, length of relationship, reward, risk, and intensity.

FIGURE 7. SPECTRUM OF COLLABORATION
Adapted from the Policy Consensus Initiative & National Policy Consensus Center.[112,113] Used with permission.

COLLABORATION
Invites shared responsibility in decision-making and implementation.

ENGAGEMENT
Implies a more active partnership including opportunities for partners and stakeholders to propose solutions and choose priorities.

CONSULTATION
Provides for more specific information gathering for improved decisions, while explicitly reserving the decision-making prerogative.

INFORMATION EXCHANGE
Allows partners to gauge reactions, gain insight into other viewpoints, and allay controversy or conflict due to misinformation.

Health in All Policies initiatives benefit from activities on all levels of this spectrum. Even if true collaboration is not yet possible, sharing information, consulting, and engaging partners in problem solving can be important steps in building trust and working agreements that can ultimately support more in-depth partnership over time. Arthur Himmelman, one of the first people to describe how collaboration differs from other processes, said, "When organizations (or individuals) collaborate they share risks, responsibilities, and rewards, each of which contributes to enhancing each other's capacity to achieve a common purpose."[114]

"The physical and emotional health of an entire generation and the economic health and security of our nation is at stake. This isn't the kind of problem that can be solved overnight, but with everyone working together, it can be solved."

—Michelle Obama, *Let's Move Launch Announcement*[115]

Collective Impact

Collective Impact is one of several approaches to multi-sectoral collaboration and is gaining traction in the United States as a way to bring together governmental and non-governmental partners. It is defined as the "commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem,"[116] and has much in common with Health in All Policies. The five conditions that make Collective Impact successful (and different from traditional collaboration) include having:

- A common agenda
- Shared measurement systems
- Mutually reinforcing activities
- Continuous communication
- Backbone support organizations

4.2 Building Intersectoral Relationships

Strong relationships are essential to the success of any Health in All Policies initiative. The Australian Research Alliance for Children and Youth identifies trust, reciprocity, and mutuality as the three essential elements of collaborative relationships.[117] This section discusses these three elements in detail, along with other tips based upon the experiences of the California Health in All Policies team.

FOCUS ON BUILDING TRUST

A Health in All Policies approach asks individuals and agencies to move out of their comfort zones and work with new partners in new ways, to speak openly about their concerns and aspirations, and to take risks. Collaboration can also raise concerns about "turf" or autonomy as agencies' work becomes intertwined, including loss of authority, resources, or ownership of an issue. Strategies include asking about and understanding these concerns, being explicit about leadership, giving credit freely to others, and sharing the limelight by giving others ample opportunity to be visible as leaders. Additionally, you should share information as widely as possible, refrain from pursuing hidden agendas, and be honest about both your own and your agency's opinions and goals. The tips listed here can help you establish, maintain, and deepen trust over time, including through potentially difficult processes.

Practice humility. When we acknowledge that we don't have all the answers and that our perspective is not always the right one, others feel more willing to speak up. Remember to be open to learning from everyone you speak with, recognize the expertise of other partners, and acknowledge differences of opinion. Listen, learn about, and demonstrate your interest in the goals, worries, frustrations, concerns, hopes, wishes, and motivations of the individuals and agencies with whom you are working. As the bumper sticker says, "Don't believe everything you think."

Respect confidentiality. While transparency and accountability are essential, partners may need opportunities to air their concerns in a confidential setting. This can foster greater openness, which can lead to new insights and better solutions. Having individual or sub-group meetings to discuss potential sensitivities with partners in advance of large group meetings can be invaluable in helping to move your process forward. Be aware of "sunshine laws" or other public meeting requirements to which your initiative may be subject.

Honor commitments. It is important to follow through on agreements you make or, if that becomes impossible, to let partners know how and why the plan has changed.

MODEL RECIPROCITY

Reciprocity represents a long-term, collaborative practice of helping each other generously and freely. This involves taking risks by committing time or other resources without an assurance that the return will be equal. Reciprocity requires shifting from a mindset of scarcity and competition for resources to a long-term, collaborative model of encouragement and support. When everyone puts effort into the process and gives a little for the overall group, each will get something back over time. A number of strategies to demonstrate reciprocity are described here.

Offer help. When opportunities arise to help your partners, make an offer. This may include sharing information, reviewing grants, serving on a committee, or even assigning your summer intern to one of your partners' projects. By taking the first step, you help create a culture of reciprocity, which will likely pay off in the long run with opportunities to gain support from your partners on higher-stakes issues.

Give credit. Sharing credit is generally easy and inexpensive, and can go a long way in supporting your partners' ongoing participation and good will. Health in All Policies can catalyze a new level of action or an innovative solution to a problem, but it may be based on the work of others who have been working on the problem for a long time. Therefore, giving credit to the others whose work provided a basis for your initiative's success is essential and if you don't know who they are, it is important to find out.

Assume good intentions. Given the siloed nature of most governments, you are likely to encounter miscommunications and misunderstandings as you broach areas in which you have limited knowledge. Chances are that if one of your partners says or does something that seems offensive, insensitive, or irrational, you are probably missing key information. If you can assume good intentions (i.e., that their intention are based on values you support), you can ask them to help you understand what they are thinking and why they are taking a particular approach. You will likely deepen your understanding of the issue, increase your ability to move collaborative solutions forward, and build trust and gain friends along the way.

PURSUE MUTUALITY

Mutuality is the idea that our goals are aligned across agencies and across policy areas. It represents a cultural shift from pursuing independent, siloed, topic-based interests to embracing shared beliefs and pursuing common goals. Because governments tend to be so siloed, Health in All Policies leaders and backbone staff can play an important role in modeling this kind of behavior. As people see the benefits of having a common vision and shared goals, they will likely embrace this idea more and more.

Discover shared values. Every person who comes to a Health in All Policies initiative brings personal and organizational values with them. Your group may have an easier time identifying shared goals if you have explicit conversations about values early in your process.

Identify win-wins and co-benefits. Intersectoral collaboration works best when partners from all sectors can see tangible gains for themselves. Whether explicitly or not, many of the people you approach to participate in a Health in All Policies effort are likely to ask themselves, "What's in it for me?" Identifying win-win opportunities can help establish buy-in, allows partners to leverage resources and increase efficiency by pursuing multiple goals through one effort, and is an essential strategy for building a mutual vision and shared goals.

EXAMPLES OF CO-BENEFITS & WIN-WIN STRATEGIES FOR HEALTH AND SUSTAINABILITY

CLIMATE CHANGE AND HEALTH. While climate change is the biggest global health threat of the 21st century, policymakers and the public are often unaware of the impacts of climate change on health.[118] Climate change has direct impacts on health—such as heat illness or injuries from flooding and other extreme weather events, and indirect—through impacts on our food, water and air quality, and security.[119,120,121] Many strategies to address climate change have important health co-benefits. For example, reducing greenhouse gas emissions from motor vehicles by driving less and walking and bicycling more can also yield huge health benefits through increased physical activity, which reduces cardiovascular disease, diabetes, osteoporosis, and other chronic illnesses.[122] Planting shade trees reduces urban heat islands,[123] and can also lower energy costs,[124] freeing up resources of low-income people for other basic needs.

COMMUNITY SAFETY. Violence or fear of violence can make people unwilling to take public transportation, less supportive of high-density living, or less likely to engage in community activities all of which can impact health and healthy behaviors.[125,126] As a result, reductions in violence and fear of violence can lead to reduced rates of injury and stress, as well as increased social and community cohesion and opportunities for physical activity. Increased community safety has potential co-benefits for several other agencies and community stakeholders, including:

- **Transportation.** Increased use of public and non-automobile modes of transportation and decreased traffic.

- **Air quality.** Reduction of automobile emissions through increased use of public transit, walking, and biking, and through greater willingness to live in dense, urban areas.

- **Law enforcement.** Reduced crime rates.

- **Businesses.** Increased foot traffic.

- **Parks and recreation agencies.** Greater use of parks for recreation.

- **Planners.** Planners may want to use design features that promote safety (such as lighting) in order to increase the appeal and usability of public space.

- **Schools.** Reduced rate of crime on campus and students' routes to and from school.

- **Housing agencies.** Reduced rate of crime in residential areas and greater willingness to live in mixed-income housing.

FARM-TO-FORK. "Farm-to-fork" policies and programs, which make it easier for people and institutions to purchase produce from local farmers, promote health by making it easier to access affordable and nutritious fresh foods. These policies and programs have co-benefits for several agencies and community stakeholders, including:

- **Economic development.** Farm-to-fork policies and programs can support the local agricultural and food economy.[127]

- **Agriculture.** Supporting local agriculture helps to preserve agricultural lands.

- **Environmental.** Agricultural lands may support habitat conservation and "ecosystem services," the ways that human communities benefit from nature, such as through clean water, timber, habitat for fisheries, and pollination of native and agricultural plants.[128]

- **Education.** Healthy eating is an essential component of supporting academic achievement.[129,130] An estimated 19%–50% of calorie intake by children occurs at school.[131]

- **Disaster preparedness.** Strong local food hubs can help communities be more resilient in the face of disasters that may cut them off from food distribution systems.

ADDITIONAL TIPS FOR HEALTH IN ALL POLICIES RELATIONSHIPS

Understand context. Pay attention to the political and organizational context in which your partners are working, including past interagency interactions, successes and failures, or other issues that may color perspectives on the current effort. For example, if an agency has been engaged in work on a controversial or sensitive topic and you see an opportunity for Health in All Policies in that area, make sure you understand their concerns and how you can get involved without inadvertently derailing the process or sacrificing one of your partners' goals.

Share information and ideas. Good health is a commonly held value that most people want to support. But regardless of how obvious the connections to health may seem to you, people working in other fields may know very little about the health impacts of their work. Therefore, part of your role is to help highlight opportunities for staff at partner agencies to incorporate a health perspective into their work by sharing data, pertinent scientific literature, and case studies from the field.

Be flexible. Health in All Policies requires tremendous flexibility, as it is a long-term strategy that takes place in an environment characterized by administration changes, staff turnover, continuously developing legislation, and funding that is often insecure or short-term. For example, legislation could mandate a change that your Health in All Policies group was already trying to achieve, which may shift the focus of your work from building agreement around what that change looks like to developing a plan for implementation. These changes also create relationship-building opportunities if you are ready to respond. For example, in cases where organizations have not worked well together, changes in administration or leadership can provide new partners for collaboration.

Make introductions. As you build intersectoral relationships, you may be surprised by how many people you know who don't know each other. You can play an important role by building bridges for others and introducing potential partners to each other.

Language matters. Every discipline, including public health, has its own jargon, language, and acronyms. A first step in building relationships is to make sure that people can understand each other. This can include avoiding abbreviations, being mindful of language that is hard to understand, and being aware of situations where differences in use of terms may cause disagreement or confusion.

Simple Words Can Have Many Meanings

Even common words or phrases can have different meanings for people working in different agencies. The common definition for the word "safety" is "freedom from danger, risk, or injury,"[132] but the meaning of the word may vary greatly depending upon who is speaking. For example, when using the word "safety":

- Criminal justice or police agency staff may be talking about freedom from crime and violence.

- Local environmental health staff may be considering whether food products are free from contamination.

- Transportation agency staff may be discussing protection from injury and death for drivers, bicyclists, pedestrians, and road maintenance workers.

- Forestry agency staff may be expressing concern about ensuring a defensible space around homes in areas facing wildfire risk, while urban fire department staff may be referring to building features such as fire alarm and sprinkler systems.

- Labor agency staff may be talking about workplace precautions to prevent injury and exposure to toxins.

These are all consistent with the dictionary definition of the word, but illustrate the need to ensure understanding among a diverse group of what is meant by even commonplace words.

Collaboration takes time. A solid collaborative effort takes a lot of time, particularly if you have many partners. It is important to allow sufficient time for relationship building, learning about your partners' goals, and developing agreements. It is helpful if you can be flexible and allow for delays when warranted, but also maintain momentum on slow-moving projects.

Get the most out of meetings. In collaborative processes such as Health in All Policies, meetings are often where relationships are built and decisions are made about goals and strategic directions. Whether a whole-group, small sub-group, or one-on-one meeting, make sure you use meeting time effectively to keep people coming back.

FOOD FOR THOUGHT. The following is a list of questions that can help you plan meetings with your Health in All Policies partners:

☐ Do you need to hold a large-group meeting, or can the work be accomplished through a smaller discussion or even by e-mail?

☐ Have you created opportunities for participants to get to know each other?

  ○ *Do you have name badges and/or tent cards? Have you prepared a participant roster?*

  ○ *Have you provided informal opportunities for networking (such as over a snack break)?*

☐ How will you encourage participant engagement and leadership?

  ○ *Are there opportunities for participants to develop agenda items, make presentations, and set goals for the group?*

  ○ *What will be the role of public health agency participants?*

  ○ *What can be done to make sure participants feel central to the initiative and not like advisors to the public health department?*

  ○ *Should you use a large-group brainstorm or small group discussions?*

☐ What will you do to prepare for the meeting?

  ○ *If you want a group to make a decision, have you spent time in advance defining the question and identifying and resolving potential disagreements?*

  ○ *When seeking input, have you identified the questions to ask, prepared any necessary informational materials, and developed an inclusive format to maximize participation?*

  ○ *Do you need additional facilitators or materials?*

  ○ *Have you notified participants of any advance preparation they should make?*

☐ Are you prepared to change an agenda or meeting format to better suit the needs of the group, to respond to an unexpected development, or to allow for discussion when conflicts arise?

☐ Have you allotted time to acknowledge accomplishments and early wins?

  ○ *Have you allotted time to give credit to others for their contributions and laud their leadership, innovation, and achievements?*

WHEN PARTNERS DISAGREE

The policymaking process, its multiple competing stakeholders, and the siloed structure of government can lead to tensions among its various agencies, and sometimes even to discordant policies. Conflict may actually increase as trust deepens and people feel more comfortable being honest with each other. Conflicts that arise in a Health in All Policies forum can reflect long-standing tensions between agencies, in some cases between two or more policies that are each explicitly health-promoting. Collaboration works best if disagreements and conflicts are acknowledged and addressed, even if they cannot be fully reconciled.

In any collaborative effort there will be times when people do not agree. In some cases, people's loyalty to their own agencies may appear to be in conflict with their loyalty to the Health in All Policies initiative. Even within these areas of conflict, there are often "zones of collaboration," or areas where people can work together toward a common vision. One goal of Health in All Policies is to extend these zones as broadly as possible.

Health in All Policies staff can help partners find common ground and mutually agreeable solutions by listening carefully to the concerns of all, encouraging respectful listening and dialogue, and pointing out areas of agreement or creative solutions. It is important to remember that actions taken with even the best collaborative intentions can result in stepping on someone else's toes. In navigating conflicts, you will need to rely and build upon the trust that you have already established.

However, all partners—including public health agencies—may at some point feel that they cannot agree to a proposed goal or action. Agreeing to respectfully disagree (and to continue dialogue) is an important strategy to prevent conflicts over specific issues from subverting the larger collaborative process.

The Groan Zone

"When people experience discomfort in the midst of a group decision-making process, they often take it as evidence that their group is dysfunctional… So let's be clear-headed about this: misunderstanding and miscommunication are normal, natural aspects of participatory decision-making. [They are] a direct, inevitable consequence of the diversity that exists in any group. Not only that, but the act of working through these misunderstandings is part of what must be done to lay the foundation for sustainable agreements… Groups that can tolerate [this stress] are far more likely to discover common ground. And common ground, in turn, is the precondition for insightful, innovative co-thinking."

—From the *Facilitator's Guide to Participatory Decision-Making*, by Sam Kaner with L. Lind, C. Toldi, S. Fisk, and D. Berger[133]

Harmonizing Policy Goals for Health: Healthy and Safe School Food

Some school districts and local health departments prohibit the on-campus consumption of produce grown in school gardens due to concerns about foodborne illness and liability. School personnel or volunteers may not be aware of the risks related to fertilizer or compost use, neighborhood animals, water or soil contamination, and practices to ensure sanitary produce conditions.[134] However, school gardens provide multidisciplinary learning opportunities for children, encourage them to eat fruits and vegetables, and provide opportunities for learning about nature and ecological processes.[135] Obesity and chronic disease prevention experts often believe that the risks of foodborne illness are small relative to the demonstrated harms of the obesity epidemic, and that effective strategies to increase fruit and vegetable consumption (like school gardens) should be widely adopted.

While these viewpoints may appear to be in conflict, school districts and local public and environmental health agencies are beginning to work together to develop processes that both assure food safety and allow students to enjoy produce they have grown.[136] This involves convening public health chronic disease prevention and food safety experts, education agencies, food and agriculture staff, and environmental health staff to consider ways to identify and share best practices that promote healthy and safe consumption of school garden produce. Health in All Policies can provide a venue for aligning goals in situations like this.

4.3 Decision-Making

Health in All Policies partners will need to make decisions together such as agreeing upon goals, selecting priorities, establishing commitments for specific action steps, or authorizing staff to carry out a project or make decisions on behalf of the group. Transparent decision-making can help build trust among partners, which is easier if groups agree upon their approach to decision-making at the start of their process. The approach to decision-making may change over time, as trust deepens and/or the nature of the work changes. By actively eliciting and discussing concerns in a safe environment before asking for a group decision you can help ensure more robust decisions that partners will feel they can abide by. To reach the best possible agreements, it is important that participants share their true preferences and perspectives, and not "go along to get along," as illustrated in the textbox about the "Abilene Paradox" (page 61). Many of the strategies discussed in the relationship-building part of this guide can help ensure that your Health in All Policies partners have access to safe spaces and opportunities for voicing honest opinions.

"Diversity and independence are important because the best collective decisions are the product of disagreement and contest, not consensus or compromise."

—James Surowiecki, *The Wisdom of Crowds*[137]

MAJORITY VOTING AND CONSENSUS

While majority voting and consensus are both common methods of group decision-making, consensus is more likely to support the kinds of collaborative work embodied by Health in All Policies because it provides an opportunity to uncover underlying concerns and build solutions that meet your partners' needs. Consensus decision-making requires that all group members either support or do not block a decision. It differs from majority voting, which generally requires that a majority (51%) or supermajority (a larger percentage, such as 66%) approve a decision. Some forms of consensus ask each partner to reveal the strength of their support for a given proposal, which can create opportunities to further strengthen the proposals through the decision-making process. The table below describes advantages and disadvantages of these two types of decision-making.

	MAJORITY VOTING	CONSENSUS
SUMMARY	Majority voting generally requires some threshold of support, such as more than half or two-thirds.	Consensus gives everyone the ability to block a decision. Requiring consensus can either mean that a decision requires unanimous support, or that nobody opposes it strongly.
ADVANTAGES	Majority voting is often considered easier, as fewer people need to agree in order to make a decision, which means that decisions can happen more quickly.	Consensus decisions require buy-in for an idea from the whole group, which can make it easier to implement. It also means that major concerns must be addressed before a proposal can move forward, which serves to strengthen proposals and leads to more meaningful decisions. Consensus works best with active participation from all parties, and can help ensure that all relevant interests are considered.
DISADVANTAGES	With voting, members of the group may be "overruled" on a given decision. It can be difficult to get a group to work together to implement a decision if not everybody is in agreement. Furthermore, if a decision is made quickly, there may not be sufficient discussion to elicit important concerns that could lead to a stronger proposal overall. Very important but minority positions or perspectives may be overlooked.	Consensus can take more time than majority voting (though it does not have to). It requires significant communication and negotiation, and can result in important initiatives being held up or blocked by one party. In addition, because the focus can shift toward appeasing concerns, a group can lose sight of its end goal and end up watering down a proposal so that while nobody minds it, nobody is enthused about it either.

The Abilene Paradox

This story, adapted from management expert Jerry B. Harvey's article *The Abilene Paradox: The Management of Agreement*,[138] demonstrates the pitfalls of group decision-making when people do not reveal their true preferences:

"On a hot afternoon visiting in Coleman, Texas, the family is comfortably playing dominoes on a porch, until the father-in-law suggests that they take a trip to Abilene (53 miles north) for dinner. The wife says, 'Sounds like a great idea.' The husband, despite having reservations because the drive is long and hot, thinks that his preferences must be out-of-step with the group and says, 'Sounds good to me. I just hope your mother wants to go.' The mother-in-law then says, 'Of course I want to go. I haven't been to Abilene in a long time.'

The drive *is* hot, dusty, and long. When they arrive at the cafeteria, the food is as bad as the drive. They arrive back home four hours later, exhausted.

One of them dishonestly says, 'It was a great trip, wasn't it?' The mother-in-law says that, actually, she would rather have stayed home, but went along since the other three were so enthusiastic. The husband says, 'I wasn't delighted to be doing what we were doing. I only went to satisfy the rest of you.' The wife says, 'I just went along to keep you happy. I would have had to be crazy to want to go out in the heat like that.' The father-in-law then says that he only suggested it because he thought the others might be bored.

The group sits back, perplexed that they together decided to take a trip which none of them wanted. They each would have preferred to sit comfortably, but did not admit to it when they still had time to enjoy the afternoon."[139]

SECTION 5: Structures to Support Health in All Policies

KEY POINTS

- While Health in All Policies can have formal or informal structures, in the long run the goal of embedding health in governmental decision-making is best supported by formal structures that are stable and foster long-term change.

- Health in All Policies initiatives require resources, and may necessitate thinking creatively about sources of support.

5.1 Embedding Health into Government Practices

While individual policy changes and projects can improve health outcomes and help build relationships with partners, a key element of Health in All Policies is creating structural or procedural changes that support the consideration of health and equity in decision-making processes across policy areas and over the long term. This is called "embedding" or "institutionalizing" Health in All Policies into the structures and processes of government. With this approach, rather than considering health and equity after decisions have been made, health considerations would be embedded into decision-making processes so that they are considered in the early stages of program development, planning, and policy making. This represents a radical shift in how government functions and requires collaboration across sectors. It is important for long-term and sustainable impact, because even in places with strong support for inclusion of health and equity, champions and leaders can leave, funding sources and policy priorities can shift, and circumstances can change.

Institutionalization of Health in All Policies requires significant capacity building and a shift in mindset for many people in government. While money is typically the bottom line for most government decision-making processes, Health in All Policies adds health as a legitimate consideration for government agencies and decision-making bodies, including city councils, county boards of supervisors, and state legislatures. Considerations can include the financial costs and benefits of the health impacts of various decisions, distribution of health impacts across a population (equity), and long-term health impacts that could be significant, but may not be captured in short-term financial projections.

> "To harness health and well-being, governments need institutionalized processes which value cross-sector problem solving and address power imbalances. This includes providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions."
>
> —Adelaide Statement on Health in All Policies[140]

Partnership for Sustainable Communities

In 2009, the U.S. Department of Housing and Urban Development, the U.S. Department of Transportation, and the U.S. Environmental Protection Agency created the Partnership for Sustainable Communities. The Partnership incorporates livability principles into coordinated federal housing, transportation, water, and other infrastructure investments with a goal of prosperous neighborhoods and reduced pollution.[141]

This kind of analysis will require people across government to understand the relationship between policy-making and health. Achieving this may include capacity-building activities such as training agency, city council, or legislative staff on the health impacts of various policies and on the use of health analysis techniques, or seating health staff in the offices of other agencies or decision-making bodies.

While healthy decision-making can take place at many levels, ultimately, Health in All Policies is about creating permanent change in government decision-making processes so that over time accounting for health considerations becomes part of the normal way of doing business across sectors in your jurisdiction. Consider this hypothetical example related to healthy multi-unit housing, showing three potential levels of change that could come from a Health in All Policies approach:

- **Improving one project or program at a time.** Analyzing a proposed plan for a new apartment building to identify ways to make it healthier may improve conditions for the hundreds of people who live there and those who live nearby.

- **Changing policy.** Changing the current building code to require healthy design in the construction of all new multi-unit housing would impact even more people for generations to come.

- **Changing systems.** Incorporating a health lens into the process for changing the building code might have an even larger impact across a much broader range of decisions that include but go far beyond housing.

All of these levels of change can promote health and may require multiple partners to work together across sectors. The level of change you decide to try to enact will be based on consideration of many factors, including feasibility. In fact, a group may take on all three levels of change over time. Think about what you and your partners are able to change, and who you need to engage to make changes at a systems level.

Integrating Health into Regional Transportation Planning

In 2012, in response to an unprecedented level of interest from community stakeholders in the health outcomes of regional planning, the Southern California Association of Governments (SCAG) established a Public Health Subcommittee. As part of its implementation of the 2012-2035 Regional Transportation Plan, the subcommittee will provide a forum for public health issues affecting regional planning and will provide strategic and policy direction for SCAG on public health issues. If SCAG maintains the subcommittee on an ongoing basis and meaningfully includes health input from the subcommittee in SCAG policies and programs moving forward, this will be an excellent example of embedding health into decision-making processes outside the public health field.

🍎 **FOOD FOR THOUGHT. Following are questions you may want to think about as you consider the institutionalization of Health in All Policies:**

☐ Is there a sustainable budget allocated for staff for your initiative?

☐ How will you build staff capacity?

- ○ *Have staff coming from outside the public health field been trained in health and equity issues?*

- ○ *Have public health staff received training on relevant issues outside public health?*

- ○ *What opportunities exist for shared staffing?*

☐ What overall strategies, goals, and targets can be enhanced by the inclusion of health and equity (i.e., strategic plans)?

☐ What government planning processes are in place, and how might health and equity be incorporated into those moving forward?

☐ Can health and equity be incorporated into executive branch analysis of legislative proposals?

☐ Can funding streams be combined or aligned to promote multiple goals, including health and equity?

☐ Are there mechanisms for assessing or evaluating whether and how departments outside public health impact health and equity?

☐ Can health and equity be integrated into mandated requirements for guidelines, requests for proposals, and data sources?

Institutionalization of Health in All Policies is a long-term goal with many steps along the way. While you may find opportunities early on to embed health into decision-making processes, you are likely to find it easier to get started with programmatic or policy changes that are shorter-term or more limited in scope. These are important and often necessary steps for building awareness, understanding, and the relationships that are essential for building long-term, permanent, and transformative change.

5.2 Structure and Formality

Health in All Policies initiatives fall along a broad spectrum of structure and formality. As you build relationships with partners, the type of structure used will depend on the availability of staff resources to undertake and sustain the effort, current levels of involvement in collaborative and intersectoral work, the level of support and commitment by leadership (within public health and other agencies), and the scope of the effort. While informal approaches may be a good first step in embedding a culture of collaboration into government processes, in the long run the goal of transforming government by embedding health in governmental decision-making is best supported by stable formal structures, capable of withstanding changes in leadership and funding.

FORMAL APPROACH

Formalizing a partnership or collaborative group can lend authority and accountability to an effort, which in turn can help bring otherwise disinterested partners to the table, and can provide justification for spending time and resources on intersectoral collaboration. It can also provide direction and structure, and help ensure progress toward long-term commitments.[142]

Many types of intersectoral governance arrangements can support implementation of Health in All Policies, as McQueen and colleagues describe in their 2012 book, *Intersectoral Governance for Health in All Policies*.[143] While most of their examples reflect a European parliamentary structure, they can also be applied to governmental structures in the United States, such as legislative oversight committees, cabinet committees, city council committees, multi-agency working groups or task forces, and inter-departmental staff units. The authors discuss joint budgeting, in which agencies pool financial resources for a common goal, and delegated financing, in which a legislative body provides funds to a "semi-autonomous statutory body" specifically to finance intersectoral programs and initiatives.

Formalizing a process usually involves a written document—such as a law, executive order, strategic plan, resolution, interagency agreement, charter, or memorandum of understanding—that explicitly lays out goals, objectives, and deliverables for the group, and may identify key partners, leaders, or processes for decision-making. A written document can also lock in details such as the membership, a timeline, and a programmatic focus, which may be useful for securing commitments and aligning disparate partners around a particular goal. Formalizing structures through legislation or budgetary decisions may facilitate long-term monetary investments, but that is not always the case,[144] and even formal processes can result in an unfunded mandate.

Because it can be difficult to anticipate everything a group will want to address, authorizing documents should allow for flexibility. Documents that outline a formal structure can inadvertently limit options regarding adding new partners or addressing new programmatic areas not included in the original language. Again, there is no "right way" to approach the structure of your initiative, and Health in All Policies configurations vary significantly and can change over time.

Following are examples of different ways that Health in All Policies initiatives have been created to support a formal structure:

- **Presidential executive order.** The National Prevention Council was established by President Barack Obama through an executive order as part of the Affordable Care Act of 2010.[145] The executive order created the council, placed it within the U.S. Department of Health and Human Services, established the surgeon general as its chair, identified leaders of 12 agencies to serve on it, and authorized the chair to add members. It also created an Advisory Group, set out a purpose and duties (including research, stakeholder engagement, and the creation of a National Prevention Strategy), established reporting requirements, and established funding. The chair was given flexibility regarding membership, and there are now 17 agencies, departments, and offices represented on the council.

- **Legislation.** The Governor's Interagency Council on Health Disparities in Washington State, which embodies many of the principles of Health in All Policies, was established by the state legislature in 2006, and was assigned "the primary responsibility of creating an action plan for eliminating health disparities by race/ethnicity and gender."[146] The council is chaired by a representative of the governor's office and is staffed by the Washington State Board of Health.[147]

- **City, county, and school partnership.** The City of Richmond, California, is developing a strategy document to support Health in All Policies approaches through a partnership between the city manager's office (which coordinates input from city agencies), the county health agency, one of the two school districts in the county, a local university, and local community groups and residents. The partnership is also working on a Health in All Policies ordinance that, if passed by the city council, will institutionalize the goals and objectives in the Health in All Policies strategy document and assign responsibility for implementation, monitoring, and reporting.[148]

- **County ordinance.** In 2010, Ordinance 16948 established an Inter-Branch Team in King County, Washington, to implement the county's "fair and just principle" in the countywide strategic plan (intended to promote fairness and opportunity and eliminate inequities).[149] The Inter-Branch Team is made up of the directors (or their designees) of all county branches, departments, agencies, and offices. The Inter-Branch Team meets monthly, sits within the Office of the Executive, and develops tools, engages the public and communities, and creates trainings and work plans.[150]

- **Interagency memorandum of understanding.** The Executive Committee of South Australia's Cabinet Chief Executive Group is responsible for overseeing development, implementation, and evaluation of Health in All Policies. This group reports to the Executive Committee of Cabinet, which is chaired by the premier and includes the treasurer, three other ministers, and the chairs of the Economic Development Board and the Social Inclusion Board. The process is formalized through a memorandum of understanding between South Australia Health and the Department of the Premier and Cabinet, which describes their relationship, roles, and function in supporting the Executive Committee.[151]

- **Incorporating health into existing government processes.** The 2002 Québec Public Health Act (Section 54) specifies that the Minister of Health and Social Services should act as an advisor to the government 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."[152] As a result, a mechanism was developed for incorporating health impact assessments and other less formal methods into a process of inter-ministerial consultation that already exists within the provincial government's structure.

INFORMAL APPROACH

Agencies and organizations can convene informally to share information and pursue joint intersectoral projects to promote health and equity, and can develop their own guidelines and expectations. Groups created on an ad hoc basis to address a specific issue or concern may have the flexibility to be able to respond to shifting needs, interests, or opportunities. Partner agencies that are wary of making long-term commitments may feel more comfortable with an informal process, and an informal approach may be necessary when it is not possible to get the political support to create a formal group.

If a group depends upon voluntary participation by agencies, partners are likely to be strongly invested in the process. At the same time, if a group is perceived as voluntary, it may be difficult to secure participation from some key players, or to secure ongoing commitments over long periods of time. While individuals in partner agencies may be interested in participating, it could also be difficult for them to obtain permission from their agency without an authoritative directive or formal invitation.

The following are examples of different ways that Health in All Policies initiatives have been structured using an informal approach:

- **Supporting a common goal.** The health agency in Contra Costa County, California, partners with the local planning department and the fire marshal on issues related to road safety, fire safety, and "complete streets." While this group has not been formally codified, the partners have worked together for a number of years to promote walkability, fire safety, and other health goals, and have all identified ways in which their own departments will benefit.[153]

- **Responding to a natural disaster.** Galveston's Health in All Policies efforts emerged from discussions at the University of Texas Medical Branch to consider health and re-building after Hurricane Ike devastated the island in 2008. Staff bring in new partners as efforts change in response to community needs, and rely on community engagement to provide input for priority work areas and to encourage agencies to join and stay engaged in the partnership.[154]

- **Creating regulatory changes.** Staff in the California Department of Public Health initiated an informal multi-sector workgroup to consider how to reduce exposures to toxic chemical flame retardants in sofas, chairs, and infant products without compromising fire safety. Workgroup participants included the Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation, the Office of the State Fire Marshal, the Office of Environmental Health Hazard Assessment, the Department of Toxic Substances Control, and the Department of Justice. That group's work led to health-promoting regulatory changes, and Governor Jerry Brown has made a firm public commitment to markedly reduce the use of chemical flame retardants.[155]

ACCOUNTABILITY AND OVERSIGHT

Whether a Health in All Policies group uses a formal or informal structure, accountability and placement are essential when working with multiple partners. Placing Health in All Policies outside of a health agency promotes a whole-of-government sensibility and can send the message from government leadership that "health is everybody's business." For example, South Australia's Health in All Policies initiative is overseen by a group of chief government executives. While the California Department of Public Health facilitates the California Health in All Policies Task Force, the Task Force operates under the auspices of, and reports to, the Strategic Growth Council, which is a cabinet-level body that provides a high level of visibility and authority. In Galveston, Texas, the local health department is engaged as a partner but the University of Texas plays the role of facilitator.

🍎 **FOOD FOR THOUGHT. Following are questions you may want to think about as you consider accountability and oversight:**

- ☐ To whom will the group, the facilitator, and the participating agencies be accountable, and how?

- ☐ How will your initiative be accountable to stakeholders?

- ☐ What are your reporting mechanisms and who is responsible for the reporting?

- ☐ How will you strike a balance between accountability to your government partners, stakeholders, funders, and others?

COLLABORATIVE LEADERSHIP AND STAFFING

While significant work may be delegated to a Health in All Policies backbone team, it will still need partners to play a major role in shaping and leading the initiative by sharing their expertise, explaining agency priorities, identifying contacts, providing information, reviewing documents, participating in meetings, making decisions, and implementing recommendations to advance the work. At the same time, as Health in All Policies initiatives move from relationship-building to implementing solutions, partner agencies may carry out some of the work on their own, separate from the Health in All Policies group. It can be exciting to see agencies outside the public health field absorb health-promoting practices into their own work, and you may struggle to let go of leadership or figure out how much you want public health to remain at the table.

Engaging partners from outside the public health field in leading Health in All Policies can build their capacity to do collaborative and health-promoting work. The more they are engaged in representing Health in All Policies, the more they will carry messages about the approach to their colleagues. Partner agencies will need authority to make decisions, and should receive credit for their leadership. Supporting partners to take leadership is a key to promoting health as a priority outside of the public health department. At the same time, even if your partners are ready to take significant leadership, the backbone team can still play an important role by making sure that the process continues to be collaborative, helping to facilitate continued connections between various agencies, and stepping in if difficulties arise.

Shared staffing can be a useful and innovative strategy to support collaborative efforts and increase intersectoral leadership. This can involve a position jointly funded by two different agencies or one agency funding a position that is housed at a different agency. For example, the County of San Diego Health and Human Services Agency partnered with the San Diego Association of Governments (SANDAG) to provide funding through their Communities Putting Prevention to Work grant to fund a land use and transportation planner with a background in public health. This position, housed at SANDAG, provides expertise on the public health impacts of land use and transportation planning and serves as a bridge between the public health and transportation agencies.[156]

5.3 Resources

Embedding the consideration of health in decision-making will require continued allocation of resources for collaboration and/or integration of health-promoting practices across government. Costs of Health in All Policies initiatives will vary substantially depending on their scope and longevity. This section describes some of the resource needs for Health in All Policies and some potential sources of support.

STAFFING NEEDS

As with many collaborative initiatives, staff will likely be your largest expense. Even a small collaborative effort involving a few agencies working on a discrete issue will likely require paid staff time. Important qualities to look for in staff include flexibility and innovation, as well as skills in meeting facilitation, consensus building, negotiation and mediation, research, and writing. It is not essential that backbone staff have expertise in all policy areas, but they should know how to reach out to partners and policy experts to bring in knowledge as needed. The role of backbone staff is discussed in detail in Section 3.1. It is also important to note the costs to partner agencies as they designate staff time to participate in meetings and implement the many projects that may grow out of your initiative.

ADDITIONAL EXPENSES

Additional expenses can include costs associated with meetings, printing, travel, and research (e.g., fees to access publications). You may also want to create subcontracts for policy expert consultation, facilitation, writing/editing, graphic design, and evaluation. Information about specific resources needed for community engagement are discussed in Section 3.2, and a description of the resources used to carry out the work of the California Health in All Policies Task Force is available in Part III.

POTENTIAL RESOURCES

To be successful with Health in All Policies approaches, you will need to be creative about identifying funding sources, including exploration of foundations, government grants, in-kind support from your own or other agencies. You may also benefit from hiring student interns who can support your work at a lower cost than other staff, while also giving you an opportunity to promote your approach to emerging leaders in public health or related fields. There may also be ways to embed health into existing processes that are already funded, or share the costs of hiring an intern, consultant, or staff member with a partner agency.

🍎 FOOD FOR THOUGHT. Below are some questions you may want to ask yourself as you think about potential resources:

☐ What funders are interested in Health in All Policies, transformative governance, intersectoral collaboration, healthy communities, or other related concepts, and might provide operational support?

☐ What funders are interested in policy areas that align with your interests (e.g., healthy eating or education), and might provide support for specific projects?

☐ If a funder is only interested in one aspect of your work, how will you address that one aspect sufficiently while maintaining focus on your core work and other priorities?

☐ Are partners in other governmental agencies or nonprofit organizations willing to assign staff or interns to work on implementing Health in All Policies projects?

   ○ *Are partner agencies willing to create new staff or intern positions to support a Health in All Policies project that relates to their agency?*

☐ Can you reduce costs by sharing resources or tools between partner agencies and organizations? (For example, if another organization is already conducting a survey of a group that you wish to learn about, perhaps you can combine efforts or simply add a few questions to the existing survey.)

☐ Can you combine resources and collaborate with other related initiatives on programs, trainings, stakeholder engagement, or other resource-intensive components of your work?

☐ Have you taken advantage of internships for undergraduate or graduate students?

   ○ *Have you looked for students who need to conduct a policy analysis, program plan, or evaluation plan as part of their coursework?*

   ○ *Have you considered reaching out to schools other than public health, such as city planning, public policy, or social work schools?*

   ○ *Do you have the staff capacity to support an intern?*

SECTION 6: Creating Healthy Public Policy

KEY POINTS

- Health in All Policies is an approach that allows government agencies to think explicitly about incorporating health into decision-making.

- Many factors, such as the context, authority, participation, resources, politics, community concerns, key leader interests, and any formal legislation or administrative action will play a role in determining the focus and scope of a Health in All Policies initiative.

- Several tools are useful in Health in All Policies initiatives, such as root cause analysis and using a health lens. Using a health lens is a systematic method of finding ways to improve health and embed health in decision-making. Health impact assessment is one method that uses a health lens.

- Evidence can be a powerful and important part of any Health in All Policies effort but can be complicated due to issues of scale, the need for data on indicators that are not monitored by public health agencies, the challenges of collaborative use of data, and the value of trying approaches that have not yet been tested.

- The health outcomes of Health in All Policies work are difficult to measure, making this work particularly challenging to evaluate. Process evaluation can be a useful way to improve the important collaborative aspects of Health in All Policies initiatives.

6.1 Choosing What to Work On and Identifying Potential Solutions

DETERMINING FOCUS

While the "all" in Health in All Policies suggests innumerable policy areas that impact the public's health, each Health in All Policies effort will need to focus on a manageable number of areas. While a Health in All Policies initiative may coalesce around one specific issue or opportunity, many groups will need to start by selecting projects to work on, or may broaden their scope over time. Factors such as context, authority, participation, resources, politics, community concerns, key leader interests, and any formal legislation or administrative action will play a role in determining the focus and scope of any Health in All Policies initiative. It is important to remember that regardless of the particular focus, a key goal of Health in All Policies is to embed health considerations into ongoing government processes and decision-making.

The following examples illustrate how groups organizing around a Health in All Policies approach have either selected a focus area or been assigned one:

- **Data and alignment with existing mission.** The Healthy Chicago Interagency Implementation Council advances efforts within 12 priority areas that were selected through an assessment of public health data and resources, and according to the health department's mission and core public health functions.[157]

- **Executive leadership direction.** The Director of the Hawaii Department of Public Health has identified eliminating health disparities as his primary goal. This gives staff leverage to think broadly about social justice issues, and staff are considering using a Health in All Policies approach to address health disparities and promote health equity moving forward.[158]

- **Governor's executive order.** The executive order establishing the California Health in All Policies Task Force includes an explicit mandate to identify policies and strategies that promote health while also advancing the environmental sustainability goals of the Strategic Growth Council, under whose auspices the Task Force sits.

- **Potential impact and general appeal.** Health in All Policies efforts in Kansas, coordinated by the Kansas Health Institute, initially focused on getting legislators to think about policies impacting the health of children as a way to have a significant and lasting impact on the larger population's health and garner broad support from partners.[159]

- **Legislation.** The legislation establishing the Washington State Governor's Interagency Council on Health Disparities dictates that the council's action plan must address a number of specific diseases, health issues, and behaviors. These include diabetes, infant mortality, HIV/AIDS, breast cancer, sudden infant death syndrome, mental health, and the immunization rates of children and senior citizens.[160]

- **Health policy agenda.** In June 2010, Baltimore's mayor established the Cross Agency Health Taskforce (CAHT) on the heels of releasing Healthy Baltimore 2015, the City Health Department's comprehensive health policy agenda. The agenda identified priority areas and indicators for action for the CAHT. It also highlighted opportunities to impact morbidity and mortality and improve the quality of life for city residents. The 21 city-agency CAHT reviewed the 10 priority areas of Healthy Baltimore 2015 and selected areas where they could strengthen existing efforts and where new efforts could be initiated.[161]

The following table describes some advantages and disadvantages of selecting a broad or narrow policy focus for a Health in All Policies initiative.

|	**BROAD POLICY FOCUS**	**NARROW POLICY FOCUS**
ADVANTAGES	Looking at broad and/or multiple issues provides opportunities for creativity, allows for more partners, and can support flexibility in responding to new opportunities or emerging issues of concern. For example, Quebec,[162] South Australia,[163] and Thailand[164] all have very broad enabling language that fosters use of a health lens for virtually any issue. Some examples of broad focus issues include chronic disease or sustainability. Single issues can still be broad, and may involve many partners and many sectors. Chronic disease, for example, touches on transportation, parks, land use, food systems and agriculture, community safety, and more.	A narrow focus on one or a few issues can make it easier for participants to familiarize themselves with the issues and the policy, programmatic, and administrative responses at hand, which can in turn make it easier to identify solutions to pursue. Even a narrow focus can involve many partners, as participants begin to unravel the interconnections between policy areas. Some examples of narrower focus issues include Safe Routes to Schools or improved nutrition in school lunches.
DISADVANTAGES	A very broad focus may be difficult to implement, result in scattered efforts, or feel overwhelming, particularly if participants lack sufficient resources or group structure. For a focus of any breadth, it will be important to identify specific goals and benchmarks.	A very narrow focus may limit the parameters of discussion and action to the point that it becomes difficult for a group to pursue emerging opportunities that were not included in the group's initial mission. A narrow focus may also limit participation, because fewer partners will see a clear role for themselves or connection to their own work.

DEFINING THE PROBLEM AND LOOKING FOR SOLUTIONS

Problem analysis is an important step toward identifying potential solutions and can help a Health in All Policies group be prepared to seize emerging opportunities as they arise. It is also useful for identifying smaller steps that can help set the stage now for greater action at some later point. Strategic planning, program planning, and policy analysis all provide strategies for understanding a problem. In general, problem analysis is an iterative process that can involve literature review (both published and gray literature) and meeting with agencies, experts, and stakeholders.

Root cause mapping. Root cause mapping was described in Section 2.2 as an anaytical tool for understanding fundamental causes of community health problems. Root cause mapping can also be used to identify potential intervention points and possible partners.

The sample map below (Figure 8) shows causal factors of obesity, and specifically explores the causal chain for excess caloric intake and insufficient caloric expenditure. This is just one example of how one could complete a root cause map and is not intended to be an inclusive map of all of the root causes of obesity. For example, this diagram does not include root causes like stress, institutionalized racism, genetics and biological factors, healthcare, or the marketing environment.

Moving from left to right, the root cause map expands, showing opportunities to identify specific policy or programmatic changes that could address those causes. In a group exercise, people can identify agencies or organizations that have influence over these root causes and write them directly on the map.

FIGURE 8. ROOT CAUSE MAP
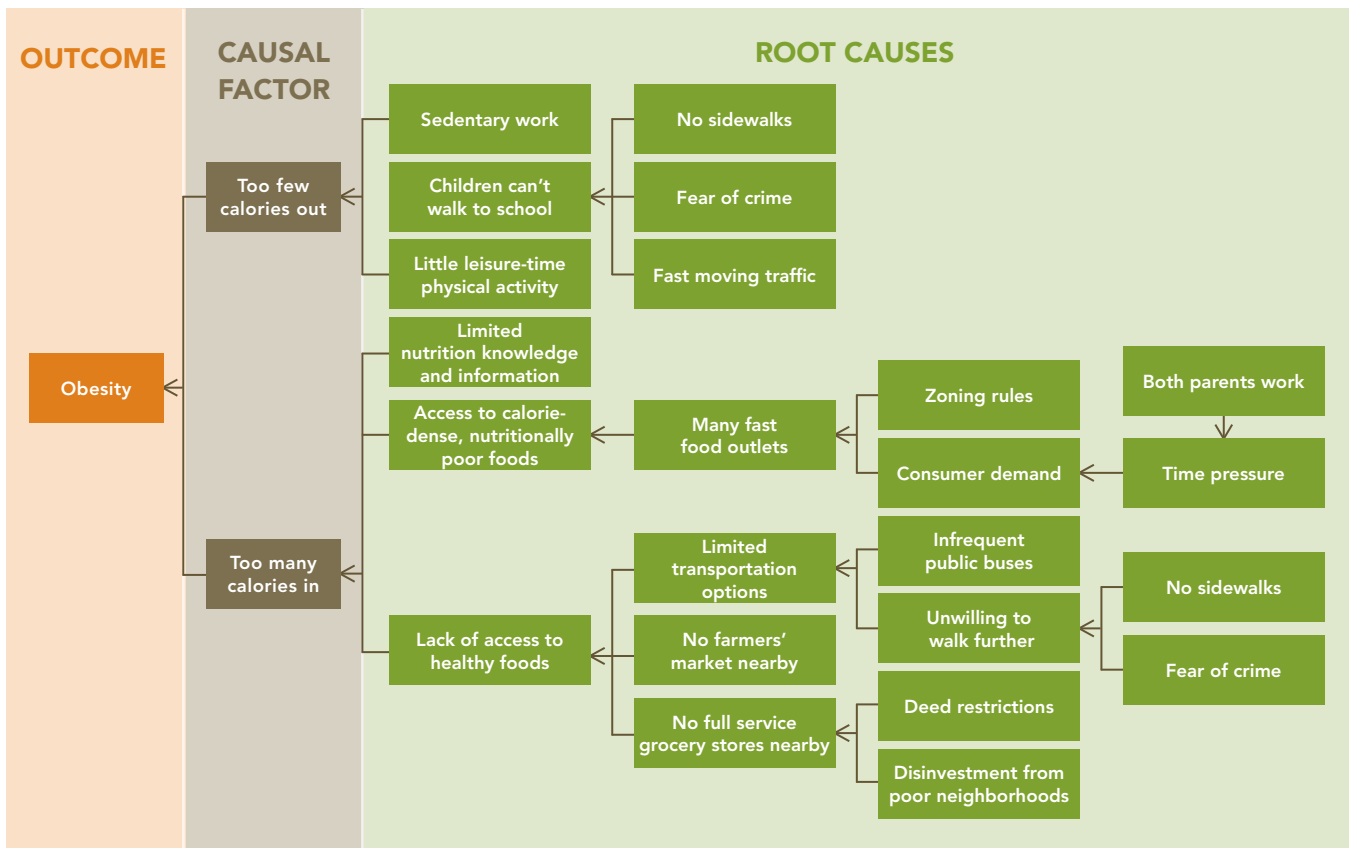
BUILDING ON EXISTING EFFORTS

Many agencies are already engaged in health-promoting work and it is important to recognize the potential for synergy with existing efforts. Helping agencies see that they are already involved in health-promoting work can illuminate opportunities to expand their role or deepen collaboration. For example, while creating its action plan to carry out the recommendations of the National Prevention Strategy, the National Prevention Council inventoried the activities that its member agencies were undertaking to promote health, highlighting areas where momentum for policy action already existed.[165] This kind of approach can help identify areas of opportunity, where a small boost of effort may have a strong impact.

ESTABLISHING PRIORITIES

Complex problems rarely have a "magic-bullet" solution, and Health in All Policies partners will likely need to choose from many possible ideas based on factors such as resources, decision-maker and community stakeholder support, or the ability to reach consensus among partners.

It is important for a group to agree in advance on what criteria will be used to select or justify a particular course of action, who will apply the criteria, and whether the criteria will be applied through a formal, defined process, or informally. Criteria should be based upon the goals of the collaborative as well as the interests of stakeholders. Possible criteria (organized alphabetically) for evaluating a proposed solution include:

- **Co-benefits & win-wins.** Does the proposed solution solve multiple problems at once, provide benefits to multiple partners, or help government achieve multiple policy goals?

- **Collaboration.** Does the proposed solution require or facilitate collaboration across agencies?

- **Cost.** What will it cost to implement the proposed solution?

   o What are government costs, private sector costs, short- and long-term costs, and both direct and indirect costs?

- **Effectiveness.** Is there evidence that the proposed solution is effective?

Effectiveness, Innovation, and Evidence-Informed Practices

Keep in mind that with complex problems such as chronic disease or climate change, there may not be hard evidence that a particular strategy will work, and many possible solutions may not have been evaluated. Therefore, you may want to look for evidence-informed solutions and emerging best practices rather than limiting policy ideas only to strategies that are supported by peer-reviewed literature. Using evidence-informed and emerging practices is common in an innovative field such as Health in All Policies.

- **Equity.** Will the proposed solution reduce inequities or change the distribution of burdens and benefits?

  o   What will be the impact of this proposed solution on sub-groups of a population, on vulnerable or under-resourced groups and communities, and on specific geographic regions?

  o   Will it shift burdens or benefits from one generation to another?

- **Feasibility.** In some ways, feasibility is a combination of many of these criteria. Often it is a proxy for resources, jurisdiction, and support from decision-makers. Essentially, is it possible to implement this proposed solution?

- **Jurisdiction.** Who has the authority to take action—including regulation, guidance, funding, and convening?

  o   Does the proposed solution require action only at the state level, or is there also a role for local (or federal) jurisdictions?

- **Magnitude of health impact.** What is the likely impact of the proposed solution on the illness/injury, health risk, or behavior of interest and what is the likely magnitude of that impact?

  o   Can the impact be quantified?

  o   What is the evidence for the effectiveness of the proposed solution in addressing identified problems or improving outcomes?

  o   Who will be affected by the proposed solution, and will different groups be affected differently?

- **Political will.** Is the proposed solution acceptable to or desired by the involved agencies, policy leaders, and the general public?

  o Are there leaders who are prepared to champion the proposal?

  o Are there powerful or influential people or groups who are likely to oppose the idea?

- **Specificity.** Is the proposed solution specific enough to allow implementation?

- **Systems change**. Will the proposed solution lead to the institutionalization of Health in All Policies efforts or embed health into decision-making?

BALANCING BIG GOALS AGAINST THE NEED FOR EARLY WINS

Early successes are essential for building morale, developing relationships and trust, creating momentum, and establishing a track record that will encourage future investments of time or other resources. It may be useful to identify some "low-hanging fruit" to get started, or identify small steps that move toward a longer-term or bigger goal. You may find it easier to take on bigger projects after your collaborative group has had some early wins and has had the opportunity to establish trust, working relationships, and social norms. But this doesn't mean that big wins should fall off your agenda. It is worth considering big goals even though the payoff may be several years—or even decades—in the future. You can also be opportunistic; when the right partners are aligned and working together, some big wins may in fact be easy.

Examples of "Low-Hanging Fruit" for Health in All Policies Initiatives

- Partner with another agency to convene a public input session on a cross-cutting topic.

- Host a meet-and-greet between partners that you think might have areas of alignment.

- Collaborate to disseminate an existing but underutilized guidance document that has strong implications for health.

- Organize a one-time workshop to educate partner agencies and their staff about the potential co-benefits of specific policies such as complete streets, school siting, or community greening.

- Convene multiple agencies around a topic to explore opportunities for collaboration, focusing on issues that are best addressed in a collaborative multi-sectoral way, such as infill development and healthy housing.

- Invite partner agencies to give input into documents or survey questions that can serve multiple goals.

CREATING DELIVERABLES

While the key elements of Health in All Policies include softer, less tangible outcomes such as improved collaboration across government agencies and increased efficiency in government operations, it is also important to produce concrete, tangible deliverables as vehicles to guide policy and document progress. Examples of such deliverables include:

- A comprehensive health strategy (e.g., the National Prevention Strategy)

- A set of recommendations that feeds into a specific process, such as strategic planning

- Action plans to carry out recommendations

- A policy paper that provides options for policymakers in a particular policy arena

- An action plan to address a specific problem (e.g., a chronic disease prevention plan)

- A health impact assessment (e.g., health impact assessment of efforts to reduce greenhouse gas emissions)

- Summit proceedings (e.g., summit on healthy and smart infill development)

- A resolution that indicates a commitment to include health and equity in government processes

OPPORTUNITIES AND CHALLENGES OF IMPLEMENTATION

A successful Health in All Policies initiative may generate new work as partners and stakeholders identify additional areas for collaborative action. It is important to acknowledge the limits of what backbone staff and other participants can realistically manage. Creating systems for accountability, reporting, and ongoing input into agenda-setting can allow the group to acknowledge accomplishments, track implementation, and make decisions that support a feasible and realistic agenda.

Another implementation challenge is that some actions may require several steps to implement, but it may be difficult to maintain momentum all the way through. For example, a group may successfully change state-level guidelines, but will miss a key opportunity for impact if the guidelines sit on a shelf without being disseminated, or without offering technical assistance and training that may be necessary for their implementation. Sometimes a small change that gets fully implemented may have greater impact than working towards a big change that gets derailed along the way.

As a group moves into an implementation stage, it can also be difficult to maintain the visionary work of developing new ideas and seizing new opportunities. Regardless of the specific projects underway, remember to keep in mind the key elements outlined in Section 1.4, and strike a balance between seeking progress on specific actions and creating shifts in how government functions, so that health is embedded in decision-making across policy areas and over the long term. Specific and early successes are important for proof of concept and to help the group stay motivated, but it is also important to continue building a vision for where the group is headed.

6.2 Looking through a Health and Equity Lens

Using a "health lens" is a systematic way of finding opportunities to improve health and equity and embed these principles in decision-making. This approach is at the very heart of Health in All Policies. Ideally one day a health lens will be incorporated across the whole of government to help ensure that key decisions with potentially significant impacts on population health and equity will be informed by information about those impacts.

Looking through a health lens simply means providing evidence that allows people to consider the positive and negative health and equity consequences of their decisions during the decision-making process. It can be carried out at a high level to identify broad connections with health, or can address the potential adverse or beneficial health consequences of a policy or program at a more detailed level. A health lens can be applied to any issue or sector and to programs, projects, and administrative or legislative policies.

In Washington State, the governor or any legislator can request that the Board of Health complete a Health Impact Review on the impacts of legislation on health disparities; between 2007 and 2013 seven such analyses—including four on education—were completed.[167]

Analysis using a health lens can take many forms and the approach will vary depending on the circumstances. Many agencies already have ongoing, required processes for analyzing different effects of projects and policies. For example, many cities and states require analysis of the short-term costs of all proposed legislation, and state and federal laws require an Environmental Impact Assessment (EIA) of development and infrastructure projects. These and other existing review processes can offer opportunities for applying a health lens. In fact, in some cases—such as the EIA process—consideration of health impacts is required (although health is generally considered narrowly in these assessments).[166] Also, impact on equity is not often considered in the EIA process. Regardless, working within existing review processes may be one effective strategy for broader application of a health lens.

In some cases, applying a health lens may provide a way to express and address core community concerns that may seem outside of the purview of any one agency. This process can serve as a tool to educate policymakers, which in turn can build support for institutionalizing the consideration of health and equity in decision-making.

HOW AND WHEN WILL THE INFORMATION BE USED?

Before you decide whether to employ a health and equity lens, be clear about your purpose, and consider how the lens will be employed and the findings will be used. For example:

- Will agencies be required to respond to findings, or are the findings purely informational?

- Will the findings be shared with the public?

- What is the best way to present findings to be the most useful to your partners and/or your other audiences?

The answers to these questions will likely depend on when and how you are applying a health lens and whether it is being incorporated into an existing, formal process or being done voluntarily as a supplementary effort.

The timing of applying a health lens in the design of projects, programs, and policies can be tricky. In general, the earlier in the process that you can identify relevant issues, the more likely it is that those issues can be taken into consideration, and the less likely that people will feel that the health issues are creating "re-work." Of course, sometimes the health and equity implications of a proposal may not be fully apparent at the outset, or opportunities for applying a health lens may not be apparent until later stages. You should also take into consideration the concerns that might arise among agencies going through a regulatory process when you are applying a health and equity lens as they may want to know how information generated by your analysis will be incorporated into their process. It is important to be sensitive to the concerns of agencies involved in a regulatory process when adding your own layer of analysis to help ease the way for efforts to incorporate a health and equity lens.

DOES HEALTH LENS ANALYSIS NEED TO BE FORMAL, STRUCTURED, AND RIGOROUS?

Applying a health and equity lens can take a wide variety of forms, including informal discussions between agencies, formal health agency input on the relationships between various policy areas and health, or a formal and structured review of relevant impacts. For example:

- Planning agency staff could informally consult public health agency staff to get input on a proposed project.

- A consumer protection agency could convene a group of experts to determine whether to embark on a regulatory process.

- Health agency staff could write a letter to another agency with recommendations based on their staff's expert opinions.

- Health agency staff could provide health-related data for incorporation into another agency's forecasting models.

- Stakeholders, health agencies, or agencies outside public health could initiate a formal and structured analysis.

The choice between more or less structured analyses rests in many cases on resources, including availability of staff with appropriate skills, or funding to obtain such staff. Even rapid, desktop health impact assessments (see discussion below), while considerably less resource-intensive than comprehensive health impact assessments, generally require more time and resources than a few informal meetings or a letter from one agency to another.

Also consider how open a partner agency is to a formal process. For example, the California Health in All Policies Task Force learned during early discussions that the term "health impact assessment" was disquieting for some agencies. While the concept of incorporating health into decision-making was well-received, the term health impact assessment was closely associated with environmental impact assessments, raising concerns such as delaying existing schedules, potential for misuse of the process (e.g., by stakeholders on either side using arguments about the methodology to forestall a particular decision), and added costs. Remember to be sensitive to and respectful of partners' fears or concerns, and to be mindful of the language used.

Applying a Health Lens to Land Use Planning in San Francisco

Community groups came to the San Francisco Public Health Department with concerns that displacement and the affordability of housing were not being addressed in the local land use planning process. The health department and community groups partnered to apply a health lens to the formal planning process in order to address this gap. As a result:

- A wide range of community stakeholders provided input on what they wanted the land use plans to accomplish.

- The health department assessed available data to compare that vision to existing conditions.

- Recommendations were developed for how to address the potential impacts of the planning process. This formal process also demonstrated clear community and scientific support for the recommendations, which led to the planning department incorporating them into its work.

- The health department successfully deepened relationships with other local agencies, establishing a commitment to intersectoral partnerships through their willingness to provide resources to support other agencies' goals.[168]

TWO STRUCTURED APPROACHES: HEALTH IMPACT ASSESSMENT AND HEALTH LENS ANALYSIS

Health impact assessment (HIA) and South Australia's Health Lens Analysis (HLA) are two different structured approaches for conducting a formal analysis of the health implications of proposed projects or policies.

A structured approach provides advantages, such as:

- Allowing transparency of process, methods, evidence, and assumptions

- Requiring definition of the scope and parameters of analysis

- Encouraging thoughtful and comprehensive assessment of a full range of health consequences

- Facilitating stakeholder participation

Health Impact Assessment. HIA is "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. An HIA provides recommendations on monitoring and managing those effects."[169] The goal of an HIA is to inform a decision-making process in an effort to minimize adverse health effects and optimize beneficial ones, paying particular attention to differential impacts on sub-populations.

The core stages of an HIA include:

1. **Screening.** Involves determining whether or not an HIA is warranted and would be useful in the decision-making process;

2. **Scoping.** Collaboratively determines which health impacts to evaluate, the methods for analysis, and the work plan for completing the assessment;

3. **Assessment.** Includes gathering data on existing conditions and predicting future health impacts using qualitative and quantitative research methods;

4. **Developing recommendations.** Makes evidence-based recommendations to reduce negative health outcomes while promoting positive health outcomes;

5. **Reporting.** Communicates findings; and

6. **Monitoring and evaluation.** Evaluates the impacts of the HIA on the decision and on process outcomes.[170]

HIAs have produced a spectrum of results, ranging from implementation of recommendations to improve health outcomes, to engaging community members more fully in the policy process, to strengthening relationships among government agencies. Particular strengths of HIAs are the inclusion of stakeholders throughout the process, the increased transparency associated with stakeholder engagement, a full description of methods and findings, and the explicit reliance on data and evidence to inform decisions to improve health.

Pioneered in the 1980's by the World Health Organization, HIA has since been embraced internationally, including through formal requirements. For example, the Thai constitution provides a right to request "that a court and an expert committee examine whether a HIA is required" for any project, and HIAs are required for major projects in designated potentially hazardous industries such as mining, steel mills, airports, and others.[171] In the United States, to date, only one state has adopted HIA requirements; in 2009, Massachusetts began to require HIAs for major transportation projects.[172]

As a voluntary practice, HIAs have gained currency rapidly across the United States and been used by local and state health agencies, community-based organizations, and nonprofit organizations. Following are a few examples:

- **Living wages, 2006.** San Francisco's Department of Public Health conducted an HIA to look at the health impacts of a proposed living wage ordinance.[173]

- **Energy assistance, 2007.** The Boston University Child HIA Working Group conducted an HIA in Massachusetts to assess the impacts of state funding for the federal Low Income Energy Assistance Program.[174]

- **Express bus route, 2011.** The Connecticut Association of Directors of Health and Southern Connecticut State University conducted a rapid HIA for a planned express bus route.[175]

- **Wind energy, 2012.** Oregon's Department of Public Health conducted an HIA examining a wind energy project.[176]

For more comprehensive information about HIAs conducted in the United States, visit the Health Impact Project at: http://www.healthimpactproject.org/.

South Australia's Health Lens Analysis Method. Health lens application is a core component of South Australia's Health in All Policies model. The South Australia Department of Health designed a formal Health Lens Analysis (HLA) process specifically to be applied very early in the process of developing policy ideas in areas with potentially large impact and of importance to the wider South Australia government.[177] The intent of the HLA process is to foster the analysis of possible alternatives when a policy is in draft form. While HLA uses similar methods to the HIA, its goal is to inform policy development at the conceptual phase.[178] In 2008, the Executive Committee of the South Australia Cabinet agreed to systematically apply a health lens across the targets identified in South Australia's Strategic Plan.

The HLA process involves five stages:[179]

1. **Engage.** Establish collaborative relationships with other sectors (including a joint work group), determine the agreed-to scope and policy focus, clarify issues, determine the analysis process, and establish evaluation criteria.

2. **Gather evidence.** Identify health impacts of the policy under review and evidence-based solutions through literature review, data collection, and qualitative research methods.

3. **Generate.** Reconcile perspectives, explore the implications of proposed recommendations, and produce recommendations in a report jointly authored by partner agencies.

4. **Navigate.** Shepherd the recommendations through the approval and decision-making process at the partner agencies and health department, including required presentations and briefings.

5. **Evaluate.** Review the process, impact, and outcomes to determine the efficacy of the HLA and report to central leadership.

HLA has been conducted in South Australia on diverse issues, including those listed below:

- **Water security, 2008.** As the first HLA, this effort was seen as a trial analysis. The project team identified the impacts associated with increasing the use of alternative water sources.[180]

- **Digital technology, 2009.** Explored digital technology access and use in low-income populations and identified solutions to increase internet access through mobile phones.[181]

- **Regional migrant settlement, 2010.** Described the impact of settlement experiences on migrant health, identified contributors to settlement experiences and outcomes, and established strategies for the positive settlement of migrants in the future.[182]

- **Transit-oriented development, 2011.** Examined the relationship between an array of urban factors impacting health, livability, and desirability of these environments. This process led to the development of a guide for planners, health professionals, designers, and engineers to support the development of livable transit-oriented developments.[183]

In these and other HLAs, a small team at the health agency undertakes the analysis in collaboration with other government agency staff and seeks to engage in the policy formation process as early as possible to ensure incorporation of health factors in the decision-making process.

KEY CONSIDERATIONS

Three common elements are recommended to all practitioners, regardless of approach:

1. Think about whether there is a good reason to do an analysis.

2. Gather available and pertinent evidence before commenting on a proposal in a different sector.

3. Be as comprehensive as possible in thinking through the potential health and equity impacts of a proposal and how they can be addressed.

🍎 **FOOD FOR THOUGHT. Before you decide whether and how to proceed with a health lens, you may want to ask:**

☐ Is there a law or mandate requiring a formal or structured analysis?

☐ Are resources (e.g., staff, funding, expertise) available to complete a structured analysis?

☐ What is the decision-making timeline?

☐ How much is known about the likely health impacts of a proposed policy and how convincing is the evidence?

☐ Is the decision likely to have very significant health consequences?

☐ Is an issue politically sensitive? How much scrutiny will your agency receive with regard to any comments it makes?

☐ Is the decision-making agency open to input on health and equity impacts, and in what form?

☐ Are stakeholders demanding formal analysis?

☐ Is the analysis likely to provide information that is not already available?

☐ Could analysis be incorporated into an existing, formal process?

Applying a Health Lens to Regional Transportation Planning

Shaped by extensive public input on the issue, in December 2010, the Nashville Area Metropolitan Planning Organization (MPO) adopted an Active Transportation Funding Policy in the 2035 Regional Transportation Plan (RTP). This policy targets at least 15% of Urban Surface Transportation Program funding toward active transportation projects. With the leadership of a full-time director of healthy communities devoted to bicycle, pedestrian, and health policy, the MPO has developed a systematic approach to rating transportation proposals, giving priority for active transport and projects that address transportation needs in high disparity areas. The MPO has utilized multiple data sources to identify and prioritize those communities in greatest need with the goal of increased physical activity and has identified health as a criterion for project selection. Including health organizations from the state and local level was identified in an evaluation of the process as a key to the success of the 2035 RTP.[184]

See the Annotated Resources for a list of tools that have been developed to support the application of a health lens. Some of these tools focus on equity, some on specific types of communities (i.e., rural or urban), and others on economic development.

6.3 Evidence and Data

Government is more effective and efficient when it focuses on those programs and strategies that work best and directs resources toward those places and populations in greatest need, or where intervention will be most impactful. Your partners outside the public health field likely rely upon evidence to make decisions about achieving their own goals, but may not have considered health or equity outcomes. One important role for public health practitioners in a Health in All Policies initiative is to provide evidence of the links between health, equity, and policy areas outside public health, and to identify intersectoral policy approaches that have been shown to work. For example, a map overlaying deaths from heat with a tree map can both show the importance of parks departments to improving morbidity and mortality and help the parks department and other partners working on urban greening make a stronger case for the importance of their programs.

Data versus Evidence

In the field of public health, *data* are simply "a collection of items of information" or the factual information, including measurements or statistics that are used as a basis for reasoning or calculation.[185] For public health interventions, *evidence* often refers to information on "the effectiveness of an intervention in achieving an outcome that will create lasting changes in the health of the population."[186] For example, schools often collect *data* on student fitness outcomes. Analyzing changes in that data after the introduction of a school-based physical activity program can provide *evidence* of program effectiveness.

It is important that practitioners of Health in All Policies provide evidence to meet external needs for justification and accountability, make data meaningful through easy-to-follow presentations, be honest about the limitations of existing data or evidence, and seek ways to build the body of knowledge about the effectiveness of Health in All Policies approaches. Health in All Policies initiatives do not necessarily require data collection or new analysis, as they can often rely upon pre-existing data. At the same time, innovation is a key feature of Health in All Policies, and this means being willing to try approaches that have not yet been tested, or for which very little evidence of promise currently exists.

The uses of evidence in Health in All Policies work are numerous, and include:

- **Helping ensure that health-promoting projects are as effective as possible.** This includes establishing priorities for action, targeting programs to meet specific needs, and determining allocation of resources.

- **As an educational and advocacy tool to support and justify a Health in All Policies approach.** This includes quantifying the need for policy change, conveying a message more effectively to policymakers and the public, and mobilizing community action to promote healthy communities.

- **Evaluation of Health in All Policies approaches, outcomes, and group processes.** This includes setting benchmarks and measuring progress.

- **As the focus of a Health in All Policies initiative to make policy or programmatic changes that improve data collection, sharing, or analysis.** This includes incorporating health indicators into existing data sets, and incorporating indicators of social determinants of health into existing health analyses.

USING EVIDENCE TO SELECT PROGRAMS OR PRACTICES

Government agencies are increasingly encouraged to adopt evidence-based policy-making—the use of scientifically rigorous evidence about "what works" in making decisions about government spending to improve health and social, environmental, and economic well-being.[187] The use of evidence in policy and decision-making can increase public accountability and ensure that desired outcomes are achieved by directing resources to programs that are proven to be effective and that do not have unintended consequences. The gold-standard for evidence is the randomized controlled trial, which is common in clinical medicine, but rare in the arena of social or economic programs because of both ethical and cost considerations.[188]

While governments should prioritize implementing policies and programs with "evidence of effectiveness in real-world environments, reasonable cost, and manuals or other materials available to guide implementation with a high level of fidelity," such programs are often not available or may not offer the best solution to the problem at hand.[189] Innovative efforts such as Health in All Policies require flexibility to encourage the exploration of emergent and creative solutions that lack rigorous evidence. These approaches are often referred to as "emerging" or "untested." They may be described as "evidence-informed" if they were developed based upon evidence (for example in a related field or in a different context), but have not been tested themselves. Even when evidence is available, it may not be applicable in every situation. It is important to consider the target population of your efforts, their self-defined needs, and the context in which evidence-based policies are implemented, so that issues such as cultural relevance and community interests are taken into consideration as evidence is weighed.

In cases of insufficient or limited evidence, when possible, it is important to gather data and evaluate your work, to contribute to the body of evidence. It is also important to be honest and transparent about what kind of evidence is being used to support a particular policy, including if there is little or no evidence because it is an innovative approach. The misuse and underuse of evidence are important to consider. Often policy decisions have more to do with synergy between multiple agency goals, feasibility, funding, and support of policymakers and the public than with scientific evidence, even though evidence may be available. This is a reality of working in a political context, but it is important for public health to continue to bring evidence to the table when possible.

Consider your audience. It is important to think about your audience, and what kind of evidence will resonate with them. In a Health in All Policies approach, your audience may care a lot about health, but may not be health experts. Chronic disease rates alone may not mean a whole lot to your audience, but they may be very interested in understanding the links between transportation or housing policies and health outcomes. Similarly, if you plan to highlight how a particular policy change could reduce obesity rates, it might be useful to also show how it could benefit both health and other kinds of goals, such as reducing food insecurity, strengthening rural economies, or reducing greenhouse gas emissions.

Given the complexity of the social determinants of health, it is important to present information in a way that allows people to intuitively grasp its meaning. When presenting statistics or other data, be aware that while some policymakers and stakeholders are very data savvy, others are put off by complex, number-laden graphs and charts. Color-coded maps can be particularly effective in showing differences in health outcomes and living conditions among neighborhoods or regions. Punctuating data with pictures and stories is an effective way of bringing them to life.

Your audience will also likely be concerned with your sources of evidence. For example, if you are presenting information on the links between health and a particular policy area to an agency with which you want to partner and you are aware that they are in conflict with an advocacy organization, you might not want to cite articles written by that advocacy organization.

Evidence to support the Health in All Policies approach. In addition to using evidence to select specific programs or practices, you may need to make a case for pursuing a Health in All Policies approach overall. Health in All Policies is a promising approach, backed by only a limited body of literature and evidence. While you may want to focus on the evidence behind the links between various policy areas and health, you should also gather data on the effectiveness of your initiatives to share with others considering adopting a Health in All Policies approach.

A HEALTH IN ALL POLICIES APPROACH TO DATA

Health in All Policies requires a new approach to data and information-gathering. For example, data on non-health outcomes are essential for measuring changes in the social determinants of health. While quantitative data are important for measuring needs and impacts, qualitative data also play an important role in Health in All Policies work. Furthermore, Health in All Policies provides new opportunities to collaborate around data collection and analysis, helping to break down silos between government agencies.

Data to Support Active Transportation

A 2009 *Lancet* article made important connections between greenhouse gases, (fossil fuel-based) transportation, and health. Woodcock et al. created a model of London that helps answer the question: "How big are the health benefits or harms of active transport or low carbon driving?" They showed that increasing use of active transport such as walking or bicycling could improve health outcomes while also achieving substantial reductions in carbon dioxide emissions.[190] The California Department of Public Health and San Francisco Bay Area transportation and air quality organizations teamed up with the original research team to apply the same model to the health and travel patterns of Bay Area residents.

The research team found that replacing up to 15% of car miles traveled with walking and bicycling would reduce the number of deaths and years of life lost due to heart disease, stroke, and diabetes by nearly 15% compared to business as usual, mostly from increased physical activity.[191] However, more pedestrians and bicyclists would be injured or killed in traffic collisions if current safety conditions were not improved. This model is an important way of providing data that can be used by regional transportation and planning organizations to help ensure that health is taken into consideration during decision-making. In fact, a number of California's metropolitan planning organizations are now considering how to use this model in mandatory plans for meeting greenhouse gas reduction targets.

Healthy Communities Indicators

The California Department of Public Health and the University of California, San Francisco, with funding from the California Strategic Growth Council are working together to create and disseminate indicators linked to the Healthy Communities Framework (available in Section 1.3). The goal of this project is to support public health and other agencies by providing data, a standardized set of statistical measures, and tools that can be used for planning and evaluation of policies, programs, and strategies to change the social determinants of health.

More information about the Healthy Communities Indicators is available at: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx.

Importance of non-health data. Intermediate measures of the impact of Health in all Policies efforts often fall outside the purview of health departments. These include tree canopy assessments, sidewalk inventories, graduation rates, transportation access, and crime statistics. While these are measured by other agencies, the information gathered is incredibly important for public health practitioners. Therefore, there is a strong incentive for collaboration to develop partnerships around data gathering, sharing, and analysis.

The Healthy Minnesota Partnership (Partnership) is an example of how non-health data can support health-promoting work. The Partnership has served as a catalyst for Health in All Polices efforts in the state through an acknowledgment that no single agency or organization alone can improve health outcomes sufficiently. The Partnership brought together 34 community partners and the Minnesota Department of Health in 2012 to develop a statewide health improvement plan.[192] As a first step, the Partnership conducted an assessment using health data and developed indicators to identify populations experiencing the greatest health disparities and inequities in health, education, income, health care, and living environments. The role of the assessment is to expand the collective understanding of the Partnership around health and its relationship to community environments, and to serve as a framework to encourage efforts by members of the Partnership to create healthy environments and opportunities for health.

See below for more discussion about sharing data among partners.

Scale matters. While a lot of data are available about the entire population of the Unites States, including data comparing the populations of different states or counties, if you want to measure equity or the social determinants of health in a meaningful way it is important to gather and analyze data at a much smaller scale in order to determine whether there are differences within or across populations and places. This can involve measuring differences across very small geographic areas, such as neighborhoods or census tracts, or differences across subsets of populations, including by age, race, ethnicity, or income. Increasing the "granularity" of an analysis can reveal geographic pockets or populations experiencing inequities, such as higher burdens of disease.

For example, the ratio of park acreage per resident may seem adequate for a given county, but examining park acreage per city or neighborhood may highlight significant differences in access to parks. Likewise, Asian Pacific Islanders are believed by some to be in better health than other ethnic groups, while in fact, there are striking health disparities within subgroups of Asian Pacific Islanders, revealed when data are disaggregated.[193] Revealing hidden disparities between subgroups can help target resources to address the disparities more effectively. When finer-grained data are not available, it is important to communicate the limitations of large-scale data in understanding health inequities and work with other agencies toward collecting data at a sufficiently detailed scale to capture all population groups within a particular community.

🍎 **FOOD FOR THOUGHT. Below are some questions you may want to ask yourself as you think about the scale of the data you are collecting or using:**

☐ What is the question you are trying to answer? Will state-level or county-level data be sufficient? Is neighborhood or census tract-level data necessary?

☐ Are there subpopulations where inequities have existed in the past? Are there new population groups or existing groups that have not been accounted for? What data are necessary to tease out those inequities?

☐ How will you define "community" (i.e., ethnic group, census block, etc.)?

☐ How can community members help you interpret data?

☐ Are there other partners who have data at a finer geographic scale?

Health and Equity Metrics in Transportation

Metropolitan Planning Organizations (MPOs) are regional agencies, designated through the Federal Aid Highway Act of 1962, that are charged with coordinating and developing Regional Transportation Plans (RTP).[194] The RTP is a thirty-year long-range plan for a region's transportation system. Generally conducted every five years, these plans identify and analyze the transportation needs of regions and provide a framework for prioritizing projects. By developing, tracking, and providing data to support MPOs in measuring health and equity performance measures, public health can support regional agencies in advancing health goals while also supporting the development of a robust transportation system.

Including health and equity metrics in the RTP is one way to embed public health considerations in transportation planning. Public health's participation in RTP development can serve to enhance the consideration and tracking of chronic diseases such as heart disease, stroke, and diabetes, as well as traffic pollution impacts of various transportation scenarios. Health can also inform possible greenhouse gas mitigation strategies and offer guidance on funding priorities based upon the public health and health equity impacts. For example, health and equity indicators can build a case for enhanced support for bike, pedestrian, and transit projects; indicate that funding should be prioritized for safety improvements in communities with high crash rates; or, support improved accessibility in transit-dependent communities.

In California a statewide coalition of health experts, community advocates, and transportation planners came together to develop metrics that could elevate health and equity outcomes of RTPs to communicate to the MPOs.[195] For example, the coalition recommends that MPOs measure and stratify all indicators by race/ethnicity, income, geography (census block or tract level, neighborhood, or community of concern), age, and disability, and a number of additional metrics.[196]

Value of qualitative data. Qualitative data can add tremendous value to a Health in All Policies group, can help guide and support prioritization of issues in your work, and can provide justification for collaboration. Qualitative methods such as interviews, focus groups, and community conversations or forums can help you identify your partners' priorities, fill gaps in quantitative data, or provide a deeper understanding of an issue, particularly in informing the "why" behind the data. For example, your dataset might indicate lower graduation rates in a neighborhood; talking to community members may bring to light underlying problems such as housing insecurity or school discipline policies that might not be apparent in "hard" data. Interviews and surveys of partners and stakeholders can also guide process evaluation of an initiative, both helping you improve a Health in All Policies initiative and contributing to the body of evidence. Finally, qualitative data from stakeholder input can be essential in helping you work on those policies and strategies that are most important for the communities to which you are accountable. Regardless of who you engage, it is important to be clear with individuals beforehand about what you will do with the information collected (stakeholder engagement is discussed in detail in Section 3.2).

Following are examples of qualitative data collection to support Health in All Policies:

- California's Monterey County Health Department undertook a county-wide community engagement process which revealed major community needs that were not under the purview of the health department. In order to address these needs, the health department wrote Health in All Policies into its strategic plan, approved by the county board of supervisors in 2011. The health department is now working on developing a health element for the county's general plan.[197]

- A qualitative survey of students at a Los Angeles school revealed that parents and students were very concerned about truancy tickets being issued to students who were late to school because of insufficient transportation options.[198] The truancy tickets not only presented a financial burden to parents, but caused students to miss additional class time because of time spent addressing the citations. Community groups used this information to launch a collaborative effort between parents, students, the city, and the courts to find better solutions to truancy concerns.

Sharing data. Not only do data play an important role in providing *direction* to Health in All Policies initiatives, but the coordinated production, sharing, and analysis of data can also serve as a *goal* of Health in All Policies efforts. For example, data can be shared to improve services and government efficiency. In Florida, Pennsylvania, and Washington agencies are sharing data and aligning other processes in an effort to simplify processes for determining eligibility and enrollment in social and health services. Technological innovations and staff skill-building efforts "enable multiple workers to share and process information on a single case (rather than assigning each case primarily to a single case worker)" to improve access to a variety of programs such as the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Medicaid, and the Children's Health Insurance Program.[199] Other uses of technology which facilitate data sharing include online applications, document imaging, electronic recordkeeping, enhanced record retrieval, and call centers.[200]

Collaborative data collection. Just as building healthy communities requires collaboration across sectors, so does collection of data related to healthy communities. Data are often collected in a siloed manner, with each state or local agency collecting data related to its own policy area (i.e., housing agencies collect housing data, while justice agencies collect data on crime). Because Health in All Policies requires data from multiple sectors, you may need to invest time and energy to access data collected by other agencies. Some states and local governments have established clearinghouses to make data more readily available to other agencies, but in other cases, your Health in All Policies group may want to spearhead the development of data access initiatives.

Data collection is resource intensive, so your partners may be interested in identifying ways to piggyback data collection efforts across agencies. Often agencies outside the public health field are interested in health data, especially if the data demonstrate the health benefits of their work. Increasingly, they are looking to public health agencies for input on how they can incorporate health into their indicators and data models. Incorporating health metrics into program and policy implementation, monitoring, and evaluation is one way to embed health and equity considerations into the work of sectors outside of public health.

There is a potential role for Health in All Policies whenever a survey is developed or updated, especially if that data might be used by others beyond the survey organizer. For example, in California, the Governor's Office of Planning and Research, a member of the Health in All Policies Task Force, conducts a yearly survey of local planning agencies and has offered to let other Task Force members suggest additional questions to gather data useful to Health in All Policies efforts.

Health in All Policies initiatives can help partners pursue joint purchasing of commercial data products, cross-training on specific agency data sources, or improved interagency access to data for analysis. It may be useful to scan the kinds of data that partners are collecting to look for areas of overlap, and to see if partners have ways of collecting data more efficiently and effectively. While intersectoral collaboration around data sharing can be a complex endeavor, it can also help reduce redundancy, save money, and increase effectiveness, especially in cases where multiple partners need the same information. For example, transportation agencies could consider broadening the scope of their data collection efforts to include assessment of transportation access to health clinics, parks, and other health-promoting sites.[201]

Data sharing can be difficult because of legal barriers, costs, and concerns about confidentiality. For example, federal and state laws and agency policies protecting the confidentiality of patients or clients can prevent data sharing. Partners may have legitimate fears about losing control of data subject to strict confidentiality and access laws. However, in some cases, barriers to data sharing are more organizational or cultural than legal, in which case Health in All Policies initiatives may provide a venue for progress.

Data sharing can also generate greater investment in particular data sources, which can help the data provider justify its efforts. For example, the California Department of Education administers the Fitnessgram,[202] an important source of information for the California Department of Public Health about physical activity and obesity in schoolchildren. When funding for Fitnessgram was threatened, public health leaders got involved in what was a successful multi-agency effort to save funding for the program.

6.4 Evaluating our Collaborative Efforts

Evaluation is an important component of any public health initiative because it can demonstrate the impacts and effectiveness of the program, promote continuous learning and improvement, help to guide program evolution, help determine effective allocation of scarce resources, and promote stakeholder engagement by seeking broad input. While evaluation of Health in All policies initiatives has been fairly limited to date, the authors suggest some ways to approach evaluating this work.

An effective evaluation of a Health in All Policies initiative will likely require participation by partners and stakeholders, and may consider a wide variety of impacts including improving health, embedding health considerations into government decision-making processes, and fostering more integrated, collaborative, and synergistic government.

PROCESS EVALUATION

Process evaluation can provide important information about the collaborative aspects of a Health in All Policies effort, the extent to which partners and stakeholders feel that the process meets their individual and organizational needs, and opportunities for improving the functioning of a group or process, including mid-course adjustments.

The following questions might be asked in a process evaluation:

- Did meetings meet the needs of participants?

- Did partners and stakeholders feel they had sufficient opportunity to participate? Did they feel their input was heard and incorporated?

- Did agency partners feel that their agency priorities and needs were taken into consideration?

- What value did agency partners see in participation?

- What components of the process were most or least useful?

- What external processes or events helped or hindered Health in All Policies efforts?

- What opportunities lie ahead?

- How can this effort be made more effective?

- Were deliverables produced on time?

Process evaluation can also be used to explore the success of applying a health or equity lens, in which case it will be useful to ask questions such as how the analysis worked, whether the health or equity analysis met the needs of all partners involved, and whether it supported the development of a collaborative climate.

California's Health in All Policies Task Force process evaluation is discussed in greater detail in Part III.

IMPACT EVALUATION

Health in All Policies initiatives ideally have multiple outcomes, ranging from creating a more collaborative and health-oriented organizational culture, to promoting healthy public policy and decision-making processes, to ultimately improving population health and equity. Impact evaluation will look at those policy and organizational outcomes that may have occurred as a result of a Health in All Policies approach or a specific policy. An impact evaluation can measure the changes that are likely to lead to health improvements and whether, and how well, a health or equity analysis worked. The evaluation could include looking for other evidence that health and equity considerations have been incorporated into policies or programs as a result of the analysis.

Questions that can help to assess outcomes related to *organizational and cultural change* include:

- Has participation led to increased trust among partner organizations and agencies?

- Has participation led to a perceived or measurable increase in collaboration across sectors?

- How do partner agencies see the relationship between health, equity, sustainability, and their own agency objectives?

- How have health experts been consulted on decisions made by non-health partners?

- What steps have partner agencies taken to impart health, equity, and sustainability knowledge to their staff?

The following questions can help to assess *policy outcomes, including structural changes to decision-making processes*:

- How have other agencies used a health or equity lens in their assessment of a particular project, program, or policy? What elements of this work have been collaborative across agencies?

- What progress has been made toward incorporating a health or equity lens into the decision-making process of sectors or partners outside the public health field, including agency partners, city councils, or legislatures?

- How have health, equity, and sustainability criteria been incorporated into funding or program evaluation criteria of partners outside public health?

- How have health, equity, and sustainability explicitly been incorporated into government guidance or policy documents?

- Have there been legislative actions to support use of a health and equity lens in decision-making?

- Have other organizations or groups developed new initiatives that build upon your Health in All Policies work?

The passage of Assembly Bill 441 (Monning) in the 2012 session of the California legislature provides one example of measurable progress toward incorporating a health lens into government guidance. In response to the California Health in All Policies Task Force's 2010 recommendations, community organizations began meeting with legislators to discuss the links between transportation, health, and equity. As a result, the California legislature voted to require that state-issued guidelines on regional transportation plans include "a summary of the policies, practices, or projects that have been employed by metropolitan planning organizations that promote health and health equity."[203]

HEALTH OUTCOME EVALUATION

Because Health in All Policies is a strategy for improving population health, it is important to use outcome evaluations to measure changes in health status that relate to policy changes and improve your initiatives accordingly. However, changes in population health status are difficult to measure, influenced by many factors that may be difficult to disentangle, and can take a long time to change. Because of these difficulties, it is important to identify intermediate health outcomes that can help demonstrate progress. Measuring changes in the social determinants of health can support collaborative work by showing improvements that are relevant to partners both inside and outside the public health field. Health outcome evaluation can also use proxy measures to indicate medium- to long-term change, such as whether partner agencies' policy priorities have shifted to consider health.[204,205]

For example, you may have evidence that violence and perceptions of violence contribute to rates of diabetes and other diseases by negatively impacting people's likelihood to get physical activity. But it would be difficult to measure the direct causal impact of a specific change in criminal justice policy on those disease rates. Instead, you could focus your evaluation efforts on intermediate outcomes such as changes in rates of violence or perceptions of violence. You could even take it one step further and look at the correlation between those changes and rates of physical activity, even if those changes are too new to be reflected in rates of chronic disease.

The following questions can be useful for evaluating changes in the social determinants of health:

- Have policy changes led to healthier communities?
  - o Has there been an increase in access to safe, sustainable, and affordable transportation options? Nutritious food and safe water? Affordable, high quality, socially integrated, and location-efficient housing?
  - o Is there greater access to affordable and safe opportunities for physical activity, and is there an increase in individuals using those opportunities?
  - o Are there more opportunities for a living wage and safe and healthy jobs?
  - o Have there been reductions in violence and crime rates?
  - o Have educational outcomes improved?

- How has equity been impacted by policy changes?
  - o Have inequities between sub-population groups widened or narrowed?
  - o Have you addressed a structural issue that particularly impacts disadvantaged populations?

🍎 **FOOD FOR THOUGHT. Here are some questions you may ask yourself in designing an evaluation for a Health in All Policies initiative:**

☐ What are the questions of primary interest to you, your partners, and your stakeholders?

☐ What relevant quantitative and qualitative data are available and accessible?

  ○ *Are resources available for primary data collection, such as surveys, interviews, or focus groups?*

☐ Is there evaluation expertise on your team, or will outside expertise be required?

☐ What resources are available to you?

☐ How will evaluation findings be used and disseminated?

SECTION 7: Talking about Health in All Policies

KEY POINTS

- In order to set the stage for understanding why Health in All Policies is a valuable approach, it is important to establish an "environmental frame" that demonstrates that the places people live, work, and play affects their health and decisions.

- Commonly held values such as fairness, efficiency, opportunity, and collaboration can be good starting points for helping people connect to Health in All Policies.

- Messages can support individual policy changes, as well as the overall concept of embedding health into government processes and decision-making.

7.1 How Do We Talk about Health in All Policies?

FRAMING THE ENVIRONMENT

Health in All Policies is a label for a larger concept rooted in the fact that the environments in which people live, work, study, and play shape their health outcomes. This is the motivating rationale behind Health in All Policies: if environments matter for health, then our society, and the government agencies that serve it, should consider health outcomes in the decisions that shape those environments. This is called looking at health through an *environmental frame*.

However, in the United States, the default frame of individual will and responsibility often obscures the environmental frame.[206] Unprompted, most people here still hold individuals accountable for their own health outcomes, especially when those outcomes can be related to what are considered lifestyle choices, such as smoking, eating, and physical activity. While it is certainly true that the decisions we make as individuals do affect our health, it is also true that environments matter a lot: individual decisions are always made in the context of social and physical environments that can affect nearly every decision. To make the case for Health in All Policies most effectively, it is important to provide an alternative to the default frame.

The idea that contexts and environments affect individuals and their health should be communicated early and often, as it is generally not the first thing that comes to mind when people are asked what to do about poor health.[207] Many believe that the best ways to address poor health are through better access to healthcare and lifestyle choices; fewer focus on creating better environments. Since the default frame of personal responsibility needs no prompting—it is the first place people's thoughts take them—the environmental frame must be triggered by reminding people how our homes, schools, offices, neighborhoods, parks, and other settings affect our daily lives, including our health. Once that idea has been triggered, people can more easily understand the need to improve environments in order to improve health, and from there it is a simple step to understanding the value of a Health in All Policies approach.

Health in All Policies: What is in a Name?

Intersectoral collaboration to promote health is not new. At different times and places, this has been called "horizontal health governance,"[208] "joined-up government," a "whole-of-government" approach, "intersectoral action for health," and simply "healthy public policy."[209,210] Another phrase used is "Health Happens Here,"[211] and many organizations apply the term "place matters"[212,213] to their work. Regardless of the name of your initiative, it is important to keep in mind the five key elements of Health in All Policies (see Section 1.4).

BUILDING ON SHARED VALUES

People usually connect with issues through the emotion that is evoked with the expression of values; thus, including an expression of values is a critical piece of effective communication. While not everyone shares the same values, many people in the United States connect with commonly held values such as fairness, efficiency, opportunity, equality, and others.

A good starting point for communicating about Health in All Policies is to understand and be able to express the commonly held values that align with a Health in All Policies approach, such as opportunity and equality. Additionally, it can be useful to think about your personal and organizational values as they relate to the five key elements of Health in All Policies (see Section 1.4). For example, one of the key elements of Health in All Policies is that work benefits multiple partners, which is related to values of efficiency, collaboration, and fairness. When you craft messages about Health in All Policies, try to identify *shared* values that could attract your audience to the concept—whether that audience is partner agencies, public health colleagues, administrators, legislators, a key community group, or the public.

"In using the term Health in All Policies we need to be mindful of the potential charge of health imperialism. Truth is, we know it's never going to be health in *all* policies, it's only ever going to be health in some policies. But if we partner with other sectors to facilitate change where we can—both where it is really important and where it's opportunistic— then we can create a snowball of change."

—Kevin Buckett, *Director of Public Health, South Australian Department of Health and Ageing*[214]

Talking About Values

Public health practitioners are generally less comfortable talking about values than numbers, statistics, and research to get their point across. But values are what help people connect to and care about an issue. Talking about values doesn't have to be philosophical or complex—it's really as simple as asking (and answering) a basic question: "Why does it matter?"

For example, why does it matter that health inequities continue to persist? Why should we care that government agencies don't work together? Why does it matter if health is considered in decision-making? The answers to these questions will resonate more with your audience if you are able to articulate and connect with the values that resonate with them, such as fairness, efficiency, or justice.

BASIC MESSAGING

Defining the target audience for the message is an essential first step. Is this a general communication to introduce the concept of Health in All Policies to the public or policymakers? Or, is this a communication to advance a specific proposal to your partners? Will a particular issue or policy example make more sense to the audience than another? Once you decide with whom you want to communicate and what you want them to know, you can start thinking about the message itself.

Messages have "moving parts" depending on the outcome you seek, the audience, and who delivers the message. The only hard and fast rules for a message as a whole are:

1. **Make sure to trigger the environmental frame *first*.**

2. **State your values.**

3. **State the solution clearly, and be sure that the solution gets at least as much attention—or more— than the problem.**

These messaging rules apply to all audiences, but each distinct audience will dictate how you apply the rules. If your audience is other government agencies, you might emphasize that breaking down silos can yield greater *efficiency*. If the audience is community stakeholders, you might emphasize *equity* or *government accountability*. You don't need to state every value you hold or incorporate every aspect of your initiative into every communication. You know your audience best, so you should choose the appropriate emphasis for each message. But it is critical that all messages, while tailored to an audience or context, be true and consistent; one of the best ways to lose credibility is to say things to different audiences that are not consistent.

Your message will be communicated not only in the words you use and the images you bring to mind, but also in the messenger. The messenger can add nuance to a message by evoking ideas and values affiliated with that person's role or stature. People pay more attention to a message from a person they respect, which is why doctors are important messengers on health issues. Identify and cultivate relationships with others who can make the case for Health in All Policies from their own perspective, or who, by virtue of who they are or the role they play, can add meaning to the message that Health in All Policies is a valuable approach.

"At the beginning of the Task Force meetings, it was very helpful to be asked to think about what the phrase 'healthy community' meant to me personally, because asking the question did make me think about the kinds of environments I want for my children so that it's easier for them to get in the habit of making healthy choices—I don't want them to be able to choose foods at school that I wouldn't offer them at home. It made me think about how it's not always just a matter of personal choice because I realize sometimes the choices just aren't there."

—Member, *California Health in All Policies Task Force*

Spend Your Time Talking about Solutions

People are more inclined to act when they feel they can *do* something to solve a problem. But often public health professionals spend more time talking about the problem than the solution, leaving their audience feeling hopeless or overwhelmed. To more effectively inspire action we need to reverse that ratio and talk more about the solution than the problem. For example: "Increased access to healthy food will improve nutrition and contribute to reducing rates of childhood overweight and adult diabetes. Ensuring that everyone has access to healthy, affordable food can be complicated, but there are meaningful steps we can take right now. That's why we're asking [specific person/agency/organization] to support the Healthy Food Financing Initiative to increase access to healthy food in our neighborhood."

CONSTRUCTING MESSAGES TO SUPPORT HEALTH IN ALL POLICIES

Remember that in developing messages to support Health in All Policies, the first job is to trigger the environmental frame by showing that where people live, work, and play affects their health and decisions. Without this framing, the role of the environment will not be clear and it will be harder for people to see the value of Health in All Policies. This trigger is important whether we are communicating about the general concept of Health in All Policies or about a specific sector or policy.

This sample message is aimed at another agency, and combines an environmental trigger with the commonly held value of collaboration:

Families are healthier when they have safe, well-maintained sidewalks that make it easier to walk to school and work.

After we've triggered the environment, we want to identify the outcomes we seek as clearly, briefly, and specifically as we can. It may make sense to incorporate a problem statement, but the object is to emphasize the outcomes and solutions over the problem.

Families are healthier when they have safe, well-maintained sidewalks that make it easier to walk to school and work, but fixing uneven and cracked sidewalks isn't something families do; it's what the city does for families. That's why we're asking the transportation department to put the Lincoln neighborhood at the top of its list, so parents there can be confident that it's safe for their kids to walk to school.

As discussed earlier, Health in All Policies presents two kinds of solutions: 1) Solutions that result in a specific policy change, and 2) Solutions that change government structures and practices to embed health in decision-making. Below is the same example with the addition of a solution more oriented toward the overarching goal of breaking down silos and embedding health and collaboration into government structures.

> *Families are healthier when they have safe, well-maintained sidewalks that make it easier to walk to school and work. We need to fix the uneven and cracked sidewalks—or blocks with no sidewalks at all—in the Lincoln neighborhood so that parents feel like it's safe for their kids to walk to school. To do that, the transportation agency and the public health agency must work together to support each other's' goals and create safe routes to schools for all of our children.*

Or, taking the Health in All Policies solution one step further, we could add:

> *To do that, the transportation agency and the public health agency must work together to create the safest routes to schools for all of our children, and make sure that the process for identifying transportation funding priorities includes criteria that account for the health impacts of different funding decisions.*

Finally, link your solution to values. While we may choose solutions based on analysis and data, it is values that move people and help them connect to issues and ideas such as Health in All Policies. Values can appear anywhere in your message, as part of the environmental trigger, the problem, or the solution.

> *Families are healthier when they have safe, well-maintained sidewalks that make it easier to walk to school and work. We need to fix the uneven and cracked sidewalks—or blocks with no sidewalks at all—in the Lincoln neighborhood so that parents feel like it's safe for their kids to walk to school. To do that, the transportation and public health agencies must work together to create safe routes to schools for all of our children. Working together, the two agencies can take advantage of their collective experience and find the best solutions so that everyone in our community can be healthy.*

All of this can be summed up as an equation for communicating effectively about Health in All Policies:

ENVIRONMENTAL TRIGGER + SOLUTION + VALUES = HEALTH IN ALL POLICIES

Below are some examples of how environmental triggers, solutions, and values might be expressed in messages to help people see why Health in All Policies is an effective and common-sense approach to creating healthy environments.

Following is an example that begins with an environmental trigger and uses the values of fairness, opportunity, and collaboration to promote the policy solution of more parks.

> *Well-maintained parks provide people with safe places to play and be active. It's not right that children in some neighborhoods have plenty of nice parks and playgrounds nearby, and others have none. That's why we are working with the Parks and Recreation Agency to make sure there are sufficient funds to build new parks and playgrounds so that all children in our community have the opportunity for safe play and physical activity.*

The environmental trigger is the statement that parks provide spaces for children to be active—the statement literally puts the environment in the frame. The value of fairness is embedded in the statement (i.e., that it's not right that children in different neighborhoods have different access to parks). The value of collaboration is implicit, because the speaker (perhaps from a public health agency) is working in collaboration with the parks and recreation agency. The solution is funding for parks in neighborhoods that lack them. Overall, the message highlights the importance of working across sectors to achieve a health goal, a core tenet of Health in All Policies.

Next are two sets of examples of how we could use this messaging approach to create strong messages around the same problem, thinking about project, policy, and systems changes and using different values that inspire different audiences. The more specific you can be (for example, naming a neighborhood rather than saying "low-income communities"), the easier it will be for the audience to relate to what you are saying.

Message example 1. *Set-Up: Families are healthier when they have safe, well-maintained sidewalks that make it easier to walk to school and work. Unfortunately, the streets in the Elmwood neighborhood have uneven and cracked sidewalks or no sidewalks at all. This means some of our children have to walk in the street to get to school, and many parents think this is too dangerous...*

Program change. Environmental trigger + equity value (audience: community group or city council)

... All families deserve safe routes to get where they need to go, not just those who live in wealthier communities. That's why we need to work together with the Public Works Agency to make fixing the sidewalks in the Elmwood neighborhood a priority and make sure there's enough funding to do that.

"By communicating the potential of global climate change to harm human health in communities across America, and by conveying the potential to improve human health through actions that limit climate change, we can enhance public understanding of the full scope of the problem, and help enable appropriate responses by individuals and communities."

—Edward Maibach, Matthew Nisbet, and Melinda Weathers[215]

Policy change. Environmental trigger + collaboration and cost-effectiveness values (audience: another agency)

… We're worried that we're starting to see health problems in kids from this neighborhood, which could bring about new costs. But we can't fix this problem working in isolation. We'd like to work with you to incorporate health into the criteria for selecting this year's transportation priority projects. Working together, we can find effective strategies to address multiple problems at the same time, which could save money for our community. If more people feel safe walking and biking, we'll have better health, which is also good for our economy.

Systems change. Environmental trigger + collaboration and efficiency values (audience: another agency)

…One problem is that health has been left out of the picture, creating high health costs and a lot of sick people. But we can't fix this problem without your help. We'd like to work together to make sure that health is part of the normal decision-making process for all future transportation policy. This will help ensure we have an even larger impact and reduce the need for additional work in the future.

Message example 2. *Set-Up: Government processes to support healthy eating and active living are inefficient and uncoordinated, resulting in missed opportunities, and even policies that are at odds with each other.*

Program change. Environmental trigger + equity and collaboration values (audience: other agencies and community-based organizations)

Individuals who have access to affordable and healthy food are more likely to have a nutritious diet, but it's harder for people in the Riverdale neighborhood to access healthy food because there is no full-service grocery store in their neighborhood. We believe that by working together to create an ad hoc committee with city agencies, local nonprofits, and members of the business sector we can bring a supermarket to the Riverdale neighborhood of our city.

Talking about Parks and Health

Parks and recreational spaces are important for health, because they offer places to play and be active, increase the aesthetic quality of neighborhoods, and can enhance social networks and support. Highlighting their health value can build public support for parks. The California Department of Parks and Recreation has partnered with the California Department of Public Health to launch a "parks prescriptions" program in which physicians write prescriptions to visit local parks, develop resources to promote healthy lunches for school field trips to parks, and promote efforts to offer healthy options at park food concessions.

Policy change. Environmental trigger + efficiency and government accountability values (audience: elected officials and city/county manager)

We are spending billions of dollars every year on healthcare for people with chronic illness when we could avoid many of these costs by making smarter investments in the first place. If we make sure our school lunches are healthier, and our sidewalks are better lit and safer for children to walk to school, we could save a lot of money in the long term. That's why we want to work with the managers of all of the city's agencies to make sure that funding decisions are made with the health of our children in mind.

Systems change. Environmental trigger + efficiency value (audience: other agencies)

Government agencies are continually being asked to do more, often with fewer staff and resources. If we could work together on a regular basis, we could eliminate redundancies, better meet our goals, and improve our ability to support communities. We know this isn't just an issue for public health and transportation, though. We need public works to help us look at street lighting, police to help parents feel that it's safe to walk to school, the school districts to provide healthy lunches, and planners to create walkable neighborhoods with inviting destinations. When you think about it, we need a formal Health in All Policies group that can meet regularly to help us figure out how all of our agencies can work together for better health.

SAMPLE ANSWERS TO COMMON QUESTIONS ABOUT HEALTH IN ALL POLICIES

There are sure to be hard questions about Health in All Policies from colleagues, partners, stakeholders, and policymakers. Below are a number of sample answers to questions using the formula of Environmental Frame + Solution + Values = Health in All Policies.

Question: How do we know that Health in All Policies works?

Answer: Public health professionals have known for a long time that we need to consider the environment and circumstances in which we live to help ensure optimal health (*environmental trigger*). Local, state, and national governments worldwide have been using a Health in All Policies approach (even before it had that name) in order to devise creative solutions to seemingly intractable health problems. Public health worked with public works agencies to build sewage and sanitation systems that reduced infectious disease and simultaneously reduced rodent populations and prevented flooding. Public health also worked with transportation agencies to introduce seat belts, safer road designs, and other innovations that together have led to major declines in rates of automobile crash deaths. Health in All Policies applies the lessons learned from those experiences to today's key health challenges (*solution*). (*Values: Efficiency, Government Responsibility*)

Question: We're all so stressed out and busy already—why should we in other agencies get involved in health when that's the job of the Public Health Agency?

Answer: Of course, the Public Health Agency has a big role to play. But we've known for a long time that community environments have a huge impact on health—even more than the effect of medical care (*environmental trigger*). In the Public Health Agency we don't have the expertise or authority to change those environments. We can only do this with your help. We all have a role to play in creating healthy environments to solve some of our most pressing health problems. If we work together, we can find solutions that will be win-wins and move us all toward shared goals. For example, we know that building bike and pedestrian infrastructure creates more jobs, decreases air pollution and greenhouse gas emissions, and increases physical activity which improves both health and academic performance for students. And we know that "farm-to-fork" activities help to protect agricultural lands, support local economies, and increase healthy eating. Leadership and innovation aren't always easy, but we owe it to the people we serve to work together to find the best ways to solve complex problems, and Health in All Policies is one strategy that will help us to do that (*solution*). (*Values: Collaboration, Efficiency, Government Responsibility*)

Question: Won't Health in All Policies be expensive? Why should other agencies spend their precious resources on issues outside their purview?

Answer: We can't afford *not* to use a Health in All Policies approach. These days, social and environmental problems are so complex that lasting solutions require everyone in government to work together. The consequences of city planning, sanitation, transportation, or food systems policies can include lifelong effects on the health of whole communities (*environmental trigger*). In part, siloed approaches got us into this problem in the first place, and the poorest communities have borne the brunt of this inefficient approach. We can do better. By investing the time and creativity now to consider how health will be impacted, we can prevent expensive problems from happening in the first place. It is not only in our best interest to consider how all policies affect health, but it is our job (*solution*). (*Values: Equity, Government Responsibility, Ingenuity or "Can-Do" Spirit*)

Question: Aren't these health problems really just the result of people making bad decisions?

Answer: People in the United States have always believed in the idea of opportunity, but some people don't have many opportunities for health. It makes sense that it's easier to exercise if you have a safe park or playground nearby, or nice, well-lit sidewalks to walk on. And we all know it's more tempting to buy a soda if you walk by lots of places that sell them cheaply on your way down the street (*environmental trigger*). Government does have a role in protecting and serving its people, especially when it's hard for people to do something by themselves. One way government can do that is by affording all people more opportunities for health, for example by building safe places to play, inviting in new food sources (like grocery stores and farmers' markets), or creating safer routes to work and school. Using a Health in All Policies approach gives all government agencies the opportunity to think big-picture about how their work will have lasting impacts, and to find the best possible solutions that serve everyone (*solution*). (*Values: Opportunity, Government Responsibility*)

CONSIDER THE WHOLE MESSAGE STRATEGY (MESSAGE, AUDIENCE, MESSENGER)

The way we talk about Health in All Policies is a critical part of our work. Health in All Policies is about changing the way government works so that health is taken into account in decisions that are made across government, with an eye toward creating healthy community environments that provide everyone with opportunities and resources for health. Because the default frame in our society is one of individualism, many people may challenge the idea that government should consider health across policy areas. To effectively communicate about Health in All Policies, it is important to consider your audience, trigger an environmental frame, use an appropriate messenger, provide a vivid description of the environment that contributes to poor health (and your vision for one that supports health), and state the values that motivate your effort to create change. Messages that incorporate each of these critical elements will be the most successful at gaining supporters and addressing other people's concerns.

PART III. CASE STUDY: CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE

The following case study on the California Health in All Policies Task Force describes a formal Health in All Policies group that has been in existence for over three years. This is just one way of doing Health in All Policies work, and there are many other ways to use this approach, as described throughout this Guide.

SECTION 8: The California Story

KEY POINTS

- The California Health in All Policies Task Force came about because a number of California's leaders across multiple agencies had a common interest in climate change, health, and childhood obesity.

- A governor's executive order provided high-level support and accountability for Health in All Policies, created a structure, and provided a policy focus.

- The Task Force engages non-governmental stakeholders and representatives of local government through workshops, stakeholder and key informant meetings, and public comment and testimony.

8.1 The Creation of the California Health in All Policies Task Force

Several key factors set the stage for the creation of California's Health in All Policies Task Force, including the Governor's strong interests in health and the environment, increasingly upstream work on the part of the public health agency, and a funding opportunity that created a venue for engaging high-level leadership.

Former California Governor Arnold Schwarzenegger's long-standing interest in fitness and childhood obesity, as well as his commitment to addressing climate change and environmental sustainability, created a "window of opportunity" for pursuing innovative policies. During his administration, the California legislature passed a series of landmark climate laws, one of which required better coordination of land use and transportation planning (SB 375 Steinberg, 2008).[216,217] Also in 2008, legislation established the Strategic Growth Council (SGC) to support state agencies in coordinating their work on climate change and sustainability.[218] The members of the SGC are secretaries from the California Business, Consumer Services and Housing Agency, the California Transportation Agency, the California Health and Human Services Agency, the California Environmental Protection Agency, and the California Natural Resources Agency. The SGC also includes the director of the Governor's Office of Planning and Research and a public member appointed by the Governor.

At the same time, the chronic disease staff at the California Department of Public Health (CDPH) were increasingly aware that, along with obesity, climate change is one of this century's biggest threats to public health. While reviewing the literature regarding obesity and chronic disease prevention strategies, as well as strategies to reduce greenhouse gas emissions, health department staff were struck with the congruence of approaches, and learned of the Health in All Policies approach.

Over a period of several months, CDPH leadership discussed the connections between obesity prevention and greenhouse gas reduction with the secretary of the Health and Human Services Agency, which oversees CDPH, specifically with respect to a "window of opportunity" for CDPH to get involved in the implementation of the aforementioned SB 375 law. In 2009, CDPH incorporated a Health in All Policies proposal into their application for Communities Putting Prevention to Work funds through the American Recovery and Reinvestment Act. The proposal identified state efforts to coordinate sustainable community development as an opportunity for public health to shape policy regarding access to safe places for physical activity. In this application, CDPH proposed that the governor convene a task force on Health in All Policies. While this piece of the proposal was not funded, the internal approval and submission process for the grant afforded an opportunity for continued discussion about the Health in All Policies approach.

In February 2010, Governor Schwarzenegger held a "Summit on Health, Nutrition and Obesity: Actions for Healthy Living."[219] During a moderated discussion with former President Bill Clinton, he announced that he would pursue eight specific actions to support healthy living in California, one of which was to issue an executive order establishing a Health in All Policies Task Force. Executive Order S-04-10 placed the Task Force under the auspices of the SGC and identified CDPH as the facilitator.[220] The SGC was identified by the governor and members of his cabinet as a natural site for this undertaking because it already included many of the agencies and departments that impact health, and because the SGC is explicitly mandated to foster coordination and collaboration of state agencies in order to promote public health and safety among other things.

Executive Order S-04-10 called for the Task Force to:[221]

- Identify priority programs, policies, and strategies to improve the health of Californians while advancing the other goals of the SGC. The SGC's goals include improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the state's climate change goals;

- Submit a report to the SGC recommending programs, policies, and strategies to improve the health of Californians while advancing the SGC's goals;

- Describe the benefits for health, climate change, equity, and economic well-being that may result if the recommendations are implemented;

- Review existing state efforts, consider best/promising practices used by other jurisdictions and agencies, identify barriers to and opportunities for interagency/intersectoral collaboration, and propose action plans;

- Convene regular public workshops to present its work plan; and

- Solicit input from stakeholders in developing its report.

"[The governor understood] that if we really care about improving the health status of the people of our state, we have to care about the health of our communities. That's why he has embraced a very broad community-based approach to prevention. [The] Health in All Policies Task Force reflects his recognition that if we're going to make success in improving health status broadly and particularly addressing health disparities and health inequities we have got to engage the community broadly: the transportation sector, agriculture, education, economic development. That's what the Health in All Policies Task Force is about. It's about working in a coordinated and coherent way to improve the communities in which people live, so that the choices people make are healthy choices."

—Kimberly Belshé, *former Secretary, California Health and Human Services Agency, November 2010*[222]

8.2 Task Force Membership

In March 2010, the SGC convened the Health in All Policies Task Force, designating 19 California state agencies, departments, and offices to participate:

- Air Resources Board

- Business, Transportation and Housing Agency

- Department of Community Services and Development

- Department of Education

- Department of Finance

- Department of Food and Agriculture

- Department of Forestry and Fire Protection

- Department of Housing and Community Development

- Department of Parks and Recreation

- Department of Social Services

- Department of Transportation

- Environmental Protection Agency

- Governor's Office of Gang and Youth Violence Policy

- Governor's Office of Planning and Research

- Health and Human Services Agency

- Labor and Workforce Development Agency

- Natural Resources Agency

- Office of the Attorney General

- Office of Traffic Safety

Each designated agency, department, and office was asked to identify a representative who was familiar with the breadth of their agency's activities, connected to staff with in-depth expertise, empowered to speak on their agency's behalf, and able to engage agency leadership in discussions and decisions about the Task Force's work. CDPH established a team of backbone staff to support the Task Force.

8.3 The Health in All Policies Task Force Process

BUILDING A SHARED VISION

Initial Task Force meetings in the spring and summer of 2010 focused on developing a common understanding of the problems at hand, identifying how each partner's work connects to public health issues, establishing a shared vision and aspirational goals for a healthy California, and exploring and developing expectations, commitments, and decision-making parameters. Five activities were particularly useful in this process:

DEVELOPMENT OF HEALTHY COMMUNITY FRAMEWORK

At the first meeting of the group in June 2010, Task Force members were asked: "When you hear the term 'healthy community,' and you think about the health of yourself and your family and kids, what comes to mind?" The responses demonstrated that the Task Force members intuitively understood that health happens in schools, neighborhoods, and workplaces, and that environments shape their own health behaviors. After several rounds of review and refinement, including discussion at the stakeholder input workshops (described below), the Task Force adopted the Healthy Communities Framework (available in Section 1.3). This framework was foundational to the Task Force's shared vision and created a map for Health in All Policies-related endeavors in California.

CREATION OF ASPIRATIONAL GOALS

Task Force members developed aspirational goals as a way of building a cohesive vision. At the first Task Force meeting, staff provided two sample goals to frame the discussion, and at subsequent meetings the group developed a total of six aspirational goals (available on page 118). Aligned with the Healthy Communities Framework, the aspirational goals focus on areas with a very clear nexus between the work of the SGC and the Task Force member agencies. The goals' simple language has made it easy for staff, other agencies, the public, and policymakers to understand and share a vision with the Task Force. Together, the Healthy Communities Framework and aspirational goals served as a good starting point for talking about the social determinants of health and the need for Health in All Policies.

ROOT CAUSE MAPPING EXERCISE

California Health in All Policies Task Force members used a root cause mapping exercise (see Sections 2.2 and 6.1 for a description and examples) to help elucidate the complexity of interrelated determinants of health and outline the need for Health in All Policies. The exercises focused on two problem statements: "Unable to walk, bike, or take public transit to school, work, play, or other essential destinations" and "Healthy and affordable food not available at school, work, or in neighborhood." The full Task Force reviewed and discussed each of the maps (drawn in real-time on large butcher paper in small groups), and then each participant noted places on the map where their agency might have a role. This process helped members visualize the complexity of the problems faced by California communities, and the necessity for and promise of intersectoral collaboration to achieve common goals.

THE CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE'S ASPIRATIONAL GOALS[223]

- **Active Transportation.** All residents have the option to safely walk, bicycle, or take public transit to school, work, and essential destinations

- **Healthy Housing and Indoor Spaces.** All residents live in safe, healthy, and affordable housing

- **Parks, Urban Greening, and Places to be Active.** All residents have access to places to be active, including parks, green space, and healthy tree canopy

- **Community Safety through Violence Prevention.** All residents are able to live and be active in their communities without fear of violence or crime

- **Healthy Food.** All residents have access to healthy, affordable foods at school, at work, and in their neighborhoods

- **Healthy Public Policy.** California's decision-makers are informed about the health consequences of various policy options during the policy development process

DEVELOPING JOINT POLICY BRIEFS

California Health in All Policies Task Force staff and key policy experts worked with Task Force members to develop policy briefs that explored the links between health and the areas of responsibility of Task Force member agencies. This process helped staff and Task Force members better understand the relationships between health and other sectors, provided staff with an improved understanding of how the partner agencies see their own work, and helped staff to more fully appreciate the importance of partner agencies' work. Working on the briefs also provided many reminders about the importance of refraining from using public health jargon or framing every issue only from a health perspective. The briefs can be viewed in Appendix 4 of the *Health in All Policies Task Force Report to the Strategic Growth Council.*[224]

ENGAGING STAKEHOLDERS

In the first four months of the California Health in All Policies Task Force, staff held over 100 individual meetings with Task Force members and policy experts. These were essential for building relationships and gathering information that shaped recommendations. The stakeholder input workshops, described in more detail below, were also an essential part of developing a vision.

DEVELOPING RECOMMENDATIONS

The Executive Order required the Task Force to produce a report with recommended programs, policies, and strategies to improve the health of Californians while advancing the SGC's goals. The Task Force followed several steps to accomplish this deliverable.

GENERATING IDEAS

From August to October of 2010, the Task Force and staff collected over 1,200 ideas for government action to improve health. Ideas came from a variety of sources including Task Force agency members, public health practitioners, academic experts, nonprofit advocacy organizations, stakeholder input workshops (see below) and a review of published literature and compilations of recommendations such as the Institute of Medicine's report *Local Government Actions to Prevent Childhood Obesity*,[225] the Robert Wood Johnson Foundation's *Action Strategies Toolkit*,[226] the surgeon general's *Call to Action to Promote Healthy Homes*,[227] and *The Climate Gap: Inequalities in How Climate Change Hurts Americans and How to Close the Gap*.[228] Many of the ideas that were generated involved elevating projects or proposals that had been developed by community organizations, but would benefit from the endorsement and involvement of state-level agencies and leadership.

APPLYING CRITERIA

The Task Force developed criteria for the selection of recommendations, which were applied informally in November of 2010. Criteria included:

- Population health impact

- Co-benefits and nexus with other SGC objectives

- Evidence-informed

- Ability to foster collaboration among state agencies and stakeholders

- Equity impact

- Measurability

- Feasibility

- Ability to transform state government culture

A health lens was informally applied by a group of health experts from a wide variety of programs at CDPH who reviewed the recommendations and rated their potential impacts on health. Staff sorted the long list of policy ideas in several ways (e.g., by government function, sector impacted, and policy topic area) in order to cluster similar ideas and gather feedback from stakeholders. Sorting the ideas also helped the Task Force identify important health policy areas that did not initially appear on the list.

DECISION-MAKING

The Task Force explored the different types of decisions that the group would need to make, discussed various approaches including consensus decision-making and gradients of agreement, and set ground rules for making decisions as a group. Task Force members chose to use a consensus decision-making process, and agreed that Task Force members should speak up with concerns so that the group could reach the best possible decisions. During these conversations, members also discussed attendance and decided that if members send a designee in their place, they need to make sure that the designee has been briefed and can participate fully in the decision-making process.

The Task Force selected its initial set of recommendations in the fall of 2010. This involved several meetings of the whole group, meetings with individual members to discuss recommendations related to their agency, and collective editing of documents to ensure that every Task Force member (and their agency leadership) felt comfortable with the ideas and specific language of the recommendations. Any Task Force member could veto a recommendation if they did not feel comfortable with it, and many recommendations were left on the cutting room floor. Reaching consensus was time-consuming and required an iterative process of repeated review and revision. However, this process built cohesion in the Task Force and strengthened its recommendations—in terms of content, acceptability, and feasibility—in large part because the Task Force addressed the concerns of and built on ideas from staff at so many different agencies. The fact that the final recommendations were based on true consensus of all participating state agencies lends tremendous credibility to the Task Force's work.

WRITING THE REPORT

Drafting the 2010 report, *Health in All Policies Task Force Report to the Strategic Growth Council*, with the Task Force's recommendations proved to be a tremendous task. The report not only required a consensus process to craft exact wording of recommendations, but also included a rationale for Health in All Policies, and a discussion of the links between each recommendation, sustainability, and health. Getting all of the partner agencies to support and approve the report involved many rounds of meetings, emails, phone calls, and sometimes negotiation between multiple partner agencies that were not in agreement. However, the process was incredibly important in allowing participants to gain a better understanding of the issues and opportunities for collaborative action.

The Task Force approved 34 recommendations and presented them to the SGC in a December 2010 report.[229] The recommendations were clustered in six topic areas, listed below, which align with the Task Force's six aspirational goals:

1. **Active transportation**

2. **Housing and indoor spaces**

3. **Parks, urban greening, and places to be active**

4. **Community safety through violence prevention**

5. **Healthy food**

6. **Healthy public policy**

It is important to note that the Task Force's recommendations do not represent an overall health strategy for the state (such as the National Prevention Strategy[230] or the Healthy Chicago Priorities[231]); they are a set of policy suggestions that this group of agencies and departments felt were feasible, had co-benefits for multiple parties, and represented a consensus that was achievable at a particular moment in time. In addition, because of the connection to the SGC, all recommendations were required to align with California's sustainability goals. The recommendations set forth in December 2010 do not address a number of important health issues or determinants of health (e.g., lactation, drugs and alcohol, poverty, and economic development) that either lacked sufficiently direct environmental sustainability links or were not viewed as within the purview of Task Force members. These topics could still be addressed in the future.

PRIORITIZING RECOMMENDATIONS FOR ACTION

When the SGC approved the Health in All Policies recommendations in December 2010, it asked the Task Force to select a smaller set of initial priority recommendations and to develop implementation plans for each. The SGC requested that the Task Force focus on near-term feasibility, actions within the SGC's jurisdiction, and efforts that could have a significant impact. With input from a second series of stakeholder input workshops conducted around the state in the spring of 2011, the Task Force selected 11 priority recommendations spanning the six topic areas of the initial report. These were presented to the SGC in June 2011.

MOVING FROM IDEAS TO ACTION

In 2012, the Task Force moved to a new stage, turning its focus to implementation.

DEVELOPING IMPLEMENTATION PLANS

From July 2011 through May 2012, Task Force staff and agency members developed eight implementation plans for the 11 priority recommendations. This was done through large and small group in-person and phone meetings, and with significant input from experts and stakeholders. The implementation plans identify action steps, timelines, agencies responsible, and deliverables. In addition, the implementation plans each describe considerations related to four cross-cutting themes that emerged from the 2011 stakeholder engagement process: 1) interagency collaboration, 2) equity, 3) community engagement, and 4) data. To develop these implementation plans, Task Force members offered ideas, committed to specific action steps, and agreed to take on leadership roles in implementing specific recommendations. For example, the California Department of Forestry and Fire Prevention took the lead on the plan for urban greening.[232]

CARRYING OUT IMPLEMENTATION PLANS

As of spring 2013, the Task Force is carrying out all eight implementation plans. Backbone staff facilitate frequent interagency meetings to coordinate efforts, and Task Force members use the implementation plan action steps and timelines to track accountability. The Task Force is completing most of the actions without any additional funding, and with voluntarily support from existing staff within partner agencies. The Task Force staff has secured additional funding to support three implementation plans related to "farm-to-fork" policies, healthy and sustainable food procurement, and community safety through violence prevention.

HARMONIZING POLICY GOALS

An important ongoing role of the California Health in All Policies Task Force is to address areas in which there is a need to harmonize multiple important and health-related policy goals across agencies. The following example illustrates how multiple agencies, through the Task Force, have worked together to create alignment between important policy goals related to land use and health.

California has enacted laws promoting the integration of transportation, air quality, and land use planning to address climate change and other public policy objectives.[233,234,235] It is challenging to implement all of these goals simultaneously, particularly in areas where many sites that might be available for affordable housing are located near busy roadways. Also, several laws, executive orders, and guidance related to land use either require or encourage state and local agencies to pursue interrelated and health-promoting goals such as:

- Promote and prioritize infrastructure, infill, and transportation-oriented development;

- Support reduction of automobile travel and vehicle miles traveled (VMT) per capita, and promote active transportation infrastructure to increase walking and bicycling;

- Keep people and goods moving, which is good for health and the economy;

- Preserve environmental and agricultural resources including land and water, which are required to feed a growing population;

- Reduce greenhouse gas emissions, to reduce catastrophic climate change impacts;

- Assure housing needs are met for all income levels;

- Mitigate known significant environmental and health impacts of projects; and

- Improve regional air quality and reduce exposure to harmful air pollutants to reduce risks for cardiovascular and respiratory disease.

In response to this challenge, the Task Force convened a multi-agency Housing Siting and Air Quality Workgroup, which seeks to increase intersectoral understanding on the part of agencies and stakeholders about the interrelatedness of these issues, the need for harmonization, and strategies to support harmonization, such as better data or more research on effective methods to improve indoor air quality in polluted areas.

ENGAGING STAKEHOLDERS

The California Health in All Policies Task Force has employed a variety of methods for engaging stakeholders and gathering their input.

STAKEHOLDER INPUT WORKSHOPS

The Task Force partnered with local health departments to host eight stakeholder input workshops across California in two rounds, in 2010 and 2011. Invitations were disseminated through partners, including Task Force members, local health departments, and the informal stakeholder group described below, and the workshops attracted between 15 and 90 attendees each. Outreach targeted community-based and health organizations and the housing, food, transportation, and environmental groups and agencies with whom they work. A professional facilitator guided staff in designing agendas and facilitated the workshops in a way that fostered solution-oriented input.

The first round of workshops introduced the Health in All Policies Task Force and engaged attendees in the "What is a healthy community?" exercise that the Task Force used early in its own process. The facilitator briefed attendees on the role of state agencies as compared to local agencies, and participants were asked to discuss how state agencies contribute to or impede their ability to advance healthy communities and to provide recommendations for state agency action. The second round of workshops gathered input on prioritization of recommendations for near-term implementation, contributing to the 11 priority recommendations described above.

The stakeholder input workshops provided several benefits including increasing awareness of and support for the Health in All Policies approach and the Task Force itself. They also provided an opportunity for people working on many different issues to meet and talk with others in their own communities, and led to broader, ongoing engagement through written and in-person public comments at SGC public meetings.

STAKEHOLDER GROUP AND KEY INFORMANT MEETINGS

Health in All Policies staff meets periodically with an informal stakeholder group of leaders from health and policy nonprofit organizations that are interested in the Health in All Policies approach and that maintain on-going engagement with local stakeholder groups in their own work to advance healthy and equitable communities. Staff also consults with experts from local health departments, community organizations, advocacy groups, academics, and others engaged in Health in All Policies efforts in the United States and abroad in order to further the work of the Task Force.

PUBLIC COMMENT AND TESTIMONY

The Task Force provides periodic progress reports to the SGC. These presentations provide an opportunity to celebrate achievements and to engage SGC members in providing additional support and guidance when needed. The SGC is subject to California law that requires state boards and commissions to publicly announce their meetings and agendas and include opportunities for public testimony and comment.

STAFFING, FACILITATION, AND RESOURCES

Task Force members devote significant time to Task Force meetings, subgroup meetings, consultation with the Health in All Policies staff team, and review of all Task Force written materials. In addition, Task Force members facilitate meetings with other staff in their departments or agencies as well as with Health in All Policies stakeholders.

The Task Force is staffed and facilitated by CDPH in partnership with the Public Health Institute. The Health in All Policies backbone staff team serves as the hub linking many concurrent projects, ensuring that the broader effort maintains coordination and momentum. To accomplish this, they develop meeting agendas, facilitate meetings, collect and compile best practices and public comments, convene public workshops, review the policy and academic literature, propose strategies for approaching tasks, and provide support for the partners engaged in implementing Health in All Policies, with continual consultation and input from Task Force members and key staff from the SGC.

EXPENSES AND RESOURCES

It is difficult to quantify the resources and expenses of the California Health in All Policies Task Force because much of the work is provided in-kind by partner agencies. The California Health in All Policies Task Force's major expenses and resources are summarized below.

Expenses.

- **Health in All Policies Task Force staff.** The current staff includes one CDPH public health medical officer who dedicates part of her time to Health in All Policies, and core staff (4.5 FTE) who are employed by the Public Health Institute. Of these, one FTE was hired through grant funding to support implementation of a specific Task Force project (healthy food procurement), while the rest address all other aspects of the Task Force's work. In-kind contributions of staff time from Task Force member agencies and the SGC are significant and vary by agency and over time. A variety of other staff at CDPH support the work of the backbone team and of the Task Force by sharing their expertise and exploring ways to align their efforts with those of the Task Force.

- **Stakeholder input workshops.** Expenses have included a professional facilitator, facility rental, food, and travel.

- **Subcontracts.** The Task Force uses subcontracts to secure input from policy experts on specific topics. For example, grant funding is allowing the Task Force to subcontract with the Local Government Commission to develop guidance materials on violence prevention through changes in the built environment.

- **Interns.** The Task Force hires two to three student interns each year to foster professional development in Health in All Policies and to support Task Force work. In 2012, the Task Force placed a summer intern in a partner agency's office, and had that intern conduct projects that involved collaboration between the host department and CDPH.

Resources.

- **California Department of Public Health.** In addition to state staff time, CDPH underwrites a portion of operational costs for the Task Force backbone staff.

- **Grants.** Primary funding for Public Health Institute backbone staff and Task Force expenses comes from The California Endowment. The Kaiser Permanente Community Benefits Foundation has also funded one staff person to implement the Task Force recommendation on healthy food procurement.

PROCESS EVALUATION OF CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE[236]

In 2012, the Public Health Institute, with funding from the American Public Health Association, hired the independent firm Harder + Company Community Research to conduct a process evaluation of the California Health in All Policies Task Force. The evaluation involved surveys and interviews of Task Force members and key stakeholders, and focused on relationships, meeting effectiveness, reasons for and barriers to continued engagement, and lessons learned about the process. Below are some highlights from the evaluation's findings.

Measuring Success

- The top three reported "elements of success" for the Task Force:

    1. **Politically and financially feasible and actionable recommendations**

    2. **Intersectoral participation**

    3. **Establishment of a high-level directive**

- Ninety percent of Task Force members indicated that the Health in All Policies collaborative process produced recommendations that will promote the goals of their own agency.

- Fifty-nine percent of Task Force members indicated that they now have greater trust in other state agencies as a result of participating in the California Health in All Policies Task Force.

- Fifty-four percent of Task Force members reported that they collaborate more with non-governmental organizations and community-based organizations as a result of the Health in All Policies process.

- Task Force members reported that the collaborative linkages and relationships established through the Health in All Policies process have fostered intersectoral collaboration on other issues, with Health in All Policies serving as a model for "effective and improved governance."

- Task Force members' motivation to stay involved was based upon the significant statewide impact and potential to improve the health of California's residents.

Learning Opportunities

- Although they were time consuming for staff, Task Force members overwhelmingly reported that one-on-one meetings with Health in All Policies staff were important for sustaining engagement, building an understanding of how agency work impacts health, and vetting ideas.

- Task Force members requested clarification of the expected time commitment and duration of participation, so that they could secure permission from their own agency leadership to engage in this work in an ongoing manner. This is especially important because there are no funds specifically to support the staff time contributed by participating agencies.

8.4 Challenges, Accomplishments, and Looking to the Future

CHALLENGES

Key challenges for California's Health in All Policies Task Force are described below.

- **Sustaining staff and other resources.** The California Health in All Policies Task Force continues to rely upon nonprofit organizations with external foundation funding to support the work of the Task Force. The California Health in All Policies Task Force does not have specific funding for the work of partner agencies, which makes it difficult to secure commitments to long-term, labor-intensive projects or processes. Each member carves out resources where they can, knowing that this work is an executive-level priority. As Health in All Policies is increasingly recognized as a successful approach for addressing complicated and interrelated issues, requests for technical assistance at the local and federal level have increased, and current resources are inadequate to meet the increasing need for this assistance.

- **No established roadmap.** Because California is the first state in the country to take this approach, there is no roadmap for how to do this kind of work, so each step is taken with heightened deliberation and scrutiny. While breaking ground is demanding, it has also made the work exciting and particularly meaningful as others look to California to share the lessons it has learned along the way.

- **Balancing implementation activities with a larger vision.** Task Force members face a continuous tension between implementing specific and feasible policy and program ideas and pursuing big picture goals such as integrating a health lens into decision-making throughout government. While it is important for any initiative to pursue both focused short-term activity and long-term planning, there is a risk that the resources required for implementation will make it difficult for the Task Force to stay focused on the big picture of embedding health and equity into decision-making processes across government.

- **Turnover in leadership and in partners.** Turnover among leaders and partners is a continual challenge for the Task Force. In 2011 a transition between gubernatorial administrations caused high turnover among agency partners. Health in All Policies Task Force staff dedicated significant time to orienting new partners and learning about their priorities—which did not always match those of their predecessors. In some cases, new agency staff were less receptive to Task Force involvement, and in other cases, new agency staff had greater enthusiasm and new ideas that needed to be incorporated into the ongoing work of the group.

- **Measuring incremental change.** The work of transforming government culture is tremendously important but can be undervalued, especially because it is difficult to measure and may take many years to achieve. Measuring the health outcomes of this work is difficult, especially because health is influenced by so many different factors. The Task Force has documented an increase in interagency trust and collaboration as a result of its work, and is achieving policy changes as well. Health and equity outcomes resulting from the Task Force's efforts are likely to take many years to become evident, and even then it may be difficult or impossible to trace them back to specific actions.

ACCOMPLISHMENTS

While its work has been challenging, the Task Force has had some notable successes, with more on the horizon. It has not only led to a cultural shift among state agencies, as described in the evaluation outcomes above, but has led to concrete changes in state policy and programs, and has spawned an awareness of and interest in intersectoral collaboration in local communities and among decision-makers and advocates across California. Many of California's successful Community Transformation Grant applications, such as San Francisco's, incorporated a Health in All Policies approach. Twelve smaller counties across California have also incorporated Health in All Policies approaches into their Community Transformation Grant work. Local jurisdictions around California are adopting formal Health in All Policies approaches, and many have expanded intersectoral collaboration as a part of their regular business practices.

California's legislature issued a joint resolution to express its support of the Health in All Policies concept and of the Health in All Policies Task Force. Issued in June 2012, Senate Concurrent Resolution 47 encourages:[237]

- Task Force members to provide leadership on implementing the recommendations put forth in the Health in All Policies Task Force Report;

- Interdepartmental collaboration with an emphasis on the complex environmental factors that contribute to poor health and inequities when developing policies in a wide variety of areas;

- Consideration of both short- and long-term health impacts, costs, and benefits, where appropriate, when weighing the merits of proposed legislation; and

- Public officials in all sectors and levels of government to recognize that health is influenced by policies related to air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, sustainable communities, and climate change, and to consider health when formulating policy.

The Health in All Policies Task Force has been named as a key partner for a number of state-level initiatives. For example, California's December 2012 *Let's Get Healthy California Task Force Final Report*, which provides a 10-year plan to make Californians healthier, lists Health in All Policies as a strategy for promoting healthier communities.[238] In addition, the Health in All Policies Task Force has been embedded within the newly established Office of Health Equity at CDPH,[239] with the recognition that achieving greater health equity is inextricably tied to the work of Health in All Policies. The Health in All Policies backbone staff are now housed within the Office of Health Equity and will be involved in developing the new Office's strategic plan.

In carrying out its implementation plans, the Task Force has seen a number of early successes. With a few exceptions, most of the early gains listed here are "low-hanging fruit" that will serve as building blocks for deeper collaboration and development of more substantial wins moving forward.

- In August 2012, the California Department of Finance executed an Interagency Agreement between the California Department of Education, the California Department of Food and Agriculture, and CDPH to develop an interagency Office of Farm to Fork, drawing resources from all three agencies. This office will promote policies and strategies to improve access to healthy, affordable food.

- The Governor's Office of Planning and Research and CDPH have partnered to identify land use strategies to expand the availability of affordable, locally grown produce. The two agencies are now integrating this information into a range of other planning programs and guidance documents.

- The Task Force hosted an orientation workshop called *Complete Streets: Designing for Pedestrian and Bicycle Safety* for staff from nine different agencies, in order to provide an opportunity for a multi-sectoral dialogue among agencies with a stake in creating "complete streets."

- The California Department of Forestry and Fire Protection worked with the Governor's Office of Planning and Research to develop a webpage that provides information for local governments to use in planning for a healthy urban forest that optimizes benefits to the environment, public health, and the economy.

- Staff from the California Department of Education, the Governor's Office of Planning and Research, the SGC, and the Task Force met to explore the linkages between health, sustainability, and school infrastructure, and to explore opportunities to promote these multiple goals through the State's General Plan Guidelines and the section of the California Code of Regulations that relates to K–12 school facilities construction and rehabilitation.

- The SGC integrated language into their Sustainable Communities Planning Grants Program to encourage regional entities applying for funding to incorporate health into their planning and decision-making processes and to partner with local health agencies.

- The Healthy Community Framework has been incorporated into programs such as the 2010 California Regional Progress Report, which provides a framework for measuring sustainability using place-based and quality-of-life regional indicators.[240]

- The SGC has funded the development of a core set of indicators to measure and monitor each of the components of the Healthy Community Framework.

- The Southern California Association of Governments has created a public health committee to support its Regional Transportation Plan, and has invited Task Force staff to serve on that committee and help the region make links to health and equity as it develops policy proposals for the upcoming plan.

LOOKING TO THE FUTURE

While the California Health in All Policies Task Force is focused on implementing its 2010 recommendations, it continues to uncover new opportunities for growth. The SGC Strategic Plan 2012-2014 leaves open the possibility of the development of a new set of Health in All Policies Task Force recommendations, and the Task Force continues to meet quarterly, with smaller multi-agency work groups focused on specific projects as needed. As relationships and trust have deepened, and as new champions have emerged in partner agencies, some topics that did not move forward in 2010 have gained traction since. For example, a newly elected superintendent of education has prioritized health promotion in schools, which has opened the doors to not only promoting physical activity, healthy food, and drinking water, but has also launched an exploration of how schools can prioritize health and sustainability when making funding decisions about infrastructure projects.

One of the priority recommendations of the Task Force is to embed health not only in programs and policies, but in government processes, by laying out a broad, voluntary process for state agencies to promote health and equity through their guidance documents, technical assistance programs, and data collection processes. In addition, the passage of the California Senate Concurrent Resolution supporting Health in All Policies opens the door for further work with the legislature on the integration of health considerations into legislative processes. Both of these could pave the way for the Task Force to make significant strides in embedding health considerations into the way that business is conducted at the state level in California. Finally, the Health in All Policies approach has resonated around the state with many local health departments and community-based organizations. A growing number of local elected bodies are exploring ways to place health considerations more squarely into the center of the policy-making process, based on the value of having a more efficient government, which in turn yields a more equitable society and a healthier, more productive population.

CONCLUSION

The public health challenges of the 21st century are extremely complex, and solutions will require actions that go beyond the purview of public health, bringing together partners across policy areas and sectors. While public health has a long history of intersectoral collaboration, Health in All Policies is an emerging approach that aims to formalize the consideration of health in decision-making at all levels of government in order to promote healthy community environments and prevent adverse health impacts in the future.

Five key elements of Health in All Policies are vital to the success of this work:

1. **Promote health and equity** by incorporating health and equity into specific policies, programs, and processes, and by embedding health and equity considerations into government decision-making processes;

2. **Support intersectoral collaboration** by bringing together partners from many sectors to recognize the links between health and other issue and policy areas, break down silos, and build new partnerships to promote health and equity and increase government efficiency;

3. **Benefit multiple partners** and simultaneously address the policy and programmatic goals of both public health and other agencies;

4. **Engage stakeholders** beyond government partners, such as community members, policy experts, advocates, the private sector, and funders; and,

5. **Create structural or procedural change** in order to fundamentally change how government works by embedding health and equity into government decision-making processes at all levels.

Health in All Policies actions and groups can take many forms, but the ultimate goal of this approach is to fundamentally change government so that agencies are aligned around a common vision for a healthy and equitable society, and so that health is considered in decision-making across sectors and policy areas. With this vision in mind, opportunities to do this work can emerge nearly anywhere. Health in All Policies can be implemented through creation of a new structure or group, or can be applied to existing processes such as strategic planning and grant-making, or both. Many options exist for how to consider health in decision-making, from using formal health impact assessment tools to an informal application of a health lens. Partners, leaders, and focus areas will vary, depending upon political support, community needs, and resources.

By their very nature, Health in All Policies initiatives will give rise to tensions between agencies on specific issues, but these tensions may be managed through relationship-building and collaborative decision-making structures. Over time, Health in All Policies can help build interagency trust and promote deeper collaboration and robust stakeholder engagement on high-stakes issues, leading to more efficient and effective governance.

This is a particularly exciting moment in public health history in the United States, as more and more attention is focused on health equity and the underlying social determinants of health. The concept of Health in All Policies is taking hold across the nation, and is being practiced under many names. This approach will evolve as more states and local governments employ this approach. There is tremendous need right now for cities, counties, and states to share their stories and help build the body of knowledge and evidence supporting Health in All Policies work. In the meantime, the authors hope this guide will help support current and future endeavors to promote healthy communities across the country.

APPENDICES

I. Glossary

ACTIVE TRANSPORTATION. Walking, biking, wheeling, and taking public transit. Public transit is considered active transportation because it generally involves an active mode at the beginning or end of the trip.

BACKBONE ORGANIZATION. Described as part of the Collective Impact Model, "backbone" organizations provide supporting infrastructure for collaborative efforts through meeting facilitation, fundraising, data collection and reporting, administration, and communications support.[241]

BUILT ENVIRONMENT. Human-made (versus natural) resources and infrastructure, including homes, schools, workplaces, roads, parks, restaurants, and grocery stores, that form the physical setting for community activities.

CO-BENEFIT. A secondary benefit arising from implementation of a policy or program that has a different primary benefit as its purpose. Health co-benefits can result when non-health policies intentionally or unintentionally impact health outcomes. A Health in All Policies approach embraces integrating efforts to address different agency goals in order to achieve "win-win" or co-beneficial solutions. For example, policies to reduce greenhouse gases may have public health co-benefits through positive impacts on air pollution, active transportation, etc. (Also see **Win-Win**)

COLLABORATION. Two or more parties or organizations working together to pursue new approaches that achieve goals that satisfy all engaged parties. In general, collaboration involves more than just an intersection of common goals, but actually working together to identify shared objectives.

COMMUNITY ENGAGEMENT. Public participation that involves dynamic relationships and promotes a mutual exchange of information, ideas, and resources between community members and public agencies in a context of partnership and reciprocity. Community engagement can include varying degrees of involvement, decision-making, and control.

COMMUNITY GREENING. Planting and managing "green" infrastructure, including trees, gardens, parks, agricultural land, and other vegetation. This term is often used interchangeably with urban greening, but is inclusive of both urban and non-urban communities.

COMMUNITY SAFETY. Community safety encompasses both the perception of safety and the implementation of strategies that protect the population from crime, violence, and injury hazards or threats. Rates of crime, violence, and preventable injury are indicators of community safety.

COMPLETE STREETS. Streets that are planned, designed, operated, and maintained to provide safe travel and access for all users, including bicyclists, pedestrians, transit riders, and motorists of all ages and abilities appropriate to the function and context of the facility.

CRIME PREVENTION THROUGH ENVIRONMENTAL DESIGN (CPTED). A method of deterring crime by creating physical environments that discourage criminal behavior and encourage healthier use of space.

DATA. The factual points of information (e.g., measurements or statistics) that are used as a basis for reasoning or calculation[242] or simply "a collection of items of information."[243] (Also see **Evidence**)

DISADVANTAGED POPULATIONS. Generally defined by economic parameters that demonstrate a low household income. More broadly, these populations result from social isolation and limited access to opportunities and resources. This cluster of factors makes it hard for members of these populations to achieve positive life outcomes. (Also see **Marginalized Groups**)

ECOSYSTEM SERVICES. The benefits to human communities from resources and processes supplied by the natural environment. Ecosystem services can be very difficult to monetize and so are often taken for granted. Examples include clean air, clean water, and wetlands that buffer coastal or riparian zones, provide habitat, and filter water flow.

EVIDENCE. Evidence can simply be "proof supporting a claim or belief."[244] For public health interventions, evidence often refers to information regarding "the effectiveness of an intervention in achieving an outcome that will create lasting changes in the health of the population."[245]

FARM-TO-FORK. A strategy to increase access to affordable healthy foods by supporting farms in production and delivery to local consumers (including individuals and organizations). This can include linking consumers directly to growers and establishing local or regional distribution systems.

GENERAL PLAN/COMPREHENSIVE PLAN. A long-term plan that includes a vision and policies for the physical development of a county or city.

GUIDANCE DOCUMENT. A written statement, often issued by a government agency, that contains instructions for meeting a set of expectations or interpreting laws or requirements.

HEALTH. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[246] Health is a fundamental component of quality of life, and a healthy population is a critical building block for a sustainable and thriving economy.

HEALTH DISPARITIES. "Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities."[247] Health disparities may result from random variation, individual biology, economic, educational, and social opportunity, social and cultural beliefs, or access to health care. Health disparities are not necessarily unfair or inequitable and may be unavoidable if changing the health determinants is impossible or ethically unacceptable.

HEALTH EQUITY. A situation in which all people have the opportunity to achieve their full health potential, with no one at a disadvantage because of socially-determined circumstances.[248] Health equity is the absence of systematic and potentially changeable differences in health (or in major social determinants of health) between socially, economically, demographically, or geographically defined populations. Achieving health equity will involve focusing societal efforts on addressing avoidable inequalities by equalizing the conditions for health for all groups, with efforts specifically placed on improving conditions for those who have experienced socioeconomic disadvantage or historical injustices.

HEALTH IMPACT ASSESSMENT (HIA). The health impact assessment process is "a systematic process that uses an array of data sources and analytic methods, and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. An HIA provides recommendations on monitoring and managing those effects."[249]

HEALTH IN ALL POLICIES (HIAP). A collaborative approach to improving health that incorporates health considerations into decision-making in all sectors and policy areas. A Health in All Policies approach convenes diverse partners to consider how their work influences health and how collaborative efforts can improve health while advancing other goals.

HEALTH INDICATOR. A measurable characteristic of an individual, population, or environment that can be used to describe its health status.

HEALTH INEQUITY. A subset of health disparities "that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity."[250]

HEALTH LENS. A systematic way of finding opportunities to improve health and embed health in decision-making. Using a health lens can involve formal (e.g., health impact assessment, South Australia's Health Lens Analysis process) or informal methods.

HEALTH OUTCOME. A change in the health status of an individual, group, or population as the result of planned or unplanned interventions rather than simply change over time. This includes intended or unintended changes resulting from government policies.

HEALTH STATUS. The National Institutes of Health defines health status as "the degree to which a person is able to function physically, emotionally, socially, with or without aid from the health care system."[251]

HEALTHY COMMUNITY. A community that embodies economic, physical, social, and service environments that are known to promote health. The California Health in All Policies Task Force defines a Healthy Community as a community that provides for the basic needs of all, quality and sustainability of environment, adequate levels of economic and social development, health and social equity, and social relationships that are supportive and respectful.

HEALTHY PUBLIC POLICY. A policy or set of policies that is explicitly responsive to health needs. It may be designed specifically to promote health or, if not dealing directly with health, have an influence on the determinants of health and, in turn, positively impact health outcomes.

INFILL. Building on, developing, or redeveloping unused, vacant, and underutilized urban or largely developed areas.

INTERDEPENDENCE. A relationship between individuals, communities, or individuals and the communities in which they live, such that each is mutually reliant upon and responsible for the other. Local, state, national, and global public health initiatives and their societal and political contexts are interdependent. Interdependence between people is the essence of community.

INTERSECTORAL COLLABORATION. A recognized relationship—ranging from a formal agreement to an ad hoc group—between different sectors of society working together in a way that can improve outcomes more effectively, efficiently, or sustainably than when working independently from one another.

MARGINALIZED GROUPS. Groups of people who are generally not considered or included in important processes, and are often discriminated against, face greater inequalities, and are deprived of inclusion and access to resources due to factors beyond their control.

METROPOLITAN PLANNING ORGANIZATIONS (MPO). A federally defined regional council of governments within a metropolitan area that is authorized to develop a Metropolitan Transportation Plan/Regional Transportation Plan.

METROPOLITAN TRANSPORTATION PLAN (MTP)/ REGIONAL TRANSPORTATION PLAN (RTP). Metropolitan Planning Organizations (MPOs) are required by federal law to produce a MTP, also known as an RTP. The RTP is a process that MPOs embark on every four to five years to identify how a region will spend transportation revenue over the next 25 years.

MOBILITY. The ability of an individual to physically move freely and easily.

MONITORING. Performing routine measurements with the goal of detecting environmental, health, or other status changes.

POLICY. An agreement on issues, goals or a course of action by the people with power to carry it out and enforce it.[252,253]

PUBLIC POLICY. A course of action adopted and pursued by governments in response to a perceived problem. Laws, regulations, decisions, funding priorities, and other actions of government express public policy. Public policies are implemented and enforced by public agencies.

PROGRAM. An organized set of procedures, routines, or activities, usually to achieve a specific goal or policy objective.

ROOT CAUSE MAPPING. A structured process for identifying key factors contributing to community health problems in order to identify methods for correcting or eliminating these underlying factors and promoting improved outcomes. This can be useful for identifying leverage points and helping agencies outside the public health field discover links to health and each other's work.

SMART GROWTH. A theory of transportation and land use planning that concentrates growth, avoids sprawl, and promotes a mixture of land uses in order to serve a community's economic, health, environmental, and social needs.

SOCIAL DETERMINANTS OF HEALTH. The biological, behavioral, economic, physical, environmental, and political factors that shape the health of individuals, communities, and jurisdictions.

STAKEHOLDERS. The individuals, groups, or organizations with an interest in a project, policy, or program but who are not already partners in a process. This can include those with decision-making authority, funders, clients, the public, community-based organizations, advocacy groups, local agencies, academic experts, or public health practitioners. In many contexts this implies non-governmental parties; in state processes this can include local governments.

SUSTAINABILITY. Creating and maintaining conditions so that humans can fulfill social, economic, and other requirements of the present without compromising the ability of future generations to meet their own needs. This can be thought of in terms of environmental, economic, and social impacts, and encompasses the concept of stewardship and the responsible management of resources.

TRANSIT-ORIENTED DEVELOPMENT. Compact, mixed-use development (including housing, offices, retail, and other amenities) that supports active transportation and is located near public transportation facilities or corridors.

VULNERABILITY. The degree to which an individual or group of people are susceptible to harm. In public health, this term is commonly used in the fields of disaster response and climate change adaptation, but can also apply to the broader social determinants of health. Vulnerability of individuals and populations to injury or chronic disease can vary as a result of socioeconomic status, social cohesion, gender, health, age, and other factors. Differences in vulnerability can often be attributed to social or health inequities.

WHOLE-OF-GOVERNMENT. Includes public agencies "working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues."[254]

WIN-WIN. A solution that is satisfactory or guarantees a favorable outcome for all parties. This may be an outcome with one benefit for all parties, or may have multiple benefits. A Health in All Policies approach seeks to find win-win solutions. (Also see **Co-benefit**).

II. Definitions of Health in All Policies

"Health in All Policies is a collaborative approach that integrates and articulates health considerations into policy making across sectors, and at all levels, to improve the health of all communities and people."
- Association of State and Territorial Health Officers (ASTHO)[255]

"Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas."
- California Health in All Policies Task Force

"Health in All Policies is the policy practice of including, integrating or internalizing health in other policies that shape or influence the [Social Determinants of Health (SDoH)]… Health in All Policies is a policy practice adopted by leaders and policymakers to integrate consideration of health, well-being and equity during the development, implementation and evaluation of policies."
- European Observatory on Health Systems and Policies[256]

"Health in All Policies is an innovative, systems change approach to the processes through which policies are created and implemented."
- National Association of County and City Health Officials (NACCHO)[257]

"Health in All Policies aims to improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors' core goals."
- South Australia[258]

III. South Australia's 10 Health in All Policies Principles[259]

A Health in All Policies approach reflects health as a shared goal across government. In particular it:

1. Recognizes 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. Recognizes 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. Recognizes 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. Recognizes that health is central to achieving the objectives of South Australia's 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. Recognizes that indicators of success will be equally long-term and that regular monitoring and intermediate measures of progress will need to be established and reported back to South Australian citizens.

9. Recognizes the need to regularly consult with citizens to link policy changes with wider social and cultural changes around health and wellbeing.

10. Recognizes the potential of partnerships for policy implementation between government levels, science and academia, business, professional organizations and non-governmental organizations to bring about sustained change.

IV. Annotated References

Part I. What is Health in All Policies and Why Do We Need It?

SECTION 1: BACKGROUND

1.1   WHAT IS HEALTH IN ALL POLICIES?

Environmental HiAP Toolkit. *National Association of City & County Health Officials. Available at: http://www.naccho.org/toolbox/program.cfm?id=32&display_name=Environmental Health in All Policies (HiAP)*
This toolkit includes a searchable database of tools and resources on Health in All Policies and environmental health policy to help raise awareness and to educate local decision-makers.

Health in All Policies: Strategies to promote innovative leadership. *Association of State and Territorial Health Officials. (January 2013). Available at: http://www.astho.org/Programs/Prevention/Implementing-the-National-Prevention-Strategy/HiAP-Toolkit/*
This document provides a description of the National Prevention Strategy, key talking points to explain a Health in All Policies approach, characteristics of successful intersectoral collaboration, and case studies of states uses Health in All Policies approaches.

Implementing Health in All Policies, Adelaide 2010. *Kickbusch, I., & Buckett, K. (Eds). (2010). Rundle Mall, South Australia: Government of South Australia, Department of Health. Available at: http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf*
This document summarizes the establishment of Health in All Policies in South Australia, reviews other international Health in All Policies examples, discusses theoretical frameworks and methodological perspectives, and provides case studies describing how Health in All Policies has been utilized in projects throughout South Australia.

1.2   WHY WE NEED HEALTH IN ALL POLICIES

A framework for public health action: The health impact pyramid. *Friedan, T.R. (2010, April). American Journal of Public Health, 100(4), 590–595.*
This article uses a 5-tier pyramid to describe the range of intervention necessary for maximum public health benefit. This model shows that interventions focusing on the social determinants of health reach broader segments of society than clinical interventions.

America's tomorrow: Equity is the superior growth model. *Treuhaft, S., Blackwell, A.G., & Pastor, M. (2011). Oakland, CA: PolicyLink, University of Southern California's Program for Environmental and Regional Equity. Available at: http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/ SUMMIT_FRAMING_WEB_FINAL_20120127.PDF*
This report makes the case that achieving equity is of vital importance to the nation's economic recovery and economic future, and frames equity as the new economic growth model. The authors highlight the opportunity to leverage the United States' growing racial and ethnic diversity as a competitive asset in the face of current workforce challenges.

Closing the gap in a generation: Health equity through action on the social determinants of health (Final Report of the Commission on Social Determinants of Health). *Commission on Social Determinants of Health. (2008). Geneva: World Health Organization. Available at: http://whqlibdoc.who.int/ publications/2008/9789241563703_eng.pdf*
This report calls for global action from the World Health Organization and all governments to close health inequity gaps in the timespan of a generation. The Commission sets forth three overarching recommendations and three principles of action to achieve this goal.

Overcoming obstacles to health. *Robert Wood Johnson Foundation, Commission to Build a Healthier America. (2008, February). Princeton, NJ. Available at: http://www.commissiononhealth.org/report. aspx?publication=26244*
This report provides data and discussion on social differences in health in the United States, including affected populations and associated costs. This report analyzes the role of social factors in the causal pathway of health disparities, emphasizes the transmission of health across generations, and provides guidance on finding solutions to reduce current health disparities.

Promoting health equity: A resource to help communities address social determinants of health.
Brennan Ramirez, L.K., Baker, E.A., & Metzler, M. (2008). Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/ healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf
This workbook provides nine case studies of communities working to achieve health equity, as well as step-by-step guidance for readers on how to start, evaluate, and maintain a social determinants of health inequities initiative.

Roots of health inequity: An online learning collaborative. *National Association of County and City Public Health Officials (NACCHO). (2012). Available at: http://www.rootsofhealthinequity.org*
This online course allows participants to explore how to address health inequities. Key topics include public health history, root causes of health inequities, principles of social justice, where to start working, and how framing works. Content allows for group-directed learning and includes interactive media, case studies, readings, and presentations.

The spectrum of prevention: Developing a comprehensive approach to injury prevention. *Cohen, L., & Swift, S. (1999). Injury Prevention, 5, 203–207.*
This article proposes a framework to support multi-faceted approaches to injury prevention that can help public health practitioners move beyond a focus on education interventions. The authors show the importance of working across a spectrum of prevention in order to meet public health prevention goals.

The spirit level: Why greater equality makes society stronger. Wilkinson, R., & Pickett, K. (2009). New York, NY: Bloomsbury Press.
This book argues that the income gap between a nation's richest and poorest is the strongest predictor of the functioning and health of a society. The authors prioritize the need for societies to achieve equality, and argue that both government redistribution of wealth and market forces can be effective in closing equality gaps.

Unnatural causes: Is inequality making us sick? Adelman, L. (Creator and Executive Producer). (2008). California: California Newsreel. Available at: http://www.unnaturalcauses.org
This four-hour, seven-part documentary series highlights the root causes of socioeconomic and racial inequities in health. A discussion guide contains pre- and post-viewing activities, comprehension and discussion questions, and suggested follow-up actions for participants.

Why place matters: Building a movement for healthy communities. Bell, J., & Rubin, V. (2007). Oakland, CA: PolicyLink. Available at: http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/WHYPLACEMATTERS_FINAL.PDF
This report establishes a framework for understanding the relationship between community conditions (class, race, ethnicity, neighborhood segregation, and the economic, social, physical, and service environments) and health. It provides case studies of how communities have addressed health disparities and includes fourteen recommendations for moving forward.

1.3   WHAT IS A HEALTHY COMMUNITY?

Beyond health care: New directions to a healthier America. Robert Wood Johnson Foundation, Commission to Build a Healthier America. (2009, April). Princeton, NJ. Available at: http://www.commissiononhealth.org/Report.aspx?Publication=64498
This report sets forth ten recommendations for building healthier communities, including action steps that community groups, schools, employers, businesses, health care providers, philanthropic organizations, and government entities can take.

1.5   A BRIEF HISTORY OF HEALTH IN ALL POLICIES

The items in this section are listed in chronological order and correspond to the timeline on page 19.

Declaration of Alma-Ata. World Health Organization. (1978, September 6-12). Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR. Available at: http://www.who.int/publications/almaata_declaration_en.pdf
The Declaration of Alma-Ata is frequently cited as the first acknowledgment of the importance of intersectoral action for health. The declaration states that both health services and efforts to engage other sectors in the social, economic, and political determinants of health are required to achieve significant health gains.

The Ottawa Charter for health promotion. World Health Organization. (1986, November 21). Adopted at the First International Conference on Health Promotion, Ottawa, Canada. Available at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
This document introduced "healthy public policies" as a key area for health promotion, calling for other sectors to invest in health and directing policymakers in all sectors to consider the health and equity impacts of their decisions.

[Health policies towards the year 2000: National health plan]. Nasjonal helseplan. Norway Ministry of Health and Care Services. (1987). Helsepolitikken mot år 2000. No 41, 1987/88. Oslo: Sosialdepartementet [in Norwegian]. (As cited in: St-Pierre, L. (2009). Governance tools and framework for Health in All Policies. National Collaborating Centre for Healthy Public Policy. Available at: http://rvz.net/uploads/docs/Achtergrondstudie_-_Governance_tools_and_framework.pdf
This white paper issued by the Norwegian health services administration in 1987, as discussed in St-Pierre, recognizes the merit of including health in all public policies.

Adelaide recommendations on healthy public policy. World Health Organization. (1988, April 5-9). Adopted at the Second International Conference on Health Promotion, Adelaide, South Australia. Available at: http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index1.html
This set of recommendations highlights the influence of non-health sectors' policies on health and calls for a political commitment to health by all sectors.

The New Zealand health strategy. New Zealand Ministry of Health. (2000, December). Wellington, NZ: Ministry of Health. Available at: http://www.health.govt.nz/publication/new-zealand-health-strategy. New Zealand's National Health Strategy presents intersectoral action as an essential lever for improving health and reducing health inequalities, both across sectors and within local government and community groups. This document serves as a map for developing healthy public policies and action plans in a coordinated way.

Public Health Act, R.S.Q. 2001, c. S-2.2. (Quebec, Canada). Available at: http://www.canlii.org/en/qc/laws/stat/rsq-c-s-2.2/latest/rsq-c-s-2.2.html
Quebec's Public Health Act of 2001 requires that government departments and agencies in Quebec collaborate with the Department of Health and Social Services to ensure the measures they enforce have no harmful effects on population health.

Public Health Objective Bill (Government Bill 2002/03:35). (Sweden) [in Swedish]. (As cited in: Hogstedt, C., Lundgren, B., Moberg, H., Pettersson, B., & Agren, G. (2004). The Swedish public health policy and the National Institute of Public Health. Scandinavian Journal of Public Health, Supplement, 64, 6–64.)
With the aim of creating the societal conditions that guarantee an equal level of health for the entire population, the Swedish National Public Health Policy of 2003 declared a focus on the social determinants of health and intersectoral public health partnerships.

Health in All Policies: Prospects and potentials. *(2006). Stahl, T., Wismar, M., Ollila, E., Lahtinen, E., and Leppo, K., eds. Finland: Finnish Ministry of Social Affairs and Health. Available at:* http://www.euro.who.int/__data/assets/pdf_file/0003/109146/E89260.pdf
Recognizing increasing wealth inequality and the connections between health and economics, the 2006 Finnish Presidency of the European Union highlighted the social determinants of health as its priority and supported implementation of the Health in All Policies approach throughout the European Union.

South Australia's Strategic Plan…through a health lens. *(2007). Department of the Premier and Cabinet. Adelaide: Government of South Australia. Available at:* http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/458/$FILE/458%20-%20O%20-%20SA%20Health%20-%20SASP%20...through%20a%20health%20lens.pdf
The South Australian government engaged a wide spectrum of governmental partners to apply a health lens to the South Australia Strategic Plan. This paper examines the health outcomes of the six interrelated objectives of the Strategic Plan, highlighting the evidence-based linkages between health and policies in "non-health" sectors.

National Health Act, B.E. 2550. *(2007) (Thailand). Available at:* http://en.nationalhealth.or.th/node/123
The Thai National Health Act allows residents to require a health impact assessment (HIA) be conducted of any project that could seriously impact environmental quality, natural resources, or community health. Further, the Act allows community participation in the HIA process and mandates the development of HIA guidelines for the National Health Committee.

Partnership for Sustainable Communities*. Department of Housing and Urban Development, Department of Transportation, and Environmental Protection Agency. Available at:* http://www.sustainablecommunities.gov
The Partnership for Sustainable Communities is a collaborative effort of the U.S. Department of Housing and Urban Development, the U.S. Department of Transportation, and the U.S. Environmental Protection Agency to help incorporate six livability principles into federal housing, transportation, water, and other infrastructure investments. This website provides resources for local communities interested in creating prosperous neighborhoods that protect the environment.

Council conclusions on Health in All Policies (HiAP). *Council of the European Union. (2006, November 30-December 1). Adopted at the 2767th Employment, Social Policy, Health, & Consumer Affairs Council Meeting, Brussels. Available at:* http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91929.pdf
This document invited the European Parliament to consider health impacts of decisions across all sectors.

National Prevention, Health Promotion, and Public Health Council. *U.S. Department of Health and Human Services, National Prevention Council. Office of the Surgeon General. Available at:* http://www.surgeongeneral.gov/initiatives/prevention/about/index.html
Created in 2010 by the Affordable Care Act, this intersectoral Council provides leadership at the federal level to advance prevention, wellness, and health promotion by coordinating all executive departments and agencies in the United States. In 2011, the National Prevention Strategy was released, followed by the National Prevention Plan in 2012.

Adelaide statement on Health in All Policies: Moving towards a shared governance for health and well-being: Report from the International Meeting on Health in All Policies, Adelaide 2010. *World Health Organization & Government of South Australia. (2010). Available at: http://www.who.int/social_ determinants/hiap_statement_who_sa_final.pdf*
The Adelaide Statement provides an overview of the Health in All Policies approach, discusses the role of health in social, economic, and environmental development, and calls upon leaders from all levels of government to take action.

For the public's health: Revitalizing law and policy to meet new challenges. *Institute of Medicine, Committee on Public Health Strategies to Improve Health. (2012). Washington, DC: The National Academies Press. Available at: http://www.iom.edu/Reports/2011/For-the-Publics-Health-Revitalizing-Law-and-Policy-to-Meet-New-Challenges.aspx*
This report recommends that federal and state governments utilize a Health in All Policies approach to consider the health impacts of policy, legislation, and regulation implementation.

Rio political declaration on social determinants of health. *World Health Organization. (2011, October 19-21). Adopted at the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil. Available at: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf*
The World Health Organization's Rio Political Declaration on Social Determinants of Health affirmed Health in All Policies' legitimacy as an approach to increase both accountability among other sectors for health and guide the development of inclusive, productive, and equitable societies.

Part II. The Nuts and Bolts of Health in All Policies

SECTION 2: GETTING STARTED

2.1   FINDING OPPORTUNITIES FOR CHANGE

Intersectoral action on health: A path for policy-makers to implement effective and sustainable action on health. *World Health Organization, The WHO Centre for Health Development. (2011). Kobe, Japan. Available at: http://www.who.int/entity/kobe_centre/publications/ISA-booklet_WKC-AUG2011.pdf* This document presents ten steps which policymakers can take to promote intersectoral health initiatives and includes several international examples of intersectoral action on health as well as a review of lessons learned in using this approach.

Partners for public health: Working with local, state, and federal agencies to create healthier communities. *Bay Area Regional Health Inequities Initiative, Public Health Law & Policy. Available at: http://www.barhii.org/resources/downloads/partners_for_public_health.pdf* This guide provides information about the public agencies that make policy decisions and implement projects related to physical environments that affect health. It includes information on each agency's structure, decision-making process, and oversight and accountability at local, regional, state, and federal levels.

2.2   EXPLORING THE BENEFITS OF COLLABORATION

Collaboration Multiplier. *Prevention Institute. (2011, July). Oakland, CA. Available at: http://www. preventioninstitute.org/component/ jlibrary/article/download/id-686/127.html* The Prevention Institute collaboration multiplier worksheets can be used to identify common goals within an intersectoral collaboration and see how each party's expertise and resources can be leveraged to achieve those goals.

SECTION 3: PARTNERS AND ROLES

3.1   GOVERNMENTAL PARTNERS, FACILITATORS, AND BACKBONE STAFF

Health in All Policies across jurisdictions: A snapshot from Sweden. *Pettersson, B. (2010, July). Public Health Bulletin South Australia. 7(2), 17-20. Available at: http://www.health.sa.gov.au/pehs/publications/ publichealthbulletin-pehs-sahealth-1007.pdf* This article discusses the "across-government" approach adopted by Sweden following the passage of a policy aimed at addressing the determinants of health. In addition to providing a case study of Sweden's experience, this article also discusses some of the key lessons learned from collaborating across government sectors to address social determinants of health.

3.2   ENGAGING STAKEHOLDERS

Community engagement in public health. *Morgan, M.A., & Lifshay, J. (2006, March). Martinez, CA: Contra Costa Health Services, Public Health Division. Available at: www.barhii.org/resources/downloads/community_engagement.pdf*
This brief article provides an introduction to the Contra Costa Health Services experience with community engagement and offers a framework for planning and implementing community engagement approaches.

Community organizing handbook. *Whitcher, J., Coyne, F., McCauley, S., & Rauenhorst, S. (2009-2010). Denver, CO: University of Denver, Center for Community Engagement & Service Learning. Available at: http://www.du.edu/ccesl/media/documents/community_handbook.pdf*
This handbook on community engagement provides a section on relationship-building that covers one-on-one relational interviews, self-interest assessment, and making contact with stakeholders.

International Association for Public Participation. *Available at: http://www.iap2.org*
International Association for Public Participation (IAP2) provides technical assistance to improve public participation within governments, institutions, and other entities that affect public interest in nations throughout the world.

Public Engagement Program. *Institute for Local Government. Available at: http://www.ca-ilg.org/public-engagement*
The Institute for Local Government offers resources for partnering with youth and immigrant populations, developing community leadership, and building sustained engagement at the local level.

SECTION 4: WORKING TOGETHER ACROSS SECTORS

4.1   THE SPECTRUM OF COLLABORATION

A Health in All Policies approach to large-scale redevelopment: The Fort McPherson BRAC case study. *Georgia State University, Georgia Health Policy Center. Atlanta, GA. Available at: http://aysps.gsu.edu/sites/default/files/documents/The_Fort_McPherson_BRAC_Case_Study.pdf*
As part of a case study on redevelopment at a former Army base, the Georgia Health Policy Center describes a spectrum within which Health in All Policies can occur.

A review of collaborative partnerships as a strategy for improving community health. *Roussos, S.T., & Fawcett, S.B. (2000). Annual Review of Public Health. 21: 369-402.*
This article defines "collaborative partnership" and reviews evidence for the effects of collaborative partnerships on community and systems change, community-wide behavior change, and population-level health outcomes. The article discusses conditions that affect effective collaboration and suggests research and practice recommendations for improving community health.

National Network for Collaboration Framework. *Bergstrom, A., Clark, R., Hogue, T., Iyechad, T., Miller, J., Mullen, S., & Perkins, D…Thurston, F. (1995). Collaboration framework: Addressing community capacity. Available at: http://www.uvm.edu/extension/community/nnco/collab/framework.html*
This document describes a framework for collaboration and clarifies process and contextual factors that can promote or inhibit effectiveness. The *Levels of Collaboration* scale, based on the work of other collaboration researchers, measures progress over five stages of collaboration: networking, cooperation/alliance, coordination/partnership, coalition, and collaboration.

Resources for Learning Circle Five. *National Resource Center for Permanency and Family Connections. Available at: http://www.hunter.cuny.edu/socwork/nrcfcpp/pass/learning-circles/five/LearningCircleFiveResources.pdf*
This short piece provides definitions, descriptions, and discussions of collaboration, and links to additional resources that support collaborative efforts.

Understanding the spectrum of collaborative governance practices. *Carlson, C. In A Practical Guide to Collaborative Governance (pp. 9-11). Policy Consensus Initiative & National Policy Consensus Center. Available at: http://www.policyconsensus.org/publications/practicalguide/collaborative_spectrum.pdf*
This publication is intended for government actors interested in collaborating with community members to improve policy and governance. The excerpt available on their website explores various levels of engagement with the community, and begins to outline the components of collaborative decision-making. The full guide provides instructions and tips on each phase of the collaboration process.

4.2 TIPS FOR BUILDING INTERSECTORAL RELATIONSHIPS

Collective Impact. *Kania, J., & Kramer M. (2011, Winter). Stanford Social Innovation Review. 9(1). Available at: http://www.ssireview.org/articles/entry/collective_impact,* and **Channeling change: Making collective impact work.** *Hanleybrown, F., Kania, J., & Kramer, M. (2011, January 26). Stanford Social Innovation Review Blog. Available at: http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work*
The authors argue that large-scale social change requires the "collective impact" of a group of actors from different sectors, rather than the "isolated impact" of one organization. Both articles describe the conditions under which a collective impact initiative is most likely to thrive. The Hanleybrown et al. article focuses specifically on how to begin an initiative, sustain it, and create alignment.

The Community Tool Box. *University of Kansas, Work Group for Community Health and Development. (2012). Available at: http://ctb.ku.edu/*
This resource contains a broad range of information for building healthy communities, including information on developing group facilitation skills, problem solving, and securing financial resources.

4.3 DECISION-MAKING

Facilitator's guide to participatory decision-making (2nd ed.). *Kaner, S., Lind, L., Toldi, C., Fisk, S., & Berger, D. (2007). San Francisco, CA: Jossey-Bass.*
This book provides tools, training, and tips for group leaders on the dynamics and processes of group decision-making, group process skills, agenda design, and discussion techniques. It also provides guidance on how to convene multiple stakeholder teams.

SECTION 5: STRUCTURES TO SUPPORT HEALTH IN ALL POLICIES

5.1 EMBEDDING HEALTH INTO GOVERNMENT PRACTICES

Stepping it up: Moving the focus from health care in Canada to a healthier Canada. *Health Council of Canada. (2010). Toronto, ON. Available at: http://www.healthcouncilcanada.ca/rpt_det.php?id=162*
This report reviews federal and provincial government efforts in Canada to address the social determinants of health. It describes various strategies that have been used, discusses intersectoral approaches to improving health, and provides a summary of recommendations set forth by the Canadian Senate.

Health in All Policies: An EU literature review 2006-2011 and interview with key stakeholders. *Howard, R. & Gunther, S. (2012, May). Equity Action. Available at:http://www.equitychannel.net/uploads/HiAP%20%20 Final%20Report%20May%202012.pdf*
This report identifies opportunities and barriers for implementation of Health in All Policies and identifies key themes and tips for improving future implementation.

5.2 STRUCTURE AND FORMALITY

Getting agencies to work together: The practice and theory of managerial craftsmanship. *Bardach, E. (1998). Washington, D.C.: Brookings Institution Press.*
Using diverse policy areas as examples, this book diagnoses difficulties of collaboration between government agencies, explains how they are sometimes overcome, and introduces ideas for public managers, advocates, and others interested in developing interagency collaborative networks.

Intersectoral governance for Health in All Policies. *(2012). McQueen, D. V., Wismar, M., Lin, V., Jones, C. M., & Davies, M. (Eds.). Copenhagen, Denmark: European Observatory on Health Systems and Policies, World Health Organization. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/171707/ Intersectoral-governance-for-health-in-all-policies.pdf*
This book provides an overview of structures used internationally to support Health in All Policies, including case studies of Health in All Policies initiatives.

Moving forward to equity in health: Partnership and intersectoral action conference working document. *Solar, O., Valentine, N., Rice, M., & Albrecht, D. (2009). Presented at the 7th Global Conference on Health Promotion, Nairobi, Kenya: World Health Organization. Available at: http://www.gchp7.info/ resources/downloads/t4.pdf*
This document establishes a political and technical basis for intersectoral action in global development strategies. It includes a discussion of the relationship between health and other sectors, the vision of health and society that supports health and health action, and the mechanisms for implementing intersectoral work at all government levels.

5.3   RESOURCES

Foundation Center. *Available at: http://foundationcenter.org*
The Foundation Center provides information on philanthropy through five regional library/learning centers and a network of more than 450 Cooperating Collections, where free local access to resources and trainings can be found. They provide training courses (both online and in the classroom), self-paced courses, tutorials, and webinars. They also maintain a database of grantmakers and their grants.

Grants.gov. *Available at: http://grants.gov/*
This is the main website to find and apply for federal grants. Those interested can subscribe to the site and receive daily notifications of new grant opportunities.

SECTION 6: CREATING HEALTHY PUBLIC POLICY

6.1   CHOOSING WHAT TO WORK ON AND IDENTIFYING POTENTIAL SOLUTIONS

A practical guide for policy analysis: The eightfold path to more effective problem solving (2nd ed.).
Bardach, E. (2000). Washington, DC: CQ Press.
This book provides an overview of the steps involved in policy analysis, laying out Bardach's frequently-used "Eightfold Path." It also provides an overview of government responsibilities.

Action strategies toolkit: A guide for local and state leaders working to create healthy communities and prevent childhood obesity. *Robert Wood Johnson Foundation, Leadership for Healthy Communities. (2009). Princeton, NJ. Available at: www.rwjf.org/pr/product.jsp?id=42514*
This guide introduces evidence-based policy options in the areas of healthy eating, active living, and the built environment. It sets forth a series of recommendations under each topic area and identifies potential stakeholders, existing policies and programs, ways to get started, and helpful resources.

Beyond the USDA: How other government agencies can support a healthier, more sustainable food system. *Gosselin, M. (2010, February). Minneapolis, MN: Institute for Agriculture and Trade Policy. Available at: http://www.iatp.org/files/258_2_107172.pdf*
This report summarizes the various roles that key federal agencies—other than the U.S. Department of Agriculture—can play in America's food system. The report lists important grant programs, resources, and ideas for policy changes. The report also includes examples of specific issue areas and the entities that influence them.

Condensed list of collected recommendations: Health in All Policies Task Force report to the Strategic Growth Council, Appendix 3. *California's Health in All Policies Task Force. (2010, December 3). Available at: http://sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf*
In developing a final list of recommendations, the California Health in All Policies Task Force collected over 1,200 suggestions from Task Force members, stakeholder input workshops, public comment, key informant interviews, and documents submitted to the Task Force. This appendix to the Task Force's 2010 report contains a condensed list of approximately 600 recommendations sorted by topic area.

ENACT local policy database. *Prevention Institute, Strategic Alliance for Healthy Food and Activity Environments. Available at: http://eatbettermovemore.org/sa/policies*
This online database catalogs promising policies in nutrition and physical activity to provide examples of local policies that have been tried and adopted.

General plans and zoning: A toolkit for building healthy, vibrant communities. *Feldstein, L. M., ChangeLab Solutions. (2007). Sacramento, CA: California Department of Health Services. Available at: http://changelabsolutions.org/sites/default/files/documents/finalbook.pdf*
This toolkit is designed for public health professionals to provide a basic introduction to how land use decisions are made and the methods for influencing and participating in those decisions.

Getting to smart growth: 100 policies for implementation. *Smart Growth Network. (2005). Available at: http://www.smartgrowth.org/pdf/gettosg.pdf*
This report describes techniques that policymakers can use to put smart growth principles into practice. The report presents successful policies and guidelines in the United States, ranging from formal legislative or regulatory efforts to informal approaches, plans, and programs. Ten smart growth principles are described, and each principle is accompanied by a series of practice tips and specific policy examples.

Making connections: Developing a food system for a healthier New York State. *New York State Council on Food Policy. (2009, December). Available at: http://www.nyscfp.org/docs/NYS_CFP_Final_Report_2009.pdf*
This report provides a list of food system recommendations for New York State, in the areas of: maximizing participation in food and nutrition assistance programs, strengthening the connection between local food and consumers, supporting efficient and profitable food production and retail food infrastructure, increasing consumer awareness and knowledge about healthy eating, and improving consumer access to safe and nutritious food.

Nutrition and physical activity: A policy resource guide. *Lamson, E., & Colman, V. (2005, February). Olympia, WA: Washington State Department of Health, Office of Community Wellness and Prevention, Chronic Disease Prevention and Risk Reduction. Available at: http://www.doh.wa.gov/portals/1/Documents/Pubs/345-239-PolicyResourceGuide.pdf*
This comprehensive guide can help groups develop nutrition and physical activity policies at state, local, and private jurisdictions. Evidence of policy effectiveness is provided when possible.

The guide to community preventive services: What works to promote health. *Community Preventive Services Task Force. (2012). Available at: http://www.thecommunityguide.org*
This online tool contains systematic reviews of program and policy interventions that have been proven to be effective, including whether interventions are right for particular communities, possible related costs, and likely return on investment.

6.2   LOOKING THROUGH A HEALTH AND EQUITY LENS

A guide for health impact assessment. *Bhatia, R. (2010, October). California Department of Public Health. Available at:* http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/HIA%20Guide%20FINAL%2010-19-10.pdf

This guide provides background on health impact assessment, outlines key steps, activities, and issues that may be faced, and identifies additional resources for health impact assessment.

A health impact assessment toolkit: A handbook to conducting HIA (3rd ed.). *Human Impact Partners. (2011, February). Oakland, CA. Available at:* http://www.humanimpact.org/component/jdownloads/finish/11/81

This toolkit provides hands-on tools for organizations interested in conducting a Health Impact Assessment (HIA). In addition to describing the steps of the actual HIA process, it provides guidance on how to decide whether an HIA is appropriate, how to determine the scope and management of a HIA, and how to collaborate with stakeholders during the process.

Health Economic Assessment Tools (HEAT) for walking and for cycling. *World Health Organization, Transport, Health and Environment Pan-European Programme. (2011). Available at:* www.heatwalkingcycling.org
This online tool allows users to estimate the economic savings from mortality reductions that result from regular walking or bicycling.

Health impact assessment: A tool for promoting health in all policies. *Gottlieb, L., Egerter, S., & Braveman, P. (2011, May). Princeton, NJ: Robert Wood Johnson Foundation. Available at:* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70449

This document provides a brief overview of health impact assessment, with examples of how it has been used and how it can support Health in All Policies. It also provides brief examples of how health impact assessment has been used in the United States.

Minimum elements and practice standards for health impact assessment (Version 2). *North American HIA Practice Standards Working Group. (Bhatia, R., Branscomb, J., Farhang, L., Lee, M., Orenstein, M., & Richardson, M.). (2010, November). Oakland, CA. Available at:* http://www.humanimpact.org/doc-lib/finish/11/9

This reference document gives guidance on health impact assessment (HIA) from two angles: 1) standards on the "minimum elements" that an HIA must include and 2) practice standards that help to "best conduct" an HIA.

Racial equity impact assessment toolkit. *Keleher, T. (2009). Applied Research Center. Available at:* http://www.arc.org/content/view/744/167/

This toolkit discusses a method for identifying how racial and ethnic groups are likely to be differentially impacted by decisions or proposed policies, including questions that can be used to consider potential racial equity impacts of proposed actions.

Rapid Assessment Tool for small-area health needs. *Dunn, J. (2009). Toronto, Canada: Center for Research on Inner City Health, St. Joseph's Health Centre. Available at:* http://www.stmichaelshospital.com/crich/reports/rapid-assessment-tool/

This tool can be used for assessing small-area health status and health needs. Also available is a presentation that describes tool development and a case study of its use.

South Australia's Strategic Plan…through a health lens. *Government of South Australia, Department of the Premier and Cabinet. (2007). Presented at the Health in All Policies conference, Adelaide, South Australia. Available at:* http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/458/$FILE/458%20-%20O%20-%20SA%20Health%20-%20SASP%20...through%20a%20health%20lens.pdf

This document illustrates how a health lens was applied to a number of target areas in the South Australia Strategic Plan, including volunteering, broadband usage, and a sustainable water supply.

Urban Health Equity Assessment and Response Tool (Urban HEART). *World Health Organization, Centre for Health Development. (2010). Available at:* http://www.who.int/kobe_centre/measuring/urbanheart/en/

Urban HEART is a tool to help people and organizations identify and analyze health inequities, find the evidence to support particular interventions, and think about health in the policy-making process.

6.3   EVIDENCE AND DATA

County health rankings & roadmaps. *Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute. Available at:* http://www.countyhealthrankings.org

This interactive website showcases rankings that assess the overall health of almost all counties in the United States. The rankings consider health behavior, clinical care, social and economic factors, and physical environment.

Sustainable Communities Index. *San Francisco Department of Public Health, Environmental Health Section's Program on Health, Equity, and Sustainability. (2012). Available at:* http://www.sustainablesf.org

The Sustainable Communities Index (formerly known as the Healthy Development Measurement Tool) is a set of indicators identified by the City of San Francisco as important components of a healthy city. The indicators span a variety of topics related to the physical, social, and economic environments of a city. The site provides a step-by-step guide to users on how the Index can be used to assess community health, gives guidance on potential policy initiatives to achieve objectives, and includes links to further resources on applying the Index.

The Campbell Collaboration. *Available at:* www.campbellcollaboration.org

The Campbell Collaboration specializes in producing systematic reviews of social interventions in crime and justice, education, international development, and social welfare, including both international and unpublished research. The Collaboration's Resource Center provides training materials and links to additional tools for practitioners searching for evidence-based interventions.

The Cochrane Collaboration. *Available at:* www.cochrane.org

The Cochrane Collaboration is dedicated to publishing systematic reviews of health care and health policy interventions. These reviews help health care providers and consumers identify effective, evidence-based ways to improve health, and span a broad range of interventions, including health education, policy initiatives, and community-based programs.

6.4   EVALUATING OUR COLLABORATIVE EFFORTS

Developing an effective evaluation plan. (2011). Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; Division of Nutrition, Physical Activity, and Obesity. Available at: http://www.cdc.gov/obesity/downloads/CDC-Evaluation-Workbook-508.pdf
This workbook was designed to complement the CDC *Framework for Program Evaluation in Public Health*. It guides users through each step of creating an evaluation plan, with accompanying worksheets, exercises, and checklists.

Evaluating comprehensive community change: Report of the Annie E. Casey Foundation's March 1997 Research and Evaluation Conference. Annie E. Casey Foundation. (1997). Available at: http://www.aecf.org/upload/PublicationFiles/community%20change.pdf
With a focus on childhood outcomes, this document supports community-level change by addressing ways to improve evaluation of community-based initiatives, common challenges in data collection, and how to engage community stakeholders.

Evaluating health impact assessment: Learning from practice bulletin. Taylor, L., Gowman, N., & Quigley, R. (2003). Yorkshire, UK: National Health Service, Health Development Agency. Available at: http://www.who.int/hia/evidence/en/practice.pdf
This brief, part of a larger series on health impact assessment (HIA) presents case studies of HIA evaluation, discusses some of the major challenges to evaluating HIAs, distinguishes between process and impact evaluation of HIAs, and provides guidance on how to successfully execute an evaluation.

Framework for program evaluation in public health. Centers for Disease Control and Prevention. (1999). Morbidity and Mortality Weekly Report, 48(RR-11). Available at: ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf
CDC's *Framework for Program Evaluation in Public Health* is a foundational guide to the essential components, methods, standards, and procedures involved in public health evaluation. It emphasises engaging stakeholders, integrating evaluation into program practice, and addressing complex public health concerns like chronic disease and health disparities.

Learning what works: Evaluating complex social interventions: Report on the symposium held on October 22, 1997. The Brookings Institution Governmental Studies Program, and Harvard University Project on Effective Interventions. (1998). Available at: http://www.brookings.edu/~/media/research/files/articles/1998/3/01politics%20mann/learningwhatworks
This report summarizes a discussion among experts about how to effectively evaluate interventions addressing complex issues like neighborhood poverty and teen pregnancy, including a discussion of major challenges and tensions in improving evaluation methods, reports on current practices, and potential next steps.

SECTION 7: TALKING ABOUT HEALTH IN ALL POLICIES

7.1   HOW DO WE TALK ABOUT HEALTH IN ALL POLICIES?

Media advocacy and public health: Power for prevention. *Wallack, L., Dorfman, L., Jernigan, D., & Themba, M. (1993). Newbury Park, CA: Sage Publications.*
This textbook places media advocacy in the context of public health by articulating fundamental tensions between strategies focused on individual behavior change and those addressing the environments in which health decisions are made. It describes strategies for agenda setting, framing, and media advocacy and is illustrated with a number of short case studies.

Meta messaging: Framing your case and reinforcing your allies. *Berkeley Media Studies Group and The Praxis Project. (2005, January). Available at: http://www.bmsg.org/sites/default/files/bmsg_report_meta_messaging.pdf*
This memo discusses "meta messaging," a concept that can help organizations working on a range of issues to construct messages that serve their own immediate strategic needs while also echoing one another's larger goals for social change.

Mobilizing public will for social change. *Salmon, C.T., Post, L.A., Christensen, R.E. (2003, June). Communications Consortium Media Center. Available at: http://www.ncdsv.org/images/MobilizingPublicWillSocialChange.pdf*
This paper describes campaigns to mobilize public will and introduces key theories, challenges, strategies, evaluation, and relevant case studies.

News for a change: An advocate's guide to working with the media. *Wallack, L., Woodruff, K., Dorfman, L., & Diaz, I. (1999). Thousand Oaks, CA: Sage Publications.*
Written for practitioners, this workbook describes essential skills for media advocacy, including how to integrate media advocacy into an overall strategy, capture journalists' attention, write letters to the editor and op-eds, and evaluate media advocacy. It incorporates worksheets and case studies for self-guided study or for working with groups.

Putting policy into health communication: The role of media advocacy. *Dorfman, L., & Wallack, L. (2001). In R.E. Rice & C.K. Atkin (Eds.), Public communication campaigns (4th ed.). (pp. 337-350). Thousand Oaks, CA: Sage Publications.*
In this book chapter, Dorfman and Wallack argue that traditional public health communications campaigns often focus on personal choice, ignoring the wide range of social and economic forces that influence health. Dorfman and Wallack find this strategy to be misdirected and they highlight how media advocacy campaigns can support policy change that can lead to broader public health outcomes at the population level.

What surrounds us shapes us: Making the case for environmental change. *Berkeley Media Studies Group. (2009, May). Available at: http://www.bmsg.org/pdfs/Talking_Upstream.pdf*
This framing brief can help organizations explain to the public how our surroundings—our neighborhoods, schools, and workplaces—influence our health, and why policies that improve those places make sense.

Part III. Case Study: California Health in All Policies Task Force

California Assembly Bill 1467 § 43. (2012, June 13). Available at: _http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1451-1500/ab_1467_bill_20120627_chaptered.pdf_

AB 1467 established the Office of Health Equity within the California Department of Public Health, and directed the Office of Health Equity to work in alignment with the Health in All Policies Task Force. Priorities outlined in the bill include developing a "comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities" and assisting state agencies to consider population health impacts in the development of policies.

California Executive Order S-04-10. (2010, February 23). Available at: _http://sgc.ca.gov/hiap/docs/about/Executive_Order_S-04-10.pdf_

This executive order, issued by former California Governor Arnold Schwarzenegger, established a Health in All Policies Task Force under the auspices of the Strategic Growth Council and identified the California Department of Public Health as the facilitator.

California Senate Bill 732. § 4. (2008, September 30). Available at: _http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0701-0750/sb_732_bill_20080930_chaptered.pdf_

Senate Bill 732 added Chapter 13 (commencing with Section 75120) to Division 43 of the Public Resource Code to create the Strategic Growth Council. The Strategic Growth Council coordinates state programs that protect air, water, and natural resources; encourage sustainable land use planning; and support the California Global Warming Solutions Act of 2006.

California Senate Concurrent Resolution 47, ch. 56. Relative to Health in All Policies. (2012, June 21). Available at: _http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml;jsessionid=2f45db1d823e85da7ba0fa24f5a2?bill_id=201120120SCR47_

This bill established legislative support for the California Health in All Policies Task Force. The Resolution encourages Task Force member agencies to provide leadership on recommendations put forth by the Task Force, supports interagency collaboration, endorses the consideration of health impacts and costs of proposed legislation, and calls on leaders at all levels of government to consider health impacts in policy development.

Health in All Policies 2010 public workshops summary and participants. California Health in All Policies Task Force. (2010). Available at: _http://sgc.ca.gov/hiap/docs/input/HiAP_2010_Public_Workshops_Summary_and_Participants.pdf_, and **Health in All Policies 2011 workshops summary and participants.** *California Health in All Policies Task Force. (2011). Available at:* _http://sgc.ca.gov/hiap/docs/input/2011_Public_Workshop_Summary.pdf_

These summaries include information on workshop locations and dates, attendees, themes, regional differences, and prioritization of Health in All Policies recommendations.

Health in All Policies Task Force priorities for near-term implementation. *California Health in All Policies Task Force. (2011). Available at: http://sgc.ca.gov/meetings/20110601/june2011-hiappriorities.doc*
This document provides rationale for the prioritization of eleven recommendations for action, considerations for implementation, and potential agencies to work together on implementation.

Health in All Policies Task Force report to the Strategic Growth Council. *California Health in All Policies Task Force. (2010, December 3). Available at: http://sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf*
This report outlines 34 recommendations for "improving the efficiency, cost-effectiveness, and collaborative nature of State government, while promoting both health and other goals of the SGC." An Executive Summary of this Report is also available: *http://sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Executive_Summary.pdf*.

Implementation plans. *California Health in All Policies Task Force. (2012). Available at: http://sgc.ca.gov/hiap/publications.html*
Eight implementation plans have been developed by the California Health in All Policies Task Force, and new plans will continue to be posted at this site as they are developed and endorsed by the Strategic Growth Council.

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