Public Health Bulletin SA

Health in All Policies

Adelaide 2010 International Meeting

Volume 7, Number 2, July 2010

Contents

Editorial

Kevin Buckett
Director, Public Health
SA Health

By now it is increasingly accepted that the old ways of managing the health system will not do. The 21st century's complex social, economic and epidemiological problems cannot be solved by 20th century approaches. Our health is mostly determined by factors outside the operational sphere of the health sector, so the health sector must move beyond managing the health care system and seriously address those determinants of health in other spheres—education, housing, transport, employment, income, welfare etc.—where they impact on health. This is the Health in All Policies (HiAP) approach.

HiAP was the focus of much discussion in Adelaide, South Australia (SA), in April this year when the South Australian Government and the World Health Organization hosted the Adelaide 2010 Health in All Policies International Meeting. This issue of the *Public Health Bulletin* presents papers from a number of the participants at the meeting and reflects on the meeting's themes and outcomes.

Professor Kickbusch provided a keynote presentation at the meeting, the themes of which are reflected in her paper in this issue. In her view health is now very much on the political agenda in ways that could not have been predicted 10 years ago. The very centrality of the health agenda in the political debate, coupled with the multi-dimensional nature of that agenda—political, economic and ideological—make it essential that health be a shared goal across all parts of government. Kickbusch suggests that the challenge for the 21st century in achieving this presents an historic effort not unlike that of the creation of the public health system and the medical care system, respectively, in the two previous centuries.

There is increasing connectivity between health and the economy as the costs of the health system spiral and take up an ever-increasing amount of the state budget, something which is clearly unsustainable. It does, however, provide an economic argument and an impetus for governments to find new ways of working. This is the theme of two papers—of Fidler and Moran, and of Lin.

Government of South Australia
SA Health

The former take up this theme from the perspective of the current global financial crisis. Their conclusion is that, in light of experience from previous crises and from empirical and anecdotal evidence, the impact of the crisis on households and on the health status of vulnerable populations can be alleviated through policy levers outside the health sector. The crisis, in their view, could be seen to provide a unique opportunity for continued reforms in the health and social sectors, and an incentive to governments to learn from various countries' experience of HiAP approaches.

Lin's paper, which is based on a commentary prepared for the 'health and the economy' thread at the meeting, posits that economic policy is an important tool for both development of, and advocacy for, policy on prevention. Mirroring Fidler, she queries whether economic crises can be turned into opportunities to put this into practice. The challenge, Lin suggests, is to reconfigure global health governance to an HiAP approach. The health sector needs to be providing the business case for this, through analysis and modelling of intervention options and policy opportunities.

Intersectoral action for health is not a new concept, but HiAP, as its newest manifestation, is more innovative. As with anything new, it is important to share ideas and learn from each other. This was very much the reasoning behind holding the international meeting: to bring as many people as possible together who are engaged in this innovative work; to see how the HiAP approach is being implemented in different countries and jurisdictions, and at different levels—national, subnational and municipal; to identify common themes and issues; and to consider any notable differences in implementation. This was with a view to learn from each other and, in so doing, advance the evolution of an HiAP approach as a principal means of addressing the social determinants of health.

SA is taking a lead in implementing HiAP based on extensive cooperation between SA Health and the central government agency, the Department of the Premier and Cabinet (DPC). The innovation of the SA model is in having an HiAP approach embedded into the state's central planning vehicle—South Australia's Strategic Plan (SASP)—and applying a 'health lens' to a range of state policies according to an agreed methodology. This approach was recommended by Professor Ilona Kickbusch who, as the Premier's Thinker in Residence in 2007, successfully introduced the concept to key agencies.

The critical factors in the success that SA has achieved so far in implementing HiAP are detailed in the paper by members of the HiAP team in SA Health, Maddock, Williams and Broderick. The Kickbusch Residency, as the catalyst for action, was crucial in gaining acceptance for the HiAP concept. In progressing the implementation, the following factors have been identified as critical: the political will within both SA Health and DPC; using SASP, with its explicit targets, objectives, indicators and reporting mechanisms, as a major driver; and establishing governance structures, and using existing structures, to implement the approach. Further critical elements are: a clear commitment to a cooperative way of working with other sectors, to establishing shared goals and visions, and to ensuring that there is no 'health imperialism' (a common criticism by other sectors of health agency approaches when seeking to work across sectors).

Many of these same elements are reflected in papers in this Bulletin[a] based on the practice of HiAP in other countries and jurisdictions. Ståhl and Perttilä, who examine the adoption of intersectoral approaches in Finland, this time at the municipal rather than the state level, argue that the approach requires political will and a commitment from the leadership if it is to succeed. Implementing it requires information and management systems to facilitate action, as well as common targets, practices and tools across sectors. They make the point that it is a very time-consuming process and results should not be expected quickly, a factor with which we in SA would concur.

Pettersson's paper on the Swedish experience agrees that the process needs to be taken slowly, is long-term and requires patience and continuous dialogue, which again reinforces the experience in SA. Pettersson is clear on the need to find common ground between health and the non-health sectors, where joint action will improve population health and at the same time achieve other sectors' goals—the win–win situation that was echoed by most other contributors. Above all, there should be no health imperialism. This again concurs with the experiences of others, including SA.

Merkel, in his discussion on the European Union experience of HiAP, also supports these arguments—that implementation structures, systems and mechanisms, as well as political will and leadership, are essential to support intersectoral action. He suggests that a legal commitment to HiAP, while very valuable, is not of itself sufficient. He points to the need for shared vision and goals between sectors, the necessity for a

[a] Copies of the presentations from the Adelaide 2010 Health in All Polices International Meeting, on which the papers are based, are at http://www.health.sa.gov.au/pehs/HiAP/adelaide-2010-presentations.htm

specific focus for the work, and clear shared objectives and deliverables. HiAP is not just a one-off activity and it must have processes to sustain it.

Writing about the Netherlands, it is van der Heiden's view that no new legal or financial instruments are necessary in that country in order to undertake intersectoral action for health. Such action should be organised around concrete objectives, with attempts made to create synergy by actively seeking ways in which the aspirations of the differing sectors can be complementary, or ways in which health can support other legitimate aspirations of these sectors. All of this requires strong coordination at the central government level. Again, these views concur with the experience of others.

Governance arrangements for HiAP, which was a key consideration for all meeting presentations on the experiences of other jurisdictions and countries, is the specific focus of the contribution from St Pierre and Gauvin. They argue for the necessity for governments to find ways of establishing intersectoral governance for health, combining horizontal and vertical structures. They present a framework for achieving this that has four dimensions—leadership, coordination and collaboration, accountability and cultural change.

Harris and Harris-Roxas pose a wider question for consideration: how do policy initiatives such as HiAP and health impact assessment take into account the achievement of broader societal goals and focus on the forces that systematically produce an inequitable distribution of health determinants. In their view consideration of these forces is necessary if we are to avoid the health imperialist model.

Geoff Mulgan, also a previous Thinker in Residence in Adelaide, provides a broad reflection on joined-up government or, as he calls it here, holistic government. As Mulgan sees it, while modern governments grew up organised into silos, the pendulum has now swung in the direction of more joined-up intersectoral approaches. He outlines five main categories of approach: top down, where joining up is a directive from the top; where it is embedded in law, e.g. the Climate Change Act in the United Kingdom; genuine collaboration by government departments; bottom-up collaboration; and measures based on data and monitoring.

Mulgan suggests that one of the factors mitigating against HiAP, or joined-up ways of working, is the cognitive capacity of the people involved. It is actually hard for staff to consider the impacts of their policy or practice on other agencies, and hard for ministers or central government agencies to consider all the possible ramifications of their actions. Nevertheless, he remains optimistic that governments are becoming better at handling complex horizontal issues—that skills are improving.

One of the major outcomes of the meeting was the realisation that health systems in most countries are struggling with very similar problems—that, in implementing intersectoral approaches, they are facing similar challenges, and that, despite differences in the way systems are organised, their approaches have many features in common. This provides the opportunity to learn from others; hopefully, the papers presented here will advance that learning.

A more tangible outcome of the meeting was the Adelaide Statement on Health in All Policies, which was developed by the meeting and is reproduced in this issue. This statement is primarily intended for leaders and policy makers in areas other than health—it talks to them about what HiAP is, what's in for them, and how advancing health determinants will help them to achieve their goals.

On a final sad note, we take this opportunity to say vale Professor Konrad Jamrozik, whose death in March this year was a great shock and a major loss to the public health community, not just here in Australia but across the world. Konrad was very generous with his time for the Bulletin, both as an author and a guest editor. In this issue his colleagues at the University of Adelaide celebrate his life and pay tribute to his memory.

Author details

Dr Kevin Buckett is Director of Public Health in SA Health. He is the presiding member of the South Australian Public and Environmental Health Council and holds an Adjunct Associate Professorship in the School of Medicine at Flinders University of South Australia. He has had a long involvement in public and environmental health and has worked in this capacity in both state and federal governments.

Dr Buckett has a background in regulatory toxicology and health risk assessment, although he has pursued a career in public sector administration and leadership over recent years. He has a strong interest in health impact analysis and primary prevention particularly in relationship to environmental and social determinants of health. Dr Buckett is taking a leadership role in the Health in All Policies initiative within SA Health, and is the editor of the SA Health Public Health Bulletin.

Adelaide Statement on Health in All Policies: moving towards a shared governance for health and wellbeing

Report from the International Meeting on Health in All Policies, Adelaide 2010

The Adelaide Statement on Health in All Policies is to engage leaders and policy-makers at all levels of government—local, regional, national and international. It emphasises that government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development. This is because the causes of health and wellbeing lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist.

The Adelaide Statement outlines the need for a new social contract between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government. The Statement highlights the contribution of the health sector in resolving complex problems across government.

Achieving social, economic and environmental development

A healthy population is a key requirement for the achievement of society's goals. Reducing inequalities and the social gradient improves health and wellbeing for everyone.

Good health enhances quality of life, improves workforce productivity, increases the capacity for learning, strengthens families and communities, supports sustainable habitats and environments, and contributes to security, poverty reduction and social inclusion. Yet escalating costs for treatment and care are placing unsustainable burdens on national and local resources such that broader developments may be held back.

This interface between health, wellbeing and economic development has been propelled up the political agenda of all countries. Increasingly, communities, employers and industries are expecting and demanding strong coordinated government action to tackle the determinants of health and wellbeing and avoid duplication and fragmentation of actions.

Need for joined-up government

The interdependence of public policy requires another approach to governance. Governments can coordinate policymaking by developing strategic plans that set out common goals, integrated responses and increased accountability across government departments. This requires a partnership with civil society and the private sector.

Since good health is a fundamental enabler and poor health is a barrier to meeting policy challenges, the health sector needs to engage systematically across government and with other sectors to address the health and wellbeing dimensions of their activities. The health sector can support other arms of government by actively assisting their policy development and goal attainment.

To harness health and wellbeing, governments need institutionalised 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.

Health in All Policies approach

The approach described above is referred to as 'Health in All Policies' and has been developed and tested in a number of countries. It assists leaders and policy-makers to integrate considerations of health, wellbeing and equity during the development, implementation and evaluation of policies and services.

Health in All Policies works best when:

- a clear mandate makes joined-up government an imperative
- systematic processes take account of interactions across sectors
- mediation occurs across interests
- accountability, transparency and participatory processes are present
- engagement occurs with stakeholders outside of government
- practical cross-sector initiatives build partnerships and trust.

Drivers for achieving Health in All Policies

Building a process for Health in All Policies requires using windows of opportunity to change mindsets and decision-making cultures, and to prompt actions. Key drivers are context specific and can include:

- creating strong alliances and partnerships that recognise mutual interests, and share targets

- building a whole of government commitment by engaging the head of government, cabinet and/or parliament, as well as the administrative leadership
- developing strong high-level policy processes
- embedding responsibilities into governments' overall strategies, goals and targets
- ensuring joint decision-making and accountability for outcomes
- enabling openness and full consultative approaches to encourage stakeholder endorsement and advocacy
- encouraging experimentation and innovation to find new models that integrate social, economic and environmental goals
- pooling intellectual resources, integrating research and sharing wisdom from the field
- providing feedback mechanisms so that progress is evaluated and monitored at the highest level.

It is not unusual that such a process can create tensions within government as conflicts over values and diverging interests can emerge. Resolution can be achieved through persistent and systematic engagement with political processes and key decision-makers.

New role for the health sector

To advance Health in All Policies the health sector must learn to work in partnership with other sectors. Jointly exploring policy innovation, novel mechanisms and instruments, as well as better regulatory frameworks will be imperative. This requires a health sector that is outward oriented, open to others, and equipped with the necessary knowledge, skills and mandate. This also means improving coordination and supporting champions within the health sector itself.

New responsibilities of health departments in support of a Health in All Policies approach will need to include:

- understanding the political agendas and administrative imperatives of other sectors
- building the knowledge and evidence base of policy options and strategies
- assessing comparative health consequences of options within the policy development process
- creating regular platforms for dialogue and problem solving with other sectors
- evaluating the effectiveness of intersectoral work and integrated policy-making
- building capacity through better mechanisms, resources, agency support and skilled and dedicated staff
- working with other arms of government to achieve their goals and in so doing advance health and wellbeing.

Next steps in the development process

The Adelaide Statement is part of a global process to develop and strengthen a Health in All Policies approach based on equity. It contributes to a critical debate that Member States and Regions of the World Health Organization (WHO) are now engaged in. The Statement reflects the track record of countries that have already gained experience in implementing such an approach.

The Statement provides valuable input into the World Conference on Social Determinants of Health in Brazil 2011, the 8th Global Conference on Health Promotion in Finland 2013, and preparations for the Millennium Development Goals (MDGs) post-2015.

Background and acknowledgements

Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to wellbeing and supportive environments.

The Adelaide Statement was developed by the participants of the *Health in All Policies International Meeting, Adelaide 13–15 April 2010.* The Government of South Australia together with WHO invited 100 senior experts from a wide range of sectors and countries to discuss the implementation of the Health in All Policies approach. The main aim of the meeting was to move the agenda forward by identifying key principles and pathways that contribute to action for health across all sectors of government, and engage the health sector in contributing to the goals of other sectors.

The 2010 meeting drew on the report of the WHO Commission on Social Determinants of Health 2008 and

Tools and instruments that have shown to be useful at different stages of the policy cycle include:

- inter-ministerial and inter-departmental committees
- cross-sector action teams
- integrated budgets and accounting
- cross-cutting information and evaluation systems
- joined-up workforce development
- community consultations and Citizens' Juries[1]
- partnership platforms
- Health Lens Analysis[2]
- impact assessments
- legislative frameworks

[1] Citizens' Juries - www.jefferson-center.org/

[2] Health Lens Analysis - www.health.sa.gov.au/pehs/HiAP/health-lens.htm

other significant documents from the ILO, OECD, UNDP, UN-ECOSOC, UNESCO, UNICEF, World Bank and the World Economic Forum. It was also able to build on earlier work by WHO including the Declaration of Alma-Ata on Primary Health Care 1978; the Ottawa Charter for Health Promotion 1986; the Adelaide Recommendations on Healthy Public Policy 1988 and subsequent global health promotion conferences; the Gothenburg Consensus Paper on Health Impact Assessment 1999; and the Declaration on Health in All Policies, Rome 2007.

Since 2007 the State Government of South Australia has been playing a leading role in promoting knowledge exchange on Health in All Policies within Australia and internationally. Their initiatives have included holding a Health in All Policies conference in 2007 to launch their work; providing continuing support to central and other agencies across their State Government; publishing guidance materials on their methods for Health in All Policies; and holding the International Meeting on Health in All Policies, co-sponsored with WHO, in April 2010.

Examples of joined-up government action

Sectors and issues	Interrelationships between health and wellbeing
Economy and employment	> Economic resilience and growth is stimulated by a healthy population. Healthier people can increase their household savings, are more productive at work, can adapt more easily to work changes, and can remain working for longer. > Work and stable employment opportunities improve health for all people across different social groups.
Security and justice	> Rates of violence, ill-health and injury increase in populations whose access to food, water, housing, work opportunities and a fair justice system is poorer. As a result, justice systems within societies have to deal with the consequences of poor access to these basic needs. > The prevalence of mental illness (and associated drug and alcohol problems) is associated with violence, crime and imprisonment.
Education and early life	> Poor health of children or family members impedes educational attainment, reducing educational potential and abilities to solve life challenges and pursue opportunities in life. > Educational attainment for both women and men directly contributes to better health and the ability to participate fully in a productive society, and creates engaged citizens.
Agriculture and food	> Food security and safety are enhanced by consideration of health in food production, manufacturing, marketing and distribution through promoting consumer confidence and ensuring more sustainable agricultural practices. > Healthy food is critical to people's health and good food and security practices help to reduce animal-to-human disease transmission, and are supportive of farming practices with positive impacts on the health of farm workers and rural communities.
Infrastructure, planning and transport	> Optimal planning for roads, transport and housing requires the consideration of health impacts as this can reduce environmentally costly emissions, and improve the capacity of transport networks and their efficiency with moving people, goods and services. > Better transport opportunities, including cycling and walking opportunities, build safer and more liveable communities, and reduce environmental degradation, enhancing health.
Environments and sustainability	> Optimising the use of natural resources and promoting sustainability can be best achieved through policies that influence population consumption patterns, which can also enhance human health. > Globally, a quarter of all preventable illnesses are the result of the environmental conditions in which people live.
Housing and community services	> Housing design and infrastructure planning that take account of health and wellbeing (e.g. insulation, ventilation, public spaces, refuse removal, etc.) and involve the community can improve social cohesion and support for development projects. > Well-designed, accessible housing and adequate community services address some of the most fundamental determinants of health for disadvantaged individuals and communities.
Land and culture	> Improved access to land can support improvements in health and wellbeing for Indigenous peoples as Indigenous peoples' health and wellbeing are spiritually and culturally bound to a profound sense of belonging to land and country. > Improvements in Indigenous health can strengthen communities and cultural identity, improve citizen participation and support the maintenance of biodiversity.

Reflections on the Adelaide 2010 Health in All Policies International Meeting[a]

Dr Rüdiger Krech
Director
Department for Ethics, Equity, Trade and Human Rights
World Health Organization

The International Meeting on Health in All Policies,[1] held in Adelaide, South Australia, in April 2010 challenged the health sector to think outside the box—not just to think, but to speak and act outside the box. This is something that is easier to advise than to deliver, but it is something that must be done in order to affect health inequities—the unfair, unjust and avoidable causes of ill health.

In 2008 the Commission on Social Determinants of Health reported the 'what' and 'why' to closing the gaps in health equity. They instructed policy makers, practitioners and researchers to look at the 'causes of the causes'. Many were left saying, 'Yes, we believe, but where do we start? How do we do it?' While in Adelaide, professionals from Australia, South America, Europe and Asia shared the 'how'. Conference participants learned from many people, from various sectors, that are already acting outside the box.

The views and experiences of colleagues from planning, trade, education, consumer affairs and other sectors brought reality to previously academic discussions. The health sector needs to learn more about their frameworks, their ways of working and how we can contribute to their goals, in the interest of improving wellbeing and decreasing health inequities.

Examining the powers and interests of other sectors to analyse the 'causes of the causes' and the determinants of health should be done with the aim of building alliances, ensuring transparency and understanding political economies. If it were easy, it would be easily done. Just as one cannot be naïve about the work involved in achieving win–win situations, the health sector cannot sit by and idly accept policy decisions that are likely to increase health inequities.

More and more, practitioners across fields are contributing to the complex policy processes that impact upon the health and wellbeing of societies. The reasons for wanting to engage in this manner, however, cannot be assumed to be the same. All sectors have their own biases, goals and constituencies that influence how and when they act. The health sector has to appreciate this in order to understand it, and must understand it in order to act in a way that puts policy making on a trajectory that is for the greater societal good. Interests will diverge on many occasions, but the Health in All Policies (HiAP) approach is urging us to make much more out of the many occasions where interests are converging.

The Adelaide Statement on Health in All Policies is one of the furthest reaching documents in terms of cross-sector advocacy. It shows that health is willing to depart from the 'health empire' and engage in a truly two-way process. It acknowledges that, while the determinants of health lie outside the health sector, so do those who can solve the problem. In the past we have wanted 'them' to join 'us' in our health promotion or disease prevention efforts. With the leadership that will come from HiAP, health will learn from the successful work of other sectors, and identify how the health sector can be a resource and how joint engagement best achieves the broader social, economic and development goals of government.

The costs of health not being involved in broader policy making, influencing the cost-effective policies and measures that can promote and protect health, have been high. Governments have underestimated the whole-of-society costs of not attending to public health. The economic impacts can be astounding. In 2003 SARS gained worldwide media attention—not just as a new infectious disease but also because of the costs to the airline and tourism industries. At an estimated cost of US$30 billion, SARS was not the first disease to have enormous societal costs. Just 3 years earlier, in 2003, plague cost India US$1.7 billion; cholera cost Peru US$770 million in 1990; and over an 8-year period (1990–98) bovine spongiform encephalopathy cost the UK an estimated US$39 billion.[2] Astonishingly, these are all costs after accounting for the direct economic impact of human sickness and death, and all have roots in policies outside the health sector.

Understandably so, there is increasing interest from business in better understanding how health—the promotion of it and the lack of it—influences their work and profits. Part of the health sector's responsibility in these new engagements is to better understand what drives big industries. They have a major stake in population health, both as contributors and recipients. The role of global industry in global health has put health into trade and influenced innovative industry approaches. HiAP should be seen as a resource in managing this interdependence.

A complementary picture of public health practice is being created—a picture that includes risk behaviour and risk factors, risk conditions and life conditions. Before, the health sector only talked about why people smoke and how to make the healthier option become the easier option. Now, we are also looking at the tobacco industry, their strategies, powers and markets; and how their 'tobacco in all policies' approach influences people's lives, drives national and global economies, and sets political agendas. As successful and groundbreaking as the Framework Convention on Tobacco Control has been, smoking and other forms of tobacco consumption are increasing in developing countries[3] and tobacco is still a highly profitable industry. Why is this so?

As health professionals, we may not like their products, but we have to admit that tobacco companies are tactical and effective. We must allow ourselves to learn from their business model.

The health sector overall needs to better understand the institutions that have such an enormous effect on population health. By employing an HiAP approach, we open doors to getting to the crux of the matter—to the analysis, systematisation and identification of options that complement multiple sectors to the benefit of broader societal wellbeing.

The World Health Organization (WHO) is determined to move HiAP forward. It is clear that health has moved up the political agenda. This is true of both global and domestic politics, and WHO is eager for health and wellbeing to prosper from this reality. At the global level WHO will pursue a 'Health in All UN Policies' approach. WHO is fortunate, like South Australia, to have leadership that already believes in the power of intersectoral action. Throughout her tenure, the Director-General of WHO, Dr Margaret Chan, has highlighted the importance of addressing the social determinants of health and of tackling health inequities, and that the way to do this is through intersectoral action across all levels of government. Our work involves reaching out to our colleagues in the International Labour Organization, the World Trade Organization, UNICEF and others to build support among their leaders as well as among their technical staff that directly support countries.

WHO is also actively engaging our member states to promote this work, to build capacity to work with partners across multiple sectors to impact broader agendas and to be better partners ourselves.

As we embark on intersectoral work, the health sector must not compromise its own mandates, including health promotion and disease prevention. This does not mean that this work should be conducted in silos, disregarding the intersectoral nature of traditional health problems. In fact, the health sector must apply an intersectoral lens to its own policies and programs, just as we are asking colleagues in other fields to apply a health lens to their work. In this spirit, in May 2010 WHO released a publication of robust experiences in implementing 13 public health programs[3]—including alcohol and tobacco reduction, mental health, injuries and violence prevention, neglected tropical diseases, and many others—using intersectoral mechanisms in a variety of settings. This body of work will guide WHO as it works to build capacity in our member states to both address critical public health problems and engage in an HiAP approach.

Anyone who has been engaged in policy making knows that the discipline should be equally called 'political arts' as 'political science'. Art and science both evolve as we explore, learn and create. This will be the case for HiAP.

Author details

Dr Rüdiger Krech is the Director of the Department of Ethics, Equity, Trade and Human Rights at the World Health Organization in Geneva. Within the department, one of the teams formulates the WHO workplan on Health in All Policies, translating the recommendations of the Commission on Social Determinants of Health into effective actions at country, regional and global levels to improve health equity.

Previously, Dr Krech was the Director for Social Security in India at the German Technical Cooperation (GTZ). He was in charge of GTZ's global social protection work from 2003 to 2008. Before joining GTZ, Dr Krech held various management positions at the WHO Regional Office for Europe in the fields of health systems, health policies, health promotion and ageing. Dr Krech has studied educational sciences, medicine, and public health, and holds a doctoral degree in public health.

References

1. http://www.health.sa.gov.au/pehs/HiAP/adelaide-2010.htm
2. World Health Organization (WHO). The world health report 2007. A safer future: global public health security in the 21st century. WHO, Geneva, 2007.
3. World Health Organization (WHO). Equity, social determinants and public health programmes. WHO, Geneva, 2010.

Health governance in the 21st century: a commentary

Ilona Kickbusch
Director, Global Health Programme
Graduate Institute for International and Development Studies, Geneva

Health is on the political agenda

For many decades the goal of the public health community and of health advocates has been 'to move health high on the political agenda'.[1] At the beginning of the second decade of the 21st century one might sometimes be reminded of the saying 'be careful what you wish for'. Health has now moved up the political agenda in developed welfare states to an extent one could not have envisaged even 10 years ago. Health has become vital to overall government performance at the national level, and because of this it has again moved out of the technical sphere into the centre of political and ideological debates. This also applies to the international arena, where discussions at the World Health Assembly are increasingly dominated by trade and intellectual property issues, which in turn reflect the geopolitical and economic interests of countries.

Increasingly, analysts cite controlling health care costs as a key tenet for broader economic stability and growth of societies. Investors draw attention to the fact that the high costs paid by US or German companies for their employees' health care put them at a competitive disadvantage. For example, Warren Buffet states that the roughly 17% of GDP spent by the US on health care, compared with the 9% of GDP spent by much of the rest of the world, 'is like a tapeworm eating at our economic body'.[2] The overall costs to society of certain health conditions are also increasingly discussed, including concerns about the effect on both the economy and productivity. For instance, there are estimates that the total cost of obesity to the Australian economy, including productivity costs and lost wellbeing, is already A$21 billion a year.[3]

In addition, other health issues have entered the political arena and are heavily debated on economic or ideological grounds: examples are the government response to global pandemics, the extent to which governments should regulate products such as tobacco, alcohol or fast food, and government actions with regard to major health inequalities. Points of debate are the freedom of markets, the responsibility of individuals, the protection of vulnerable groups and the extent of state intervention. As the chronic disease agenda expands, this conflict between health interests and market forces will increasingly shape public health policy.

A few examples from the English-speaking world illustrate how health debates drive elections and force governments to action in order to keep or strengthen their electoral base. During the US elections a poll released in early November 2008 found that voters supporting Barack Obama listed health care as their second priority; voters supporting John McCain listed it as fourth. Affordability was the main health care priority among both sets of voters. Obama voters were more likely than McCain voters to believe that government can do much about health care costs.[4] President Obama delivered to his voters—in early 2010 a major health reform was adopted in the United States, but along a clear ideological divide. No Republican voted for the reform. Similar divides can be witnessed between political parties in other countries.

Health has moved up on the political agenda in developed welfare states precisely because of its relevance both to the economy and to the social rights and expectations of citizens. In consequence, health has also had a high profile in the 2010 election debates in the United Kingdom and Australia—and, increasingly, heads of government rather than health ministers are seen to deliver the key messages.

For several weeks in early 2010 the Australian Prime Minister toured hospitals to underline the importance his government attaches to the funding and delivery of health care. He made a well-scripted point of sitting at the bedside—frequently in a doctor's coat—and speaking to individual patients and, through them, to the voters: *we care for each and everyone of you*. His campaign indicates how health has become a very special mix of hard and soft politics, oscillating between hard economic data and emotional commitments to 'patients first'. One is reminded of Virchow's famous quote: *politics is medicine at large*.[5]

The issues at stake

Of course the response by governments to health challenges has always been subject to mixed motivations. While it is easy to be highly sceptical of many of the political machinations around health and health care, there is no doubt that governments are facing significant challenges in relation to health. This is complicated by the fact that they not only face new issues but that these issues can only be resolved if the governance of health in 21st century societies is

approached in a different way.[6] Six issues in particular need to be addressed. While they are presented in no particular order below, it is important to highlight that all are occurring simultaneously and that many of them interface not only with one another but with many other areas of government responsibility.

1. Ageing of societies: More people will reach older ages. While there is no automatic correlation between the ageing society and the rise in health care costs—even though this is maintained regularly in the political debate—there is a need to ensure the financing of long-term care, in particular for the very old and for the increasing number of people with dementia. The greatest concern is that the present health care system is not prepared for the demographic shift, and that an increase in chronic disease may lead to unhealthier older cohorts in future.

2. Wellbeing of children: Children born at the turn of the 21st century could be the first to have a lower health and life expectancy than their parents. Problems include rising rates of obesity and diabetes, as well as a range of developmental disorders and mental health problems. This is primarily a challenge for health promotion and prevention, precisely those areas that are underfunded in all health care systems. The present system clearly lacks incentives for an integrated approach to child wellbeing.

3. Health systems organisation and financing: Health care costs have been rising for several years in many countries, and control of this growth has become a major policy priority. The recent economic slowdown and rising federal deficits have reinforced the strain in some countries. Yet the debate on money is rarely accompanied by a debate on a reorganisation of the system to suit present and future needs. Most health systems as currently structured are unsustainable without significant reform as they are not geared to respond to the problems at hand. They are provider rather than patient driven and are still set up to deal with acute rather than chronic disease, as are health insurance systems.

4. Ongoing threat of global infectious disease pandemics: The threat of global pandemics is rising—over the last few years governments have had to respond to SARS, avian flu and swine flu. This rise indicates that health policy is no longer just a national concern but needs to be part of a larger global policy consensus. Not only are these pandemics a threat to population health and a country's security, but they also carry the potential for significant economic fallout. The economic repercussions of SARS reportedly cost the Asia–Pacific region about US$40 billion because of disrupted trade.[7] Governments are faced with significant investment in surveillance and readiness for emergency response, as well as measures to mitigate the effects if the worst ever does happen. Many of these investments are criticised if a crisis does not materialise.

5. Global chronic disease and mental health challenge: It is estimated that health care costs for chronic disease treatment now account for a major part of national health expenditures. In addition to these costs, there are significant indirect costs to individuals and businesses through lower productivity and loss of earnings. The burden of diagnosed type 2 diabetes in Australia is an estimated A$3 billion a year, with average costs per person at A$5360 plus A$5540 in benefits, totalling A$10 900.[8] There are clear, cost-effective interventions that can be put in place to prevent and treat chronic disease, and to respond to mental health problems. But they are still neglected. Governments also face conflicts because action on chronic disease can impinge on major private sector interests as well as compromise the government's tax base.

6. Increasing health inequalities: Social inequalities have a significant health impact. But the social gradient in health is not only related to less healthy life years and earlier death—access to health services is also becoming less equitable in many countries. Medical debt is a key factor in personal bankruptcy in the United States, patients' out-of-pocket costs have grown significantly in many countries, and waiting times are longer for people with less financial resources. In Australia indigenous Australians live, on average, almost 20 years less than other Australians.[9]

Need for innovation and a new institutional approach

The need for change is not only faced by the health sector—in general the sector-based approaches to governance do not fit the interdependent 'wicked problems' of the 21st century. As governments are under increasing pressure to increase performance, they gradually add new administrative forms of governance, for example by forging new strategic relationships both within government and with non-state actors.[10]

Frequently, this also means increasing the emphasis on central government and core executive capacity, together with increased coordination. This has also been called the whole-of-government approach and has been defined as follows—public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal or informal. They can focus on policy development, program management and service delivery. Joined-up government is generally focused on improving outcomes.[11]

In consequence, the balance appears to be shifting from 'intersectoral action *for health*' to 'intersectoral action *for shared societal goals*'.[12] For example, a shared societal goal such as 'equity' would have *health* as one important indicator—both the health sector and other sectors would be accountable for their respective contributions towards such a goal. This is critical for health policy because good or bad health outcomes *depend* on the action of other sectors but also *affect* the outcomes of a wide range of other sectors.

A typical example is food policy. A recent study[13] highlighted the changes most likely to have the most significant and immediate impact on making diets more sustainable. These are reducing consumption of meat and dairy products, reducing consumption of food and drink of low nutritional value (i.e. fatty and sugary foods), and reducing food waste. In all these changes, health, environmental, economic and social impacts are likely to complement each other—but at the same time they all imply significant societal, environmental and economic challenges and significant conflicts, particularly with producers.

Because of the complex interdependencies, Health in All Policies gains much broader dimensions than usually discussed.[14] Good health outcomes can be considered as:

- an intrinsic societal goal and a right of citizens
- a key contribution to other societal goals such as equity and social and economic development
- a critical economic factor in global competitiveness and managing national budgets
- a support to the goals of other sectors
- a way to control health care costs.

This multidimensional character needs an integrated and dynamic policy response across portfolio boundaries, making health a shared goal across all parts of government. However, in most governments the incentives continue to be aligned with outputs for individual departments rather than for outputs shared across agencies and departments. This reduces the effectiveness of the public sector in general as well as in individual areas such as health. But the health sector itself is also not well equipped (and often not willing) to deal with many of the contemporary public health challenges. It is a particularly vertical configuration with a concentration of specialist medical knowledge and very well organised professional special interests.

The challenge is to create new approaches to health governance that respond to the challenges at various structural levels, and incorporate a concern with health impacts into the policy development process of all sectors and agencies. This presents a historic effort akin to the creation of the public health system and the medical care system in the late 19th and early 20th centuries. We are far from having a Health in All Policies governance system in place.

The 21st century health policy approach

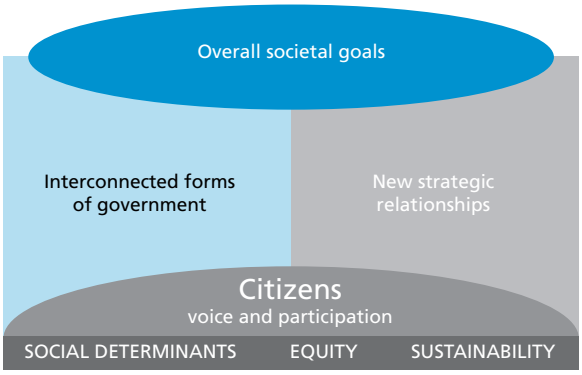

Figure 1: The 21st century health policy approach

Author details

Professor Ilona Kickbusch is known throughout the world for her contributions to innovation in public health, health promotion and global health. She has had a distinguished career with the World Health Organization and Yale University. She is a sought-after speaker and advisor on policies and strategies to promote health at national and international levels. She now works as an independent global health consultant based in Switzerland, and is the Director of the Global Health Programme at the Graduate Institute for International and Development Studies in Geneva.

Professor Kickbusch was the Thinker in Residence in Adelaide in 2007 and her Residency was the catalyst for the Health in All Policies approach in South Australia. She was a driving force behind the Adelaide 2010 Health in All Policies International Meeting and was the Principal Meeting Advisor.

References

1. World Health Organization. Adelaide recommendations on healthy public policy. Second International Conference on Health Promotion, Adelaide, South Australia, 5–9 April 1988. http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index.html
2. http://www.investopedia.com/university/greatest/warrenbuffett.asp
3. Access Economics. The economic costs of obesity. Report prepared for Diabetes Australia, October 2006. http://www.accesseconomics.com.au/publicationsreports/getreport.php?report=102&id=139
4. Blendon RJ, Altman DE, Benson JM et al. Voters and health reform in the 2008 presidential election. N Engl J Med 2008; 359(19):2050–61. doi:10.1056/NEJMsr0807717. PMID 18974307
5. http://www.pathguy.com/virchow.htm
6. Kickbusch I (ed.). Policy innovations for health. Springer, New York, 2009.
7. Congressional Research Service (CRS). Report for Congress. US and international responses to the global spread of avian flu: issues for Congress. CRS, Library of Congress, Washington DC, 2006. http://www.fas.org/sgp/crs/misc/RL33219.pdf
8. http://www.diabetesnsw.com.au/research/cost.asp
9. Australian Bureau of Statistics (ABS). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. ABS Cat no. 4704.0. Commonwealth of Australia, Canberra, 2008.
10. Bell S, Hindmoor A. Rethinking governance: the centrality of the state in modern society. Cambridge University Press, Cambridge, 2009.
11. Australian Public Service Commission. Connecting government: Whole-of-government responses to Australia's priority challenges. Commonwealth of Australia, Canberra. 2004. www.apsc.gov.au/mac/connectinggovernment.htm
12. Public Health Agency of Canada. Crossing sectors: experiences in intersectoral action, public policy and health. Public Health Agency of Canada, 2007.
13 Sustainable Development Commission. Food security and sustainability. http://www.sd-commission.org.uk/publications/downloads/SDCFoodSecurityPositionPaper.pdf
14. Kickbusch I. Health in All Policies: the evolution of the concept of horizontal governance. In Kickbusch I & Buckett K (eds), 'Implementing Health in All Policies: Adelaide 2010.' Department of Health, Government of South Australia, Adelaide, 2010.

Holistic government and what works

Geoff Mulgan
Director
Young Foundation, United Kingdom

Background

For much of human history the main concern of governments was security and military power. In the 20th century economies became all-important, and every government department had to learn how to speak an economic language. Now, new perspectives are demanding attention, including the environment, health and wellbeing. Health in All Policies (HiAP) is part of this story and also part of the broader story of the efforts to make governments join up. Modern government grew up organised in vertical silos—departments, agencies and functions. Many of the reforms of the last decades of the 20th century reinforced these silos, with targets and performance management tools directed to individual silos. This was the promise of the 'new public management' (NPM) theories that spread, particularly around the English-speaking world, in the 1970s and 1980s. Their premise was that greater focus and specialisation would deliver benefits, especially if these could be precisely measured and monitored.

It is important to recognise that some of these ideas still have momentum, and many of the world's management consultancies are still promoting NPM ideas nearly 40 years after they were first introduced. In this view the priority for any government is to be as precise as possible about targets and about allocation of these targets to specific departments and agencies.

Joined-up government measures

But the pendulum swing in the other direction has now been underway for nearly 20 years. Scandinavia has often led the way, not just with HiAP but also with creative ways of linking various parts of government (most recently in Finland during the 2000s). In the UK joined-up government began in the early 1990s with the creation of integrated budgets for urban regeneration. There have since been a host of experiments and measures in several areas. Some have focused on measurement and targets—one-third of UK government targets are now shared across departments. Nearly 200 indicators are used to assess how well local areas are doing. A process of

'comprehensive area assessments' looks, in the round, both at how well areas should be performing and how well they are performing. There have been cross-cutting policy teams in areas such as social exclusion and regulation; dual policy teams linking sports and health; and ministers with responsibility for teams in other departments. Data management has been a live issue; for example, one large experiment has tried to introduce a single database for children at risk to help the management of both risk and protective factors, and ensure that different professions can deal with both children's and families' needs in the round.

Categorising the measures

These measures can be roughly divided into five categories.

The first is essentially top down, using the authority of the Prime Minister, President or Chief Executives to require other departments and agencies to collaborate. These tools can be very effective but they are very dependent on the authority and attention of the leader(s), which is always the scarcest resource in any jurisdiction.

The second is newer and embeds cross-cutting perspectives through law. The clearest example of this is the Climate Change Act in the UK, which has set up an arms-length body with the power to assess and block government measures that threaten the achievement of climate change targets. Legal powers relating to equality are another example of this—they can mobilise the courts to force policy makers to take action on cross-cutting issues.

The third is more genuinely collaborative, coming from cooperation between departments and agencies when there is a shared conviction of the need for change. Many joint initiatives between two, or occasionally three, departments are of this kind, and the benefits of cooperation are evident to all parties.

Fourth, there are bottom-up collaborations, when professions come to believe in a new way of working. At the community level measures are often joined-up almost automatically because the needs of individuals or organisations are evident.

Finally, there are measures that emphasise data, monitoring and impact assessments, but without necessarily much force for departments to act on their implications.

Mapping the categories

We can map these categories on two axes—one that shows how much formal power drives joined-up government versus how much is voluntary, and the other that shows how many fields or players are being integrated or coordinated. The promised land of integration is the top right-hand corner of this diagram, where formal powers force collaboration across a wide range of issues. In practice, however, this is the hardest space to occupy and the hardest to sustain. Political attention will always be a very scarce commodity. It may also be more shaped by live issues and events, for example alcohol or obesity rather than health in the round, or climate change rather than the environment. But other parts of this diagram can be just as important in driving long-term change: new indicators can change how people think; and loose networks can, with patience, transform how governments behave. In these other parts of the diagram good cooperation skills are needed—the ability to listen, understand others' perspectives and pressures, find win–win solutions, and find early wins that build confidence and mutual trust.

Discussion

This diagram emphasises the scarcity of political and governmental attention. But there is also another crucial scarcity where HiAP is concerned—cognitive scarcity. It is simply harder to think in many dimensions—harder for front-line workers to consider the possible impact of their decisions on other agencies, and for ministers or central departments to consider all the possible ramifications of their actions. This is why all organisations simplify decisions and make them routine, often as rules or laws, to save themselves the trouble of lengthy deliberation over every action.

Joined-up government depends on higher levels of cognitive capacity—better trained front-line staff as well as better trained staff higher up the hierarchy. Ideally we want more people with 'T'-shaped skills—deep specialisations in fields like medicine or planning, but also a broad understanding of other fields. These are all desirable but difficult in the real world, when people are busy, are coping with multiple pressures, and may already be operating at the limits of their skills and knowledge.

These limits again explain why joining-up has to be selective. As Gertrude Stein put it, not everything can be about everything. I remain optimistic that government is slowly and steadily becoming better at

handling complex, horizontal issues, partly because its own skills are improving. One other change may be critical—the greater ease of access to data. This is being achieved by the next generation of the web (and cloud computing) in combination with legal changes making raw data available to the public to mash and mine. These shifts allow for much richer and more complex feedback messages to governments.

The general problem is that cross-cutting frameworks are necessarily embedded in bureaucratic processes of coordination, measurement and evaluation. They can seem rather abstract, yet their purpose is very practical—how to better solve problems like smoking or pollution. Presenting solutions in this way, as practical responses to practical problems, can help overcome the barriers and sustain both political will and bureaucratic commitment.

Author details

Dr Geoff Mulgan, one of the world's leading experts on social and organisational innovation, has been director of the Young Foundation, in the United Kingdom (UK), since late 2004. Between 1997 and 2004 Dr Mulgan had various roles in the UK government, including director of the Government's Strategy Unit and head of policy in the Prime Minister's office. He was previously the founder and director of the think tank Demos. He has been a lecturer in telecommunications, an investment executive and a reporter on BBC TV and radio. He is a visiting professor at the London School of Economics, University College London and Melbourne University, and a fellow of the Australia and New Zealand School of Government (ANZSOG). He is an adviser to many governments around the world. In 2007 and again in 2008 Dr Mulgan was Thinker in Residence in Adelaide, South Australia. His legacy was to draw attention to the growing importance of social innovation—what it is, why it matters and how it can be applied in South Australia to generate new ideas that work.

Health in All Policies: European Union experience and perspectives

Bernard Merkel[a]
Minister Counselor
Head of Food Safety, Health and Consumer Affairs
European Union, Delegation to the
United States of America

Background

Right from the introduction of the first explicit public health provisions in the Maastricht Treaty in 1992, the European Union (EU) has had a specific commitment to Health in All Policies (HiAP). Article 129 of the treaty said: 'Health protection requirements shall form a constituent part of the Community's other policies'. This provision was strengthened in the Amsterdam Treaty of 1997. Article 152, which replaced Article 129, begins with a clear statement on HiAP: 'A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.' And in the Lisbon Treaty, ratified at the end of 2009, this wording is maintained, with the sole substitution of the word 'Union' for 'Community'.

HiAP approach

One might imagine that the integrationist spirit promoting HiAP was the result of various declarations on public health, such as the Ottawa Charter for Health Promotion of 1986, or the 1988 Adelaide Recommendations on Healthy Public Policy. In fact, the integrationist approach is a common thread running throughout the treaty, and similar provisions can be found in other policy areas, such as environment and consumer policy.

Irrespective of its origin, the key point is that this legal provision is helpful but not enough by itself. It is, in essence, exhortatory.[1] It sets out an end but not the means to achieve it. It provides a mandate and legitimacy to act, but what is required—what is always required—are structures and systems to translate it into concrete actions, together with the political leadership and will to ensure that the actions are taken. These factors are perhaps even more important in relation to an integrationist agenda, where, by definition, it will be necessary to obtain the active cooperation of actors in other key policy fields, not all of whom will necessarily regard this as a positive development.

[a] The views expressed in this paper reflect the personal views of the author and are not in any way those of the European Commission

European Union health strategy

One way to achieve such cooperation is to create an all-of-government mandate to make sure that everyone accepts the goal and its translation into actions. In the European Commission (EC) the Directorate General for Health and Consumers (DG SANCO) tried to accomplish this by drawing up an overall health strategy for the EU. The aims of this approach, apart from getting agreement on general policy principles and objectives, were to:

- outline a vision, not just for the health sector but for the EC as a whole
- show how health goals and objectives were interlinked with those in other areas, e.g. the role that health plays in economic development and social cohesion
- tie in other departments to the goals set out and so ensure that their actions and policies would refer to the goals
- develop a process to implement specific actions to pursue the objectives.

In taking this forward DG SANCO followed the EC's standard procedures. First, a policy document was prepared for general consultation.[2] The consultation outcome was then analysed and used to inform detailed proposals which were accompanied by an impact analysis. These were eventually agreed to by the EC and published on 23 October 2007 as a White Paper, *Together for health: a strategic approach for the EU 2008–2013*. The Council[3,4] and European Parliament[5] later endorsed these proposals as the basis of the overall EU approach.

This approach took about 4 years in all from its initial conception to final political agreement. Its outcome was very positive, leading to general acceptance of one overall health strategy that included a commitment to HiAP as a key principle.[6] In addition, it enabled the establishment of several coordination mechanisms, notably a senior cooperation group with member states and a partnership with the Committee of Regions.[7] Within the EC the existing Inter-service Committee on Health[8] was reinforced and regular high-level policy dialogues with other EC services were instituted.

However, despite these achievements, there are also limitations. First, the health strategy covers a short period—only 5 years—which inevitably raises the issue of whether the approach will be sustained in the future. Second, despite the commitment to pursue health goals, it is in practice easy for this to be overridden in response to political and economic developments such as the global financial crisis. Third, the strategy's success depends on the continuing willingness of partners to cooperate—which cannot be taken for granted. Finally, to be effective, the principles of the strategy must be translated into concrete actions, which in turn means that the necessary resources have to be found.

Health and consumer issues

A second DG SANCO initiative on HiAP focused on trying to combine work on health with that on consumer issues. Generally speaking, these two areas are regarded as completely separate, but in today's globalised and commercialised world there are major points of similarity and synergy. For example, both policy areas are concerned with improving the information and literacy, and thus the empowerment, of the general public (whether as citizens, consumers, or patients and their families and friends). Similarly, they also both emphasise the protection of the public against particular threats to their physical and mental health and safety. Lastly, they share a concern not only to address people's behaviour, but also to tackle basic socioeconomic determinants that lead to health inequalities and to differences in people's ability to exercise their rights as consumers.

In addition, several practical considerations underpinned this initiative. Within the EC, DG SANCO was responsible for both areas of activity, which were based on (broadly) similar treaty provisions (Articles 152 and 153 respectively). The two funding programs supporting actions in each area were similarly relatively small. It seemed, therefore, that there was much to be said in favour of combining the two programs into one large one.

In light of this, the EC published a proposal on 6 April 2005 for a joint Programme of Community Action in the Field of Health and Consumer Protection 2007–2013. However, this initiative failed to find support; indeed, it was almost universally condemned.[9] Consumer organisations and authorities feared that their interests were being ignored and that they were in some sense being taken over, while health organisations were concerned that key health issues were being forgotten and that commercial aspects would taint the public health agenda. Without outside support the initiative foundered, and the Council and European Parliament agreed that, as before, there should continue to be separate consumer and health

programs. Ultimately, despite their similarities and potential synergies, consumer policy and health policy have separate concerns, organisations and interests that cannot simply be yoked together without first obtaining the acceptance of major stakeholders.

Health and EU funding instruments

Another DG SANCO initiative was the effort to integrate health into the European Structural Funds (the Funds). The Funds are the EU's largest spending instrument and are aimed at resolving economic and social problems, particularly in the poorer and less developed countries and regions. Health was not originally covered by the Funds, and DG SANCO's aim was to ensure that, in future, the Funds would devote significant resources to meeting health objectives and that money invested in health would be invested effectively.

This initiative was successful, and today a proportion of the Funds' resources go towards health objectives. To achieve this required sustained intervention throughout the decision-making process. First, there was a need to liaise with EC services and national governments when the general framework for the Funds was being negotiated, in order to have health included as a clear objective within the Funds' scope. Second, it was necessary to ensure that those involved in the Funds' implementation at both national and regional levels appreciated that health was now covered. Third, leading stakeholders were identified who could champion health initiatives in their countries. Fourth, a great deal of technical work was undertaken to see if and how health was being addressed in the funding proposals being prepared, and to provide advice and expertise to those who were developing projects to help make them as effective as possible. Finally, following funding of the proposals, health-related projects were monitored, and will eventually be evaluated.

But there are some limitations to this success story. Making health an explicit aim of the Funds does not mean that it is always properly taken into account in decisions in other policy areas. Similarly, ensuring that actions are taken that aim to improve health does not mean that they necessarily address the most important health issues, or that they address them in the most effective manner. Finally, although health is now covered by the Funds, the amount devoted to it is still small compared with other investment areas such as energy and transport infrastructure.

Conclusion

Some clear lessons have emerged from the EU's experience to date with HiAP. Having a legal commitment is valuable but not, in itself, sufficient—implementation structures and mechanisms and, above all, political will to act are essential. Moreover, in taking action, it helps to have a shared vision and goals with the other policy areas involved. There must be a focus for the work with clear objectives and deliverables. Most importantly, to be effective, this cannot be a one-off process—ways must be found to ensure that the efforts made and the gains secured can continue on a sustainable basis.

Author details

Dr Bernard Merkel is British. He is currently the Head of the Food Safety, Health and Consumer Affairs section of the Delegation of the European Union in Washington. His previous post was Head of the Health Strategy and Health Systems Unit in the Health and Consumers Directorate General of the European Commission in Brussels. In that position he led the work to produce the EU's first overall health strategy, *Together for Health*, which was published in 2007, as well as developing policy initiatives on health care in the EU, including a draft directive on patient rights in cross-border health care.

Before joining the EC, Dr Merkel worked in the UK Department of Health and Social Security on health policy issues such as AIDS, child health and reform of the National Health Service, as well as on social security programs on poverty and disability. He was also for a time Private Secretary to the Secretary of State. He has been a Visiting Fellow at the London School of Economics (LSE Health) and is an Honorary Senior Lecturer at the London School of Hygiene. He is a member of the Editorial Board of Eurohealth and author of several articles on health policy. His training is mainly in the social sciences, in which he has a doctorate in political theory.

References and comments

1. It is unclear whether this treaty provision, which sets out a broad obligation, is in fact justiciable, i.e. that there is any possibility of taking legal action to hold people to account for its fulfillment. To my knowledge there are no European Court of Justice rulings in this area. However, it would be interesting to see whether there have been any relevant legal cases in other policy areas with this kind of legal provision in the treaty, and how far they have gone.
2. European Commission (EC). Enabling good health for all: a reflection process for a new EU health strategy. EC, Brussels, 2004. http://ec.europa.eu/health/ph_overview/strategy/reflection_process_en.htm
3. The Council is the body that brings together representatives of the governments of the EU's member states.
4. Council conclusions of December 2007 and June 2008.
5. European Parliament resolution of 9 October 2008 on 'Together for health: a strategic approach for the EU 2008–2013'.
6. The others were strategies based on shared health values, health as the greatest wealth, and strengthening the EU's voice on global health.
7. This committee is an institution of the EU consisting of representatives of regional and local authorities.
8. This committee brings together the different Commission services concerned with health issues. It was reconstituted following the strategy, with different subgroups being set up to pursue different elements of the strategy.
9. There were, however, a few supporters of the initiative. Probably the most outspoken was Professor Ilona Kickbusch. See her editorial 'The health society: importance of the new policy proposal by the EU Commission on Health and Consumer Affairs', Health Promot Int 2005; 20(2):101–103.

Health in All Policies across jurisdictions—a snapshot from Sweden

Bosse Pettersson
Independent Public Health Consultant, Sweden
& former Deputy Director-General
Swedish National Institute of Public Health (SNIPH)

Introduction

Health in All Policies (HiAP) is essentially concerned with improving the health of the population through across-government, or intersectoral, action on the determinants of health. But only by establishing mechanisms for this across-government dialogue can action occur. It is a collaborative and integrated approach across ministries, seeing health as a serious policy concern in all departments of government. This paper is a case study of this approach in Sweden, highlighting some of the lessons learnt in one country. Some background will be required to put this into context, first on Sweden generally, but also on Swedish public health processes and mechanisms for intersectoral action.

Sweden—some facts

Sweden has a population of just over 9 million, with an urban component that is steadily increasing. Only about 10% of the 290 municipalities have had a population increase over the past years. The population is ageing, and it is estimated that 25% will be over 65 years of age in 2030. The fertility rate has varied around 1.8 for many years and, together with a positive net migration, Sweden has experienced a slight population growth over the past decades. The health status of the population is comparatively very high, with the country having one of the highest life expectancies in the world—in 2006 it was 83 years for women and 79 years for men.[1] It has the lowest rate of smoking in Europe,[2] also being one of the lowest in the world. Alcohol consumption has increased by 30% following membership of the European Union in 1995 and is now slightly below the European Union average. Infant and neonatal mortality rates are also among the lowest worldwide. Sweden has universal access to health and medical services, which are almost completely tax funded.

While the county has a relatively low level of income inequality and the health status of the population is high and improving in absolute terms for most

people, this improvement is significantly slower for the least privileged groups and, in relative terms, health inequalities are increasing. Life expectancy between the highest and lowest socioeconomic status local geographic areas may differ by up to 6 years for Swedish men and 2 years for women. From the late 1980s until the first years of the 21st century there has been a significant increase in sick leave across the working population, particularly among women who are employed in the public sector. Other observations are an increase in overweight and obesity; an increase in violence-related injuries, correlating with the higher alcohol intake; an increase in fatal falls among the elderly; and a self-reported increase in mental health problems. So, while the overall picture of the health of the Swedish population is positive, there are sectors of the population that are disadvantaged relative to the majority, and their problems are increasing.

Public health process and structures

Sweden has a mixed parliamentary system with three autonomous levels of government—central, regional, and municipal or local. All levels are involved in the organisation and delivery of public health and health services. However, being a national state, legislation and taxation powers rest with the Riksdag (national Parliament). Compared with other countries, Sweden (like other Nordic countries) has a large number of municipalities, which means not only significant decentralisation but also numerous small entities with difficulties in maintaining legislated service levels. The municipalities have responsibility for decisions that impact on the determinants of health,[3,4] as they manage schools, childcare, and care of the elderly and disabled, as well as having responsibility for water and sewerage infrastructure. The municipal administration, including its public health board, share a significant responsibility for the maintenance of public health,[5] together with the 21 regions (County Councils) whose main concerns are health and medical care services including epidemiological surveillance

In 2003 the Swedish Riksdag adopted, through a bill from the former Social Democratic government, a national public health policy with the aim of 'creating societal conditions to ensure good health on equal terms for the entire population'.[6,7] The policy has 11 objective domains that cover the most important determinants of health of the Swedish population. The policy was updated in 2008 after a new right-centre government took office in 2006. The bill 'A renewed public health policy' was adopted by the Riksdag although the overall aim remained unchanged. The wording of the 11 objective domains was expressed in more neutral language by, for example, taking out words like 'favourable', replacing 'healthier' with 'health', and using 'health promoting' instead of 'a more health promoting'. For obvious reasons, a right-centre government is adding greater elements of individual choice and responsibility, but also focusing on involvement at the local level, with a renewed focus particularly on children, young people and the elderly. The renewed policy also has an emphasis on initiatives aimed at strengthening and supporting parents, increasing suicide prevention efforts, promoting healthy eating habits and physical activity, and reducing the use of tobacco, alcohol and illicit drugs.[8,9]

Since 2003 the new policy, through its implementation (and sometimes because of the lack thereof), has contributed to putting health relatively high on the political agenda. It has a deliberate focus on the social determinants of health and intersectoral public health work, nationally, regionally and locally. It aims at developing population health and public health action prompted through regular monitoring and reporting to both government and the Riksdag.[10] With its 11 objective domains, the policy has set public health targets upstream—in the health determinants—rather than downstream—in disease and health outcomes.

Structures to support across-government approaches in Sweden

It is within the structures put in place by the National Public Health Policy that across-government action is undertaken. A special Minister of Public Health has carriage of the policy, with access to a high-level national steering committee composed of directors-general from key national state agencies and a representative of regional and local authorities. The achievements of the 11 public health objectives are defined according to the remits and responsibilities of the government departments, respectively, and should be executed through defined national state agencies. However, the overall responsibility for monitoring and coordinating the implementation of the policy rests with the Swedish National Public Health Institute (SNIPH).[11] In doing this, SNIPH has, among other initiatives:[12]

> developed and made available the indicators on the determinants of health

- developed planning and steering tools for reviewing and integrating public health at the local municipal level
- arranged different training activities in health and other sectors
- developed health impact assessment and other tools.[13]

Lessons learnt in implementing across-government approaches in Sweden

The experiences in Sweden with across-government approaches in dealing with the social determinants of health may be instructive and useful to other jurisdictions undertaking similar measures. While there are a number of topics that could be covered, this paper highlights three subjects:

1. the process for identifying shared concerns—what determines health in other sectors
2. health imperialism, ownership and language—how to respect other sectors' territories
3. experiences of governance arrangements in implementing the public health policy.

The process for identifying shared concerns

Understanding health outcomes and health status through the lens of health determinants is not an easy concept for sectors other than health to understand. While such an understanding is absolutely essential to the work, it requires a continuous dialogue. Working with other sectors to enable them to understand the impact of their policies and programs on health, both positively and negatively, needs to be taken within a realistic timeframe as it is not likely to be a familiar concept. It is also a long-term process, requiring both time and mutual patience. The dialogue needs to be firmly anchored for those staff in leadership roles, so that they can drive the process within their organisations.

In conjunction with the partner sector, the process needs to identify those currently existing health determinants for which the sector has responsibility, and then make the most of opportunities for intersectoral work on those determinants, be it legislation or other administrative initiatives, or different actions. It is particularly necessary to find common ground where there will be an improvement in the health of the population, as well as the opportunity for the partner sector to meet their own basic goals in dealing with health determinants. Development of indicators for monitoring progress and evaluating the success of the work is vitally important. It is paramount that the process be collaborative, with the indicators being jointly developed and accepted.

Health imperialism, ownership and language

For across-government work to succeed, it is absolutely vital that, from the outset, the partners agree to work on an equal footing—there must be no health imperialism. The other sectors' language, ways of operating and concepts must be respected. Without such an approach, there is little value in attempting to engage across sectors. It will not be easy for public health to take this approach—after all, they may be considered the experts when it comes to health. But on this joint stage it is important to remember that the partners are experts in their own policy terrains and it is important to respect this. The rule is, do it their way, offer support when requested, and always show respect.

It is imperative to recognise that many sectors actually 'do health' under different labels and the health sector needs to learn how to 'read' them. For example, Stockholm's public transport system incorporates programs for passengers to feel safe, as well as improved time-keeping, instant information and tidiness. Such measures also prevent injuries, may reduce stress and improve hygiene. The health sector needs to strive to find an interface with the partner sector where this mutuality can be supported and extended. Each sector has its own language and its own jargon. When working with other sectors, the health sector needs to leave its jargon behind in the health office. It must become familiar with the policy remit of partners, and it must read and learn from the policy and strategic documents of the sectors with which it is working. This requires preparation!

Experiences of governance

Across-government approaches require new models of governance. Leadership is crucial to the success of this work, but it is necessary to differentiate between the different levels of leadership required—they could be termed administrative, scientific and political. Administrative leadership requires appropriate planning tools and datasets. We need to be aware of the regular policy cycle of partners, and consider opportunities for using policy development processes to deal with the social determinants. Health can take a leadership role in the scientific domain through access to scientific data to help make the case for working on particular health determinants. Political leadership and the political will to implement an across-government way of working

are vital. This requires a mechanism whereby health determinants are identified by each government department, along with an obligation to contribute to overall health improvement by systematic action, as part of a coherent multisectoral public health policy.

Furthermore, it is critical to institutionalise such structures, which in Sweden is a major part of SNIPH's facilitation role. To ensure progress it is important to establish a process for monitoring—setting measurable targets and developing feasible indicators forged into a formal reporting process. With the exception of tobacco prevention, Sweden is lacking such measurable targets. SNIPH manages a participatory process with other state agencies, regions and municipalities for public health policy, reporting on the fulfilment of the national strategy. The reporting is mandatory for state agencies. The monitoring and evaluation data is published in a public health policy report, the first of which was published in 2005[14] and the second is to come in the fall of 2010. In turn, the government will prepare a communication to be presented to the Riksdag.

Other observations

This across-government public health policy based on health determinants is very much a learning-by-doing process. It takes time, so it is not realistic to except a range of health outcomes in the short term. The health sector must be ready and willing to learn from other sectors and to engage more directly with the policy development process. Finally, there is a need for a critical mass of staff to make this happen. This need not be a large number—a small group (5–10) of well-situated, well-supported and committed staff can initiate significant change.

Conclusion

Genuine and effective collaboration can only be achieved by recognising and dealing with the challenges inherent in intersectoral work. This is the heart of HiAP and absolutely necessary to address the health determinants and health inequity. Hopefully, in highlighting some of the lessons learnt in Sweden, this paper may assist others in this collaborative way of working.

Author details

Dr Bosse Pettersson is currently an independent Public Health Consultant in Sweden. Dr Pettersson has an educational background in the social and behavioural sciences, public administration, and political and public health sciences. He has had over 30 years' experience in public health and has held a number of positions over that time, including Head of Division at the National Board of Health and Welfare, Head of Director-General's Office and Deputy Director-General at the Swedish National Institute of Public Health, and Senior Adviser in Public Health Policy at the Ministry of Health and Social Affairs. He was Secretary-General of the 3rd International Health Promotion Conference 1991 in Sundsvall, Sweden, and since 1988 has been a senior guest lecturer at Karolinska Institute. Dr Pettersson has extensive international experience: with the World Health Organization since 1984, the European Union expert groups since 1994, with Nordic collaboration since 1979, and as a guest lecturer, mainly in Europe. The major focus in his work is on health promotion, intersectoral collaboration, health inequalities and policy making.

References

1. http://www.socialstyrelsen.se/publikationer2009/2009-126-71 (in Swedish only)
2. http://ec.europa.eu/public_opinion/archives/ebs/ebs_332_en.pdf
3. Allin S, Mossialos E et al. Making decisions on public health: a review of eight countries. European Observatory on Health Systems and Policies, World Health Organization, Brussels, 2004.
4. http://www.fhi.se/en/Public-Health-in-Sweden/Public-health-issues-at-the-regional-level/
5. http://www.fhi.se/en/Public-Health-in-Sweden/The-local-municipalities-role-in-public-health/
6. Hogstedt C, Lundgren B, Moberg H, Pettersson B, Ågren G (eds). The Swedish public health policy and the National Institute of Public Health. Scand J Public Health, 2004; 64:6–64.
7. Backhans M, Moberg H (eds). Health for all? A critical analysis of public health in eight European countries. Swedish National Institute of Public Health, 2008.
8. http://www.fhi.se/en/Public-Health-in-Sweden/
9. Lundgren B. The making of a health policy. Int J Health Serv 2009; 39(3): 491–507; and Pettersson B. Transforming Ottawa Charter health promotion concepts into Swedish public health policy. Promot Educ 2007; XIV(4): 244–249.
10. Orienting policies on health determinants: the process of target setting in Sweden 1985–2006—lessons to learn. Public lecture in Graz, Pallais Attems, 8 June 2006.
11. http://www.fhi.se/en/About-FHI/Main-tasks/
12. St-Pierre L, Hamel G, Lapointe, McQueen D, Wismar M. Governance tools and framework for health in all policies. http://www.rvz.net/data/download/IS_studie_Brussel_-_engels.pdf
13. Knutsson I, Linell A. Health impact assessment development in Sweden. Scand J Public Health 2010; 38:115–120.
14. (http://www.fhi.se/en/Publications/All-publications-in-english/The-2005-Public-Health-Policy-Report/)

Health behind the dykes: health in a lot of policies in the Netherlands

Lejo van der Heiden
Department of Public Health
Ministry of Health, Welfare and Sport, the Netherlands

Introduction

Whereas the Netherlands was once one of the leading countries in public health, attention dwindled somewhat in the early years of this century. Worries over adverse health trends prompted the government to propose a new vision on prevention in 2007, in which intersectoral health policy is once more a key element. Using a concept of parallel interest, the Ministry of Health has adopted a more humble approach of cooperation with other sectors, whereby health interests do not necessarily take the lead. Important elements are the adoption of a program-based and problem-oriented approach in which a wide range of both actors and instruments are involved. Patience and a long time horizon are also key elements.

Public health trends

The Netherlands has a rather strong track record in public health, albeit with mixed results. In the 1950s and 1960s we were one of the leading countries in the world in terms of life expectancy. This was due in large part to a strong focus on primary care; a well-organised public health sector; and a leading, if sometimes patronising, role of both local and national government. It is no wonder that the Netherlands was, in the early 1980s, a strong defender and follower of the Health for All movement of the World Health Organization.

Changes in society, culture and demography over the last 30 years have diminished the above image, and the Netherlands is now on par with most Western European countries in terms of life expectancy, with men slightly above the average of the EU-15 countries[1] and women slightly below. One of the major explanations for this change is the fact that Dutch women took up smoking earlier and en masse in the 1960s and 1970s compared with women in other countries.

Looking at present trends, one can state that the Netherlands is not doing badly (e.g. over the last few years life expectancy has notably increased), but there are a number of concerns. Our youth are making a poor start, and lifestyle trends of persons up to 20 years of age are worrisome. Health inequalities are high and probably increasing.[2] We are witnessing, as in most countries, a strong increase in chronic diseases, thus putting pressure on the health care system in terms of both financial and human resources. Despite the general focus on finance and cost containment, the pressure on human resources is probably even more acute. We have calculated that in 2025 we will need 400 000 more health care workers. This means that, with an ageing population, one out of every three(!) school leavers should opt for a career in health.

Dwindling attention for public health

Despite visionary government reports, the fact that the Netherlands was one of the first countries to develop health impact assessments (and experiment with them), and despite two large and influential government commissions on health inequalities, major results or breakthroughs in public health did not materialise in the 1990s. In the early years of this century, attention for public health matters dwindled somewhat, apart from brief political and societal attention to crises like outbreaks of SARS and avian flu. Two major factors contributed to this—the then government put a lot of emphasis on individual responsibility for healthy behaviour, and the Ministry of Health itself was totally engrossed between 2002 and 2006 with extensive reform of the health insurance system.

New vision

In the past few years interest in and attention to public health has grown again. In 2007 the new government published a new vision on prevention,[3] in which two main lines of connection and action form the mainstay of the Ministry's new public health policy—the association between preventive and curative care and the association between (health) behaviour and the setting (or environment) in which it takes place. It is the latter that is important for this paper and that brings us to the present Dutch version of Health in All Policies (HiAP). The 2007 vision paper concluded that:

> *'The average person in the Netherlands can look forward to a longer life and more years of good health than at any time in the past. Nevertheless, the nation's health could be improved considerably if healthier lifestyles were followed—both by people who are presently in good health and by people with (chronic) conditions. In this context, following a healthier lifestyle means 'simply' looking after oneself: eating sensibly, getting enough exercise, not smoking and not drinking too much. Decisions about such matters are not made in isolation, however, but in the context of*

influential social and physical settings. The way these settings operate and the dynamics within them have a profound effect, and the government has an important responsibility in this regard. One of the keys to improving the nation's health is therefore the relationship between a person's setting and his/her lifestyle.'[3]

This relationship between behaviour and setting is the basis for the important slogan 'making the healthy choice the easy choice'.

HiAP in the Netherlands

So why do we involve ourselves with HiAP? It is important to realise that most health gains are achieved outside the traditional health sector. This was the case in the 19th century, when major investments in sewerage and clean drinking water had a huge effect on the health of the population. It is still the case in the 21st century, where the major determinants of non-communicable diseases, such as smoking and obesity, involve social, political, physical and cultural aspects. We are dealing with complex and socially interrelated problems, which require both multi-dimensional analysis as well as a multi-stakeholder approach.

Parallel interests

This complexity and the multi-pronged relationships are the basis for the new HiAP approach of the Ministry of Health, which has opted for a more modest and service-oriented role conceptualised through the theme of parallel interests. Each individual citizen stands to gain from being in good health. However, various other parties—friends and family, employers, co-workers and associates, the government and the care sector—also have an interest in the health of the individual and of the community as a whole. In practice the interrelationships are complex, with countless interfaces and occasional conflicts between the various responsibilities and aspirations. The important thing is that 'an interest in' also means 'a responsibility for'. In some cases health is itself the focal point, while in others health serves to support other fundamental values. In short, we feel that in the past we were preaching too much, while we have so much to sell! The government now actively seeks to identify fields in which the reasonable aspirations of the various actors—in relation not only to health but also to economic or social matters in which their nature or mission gives them a special interest—are in harmony. In this context health is not necessarily the primary objective, but may merely be supportive of an organisation's or a person's aspirations or responsibilities.

Reversing undesirable trends in health requires focus, cooperation, perseverance and, therefore, long-term commitment. An example of complementary aspirations is the case of employers and entrepreneurs. They have a stake in reducing workplace absenteeism and preventing labour market drop-out, and these aspirations are in harmony with the improvement of workers' health. A healthy workforce is advantageous in terms of corporate health, labour productivity and profitability. Another example is schools. There is a growing body of evidence for an association of poor school performance and absenteeism with alcohol and drug use among young people. Evidence suggests a positive correlation between fitness and exercise and cognitive performance. School teachers thus have an interest in promoting good health, not to please the health sector but to realise their own legitimate aspirations. By maximising the contribution that the health care sector can make to society, the government seeks to stress that investments in health are not a social cost factor but an investment in human capital, and thus a prerequisite for a vital economy.

Intersectoral advice

To elaborate this concept of parallel interest further, the government asked advice from four independent advisory bodies—the Economic Development Council, the Council for Public Health and Health Care, the Council for Public Administration and the Education Council—on ways to enhance intersectoral health policies. In itself it was an unprecedented intersectoral move to have these sectoral advisory bodies jointly reporting.

According to the four councils, intersectoral health policy is, by definition, a matter for the government as a whole. Its most important task is to create awareness of health issues and a sense of urgency among all social actors. The councils therefore recommended that the coalition agreement upon which any new administration is based should deal explicitly with this topic. The health of the Dutch population is sufficiently important to warrant such a move, and cooperation at all levels—including the Cabinet level—is necessary for success. Primary responsibility for getting people in other policy domains and in all tiers of government to focus on public health lies with the Ministry of Health, Welfare and Sport. To this end the councils recommended the setting up of an interdepartmental unit under the leadership of the Minister of Health. Unfortunately, Cabinet decided not to heed this recommendation.

At the local level, municipalities need to be able to play their part, and the chair of the public health committee has a key part to play. Greater municipal involvement

would, however, imply the availability of more public health-related expertise and capacity. There is also a need to improve cooperation with municipal health services.

One of the most important findings of the councils is that further legislation or regulation are not required in these areas at the present time. However, there is a need to propagate best practice and to increase awareness of the effectiveness of prevention. The councils further concluded that disadvantaged socioeconomic groups should be prioritised. A geographically focused approach is well suited for use in the context of an intersectoral strategy for tackling unacceptable health inequalities. Better and safer housing, better schools, safer workplaces, effective reintegration and health-optimised planning of public spaces can all contribute to better health in the communities where improvements are most needed.

Good examples

The present government has already been seriously working on this last recommendation. One of the main priorities of the present Cabinet is the transformation of 40 problem districts in large cities into power districts. A so-called Programme Ministry integrating all the different sectors including health was specially created for this priority—the Ministry of Housing, Districts and Integration. It follows a program-based approach in which the focus lies with the inhabitants and their problems. Analysis of these problems is crucial. Health was originally not one of the five main areas within the approach as proposed by the new Ministry, but, at the request of the inhabitants themselves, 9 out of the 18 cities involved have now included an experimental 'healthy neighbourhood'. The three key elements are improvement in the health situation of the people, a healthy living environment and easily accessible primary health care facilities that also offer preventive activities.

Another successful example of intersectoral health policy is road safety in the Netherlands, which has one of the lowest levels of mortality from road accidents in the world. The number of casualties dropped from approximately 3000 in the mid 1970s to 720 in 2009, while the number of travelled kilometres nearly doubled. This is a very spectacular result in which the Ministry of Health hardly played a role. Road safety is mostly dealt with by the Ministry of Transport but a whole range of other actors, most notably local authorities and the car industry itself, are involved. A range of instruments was applied too. Legislation (for compulsory safety belts, speed limits, etc), strict controls and heavy fines, government health campaigns (e.g. 'drunken driving' media campaigns), civil engineering (innovation in car design: ABS and airbags) and physical planning (e.g. speed bumps, road design, roundabouts) all contributed and were together responsible for the remarkable success.

The way ahead

The Ministry of Health is now working hard to establish better, more service-oriented contacts with other ministries, elaborating on the elements of the abovementioned successes—a program-based and problem-oriented approach such as the one used in the power districts. This should be implemented in an all-encompassing way (in terms of sectors, actors and instruments). By less preaching and more serving, we are presently gaining confidence and building up relationships to become a trustworthy partner once more, whereas in the past contacts were too erratic. We would be content if we could include health in a lot of policies, rather than aiming for health in all policies.

One of the methods used is the development of business cases, whereby more emphasis is put on social benefits and economic analysis. In the end it is always money that matters. Convincingly showing other actors that it is in their own (financial) interest to invest in health activities is a better way than merely telling them to do so or begging them. We do not focus solely on other government departments but, rather, on other actors (e.g. employers, industries, schools, local government, and citizen and consumer groups), as in the French obesity approach, EPODE.[4] What should be clear from the start in these complex situations in which political aspirations, cultural and societal norms, and the social and physical environment are all involved, is that a long-time horizon is absolutely necessary. Patience and time are of the essence!

We will further elaborate upon these concepts in our national white paper on prevention, which is due by the end of 2010.

Author details

Mr Lejo van der Heiden is at present Head of the Public Health Care Unit within the Department of Public Health of the Ministry of Health, Welfare and Sport, the Netherlands. His responsibilities include overall public health strategy, public health infrastructure, national screening programs, the program for chronic diseases and intersectoral health policies. He is co-author of the Dutch vision on prevention: 'Being healthy, staying healthy'. He worked at the International Affairs Department

of the Ministry of Health between 2001–06, where he was responsible for global health affairs and acted as the liaison person for the World Health Organization.

Before joining the Ministry of Health, Mr van der Heiden worked for a long period in development cooperation, employed by the Ministry of Development Cooperation and the European Union (among other places, in Botswana and Nepal), specialising in strategic planning, integrated rural development and nature conservation. He studied human geography at the University of Utrecht (the Netherlands).

References and comments

1. EU-15: the fifteen Western European countries that made up the European Union (EU) before the major enlargement of the Union in 2004; presently, the EU consists of 27 countries.
2. Differences in life expectancy between the highest and lowest education levels are 7.3 years for men and 6.4 years for women. Differences in healthy life expectancy are even bigger, amounting to 14 years. See: Bruggink JW. Ontwikkelingen in gezonde levenverwachting naar opleidingsniveau. Bevolkingstrends 2009; 57(4):73–77.
3. Ministry of Health, Welfare and Sport, the Netherlands. Being healthy and staying healthy, a vision on health and prevention. 2007.
4. EPODE (ensemble, prévenons l'obesité des enfants)—a French acronym for an integrated approach to combat obesity at the local level. See: www.epode-european-network.com/.

Health in All Policies at the local level in Finland

Timo Ståhl
Development Manager
National Institute for Health and Welfare, Finland

Kerttu Perttilä
Development Manager
National Institute for Health and Welfare, Finland

Introduction

Intersectoral action for health, and the more recent Health in All Policies (HiAP) approaches have been introduced as strategies for integrating health consideration into other (non-health) policies. The literature on the topic discusses the principles and advantages of, and the necessity for, the approach. The implementation of these strategies, which is discussed to some extent in the literature, appears to be focused mainly at the national level since, in many countries, it is this level that is the most important for formulating and implementing policy.[1,2] At the local level specific projects or tools such as health impact assessment are considered, as a means for implementing intersectoral action.[3,4,5]

This paper focuses on intersectoral action and management of health promotion at the local level. Specifically, we present the experiences from a long-term project with local governments in Finland that aimed to develop structures, management processes and tools for intersectoral action in implementing the basic principles of HiAP.

A few facts about governance in Finland

Finland has a rather small population—5.3 million inhabitants. The political-administrative structure is highly decentralised, with local government (i.e. the municipalities) having a major role in organising all basic services. In total there are 342 municipalities in Finland.

At the national level the government proposes Acts to the Parliament for approval. The ministries prepare the proposals and also monitor the implementation of legislation. The municipalities implement the legislation but have freedom to decide how it will be implemented, for example how they will organise the services required. The national authorities, for example the ministries, don't have any 'hard' measures, such as

fiscal measure, to guide the municipalities other than legislation, and guidance is mostly information and funding of national development processes.

Local government in Finland relies on self-government by the residents. The constitution safeguards the role of self-government, with residents electing the municipal council as the supreme decision-making body. According to the Local Government Act (the Act), local authorities have the right to levy taxes and make independent financial decisions. At this level residents pay taxes based on their income and ownership of real estate, and company taxes are based on operating profit. Taxes at the national level (e.g. on income, alcohol, tobacco, fuel, and goods and services) are decided by the Parliament.

Local authorities provide all basic services such as education, social and health services, housing, public transport, waste management, sewerage, water supplies, town planning and land use. The financial responsibility for organising these services lies with local authorities, with an annual fixed amount of money (not 'ear-marked') directed to the municipalities from the state to fulfil their legislative obligations.

Local management structures for health promotion

As a measure to fulfil the obligations under the Act, i.e. to promote the health and welfare of the citizens, in 2003 the then National Research and Development Centre for Welfare and Health (STAKES), which is now the National Institute for Health and Welfare (THL), established a development project with 12 municipalities; the project concluded in 2009.[6] As the Act states, health promotion is the task of municipalities in Finland which means that every administrative sector is responsible for health promotion. Thus, there was a clear need for permanent health promotion structures and management systems that would support intersectoral action and the implementation of HiAP.

Results and experiences from this development project are reported below. We believe that they are applicable to countries that have delegated powers from the national level to lower levels, e.g. regions, districts or municipalities. However, the structures and mechanisms presented for such intersectoral action are neither setting-specific nor dependent on the governance structure. Therefore, they can also have relevance for countries with governance arrangements where regional or national authorities provide many of the services which are administered at the municipal level in Finland.

Prerequisites for building structures for health promotion at the local level

During the development work several prerequisites for building capacity for health promotion in municipalities were identified, as follows:

1. Commitment of the leaders of the municipality is a crucial factor—health promotion must be part of the municipal strategy.
2. Real-time data and follow-up systems are needed as a basis for action. Information on population health and welfare is necessary and the service system needs to be able to respond to health needs as required.
3. The management system must facilitate systematic and coordinated intersectoral cooperation across the different administrative sectors.
4. In order to act effectively, the management system needs an implementation structure for health promotion that makes it possible to achieve common health targets.
5. In order to be effective and able to provide services of good quality, organisations need to develop and adopt common practices and tools.
6. Health promotion needs competent personnel—skills and knowledge in health promotion need to be strengthened at both strategic and professional levels.
7. Resources for health promotion need to be allocated within the action plans and annual budgets of each administrative sector. Tasks that need joint action and bridge sectors need specific resources from the management of the municipality.
8. Follow-up and reporting of both the health status of the population and the ability of the services to meet the needs of the residents needs to be in place, and the results of the achievement of health targets need to be communicated regularly to management, politicians and the citizens of the municipality.

All these prerequisites are important and the municipalities cannot work effectively if they are not taken seriously; however, the management system is considered to be the central underpinning factor. More details are presented below on the management system and the specific tasks required for a successful outcome.

Management system

One of the most important, if not *the* most important, prerequisites lacking from the Finnish municipalities prior to the development project was a clear management system for health promotion—without it, ongoing and long-lasting achievement of intersectoral action was seen to be very difficult if not impossible. As a cornerstone of intersectoral action at the local level, a management system for health promotion was created in the project municipalities. Figure 1 illustrates the generic management system model, which can be adjusted according to the size and structure of the municipality.

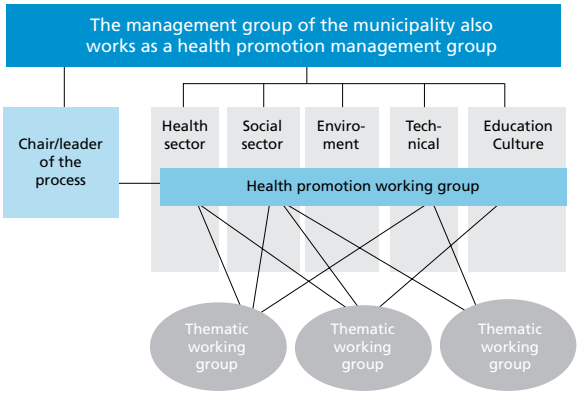

Figure 1: Management structure for health promotion in local government

Management of health promotion is part of the 'normal' management system in each municipality, and therefore cannot be disconnected from the municipality's established management system. Hence, the management group of the municipality acts also as a management group for health promotion.

The *management group* directs the work of the health promotion working group, decides on health promotion strategic goals and allocates resources on horizontal issues—those issues that will need to be worked on jointly across sectors and are not possible to implement within the normal budgets of the individual sectors.

The chair of the *health promotion working group* is also a member of the municipality's management group. It is important that there is a direct contact between the working group and the management of the municipality. The chair is also the leader of the health promotion process in the municipality. The members come from each sector (see Figure 1). It is recommended that the members are managers of the branches so that they have the appropriate authority to represent the branch and implement the tasks agreed to by the working group. Representatives from the non-government sector, the scientific community, and local institutions and businesses can be invited to join the health promotion working group.

The early experiences of the project indicated that it is important that the working group has clear and specific tasks. The members of the group need to understand both their role and the management group's expectations of them from the very beginning. The following tasks at the least should be undertaken:

- collecting information (from every sector) on the health, health determinants and welfare of the population, and preparing a concise report annually and a more comprehensive report every fourth year (the local electoral period)
- reporting the collected information to the management group, politicians and the public
- developing proposals for setting municipal health promotion strategic goals
- agreeing on the distribution of work and cooperation between sectors
- coordinating health promotion activities and implementing municipal health and health promotion goals
- monitoring and assessing the implementation, and reporting the implementation of sector-specific tasks back to the management group
- reporting to the municipal management group on achievement of the goals.

Experience with different municipalities has indicated that preparation of the health and welfare report on population health and health determinants is a good starting point for intersectoral action. It is a concrete task and requires good communication among members of the working group. It is not possible to achieve anything remarkable without genuine, active communication.

It is usual that many *thematic working groups* (see Figure 1) are working on projects simultaneously in the municipality, for example groups promoting preventive drug work, mental health and sexual health. The working group needs to be conscious of these groups and coordinate their work in order to guarantee effective outcomes and prevent overlap.

Conclusions

Permanent structures and a horizontal management system for health promotion work appear to assure the recognition of health promotion as an important strategic focus area at the municipal level in Finland. They also enable and facilitate the definition of implementation responsibilities between sectors, and of common indicators for monitoring the process and outcomes of the work. The structure also provides a common ground for following up and evaluating the objectives. Management practices that cross sector-specific administration and are grounded in cooperation also ensure the development and adoption of similar methods and tools. One important outcome of building up these structures and management systems is that health promotion becomes an important shared objective in decision-making—intersectoral action is seen in this context as a tool for achieving the objectives, not an intrinsic value in itself.

This project has taught us that intersectoral action for health at the local level is a time-consuming activity that does not provide fast results. From our experiences in Finland, it can take several years before intersectoral action begins to be institutionalised and all sectors understand and accept their role in the work. However, focusing on concrete joint work in the beginning will enhance the process of institutionalisation within the working group. Because of this long timeframe, permanent structures are also needed to 'tolerate' changes of membership in the group without losing all the work that has already been done.

One concrete result of the activities of these groups (management, working and thematic working groups) is improved health and welfare consciousness within each sector. As a tangible output, we can expect a concise annual health and welfare report and a more comprehensive report every 4 years. Thus, a municipality-based monitoring and evaluation system is developed step by step. It is important that municipalities can plan their services and activities on the basis of needs assessment. Other results include joint activities initiated by the working group, more coherent and thematic ways of working and the adoption of new tools (e.g. health impact assessment) for intersectoral action.

Author details

This paper is based on a presentation titled *Health promotion capacity of local governments* given by Dr Timo Ståhl at the Adelaide 2010 Health in All Policies International Meeting.

Dr Ståhl is the Development Manager and Adjunct Professor (Health Promotion) with the National Institute for Health and Welfare in Finland. He has 15 years' experience in health promotion with a major interest in policy evaluation, particularly of across-sector horizontal policy. Dr Ståhl is currently leading a nation-wide project to develop a benchmarking system for local health promotion capacity in Finland.

Dr Kerttu Perttilä is the Development Manager at the National Institute for Health and Welfare, Finland. With a background in nursing, Dr Perttilä has 16 years experience in developing and studying health promotion in municipalities and regions, focusing on health promotion structures, strategies and tools, and management to enable health promotion. She has worked for the past several years in developing and studying the nation-wide primary health care system and special medical care services in Finland. Currently, her major responsibilities involve leadership of a project on economic assessment of health promotion in municipalities and supporting Finnish regions and municipalities to develop their health promotion structures, management and practices.

References

1. Koivusalo M, Santalahti P. Healthy public policies in Europe: integrating health in other policies. Final Report. GASPP occasional papers no 5/1999. National Research and Development Centre for Welfare and Health (STAKES), Finland, 1999.
2. Ståhl T, Wismar M, Ollila E, Lahtinen E, Leppo K, (eds). Health in all policies: prospects and potentials. Ministry of Social Affairs and Health, Helsinki, 2006.
3. Blau J, Enrst K, Wismar M et al. The use of health impact assessments across Europe. In: Ståhl T, Wismar M, Ollila E et al (eds). Health in all policies: prospects and potentials. Ministry of Social Affairs and Health, Helsinki, 2006:209–230.
4. Kauppinen T, Nelimarkka K, Perttilä K. A case study of the role of health impact assessment in implementing welfare strategy at local level. In: Ståhl T, Wismar M, Ollila E et al (eds), Health in all policies: prospects and potentials. Ministry of Social Affairs and Health, Helsinki, 2006:253–266.
5. Public Health Agency of Canada. Crossing sectors: experiences in intersectoral action, public policy and health. Public Health Agency of Canada, 2007.
6. Perttilä K, Uusitalo M (toim.) Terveyden edistämisen paikalliset rakenteet ja johtaminen TEJO-hankkeen väliraportti 2003–2005. Management and structures for local health promotion. Interim report 2003–2005. Raportteja 4/2007. STAKES, Helsinki, 2007.

Health in All Policies: critical elements of South Australia's approach

Agnes Maddock*
Senior Project Officer

Carmel Williams*
Manager, Health in All Policies

Danny Broderick*
Senior Policy Officer

*Public Health, SA Health

Introduction

Health in All Polices (HiAP) is an innovative approach for action on the social determinants of health that takes as its starting point the need for whole-of-government, or intersectoral, action. 'Learning by doing' has been a key feature of the implementation of HiAP across the South Australian (SA) Government. Part of this has also been learning from other countries and jurisdictions about their models, structures and processes, and challenges and successes. This paper reflects upon what has been identified as some of the critical elements for implementation in SA. It is hoped that an examination and discussion of these elements may assist other jurisdictions in development of approaches to HiAP in their specific contexts. We then look at what the next steps are as we move to integrate HiAP more securely as a standard approach across government.

Critical elements of success—the SA experience

Catalyst for action

In SA the catalyst for even beginning to think about HiAP was the Adelaide Thinker in Residence (ATIR) Program[1] and Professor Ilona Kickbusch's residency as part of the program. This program brings world-leading thinkers to live and work in Adelaide to assist in the strategic development and promotion of the state.

The ATIR program is a specific initiative of the Premier of South Australia. His personal involvement in the selection of thinkers means that they are given high prominence and visibility, and that their ideas promote significant public attention and debate. The ATIR platform provided Professor Kickbusch with regular access to the Premier, individual Ministers, the Cabinet as a whole, public sector chief executives and senior bureaucrats, and policymakers. Through several significant events, there was opportunity to engage directly with the SA public, enabling Professor Kickbusch's ideas and proposals to gain early and significant traction at several levels.

In 2007 Professor Kickbusch took up her first residency, part of which involved a desktop analysis of SA's major planning framework, South Australia's Strategic Plan (SASP). The final report of her residency in 2008 made specific recommendations regarding implementing HiAP using the SASP framework.

Mandate for action

Professor Kickbusch's final report of her residency and its recommendations were accepted by the Premier and, in its response to the report, the SA Government made an undertaking to implement HiAP across government. Governance structures were required to enable a systematic approach to intersectoral initiatives and these were agreed by the Executive Committee of Cabinet (exCom), the most senior committee of the state government. This mandate has been a key to HiAP's acceptance across government.

Policy drivers for action

The Kickbusch report clearly identified that the necessary policy driver to harness the HiAP wagon to was SASP—the blueprint for all government action. It has explicit objectives and targets, and the achievement of each of these targets is the responsibility of the chief executive of the government agency required to take the lead on the target. Many of these targets are 'stretch targets'—in which it is recognised that their achievement will require innovative approaches and new ways of working. In updating SASP in 2007, the Premier stated that: 'Innovation and creativity must be at the centre of everything we do'.[2] This has provided a favourable climate in which HiAP can develop.

Another important contributor in the development of the HiAP approach in SA has been the recognition by the health sector that SASP not only provides a framework for policy action across the state, but that this same framework can be used to guide action to address the determinants of health. The six objectives and 98 targets contained in SASP[2] mirror factors that can influence the health outcomes of populations. For example, employment/ unemployment, education, housing, transport, food production, environment and communities all have targets under SASP and also represent determinants of health. The HiAP process supports

SASP as it provides a mechanism to enable joined-up government action. Many of the targets can only be achieved if action is taken across sectors but, typical of government arrangements in most western democracies, current structures make this type of work difficult.

SA has been able to develop an HiAP model that supports cross-sector collaboration. An important feature of this model is the 'health lens', which systematically examines the connections between the health and wellbeing of the population and the SASP target, and works to identify policy actions that will assist in the achievement of the target under examination as well as benefit population health. The HiAP model couples the health lens with a high-level, centralised SASP governance structure—an important mechanism for all government sectors as it provides legitimacy for the approach and a mandate to act.

Government structures to enable action

Following endorsement of the Kickbusch report, the government established the mechanisms and structures to operationalise HiAP. ExCom, chaired by the Premier, is the custodian of SASP and responsible for overseeing its implementation. The ExCom Chief Executives Group (CEG)—which includes senior permanent and statutory chief executives who support the work of ExCom—was charged with responsibility for overseeing the development, implementation and evaluation of HiAP across government. It is this group which selects the SASP targets that HiAP will be applied to, and it is to this group that HiAP reports. The Office of ExCom in the Department of Premier and Cabinet (DPC) works with SA Health to support the implementation of SASP.

This structure provides support for HiAP at the highest level of government. The central government agency, DPC, and SA Health are required to jointly implement and support HiAP. The roles of DPC and SA Health are well defined—with DPC taking prime responsibility for coordination and liaison with CEG, and SA Health facilitating the health lens analysis work. This partnership continues to evolve as the two agencies develop a better understanding of each other's organisational cultures and policy imperatives. The framework for the partnership is expressed through a formal memorandum of understanding agreed to and signed by the chief executives of the two departments. It would not be possible for SA Health to implement HiAP without this strong relationship with and active involvement of DPC.

In addition to central government structures to implement HiAP, SA Health has established a high-level governance structure within the department and provided dedicated staff resources to its implementation. As has been confirmed by SA's experience, as well as those in other countries, the number of staff required to implement HiAP approaches across government is not great (several presenters at the Adelaide 2010 Health In All Policies International Meeting confirmed that a small team of four to eight staff seemed to be optimal).

Values orientation—how we act

A fundamental feature of HiAP in SA is the values orientation that underpins all of the work undertaken jointly between SA Health and other government departments. A core tenet of the approach is that SA Health *facilitates* the work and does not *lead* the work—leadership is the responsibility of the government department with which SA Health is working. Great care is taken not to behave as health imperialists but to be catalysts for action. It is important to recognise and work with the expertise that individuals from other agencies bring to the HiAP approach. This ensures that those people with the knowledge and detailed understanding of the policy issue under examination are the leading voices in the deliberations and decision-making. SA Health also brings its expertise to the discussion but does not seek to dominate. The process of joint investigation supports the development of a shared understanding between all involved, leading to a common view about the best solutions.

Summary

There are many factors that have been important for the progress to date in the implementation of HiAP across government in SA, including the expertise and willingness of partners from government agencies to work cooperatively with SA Health. Without this partnership and support it would not have been possible to develop the HiAP model and the health lens approach. A more detailed description of the governance arrangements supporting the HiAP initiative, and an explanation of the five steps that make up the health lens, can be found in *Implementing Health in All Policies, Adelaide 2010*[3] and *The South Australian approach to Health in All Polices: background and practical guide*.[4]

Next steps for HiAP in SA

The SA HiAP initiative has achieved some early success, but there is more to be done to ensure its ongoing sustainability within the state. Although HiAP has to date received significant support at the political and bureaucratic level, it is sensible to plan for a time when, due to shifting demands and priorities, there may be less visible support. In fact, international experience has found that successful cross-sector initiatives can be cut following a change of government priorities or a change of government. The next phase of development for HiAP will be to build capacity across sectors and within the health system to embed the HiAP approach into the everyday work of policymakers, and in this way integrate the approach. There is a range of mechanisms to achieve this, including legislation, workforce development, incentives and other capacity-building strategies.

Secondly, and of equal importance, is the need to produce the evidence that HIAP is effective—that it delivers improved policy outcomes for other sectors and, at the same time, can bring about improved population health. As health outcomes will often have a significant lag time between delivery of the intervention and the final result (often counted in decades rather than years), it is necessary to identify interim health indicators and use these as markers of health improvement. There is considerable technical work involved in designing effective evidence-gathering systems that capture the impact of cross-sectoral work. The next phase of the HiAP initiative will require that attention is given to establishing these mechanisms.

Currently, the HiAP approach has been developed and applied only in state government sectors. However, there has been growing interest expressed by local government to explore and apply this approach. Local government in SA is increasingly applying SASP as an overall strategic planning framework, and this would provide an excellent opportunity for transfer and adaptation of HiAP methods and processes to this sector. It is also expected that, with the adoption of modernised public health legislation in SA (at the time of writing the new Public Health Bill is near finalisation), local government will have a clearer set of enablers to adopt HiAP approaches. Currently, SA Health is working with 'early adopters' within this sector, who are examining how HiAP can be applied in their areas. It is therefore possible that HiAP could become a feature of planning and policy development in local government over the next few years.

Lastly, while the SA HiAP approach has been able to demonstrate some early success in working on public policy issues (i.e. the priority issues of other government agencies), it has less experience in applying the HiAP approach to health policy issues. The approach and underlying values within HiAP have been specifically designed to consider public policy issues and their connection to health and wellbeing. When applying the HiAP approach to priority health policy issues (such as obesity), it will be necessary to adapt the model so that other government agencies are able to clearly see the direct benefit for their organisation and corporate goals, and to clearly articulate this benefit early in the process. Preliminary work is underway to apply the adapted HiAP approach to a priority health policy issue, and early indications are promising. Although there is still much to be done, it is expected that the HiAP approach in SA will evolve so that it works effectively on priority issues in both public policy and health policy, resulting in improved health, social and economic outcomes.

Author details

Ms Agnes Maddock is a senior project officer in the Public Health Directorate, SA Health and has an educational background in sociology and political science. She has had a long experience in health in community health, health promotion, women's health and public health, with involvement in projects and programs as diverse as the SA Cervix Screening Program, the Newborn Hearing Screening Program and the SA Healthy Weight Strategy. She is currently assisting in the drafting of the SA Health Primary Prevention Plan. Ms Maddock has editorial responsibility for the SA Health Public Health Bulletin.

Ms Carmel Williams is the manager of the Health in All Policies initiative in SA Health and oversees the development, implementation and evaluation of the initiative across government in South Australia. She was catalyst for Professor Ilona Kickbusch during her residency as 2007 Adelaide Thinker in Residence, and continues to work closely with her on the Health in All Policies initiative.

Ms Williams has a long and extensive experience in health promotion and public health where she has specialised in working across sectors both within and outside of government. Within this work she has taken a particular focus on the social determinants of health and equity. She has qualifications in education and public health. In 2008 Ms Williams was awarded the Leadership for Health Promotion Award by the Australian Health Promotion Association SA Branch, partly in recognition for her role as convener of the 2007 National Australian Health Promotion Association Conference.

Mr Danny Broderick is a senior policy officer in the Public Health Directorate, SA Health and has a long background in South Australia's health system. He has held several leadership and

executive management positions within community health and primary health care agencies and has been a long term advocate for primary health care reform in South Australia and nationally.

Mr Broderick has a worked directly to the former Minister for Health and was an active participant and advisor in health reform in South Australia during the first term of the current government. He is currently concluding a systematic review of the Public and Environmental Health Act with the aim of modernising the legislation and ensuring it is designed to respond to 21st century public health issues. He is also a member of the Health in All Policies Unit in SA Health.

References

1. Adelaide Thinker in Residence. http://www.thinkers.sa.gov.au/
2. http://saplan.org.au/content/view/25/61/
3. Kickbusch I, Buckett K (eds). Implementing Health in All Policies: Adelaide 2010. Department of Health, Government of South Australia, Adelaide, 2010.
4. Department of Health. The South Australian approach to Health in All Polices: background and practical guide. Department of Health, Government of South Australia, Adelaide, 2010.

Intersectoral governance for Health in All Policies: an integrated framework

Louise St-Pierre
Head of Projects
National Collaborating Centre for Healthy Public Policy
Québec, Canada

François-Pierre Gauvin
Research Officer
National Collaborating Centre for Healthy Public Policy
Québec, Canada

Introduction

The emergence of large-scale public health problems, such as health inequalities and obesity, is seen as a complex social problem in which the causes are multifactorial and the solutions require the shared action of several government sectors. This complexity makes it necessary for governments to find ways of ensuring the establishment of intersectoral governance for health[a] that combines both horizontal and vertical management. The aim of the Health in All Policies (HiAP) approach is to address these problems, as was recalled at the recent meeting held in Adelaide by the World Health Organization (WHO) and the South Australian Government. However, as was noted in the statement published at the conclusion of this meeting, such a strategy 'requires a new form of governance where there is a joined-up leadership within government, across all sectors and between levels of government'.[1]

The implementation of this type of governance presents many challenges, which could be summarised in the following questions, posed elsewhere by Kickbusch:[2]

- 'How should the power dynamics and relationships between health and other sectors be managed so that a fruitful relationship can be developed?
- How do you develop a common goal given the current institutional arrangements where each sector is striving to achieve its own goals?
- How do you develop a culture of cooperation given that sectors, and their leaders, are in competition for resources and 'their time in the sun'?'.

[a] We consider the term 'intersectoral governance' to be synonymous with the terms 'joined-up government', 'network government', 'horizontal governance' or 'integrated governance'. For a discussion of what distinguishes these terms, see Gagnon and Kouri (2008): http://www.ncchpp.ca/docs/Integrated_governance_AN.pdf

The aim of this article is to explore some pathways to solutions that allow these challenges to be met. While acknowledging the influence that national and cultural contexts have on government structures, we wish to propose a conceptual framework that presents various possible politico-administrative arrangements in an integrated manner, along with the conditions favourable to intersectoral health governance (see Table 1).

This framework draws on the literature concerned with governance, the concept of health stewardship and policy analysis. We hope that it will be useful to public health actors who want to identify the mechanisms for intersectoral governance for health that have already been established by their governments, as well as those that might still be developed, to ensure an across-government approach to health.

This paper will begin with a brief overview of the main concepts underlying the integrated framework, before presenting the content derived from these concepts.

Governance

The concept of governance is described variously in the literature, depending on the fields of interest of authors. We are interested here in the notion of state governance, defined as the functions exercised by a country's government authorities to orient actions toward collective goals related to the common good.[3,4] These actors are found as often in the private sphere as in the public sphere, and at all levels of government. At the level of public administration, the 'new governance' is viewed by many authors in this field as a modern approach to managing state affairs. It is based on the idea that government authorities cannot rely solely on their hierarchical power to command the introduction of desired changes, but must use the means available to them to guide, direct and negotiate.[5–7] Three central themes draw particular attention to the new governance of states: government leadership that values multiple relationships and draws on the contributions of various actors; collaborative decision-making processes; and clear accountability mechanisms that are adapted to intersectoral functioning.[4,8–11]

According to Durose and Rummery,[11] the central idea behind governance is to promote the establishment of coherent public policies through a program of governmental action based on intersectoral collaboration and policy integration. However, intersectoral collaboration often requires that the organisational culture within a public administration be adapted, since it is generally aligned with the logic of a sectoral approach.[12]

We can therefore identify four broad dimensions of intersectoral governance for health: leadership, coordination and collaboration, accountability, and cultural changes. Each of these dimensions is examined below using examples of their application to the field of public health.

Leadership

Leadership at the highest government level is one of the success factors for intersectoral governance most often evoked in the literature.[13–15] The commitment of the Prime Minister and the Treasury Department to the program aimed at combating health inequalities in the United Kingdom is an example of this type of leadership.16 We shall consider here two dimensions of such leadership: the ability to channel the will of citizens or of key actors toward a clear and inspiring vision; and the use of the policy tools available to governments to ensure the convergence of actions in support of this vision.

As regards the first dimension, experience has shown that an intersectoral governance strategy is more likely to be effective when it is guided by a comprehensive policy that is implemented, firstly, at the highest level of management[17] and whose objectives have been determined through broad consultation.[18,19] Boffin,[19] in fact, maintains that interdepartmental collaboration for health depends on the vision and the leadership of the central government and the capacity to make visible the contribution of each sector involved. We can point to the experience of Sweden, whose public health program, adopted in 2003, was the subject of a large-scale public consultation. This gave rise to a program directed toward objectives related to the structural determinants of health. These objectives are associated with over 30 governmental sectors and are formulated such that they can be tied in with the various intersectoral missions.[20]

The second dimension of leadership involves the use of policy instruments that are at the disposal of government authorities. Lascoumes and Le Galès identify four types of instruments: legislative and regulatory; economic and fiscal; incentives; and informative and communicative.[21] These instruments are used to influence the behaviour of individuals or organisations by placing limits on certain choices and facilitating others.[22] The funding of intersectoral work, for example, is among the incentive measures

considered important to ensuring the involvement of non-health sectors.[23] Legislative measures that establish the practice of health impact assessment, such as are found in the Canton of Geneva, in Quebec or in Thailand, are illustrations of the type of coercive measures used by certain governments to force policy makers to take into account the health implications of all policies.

Coordination and collaboration

As mentioned above, mechanisms for coordination and collaboration lie at the heart of any intersectoral governance initiative. They ensure that work extends beyond sectoral boundaries. In addition to encouraging discussion among various sectors and levels, the establishment of these mechanisms promotes a common understanding of issues, a synergy of action, and the maximisation of resources, all while favouring the coherence of government decisions. They may involve collaborative processes or the establishment of formal structures, such as interdepartmental committees, steering committees, networks or work units whose mandate is to ensure coordination and collaboration. The implementation of intersectoral governance is, thus, made easier when it is supported by a highly placed authority within the hierarchy, and when responsibility rests with that authority.[12,17] Supranational committees responsible for intersectoral coordination for health have, in fact, been established in many countries; for example, in Finland a national multisectoral public health committee, appointed by Parliament, was established to oversee coordination between sectors.[24] Interdepartmental committees are another kind of structure that is frequently set up to ensure coordination and collaboration.

However, such structures do not only present advantages. They can be costly in terms of resources and energy, and potentially ineffective if poorly managed and without strong commitment from the participants.[13,23] Similarly, the establishment of permanent structures, such as units supporting the practice of health impact assessment, generally requires a significant investment. However, they ensure a more stable and long-term commitment than ad hoc committees or networks.[14]

Accountability

Particular attention is paid to accountability in intersectoral governance because the sharing of responsibilities that characterises it leads to a dispersal of responsibility, making it important to establish a clear framework for accountability.[14,15,17] It is often noted that traditional frameworks for accountability within government are not adaptable to an intersectoral approach. It is thus necessary for governments to be innovative in this area.[25]

On a practical level, such accountability can vary in form. It may involve independent evaluation of programs or reports on the attainment of objectives produced jointly by several sectors. These reports may be submitted to the departmental authorities concerned, to governing bodies or even to parliamentary authorities. In Sweden, for example, it has been decided that an evaluative report on the intersectoral public health policy shall be presented to Parliament every 4 years. In Quebec an evaluation of the government's multisectoral action plan to combat obesity is the subject of a yearly presentation to the Prime Minister's cabinet.[26]

Cultural changes

Intersectoral governance must also be supported by an organisational culture that cultivates new ways of thinking and doing. This less tangible dimension is often eclipsed when horizontal management is undertaken.[12,27] It is possible to identify three strategies aimed at establishing a suitable organisational culture: capacity building; the reshaping of values; and collective learning.[28]

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.[29] 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. Practical guides to health impact assessment or the health lens tool are concrete methods used by governments to support knowledge and skills development.

In addition, it seems important to influence the values and beliefs of certain government actors. Indeed, these actors tend be more committed to, or to cooperate more fully with, an intersectoral governance for health approach if it conforms to their values and beliefs.[27] Consequently, social marketing campaigns, directed as much toward other sectors of government action as to partners and citizens, constitutes a sphere of activity that should not be ignored. The dissemination

of information about health determinants, the economic impact of disease prevention on health care costs, or the success of intersectoral initiatives are all subjects that can promote the values underlying the intersectoral governance for health approach.

Finally, collective learning based on experiences and the lessons to be drawn from them helps create the kind of fundamental shift that can ensure sustainable change.[14] Advisory committees, research activities or citizen boards are mechanisms that can be useful in this regard.

Integrated framework

Table 1 illustrates the framework of conditions for intersectoral health governance.

Table 1: Integrated framework of conditions for intersectoral health governance

Dimensions	Leadership	Coordination and collaboration	Accountability	Culture		
				Capacity building	Reshaping of values	Collective learning
Key conditions	Clear commitment from authority and political will	Intersectoral structures (formal and informal)	Formal control mechanisms and procedures	Knowledge transfer strategies (for both health and non-health sectors)	Social marketing campaigns (for both health and non-health sectors)	Advisory committees
	Comprehensive national health strategy	Stakeholder engagement	Evaluation and monitoring (processes and outcomes)	Training	Dissemination of information (e.g. about health determinants, the cost of health systems or best practices)	Research activities
	Support by different policy tools	Specific units with coordination responsibility	Public reports	Practice guidelines e.g. for health impact assessment		Citizen boards

Conclusion

During the Adelaide 2010 Health In All Policies International Meeting, participants stressed the need for better understanding among public health actors of the across-government dynamic through which intersectoral governance for health develops. At present there are few resources to which public health actors can refer. In fact, this is an emerging field of knowledge and research, and few studies are available to shed light on the effectiveness of various government strategies. By referring to disciplinary fields that focus on governance, health stewardship and policy analysis, we can gain understanding of the principal conditions that lead to success. These conditions have been identified as:

- strong and consensual type of leadership
- the establishment of structures for coordination and collaboration
- the existence of clear accountability frameworks
- the use of methods that support the establishment of a suitable organisational culture.

Many dimensions remain to be explored in the effort to improve public health practices related to HiAP. The actual, long-term effectiveness of a win–win perspective (which is often associated with HiAP), the necessary adjustment of the role of public health actors, and the impact of assigning precedence to health in government decision-making are among the aspects to be explored. However, many governments have chosen not to wait until all the answers have been found before acting—their initiatives thus represent important resources to build knowledge about this social innovation in the healthy public policy field.

Author details

Ms Louise St-Pierre is the Head of Projects at the National Collaborating Centre for Healthy Public Policy (NCCHPP) in Québec, Canada, a pan-Canadian organisation on knowledge transfer to support public health actors. She has a long experience in health promotion at local, national and international levels. She received her Masters degree and pursued a doctoral study in community health at Université Laval, Quebec City, Canada. Ms St-Pierre is also a collaborator for the World Health Organization Collaborating Centre on Non Communicable Disease Policy at the Public Health Agency of Canada

Dr François-Pierre Gauvin is a Research Officer at the National Collaborating Centre for Healthy Public Policy in Québec, Canada. A political scientist by training, (Université Laval, Quebec City, Canada), he completed his doctoral studies in health research methodologies at McMaster University, Hamilton, Ontario, Canada in 2008. Dr Gauvin's work pertains, among other things, to public engagement and evidence-informed decision-making.

References

1. Adelaide Statement on Health in All Policies. World Health Organization, Government of South Australia, Adelaide 2010.
2. Kickbusch I, Buckett K. Health in All Policies: the evolution. In Kickbusch I & Buckett K (eds), 'Implementing Health in All Policies'. Department of Health, Government of South Australia, Adelaide, 2010:5.
3. Atkinson RD. Network government for the digital age. Progressive Policy Institute, Washington, 2003.
4. Flinders M. Governance in Whitehall. Public Adm 2002; 80(1):51–75.
5. Pierre J, Peters BG. Governance, politics and the state. Macmillan, Basingstoke, 2000.
6. Peters BG. The changing nature of public administration: from easy answers to hard questions. Asian J Public Adm 2002; 24(2):153–183.
7. Stoker G. Governance as theory: five propositions. Int Soc Sci J 1998; 50(155):17–28.
8. Lemieux V. Les rôles du gouvernment dans la gouvernance. In Jason J, Thomas PG, Lemieux V & Aucouin P (eds), 'La modernisation de la gouvernance: une première exploration'. Centre de gestion canadien, Ottawa, 2000; 126–154.
9. Van Gramberg B, Teicher J, Rusailh J. Reinventing government in Australia: whole of government in a federation. Working Papers Series 4/2005. School of Management, Victoria University, Victoria, 2005.
10. Institute of Public Administration Australia (IPAA). Working together: integrated governance. IPAA, Brisbane, 2002.
11. Durose C, Rummery K. Governance and collaboration: review article. Soc Pol. & Society 2006; 5(2):315–321.
12. Bourgault J, Lapierre R. Horizontalité et gestion publique: rapport final au Centre canadien de gestion, au Réseau du leadership, au Conseil des hauts fonctionnaires fédéraux du Québec et à l'École d'administration publique. Centre canadien de gestion, Ottawa, 2000.
13. Gagnon F, Kouri D. Integrated governance and healthy public policy: two Canadian examples. National Collaborating Centre for Healthy Public Policy, Montreal, 2008.
14. Barr V, Pedersen S, Pennock M, Rootman I. Health equity through intersectoral action: an analysis of 18 country case studies. Public Health Agency of Canada; World Health Organization, Ottawa, 2008.
15. Geneau R, Fraser G, Legowski B, Stachenko S. Mobilizing intersectoral action to promote health: the case of ActNowBC in British Columbia, Canada. Public Health Agency of Canada; WHO Collaborating Centre on Chronic Non Communicable Disease Policy, Ottawa, 2009.
16. Keon JW, Pépin L. Population health policy: international perspectives. Canadian Senate, Ottawa, 2008.
17. Australian National Audit Office (ANAO). Better practice guide on public sector governance, volumes 1 and 2. ANAO, Canberra, 2003.

18. Ling T. Delivering joined-up government in the UK: dimensions, issues and problems. Publ Adm 2002; 80(4):615–642.
19. Boffin N. Stewardship of health systems: review of the literature. Institute of Tropical Medicine, Antwerp, 2002.
20. Hogstedt C, Lundgren B, Moberg H, Pettersson B, Agren G. The Swedish public health policy and the National Institute of Public Health. Scand J Public Health 2004; 32(suppl.64):6–64.
21. Lascoumes P, Le Galès P. Introduction: l'action publique saisie par ses instruments. Académique, Paris, 2005; (1):1—44. http://www.cairn.info/gouverner-par-les-instruments--9782724609492-page-11.htm
22. Howlett M, Ramesh M. Studying public policy: policy cycles and policy subsystems. 2nd edn. Oxford University Press, Don Mills, Canada, 2003.
23. Rounce A, Beaudry N. Using horizontal tools to work across boundaries: lessons learned and signposts for success. Canadian Centre for Management Development (CCMD); Ministry of Transport, Ottawa, Canada, 2002.
24. Stahl T, Lahtinen E. Towards closer intersectoral cooperation: the preparation of the Finnish national health report. In Stahl T, Wismar M, Ollila E, Lahtinen E & Leppo K (eds), 'Health in All Policies: prospects and potentials'. Ministry of Social Affairs and Health, Helsinki, Finland, 2006; 169–185.
25. Wilkins P. Accountability and joined-up government. Aust J Public Adm 2002; 61(1):114–119.
26. Ministère de la Santé et des Services Sociaux (MSSS). Plan d'action gouvernementale de promotion de saines habitudes de vie et de prevention des problèmes reliés au poids-2006–2012: investir pour l'avenir. MSSS, Québec, 2006; 50.
27. Bakvis H, Juillet L. Le défi de l'horizontalité: ministères responsables, organismes centraux et leadership. École de la fonction publique du Canada, Ottawa, 2004.
28. Schneider A, Ingram H. Behavioral assumptions of policy tools. J Polit 1990; 52(02):510–529.
29. Travis P, Egger D, Davies P, Mechbal A. Towards better stewardship: concepts and critical issues. Report No: WHO/EIP/DP/02.48. World Health Organization, Geneva, 2002.

The financial crisis: a case for Health in All Policies?

Armin H Fidler
Lead Advisor, Health Policy and Strategy
Health, Nutrition and Population
Human Development Network
The World Bank

Valerie Moran
Health Analyst, Health Division
Employment, Labour and Social Affairs Directorate
Organisation for Economic Co-operation
and Development (OECD)

Introduction

The recent global financial crisis has affected most countries at all income levels. It would go beyond the scope of this paper to attempt to fully analyse the nature of the crisis or how it differs from previous economic downturns. However, we try to deduce from past experiences what lessons may be derived from a recession's health and social impact, and we make the case that a health lens in other sectors' policies can mitigate the impact of an economic downturn. We examine which economic and social groups have been most affected by the negative impact of such a crisis, and which sector policies (other than direct health services investments) can be put in place in order to prevent and lessen potential adverse effects. From a review of empirical and anecdotal evidence, we conclude that governments, as part of a Health in All Policies (HiAP)[1] approach can protect social safety nets during and after an economic downturn by means of sustained supply of basic services and active labour market policies,[a] and with targeted demand-side approaches like conditional cash transfers,[b] concentrating on the most vulnerable groups.

Effect of the economic crisis

Different from previous regional economic crises, this current crisis has taken on a global dimension in that it started in the most developed countries and spread to middle and lower income countries. The crisis originated in the collapse of the United States (US) subprime market and the ensuing disintegration of major financial institutions in the US and Europe. It was exacerbated by global imbalances in savings and liquidity between countries such as the US and China.[2]

[a] Active labour market policies are government programs that intervene in the labour market to help the unemployed find work.

[b] Conditional cash transfer programs provide cash payments to poor households that meet certain behavioural requirements, generally related to children's health care and education.

Economists point to data in the US, Japan, France and Germany that is hinting at early signs for a recovery, but the shape and duration of such an upswing remains unpredictable as yet. Evidence from past crises indicates lag effects in employment and social sector recovery.[3] The Organisation for Economic Co-operation and Development (OECD) predicts cuts in social spending as governments struggle with high levels of debt[4] fuelled by high unemployment, large fiscal outlays for stimulus packages and banking bailouts.

There is fear of a European divide—in terms of both the effect of and recovery from the current crisis—resulting in apprehension of a two-speed Europe, even within the Eurozone. France and Germany registered positive economic growth in the second quarter of 2009 and sustained this trend for the remainder of the year, while Spain continued to experience negative growth.[5] The credibility and future of the euro has been threatened by the economic woes of Greece, where the combination of a budget deficit measuring -12.7% of GDP and a public debt of 113.4% of GDP have led to fears that the International Monetary Fund (IMF) would need to rescue the economy.[6] The severe recession has already necessitated IMF bailouts for Latvia, Hungary, Iceland and Ukraine. The World Bank, the European Bank for Reconstruction and Development (EBRD) and the European Investment Bank (EIB) have provided US$31.1 billion in support of eastern Europe.[7] However, some countries in the region have emerged from the crisis relatively unscathed; for example, Poland registered positive GDP growth throughout 2009.[8]

During 2009 economic performance in Europe was mixed, falling by 4% that year, with the European Commission (EC) predicting GDP to grow by 0.7% in 2010 and 1.5% in 2011.[9] The traditional lag in employment growth means that unemployment in the European Union (EU) is expected to reach 10.7% in 2010 and climb to 10.9% in 2011. However, European countries have been affected variably, with many such as Spain, Ireland, Hungary and Portugal registering unemployment rates in double digits, while others such as Norway and the Netherlands have rates of less than 5%.[10] Earlier labour market reforms that increased labour flexibility may have prevented or perhaps just delayed more substantial job losses. At present, socioeconomic groups with temporary contracts (e.g. young people, short-term contractors and migrant workers) as well as the self-employed remain the worst off.

Who is most affected?

As the labour market situation deteriorates, the negative impact on households and workers is mounting. However, as a Red Cross study focused on its European administrative region demonstrates, certain groups in society are more vulnerable to the adverse effects of the crisis. These groups include children, the young, the elderly, the unemployed, migrants, refugees and asylum seekers.[11] The UK and Ireland have witnessed a rapid turnover of workers from the new member states (NMS)—of 1.4 million NMS workers who came to the UK after 2004, half returned by 2008. Romanian and Bulgarian migrants entering Spain declined by more than 60%, while the number of migrants leaving Spain doubled from 120 000 in 2006 to 232 000 in 2008.[12]

Europe's demographic challenge further compounds this situation. Long-term care is another good example of a public policy that must be pursued with a health lens in mind. The EC's 2009 Ageing Report, *Dealing with the impact of an ageing population in the EU*, states that

> *'…the economic downturn makes the challenges created by ageing more acute…Without policy interventions, demographic changes will lead to reduced economic growth, a rising burden of dependency and threats for public finances through expenditure pressure on pensions, health and social services.'* [13]

There remains a 10-year window for structural reforms to health, pension and education systems to be implemented, as a large drop-off in the size of the labour force is predicted in the next decade. Rising health care costs within long-term care and the need for quality of life and social protection of the elderly are additional HiAP challenges for governments during the next decade.

Previous economic crises have shown that health and social expenditures tend to recover slower than the rest of the economy, thus putting the poor and vulnerable most at risk.[14] Already, 16% of the EU population, ranging from 10% in Nordic countries to 25% in Italy and the Baltic States, is at risk of officially defined poverty, even after social transfers.[15] Unemployment-related income reductions will affect nutrition, transport and health care expenditures of households. Citizens of new European member states, who, during the transition years, succeeded in entering the middle class are at risk of falling back into poverty, particularly when a catastrophic health event occurs in the absence of social safety nets.

From past financial crises we have learned that they directly impact households, negatively affecting demand for, and utilisation of, health services.[9] Devaluation of local currencies may result in reduced consumption of essential drugs as local currency prices increase, contributing to deteriorated health status. Italy has signalled a possible correlation between the crisis and increased heroin substance abuse.[16] Also, in times of stress, people tend to partake in less healthy behaviours such as higher fat intake, less frequent exercise and increased smoking.[17] Those in lower income categories may need to take on extra low-paying jobs, thus having less leisure time for family, children and exercise. People may consume less nutritious food due to a reduction in household income, and forgo necessary preventive and curative care.[18,19] Such behaviour changes could result in adverse health outcomes in the future as a long-term consequence of the crisis. In addition, evidence suggests that, in age groups less than 65 years, increases in unemployment are associated with premature mortality from suicide.[20] However, empirical evidence in Europe thus far has revealed only limited changes in effective health service utilisation.[15] While an economic downturn may trigger a change in health-seeking behaviours (access to service barriers) or exacerbate such behaviour changes as are detrimental to good health, we need to recognise that the 'control knobs' for affecting such choices are mostly in sectors outside the health domain—for example fiscal policy in the case of taxation (tobacco, alcohol, sugar), trade, agriculture and food safety; community education (trans-fats, food labelling); or the education system (healthy school lunches, nutrition education).

In the face of a crisis, real government spending on health care in countries of all income ranges tends to decline. This is due to reduced tax revenues, currency devaluations and, in the case of middle-income countries, potential reductions in external assistance as well as lower remittances. As already experienced in the new member states and other countries in eastern Europe, the lower income countries with weaker fiscal positions and prevailing structural problems show the largest negative effects.

Policy responses

From evidence and case studies around the world, we can deduce that the impact of the crisis on households and the health status of the vulnerable population can be alleviated through policy levers outside the health sector proper, such as appropriate social protection and social risk-mitigation measures. In parallel there is an urgency to formulate new policies and effective responses to the employment and social cohesion challenges imposed by the economic downturn. In recognising the importance of jobs for family health and welfare, governments not only need to tackle unemployment through active labour market policies, but also adapt and modernise social assistance, and health care and public health services. Income support programs, conditional cash transfers and active labour market policies can stimulate demand, facilitate transition back to work and avoid social exclusion. Such policies will also cushion the potential negative health impacts of the crisis as they support households to cover their basic needs and provide much needed social safety nets.

There is good international evidence that appropriate means testing to target the poor, tax credits for low-income populations, and conditional cash transfer programs to incentivise the consumption of services that constitute public goods (e.g. education, vaccination) have contributed to protect vulnerable population groups in highest need.[21] In order to maintain existing jobs, several instruments have been used—increasing job subsidy and public sector job creation programs; reducing employer social contributions; creating or expanding short-term work schemes; and policies combining aspects of all three.[22] It is also vital to ensure rapid (re-) integration into labour markets by means of vocational training, sickness or disability benefits, and unemployment benefits. The most vulnerable can be protected by increasing the minimum wage; extending unemployment benefits, housing or family allowances; and introducing measures to protect against over-indebtedness or repossession.

In this context the crisis provides a unique opportunity in many countries for continued reforms in the health and social sectors—and clearly an incentive to be aware of and learn from countries' experience with HiAP.[23] While it is vital that governments maintain adequate revenues for the health sector, they must be circumspect about how this is achieved. Because of its negative impact on labour markets, it is not advisable to increase payroll taxes. Rather, it is better to experiment with increases in indirect ('sin') taxes on tobacco, alcohol and unhealthy foods in order to compensate for potential revenue shortfalls and protect pre-crisis levels of public spending on health. Evidence of these policies can be seen in New York state, where an 18% tax on non-diet soft drinks was proposed in order to raise revenue to fund the state's largest ever budget deficit.[24] Countries such as Slovenia and Poland have also enacted such measures—the former increased

excise taxes on alcohol and tobacco and the latter used revenues from increased excise taxes on alcohol to finance a social solidarity fund.[7]

In times of economic downturn, governments may also face the necessity of containing costs and curtailing public expenditure. Instead of indiscriminate budget cuts across the board, this can be achieved in the social sectors by postponing selected capital investments, reducing overheads, and reducing overcapacity by rationalising hospitals and improving the targeting efficiency of social programs. Other measures may include transparent pharmaceutical policies to exercise expenditure control; public tendering of health goods for economies of scale; sound registration and prescription practices; and investment in cost-effective public health programs, epidemiologic surveillance and health technology assessment in order that decision-makers have up-to-date intelligence on how to improve allocative efficiency.[c] But it is of utmost importance that governments and policy makers protect the most vulnerable households by safeguarding pro-poor spending on health, maintaining primary health care, protecting against catastrophic health expenditures, and ensuring the use of transparent, formal cost sharing, including exception policies for the indigent in lieu of under-the-table payments.[25] In addition to such direct safeguards within the health sector,[26] there are a number of policy interventions in other sectors that should be examined through a 'health lens' with regard to their potential impact on health status and social protection for the population.

Author details and sources

This paper is based on a presentation given by Dr Armin Fidler at the Health in All Policies International Meeting in Adelaide, South Australia, on 15 April 2010. Dr Fidler is Lead Advisor, Health Policy and Strategy, on Health, Nutrition and Population in the Human Development Network of the World Bank. He holds a Doctor of Medicine Degree from the University of Innsbruck, Austria; a Diploma in Tropical Medicine and Hygiene from the Bernhard Nocht Institute, Hamburg, Germany; and Master of Public Health and Master of Science degrees in Health Policy and Management, both from Harvard University's School of Public Health. He also earned certificates in Management from the Harvard Business School and in Public Finance and Welfare Economics from the London School of Economics and Political Science. Dr Fidler formulated the concept and intellectual content of the paper and provided input in terms of research and data.

Ms Valerie Moran is a Health Analyst in the Health Division of the Employment, Labour and Social Affairs Directorate of the Organisation for Economic Co-operation and Development (OECD). She previously held the position of Junior Professional Associate in the Health, Nutrition and Population Unit of the Human Development Network of the World Bank. Ms Moran holds undergraduate and postgraduate degrees in economics, sociology and politics from the National University of Ireland, as well as an MSc in Health Economics from the University of York, UK. Ms Moran contributed substantial input to the paper in terms of research and writing.

References

1. Government of South Australia. Health in All Policies: the South Australian approach. http://www.health.sa.gov.au/pehs/HiAP/infopamphlet-hiap-phcc-1004.pdf
2. European Commission. Economic crisis in Europe: causes, consequences and responses. Office for Official Publications of the European Communities, Luxembourg, 2009.
3. Organisation for Economic Co-operation and Development (OECD). Helping workers weather the economic storm. OECD, Paris, 2009.
4. Organisation for Economic Co-operation and Development (OECD). Government at a glance 2009. OECD, Paris, 2009.
5. Organisation for Economic Co-operation and Development (OECD). Stat Extracts 2010. Quarterly National Accounts: quarterly growth rates of real GDP. OECD, Paris, 2009. http://stats.oecd.org/index.aspx?queryid=350
6. The Economist. A ruinous picture: Greece may need more support than you think. The Economist Online, 26 March 2010. http://www.economist.com/daily/news/displaystory.cfm?story_id=15785561
7. www.worldbank.org/financialcrisis/bankinitiatives.htm
8. European Commission. Eurostat news release, Euroindicators, 30 October 2009. http://ec.europa.eu/eurostat
9. European Union. Autumn forecast 2009–2011: EU economy on the road to a gradual recovery. Press release. www.europa.eu
10. Organisation for Economic Co-Operation and Development (OECD). OECD unemployment rate broadly stable at 8.6% in February. Press release. http://www.oecd.org/dataoecd/15/62/44976756.pdf
11. International Association of Red Cross and Red Crescent Societies. The economic crisis and its humanitarian impact on Europe: testimonies from the Red Cross and Red Crescent. International Federation of Red Cross Europe Zone Office, Budapest, 2009.
12. Fix M, Papademetriou DG, Batalova J, Terrazas A, Yi-Ying Lin S, Mittelstadt M. Migration and the global recession. Migration Policy Institute, Washington DC, 2009.
13. European Commission (EC). Dealing with the impact of an ageing population in the EU (2009 Ageing Report). EC, Brussels, 2009.

[c] This is a situation in which it is impossible to make one person better off by reallocation of goods or services without making another person worse off.

14. Gottret P, Gupta V, Sparkes S, Tandon A, Moran V, Berman P. Protecting pro-poor health services during financial crises: lessons from experience. In Chernichovsky D & Hanson K (eds), 'Innovations in health system finance in developing and transitional economies'. Emerald Group Publishing, United Kingdom, 2009.
15. European Commission (EC). Joint report on social protection and social inclusion 2008. EC, Brussels, 2008.
16. World Health Organization (WHO). Health in times of global economic crisis: implications for the WHO European Region. Overview of the situation in the WHO European Region: background paper. WHO Regional Office for Europe, Copenhagen, 2009.
17. Ng DM, Jeffrey RW. Relationships between perceived stress and health behaviours in a sample of working adults. Health Psychol 2003; 22(6):638–642.
18. Stuckler D, Basu S, Suhrcke M, McKee M. The health implications of the financial crisis: a review of the evidence. Ulster Med J 2009; 78(3):142–145.
19. Catalano R. Health, medical care, and economic crisis. N Engl J Med 2009; 360(8):749–751.
20. Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. The Lancet 2009; 374(9686):315–323.
21. Fiszbein A, Shady N. Conditional cash transfers reducing present and future poverty. The World Bank, Washington DC, 2009.
22. Organisation for Economic Co-operation and Development (OECD). Addressing the labour market challenges of the economic downturn: a summary of country responses to the OECD-EC Questionnaire. OECD, Paris, 2009.
23. Kickbusch I. Healthy societies: addressing 21st century health challenges. Report prepared by Professor Ilona Kickbusch (Adelaide Thinker in Residence). Department of the Premier and Cabinet, Adelaide, May 2008. http://www.thinkers.sa.gov.au/images/Kickbusch_Final_Report.pdf
24. McColl K. Fat taxes and the financial crisis. The Lancet 2009; 373:797–798.
25. Hou X, Chao S. An evaluation of the initial impact of the medical assistance program for the poor in Georgia. World Bank policy research working paper. World Bank, Washington DC, 2008.
26. Hopkins S. Economic stability and health status: evidence from East Asia before and after the 1990s economic crisis. Health Policy 2006; 75:347–357.

Economic growth, economic decline and implications for Health in All Policies[a]

Vivian Lin
School of Public Health
La Trobe University, Victoria

Background

There has now been nearly two decades of discourse on the importance of health for the economic development agenda. The groundbreaking 1993 World Development Report[1] called for governments to invest in health, and particularly in cost-effective interventions, as an essential ingredient for economic development. The subsequent report of the World Health Organization's Commission on Macroeconomics and Health[2] squarely put on the global agenda the importance of funding for prevention programs. In the developed countries the Organisation for Economic Co-operation and Development (OECD) has further followed this line of thinking in its analysis of the burden of chronic disease and the need for prevention.[3] The OECD analysis on the loss of productivity due to chronic disease and disability has underpinned the thinking of the Council of Australian Governments (COAG) in both the Australian Better Health Initiative[4] and its diabetes initiative.[5]

Thus, economic analysis can be, and has been, an important tool for policy development and policy advocacy for prevention. The 'Abelson Report' in Australia[6] has been referred to by the 'Wanless Report'[7] in the UK as an example of the kind of analysis that the world needs.

Health in All Policies approach

However, using economic analysis to argue for investment in prevention is not the same thing as arguing for Health in All Policies (HiAP). Fundamentally, HiAP is not about growing the budget allocation to public health and health promotion,[b] but about achieving co-benefits that accrue to multiple sectors, and about an approach to governance. It is not demonstrating that a workplace-based health promotion program on chronic disease lifestyle risk

[a] This paper is based on a commentary prepared for the 'Health and the Economy' session at the Adelaide 2010 Health in All Policies International Meeting. The session was led by a presentation by Dr Armin Fidler (see this issue of the Bulletin).

[b] as appeared to be suggested by the line of questioning adopted by the meeting facilitator.

factors will lead to a predictable level of improvement in productivity or absenteeism. Rather, good employment practices, including looking after the health and welfare of employees, will contribute to better productivity; and healthier workers will contribute to the economic and social wellbeing of both the community and their workplaces. Thus, good health and good workplaces all contribute to a better human condition and a better society. The challenge is how to develop the governance framework that will lead to adoption and implementation of effective practical mechanisms in multiple settings.

Impact of economic decline

In times of economic decline, such as the global financial crisis, the link between economic position and health, particularly health inequities, becomes even more pronounced. There is longstanding literature on unemployment and health (following Brenner's early work)[8] and on charting the importance of both class and gender in influencing the historical impact of economic stresses on mortality.[9] The recent global financial crisis has put particular stressors on the poor everywhere, and particularly in low- and middle-income countries.[c] Strengthening health and social safety nets has clearly been an important response to cushion the worst of these impacts. But what would need to be done to maintain and improve health in the future? Would investments to ensure universal coverage to primary health care be a next step? Or would ensuring the rapid process of urbanisation in developing countries create health for new migrants?

In Australia the government's stimulus package did not consider the differential social and health impacts, perhaps due to a lack of analysis that modelled such impacts and advocacy for a more nuanced approach, and the speed at which the government was responding. The health sector was probably too focused on delivery in its own programmatic silos (and the debates about health reforms) to consider how to engage effectively in broader economic and social policy developments. Could social inclusion and environmental sustainability—as important determinants of health and health inequity—have been a greater consideration in the stimulus package, particularly in infrastructure investments? Could the health reform debates that took place over this period have incorporated greater consideration of health equity and governance arrangements, including an HiAP approach?

Discussion

Can economic crises be turned into opportunities? The challenge stemming from this crisis, at the global level and from the perspective of acting on the social determinants of health, is to reconfigure global governance to an HiAP approach. Can global institutions—trade, economics, labour, health, aid, environment etc.—actually be better aligned to deliver a more equitable, healthier, socially tolerant, democratic and productive society? This is a long-term project that will need to involve strong input from civil society, along with development of new forms of network governance, which have been seen more in HIV/AIDS than in other areas of health endeavour.

There is an opportunity in Australia to take advantage of a political window of support for prevention, and translate the rhetoric into reality. To do so is not simply a matter of government funding for programs, nor the creation of a single national institution to provide leadership, although both are important strategic elements. An HiAP approach points to the importance of a more integrated approach across government, to resource allocation, programming and use of such policy levers as financing incentives and regulation. The role of the health sector is, in part, to provide the business case, through analysis and modelling of intervention options, to support policy development that integrates policy considerations.

Recognising that businesses, community organisations and individuals are all co-producers of health, the exercise of a government stewardship role within an HiAP framework would create the conditions to support all actors to be co-investors in health. Incentives for exercising greater corporate social responsibility, being good employers, and developing health-promoting technologies and products are examples of bringing economic, social and health interests together. Incentives for locality development—to create both vibrant local economies and social connectedness—would be another way of using policy levers.

Ultimately, the challenge for the HiAP approach is in the implementation of not only a joined-up decision-making process in government, but of joined-up approaches in communities, workplaces and other social institutions to achieve real co-benefits. This requires collaborative planning in each setting, mobilisation of interested parties, skilled workforces, sound local information and sufficient resources. The short-term nature of political cycles, unfortunately,

[c] as outlined by Dr Armin Fidler in his presentation at the meeting.

work against consistent and prolonged implementation efforts. So the governance challenge for HiAP is about establishing both accountable and transparent processes for decision-making and monitoring implementation, and processes that allow for collective learning and adjusting the course of action as implementation progresses.

Author details

Dr Vivian Lin is the Chair of Public Health (and was Head of the School of Public Health from 2000–05) at La Trobe University in Melbourne. She was previously the Executive Officer for the Australian National Public Health Partnership. She has held senior positions within the NSW Health Department, the National Occupational Health and Safety Commission, and the Victorian Department of Health. In recent years she has been a member of the boards of the Cooperative Research Centre for Aboriginal Health, the inaugural President of the Chinese Medicine Registration Board of Victoria, convenor of the Australian Network of Academic Public Health Institutions (ANAPHI) and a member of the Australia–China Council.

Dr Lin consults for the World Bank, World Health Organization, and the UK Department for International Development, particularly in China and the Asia–Pacific region, on health systems and health promotion. Her research interests are in political economy and social determinants of health, health system development and public health policy and its implementation.

References

1. World Bank. World Development Report 1993: investing in health. World Bank, Washington DC, 1993.
2. World Health Organization (WHO). Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health. WHO, Geneva, 2001.
3. Sassi F & Hurst J. The prevention of lifestyle-related chronic diseases: an economic framework. OECD Health Working Paper No. 32. Organisation for Economic Co-operation and Development (OECD), Paris, 2008.
4. Council of Australian Governments. Council of Australian Governments' meeting 10 February 2006 [online]. Barton, ACT, 2006. http://www.coag.gov.au/coag_meeting_outcomes/2006-02-10/index.cfm
5. Council of Australian Governments. Council of Australian Governments' meeting 13 April 2007 [online]. Barton, ACT, 2007. http://www.coag.gov.au/coag_meeting_outcomes/2007-04-13/index.cfm
6. Abelson P. Returns on investment in public health: an epidemiological and economic analysis. Report prepared for the Population Health Division of the Commonwealth Department of Health and Aged Care, Canberra, 2001.
7. Wanless D. Securing good health for the whole population. Report to the Prime Minister, the Secretary of State for Health and the Chancellor of the Exchequer, London, 2004.
8. Brenner M, Mooney A. Unemployment and health in the context of economic change. Soc Sci Med 1983, 17:1125–1138.
9. Bengtsson T, Campbell C, Lee J A. Life under pressure: mortality and living standards in Europe and Asia, 1700–1900. MIT Press, Cambridge, 2004.

Health in All Policies: a pathway for thinking about our broader societal goals

Elizabeth Harris
Ben Harris-Roxas
Centre for Health Equity Training, Research and Evaluation (CHETRE)—part of the UNSW Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine
University of New South Wales, Sydney

Introduction

Improving the health and life chances of the population cannot be achieved by the health sector working alone. The important role of other sectors in shaping health is not a new idea. As we move from the Declaration of Alma-Alta,[1] the Ottawa Charter[2] and the Adelaide Recommendations on Healthy Public Policy[3] to the Healthy Cities Movement, the Halifax Conference on Intersectoral Action for Health[4] and, most recently, the Adelaide Statement on Health in All Policies,[5] we can see that intersectoral action for health has been constantly rebranded to give new impetus to action that tries to look beyond hospital waiting lists and curative services to improve the health of the population.

Evidence and pathways of the relationship between population health and the social, economic and political environments in which people live are now better understood. We also have a better idea of the factors that will encourage other government sectors to collaborate with the health sector to achieve common goals. Many of these were powerfully highlighted at the Adelaide 2010 Health in All Policies International Meeting.[6] They include high-level political support; a clearly understood overlap in goals that could best be met by working together; cross-sectoral processes for priority setting and governance; and an in-depth understanding of how partner organisations work and operate, and their disciplinary bases.

The purpose of this paper is to discuss how our increased sophistication in understanding and taking action on the social determinants of health is forcing us to identify the values and goals of society that are driving the distribution of these determinants. We then consider how Health in All Policies (HiAP) and health impact assessment (HIA) provide a way of increasing links between sectoral interests to achieve common societal goals.

The distribution of the social determinants of health

The World Health Organization (WHO) Commission on the Social Determinants of Health[7] has expanded our understanding of the determinants of health to include the broader forces that determine the distribution of the determinants—also referred to as the 'causes of the causes' (Figure 1). The broader forces that systematically produce an inequitable distribution of the social determinants of health include history; the power and stability of social, economic and political institutions; the values and norms of mainstream society; and the role of the state (Figure 1). For example, we know that education is a major social determinant of health, but what are the wider forces that shape school participation, the quality of schools, parental attitudes to schools, levels of investment in education and the variable nature of health-promoting environments?

This is new territory for many people who have adopted the social determinants of health framework. Recognising the importance of factors such as unemployment, transport and food in determining health is not synonymous with recognising the importance of other factors that determine their distribution. In other words, the social determinants of health by themselves do not explain the systematic patterns of health inequity in society.

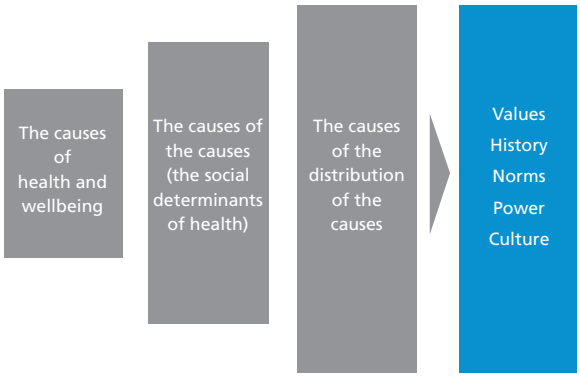

Figure 1: The determinant of the distribution of the determinants of health

Identifying 'broader societal goals'

The importance of HiAP as a means of achieving broader societal goals was raised several times during the Adelaide meeting.[6] Unfortunately, while these goals were alluded to, they were not systematically explored. Working to address these broader factors that determine the distribution of the determinants of

health will require the development of new theoretical and practical (and potentially more political) approaches to creating environments for health. It will also involve identifying and discussing values and assumptions that often influence but are rarely explicit in the policy making process, such as equity, justice, transparency, sustainability, democracy and fairness.

Without such an explicit discussion, we will continue to be locked into a health model where health outcomes continue to be seen as the primary outcomes of intersectoral action. The HiAP process, with its emphasis on 'win–win' outcomes, attempts to address this, but we can anticipate that eventually there will be challenges from the health system investing in the core priorities of other sectors if there are not clear benefits to the health sector. Linking HiAP closely with government priorities and a central agency overview is helping to minimise this risk.

We in the health sector are not alone in discovering that many of the complex problems we face in society are interconnected. Tackling the so-called 'wicked' problems has seen the emergence of many groups working for joined-up policy.[8] As the Business Council of Australia's submission to the National Health and Hospitals Reform Commission makes clear, the health of the workforce is seen as a central concern for business in Australia:

> *'…that improving health is essential to increasing workforce participation and productivity and improving the capacity of all citizens to fully participate socially and economically. Improved health is an investment in future prosperity in the same way that school education, industrial research and roads are investments in the future. Without improved health we cannot lift participation in the workforce by many under-represented groups and lift productivity.'*[9]

New stakeholders are also emerging. In our work in HIA[10–12] we have observed increased interest in capacity building for intersectoral action from extractive industries, non-government organisations, remote Aboriginal communities, local government and many government departments. In the short term their focus is often on engaging with HIAs or building their workforce and organisational capacity to undertake HIAs. In the longer term these HIAs often result in an improved understanding of health, enabling engagement across the planning cycle (Figure 2)—beyond the point prior to implementation when HIA is usually undertaken.

The health lens as part of the policy development process

The linear nature of the policy cycle often reflects a conceptual ideal rather than reality;[13] however, there are numerous examples of HIAs enabling subsequent collaborative problem identification, needs assessment, options discussions, evidence collection and synthesis, and planning.[14–16] Flexibility and responsiveness to the needs of partners is essential in trialling new ways of working together. The health lens used in the HiAP process lends itself to being brought into the policy development cycle in a flexible way.

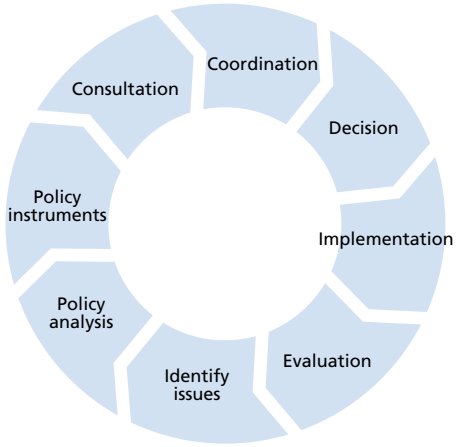

Figure 2: The policy cycle
Source: Bridgman and Davis 2006[26]

The development of the health lens[17] was a response by the South Australian Department of Health's concern that the HIA process is generally undertaken at the point in the planning process prior to implementation where there is a substantive proposal to be assessed. This occurs later in the planning cycle and often means it is difficult to fundamentally change decisions that have already been made. The health lens represents a complementary approach that can be used when a policy is less developed, thus enabling analysis of more fundamental alternatives than would be possible if the policy was already in draft form. The health lens has many procedural similarities to HIA, and it is worth noting that the use of HIA in several contexts emphasises the importance of assessing policy alternatives in a manner that is consistent with the health lens.[18–21]

Like HIAs, all health lens analyses are undertaken to learn something, although the nature, scope and purposes of this learning are not usually recognised as an issue. Glasbergen[22] describes three types of learning that can

result from using decision-support tools, namely:

1. technical learning, which involves searching for technical solutions to fixed objectives
2. conceptual learning, which involves redefining goals, problem definitions and strategies
3. social learning, which emphasises dialogue and increased interaction between stakeholders (this is distinct from the concept of social learning used in psychology).

This is worth considering because the health lens was developed with the goal of informing activity earlier in the planning cycle, before a proposal has been developed. This will involve both conceptual and social learning. These types of learning require more sustained and meaningful stakeholder involvement when compared with other, more technical and technocratic, decision-support tools such as HIAs and health lens analyses. The main issue is to use them in ways that are transparent, evidence informed and fit for purpose. Our work on HIA suggests that there are four broad purposes for conducting HIAs[23] (Table 1). The health lens, with its focus on government policy, is probably best seen as a decision-support tool that, in its current form, has limited scope to be community-led or used for advocacy reasons by groups outside government. Like HIA, its process is 'fit for purpose' in progressing policy goals.[24,25]

Table 1: A comparison of the potential forms of health impact assessments (HIAs) and health lens analyses

Forms	Purpose	HIA	Health lens
Mandated	Meeting a regulatory or statutory requirement	✓	✓
Decision-support	Voluntarily improving decision-making and implementation	✓	✓
Advocacy	Ensuring that under-recognised health concerns are addressed in design, decision-making and implementation	✓	
Community-led	Ensuring that health-related concerns are identified and addressed, and enabling greater participation of communities in decisions that affect them	✓	

Based on Harris-Roxas and Harris[24]

Conclusion

There is a growing acceptance of the role of the social determinants of health in creating healthy populations. We believe that this is allowing us to seriously ask ourselves what are the forces driving the distribution of these social determinants and how do they shape and reflect our broader societal goals. This will bring new challenges in developing the language to discuss values and principles as central to health improvement. Both HiAP and HIA provide practical ways of increasing links between sectoral interests to achieve broader societal goals.

Author details

Ms Elizabeth Harris is the Director of the Centre for Health Equity Training, Research and Evaluation (CHETRE), which is part of the Division of Population Health and one of the Centres for Primary Health Care and Equity at the University of New South Wales. Originally trained as a social worker, she has worked as a clinician, manager and researcher in hospital, general practice, community health and public health settings in rural, regional and urban areas of Australia as well as several Pacific countries.

Ms Harris's research interests are in the areas of comprehensive primary health care and equity, with a special focus on early childhood intervention programs in disadvantaged populations and communities; and the development of healthy public policy, including health impact assessment (HIA). In 1995 she was part of a team that undertook a review of intersectoral action for health in Australia. CHETRE's work on HIA has recently been recognised by the International Association of Impact Assessors and awarded their 2010 Institutional Award.

Mr Ben Harris-Roxas has been involved in the field of HIA since 2003. He has been involved in more than 20 HIAs and has trained more than 300 people in HIA. He coordinates a Masters-level course on HIA and has published widely on the topic. Mr Harris-Roxas is part of a team that has received Australian Research Council funding to evaluate the impact and effectiveness of HIAs conducted in Australia and New Zealand over the past five years. He maintains the HIA Connect website and the HIA blog, as well as the HIA Asia Pacific and HIA Academic listservs. He also edits the International Association for Impact Assessment's Health Quarterly.

References

1. World Health Organization (WHO). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. WHO, Geneva, 1978.
2. World Health Organization (WHO). Ottawa Charter on Health Promotion. WHO, Geneva, 1986.
3. World Health Organization (WHO). Adelaide recommendations on healthy public policy. Second International Conference on Health Promotion, Adelaide, South Australia, 5–9 April 1988. WHO, Geneva, 1988.
4. World Health Organization (WHO). Report on a conference on intersectoral action for health: a cornerstone for health-for-all in the 21st century, 20–23 April 1997, Halifax, Nova Scotia, Canada. WHO and the Canadian Public Health Association, 1997.
5. Adelaide Statement on Health in All Policies. World Health Organization, Government of South Australia, Adelaide 2010.
6. http://www.health.sa.gov.au/pehs/HiAP/adelaide-2010.htm
7. World Health Organization (WHO). Closing the gap in a generation: health equity through action on the social determinants of health. Commission on the Social Determinants of Health, WHO, Geneva, 2008.
8. Stewart-Weeks M. From control to networks. In Colebatch H (ed.), 'Beyond the policy cycle: the policy process in Australia'. Allen & Unwin, Sydney, 2006; 184–202.
9. Business Council of Australia (BCA). Fit for the job: adapting to Australia's new health care challenges. Submission to the National Health and Hospitals Reform Commission. BCA, Melbourne, 2009.
10. Harris P, Harris-Roxas B, Harris E, Kemp L. Health impact assessment: a practical guide. UNSW Research Centre for Primary Health Care and Equity and NSW Health, Sydney, 2007.
11. Harris-Roxas B, Harris P. Learning by doing: the value of case studies of health impact assessment. NSW Pub Health Bull 2007; 18(9–10):161–163.
12. Harris-Roxas B, Simpson S. The New South Wales Health Impact Assessment Project. NSW Pub Health Bull 2005; 120–123.
13. Everett S. The policy cycle: democratic process or rational paradigm revisited? Aust J Public Adm 2003; 32(2):65–70.
14. Mathias K, Harris-Roxas B. Process and impact evaluation of the Greater Christchurch Urban Development Strategy Health Impact Assessment. BMC Public Health 2009; 9(1):97.
15. Wismar M, Blau J, Ernst K, Figueras J (eds). The effectiveness of health impact assessment: scope and limitations of supporting decision-making in Europe. European Observatory on Health Systems and Policies, World Health Organization, Copenhagen, 2007.
16. Dannenberg AL, Bhatia R, Cole BL, Heaton SK, Feldman JD, Rutt CD. Use of health impact assessment in the US: 27 case studies, 1999–2007. Am J Prev Med 2008; 34(3):241–256.
17. Health SA. South Australia's Strategic Plan… through a health lens. South Australian Department of Health, Adelaide, 2008.
18. Kauppinen T, Nelimarkka K. A review of Finnish social and health impact assessments. J Environ Assess Policy Manag 2004; 6(1):1–17.
19. Kauppinen T, Nelimarkka K, Perttilä K. The effectiveness of human impact assessment in the Finnish Healthy Cities Network. Public Health 2006; 120(11):1033–1041.
20. Sukkumnoed D, Kessomboon P, Nusaraporn Kessomboon, Nuntavorakarn S, Sabrum N. Health impact assessment training manual: a learning tool for healthy communities and society in Thailand, Southeast Asia, and beyond. Research and Development Program on Healthy Public Policy and Health Impact Assessment, Health Systems Research Institute, Bangkok, 2007.
21. Forsyth A, Slotterback CS, Krizek KJ. Health impact assessment in planning: development of the design for health HIA tools. Environ Impact Assess Rev 2010; 30(1):42–51.
22. Glasbergen P. Learning to manage the environment. In Lafferty W, Meadowcroft J (eds), 'Democracy and the environment: problems and prospects'. Edward Elgar, Cheltenham, 1999; 175–193.
23. Harris-Roxas B, Harris E. Differing forms, differing purposes: a typology of health impact assessment. Environ Impact Assess Rev 2010; in press.
24. Joffe M. How do we make health impact assessment fit for purpose? Public Health 2003; 117(5):301–304.
25. Milner SJ, Bailey C, Deans J. 'Fit for purpose' health impact assessment: a realistic way forward. Public Health 2003; 117(5):295–300.
26. Bridgman P, Davis G. The Australian policy handbook (3rd edn). Allen & Unwin Academic, Sydney, 2006.

Obituary: Konrad David Jamrozik

Medical doctor, researcher, administrator, anti-smoking campaigner

Born: 2 May 2 1955; Leigh Creek, South Australia
Died: 24 March 24 2010; Adelaide, South Australia

Konrad Jamrozik was Head of the School of Population Health and Clinical Practice at the University of Adelaide. In the short time that he was Head of School he created an exciting research momentum with the establishment of public health capacity programs and two major research programs in rural South Australia, and he brought a passion and commitment to population health.

He was a tireless campaigner against smoking. Konrad's first interests in tobacco control began as a young medical intern at the Royal Hobart Hospital during the late 1970s, where he became acutely aware of the dangerous consequences of smoking and the impact it was having on patients.

Konrad had entered medical school at the University of Adelaide at age 16, having grown up in the Adelaide Hills where he attended Belair Primary School and Blackwood High School. He transferred to the University of Tasmania when his family relocated to Hobart.

Having been awarded a prestigious 4-year Nuffield Dominions Fellowship to study at Oxford University, Konrad completed a DPhil (PhD), examining various strategies for the promotion of the cessation of smoking in general practice.

Following Oxford, he was appointed as Lecturer in Community Medicine at the University of Papua New Guinea in Port Moresby, where he was also a clinical assistant on the leprosy service. He moved to the University of Western Australia in mid 1984 to take up a research fellowship in the Unit of Clinical Epidemiology. He subsequently held lectureships in medicine and public health at the University of Western Australia (UWA), and was promoted to Professor of Public Health at UWA early in 2000.

From December 2000 until September 2004 he held the Chair in Primary Care Epidemiology at Imperial College, London. He then moved to Brisbane as Professor of Evidence-based Health Care at the University of Queensland, then in 2007 to the University of Adelaide where he took up the role as Head of the School of Population Health and Clinical Practice.

Since the mid 1980s, Konrad combined his academic and clinical work with his passion for tobacco control —as a part-time activist but full-time advocate.

As an academic expert he generated significant new evidence on the impact of smoking on vascular disease, particularly on stroke. He analysed the evidence as a member of numerous expert groups including the National Health and Medical Research Council's Second Working Party on Passive Smoking, an enquiry that the tobacco industry found so threatening that they sought to gag its members through legal action.

Konrad was an outstanding and prolific researcher, contributing more than 280 research papers to the scientific literature on areas as diverse as stroke prevention, medical ethics, clinical trials, tobacco control, cardiovascular medicine, breast cancer, men's health and many others.

He had wide interests, such as the prevention of vascular disease, procedural care and new strategies in health promotion, and assessing the uptake and impact of the results of clinical trials in day-to-day practice, especially in the area of cancer.

In addition to his academic career, which focused on preventing disease, he worked 'at the coalface' as a cancer clinician, helping to treat the cancer cases where prevention efforts had failed.

He spent periods working and studying at the World Health Organization in Geneva, Harvard University, and in many other places including Uzbekistan.

Konrad was awarded Life Membership of the Australian Council on Smoking and Health, the Inaugural President's Award from the National Heart Foundation of Australia and a special Research Assistance grant for Outstanding Teachers from the University of Western Australia. He was a Rowden White Overseas Travelling Fellow of the Royal Australasian College of Physicians, and an International Cancer Research Technology Transfer Fellow at the International Agency for Research on Cancer, Lyon, France. He was also a Fellow of the Public Health Association of Australia and winner of the Nigel Gray Medal for outstanding contribution to tobacco control.

He was born at Leigh Creek, South Australia, the eldest of three children to parents Adam Jamrozik and Ruth Errey. He died as a result of a sarcoma. He is survived by his wife Lesley and children Zeb, Harriet, Magnus and Aleksander.

An unforgettable, extraordinary, dedicated man, a loyal and caring friend, and a colleague with commitment to justice and excellence, he will be sorely missed.

Authors: Professor Judy Stratton, Professor Annette Braunack-Mayer, Judith Watt and Professor Justin Beilby

Communicable Disease Control Branch

Disease Surveillance and Investigation Report 1 January to 31 March 2010

The Disease Surveillance and Investigation Section (DSIS) of the Communicable Disease Control Branch (CDCB) conducts statewide surveillance for notifiable diseases enabling analysis of health data and initiation of specific public health actions to prevent further spread of disease. Specified data are provided regularly to the National Notifiable Diseases Surveillance System.

Weekly summaries of notifiable diseases in South Australia (SA), as defined in the *Public and Environmental Health Act* 1987, are published on the SA Health website. Included are counts of notified infections, information about current cluster and outbreak investigations as well as historical data.

Some investigation and control activities are conducted in conjunction with partner agencies that provide additional expertise and authorities under other Acts in SA. These agencies include OzFoodNet Australia, SA Pathology, Primary Industries and Resources SA (PIRSA), and Environmental Health Officers (EHO) from local government. Partners in SA Health include SA Infection Control Service, Food Policy and Programs, Health Protection Programs, and Scientific Services.

Summary

Between 1 January and 31 March 2010 the DSIS collected a total of 2698 reports of notifiable diseases, including 1484 cases of pertussis and 544 reports of gastrointestinal disease. Pertussis notifications peaked in November 2009 and have declined since, but continue to dominate respiratory infections.

- Investigation and control activities included:
  - 1484 pertussis cases
  - 11 cases of Shiga-toxin producing *E. coli* infection
  - 7 cases of invasive meningococcal disease
  - 3 cases of hepatitis A
  - 1 case of paratyphoid
  - 1 case of typhoid fever
  - 9 outbreaks of gastroenteritis in aged care facilities
  - 3 cases of Q fever.
- In partnership with OzFoodNet, foodborne disease investigations included:
  - 5 outbreaks of illness due to *Salmonella*
- In partnership with Health Protection Programs, investigations included:
  - 2 cases of *Legionella pneumophila* serogroup 2
  - 1 case of *Legionella pneumophila* serogroup 1.

VECTORBORNE DISEASE

Ross River virus and Barmah Forest virus are both arboviruses or viruses spread by arthropods, in this instance via mosquitoes. These infections usually demonstrate cyclic patterns of disease, peaking in summer months. A prevention program, the *Fight the Bite* campaign, has operated in SA since December 2004. Health messages about the prevention of mosquito-borne disease to the community have been extended this year due to unseasonably wet conditions in northern SA.

Common symptoms of local arboviral diseases include arthralgia, rash, flu-like symptoms and swollen glands, ranging from mild to disabling. Severe complications occur rarely. Blood tests confirm the diagnosis, usually by demonstration of specific arboviral antibodies in acute-phase sera.

Barmah Forest infection

In the first quarter of 2010, nine cases of Barmah Forest virus infection were reported, consistent with ten in the same period of 2009. Cases comprised five males and four females, with an age range of 20–72 years.

Ross River infection

Between 1 January and 1 March 2010, 82 cases of Ross River virus infection were reported, consistent with 77 in the first quarter of 2009. Cases comprised 36 males and 57 females aged 9–79 years. Since the epidemic of 2005–06, the background level of Ross River virus infection is higher than previous inter-epidemic periods. This may partly reflect increased awareness of the disease resulting in increased testing (Figure 1).

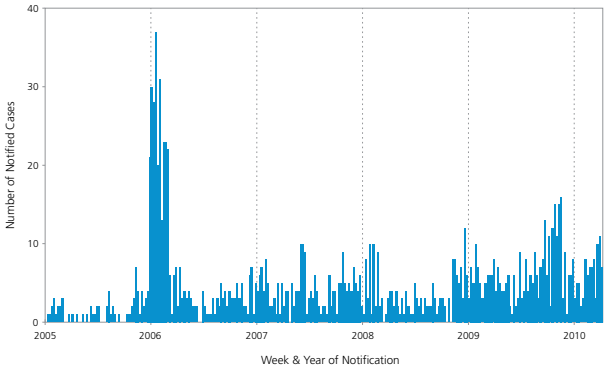

Figure 1: Notified cases of Ross River virus infection by week of notification, 1 January 2005 to 31 March 2010
Seasonal variation in Ross Rover virus disease is observed, generally coinciding with summer. In the past four years background levels of disease have increased.

Chikungunya virus

One case of chikungunya virus infection was reported during the first quarter of 2010 and is only the second case recorded in SA since becoming notifiable. The case was a 20 year-old female who had acquired the infection whilst travelling in south-east Asia.

Dengue fever

During the first quarter of 2010 one case of dengue fever was recorded, compared to eight cases in the same period of 2009. The case was a 9 year-old male who had acquired the infection in south-east Asia.

Malaria

The three cases of malaria reported in the first quarter of 2010 were all acquired overseas. Cases comprised one male and two females, aged from 15–30 years. One case caused by *Plasmodium vivax* reported exposure in Papua New Guinea. Two cases reported exposure in Africa; one infection was caused by *Plasmodium falciparum* and in the other case the *Plasmodium* species could not be further characterised.

ZOONOSES

Hydatid Disease

Hydatid disease caused by the larvae of the tapeworm *Echinococcus granulosus* is now rare in SA and can result from exposure to dogs which have eaten infected offal from sheep and other herbivores. Hydatid cysts, which usually appear in the liver or lungs but can occur in other viscera, are a result of this infestation.

One case was reported in the first quarter of 2010 in a 34 year-old female from metropolitan Adelaide, whose medical history suggested past rather than recent infection.

Q fever

Q fever is a zoonotic disease caused by *Coxiella burnetii*. Cases often have direct exposure to animals, commonly sheep, cattle or goats, which are natural reservoirs for this infection. Typically, cases are males aged between 15 and 60 years who have occupational exposure to animals in the meat and livestock industries.

During the first quarter of 2010 three cases of Q fever were recorded, consistent with two cases in the same period of 2009 (Figure 2). Cases comprised two males and one female, aged between 27–64 years. All cases had plausible occupational exposures for this infection.

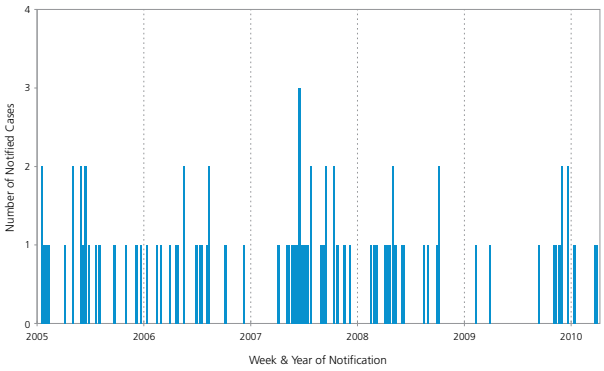

Figure 2: Notified cases of Q fever in SA, 1 January 2005 to 31 March 2010

VACCINE PREVENTABLE DISEASES

Influenza

In addition to the collection of influenza data through the state notifiable diseases system since May 2008 when it became a notifiable disease, CDCB undertakes syndromic surveillance by collating datasets from laboratory and clinical sources to describe influenza-like illness in SA.

SA Pathology laboratories and medical practitioners report positive influenza tests to CDCB. Clinical diagnoses of 'influenza-like illness' are collected from two sources: Royal Australian College of General Practitioners members participating in the Australian Sentinel Practice Research Network (ASPREN), and emergency departments of several public hospitals.

These combined data provide a weekly picture of confirmed influenza infections and influenza-like illness activity across the state (Figure 3).

In the first quarter of 2010, 32 influenza cases were recorded, compared to 14 in the same period of 2009. Among these, 13 cases were caused by influenza A virus and eight were due to infection with influenza B virus. Cases comprised 17 males and 15 females aged 5–73 years.

Among cases of Influenza A, in 11 instances the virus was further characterised as influenza A H1N1 2009 virus, the pandemic strain. The National Pandemic H1N1 (2009) Influenza Vaccination program continued this quarter, in addition, this strain was included in the seasonal influenza vaccine.

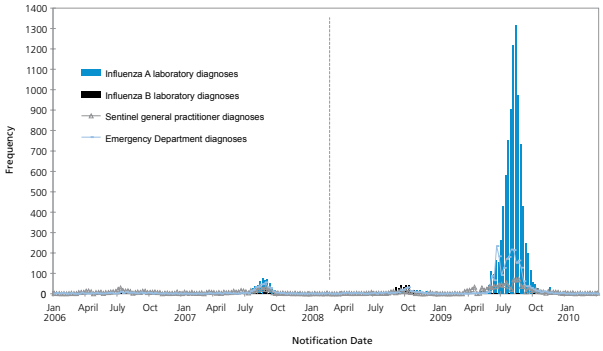

Figure 3: Laboratory and clinical influenza-like illness diagnoses in SA, 1 January 2006 to 31 March 2010
This graph depicts the dominance of pandemic influenza notifications in 2009 which effectively overshadow local epidemics in recent years. Information about influenza and respiratory disease is available at www.health.sa.gov.au/pehs/.

Invasive *Haemophilus influenzae*

The introduction of Hib vaccine in 1997 resulted in a reduction in the number of cases of invasive disease in children due to *Haemophilus influenzae* type b. However, cases of disease may occur in adults and unimmunised or partially immunised children. Other types of *Haemophilus influenzae* also cause disease.

Three cases of invasive *Haemophilus influenzae* disease were reported in the first quarter of 2010. Cases comprised two males and one female aged 1–90 years. All cases were hospitalised. One *Haemophilus influenzae* isolate was type a; the other two isolates were typed as non-groupable.

Invasive pneumococcal disease

Streptococcus pneumoniae is the cause of invasive pneumococcal disease and many individuals carry the organism in the respiratory tract without symptoms. *S. pneumoniae* is a frequent cause of otitis media in children and pneumonia in all age groups. Two vaccines help protect against some of the 90 identified serotypes of *S. pneumoniae*. A 23-valent vaccine is commonly used for adults; and a 7-valent vaccine for infants and children.

Between 1 January and 31 March 2010, 16 cases of invasive pneumococcal disease were reported, compared to 19 cases for the same period in 2009. Cases comprised ten males and six females, with an age range from <1–94 years; five (31%) of these were aged less than 5 years (Figure 4). One case was an adult Indigenous male. One death was reported for the period.

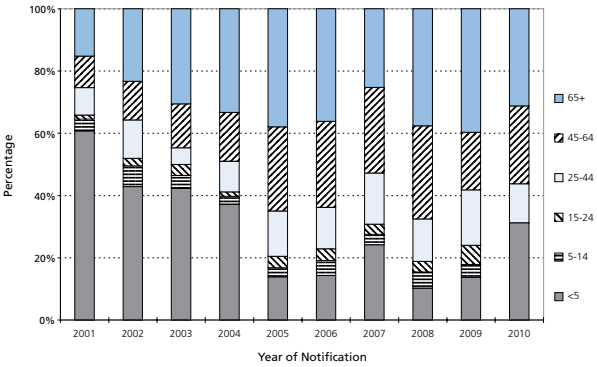

Figure 4: Notified cases of invasive pneumococcal disease in SA, by age-group proportions and year of notification, 1 January 2001 to 31 March 2010

Pertussis

Despite pertussis vaccination being available in SA for many years, *Bordetella pertussis* infection (whooping cough) remains a common community infection. Pertussis demonstrates variation in time, appearing as dramatic increases in disease, roughly every 3 to 5 years.

Between 2004 and late 2006 an apparent escalation of pertussis cases occurred. Some of this increase is now thought to reflect changes in laboratory testing, and some reported cases may have reflected past rather than current infection.

Since September 2008 a resurgence of cases has occurred, in part due to the higher sensitivity of molecular tests (PCR) compared to serology and culture, which were commonly used tests before the introduction of PCR.

In the first quarter of 2010, 1484 cases of pertussis were notified, compared to 734 in the same period of 2009 (Figure 5). Cases comprised 655 males and 829 females with an age range of <1–93 years. Cases were geographically dispersed throughout SA. Sixteen cases were reported in Indigenous Australians.

Consistent with the last quarter, 67% of cases were aged over 20 years at the time of diagnosis. One hundred and forty-one cases were aged less than 5 years. Of the cases aged less than 5 years, 108 were fully or partially vaccinated; 26 were not vaccinated (most were too young for vaccination) and in 7 instances the vaccination status could not be determined. No deaths have been recorded in the under 5 year age-group in SA since 1995; this is reflective of the effectiveness of vaccination in reducing deaths and severe complications.

All cases in children aged less than 5 years require urgent public health follow-up. Approximately 25 cases of pertussis occurred in children who attended childcare centres, and antibiotic chemoprophylaxis was recommended in one instance where there were susceptible contacts. Information and advice was provided to childcare centres from *The Australian Immunisation Handbook* (9th Edition) and *You've Got What?* Some childcare workers and children were recommended to seek vaccination.

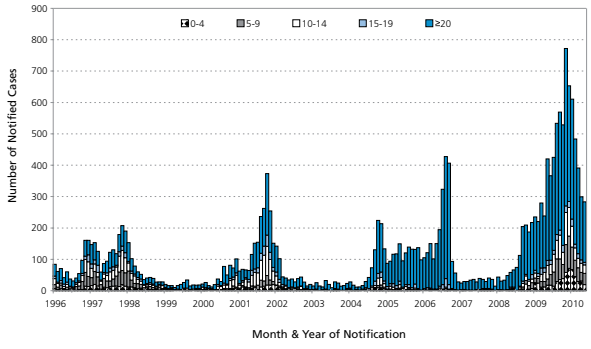

Figure 5: Notified cases of pertussis by year and month of notification and age group, 1 January 1996 to 31 March 2010
This graph demonstrates the impact of vaccination on the temporal frequency of cases between 1996 and 2005, first in the 5–9, then 10–14 and latterly, 0–4 year age-groups. The recent increase encompasses all age-groups.

Rotavirus

Rotavirus causes a gastrointestinal illness, commonly in children; most children are infected within the first three years of life. It is a major cause of hospitalisation due to gastroenteritis for children under 5 years. Vaccination was introduced in July 2007 and notification of rotavirus in SA commenced in May 2008.

In the first quarter 2010, 48 cases were reported (Figure 6). Cases comprised 23 males and 25 females aged from <1–66 years; 32 cases were less than 5 years of age.

Of the 20 cases aged less than 2 years 14 were appropriately vaccinated for age. One case was too young to be vaccinated.

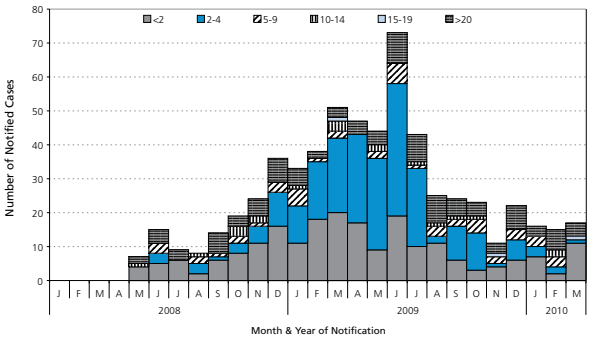

Figure 6: Notified cases of rotavirus in SA by age-group, 1 May 2008 to 31 March 2010
Rotavirus infection became notifiable in SA on the 1 May 2008.

Varicella

During the first quarter of 2010, 425 cases of varicella infection were reported, consistent with 411 cases reported for the same period of 2009 (Figure 7). Cases comprised 178 males and 247 females with ages ranging from <1–101 years.

Medical notification characterised 81 infections as chickenpox, these cases had an age range of <1–101 years, but 86% of cases were less than 30 years of age. A further 267 cases were characterised as shingles; these cases ranged in age from 2–94 years; 87% were 20 years of age or more.

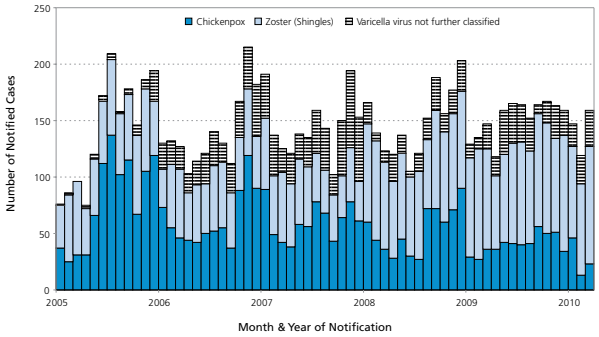

Figure 7: Notified cases of varicella virus, shingles and chickenpox by month and year of notification, 1 January 2005 to 31 March 2010
Classification of varicella infection as either shingles or chickenpox is obtained from medical notification.

GASTROINTESTINAL DISEASES

In the first quarter of 2010 gastrointestinal illnesses accounted for 20% of disease notifications in SA, compared to 34% of notifications for the first quarter of 2009. This difference is attributable to the increase in pertussis notifications and a decrease in activity of *Salmonella* and *Campylobacter* in this quarter (Figure 8). Five hundred and forty-four cases of gastrointestinal disease were recorded for the period under review.

Among 14 outbreaks of gastrointestinal illness investigated during the quarter were nine clusters in aged care facilities; eight caused by norovirus and one caused by sapovirus. Five outbreaks of *Salmonella* infection were also investigated.

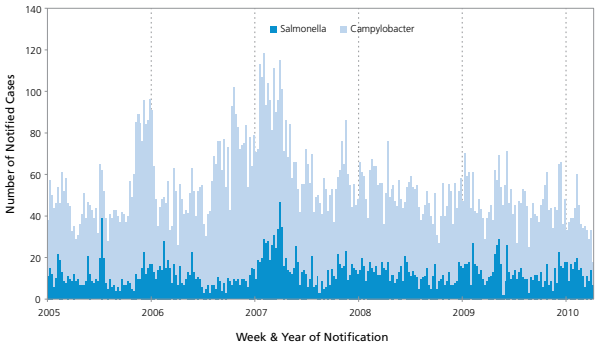

Figure 8: Notified cases of Campylobacter and Salmonella infections by week and year of notification, 1 January 2005 to 31 March 2010
Notifications of Campylobacter infection have decreased since 2007.

Campylobacteriosis

Campylobacter infection was the most commonly reported gastrointestinal disease in SA during the quarter and accounted for 60% of these diseases. In the first quarter of 2010, 324 campylobacteriosis notifications were received for cases resident in SA, compared to 426 cases during the same period of 2009. Cases comprised 182 males and 142 females, with an age range of <1–87 years; 15% of cases were aged less than 10 years at diagnosis.

No clusters of campylobacteriosis were detected in the period under review.

Cryptosporidiosis

Cryptosporidiosis is a parasitic infection of the bowel and *Cryptosporidium* parasites can be found in a range of animals as well as humans. The parasite is spread by the faecal-oral route and commonly occurs by drinking contaminated water; accidental ingestion can occur whilst swimming. Those diagnosed with cryptosporidiosis should be excluded from swimming for 14 days after symptoms disappear.

Eighteen cases were reported in the first quarter of 2010 compared to 37 for the same period in 2009 (Figure 9). Cases comprised 8 males and 10 females, with an age range of <1–43 years. Residents from both metropolitan and rural areas of SA were among the cases.

Cryptosporidiosis cases with reported risks potentially requiring public health action are referred to local government EHOs, as well as the Water Quality Section of SA Health's Scientific Services Branch.

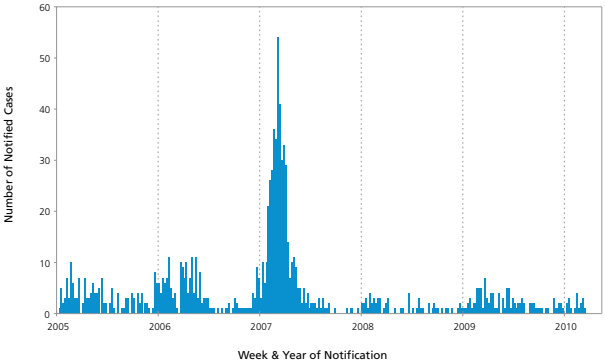

Figure 9: Notified cases of cryptosporidiosis by week and year of notification, 1 January 2005 to 31 March 2010

Hepatitis A

Hepatitis A virus causes acute infection by the faecal-oral route in humans, varying in clinical severity. Most cases in SA are imported from countries where hepatitis A is endemic. Symptoms, which typically occur 15 to 50 days after infection, can include obvious jaundice but exposure can be difficult to pinpoint because of the extended incubation period. Outbreaks due to contaminated food or water have been reported in Australia, including the 2009 outbreak across Australia that was associated with semi-dried tomatoes (Figure 10).

Three cases of hepatitis A were reported during the first quarter of 2010, consistent with three cases for the same period of 2009. All cases were male and aged between 4 and 30 years. Two cases reported recent overseas travel to countries where hepatitis A infection is endemic; one case acquired the infection in Australia. Contact tracing is undertaken for all cases of hepatitis A infection and vaccine or immunoglobulin is recommended for close contacts.

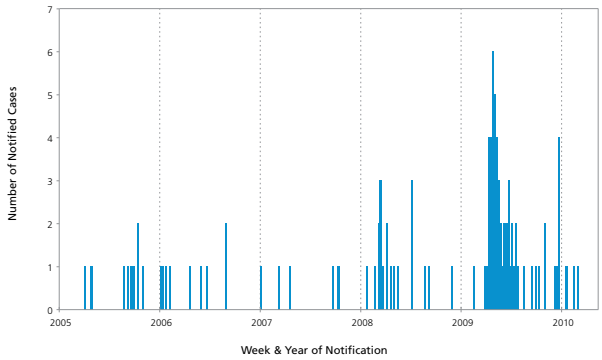

Figure 10: Notified cases of Hepatitis A by week and year of notification, 1 January 2005 to 31 March 2010

Listeriosis

Infections caused by *Listeria* are rare in SA. When cases occur, commonly the person also has a chronic illness. Listeriosis cases are interviewed using a targeted food risk questionnaire to ascertain the likely source of the agent of infection.

One infection due to *Listeria monocytogenes* serotype 1 was reported in the first quarter of 2010, compared with four cases for the same period of 2009. The case was a 73 year-old male from rural SA who had been hospitalised interstate for the whole incubation period. This case was referred to the relevant interstate jurisdiction for further investigation.

Paratyphoid

Paratyphoid is caused by the bacterium *Salmonella* Paratyphi and usually causes an acute enteric illness associated with fever. Paratyphoid disease is usually less severe and less likely to cause a carrier state than Typhoid.

One case of paratyphoid was reported during the quarter in 35 year-old female who became unwell with a febrile illness on return to Australia from India. Public health action involved faecal clearance testing of cases and household contacts. No further cases emanated from the case. The infection was caused by *Salmonella* Paratyphi A.

Salmonellosis

Salmonella infection is usually the second most commonly notified gastrointestinal illness in SA, and accounted for 32% of gastrointestinal infections reported between January and March 2010 when 173 cases were reported consistent with 176 cases in the first quarter of 2009 (Figure 8).

Cases comprised 89 males and 84 females, with an age range from <1–85 years. In contrast to campylobacteriosis, 25% of cases were aged less than 10 years. Cases resided in a range of rural and metropolitan locations in SA. Laboratory tests characterise *Salmonella* isolates by serotype and phage type.

Among 90 cases attributed to infection by the *Salmonella* Typhimurium serotype were isolates classified into 17 different phage types. *S*. Typhimurium phage type 9 caused 30 infections; *S*. Typhimurium 135a caused 16, *S*. Typhimurium phage type 108 caused 11 and *S*. Typhimurium 193 caused 10 infections.

The following outbreaks were investigation in this period:

S. Typhimurium phage type 9

An outbreak of *Salmonella* Typhimurium phage type 9 cases was investigated in January 2010 when 23 cases were notified between 1 January and 1 March 2010. Hypothesis-generating questionnaires established that nine cases were associated with a metropolitan bakery but no specific food source was identified. An environmental inspection of the food premises highlighted a number of food handling issues which have been addressed.

Information collected during this investigation identified a group function held at a private residence where six cases of illness occurred; three were confirmed

as caused by *Salmonella* Typhimurium 9. Results of a cohort study did not identify a specific food source.

S. Typhimurium phage type 108

A cluster of nine cases of salmonellosis caused by *Salmonella* Typhimurium 108 was investigated in January 2010. The cluster comprised six males and three females with an age range of 1–85 years. Of seven cases interviewed with hypothesis-generating questionnaires, one case travelled interstate and another case had travelled within SA during the incubation period. Analysis of data collected by the questionnaires did not identify a source for the infection.

S. Typhimurium phage type 135a

A cluster of ten cases of *Salmonella* Typhimurium 135a was investigated in January 2010. All cases were assessed with hypothesis-generating interviews and no common foods or other links were identified.

A further cluster of seven cases of *Salmonella* Typhimurium 135a was investigated in March 2010. Five cases were aged 3 years and under. Cases were scattered across metropolitan and rural locations. Hypothesis-generating interviews again did not establish common foods or other links between cases.

Shiga-toxin producing *Escherichia coli* (STEC)

Among the enterohaemorrhagic *Escherichia coli* (EHEC) bacterial strains is Shiga-toxin producing *E. coli* (STEC). Some of these infections cause bloody diarrhoea, and a small proportion of cases progress to Shiga toxin-mediated haemolytic uraemic syndrome (HUS). This syndrome can cause severe, chronic disease. In SA, faecal specimens from patients with bloody diarrhoea are screened in a central SA pathology laboratory for genes encoding the STEC toxins, enabling prompt notification of such infections.

Between 1 January and 31 March 2010, 11 cases of STEC infection were reported, compared to 23 for the same period in 2009. All cases were interviewed with a standard risk questionnaire to collect comprehensive food and environmental data; no links were found between sporadic cases. Cases comprised four males and seven females aged 2–85 years. Cases resided in a range of rural and metropolitan locations. No foodborne outbreaks were identified during the quarter; however a number of cases had plausible environmental exposures.

Shigellosis

Shigella is a bacterial cause of gastrointestinal disease with typical symptoms including fever, diarrhoea, vomiting and stomach cramps. *Shigella* bacteria are generally spread by person-to-person contact when contaminated objects or food are put in the mouth. The infectious dose is low, that is, few *Shigella* bacteria are needed to cause an infection. These bacteria do not infect animals, nor do they not survive very long outside the body. Appropriate antibiotic treatment shortens illness and reduces the risk of spread to others.

In the first quarter of 2010 nine cases of shigellosis were reported. This is a 50% decrease from the 18 cases reported in the same period of 2009 (Figure 11). Cases comprised four males and five females with an age range of 2–82 years. Four cases reported recent overseas travel; another four cases, including 2 siblings, acquired the infection locally; and one case had no exposure or travel data available at the time of report.

Whilst the number of notifications has decreased, the proportion of infections due to *Shigella sonnei* biotype g has increased (Figure 12). This quarter there were six cases caused by *Shigella sonnei* biotype g, two cases due to *Shigella flexneri* biotype 3a and one caused by *Shigella sonnei* not biotyped.

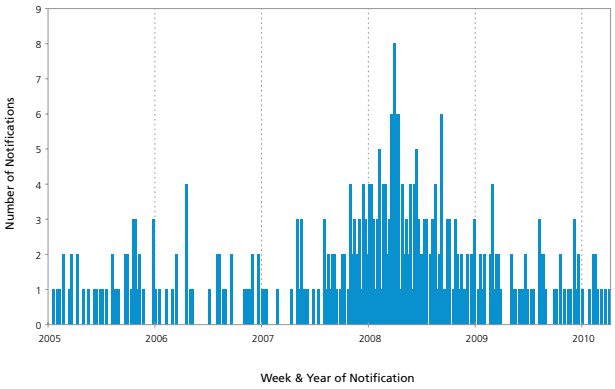

Figure 11: Notified cases of shigellosis by week of notification, 1 January 2005 to 31 March 2010

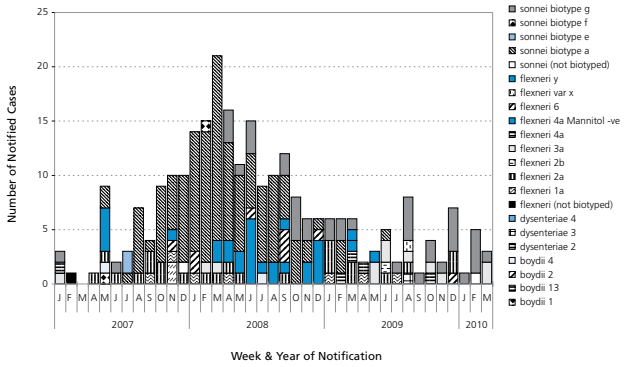

Figure 12: Notified cases of shigellosis by isolate type and month, 1 January 2007 to 31 March 2010

Typhoid fever

Most infections of *Salmonella* Typhi detected in SA are acquired overseas. Untreated typhoid fever has significant mortality. Typhoid is transmitted by consumption of food or water contaminated with *S*. Typhi. Unlike other *Salmonella* infections, up to 10% of those infected can become asymptomatic carriers of the infection.

One case of *S*. Typhi infection was notified in the first quarter of 2010 in a 9-year old male who had recently returned from an overseas country where typhoid is common. Contact tracing was undertaken covering the period of infectiousness in Australia; no contacts became infected.

Yersiniosis

Three cases of *Yersinia enterocolitica* infection were notified between January and March 2010, consistent with two cases in the same period of 2009. All cases were male, aged 1–11 years.

OTHER DISEASES

Creutzfeldt-Jakob disease

Creutzfeldt-Jakob disease is a prion disease which affects the brain; it has two forms, classical and variant. Disease progression and clinical signs of each form are distinctive, and both are fatal. The diagnosis is confirmed after the death of the case.

One case of sporadic classical Creutzfeldt-Jakob disease was reported in the first quarter of 2010. The case was an 86 year-old female from metropolitan Adelaide.

Invasive meningococcal disease

Historically in Australia notifications of invasive meningococcal disease caused by *Neisseria meningitidis* included a proportion of cases attributed to *N. meningitidis* serogroup C and were associated with a particularly poor prognosis. Routine meningococcal C vaccination, implemented in 2003, offers vaccine to children and adolescents in the high risk age-groups of 0–4 and 15–24 years, and the program has resulted in a significant decrease in cases associated with serogroup C. The predominant serogroup of *N. meningitidis* responsible for disease remains serogroup B, for which no vaccine is available.

Seven cases of invasive meningococcal disease were reported in the first quarter of 2010, compared to four for the same period in 2009 (Figure 13). Cases comprised three males and four females, with an age range of <1–45 years. In accordance with national guidelines, immediate contact tracing occurs with all cases; clearance antibiotics are provided for close contacts as well as vaccination, where appropriate.

Five infections in this period were due to *N. meningitidis* serogroup B, one to *N. meningitidis* serogroup Y and one to *N. meningitidis* serogroup C, the latter infection was in an unvaccinated adult male.

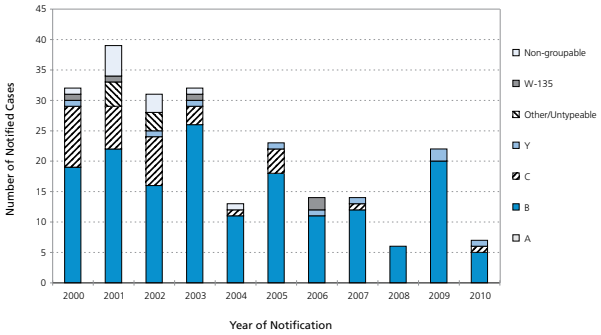

Figure 13: Notified cases of invasive meningococcal disease, by year of notification and serogroup, 1 January 2010 to 31 March 2010

Legionellosis

Six sporadic cases of Legionellosis were reported during the first quarter of 2010, from both metropolitan and rural SA. Laboratory tests attributed one case to *Legionella pneumophila* serogroup 1, two cases to *Legionella pneumophila* serogroup 2 and three cases to *Legionella longbeachae* (Figure 14). All cases of *L. pneumophila* are referred to Health Protection Programs for environmental investigation.

The *L. pneumophila* serogroup 1 infection was reported in a 78 year-old male from metropolitan Adelaide. The environmental investigation did not identify a source.

The *L. pneumophila* serogroup 2 cases occurred in a 77 year-old female and a 65 year-old male from metropolitan Adelaide, and no links were established between these cases. *L. pneumophila* serogroup 2 was identified in environmental samples from the residence of one case.

The three cases due to *L. longbeachae* were two males and one female aged 47–86 years. Two cases had recent gardening as a risk for acquiring this infection; the other case had an underlying chronic illness and no obvious high risk exposure.

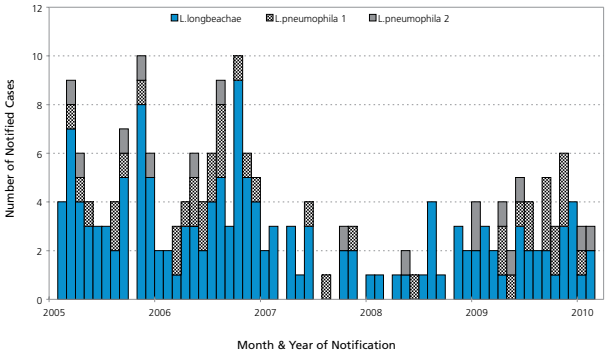

Figure 14: Notified cases of Legionella infection by month and year, 1 January 2005 to 31 March 2010

Leprosy

During the first quarter of 2010, one case of leprosy was notified in a 27-year old male student who probably acquired the infection overseas before arriving in Australia.

These data are provisional and subject to further revision.

Table 1: Notifiable diseases in South Australia: 1 January to 31 March 2010 and annual comparisons 2005–2009

Disease	2005		2006		2007		2008		2009		2010
	Jan-Mar	Total	Jan-Mar	Total	Jan-Mar	Total	Jan-Mar	Total	Jan-Mar	Total	Jan-Mar
Anthrax	0	0	0	0	0	0	0	0	0	0	0
Barmah Forest virus infection	9	27	92	190	19	60	9	38	10	37	9
Botulism	0	0	0	0	0	0	0	0	0	0	0
Brucellosis	0	0	0	0	0	1	0	0	1	2	0
Campylobacteriosis	460	2113	427	2471	926	2731	526	1984	426	1779	324
Chikungunya[3]	-	-	-	-	-	-	0	1	0	0	1
Chlamydia (genital)[1]	677	2706	791	3127	932	3480	912	3652	899	3762	1050
Cholera	0	2	0	0	0	1	1	0	0	0	0
Creutzfeldt-Jakob disease	0	0	0	0	1	3	1	3	0	3	1
Crimean-Congo Haemorrhagic Fever	0	0	0	0	0	0	0	0	0	0	0
Cryptosporidiosis	52	160	69	191	332	459	29	61	37	105	18
Dengue Fever	1	5	3	10	5	23	9	31	8	18	1
Diphtheria	0	0	0	0	0	0	0	0	0	0	0
Donovanosis[1]	0	0	0	0	0	0	0	0	0	0	0
Ebola Fever	0	0	0	0	0	0	0	0	0	0	0
Gonorrhoea[1]	93	401	133	503	105	458	109	485	100	369	89
Haemophilus influenzae infection (invasive)	3	13	2	8	4	18	3	11	4	12	3
Hepatitis A	0	9	4	9	2	5	8	19	3	59	3
Hepatitis B[1]	68	276	71	262	70	328	75	283	67	304	77
Hepatitis C[1]	180	722	188	694	147	610	147	583	137	551	119
Hepatitis D[1]	1	7	1	6	3	12	3	13	5	15	1
HIV[1]	20	50	20	61	25	55	12	47	13	52	13
Hydatid disease	0	2	0	2	1	7	1	12	1	4	1
Influenza[3]	10	273	3	87	6	280	4	484	14	10749	32
Lassa Fever	0	0	0	0	0	0	0	0	0	0	0
Legionellosis	7	57	4	62	5	20	3	18	9	44	6
Leprosy	0	0	0	1	0	2	0	0	0	0	1
Leptospirosis	0	3	0	1	0	0	0	0	0	0	0
Listeriosis	1	6	1	5	1	7	1	1	4	4	1
Lyssavirus	0	0	0	0	0	0	0	0	0	0	0
Malaria	18	43	8	34	3	24	5	17	3	32	3
Marburg disease	0	0	0	0	0	0	0	0	0	0	0
Measles	0	0	0	9	0	1	1	2	1	3	0
Meningococcal disease (invasive)	2	23	3	18	1	16	1	19	4	22	7
Mumps	3	8	1	20	2	22	7	18	5	12	0
Mycobacterial disease (non-tuberculous)[2]	11	69	16	54	8	68	8	56	21	83	14
Ornithosis	0	1	0	0	0	3	0	0	0	3	0
Paratyphoid Fever	4	6	2	4	0	4	0	5	0	2	1
Pertussis	296	1409	375	2152	56	382	87	1294	734	5219	1484
Plague	0	0	0	0	0	0	0	0	0	0	0
Pneumococcal disease (invasive)	20	134	14	104	5	91	7	117	19	146	16
Poliomyelitis	0	0	0	0	0	0	0	0	0	0	0
Q Fever	5	20	4	16	0	24	3	16	2	10	3
Ross River Virus infection	17	92	248	362	55	214	55	183	77	332	82
Rotavirus[3]	-	-	-	-	-	-	0	132	122	434	48
Rubella	0	0	1	2	0	1	1	1	1	3	0
Salmonellosis	155	576	191	556	333	868	192	647	176	684	173
Severe Acute Respiratory Syndrome (SARS)	0	0	0	0	0	0	0	0	0	0	0
Shigellosis	8	47	5	37	5	59	50	143	18	52	9
Smallpox	0	0	0	0	0	0	0	0	0	0	0
Shiga toxin producing E. coli / HUS / TTP	5	38	12	38	22	42	11	39	26	68	11
Suspected Food Poisoning	10	66	111	513	26	446	4	62	2	6	2
Syphilis[1]	3	13	10	43	8	50	12	49	7	40	8
Tetanus	0	0	0	0	0	0	0	0	0	0	0
Tuberculosis[2]	13	46	17	72	8	61	11	62	21	58	24
Typhoid Fever	0	2	1	2	3	5	1	3	0	2	1
Varicella infection	258	1741	390	1682	454	1748	430	1783	411	1824	425
Yellow Fever	0	0	0	0	0	0	0	0	0	0	0
Yersiniosis	3	7	4	11	4	17	4	20	2	3	17

[1] Data collected by Sexually Transmitted Diseases Services [2] Data collected by SA Tuberculosis Services [3] notifiable since 1 May 2008

Public Health Bulletin SA

The Public Health Bulletin South Australia is a publication of SA Health. The Bulletin aims to provide current data and information to practitioners and policy makers emphasising the value of orienting services towards prevention, promotion and early intervention and to support effective public health interventions.

Editorial correspondence

The editorial team welcomes correspondence and suggestions for public health themes for future issues of the Public Health Bulletin. Comments and reports should be 500-600 words. Guidelines for authors are available from the managing editor. Please address all correspondence to:

The Managing Editor
Public Health Bulletin South Australia
Public Health
SA Health
PO Box 6 Rundle Mall SA 5000
Fax (08) 8226 7102
Email phbsa@health.sa.gov.au

Distribution

To add your name to the electronic distribution list for the Public Health Bulletin South Australia please email: phbsa@health.sa.gov.au

The Public Health Bulletin can also be accessed in PDF format at
http://www.dh.sa.gov.au/pehs/publications/public-health-bulletin.htm

Disclaimer

The articles appearing in this publication represent the views of the authors and not necessarily those of the Minister for Health or the Department of Health. No responsibility is accepted by the Minister for Health or the Department of Health for any errors or omissions contained within this publication. The information contained within the publication is for general information only. Readers should always seek independent, professional advice where appropriate and no liability will be accepted for any loss or damage arising from reliance upon any information in this publication.

For more information

www.health.sa.gov.au
phbsa@health.sa.gov.au
Department of Health
PO Box 6, Rundle Mall, SA 5000
Fax: 8226 7102

 ISSN: 1449-485X Printed July 2010. DH-PH10039.2

Government of South Australia
SA Health