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A scoping review of the implementation of health in all policies at the local level

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ABSTRACT

Objectives: Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implication of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. HiAP implementation can involve engagement from multiple levels of government; however, factors contributing or hindering HiAP implementation at the local level are largely unexplored. Local is defined as the city or municipal level, wherein government is uniquely positioned to provide leadership for health and where many social determinants of health operate. This paper presents the results of a scoping review on local HiAP implementation.

Methods: Peer reviewed articles and grey literature were systematically searched using the Arksey and O'Malley framework. Characteristics of articles were then categorized, tallied and described.

Results: 23 scholarly articles and four government documents were identified, ranging in publication year from 2002 to 2016 and originating from 14 countries primarily from North America and Europe. A wide range of themes emerged relating to HiAP implementation locally including: funding, shared vision, national leadership, ownership and accountability, local leadership and dedicated staff, Health Impact Assessment, and indicators.

Conclusion: Common themes were found in the literature regarding HiAP implementation locally. However, to better clarify these factors to contribute to theory development on HiAP implementation, further research is needed that specifically investigates the facilitators and barriers of HiAP locally within their political and policy context.

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1. Introduction

As social determinants of health (SDH) are the primary factors influencing population health and health equity, health policy must shift its focus from the illness-oriented health care sector toward sectors whose policies affect the social environments of daily living. Public policies from various sectors can create environments that make the healthy choice the easy one. The Canadian Medical Association [1] recently urged the Canadian government to adopt a clear mandate to focus on the health of the population and to have all legislation subject to a health lens to determine potential health implications. Such an approach to health policy is known as Health in All Policies (HiAP). HiAP is “an approach to public poli-

cies across sectors that systematically takes into account the health implication of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity” [2]. It is based on the recognition that health is primarily determined by the SDH. HiAP may include the use of formal tools, such as Health Impact Assessment (HIA). HiAP involves intersectoral collaboration (ISC) but is distinguishable from other intersectoral initiatives to advance health equity in that it is coordinated by formal structures and mechanisms of governments, and it is explicitly linked to structural or long-term governmental policies or agendas (as opposed to being ad hoc) [3]. By addressing the primary factors affecting health within non-health and health sectors, HiAP is a viable option for governments wishing to ameliorate health inequalities and rising chronic diseases, and promote population health and health equity, particularly within Canada where there is growing interest in HiAP in general and specifically interest in local jurisdictions in guidance on HiAP implementation [1,4–7].

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The existence of health inequalities in Canada is firmly established with recent evidence indicating that over the past decade, there has been minimal or no progress made in reducing health inequalities related to income [8]. Since the 1990s, the highest income earners in Canada have had higher income increases than the lowest; this increase in income inequality was observed in all provinces [8]. Lower socioeconomic position is associated with shorter life expectancy and worse health outcomes [9]. The average life expectancy for the lowest income earners in Canada from 2005 to 2007 was 78.7 compared to 82.2 for the highest income earners [10].

Increasing health inequalities in Canada also imposes notable costs. In addition to the direct physical costs certain populations are unfairly burdened with, Canadians in the lowest income quartile have the highest average age-standardized health care costs [11]. Socio-economic inequalities in health cost a direct economic burden of at least \$6.2 billion on acute-care hospitalizations, prescription medications, and physician consultations, which equates to \$190.50 per capita annually [11].

Any attempt to control these costs, lessen health inequalities, and curtail the rise of chronic diseases must include addressing the root causes. The Canadian Medical Association recognizes the significant impact of SDH on population health. The conditions in which we are born, grow, live, work and age are the SDH; these conditions are formed by the distribution of money, power, and resources at global, national, and local levels [12]. The unequal distribution of health, whereby health status follows a socioeconomic gradient, is not a natural occurrence but rather the result of a combination of poor social policies and programs, unfair economic arrangements, and bad politics [9].

An early example of intersectoral action for health occurred in the 1970s when Finland launched the North Karelia Project in response to Finnish men being identified as having the highest international records in coronary heart disease mortality [13]. The North Karelia project was a comprehensive community-based initiative that used preventative services, media activities, training of professionals, and environmental changes to target heart disease risk factors—namely high cholesterol, elevated blood pressure, and smoking—and ultimately reduce cardiovascular disease mortality [14]. The initiative was largely successful; there was an 85% decline in age-adjusted coronary heart disease mortality rates among 35–64-year old males in North Karelia from 1969 to 1971 to 2006 [14]. Despite the term Health in All Policies being introduced by the Finnish Presidency of the European Union in 2006, other countries and regions have mandated HiAP-like approaches since the 1970s, including Finland, which adopted the Health 2015 strategy in 2001. Since the 1970s, other countries and regions have adopted HiAP approaches. However, Shankardass et al. [15] conducted a scoping review, identified 16 cases of HiAP, and found that most cases had been implemented after the year 2000. Thus, while HiAP initiatives are increasing, their emergence is fairly recent. Similarly, literature on HiAP has been recently emerging but remains limited. Shankardass et al. [16] note that there has been no attempt to systematically review or synthesize evidence of how and why strategies for HiAP work.

In order to address the range of determinants of health, implementation of HiAP must occur at the national, regional, and local government levels; however, factors contributing to or hindering HiAP implementation at the local level are largely unexplored. Few authors have focused on the HiAP implementation primarily at the local level. Rantala et al. [17] examined intersectoral action for health at the local level in 25 cases, which included HiAP initiatives, and found several common facilitating factors and challenges. Van Vliet-Brown et al. [18] conducted a scoping review and found three broad themes related to the utilization of the HiAP approach in municipal government settings. Local is defined

as the city or municipal level, wherein governments are uniquely positioned to provide leadership for health and many SDH operate [19]. Local governments influence health and health equity through city planning processes such as transportation, health promotion, land-use policies, and building standards [17]. Moreover, local governments may be better attuned to the particular community needs. In Canada, the provinces and territories determine the amount of power given to municipalities. Municipalities carry out various provincial and national policies and legislation; nevertheless, to varying degrees, they are autonomous and responsible for addressing local needs through policy development and evaluation. Given the differentiated role of municipal governments, HiAP implementation at the local level will likely differ from provincial and national initiatives.

Additionally, local policies can influence regional policy development. Shipan and Volden [20] analyzed vertical policy diffusion from city governments to state governments and found evidence of local-to-state diffusion. Local HiAP implementation is critical for overall policy success, and independent local initiatives may have potential for upward diffusion; therefore, more research should study how HiAP is implemented within local governments.

HiAP initiatives are often idiosyncratic to the setting in which they are implemented [16]. Contextual factors must be considered for successful policy implementation. For example, many community based interventions based on the North Karelia project have been attempted with disappointing outcomes; however, McLaren et al. [21] found that many published studies on community-based interventions targeting chronic disease did not adequately account for, or report on, the contextual features of the population and setting being targeted. Since the successful implementation of policies depends on consideration of associated contextual factors, it is necessary to identify the facilitators and barriers of HiAP implementation at the local level.

Therefore, this paper presents the results of a scoping review of HiAP implementation at the local level has been completed. The research question that guided this scoping review is, ‘What has been published about the factors facilitating or hindering HiAP implementation at the local level?’ The objective is to examine and map published literature, with the purpose of synthesizing the state of knowledge and informing further research; specifically, results of this scoping review will aid in hypothesis/theory development.

2. Methods

The framework selected for this scoping review was based on the Arksey and O'Malley [22] framework with revisions made based on *The Joanna Briggs Institute Scoping Reviews Manual 2015* [23] and work by Levac et al. [24]. The purposes of this scoping review are to assess the extent, range, and nature of research activity, to identify gaps in the literature, and to inform further research [22].

For the purposes of this review, local, and implementation have been defined. Local is defined as the city or municipal level and can also be described as a town, township, or village [25], as compared to the provincial/territorial, state, or regional level, and the national level. Implementation is defined as the act of carrying out HiAP mandate [3], or putting HiAP into effect.

2.1. Search strategy and data sources

Medline, Embase, Worldwide Political Science Abstracts, PAIS international, and HealthSTAR/Ovid Healthstar databases were selected to ensure comprehensive coverage of journals, and to ensure broad discipline coverage. Limits were set to English language and 1970–present since most HiAP initiatives have occurred

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