Chapter 17
From Urban Projects to Healthy City Policies

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Introduction

The urban health world is rife with projects—to alleviate poverty, empower communities, provide better roads, increase access to education, secure primary care, etc. Many of these initiatives, rightly, have a fixed life. A new school needs to be built; upon completion it requires staff and maintenance: these are entirely different things that can be managed well on a project basis. But a proper policy would take a longer term perspective that includes not just the building and maintenance of the infrastructure. Such a policy would set parameters to how infrastructure relates to continued access, how both of these relate to the delivery of a curriculum, and how to undertake regular reviews of accomplishments.

Goumans and Springett (1997) have identified that many Healthy Cities suffer from projectism. Interestingly, although this term (alternated with 'projectitis') has become an integral part of the vernacular of the—critical—government bureaucrat, we have been unable to ascertain an authoritative definition for it. In development studies, Pareschi (2002) and Little (2005) refer to projectism when they describe the tendency of the international development community (the 'do-gooders' (Christensen 2004) in development aid) to impose a project format with defined beginning and end, contained resources (money, people) in time and space, on daily activities undertaken by indigenous communities that by their very nature are organic and ongoing, e.g. the defence of territory, production of food, and political organization. Such project 'containment', they assert, can provoke major changes in cultural values, leadership patterns, time conceptions, organizational structure, and political relations in affected indigenous communities. True as this may be, the

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popularity of projectism/itis suggests that the phenomenon may have detrimental effects in high-income, industrialized nations as well. A definition that reaches beyond indigenous culture into (Western) bureaucratic and political values might read 'The reflex, intention and action to contain organisational and community efforts in terms of resource allocation, time, space and conceptualisation purely for the sake of accountability and management purposes, not because the effort at hand necessarily lends itself to such limitation'.

Goumans and Springett (1997) have investigated the potential of Healthy Cities to move beyond projects and projectism, and found that ample opportunities exist to move into longer term programmes or policies that embed the value base and strategic outlook of the approach. In this chapter we take a look at the conditions that may facilitate such a longer term endeavour.

Policy Diffusion and Glocalization

Some research suggests that achieving policy innovation, which is required for introducing systemic and sustainable intersectoral perspectives across society, cannot be achieved at the national level, or not at that level alone. Policy diffusion researchers (e.g. Shipan and Volden 2008) argue that local governments drive policy innovation and diffusion of novel policies horizontally to other local governments, and vertically to regional and national governments. For example, policy diffusion facilitated the Netherlands' efforts to develop a broad Healthy Public Policy in the 1980s (de Leeuw and Polman 1995). Global commitments, such as the Kyoto Protocol for climate change adaptation and mitigation or the Framework Convention for Tobacco Control, can be seen as crucial benchmarks for the need to develop new policy types. Policy innovation does not happen exclusively bottom-up or top-down, but must be characterized as happening through a process called 'mixed scanning' (Etzioni 1967, 1986) in which systems of incremental and reciprocal checks and balances between governance levels create opportunities for change.

A key term that has been encountered throughout this book is 'glocal'. 'Glocal health' (de Leeuw 2001; de Leeuw et al. 2006; Kickbusch 1999) is a term used to recognize and appreciate the intricate and inseparable interface between global developments (e.g. climate change or trade) and local responses (e.g. councils adopting building codes that account for the increased risks of flooding and heat islands, or offering favourable opportunities for local entrepreneurship to engage in international forums). This glocalization dynamic is reciprocal. Less likely or desirable global developments may be mitigated—or exacerbated—by local action. For instance, the increasing number of local governments around the world adopting 'zero-carbon emission' policies (e.g. Koehn 2008) not only contribute to possible reductions in climate change risks, but also send signals to their colleagues, at local as well as higher government levels, that such actions are feasible and effective. Through policy diffusion these local policies impact on global change. In fact, analyses of local government efficacies in the late 1980s and early 1990s led to the

introduction of the terms ‘glocal’ and ‘glocalization’ into our vocabularies (Swyngedouw 1992). Virtually every development and phenomenon in Healthy Cities has glocal dimensions.

Health as a Social Resource and Created in All Policies

So why would we make policy at all? Healthy people are an important resource for society. Healthy communities are thriving communities, not just in economic terms (because they may more comprehensively contribute to building their common resources) but certainly also in terms of social development and the resilience to cope with shifts and challenges in their social and natural environments. Societies and communities with high levels of positive health are resilient. They can face adversity better.

A firm expression of the nature of such a health perspective is often found in its definition as engrained in the Constitution of the World Health Organization (1948):

> Health is a state of complete physical, mental, social [and spiritual, Larson 1996] well-being and not merely the absence of disease or infirmity.

In spite of this broad framing of health, in many countries the health service delivery (or ‘sick care’) sector is not fully embracing these views and their consequences. Most healthcare establishments focus on individual treatment and disease prevention, and are challenged to adopt a full social model of health. Around the world, the health delivery industry has become a dominant economic sector in its own right and efforts to involve it in actions to promote community health (rather than cure and prevention of disease) face strong beliefs that individual-focused interventions are better, quicker, or more effective.

The microbiologist-philosopher Dubos (1959) recognized the profound interface between individual and social health and defined health as

> the expression of the extent to which the individual and the social body maintain in readiness the resources required to meet the exigencies of the future.

The key to appreciating this definition is the notion of ‘the social body’: it refers to community as well as society and its institutions. The institutions can be seen as tangible ‘hardware’ (hospitals, transport services, bodies of government) but also in a more sociological sense. The formidable Ahrendt (1970) saw an institution as ‘a body of people and thought that endeavours to make good on common expressions of human purpose’. This idea of an institution (as in ‘the institution of marriage’ rather than ‘the hospital institution’) has intimate relations to concepts of government and governance.

The ways in which local governments are shaped are functions of both the philosophical and structural views of institutions. In democratic traditions, the assumption is that local government can directly represent constituents and respond to individual, family, community, and neighbourhood needs. But that assumption is firmly based in other assumptions about representation and eligibility of people to

partake in the communal and political processes leading to the values that pervade governance, and the resulting shape of government.

A key aspiration of modern glocal government is to deliver justice. As Spinoza (1670) said,

> the ultimate end of the State is not dominion, nor restraint by fear, nor the exaction of obedience; on the contrary, its end is to free every man from fear, so that he may live securely.

contrast this with Ronald Reagan's definition of government as

> like a big baby—an alimentary canal with a big appetite at one end and no sense of responsibility at the other (Adler 1981, p. 30)

and the clash of political ideologies will be clear.

Governments can secure and facilitate different forms of justice (e.g. Ruger 2005):

- Procedural justice—decision-making about policy, programme, service design, and delivery—making the composition of decision-making bodies more descriptively representative of the community (in cultural, socioeconomic, gender, etc. senses); and strengthening communities' power to define 'agenda' items independently of the 'dominant culture'
- Substantive justice—influence—putting items on the agenda, influencing discussion and debate on all agenda items, and influencing the outcomes of decision
- Distributive justice—ensuring that the population has equitable opportunities to access social resources including high-quality health care, but also preventive services and education, employment, transport, etc.

We assert that local government is an expression and instrument of priority setting for shaping the resources for health that Dubos describes, and creating the forms of justice that allow people to fully participate. This happens through policy development and the management of social and environmental assets. The growing body of evidence, over recent decades, on the social, political, and commercial determinants of health may well enable local government better than other levels of government and governance to take decisive action. Evidence from the other chapters in this book shows that local governments (and especially Healthy City ones) are in closer contact with their constituents and would purportedly be able to respond more effectively and quickly to needs expressed. Clearly this is an ideal-type description: not all local governments are transparent and accountable, and not all people may be, or may feel, represented. This is particularly true for slum dwellers. Sometimes urban inequities are literally hidden—in many Third World cities the slums and their informal populations are located in gullies and ravines. But in others, the favelas rise up high on the slopes surrounding affluence. It appears that technology can come to a degree of rescue, whether it is enabling social connectedness in Nairobi slums (Corburn and Karanja 2014) or physical connectedness through novel public transportation solutions in Medellin, Colombia (Díez et al. 2015).

Local government also has the potential to address the wider determinants of health and health equity. The determinants of health extend far beyond the workings

of the health care system, and include the provision and levels of education, the availability of work and employment and standards, the quality of the built and natural environment, the existence of intangible things like a sense of community and solidarity expressed in 'social capital', and the apparent immutability presence of general social gradients between those at the highest and lowest ends of the socioeconomic spectrum.

Families and communities, and their elected representations in local governments, most directly suffer and enjoy the negative and positive consequences of their decisions on how their lives are shaped in all these domains. Complex and connected issues require complex and integral responses. Local government does not stand alone in this—it can respond (and has responded, e.g., through the Healthy Communities and Healthy Cities networks) more efficaciously to population needs; but at the same time it is bound by regional (provincial, state) and (inter)national contexts. Horizontal and vertical collaboration and synergy can and should be sought.

Moving from Singular to Complex

Analyses of the workings of modern society and its institutional structures (governance, democracy, leadership, etc.) have shown that traditional sectoral and vertical (top-down) responses may yield short-term success but may not address the systemic and complex causes of problems. The consequence of such analyses has been a call for better integration of (and within) problem formulation, policy development, and comprehensive action. Such integration would assume equitable access of highly heterogeneous stakeholders to all elements of enormously multifaceted systems (anyone should have access at any time wielding the same influence over the process, no matter who and where they are—a utopian ideal). It is no wonder that solving this issue has eluded politicians, scholars, practitioners, and communities.

At an *abstract* level, the solution has been found in concepts such as 'systems thinking', 'complexity science', and identification of problems as being 'wicked', 'messy', or 'fuzzy'. For *policy-making*, those terms have translated into perspectives on 'whole of government', 'joined-up government', 'integral government', and 'horizontal government' (Carey 2016; Carey and Crammond 2015; Pollitt 2003). There is a strong argument to be made that these perspectives play out best at the local level because it is there that cooperation between state, market, and civil society actors is considered most likely to produce coordinated planning and action (Christensen and Lægreid 2007). The search for whole, joined-up, integral, or horizontal local government approaches achieved momentum, some scholars and politicians claim, since the (perhaps overly zealous) adoption of 'new public management' (NPM) principles from the 1980s. In NPM citizens are viewed as customers, and public servers/administrators are considered managers of product and service delivery.

The assumption of NPM was that marketization of public goods would yield greater efficiencies. However, vulnerable, socially excluded, marginal, and under-

represented populations in particular often cannot claim a voice of influence and power in this pseudo-economic discourse. Governments have tried to repair the resulting gaps in the system with the application of (often cunningly rhetorical) tools that go by monikers such as 'new social partnerships' and 'empowered clients'. In many cases a new balance between complete state control (the 'nanny state' caring for everyone 'from cradle to grave', cf. Rivett 1998) and full dissolution of services to commercial sectors is yet to be struck.

In the health field, the recognition of 'health' as an issue across social and government sectors has led to the launch of *policy* perspectives such as 'Healthy Public Policy' and 'Health in All Policies'. In *action* terms (that is, for specific intervention development) we have seen the emergence of terms like 'strategic', 'comprehensive', 'multisectoral', or 'intersectoral' action.

In the scientific literature we see important efforts to distinguish between all these terms. Analysts also suggest ways in which they interrelate. A Canadian publication (Gagnon and Kouri 2008) starts this discussion with a description stemming from Australia of 'integrated governance':

> the structure of formal and informal relations to manage affairs through collaborative (joined-up) approaches which may be between government agencies, or across levels of government (local, state and Commonwealth) and/or the nongovernment sector.

This describes the overarching principles driving both policy and intervention responses to complex systems issues in health development: managing health, health development, and health equity through collaborative approaches. The current perspective on Health in All Policies (HiAP) finds a basis in the call to develop Healthy Public Policies in the Ottawa Charter (1986).

Around the world, governments at all levels have experimented with integrated health policies. Some of these actually inspired the pronouncements of the Ottawa Charter, e.g. the Norwegian Farm–Food–Nutrition policy, the Chinese 'barefoot doctors' programme, and women's health initiatives in the Americas. Two initiatives from opposite ends of the world started the developmental process of what now is called HiAP. One came from Finland during its presidency of the European Union in 2006: Finland, building on its experience in the long-running North Karelia project (labelled a 'horizontal health policy'), urged other members of the Union to engage in

> a horizontal, complementary policy-related strategy contributing to improved population health. The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health. (Ståhl et al. 2006)

The other came almost simultaneously from the government of the state of South Australia, which identified opportunities for a broad policy programme to invest in the health of its people:

> Health in All Policies aims to improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors' core goals (Ståhl et al. 2006, quoted in Baum et al. 2015; Rudolph et al. 2013).

These provided impetus for the organization of the Eight Global Conference on Health Promotion where a statement and framework were adopted that expressed HiAP as follows:

> Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being. (World Health Organization 2014a, b)

In different countries and jurisdictions the emphases of the different dimensions of HiAP vary. Consistently, values (in **bold**) associated with the concept centre around the importance of **collaboration** between sectors of **public policy-making** in good **partnership**. Other aspects where less coherence exists between the different jurisdictions include **health equity**, the attainment of **synergy**, HiAP leading to or driven by **accountability**, the character of **innovation**, ways of **integration**, and the very **nature of policy**, e.g.:

> Health in All Policies is a collaborative approach that integrates and articulates health considerations into policy making across sectors, and at all levels, to improve the health of all communities and people.—US Association of State and Territorial Health Officers. (ASTHO)
>
> Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. (California Health in All Policies Task Force)
>
> Health in All Policies is the policy practice of including, integrating or internalizing health in other policies that shape or influence the [Social Determinants of Health (SDoH)] … Health in All Policies is a policy practice adopted by leaders and policy makers to integrate consideration of health, well-being and equity during the development, implementation and evaluation of policies. (European Observatory on Health Systems and Policies)
>
> Health in All Policies is an innovative, systems change approach to the processes through which policies are created and implemented. (National Association of County and City Health Officials) (from Rudolph et al. 2013)

Shifts like these don't just happen. They are the result of, and embedded in, intricately connected webs (Kickbusch (2012) identified those for the health promotion endeavour as rhizomes) that grow, dissolve, reconnect, and interact between people, agents, and events. Callon (1984) and Latour (1987) based their actor-network theory (ANT) on such a view of social, policy, and technology development. This is not the place to engage in a fully fledged ANT analysis; instead we will list six keystone developments that made the current momentum for HiAP possible.

Primary Health Care

One foundation and lasting contribution to our thinking about Health in All Policies has been the drive towards primary health care (PHC). At the WHO/UNICEF conference on Primary Health Care in Alma Ata in 1978, the concept was defined (UNICEF and WHO 1978) as

> essential health care based on practical, scientific and socially acceptable methods and technology. It is made universally accessible to individuals and families in the community through their full participation and at an affordable cost to the community and country.

In its further development, PHC became more fine grained, and two perspectives emerged. One was a horizontal (comprehensive, systems-driven) approach aligned with a set of strong values around equity, participation, and community-driven bottom-up action for health and well-being, and the other a vertical (disease and health care-driven) approach aligned with the need to address specific (burdens of) disease in many countries, and grounded in existing institutions and patterns in the delivery of clinical interventions. Ideology-inspired debates have raged, contrasting the superiority of each approach. Reviews show that vertical programmes, particularly those targeting infectious disease morbidity, may yield short-term and specific health gains (e.g. from vaccination campaigns), but that long-term population health development (e.g. aiming at the reduction of the incidence of non-communicable disease [NCD]) does not unequivocally benefit from such selective approaches (e.g. Magnussen et al. 2004). Vertical programmes work for particular threats, and horizontal programmes contribute to general well-being. In particular, addressing health equity and NCDs does not align well with a selective, vertical approach. Evidence has emerged that, depending on the existing health profile and management of (social) determinants of health in different communities and countries, an appropriate balance between the two should be struck. Building on a mix between vertical and horizontal primary health care, the aspiration should be to engage in the development of comprehensive health strategies accessible to all (Rasanathan et al. 2011).

Community Development and Asset Thinking

In North America, planning emerged as a discipline early in the twentieth century. Initially the planning professional focused on urban development, but soon social planning and other areas such as health and environmental planning were added to the repertoire of the planner. Considering the 'best' ways of planning, experts before long found that the full participation of people in planning considerations was important. What 'full participation' entailed was (and perhaps continues to be) a matter of debate, and Arnstein's 'ladder of participation' as well as Davidson's 'wheel of participation' have contributed significantly to insights into the circumstances and degrees of public participation in the planning endeavour. These views have also made a significant contribution to public health and health promotion practice around the world (Wallerstein 2006), in the Americas (Wallerstein and Duran 2006), and in European Healthy Cities (Boulos et al. 2015; Green and Tsouros 2008).

A second tradition in this arena was driven by Paulo Freire's work in the area of community development through new forms of education, famously called 'the pedagogy of the oppressed' (originally published in 1968 in Portuguese, translated

into English in 1970; his *Politics of Education* (1985) gives a good reflective overview). The views espoused by Freire and others in this tradition hinge on a philosophy that all in society should be able to engage with personal and social development equitably, through open forms of democracy and decision-making. In order to attain such a capacity, empowerment was, and remains, a key strategy in (local) (health) development.

Others have taken this important work as a starting point for, for instance, asset-based community development (recognizing that the people in particular social contexts are an important resource for change), deliberative democracy, and a particular form of the latter, participatory budgeting. The 'father of asset-based community development' is John McKnight. He sees community assets as all the potential resources in a community—not only financial, but also the talents and skills of individuals, organizational capacity, political connections, buildings and facilities, and so on (Kretzmann and McKnight 1993). Some authors (e.g. Page-Adams and Sherraden 1997) criticize such a broad conceptualization as assets might be taken to mean 'all good things', and in order to make assets more tangible they prefer to frame them in a more economic manner. Such a view denies, in our view, the fact that social and health equity both depend on much more than financial and resource capability, and also involve culture, history and heritage, and context (Wilkinson and Pickett 2010).

The asset model presented by Morgan et al. (2010) aims to redress the balance between evidence derived from the identification of problems to that which accentuates the positive capability to identify problems jointly and activate solutions, and so promotes the self-esteem of individuals and communities and leads to less dependency on professional services. This can lead to an increase in the number and distribution of protective/promoting factors that are assets for individual- and community-level health. The asset approach should be seen as the 'shiny' side of the coin. The deficit approach remains valuable in responding to acute crises (at individual, community or societal levels), but in evidence terms at least, the asset model may help to further explain the persistence of health and well-being inequities despite increased efforts to do something about it.

Harrison et al. (2004) have defined health assets as resources that individuals and communities have at their disposal and that protect against negative health outcomes, or promote health status. These assets can be social, financial, physical, environmental, or human resources (e.g. education, employment skills, supportive social networks, natural resources) (Harrison et al. 2004). As such, a health asset can be defined as any factor or resource which enhances the ability of individuals, groups, communities, populations, social systems, or institutions to maintain and sustain health and well-being and to help to reduce health inequities. These assets can operate at the level of the individual, group, community, or population as protective (or promoting) factors to buffer against life's stresses. Obviously a balance needs to be struck between the intangible assets (skills, knowledge, intents, and aspirations) and the hardware assets of a community (schools, work, infrastructure, etc.). Even when both are available there may still be a disconnect between the two: individuals, families, and communities may want to improve their health, but insidious factors such as (health)

literacy, culture, sexism, and racism may stand in the way of full and equitable access and use. An asset-based health approach should carefully take into account all elements of a complex individual, social and ecological environment.

Effectively mobilizing and empowering communities for their health, health equity, wealth, and well-being is an inherently political enterprise and may upset the status quo. Not all governments, locally or nationally, may see the full benefits of participation and empowerment. The maturity of government and governance styles as well as patterns of accountability, transparency, and responsiveness to need may not always allow for the full mobilization of community assets. We will return to these challenges later in this chapter.

The Ottawa Charter: A Lasting Foundation of the New Local Public Health

Due to a growing recognition that health lifestyle change through traditional behavioural (health education) interventions had limited efficacy, and needed to be embedded in broader social change, the World Health Organization with Health Canada and the Canadian Public Health Association organized the first international conference on 'the move toward a new public health' in Ottawa, in 1986. The conference, followed by a series of global health promotion conferences, culminated in the adoption of the Ottawa Charter (World Health Organization et al. 1986). The Charter defined health promotion as 'the process to enable individuals, groups and communities to increase control over the determinants of health and thereby improve their health'.

The conference and its Charter saw a responsibility to enable, mediate, and advocate a broad view of health and health action in four areas:

- To reorient health services towards a broader, participatory, and health-promoting position in society at any level
- To create supportive social, economic, natural, and built environments to create and sustain health promotion and to address the determinants of health equitably
- To invest in personal skills and community action to drive and complement these actions
- To build healthy public policy, recognizing that health is created across many sectors in society that all have the potential to enhance institutional, community, and personal health

Reviews of the accomplishments of the Ottawa Charter have found that substantial progress has been made in our understanding of the drivers of success in each of these fields. Our understanding of the complex nature of natural, social, political, and commercial determinants of health has increased, as has our appreciation of the impact of policies on all of these. Great advance has been documented in linking ('enabling, mediating, and advocating') individual and community health potential

with systemic action on environments for health. The only area where success has been lagging is the reorientation of health services (Ziglio et al. 2011).

The global community of health promoters continues to work on the basis of these principles and advances, and implements these especially in the context of 'healthy settings'—a concept that the Charter launched:

> Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Economic Development and the Role of the World Bank

Health and economic development go hand in hand, although the interface between the two can best be described as 'fuzzy', or in terms of complex systems policy development 'wicked'. The fact that investment in health is a sound economic strategy started to gain traction from the late 1980s and achieved prominence for the first time in the 1993 World Bank's world development report *Investing in Health*. A strong case was made of the importance to national economies and local communities of addressing health and disease factors that impeded full economic development (Jamison 1993). The report was criticized for espousing New Public Management and neoliberal principles of outsourcing and privatizing health as a public good (including, e.g., the supply of safe drinking water) and quantifying the impact of disability on economic development through a measure called the 'disability-adjusted life year' (DALY) (e.g. Navarro 2007). However, it succeeded in placing health promotion and public health management on global and local agendas as legitimate strategies for development. The argument for HiAP, also at the global level between international bodies, has evolved in the past 20 years with the family of UN agencies, including World Bank, UNDP, and WHO, now mobilized for NCD action.

The argument has been developed and refined over the years; for instance, in the Jeffrey Sachs-led WHO Commission on Macro-economics and Health. More recently the WHO Commission on Social Determinants of Health (the Marmot Commission, WHO Commission on Social Determinants of Health (2008)) forcefully indicted unequal economic conditions and pervasive poverty as one of the most critical drivers of health inequity around the world. Impressively, the global Marmot Report has had a number of regional (Europe), national (e.g. Brazil, England), and local (Malmø) reincarnations, highlighting the opportunities and benefits of political action on the social determinants of health. In recent years there has also been a move to take the discourse further, with some starting to address commercial and political determinants of health. Recently WHO and UNDP issued *Guidance Note on the Integration of Noncommunicable Diseases into the United Nations Development Assistance Framework* (2015), an expression

of the joint-agency work that was an outcome of the high-level meeting at the UN in which NCDs were given utmost priority. In the *Guidance Note* the vicious cycle of poverty and health is described with great insight into the implications of this perspective for local government action.

Health Equity

The recognition that health is unequally distributed across populations is not new to the twenty-first century. The terminology used for this phenomenon is possibly as political as its causes and consequences. Various terms are pertinent to this discourse, including 'health disparities' and 'health differences' (scholars of the unfair distribution of resources and its consequences in society claim that these are deliberately 'value-free' functional descriptors to obscure the political nature of the issue) and 'the social gradient' (the statistical slope between those at the top of a socioeconomic spectrum and those at the bottom) upon which most health and disease expressions can be mapped. **(In)equality**, some say, is purely a description of that social health gradient, whereas **(in)equity** conveys a view of the moral and social injustice of such differences in society. Wilkinson and Pickett (2010) describe how equitable societies provide and create better opportunities for health for all, including enhanced economic development, sustainability, and educational attainment. Striving for equity is not necessarily a requirement or prerogative of national government alone—it depends and thrives on a vibrant civil society and its political representation, extending from local action to global policy and the other way around.

Equity is a driving concept in various global strategies, including those on climate change, sustainable development, and gender. Particularly in the health domain, the work by the Marmot Commission has been instrumental. Its report reviews the causes and consequences of health inequity, and demonstrates that it is possible to close the gap within a generation. Policy and action at every level are required to mitigate the possible negative influences of globalization on equity; some authors, however, also allude to the significant potential that global connectedness through new social media may have on an equity agenda.

Globalization, the Rise of the Local, and Governance for Health

The idea that we live in a globalized world has become a mainstream perspective in the twenty-first century. Goods, capital, and knowledge travel, sometimes with the speed of light, around the world. Globalization goes beyond the bounded role of the traditional nation-state. Indeed, although countries continue to collaborate and expand their vision in the globalized world, the phenomenon to no small extent is driven by commercial interests—but also by a new global civil society. The latter includes NGOs like Greenpeace, Médecins Sans Frontières, Amnesty International, Human Rights Watch, and the Peoples' Health Movement.

The actions of this variety of actors on the global scene have made the traditional borders of sovereign states more permeable. No country can thrive without interaction, not just with its neighbours but across the globe, and not just with other countries but with such 'non-state actors'. In discussions about global health governance, experts agree that a new architecture for managing health and health systems in this context is very important. At the same time, new technologies and social media offer new opportunities for knowledge development and community mobilization (de Leeuw et al. 2013).

Local governments around the world see the dissolving integrity of the nation-state as an opportunity to take action. The challenges to the sovereign nature of the nation-state have become prominent during (and in the aftermath of) the SARS epidemic; authors such as Fidler (2007) argue for a new architecture of global health governance (De Leeuw 2013). NCD control, Ebola, HIV/AIDS, the Zika and Chikungunya viruses, and other health issues have become a global health concern, and new options for policy development at the interface between global and local need to be developed. This has happened through the creation of networks of cities around themes such as climate change and sustainability, age-friendly cities, and knowledge and creativity. Assessments of these networks show that such contacts benefit the quality of policy development and actions to improve the quality of life of their citizens. These developments interface with a current discourse about governance.

Governance

Geidne et al. comprehensively review the emergence of the concept of governance as relevant for local health development. They explain that a focus on governance, as complementary to studies of government, derives from a more refined understanding of the scope and nature of the welfare state. This understanding has led to a convergence of ideas that 'government directed by sovereign politicians is not necessarily the most rational arrangement' (Geidne et al. 2012, p. 307). Stoker (1998) argues that, despite there being no unequivocal definition of governance, a consensus exists that it refers to the development of governing styles that blur the boundaries between, and within, the public and private sectors. This makes governance a multidimensional and contextually relevant approach to local arrangements for health development, but also a phenomenon that can be construed as a messy research problem (e.g. Sinkovics and Alfoldi 2012), and 'evidence' for it must be generated in ways beyond the epidemiological paradigm of (quasi-)experimental studies.

There is a profound connection between governance and health (e.g. Marmot et al. 2008; Plochg et al. 2006; Vlahov et al. 2007). In a foundation report for the WHO European Region Health 2020 strategy, Kickbusch and Gleicher (2012) build on this evidence and argue that there is a difference between health governance and governance for health: (1) the governance of the health system and the strengthening

of health systems is called health governance; and (2) the joint action of health and non-health sectors, of the public and private sectors, and of citizens for a common interest is called governance for health. The definition of the latter they propose is

> the attempts of governments or other actors to steer communities, countries, or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches.

> In many reports and pronouncements the concepts of health governance, health policy, and health action are used interchangeably, especially when they deal with complex intersectoral endeavours. It is useful to distinguish between these, particularly as there is value in seeing an overlapping.

Intersectorality and Governance

Intersectoral governance can be defined as

> the sum of the many ways individuals and institutions, public and private, manage the connections of their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest. (Commission on Global Governance 1995)

In the European Region of WHO, from the early stages of the programme, a commitment to intersectoral governance has been a criterion for designation as a Healthy City. From phase II onwards, cities needed to submit evidence that they had established an intersectoral steering committee (ISC) that would oversee policy and intervention development (Heritage and Green 2013; Lipp et al. 2013). There are no specific requirements to the design or architecture of such ISCs, as they are often driven by unique local contexts and requirements. Whether cities lived up to the expectation beyond their formal application commitments was ascertained via annual reporting templates. Virtually all members of the network reported that they did establish an ISC, although the frequency with which this body met was variable. In some cities it met only once a year, and in others more regularly, up to monthly. In cities where the ISC met annually, the role of the body was more at a systems and regulatory level, such as driving and approving policy development and monitoring of intersectoral deliverables; ISCs that met more regularly tended to engage more directly in the operational aspects of partnership development, such as allocation of resources and direct supervision of working relationships.

Both the strategic and the operational aspects of intersectoral governance are important. In their multiple governance framework, Hill and Hupe (2006) show these different dimensions of governance as complementary requirements for effective and transparent policy development and implementation (Fig. 17.1). Intersectoral governance moves between, and encompasses, an architecture in which implicit and explicit rules at a systems level (‘institutional design’ in Fig. 17.1) explicitly connect to the way in which individuals in collaborative pro-

Scale of action situations	*Constitutive Governance*	*Directive Governance*	*Operational Governance*
		Action level	
SYSTEM	Institutional design	General rule setting	Managing trajectories
ORGANISATION	Designing contextual relations	Context maintenance	Managing relations
INDIVIDUAL	Developing professional norms	Situation-bound rule application	Managing contacts

Fig. 17.1 Multiple governance framework (Hill and Hupe 2006)

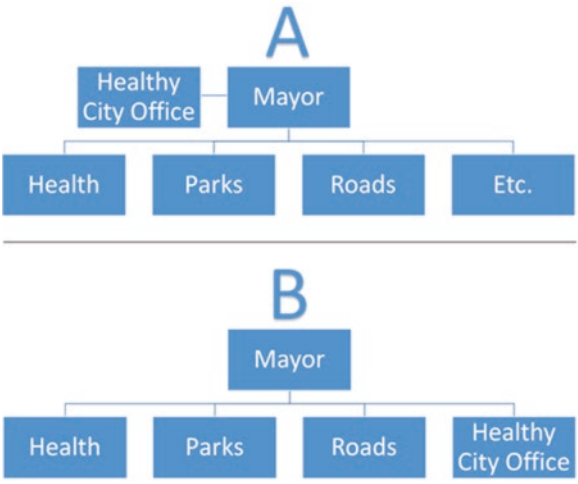

Fig. 17.2 Coordinating Healthy Cities: a staff function (**a**) or line responsibility (**b**)

cesses manage their contacts. Since Healthy Cities in Europe have been deliberately considered a natural laboratory of health policy innovation at the local level (Tsouros 1995), in hindsight it has been appropriate that the specific terms of reference of ISCs have never been spelt out in great detail. This flexibility has allowed the emergence of all types of governance, and an evolution of praxis in which these different levels and types of governance have been tried, tested, and connected.

Regarding the actual architecture of intersectoral governance arrangements in Healthy Cities, all designated cities are required to have a coordinating office. Similar to the flexibility in terms of reference for the ISCs, WHO has not set specific expectations regarding the organizational positioning of this office. There has been an ongoing debate whether this coordinating body should be directly associated with the local government executive office, that is, as a staff unit appended to the Mayor's office (Fig. 17.2, model A), or should be a line unit at a relatively high hierarchical level able to coordinate efforts within government (Fig. 17.2, model B). Both models can serve a distinctive purpose, depending on the nature and maturity

of the Healthy City. The evaluation of phase V revealed another type of governance architecture whereby Healthy Cities increasingly integrate and devolve the responsibility for intersectoral action for health throughout both the government and civil society.

Intersectorality and Action

Intersectoral action is the engagement of relevant sectors, both within and outside the public policy arena, in the implementation of activities, programmes, and projects that have a multidimensional nature. Obesity, for instance, has lifestyle-choice dimensions but must also be addressed through structural interventions in the obesogenic environment (Kirk et al. 2010), e.g. in public transport, food security, and community development. Ideally this requires a policy and managerial context that embraces the values of HiAP described below, and it is important that different sectoral stakeholders collaborate effectively.

Lipp et al. (2013) show that from phase II through phase IV of the European Healthy Cities programme, intersectoral action has expanded and strengthened. For example, the 31 cities participating in both phase III and phase IV increased the extent of partnership working in all sector studies: health services, social services, education, urban planning, voluntary, environmental protection, transport, and economic development. For phase V, Farrington et al. (2015) show that Healthy Cities, in trying to address the prevention of non-communicable disease, also make explicit efforts to work intersectorally in distal determinants of health. European Healthy Cities, they find, recognize that to make healthier choices easier requires appropriate structuring of the upstream determinants of health. For example, interventions in the built environment to make active living an easier choice include investment in city sports and exercise facilities, investment in cycling infrastructure, and redesignating streets for pedestrians only.

Successive European Healthy Cities evaluations therefore show that local governments are not only embracing intersectoral work through the creation and maintenance of appropriate governance architectures, but are also increasingly deploying resources in terms of operational action to deal with complex problems in dynamic partnerships. Following the programme logic of realist synthesis, this suggests that the social determinants of health are being addressed more effectively and sustainably.

Intersectorality and Policy

Elsewhere I have argued, with Clavier and Breton, that ‘policy’ can mean different things to different actors at the same time. A bureaucrat may use the word ‘policy’ to indicate ‘standard operation procedures’, a community activist may mean by it ‘a dictate coming from above’, and a politician may use the term to denote ‘an intention

to change'. Not surprisingly, the same diversity is found in the field of political science. For the purpose of this chapter, and to distinguish meaningfully between governance, action, and policy, we define the latter as

> the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe (De Leeuw et al. 2014).

Such an approach clearly distinguishes between the policy issue, its resolution, and the tools or policy instruments that should be dedicated to attaining that resolution.

Thinking about intersectoral health policy has evolved over the years. Healthy Cities engage enthusiastically—and beyond mere rhetoric—in the development of health and health equity in all policies. Building on a strong foundation in the various political statements on Healthy Cities over the years and most recently in the Athens Declaration (Tsouros 2015), local governments work with diverse stakeholders from the public and civil society sectors to develop such policies. The nearly three decades of Healthy City development are clearly leaving a legacy, in that Healthy Cities manage the politics and logistics of interorganizational work effectively. This is clearly dependent on strong yet flexible governance arrangements and demonstrated commitments to the action component of intersectorality (McQueen et al. 2012a, b)

In the evidence on intersectoral policy development and implementation compiled for European Healthy Cities (de Leeuw et al. 2015), there was an interesting mix between more traditional health approaches, such as a programme on active living in Izhevsk, Russian Federation, and initiatives where the health sector has more peripheral ownership, such as a programme on sustainability in Amaroussion, Greece. This is precisely the message for effective HiAP development—that the health sector has the capacity to share, redistribute, and even disavow ownership of policy initiatives beyond its traditional remit. Healthy Cities show that such actions do not compromise but strengthen the integrity of health sector policy-making capacity.

The Consequence: Health in All Policies

The above developments have created a strong historical footing for the development of Health in All Policies. They are, however, often seen as abstract global concepts and aspirations rather than operational local inspirations. In this second decade of the third millennium there are, nevertheless, many reasons why local governments and their communities in particular should be inspired to make a real difference. We compile five themes that drive further action.

The Health Promotion Evidence Base

It is important for society and its communities to spend their resources where they matter. Although it can be easily contested what 'where it matters' actually means in different contexts (for instance, a national re-election campaign of a politician

based in a megacity would probably not recognize the needs of rural and remote communities to their fullest magnitude), this idea has driven the development of evidence-based (health) policy. Substantial impact on this broader aspiration was made by the evidence-based medicine mantra that has its foundation in the work of Archibald Cochrane. He found that many medical practices were not firmly rooted in evidence of effectiveness (whether something produces the intended result) or efficiency (how well it produces that result). The consequence of this position was that decision-makers, both in policy and in practice, invested in approaches to demonstrate the effectiveness of medical procedures.

This effort has had its influence on policies that espouse a broad social model of health and health promotion, both globally and locally. The methods to generate evidence of effectiveness on this arena are, naturally, different from the often controlled circumstances under which clinical procedures can be tried and tested. Where in clinical environments an assumption is that an experimental group can be matched with a control group, is it much harder in reality to find the perfect experimental match for, for example, a barrio in Medellin, in order to test the effectiveness of social investment.

Yet very good progress is being made in demonstrating the effectiveness and efficiency of health policy and health promotion. Evaluation efforts around Healthy Cities show that it is easier to achieve public participation and good governance for health at the local level. Equity is a concept close to the heart of many local politicians. International research shows that health and health equity impact assessments are not just highly effective tools for measuring the consequences for population health of broad social, environmental, and economic change, but also have a significant impact on the quality and sustainability of policy development and implementation. Concepts like Healthy Urban Planning that embrace a wider view of transport and mobility show not just health, but far broader social improvement.

The Ottawa Charter for Health Promotion also launched the ideas of settings for health (‘where people live, love, work and play’) as a critical aspect of health development. Significant evidence has been accumulated on the efficacy and health impacts of initiatives beyond Healthy Cities, for instance in Health Promoting Schools (globally the most significant network of settings for health with tens of thousands of participating primary and secondary schools, currently expanding into kindergarten environments), Health Promoting Market Places, Healthy Islands (notably in the Pacific through the Yanuca Declaration, linked to the Barbados Programme of Action), Health Promoting Universities, Health Promoting Prisons, and Healthy Transport.

This evidence continues to be compiled by international organizations like WHO, UNDP, IUHPE (the International Union for Health Promotion and Education), and other global agencies, but also through networks of civil society like international city networks (e.g. C40 and Healthy Cities) and academia. There is, in fact, ‘meta-evidence’ that networking for evidence generation enhances the quality, relevance, and responsiveness for glocal action.

Universal Health Coverage

The enthusiasm and vigour that were originally part of the Alma Ata Declaration on Primary Health Care were rekindled a few years ago when the World Health Assembly formally re-endorsed the broad social nature of the Declaration. It was further sustained by a global campaign to work towards universal health coverage (UHC) at all levels of governance and health system operation. It is defined as

> ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (World Health Organization 2016).

In some instances UHC is conceived as an exclusively financial issue that requires fiscal programmes and discipline to redistribute key social resources. The evidence shows that, in fact, the monetary dimension is maybe the least problematic to address. Moving from divisive health (delivery) services towards inclusive ones requires much more than the reallocation of resources.

UHC has many benefits and creates ample win–win situations, apart from the obvious health gain. They secure a (human) rights-based perspective on population health, have the potential to organize and rally communities for social and economic development, and have the strong potential for higher quality health information collection and management, thus adding to more bespoke evidence-based local health policy.

Local governments may not always have control over fiscal opportunities and the management of health facilities and professionals. Often these are organized and financed at higher levels of governance, and partly for good reason: not every town needs highly specialized neurosurgeons and expensive fMRI scanners. But the essential population-based 'first point of contact' with the health system, i.e. primary care, is by its very nature integrated in local communities—even where there may be no doctor. Community health workers and local health posts play critical roles in maintaining and integrating universally accessible and appropriate health and social support; they are also the natural champions of (local) community development. Even when there are no formal governance arrangements for local government institutions (and in slum areas may even have an informal nature), these professionals and their operational bases are very much part of the social and political landscape of local government.

UHC at point of delivery is therefore a concern for local action, whether it has been formalized as a local government remit or not. Experiences from the Americas, e.g. of people-centred programmes in Mexico and Brazil, show that UHC is possible and yields significant dividends, not just for population health but more broadly for social development (Quick et al. 2014). Evidence suggests that success of UHC schemes depends on the presence of (1) the strength of organized progressive groups in local communities; (2) the potential of mobilizing adequate economic resources; (3) the absence of significant societal divisions; (4) a weakness

of institutions that might oppose it (such as for-profit hospital enterprises); and (5) a skilful identification and opening up of windows of opportunity by (local) policy entrepreneurs (McKee et al. 2013).

Determinants of Health

The description of the social gradient in health (that is, the fact that health parameters like mortality, morbidity, and life expectancy follow the patterns of the distribution of wealth, prestige, status, and education in society) has moved from a mere epidemiological curiosity to a political issue. Increasing numbers of governments endeavour to place health equity and its causes high on their political agendas. This happens with varying degrees of success.

There have been arenas of governance with such a strong belief in their equitable nature that a debate around the sheer existence of health inequity in those societies and communities has been unimaginable. There are also cases where existing inequity is attributed to personal lifestyle choice rather than to broader determinants of health. This so-called lifestyle drift can be inspired either by uninformed behaviourist tendencies (assuming that all human behaviour is entirely within the control of the individual) or by political ideologies like conservative liberalism (assuming that the fate of societies can be entirely attributed to the resourcefulness of its individual members). The evidence, however, demonstrates that individual choice is determined by social, environmental, cultural, economic, natural, and built environments. Clearly these interact in extremely intricate ways. They are also the result of political preference, and of commercial interest.

Both England's report *Fair Society Healthy Lives* and the Swedish *Socially Sustainable Malmö* stress the interrelation between policies that aim to

- Give every child the best start in life
- Enable all children, young people, and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

A Reflection on Silos: How Did We Get into Them, and How to Move Beyond Them

One of the most prominent challenges in establishing cross-cutting policies and actions is to move outside traditional disciplinary and sectoral boundaries—silos. How did we end up with, and in, those silos?

The classic ideal of a good citizen was that of the Renaissance man, of whom perhaps the best example is Leonardo da Vinci (1452–1519), the Italian polymath, painter, sculptor, architect, musician, mathematician, engineer, inventor, anatomist, geologist, cartographer, botanist, and writer. Typically Da Vinci would not regard himself as any of these 'professions'—he accomplished all of this without silos. And certainly he was not unique—many advances to modern society have been made by men and women who branched out across scientific disciplines and the arts.

This comprehensive integration of the sciences and the arts, not just in one person but in a world view, was challenged in the period of Enlightenment, in the sixteenth and seventeenth centuries when the world view evolved towards one of a separation of body and mind, and of distinctly different disciplines arguing that the observed world could be understood mainly through rigorous analysis, that is, deconstructing it into its unique parts. Scholars started to focus on particular bodies of knowledge and developed strong theories for each. When in the nineteenth century medicine, as one of these disciplines, became highly professionalized (influenced by the industrial revolution and a growing upwardly mobile middle class) these disciplines started to specialize even further. The process is sometimes called 'hyperspecialization' and today can be witnessed in the proliferation of academic journals focusing on quite particular areas of interest.

Hyperspecialization is one reason that modern societies operate in management and policy silos. Professionalization is another. This is the process of establishing acceptable qualifications, a professional body or association to oversee the conduct of members of the profession, and some degree of demarcation of the qualified from unqualified amateurs. The process creates a hierarchical divide between the knowledge authorities in the professions and a deferential citizenry and creates strong patterns of inclusion and exclusion: building a bridge requires an engineering professional, taking someone to court needs legal professionals, and treating disease must involve qualified medical professionals.

Specialist and professional segregation are continuously challenged. In the early twentieth century, for instance, debate raged in North America whether public health was within the remit of the medical profession. The matter was resolved with the publication of the Flexner Report (Flexner et al. 1910), urging a proper 'scientific' approach to clinical medicine teaching, thus excluding public health. In Europe—and in countries that followed a European model of health professionalization—medical education continued to include public health matters under the banner of 'social medicine'.

Specialization and professionalization created formidable commercial and political forces to maintain and protect their status quo. Even when the evidence base concerning social determinants of health rationally dictates collaboration and integration of efforts, these forces often prevent successful and effective action and policy development.

There is a growing body of rhetorical and evidence-based knowledge that addresses these problems. Effective partnering for health starts with the recognition that the capacities of a discipline or specialty in isolation are insufficient to make a difference. The process that enables such a recognition requires the presence of

leadership, communication and analytical skills, and something that can be called social entrepreneurship (the capacity to advocate, mediate, and manage opportunities and differences in diverse communities of policy and practice). Firm pronouncements by executive offices (e.g. a mayor, CEO, or spiritual leader) in support of reaching out to other sectors are indispensable. Reliable and sustainable grounding of such positions in community action helps maintain momentum.

Such approaches to removing the walls of silos play out at a relatively high level of abstraction; a workforce that is receptive to interdisciplinary work and has been trained to reach out to others is, of course, vital, too. Increasingly we see programmes and curricula across primary, secondary, and tertiary education that do in fact embrace such values.

Health in All Policies: State of the Art and Local Opportunity

Policy and Action

The terms *intersectoral action* (sometimes *intersectorial action*) and *multisectoral action* have been part of the rhetorical repertoire of public health and health promotion since the mid-1970s. The terms achieved credence through the Alma Ata Declaration, the Ottawa Charter, and a series of other pronouncements by global bodies including WHO. The international discourse has also included arguments and evidence around variations of ideas about working together for health on the spectrum networking–coordinating–cooperating–collaborating (see Lipp et al. 2013 for a brief discussion). Although there may be conceptual shades of grey around the interpretation of these terms, this focus of public health and health promotion clearly hinges on the noun *action*.

Agencies, individuals, groups, and communities may come together to jointly *act* on health concerns or determinants of health—but this does not necessarily mean that these actions are either *driven by policy* or *result in policy*. A series of case studies, however, are starting to build an evidence base that demonstrates that successful intersectoral action may inspire the need for HiAP. HiAP, however, may not necessarily lead to intersectoral action: for instance, policies to limit lead (Pb) content in paints and gasoline are singularly industrial–economic in nature, and apart from commitments required by industry do not necessitate the deep involvement of other government sectors.

Considering the importance of successful intersectoral action for the development of HiAP, it may be worthwhile to reflect on the reasons why it appears such a challenge to break the walls of the silos and move beyond pithy interests. Irwin and Scali (2010), at the request of WHO, assessed the reasons for the failure of intersectoral action and policy to become an ‘easy’, ‘mainstream’ effort. They show that intersectoral action for health failed because (1) it was driven by the health sector alone; (2) the intersectoral rhetoric was effectively challenged by the absence of supporting empirical evidence and research programmes to establish such evidence; (3) public health was ‘messed up’ by New Public Management ideologies that

moved health responsibilities out of government into private and civil society spheres and complicated matters; and (4) international donors and healthcare agencies achieved rapid success with single disease-focused vertical delivery programmes.

It appears that, with the resurgence of primary health care, the strengthening of UHC, and an increasing commitment to equity around the world, the seesaw with neoliberalism and free market principles on one side and deeper human values on the other have become balanced again, and that the political climate for successful intersectoral action initiatives is more positive. This is expressed in the commitment to HiAP formation and implementation, but the limitations and challenges in the comprehensive embrace of integral action will remain and need to be addressed.

This discussion on the critical connection between action and policy raises the question of what the process to attain and sustain Health in All Policies will entail, and which actors need to be engaged. McQueen et al. (2012a, b) describe various governance models for HiAP. These have been mapped onto the different elements of the policy process (Fig. 17.3) and hinge on seven best practice models for HiAP implementation. Different (groups of) government and non-government agencies can play different roles during the HiAP process. Figure 17.3 describes some of the governance parameters for positioning HiAP development within government structures. In addition to this, we have also identified eight institutionally different structural interaction patterns (Fig. 17.4) that describe the linkages between the health care system and its public policy agencies (e.g. a Ministry of Health at the national or provincial level; or a public servant within a local government agency with a public health remit), other public sector agencies and executives (the office

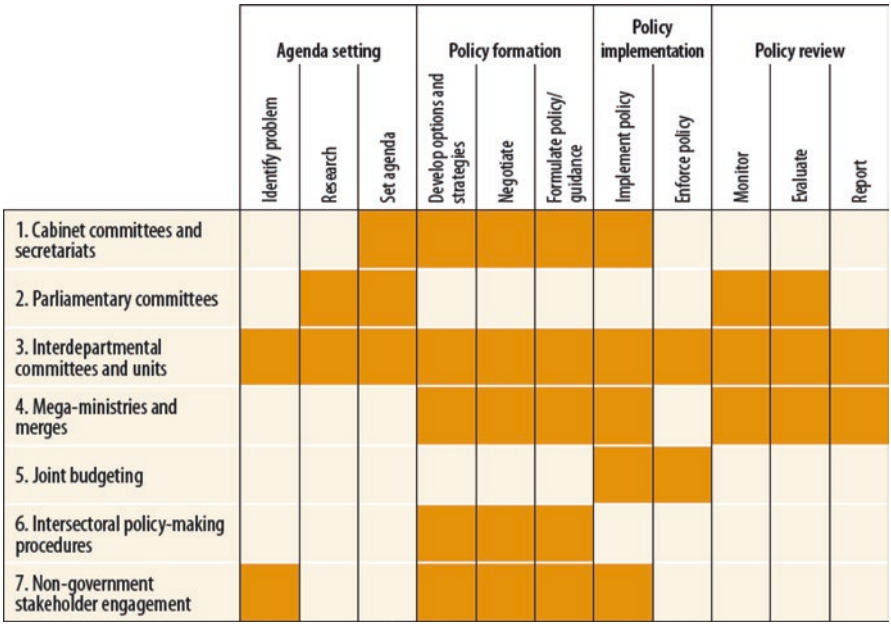

Fig. 17.3 Actors engaged in governance for HiAP. WHO (2015), based on McQueen et al. (2012a, b)

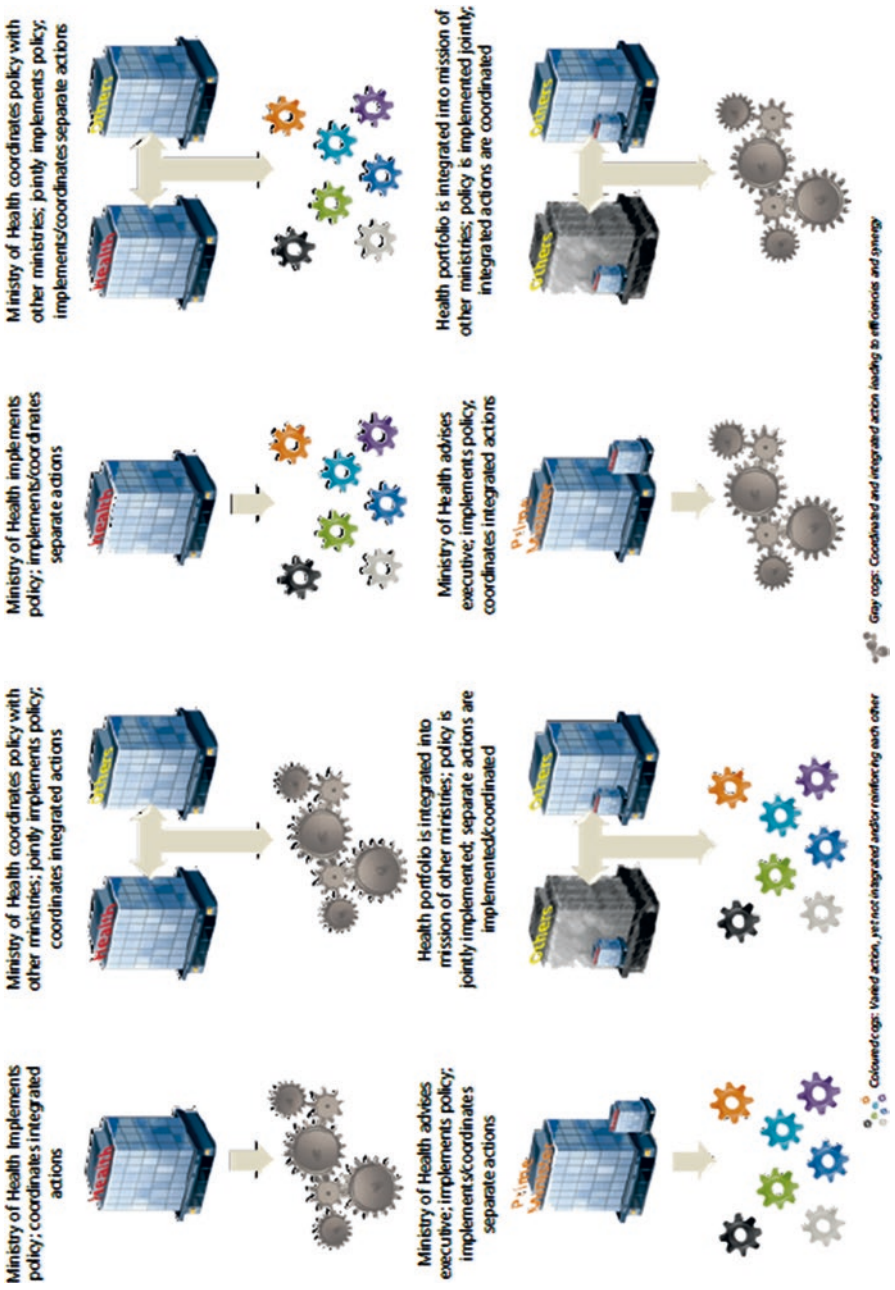

Fig. 17.4 Eight ways to coordinate between sectors, and implement HiAP in integrated or separate action

of the president or mayor, for instance), and the shape that intersectoral action for health and health equity may take.

It would be an illusion to think that inter-agency integration or collaboration will automatically lead to integrated action. There are many cases where collaboration still leads to a multitude of singular projects without a lot of systemic and synergy consequences. An example might be inter-agency collaboration on road safety: even where there may be agreement on the nature of a road safety issue (e.g. child fatalities) and action is taken, those actions may not be coordinated and sometimes may be counterproductive. Road design, improvements, trauma response, safety communications (signage), and behaviour communications (promoting seatbelts and helmets) should be jointly assessed and developed. If they are not, the whole of the roadscape may be messy and confusing and the total effectiveness of interventions significantly decreased.

On the other hand, we know examples where the health sector successfully drives systemic and sustainable intersectoral action in cases where the sector is given the opportunity to engage with local communities. An example would be the integration of health checks, childcare, and (health) literacy training in 'casas de cultura' (Latin America) or community hubs.

Key to the success of *any* approach is the assessment of win–win opportunities, playing to the strengths of each sector and community, 'going with the flow' rather than against it, demonstrating co-benefits to those involved (and that goes beyond government sectors), avoiding turf wars, and a more comprehensive appreciation of different forms of evidence that are generated and applied beyond the health system alone. This includes the exploitation of successful inter/multisectoral action driven by stakeholders outside the health and public sectors.

Partner for Purpose

Intersectoral action and HiAP must not happen for their own sake. Collaboration without joint ownership and outcomes, and integrated policy addressing one-dimensional issues, is senseless. Many lessons have been learned from the integrated partnership agenda in health promotion, particularly in Healthy Cities (e.g. Lipp et al. 2013). Planned action to connect, integrate, and scope the integral policy agenda needs to address the following evidence-based stages:

- Map and recognize organizational mission and resource capacities and acknowledge the boundaries of the traditional organizational footprint.
- Describe organizational challenges in addressing issues and populations that permeate and move beyond the organization's legitimate area of concern.
- Map and include organizations that cover the same, similar, or different issues and populations, or share the same, similar, or different approaches and interventions to deal with these.
- Recognize the legitimate potential of other stakeholders to be involved in intersectoral action or integral policy development and strive for transparency in sharing these views.

- Scope the dimensions of probable and possible collaboration and factors that may stand in the way of respectful joint action.
- Involve real authorities and decision-makers, including organization executives as well as street-level bureaucrats (frontline implementation personnel who deal with inter-sectoral action challenges on an everyday basis), in shaping the joint agenda.
- Formalize and celebrate each of these stages, as far as possible including individuals, communities, and neighbourhoods that are at the 'pointy end' of the implementation of action and policy outputs.
- Make all stakeholders in these processes, as far as is culturally and organizationally possible, accountable for their actions, but apply the 'Chatham House Rule' (full confidentiality of sensitive and strategic considerations) wherever necessary.

Identify Existing Supportive Structures and Processes and Agendas for Their Development

In this book we have seen that in many local government areas there are already effective structures and processes that would further facilitate the development of inter-sectoral action for health and a strongly associated integral policy development potential. Such structures and processes include

- An engaged and empowered community
- Successful experience in deliberative democratic and participatory processes
- Successful experience in partnerships and collaboration for health and well-being
- A broad recognition of the urgency of NCD strategies, supported at executive and council levels
- A broad recognition of the 'causes of the causes' of ill health, supported at executive and council levels
- An existing agenda to strengthen or move towards universal health coverage
- Existing role models and examples of inter-sectoral action and HiAP in other local governments in the countries, for instance, connected through Healthy Communities networks
- Vertical integration of governance models for inter-sectoral action and HiAP between different levels of government
- Existing evidence of social, economic, and sustainability win–win situations, and ongoing connections with local and national agencies and structures that may support the creation and maintenance of such evidence (e.g. local and national universities and NGOs)

Build Lasting Capacity

Addressing the complexity of modern health and health equity issues requires a lasting, continuous process. The establishment and implementation of one Health in All Policy in one place cannot be considered the end point. It is a stage in an

evolutionary practice: the policy needs to be reviewed, adapted, and renewed to meet the exigencies that it has created. The context, and local stakeholders, in which this happens will constantly change. Political shifts may require a renewal of executive commitment; evolving community concerns will dictate ongoing participatory consultative action; and technological advances may inspire new solutions.

The local government apparatus will require a firm grounding in flexible understanding of the foundations of inter-sectoral action and HiAP, and the processes required to maintain and develop its potential and impact. The above steps, when documented and conscientiously applied, form a local basis for sustained capacity to address new complex health issues through HiAP and inter-sectoral action. A form of 'corporate memory' is required to keep such lessons on the radar, and a public repository (virtual or real) can be such a resource.

Various organizations, often at the interface of policy and practice, offer capacity-building programmes that engage with real-life environments and aim to integrate new understanding and improved potential for sustained change in local health development. One example is the Learning by Doing programme (Harris-Roxas and Harris 2007; Pennington et al. 2015) that makes local government agents across sectors engage in, and reflect on, health impact assessments. Another example is the efforts of the Victoria Health Promotion Foundation (Australia) to build capacity for local operators to include broad determinants of health thinking (Environments for Health) in actual processes towards the development of compulsory municipal public health plans through its 'Leading the Way' programme (VicHealth 2002).

Conclusion

We started this chapter by asserting that many local initiatives merit a project approach with dedicated temporal and resource dimensions. But to drive those projects in an integrated vision they should transcend themselves, transforming into a perspective that connects an overall vision for the future of a glocal issue or environment. We have described how such vision has been given momentum by developments both local and global, firmly grounded in a set of coherent values including equity, participation, sustainability, and accountability. It is not just preferable to work towards policy for health: it is the *only* thing to do to respond to the needs of communities, and through integrated connections between sectors, in Health in All Policies.

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