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Examining Whether The Health-In-All-Policies Approach Promotes Health Equity

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ABSTRACT Scholars and public health advocates have expressed optimism about the potential for the health-in-all-policies approach to address social disparities in health, but little research has been done on whether it promotes health equity in practice. Based on sixty-five in-depth interviews with US officials in the public and private sectors conducted in five states in 2016–17, we found a relationship between the use of the approach and the prominence of health equity as a policy concern. In emphasizing the social determinants of health, the approach gives public officials and policy entrepreneurs a framework for promoting this goal. In some areas, we found a gradual transition in focus from health generally to health equity. Overall, we found that practitioners of the approach introduce equity selectively and strategically.

The concept of health in all policies (HiAP) has become increasingly prominent in US policy discussions over the past decade.[1] Major public health organizations, academic researchers, and nonprofit organizations have promoted it, and a growing number of governments at various levels are using it.

Health in all policies does not refer so much to a specific set of policies per se as it does to a process for integrating health into governmental policy making.[2] Its dual premise is that the most important factors affecting health are social, economic, and environmental and that the policies affecting them typically fall outside the jurisdiction of most health departments.[3] As Linda Rudolph and coauthors define the concept, "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."[4] The ambition of the HiAP approach is to break down institutional barriers to collaboration.

Because the social determinants of health are marked by large racial, ethnic, and income disparities,[5] the approach is often touted as a means of promoting health equity. However, the Centers for Disease Control and Prevention (CDC) defines it as a "collaborative approach that integrates and articulates health considerations into policymaking across sectors," only then adding that the "approach may also be effective in... achieving health equity."[6]

Our research question was whether the HiAP framework serves this purpose in practice. Do government officials and advocates use the framework to elevate health equity as a policy concern across sectors and jurisdictions? In this article we report the results of a qualitative study of HiAP initiatives across five states and fourteen localities. We found that HiAP is a useful framework for promoting health equity but that the HiAP-equity connection is issue dependent and conditional on the preferences of other actors in the political environment.

Study Data And Methods

This study is in the tradition of what qualitative social scientists refer to as grounded theory. Grounded theory is an inductive approach to generating hypotheses instead of testing preex-

isting ones in a generalizable way.[7] It is especially useful when research on a topic is at an early stage.

GOAL Our goal was to examine the relationship between the HiAP approach and the promotion of health equity as practitioners understand and implement it. To put it differently, the purpose at this stage was not to explain variation in the uptake of the approach, but to investigate how officials who employ it do or do not use it to promote health equity.

INTERVIEWS Given this purpose, we conducted a multisite, interview-based study. As shown in exhibit 1, we conducted sixty-five semistructured interviews and six reinterviews in five states (California, Colorado, Maryland, Massachusetts, and Washington) across fourteen localities. Seventy-seven percent of our interviewees were government officials, almost three-fourths of whom worked at the local level. The interviews, conducted in the period July 2016–July 2017, were confidential and ranged from forty-five to ninety minutes in length. Together, the authors developed a semistructured interview protocol and conducted all of the interviews, almost all of which were in person.

Although the interviews probed several features of HiAP initiatives, such as their formation, implementation, and strategic goals, this article focuses on the connection between the HiAP method of cross-departmental collaboration and the role of health-equity considerations. We examined reports and other documents to supplement the interview results, but because comparable documents were not available in all cases, this article is based only on the interviews. We pretested the protocol, made appropriate modifications, and used the revised protocol in our interviews.

SITE SELECTION The primary criterion for site selection was to identify states and localities where HiAP initiatives were already under way. In a study with a small sample size, standard stratification is not possible. Instead, we sought variation in whether the use of the HiAP approach was relatively new or long-standing and well developed. We also chose sites from both urban and rural areas and in three different regions of the US.

To identify an initial list of sites, we conducted a literature review on the topic, examined the LawAtlas legal database, and consulted with knowledgeable experts in the field. The experts included academic and independent policy researchers and representatives of two national public health organizations. These sources sometimes identified specific participants for us to interview, but we primarily relied on government and health policy websites to identify potential interviewees. Once people agreed to participate, we used a snowball sample to identify other participants. Our goal was to identify a wide range of actors involved in HiAP initiatives.

DATA ANALYSIS The primary form of data analysis was descriptive but systematic, comparing and contrasting information across sites along the several dimensions of interest. To conduct the analysis, both authors carefully read each transcript to identify common elements as well as departures from them. About 75 percent of the interviews were recorded and transcribed, thus capturing participants' verbatim responses. In the other interviews, the authors took extensive notes that were later transcribed. Both authors reviewed all of the transcripts for common elements. The importance of health equity in HiAP collaborations was a prominent theme in the interviews, and both authors reread and coded the transcripts with that focus in mind.

LIMITATIONS We do not wish to overstate the generalizability of our findings. They suggest that practitioners view the HiAP approach as having considerable practical value in many contexts. But this study had certain limitations that should be taken into account when interpreting the results.

First, the study was not designed to make broad claims. It relied on a small sample of sites and participants. By examining the views of participants, it suggests common considerations and specific observations that should inform future conceptual and empirical work.[8]

Second, our study focused on health equity in cases where a HiAP initiative already existed. It could not explain whether and why health-equity concerns played a role in the adoption of the

EXHIBIT 1

Characteristics of interviewees, by type of official

	Number	Percent
INITIAL INTERVIEWS		
State officials		
Public health	10	15
Other	3	5
Local officials		
Public health	24	37
Other	13	20
Foundation or NGO officials	10	15
Private-sector officials	5	8
Total	65	100
REINTERVIEWS		
Local public health officials	4	67
State public health officials	2	33
Total	6	100

SOURCE Authors' interviews conducted in 2016–17 with sixty-five state and local officials and advocates. **NOTE** NGO is nongovernmental organization.

HiAP approach in the first place. The fact that the use of the health-equity frame is strategic makes answering this question difficult. Practitioners who are already inclined to promote health equity may be more likely to adopt the approach.

Third, the HiAP framework is not the only way to introduce greater attention to social disparities in health. The alternatives, which were not part of this study, include Accountable Health Communities and anchor institutions (large, place-based entities such as hospitals and universities that provide resources to improve community health).[1]

Study Results

Our analysis produced three related themes regarding the emphasis of the health-in-all-policies approach on cross-sectoral collaboration and health equity as a goal. The first concerns the general relationship between health in all policies and health equity; the other two concern the conditions under which the relationship holds.

HEALTH IN ALL POLICIES REINFORCES ATTENTION TO HEALTH EQUITY Early in the interviews, we asked participants what the HiAP approach meant in the context of their work. Not surprisingly, their responses varied, but the interviews revealed several common features of the approach as policy practitioners understand it. Consistent with the academic definition, all respondents identified cross-sector collaboration as a central feature of the approach. Likewise, almost all emphasized that its purpose is to address the social determinants of health.

The application of the HiAP approach on the ground varied in the emphasis placed on health equity. For instance, health officials sometimes work with parks and recreation departments to create opportunities for physical exercise that would otherwise be unavailable to low-income residents. But not all parks are located in low-income areas, and their development need not be motivated by equity concerns.

Nonetheless, we found a positive relationship between the HiAP approach's process of cross-sectoral collaboration and health equity as a specific, self-conscious goal. As exhibit 2 shows, interviews at every site but one indicated that health in all policies provides a useful framework for promoting health equity.

For some practitioners, health equity is a defining goal. For example, a public health official in Colorado commented: "We're not interested in partnering just for the sake of partnering, but we're interested in partnering to improve outcomes for our most vulnerable and marginalized communities in Colorado."

A local health official in Massachusetts described the importance of equity in collaborating with the transportation department: "It's always front and center. I can honestly say that half the time at these DOT [Department of Transportation] meetings, all I'm bringing to the table...is the equity perspective, consistently asking the question of who is benefiting and who is not benefiting."

A state official in California captured the prevailing view in his state: "HiAP and health equity are synonymous. HiAP is an equity framework."

In contrast, one interviewee in Seattle, Washington, argued that health equity is a more inclusive and comprehensive term than health in all policies, observing that people's eyes glaze over when the term "HiAP" is used. The respondent added that "HiAP" evokes what some refer to as public health imperialism.

In two states, attention to health equity has increased over time. As a California state official explained: "It was easier at first to discuss HiAP, not health equity, because the unequal distribution across the benefits created winners and losers. Now, health equity is part of everything we do. All departments are required to focus on and promote health equity. It is part of the overall mission."

Similarly, the Colorado Department of Public Health and Environment recently created and staffed an Office of Health Equity, whose purpose is to promote cross-sectoral efforts to address social disparities in health.

In sum, there is consistent evidence across five states and fourteen localities that public officials and advocates see the HiAP approach as a means of promoting health equity. But the numbers in exhibit 2 fail to capture differences in degree across states and localities; notably, the emphasis on equity in HiAP initiatives varied with the specific problem being addressed and the preferences of other actors in the strategic environment.

THE HIAP–EQUITY CONNECTION IS ISSUE DEPENDENT As noted above, the goal of the HiAP approach is to create cross-sector collaboration

EXHIBIT 2

Numbers and percentages of sites where selected health-in-all-policies (HiAP) themes were prominent in interviews

The HiAP approach:	Number of sites	Percent of sites
Reinforces attention to equity	18	95
Has an issue-dependent connection to equity	14	74
Has a strategic connection to equity	11	58

SOURCE Authors' analysis of information in interviews at nineteen sites conducted in 2016–17 with sixty-five state and local officials and advocates.

The goal of the HiAP approach is to create cross-sector collaboration at a high level of institutional integration.

at a high level of institutional integration. In some jurisdictions, task forces or commissions were established by legislation, local ordinances, or governmental proclamations to mandate or facilitate cross-sector collaboration.[9] Interviewees in those jurisdictions noted that an official legal imprimatur is useful to encourage buy-in for cross-sector collaboration.[10] In California, for instance, the legal authority initially took the form of a state-mandated task force located within the Department of Public Health. The task force now resides in the independent, state-level Strategic Growth Council.

In practice, the HiAP approach need not take an encompassing institutional form. In fact, interviewees in only six sites discussed it in terms of a formal mandate. Collaborations develop through informal networks or working groups that are problem driven or issue specific. By far, the dominant strategies are arrangements in which public health officials initiate work with one or more departments on one issue and then engage a different set of departments on another issue, with the emphasis on equity varying across them. As exhibit 2 shows, interviewees involved in HiAP at 74 percent of the sites discussed the attention to equity primarily in issue-dependent terms.

For example, one public health official in Massachusetts characterized the HiAP approach as a set of bilateral relationships. His department partnered with the transportation department on citywide bike lanes to increase exercise and reduce obesity, and with the housing department to reduce smoking in low-income housing. In another, a Colorado official was part of a housing coalition on lead mitigation and tobacco prevention programs but did not collaborate with other governmental agencies. We observed similar bilateral arrangements across agencies in California regarding transportation, safe streets, and sometimes narrow environmental issues such as tree planting to reduce so-called heat islands in low-income neighborhoods. Often the initial project would lead to more extensive efforts, especially to secure joint grant funding.[11]

To a lesser degree, the interviewees emphasized informal collaborations that are problem centered but multilateral, such as initiatives falling under the rubric of "healthy eating, active living" (HEAL). The explicit goal of such programs is to promote health equity by improving low-income residents' access to healthy food, transportation, and recreation. One county health director observed that their HEAL program has stimulated an informal working group that includes city and county health, transportation, parks and recreation, and school officials, as well as local grocery stores and food banks.

Equity-centered collaborations emerged around problems, or clusters of related problems, in other areas as well. One local governmental official in Maryland stated as a matter of fact that "a HiAP-based housing initiative including weatherization, lead paint removal, roof repairs, and making the house safe from falls is inherently an equity-oriented program." Housing-centered HiAP initiatives existed in four of the five states.

THE HIAP–EQUITY CONNECTION IS STRATEGIC

State and local public health officials are not autonomous: They implement their missions in a political and institutional environment that includes collaboration with other actors whose reactions they must anticipate. This is especially true when they use a HiAP approach, which depends on the assent and support of political actors beyond their own organization and often beyond their own level of government.

As exhibit 2 shows, interviewees at a majority of our sites indicated that they emphasize health equity selectively and strategically based on the value that other actors in the political environment place on it. Yet interviewees mentioned three separate sets of actors as important in these calculations: the ideological leanings of elected officials and their constituents, the ideological leanings of nongovernmental organizations (NGOs), and the role of federal agencies that provide grants for cross-sector collaborations to reduce social disparities in health.

▶ **IDEOLOGICAL CONTEXTS:** The importance of the ideological contexts in which policies develop was a major theme in four of the five states. Interviewees stressed that using the HiAP approach to promote health equity in an area with conservative politicians and constituents can be counterproductive. One staff member of a Colorado nonprofit observed: "We're a purple state. The Denver metro area is very different than the rest of the state. So we have a lot of counties where...[if] you add any additional policies of

health language [about] equity, that's definite overreach."

More bluntly, the health director in a rural Colorado county said, "We care about equity; we just don't tell anybody."

In California and Massachusetts the political environment at the state level makes it easier to tie cross-sectoral initiatives to social disparities. But at the local level there is still variation. One respondent reflected on the HiAP approach in Boston, noting: "We're coming to appreciate the position that we have here, being what I would consider a more progressive state—that we want to be more candid with those conversations and not shy [away] from [them]. There's huge race component to having these conversations [in Boston].... That's our lead into the conversation to talk about what disparities exist, but the western part of Massachusetts, for example, is incredibly white and not going to treat [the race component] as receptively."

Similarly, a Seattle official observed: "In some areas, you can't talk about equity but could have health in all policies. In some communities you need to lead with race; in others, [you] won't get far with race."

A staff member for a community-centered nonprofit generalized the importance of political strategy: "[One] needs to understand the ideological context. After we've picked our battle—fighting on low-income housing, for example—we need to be careful. How do we explain our involvement as a health organization? How do we know our audience?"

Indeed, two or more audiences may be in conflict. Interviewees in three states noted the need to address disparities in access to public transportation. But changing routes to redress existing inequities usually means reducing access for more affluent communities, hence engendering political resistance.

▶ **THE ROLE OF SUPPORTING ORGANIZATIONS:** Our interviewees also emphasized the incentives for equity-motivated policies that NGOs offer. Health officials in all five states mentioned health foundations as the most important NGOs contributing to their health-in-all-policies and health-equity programs.

The mechanism by which foundations promote health equity through the HiAP approach is somewhat different from how other actors engage in political advocacy. Foundation grants and other forms of assistance subsidized the collaborative work of officials who already considered equity a health policy priority. In turn, those officials often fashioned their initiatives to attract additional foundation support. Because creating and sustaining collaborations with other governmental agencies is time consuming, foundations helped public health officials overcome simple resource constraints.

For instance, one official noted a foundation's role in developing HiAP initiatives in Colorado: "Our early work in health in all policies was through LiveWell.... [N]onprofits provide technical assistance and space; they do work around convening stakeholders and coalitions."

Other foundations at our sites, such as the California Endowment, the Colorado Health Institute, and the Robert Wood Johnson Foundation, provided grants and assistance.

Federal agencies have also been an important source of funding for HiAP approaches. For instance, localities in four of our five states have received CDC Racial and Ethnic Approaches to Community Health (REACH) grants. These grants funded partnerships to address the following three problems that exhibit major social disparities and cut across sectors: tobacco use, poor nutrition, and physical inactivity.[12]

Discussion

Our sites contained a mix of health-in-all-policies initiatives at various stages of development: Eight were at a relatively early stage of development, and six had been active for several years. Not surprisingly, there was considerable variation across the sites on how HiAP and equity initiatives were defined and governed and on the institutional capacity of health and other governmental officials.

Nonetheless, certain patterns emerged that are consistent with the conceptual approaches that Aaron Wernham and Steven Teutsch[2] and Lauren Gase and colleagues[3] have identified. Over time, for example, the decision-making process for implementing health in all policies changed toward elevating equity as a policy concern. Consistently, HiAP efforts started small, based on bilateral interpersonal relationships, and in a few instances demonstrated proof of concept to other governmental agencies and community organizations. Initial success then led to joint grant-making efforts that reinforced informal cross-sectoral networks.

No one who advocates using the HiAP approach promises dramatic—much less near-term—results, and it is not the only means of promoting health equity.[1,2] But there was no consistent evidence across sites that its application produced either broad policy changes or actual reductions in social disparities in health. In the minds of most practitioners, the approach is a means to achieving both of these objectives. At this point, we do not know if it will prove to be a effective means of changing either of them.

Implementation and evaluation take time, but

Proponents of the HiAP approach face ideological barriers in a very contentious political environment.

in our case studies, no one reported collecting systematic data that could show how these initiatives have changed more than a few problem-specific policies. At a few sites, specific policy changes did emerge from HiAP collaborations. While they were not inconsequential, neither were they striking examples of the broad ambition of the HiAP approach to improve population health. California provided the best case evidence for major policy effects, but the broader applicability of its model is still unknown.

In any event, it is hard to envision how to evaluate the effects of HiAP initiatives on health outcomes. To the extent that this approach might produce significant policy changes, there are many steps in the causal chain between such changes, policy implementation, changes in health determinants, and, finally, changes in health outcomes.

Policy Implications

Discernible changes in outcomes are no doubt too much to ask for at this point, but understanding how the health-in-all-policies approach changes the decision-making process is the first step. The experience of the practitioners we interviewed suggests several implications for how others might use the approach to shift the conversation in non–health departments to address social disparities in health. We will underline three.

First, we emphasize the importance of political opportunism. Good strategies must anticipate the reactions of others in the political environment, and our interviewees suggested that opportunistic strategies take account of other factors.

As reflected in our results, proponents of the HiAP approach face ideological barriers in a very contentious political environment. How to respond to these barriers is challenging. A few interviewees suggested simply avoiding the use of terms such as *equity* or *race* in program implementation. Instead, they argued that framing the discussion around income and disease-specific indicators is more productive. In a few cases, interviewees observed that in pro-business or more libertarian communities, there has been some success in making the economic case for healthy living initiatives that would attract people and businesses to the community. In essence, the argument is that the HiAP approach will reduce economic losses and free up resources for other uses. Health equity might be an important, if less explicit, by-product of this strategy.

Second, institutionalization of health in all policies helps, but practitioners should not wait for the adoption of broad mandates. The creation of official cross-sector arrangements, such as the California Health in All Policies Task Force, helps break down jurisdictional barriers. Yet our interviews in other states and localities suggest that institutionalization is not a necessary condition for the approach's effectiveness in promoting health equity. For instance, Boston created a HiAP task force in 2013, but it quickly disappeared with no record of its proceedings or even a membership list. Nonetheless, as we noted above, HiAP initiatives promoting equity survive in Boston.

It is also important to note the entrepreneurial efforts of health officials and others who look for contexts in which another department's problems intersect with health. Sometimes these relationships are transitory, ending when priorities and personnel change. But often they are not. Our study shows multiple examples of working groups or teams without names that lasted for long periods. What holds such groups together is not an institution but a social network, a collective of professionals who know each other and work together on a common problem.

Third, promoting equity through a HiAP approach requires resources. In many of the sites we examined, health officials have a hard enough time fulfilling the basic responsibilities within their own jurisdictions, let alone engaging in the difficult work of implementing the approach across other agencies. Moving outside one's own jurisdiction takes time, personnel, and training. To recall one example, the creation and staffing of an Office of Health Equity in Colorado's Department of Public Health and Environment exemplifies a response to that problem. Other sites are building capacity by looking to NGOs and other actors that promote health equity. Future practitioners should use grants, technical assistance, and other forms of support to expand the HiAP concept in practice.

We found a relationship between the application of collaboration in the style of the HiAP approach and the prominence of health equity as a multisector policy concern. In emphasizing

the social determinants of health, the approach gives public officials and policy entrepreneurs a framework for promoting health equity. In some areas, we found a gradual transition in focus from health generally to health equity. At the same time, the connection between the approach and health equity is variable, organized around specific issues of interest to cross-agency collaborators. Finally, we found that framing HiAP initiatives in equity terms tends to be strategic. Health officials anticipate and adapt to the incentives and constraints that other institutional actors encounter. Each of these findings, we have suggested, offers lessons for other policy actors in applying the HiAP approach.

Future Research

The health-in-all-policies strategy is not the only one for addressing health disparities. Future research should assess these other approaches, especially in contexts similar to those in which the HiAP strategy has been used.

A second set of questions deals with message framing. How can practitioners best frame responses to the political challenges noted above? Third, what policy changes resulting from health-in-all-policies and health-equity initiatives have emerged to reduce health disparities?

Fourth, data collection and measurement difficulties need to be addressed. Though not described above, our interviews indicated that respondents were struggling to define and measure health-in-all-policies and health-equity program outcomes. A conference to obtain consensus on how to measure program outcomes is essential to determine whether to continue investing in HiAP initiatives.

Answering these questions will help both researchers and practitioners push the HiAP approach to its full potential in addressing social disparities in health. ■

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