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Health In All Policies For Government: Promise, Progress, And Pitfalls To Achieving Health Equity

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HEALTH IN ALL POLICIES FOR GOVERNMENT: PROMISE, PROGRESS, AND PITFALLS TO ACHIEVING HEALTH EQUITY

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CONTENTS

***"NOW, THEREFORE, BE IT RESOLVED** that it shall be the policy of the City of Chicago to apply a Health in All Policies approach to the City's decision making, including policy development and implementation, budgeting, and delivery of services."*[1]

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1. This quote is from the Chicago City Council Resolution passed on May 16, 2016. *See* CHICAGO DEP'T OF PUB. HEALTH, CITY OF CHICAGO HEALTH IN ALL POLICIES TASK FORCE: FINAL REPORT 15 (Aug. 1, 2017) [hereinafter CHICAGO HIAP TASK FORCE REPORT], https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/HealthInAllPoliciesReport_08012017.pdf.

Health in All Policies (HiAP) is a tool that has been developed over the last forty years to promote health and health equity. HiAP is defined as an approach to public policies across all governmental sectors to systematically address the health and health-system implications of decisions, seek synergies, and avoid harmful health impacts. While the adoption of HiAP at every level of government has been accelerating, many residents and community-based organizations advocating for health and health equity may not be fully aware of the promise and progress of the HiAP approach to government policy development and implementation. Using the recent adoption of a HiAP policy in the City of Chicago as a case study, this Article presents the foundational history for HiAP; the resulting theoretical and pragmatic understanding for HiAP's potential utility; the limitations of HiAP; and, the potential ways residents and community based organizations can support local government implementation of HiAP.

I. WHY HEALTH IN ALL POLICIES?

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[2]

Health was defined by the World Health Organization (WHO) in 1948 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[3] Over the last seventy years, significant work has been undertaken to identify the factors that promote health. In 2010, the Centers for Disease Control and Prevention (CDC) released the CDC Health Impact Pyramid in order to describe the factors that affect health.[4] The top three layers of the Health Impact Pyramid involve the implementation of protective interventions (such as immunizations, smoking cessation interventions, and colonoscopy), clinical interventions (such as treatment for high blood pressure, cholesterol, and diabetes), and counseling and education (such as eating healthy and being physically active).[5] While most of the past and current health resources have focused on these areas of personal lifestyle choices, prevention, and early treatment, the overall health impact on a population is relatively small. The bot-

2. WORLD HEALTH ORG., CONST. pmbl., N.Y. (July 22, 1946) (adopted by the Int'l Health Conference in N.Y. on June 22, 1946 by the representatives of 61 states), https://www.who.int/governance/eb/who_constitution_en.pdf.

3. *Id.*

4. Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590, 591 (2010).

5. *Id.* at fig.1.

tom foundational layers of the CDC Health Impact Pyramid have the largest impact. These layers involve addressing socioeconomic factors (such as poverty, education, and housing inequities) and changing the context so that the default options for people match the healthiest decisions.[6] Some examples for changing context at the socioeconomic level are requiring fluoride be added to the drinking water supply to prevent dental carriers rather than persons having to buy fluoride supplements, implementing laws restricting smoking in enclosed places to provide cleaner indoor air and to reduce pulmonary disease, and taxes on sugary beverages to encourage more consumers to choose healthier beverage options in order to reduce obesity.

Many drug, device, and policy innovations based on scientific and social advancement have improved human health over the last century. In the United States, the efforts have resulted in an increase in life expectancy from 47.3 years in 1900[7] to almost 78.6 years in 2017.[8] However, not all have benefitted from the overall increase in life expectancy. Health equity, defined as all people having the opportunity to attain their full health potential with no one disadvantaged from achieving this potential due to their social position or other socially determined circumstance,[9] has not been achieved. For instance, the life expectancy of men in the United States is 76.1 years compared to the life expectancy of 81.1 years for women.[10] Reports indicate "[t]he difference in life expectancy between white and black population was 3.5 years in 2017 . . . ."[11] In 2006, having a bachelor's degree or higher at age twenty-five, compared to having no high school diploma, was associated with a 9.3 year increase in life expectancy for men and an 8.6 year increase in life expectancy for women.[12] As described in the WHO Health Equity Framework, a complex feedback loop exists where structural determinants of health inequities influence, and are influenced by, social determinants of health, which, in turn, result in

6. *Id.* at 591.

7. Elizabeth Arias, *United States Life Tables, 2002*, 53 NAT'L. VITAL STAT. REPS. at 34 (Nat'l Ctr. for Health Statistics No. 7, Nov. 10, 2004).

8. Elizabeth Arias & Jiaquan Xu, *United States Life Tables, 2017*, 68 NAT'L. VITAL STAT. REPS. at 1 (Nat'l Ctr. for Health Statistics No. 6, June 24, 2019).

9. Paula A. Braveman, *Monitoring Equity in Health and Healthcare: A Conceptual Framework*, 21 J. HEALTH, POPULATION, & NUTRITION 181, 182 (2003).

10. Arias & Xu, *supra* note 8, at 3.

11. *Id.* at 5.

12. NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2011: WITH SPECIAL FEATURE ON SOCIOECONOMIC STATUS AND HEALTH 37 (2012), https://www.cdc.gov/nchs/data/hus/hus11.pdf [hereinafter NCHS, HEALTH, UNITED STATES, 2011].

inequities in health and well-being.[13] Structural determinants of health inequities include the socioeconomic and political context determined by the form of governance, macroeconomic policies, social policies, public policies, and culture/societal values.[14] These levers influence socioeconomic position based on interacting characteristics such as social class, gender, race/ethnicity, education, occupation, and income; which then result in differing material circumstances, behaviors and biologic factors, and psychosocial factors.[15] The factors which impact individual health also feedback to influence socioeconomic and political context and socioeconomic position.[16]

II. What is the History of the Health in all Policies Concept

"Health in All Policies [HiAP] 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. A Health in All Policies approach is founded on health-related rights and obligations. 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."[17]

Governmental policies now are recognized as significant contributors to the structural determinants of health inequities. While HiAP can be traced back to the origins of the WHO,[18] most scholars emphasize the WHO Declaration of Alma-Ata 1978[19] as the foundation for

13. O. Solar & A. Irwin, A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2, at 5 (World Health Org., Geneva (2010)), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf. "Illness can 'feed back' on a given individual's social position, e.g. by compromising employment opportunities and reducing income; certain epidemic diseases can similarly 'feed back' to affect the functioning of social, economic and political institutions." *Id.* at 5.

14. *Id.* at 5.

15. *Id.* at 6.

16. *Id.*

17. World Health Org., *The Helsinki statement on Health in All Policies* (The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 (June 2013)), https://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/ [WHO, *Helsinki Statement*].

18. World Health Org., *Health in All Policies (HiAP) Framework for Country Action*, 29 Health Promotion Int'l, i19, i20 (2013) [hereinafter WHO, *HiAP*].

19. Linda Rudolph et al., *Health in All Policies: A Guide for State and Local Governments*, Am. Pub. Health Ass'n 1, 19 (2013), http://www.phi.org/uploads/application/files/udt4vq0y712qpb1o4p62dexjlgxlnogpq15gr8pti3y7ckzysi.pdf.

the ideas, actions, and evidence that are encompassed in the HiAP concept. After the HiAP concept was embedded in the 1986 WHO Ottawa Charter for Health Promotion,[20] national government implementation initially was described in the 1987 Norwegian publication, *Health Policy Towards the Year 2000*.[21] HiAP also was discussed at the WHO International Conference on Health Promotion in Adelaide, Australia in 1988.[22] Further government adoption occurred via the National Health Strategy in New Zealand (2000),[23] the Public Health Act in Quebec, Canada (2001),[24] and the National Public Health Policy in Sweden (2003).[25] The goal of increasing policymaker accountability for the consequences of public policies on health systems, determinants of health, and well-being, was theorized to support sustainable development.[26] The WHO Commission on Social Determinants of Health in 2005 solidified the importance of HiAP due to the structural determinants of health inequities model.[27] Over the next ten years, the HiAP concept was incorporated into the Finnish Presidency Health Theme of the European Union (2006),[28] the State Strategic Plan of South Australia (2007),[29] and the Thai National Health Act (2007).[30] In 2009, the Partnership for Sustainable Commu-

20. *Id. See also World Health Org.*, *The Ottowa Charter for Health Promotion* (First International Conference on Health Promotion, Ottawa, Canada (Nov. 21, 1986)), https://www.who.int/healthpromotion/conferences/previous/ottawa/en/.

21. Rudolph et al., *supra* note 19, at 19. *See also* Norway Ministry of Health & Care Servs., *Health Policy Towards the Year 2000*, NAT'L COLLABORATING CTR. FOR HEALTHY PUB. POLICY (1987).

22. Rudolph et al., *supra* note 19, at 19. *See also* WORLD HEALTH ORG., *Adelaide Recommendations on Healthy Public Policy* (Second Int'l Conference on Health Promotion, Adelaide, South Australia (Apr. 5-9, 1988)), https://www.who.int/healthpromotion/conferences/previous/adelaide/en/index1.html

23. Rudolph et al., *supra* note 19, at 19. *See also* Hon. Annette King, *The New Zealand Health Strategy 2000*, THE NEW ZEALAND MINISTRY OF HEALTH (Dec. 2, 2000), https://www.health.govt.nz/system/files/documents/publications/newzealandhealthstrategy.pdf.

24. Rudolph et al., *supra* note 19, at 19. *See also* Public Health Act, R.S.Q 2001, c S-2.2 (Quebec, Canada), https://www.canlii.org/en/qc/laws/stat/rsq-c-s-2.2/latest/rsq-c-s-2.2.html.

25. Rudolph et al., *supra* note 19, at 19. Public Health Objective Bill (Gov't Bill 2002/03:35), Sweden (2003).

26. WHO, *HiAP*, *supra* note 18, at i20. *See* NCHS, HEALTH, UNITED STATES, 2011, *supra* note 12, at 37.

27. WORLD HEALTH ORG., *Closing the gap in a generation: Health equity through action on the social detriments of health (Final Report of the Commission on Social Detriments of Health*), COMMISSION ON SOCIAL DETRIMENTS OF HEALTH, Geneva (2008).

28. Rudolph et al., *supra* note 19, at 19. *See also* T. Stahl et al., *Health in All Policies: Prospects and potentials*, FINNISH MINISTRY OF SOC. AFF. & HEALTH (2006), http://www.euro.who.int/__data/assets/pdf_file/0003/109146/E89260.pdf.

29. Rudolph et al., *supra* note 19, at 19. *See also South Australia's Strategic Plan. . .through a health lens*, AUSTRALIAN GOV'T, DEP'T OF HEALTH (2007).

30. Rudolph et al., *supra* note 19, at 19. *See also* National Health Act, B.E. 2550 (2007) (Thailand).

nities described the concept in the United States followed by work of the California Health in All Policies Task Force (2010);[31] the National Prevention, Health Promotion and Public Health Council (2010);[32] and, the Institute of Medicine's report, *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (2011).[33] In 2010, HiAP was included in the European Union Council Conclusion Statement on Health in All Policies and in the Rio Political Declaration on Social Determinants of Health (Brazil, 2011).[34] In 2013, the theme of the Eighth Global Conference on Health Promotion (Helsinki, Finland) was HiAP.[35] The Global Conference resulted in the creation of a HiAP framework implementation document.[36] Over the decades, HiAP has come to reflect the principles of:

- **legitimacy** grounded in the rights and obligations conferred by national and international law;
- **accountability** of governments toward their people;
- **transparency** of policy-making and access to information;
- **participation** of wider society in the development and implementation of government policies and programs;
- **sustainability** in order that policies aimed at meeting the needs of present generations do not compromise the needs of future generations;
- **collaboration** across sectors and levels of government in support of policies that promote health, equity and sustainability.[37]

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31. Rudolph et al., *supra* note 19, at 19. *See also Health in All Policies Task Force*, STATE OF CA. DEP'T OF JUST., OFF. OF THE ATT'Y GEN., https://oag.ca.gov/environment/communities/policies.

32. Rudolph et al., *supra* note 19, at 19. *See also* NAT'L PREVENTION COUNCIL, *National Prevention, Health Promotion, and Public Health Council*, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFF. OF THE SURGEON GEN. (June 2011), https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf.

33. Rudolph et al., *supra* note 19, at 19. *See also* INST. OF MEDICINE, *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges*, COMM. ON PUB. HEALTH STRATEGIES TO IMPROVE HEALTH (2011).

34. Rudolph, *supra* note 19, at 19. *See also* WORLD HEALTH ORG., *Rio Political Declaration on Social Determinants of Health* (World Conference on Soc. Determinants of Health, Rio de Janeiro, Brazil (Oct. 21, 2011)), https://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf.

35. WHO, *Helsinki Statement*, *supra* note 17.

36. WHO, *HiAP*, *supra* note 18, at i19.

37. *Id.* at i20 (quotation marks omitted).

The HiAP Framework attempts to ensure that policies from all sectors have positive or at least neutral impact on health and health equity.[38] The five key elements of HiAP needed for sustainable impact are: (1) promoting health and equity by incorporating the ideas into specific policies, programs, and processes in addition to embedding health equity considerations into government decision-making processes; (2) supporting intersectoral collaboration by bringing together stakeholders from many sectors to recognize the links between health and other issues and policy areas, to break down silos, to build new partnerships, and to increase government efficiency; (3) benefiting multiple partnerships that address the synergistic policy and programmatic goals of both public health and other governmental agencies; (4) engaging stakeholders beyond government partners such as community members, policy experts, advocates, the private sector, and funders; and, (5) creating structural or procedural change on how government works by embedding health and equity into all levels of government decision-making.[39] Four basic HiAP strategies include making health at the core of policy, programs, and initiatives; creating sectoral "win-win" scenarios; emphasizing cooperation where benefits are for the public good; and limiting potential damage from negative health impacts of policy proposals if they cannot be reduced entirely.[40]

III. How Governments Adopt Health in all Policies Initiatives

***"BE IT FURTHER RESOLVED** that the City of Chicago establishes a Health in All Task Force to identify and pursue opportunities to improve health, including but not limited to affordable, safe, and healthy housing; active living and transportation; quality education; access to health food; clean air, water, and soil; parks, recreation, and green spaces; economic opportunity; and safety and violence prevention. All departments shall participate in developing ongoing channels for cross-department collaboration, identifying and pursuing funding streams that support improved health outcomes, ensuring new investments support community health goals, incorporating health criteria into planning and policy development, sharing relevant data, and participating in collaborative efforts to understand how built environment policies and programs are affecting health outcomes. The*

38. Kimmo Leppo, *Health in All Policies: Perspectives from Europe*, 5 Pub. Health Bull. S. Austl. 6, 7 (2008).

39. Rudolph et al., *supra* note 19, at 17–19.

40. Eeva Ollila, *Health in All Policies: From rhetoric to action*, 39 Scandinavian J. Pub. Health 11, 11, 13–14 (2011).

Health in All Policies Task Force shall be composed of all department commissioners or their designees, and the Department of Public Health shall lead the Task Force."[41]

While the last fifteen years have seen an acceleration in local, state, and national governments enacting the HiAP framework in laws and ordinances,[42] work into why such policies take hold in certain governing bodies (especially at local levels) has not been fully explored.

A. Theoretical Frameworks for Adoption: The Multiple Streams Approach

The Multiple Streams Approach posits that public policy is shaped by ideas, interests, and institutions that interact in unpredictable yet ultimately understandable ways in three "streams": problems, policies, and politics.[43] For policies to be adopted, a policy window needs to emerge where convergence occurs among "problem definition, policy solutions, and political support."[44] Clarity of the problem has been highlighted with research firmly establishing links between the conditions that define where people live, work, and play and the population's health and well-being.[45] Political support in local municipalities comes from the need to develop and sustain healthy communities—the communities where people prefer to reside.[46] The HiAP framework developed by the WHO and other institutions offers a potential policy solution. HiAP laws (laws that use the term "HiAP") and HiAP-like laws (laws that do not explicitly use "HiAP", but contain HiAP elements) have been increasingly passed in jurisdictions in the United States.[47] While these laws all contain similar elements, such as an emphasis on "achieving better public health outcomes through increased intersectoral collaboration,"[48] differences exist on explicit mention of the emphasis on health equity;[49] on the use of task forces

41. CHICAGO HIAP TASK FORCE REPORT, *supra* note 1, at 15.

42. Aaron Wernham & Steven M. Teutsch, *Health in All Policies for Big Cities*, 21 J. PUB. HEALTH MGMT. PRAC. S56 (2015).

43. Michael D. Jones et al., *A River Runs Through It: A Multiple Streams Meta-Review*, 44 THE POL'Y STUD. J. 1, 14–15 (2015).

44. Fran Baum et al., *Evaluation of Health in All Policies: concept, theory and application*, 29 HEALTH PROMOTION INT'L. i130, i136 (2014).

45. SOCIAL DETRIMENTS OF HEALTH: THE SOLID FACTS 10 (Richard Wilkinson & Michael Marmot eds., 2d ed. 2003).

46. Wernham & Teutsch, *supra* note 42, at S57.

47. Dawn Pepin et al., *Collaborating for Health: Health in All Policies and the Law*, 45 J. LAW MED. ETHICS 60, 61 (2017).

48. *Id.*

49. *See e.g.*, D. C. Exec. Order No. 2013-209 (Nov. 5, 2013), http://www.sustainabledc.org/wp-content/uploads/2014/12/13-Health-in-All-Policies.pdf; Vt. Exec. Order No. 07-15 (Oct. 6, 2015).

in implementation.[50] Also, the depth of the law provisions may vary where all elements of HiAP as described in the WHO framework[51] are incorporated or only some HiAP elements are added.[52]

B. Theoretical Frameworks for Adoption: Complex Systems

Ketan Shankardass and colleagues proposed a systems framework where policies using the HiAP framework are an emergent property of a complex system within the boundaries defining government and influenced by extra-governmental systems.[53] Systems theory is a meta-theory[54] that posits that components are organized into subsystems that inherently are interdependent.[55] The dynamic feedback and feed-forward loops result in subsystems affecting each other in complex and unexpected ways. Emergent properties can result where they are not possessed by any single system component.[56] Emergence refers to a process by which the system acquires a property.[57] The complex system described by Shankardass and colleagues involves having an executive subsystem (also known as leadership) engaging with an intrasectoral subsystem (within sector work) and both engaging with an intersectoral subsystem (across sector work).[58]

The executive subsystem is "responsible for the creation and implementation of legislative mandates related to the implementation of HiAP initiatives."[59] The agents are political elites who are driven by a political ideology, "a cluster of ideas, beliefs, values, and attitudes that constitute a normative lens" to "interpret and act upon social and political issues."[60] The political elites utilize the political ideology to develop a policy agenda, a "finite set of social and political issues upon which governments act."[61]

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50. *See e.g.* Commission for Health Advocacy and Equity Act, 23 R.I. GEN. LAWS ANN. § 23-64.1-4 (West 2011); Summit County, Ohio, Res. No. 2016-165 (May 9, 2016).

51. WHO, *Helsinki Statement*, *supra* note 17.

52. *Id.*

53. Ketan Shankardass et al., *The implementation of Health in All Policies initiatives: a systems framework for government action*, 16 HEALTH RES. POL'Y AND SYS. 1, 7 (2018).

54. *See generally* Kenneth E. Boulding, *General Systems Theory - The Skeleton of Science*, 2 MGMT. SCI. 197 (1956).

55. *See generally* Ludwig Von Bertalanffy, *An Outline on General System Theory*, BR. J. PHILOS. SCI. 134, 138 (1950).

56. MINGERS J. SYSTEMS THINKING, CRITICAL REALISM AND PHILOSOPHY: A CONFLUENCE OF IDEAS 30 (London, Routledge 2014).

57. *Id.*

58. Shankardass et al., *supra* note 53, at 3–4, fig.1.

59. *Id.* at tbl.1.

60. *Id.*

61. *Id.*

The intrasectoral subsystem involves "the pursuit of sectoral objectives, which may be affected by implementation of HiAP initiatives."[62] The agents are high-ranking civil servants provided the "authority over the policy process delegated to them by political elites."[63] Sectoral ideology and sectoral power influence sectoral objectives.[64] Prior experience working with other sectors in addition to the awareness and capacity of civil servants influence the ability of a sector to support implementation of HiAP-based policies, programs, and projects.[65]

Finally, the intersectoral subsystem involves "facilitate[ing] the horizontal and vertical coordination of the HiAP policy agenda across sectors of government and with extra-governmental partners."[66] The agents are expert advisors who are "consulted in planning and executing the implementation of HiAP initiatives."[67] A HiAP legislative mandate combined with supporting financial arrangements enables the expert advisors to manage the processes for generating institutional HiAP implementation capacity.[68]

The successful emergence of government policies, programs, and initiatives using the HiAP framework requires addressing the fundamental causes of health disparities, conducting research using appropriate methods on the key questions, developing the necessary skills and experience in the workforce, and avoiding "health imperialism."[69]

C. Implementation Components

The process of adoption inherently influences implementation by setting the intent for HiAP. However, theoretical frameworks for implementation are less well developed; however, key components for successful implementation have been described based on empirical observations of HiAP implementation processes by various levels of government.

The WHO HiAP framework identified six key components necessary for HiAP implementation.[70] First, the "need and priorities" must

62. *Id.*
63. *Id.*
64. Shankardass et al., *supra* note 53, at tbl.1.
65. *Id.*
66. *Id.*
67. *Id.*
68. *Id.*
69. Wernham & Teutsch, *supra* note 42, at S61–62.
70. WHO, *HiAP*, *supra* note 18, at i22.

be established.[71] Not all government actions may require HiAP. Next, a "planned action" must be defined and "supportive structures and processes" described.[72] Then, "assessment and engagement" must be addressed followed by evaluation ("monitoring, review, and reporting").[73] Finally, "[building] capacity" promote continued engagement in the HiAP cycle is needed.[74] The components do not need to be followed exactly in order. Also, adaptation to specific governance, economic, and social context is necessary for finding solutions to complex system issues.

In a recent scoping review of the literature focusing on implementation of the HiAP framework on a local scale, a key factor for successful initiation of the HiAP process was funding from external sources backed by internal sources for sustainability.[75] Another key factor was a shared vision across sectors, especially non-health sectors, so that fears of added review resulting in cost and delay could be allayed.[76] Building ownership and accountability for HiAP implementation with clear roles and expectations was important—especially among key agents in the executive, intrasectoral, and intersectoral sub-systems.[77] Leadership, at a government level above the municipality, that advocates and supports HiAP implementation, along with local sectoral leadership and dedicated staff facilitated adoption, leads to more rapid implementation. Use of Health Impact Assessments—a combination of procedures, methods, and tools that assess the effects of a policy, program or project on health and health equity—[78]has enabled a common decision-making mechanism to be utilized by all agents in order to consider health and health equity in all policies.

IV. How can Health in All Policies Impact be Evaluated?

***"BE IT FURTHER RESOLVED** that the Task Force shall submit a report to the City Council by January 31, 2017, on the Task Force's findings. At a minimum, the report shall address the following: i) existing community health needs and priorities; ii) short-term, medium-*

71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*
75. Maria Guglielmin, Carles Muntaner, Patricia O'Campo & Ketan Shankardass, *A scoping review of the implementation of health in all policies at the local level*, 122 Health Pol'y 284, 287 (2018).
76. *See id.*
77. *See id.*
78. World Health Org., *Health Impact Assessment: Main concepts and suggested approach*, WHO Regional Office for Europe (1999).

term, and long-term recommendations for changes to policies, practices, and procedures that will improve community health and reduce health inequities; and iii) the need for and sources of funding to implement a Health in All Policies approach in the City of Chicago. The report may also identify how such changes will provide environmental, economic, or other benefits."[79]

While more jurisdictions, especially in the United States, have been enacting HiAP legislation,[80] the overall evaluation of HiAP-based governmental activities on achieving health and health equity outcomes continues to evolve. Theoretical, methodological, and practical challenges to evaluation exist because HiAP occurs within changing political and operational contexts with numerous diverse agents engaged.[81] HiAP is complex. Given that HiAP policies, programs, and initiatives emerge in dynamic systems that have feedback loops, the path to outcomes is non-linear. A proposed evaluation technique for HiAP is complex program evaluation.[82] "Complex program evaluation is characterized by the use of multiple methods, including qualitative methods, quantitative data analyses, and a mix of process (implementation), impact and outcome evaluations."[83] A key component of the evaluation is logic models based on the theory of change[84] that are augmented by real-world understandings, especially of context, through the use of techniques such as HiAP Analysis using Realist Methods On International Case Studies (HARMONICS).[85] Given HiAP principles are "broad directional statements that can have very different operational implications based on context," the focus for HiAP is not about establishing "causality through statistical tests of correlations."[86] Rather, the focus is about a "burden of evidence that supports logically coherent chains of relations that emerge through the contrasting and comparing of findings from many forms of evidence."[87] Building a logic model based on the theory of change relies more on the strength of the argument linking HiAP's implementation to short-term impacts and then longer term health gains, rather than

79. CHICAGO HIAP TASK FORCE REPORT, *supra* note 1, at 15.

80. Pepin et al., *supra* note 47, at 61.

81. Baum et al., *supra* note 44, at i133.

82. *See* MED. RES. COUNCIL, *Developing and Evaluating Complex Interventions* (2008), https://mrc.ukri.org/documents/pdf/complex-interventions-guidance/.

83. Adrian E. Bauman et al., *Rethinking the evaluation and measurement of health in all policies*, 29 HEALTH PROMOTION INT'L i143, i145 (2014).

84. *Id.*

85. *See generally* Shankardass et al., *supra* note 53.

86. Baum et al., *supra* note 44, at i135.

87. *Id.*

on traditional randomization (which tends to be impractical in complex social systems).[88] Policy makers and funders need to be aware that HiAP final health and health equity impacts are from a long-term process which requires a need to maintain a commitment to HiAP over longer time spans. Evaluators also must be aware of the time pressures and the need to implement well-designed monitoring systems to produce tracking of implementation and impact at multiple stages. Also, evaluators may need to consider how to incorporate techniques to determine when HiAP approaches should be deemed ineffective and discontinued, or when the potential for change is overwhelmed by contextual factors.[89]

As of 2017, the City of Chicago (with leadership from the Chicago Department of Public Health, CDPH) had collaborated with multiple other departments to define sixteen recommendations to promote HiAP.[90] The overarching goals were to (1) deepen commitment to community representation and racial equity; (2) maximize effectiveness through dedicated staffing for HiAP work; and (3) align the HiAP agenda with City initiatives.[91]

In order to leverage data from across city departments to achieve HiAP goals, data collection recommendations involved "incorporate[ing] health-related indicators as appropriate into surveys and other data collection efforts by City departments and sister agencies . . . [and] [s]tandardiz[ing] the indicators to allow for comparison and analysis across data sets."[92] Data sharing involved "creat[ing] a formal data-sharing agreement between the City and sister agencies."[93] In order to ensure that a health perspective is more frequently brought to the community, the Chicago HiAP Task Force recommended that city departments and sister agencies coordinate cross-departmental community engagement to allow other departments the opportunity to of-

88. *Id.*

89. Vinay Prasad & John PA Ioannidis, *Evidence-based de-implementation for contradicted, unproven and aspiring health practices*, 9 IMPLEMENTATION SCI. (Jan. 8, 2014), http://www.implementationscience.com/content/9/1/1.

90. Recommendations for achieving HiAP goals involved data collection; data sharing; community engagement; training of public information officers; cross-sector grant applications; employee health; connecting residents across departments; health and human services resources; trauma-informed City; active design; proactive housing inspections; zoning and licensing code review; health impact reviews; evaluating projects and funding decisions; health criteria in request for proposals and requests for queries; and, a HiAP staffer. CHICAGO HIAP TASK FORCE REPORT, *supra* note 1, at 1–2.

91. *Id.*

92. *Id.* at 1.

93. *Id.*

fer their perspectives on government sponsored events.[94] The Task Force also recommended the training of public information officers in each department and sister agency to "[i]ncorporate health messaging into press releases and public-facing materials."[95] "[C]ross-sector grant applications to increase funding and support" health impact initiatives were recommended.[96] Since city governments tend to be one of the largest employers of its residents, "a coordinated strategy to promote the health of City employees" was recommended.[97] This coordinated strategy was focused on improving the connection of residents across departments in order to foster "no-wrong door"[98] service situations by "pursu[ing] expansion of 3-1-1 to include comprehensive information about [available] health and human services" and resources.[99] The Task Force further recommended the transformation process needed to become a "trauma-informed city."[100] This would be accomplished by "1) ensuring all frontline employees . . . receive training to improve resident services, 2) piloting efforts to change practices and cultures within departments, and 3) evaluating these efforts to determine how and whether to expand" departmental transformation.[101] Additionally, the Chicago HiAP Task Force recommended that city departments and sister agencies engage in more physical activity during the planning, construction, and modification of buildings and infrastructure with the ongoing commitment to "healthy homes [through] proactive inspections to identify health hazards early, especially in high hardship neighborhoods . . . ."[102] "Conduct[ing] a health impact review of the zoning and licensing code" was recommended along with requesting health impact reviews of "proposed projects, policies and ordinances."[103] The Chicago HiAP Task Force also recommended that city departments and sister agencies "incorporate health-related criteria into decisions on project approval and funding" for city-funded projects, tax increment financing zone projects, and transportation projects."[104] Finally, given the constant need for en-

94. *Id.*

95. CHICAGO HIAP TASK FORCE REPORT, *supra* note 1, at 1.

96. *Id.*

97. *Id.*

98. "No wrong door" is a concept that means that a person is able to present an issue to a service agency and the service agency is able to address the issue in an efficient manner even if the request is not in the direct scope of the agency.

99. CHICAGO HIAP TASK FORCE REPORT, *supra* note 1, at 1.

100. *Id.*

101. *Id.*

102. *Id.* at 2.

103. *Id.*

104. *Id.*

gagement and monitoring, the Task Force recommended that a dedicated HiAP staff position be created for "HiAP education and support, conduct health impact reviews and assessments, and promote health-related initiatives across departments."[105]

In its Year One progress report on HiAP implementation in 2019, the CDPH highlighted key progress on the priority recommendations made by the Health in All Policies Task Force.[106] Key steps were made for the CDPH to partner with other city departments "to analyze and disseminate up-to-date data"[107] through a publicly accessible online portal, the Chicago Health Atlas.[108] "A condensed health impact review process" was developed and implemented with the Department of Planning and Development along with community partners for two re-development projects.[109] Health equity language and criteria were added into CDPH's requests for proposals and quotations, and in the development of cross-sector grant applications through the Office of Budget and Management.[110] Further advances were made in coordinating departmental efforts to make homes and neighborhoods healthier places, building community awareness and participation, and expanding access to coordinated city services.[111]

V. How can Government Accountability for Using Health in All Policies Increase?

"*It is much easier to set goals than to put them into action, implementation considerations tend to be less accounted for than the other processes in policy development.*"[112]

Any implementation of HiAP framework in local government will run into challenges after its initial peak novelty fades—given the complexity of coordination for building capacity to nurture due to crisis management, political change, and governmental inertia. The Year One Progress Report for the City of Chicago's HiAP efforts ends with a statement that the "CDPH will re-engage City partners" in order to

105. Chicago HiAP Task Force Report, *supra* note 1, at 2.

106. *See* Chicago Dep't of Pub. Health, Getting to the Root: Healthy Chicago Symposium Report (Feb. 2019) [hereinafter Healthy Chicago Symposium Report], https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/SymposiumReport.pdf.

107. *Id.* at app'x. C, 1.

108. Chicago Health Atlas, www.chicagohealthatlas.org (last visited Mar. 9, 2020).

109. Healthy Chicago Symposium Report, *supra* note 106, at app'x. C, 1.

110. *Id.* at app'x C, 1–3.

111. *Id.* at app'x C, 2–3.

112. Gambhir Bhatta, International Dictionary of Public Management and Governance 456 (London, Routledge 2005).

deepen commitment to community representation and racial equity, maximize effectiveness through dedicated staffing for HiAP work, and align the HiAP agenda with City initiatives.[113] While the HiAP framework is focused on the internal work of governments, non-governmental sectors can play a pivotal role in nurturing accountability.

First, as mentioned in the Year One Report, government "cannot fully address health inequities in our city without including those most impacted in decision-making and implementation."[114] While governments attempt to engage with communities, structural barriers of community meetings and participatory planning limit the public's understanding of the HiAP framework as a tool for change.[115] Community based organizations, academic scholars, and the press can (1) raise awareness that the local government has passed a HiAP framework ordinance and (2) help people understand what the tool can accomplish. Similarly, residents can continue to work with elected officials that passed the ordinance to make them aware of the importance of oversight, asking for follow-up reports of progress, and confirming (through petitions and letter writing campaigns) that the community would support the use of revenues, namely tax revenues, to strengthen the HiAP framework. For instance, recent legislation to legalize and tax recreational marijuana could be used to fund positions to support HiAP dedicated staffing. Similar options may exist for taxes on electronic cigarette sales for some local governments.

Next, multi-stakeholder community organizations focusing on health, health equity, and bettering government organizations can work with private funders and academic scholars to develop tools such as HiAP "report cards" designed to track government activity. They also could advance the theoretical and practical understanding of HiAP. Academic institutions with Master of Public Health or Master of Public Administration programs could offer coursework and adult learning options on HiAP theory and implementation to build a better civic workforce. Also, coordinated efforts by non-governmental groups can help in identifying priority areas for HiAP work and continue to work on innovative ways to build out the complex program evaluation tool kit.

Finally, the judicial system could be used as a check on the legislative system in order to encourage governments who do not seem to be implementing HiAP ordinances to do so. Such actions could be of last resort but can help protect the principles of HiAP and ensure imple-

113. HEALTHY CHICAGO SYMPOSIUM REPORT, *supra* note 106, at app'x. C, 3.
114. *Id.*
115. *Id.*

mentation. Health law engagement aimed at strengthening implementation of HiAP ordinances should be pursued, as it benefits constituents.

To date, courts have yet to make determinations in cases in which community groups have appealed local government decisions regarding HiAP ordinances.[116] Initiatives at both the state and local level are important for improving the health of all people by integrating health considerations into decision-making and policy sectors.[117] A community group could thus potentially use the judicial system as a tool to seek redress and prevent their local government from taking steps to plan further developments that could potentially harm the health of the community in the event that the requirements of a HiAP ordinance are not enacted or upheld. Citizens have constitutional rights which may be asserted against the government in courts. The First Amendment of the United States Constitution protects the "right of the people peaceably to assemble" and the right "to petition the government."[118] The public generally has an interest in ensuring that ordinances directed towards public health are implemented by their communities; therefore, assuming that a community is able to show that they have standing, they could potentially bring an action against their local government to assert their right to enforcement of the policies.[119]

A "determination of who may sue" in matters involving the government "is controlled, to some extent, by the statutes governing those actions" or by "statutes giving government bodies the power to sue and be sued."[120] A community group could seek action against their government in two potential ways. First, the community, or an individual citizen from the community, could seek a declaratory judgment, which is a binding judgment from a court and asserts the relationships and rights between parties to a matter.[121] A declaratory judgment would not provide for any enforceability of a HiAP ordinance, however, but would instead state the court's "authoritative opinion" regarding the matter.[122] Second, a community group or individual would have an option to bring a civil suit against their local government for

116. This portion of the Article is meant to address state law implications of decisions regarding HiAP ordinances.

117. *See* Linda Rudolph & Julia Caplan, *Health in All Policies: A Guide for State and Local Governments*, PUB. HEALTH INST. (2013), http://www.phi.org/resources/?resource=hiapguide.

118. U.S. CONST. amend. I.

119. 1A NICHOLS ILL. CIV. PRAC. § 10:13 (2019).

120. *Id.*

121. AM. JUR. 2d, *Declaratory Judgments* § 130 (2020).

122. *Id.*

either injunctive or monetary relief.[123] Injunctive relief generally allows a court to have discretion to enforce "personal rights in a particular case."[124] However, the scope of injunctive relief against "an agency of state government must always be narrowly tailored."[125] An injunction is typically used to stop a defendant from continuing allegedly harmful actions.[126] In order to obtain an injunction, the community group must be able to show that they have suffered or will suffer "an irreparable harm" from the failure of the government to uphold or enact the HiAP ordinance.[127] Alternatively, a community group may potentially be able to sue for monetary damages for any harm suffered as a result of the government's failure to enact or follow a HiAP ordinance; yet, it is important to note that immunity rules relating to government officials may apply, depending on the circumstances.[128]

Despite the current lack of case law directly regarding HiAP ordinances, courts have historically made determinations relating to the health of communities in terms of the environment. An Ohio court previously made a determination appealing the decision of the Environmental Board of Review, which required the city to begin fluoridating its water supply.[129] The court held that the decision to fluoridate water "bears a substantial relationship to the public health," thus allowing the ordinance to be enforced.[130] Moreover, the court held that decisions relating to the public health benefit of a health policy that is to be implemented falls within the discretion of the General Assembly.[131] Thus, if making a determination regarding the benefit of public health policies, such as a HiAP ordinance, a court would likely defer to the legislative branch.[132]

In general, enacted regulations or ordinances by a municipality "must yield to general laws of statewide scope and application," meaning that any HiAP ordinance at a municipal level that is enacted must first comply with state laws.[133] More specifically, when considering the City of Chicago, Illinois state laws will first apply to any HiAP

123. 1A NICHOLS ILL. CIV. PRAC. § 10:13 (2019).

124. AM. JUR. 2D, *Injunction to Enforce Personal Rights in Federal Courts* § 79 (2020).

125. *Id.*

126. 21A ILL. LAW AND PRAC., *Injunctions* § 72 (2019).

127. *Id.*

128. *Immunity of Government Officers Sued as Individuals for Official Acts*, U.S. DEP'T OF JUST. (2020), https://www.justice.gov/jm/civil-resource-manual-33-immunity-government-officers-sued-individuals.

129. Canton v. Whitman, 337 N.E.2d 766, 772–73 (Ohio 1975).

130. *Id.* at 770.

131. *Id.* at 772–73.

132. *Id.* at 773; Brown v. City of Canton, 414 N.E.2d 412, 413 (Ohio 1980).

133. *Canton*, 337 N.E.2d at 769 (internal citations omitted).

ordinance, then the city will be responsible for implementing the policies through its departments.[134] An Illinois statute recently took effect that will directly impact HiAP ordinances by municipalities.[135] The Health in All Policies Act defines a HiAP framework and sets forth guidelines to be followed within the state for approaches to improving health outcomes.[136] Historic environmental law determinations may also be useful when considering the potential recourse for such community groups. In environmental law actions, courts have held that there must be "procedural inadequacies" and a "substantial possibility of significant environmental impact" to challenge a government's actions.[137] Environmental law determinations may be analogous to a determination regarding a HiAP ordinance since both seek to generally avoid harmful health impacts. Assuming that the policies do comply with state law, and that the community group has standing, then recourse for failure to uphold a HiAP ordinance would likely be possible since Illinois law provides that "all other ordinances, resolutions and motions, shall take effect upon their passage unless they otherwise provide."[138] This means that an ordinance implementing HiAP should be upheld from its effective date.[139] Furthermore, "all ordinances . . . in force in any municipality . . . shall continue in full force and effect until repealed or amended . . . ."[140] Implementation of a HiAP ordinance largely depends upon governmental departments, and in the event of the failure to implement such policies, citizens or a community group will likely have recourse, depending on the circumstances surrounding the failure to uphold the policies.[141]

Conclusion

HiAP has been proposed as a mechanism for developing better policies and governance to promote health and health equity. While more governmental bodies have legislated the use of the HiAP framework, the execution and evaluation of such framework has been limited to date. Some of the difficulties are that HiAP focuses heavily on governmental sector interventions and has somewhat limited influence from outside (non-governmental) factors. Better tools need to be utilized to provide non-governmental, community-based organizations,

134. *Id.* at 770.
135. 410 Ill. Comp. Stat. 155/1-99 (2020).
136. *Id.*
137. Waltham v. U.S. Postal Serv., 786 F. Supp. 105, 140–44 (D. Mass. 1992).
138. 65 Ill. Comp. Stat. 5/1-2-4 (2019).
139. *Id.*
140. 65 Ill. Comp. Stat. 5/2-1-3 (2019).
141. Shankardass et al., *supra* note 53.

and community residents, the opportunity to hold the government sector accountable for the implementation of HiAP in order to unleash the true power of the policy.