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## SPECIALTY SECTION

This article was submitted to  
Public Health Policy,  
a section of the journal  
Frontiers in Public Health

RECEIVED 03 August 2022

ACCEPTED 23 January 2023

PUBLISHED 09 February 2023

## CITATION

Lilly K, Kean B, Hallett J, Robinson S and  
Selvey LA (2023) Factors of the policy process  
influencing Health in All Policies in local  
government: A scoping review.  
*Front. Public Health* 11:1010335.  
doi: 10.3389/fpubh.2023.1010335

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# Factors of the policy process influencing Health in All Policies in local government: A scoping review

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**Objectives:** This review aimed to identify factors in the policymaking environment that influence a Health in all Policies approach in local government, how these vary across different municipal contexts, and the extent that theories of the policy process are applied.

**Methods:** A scoping review was conducted to include sources published in English, between 2001 and 2021 in three databases, and assessed for inclusion by two blind reviewers.

**Results:** Sixty-four sources were included. Sixteen factors of the policy process were identified, expanding on previously reported literature to include understanding and framing of health, use of evidence, policy priority, and influence of political ideology. Eleven sources applied or referred to theories of the policy process and few reported findings based on different local government contexts.

**Conclusion:** There are a range of factors influencing a Health in All Policies approach in local government, although a limited understanding of how these differ across contexts. A theory-informed lens contributed to identifying a breadth of factors, although lack of explicit application of theories of the policy process in studies makes it difficult to ascertain meaningful synthesis of the interconnectedness of these factors.

## KEYWORDS

healthy public policy, municipality, political science, policy theory, determinants of health, health equity, health promotion

## Introduction

Improving the health of populations requires a shift from individual behavior approaches and advances in healthcare to addressing social, environmental, political, economic and physical determinants of health (1). Influencing health determinants such as housing, transport, sustainability, social services and infrastructure design requires cooperation across all sectors, including those outside of the healthcare system. This approach is referred to as Health in All Policies (HiAP) (2).

Local government (LG), also referred to as municipalities, operate across a diverse range of sectors with the responsibility for urban planning of neighborhoods, transport options, employment conditions, establishment of accessible local facilities and contribution to the social capital of communities (3). While there are different governance structures and legislative environments of LG between countries, LG are universally the closest tier of government to the community, able to engage and connect with the public and create collaborative opportunities between different sectors (3). For these reasons, LG are deemed the most feasible tier of government to address health determinants across a range of policy areas (4–6). However, there is little attention in the literature given to how LG policymaking environments make these decisions to address health determinants (or not).

To date, there have been two scoping reviews that have identified themes that enable or challenge LG in implementing a HiAP approach, locating literature up to 2015 (7) and 2016 (8). Findings from these reviews identify key enablers such as available funding and strong leadership or champions in both local and higher tiers of government (7, 8), along with community engagement (7). The role of national legislation is also considered a facilitative tool in the policy process, particularly if allowing for autonomy at a local level (7, 8). Health impact assessments are acknowledged as useful, albeit require political commitment, training and support to be feasible (8). The importance of intersectoral collaboration is an identified facilitator for achieving implementation of HiAP, although it was deemed an extra task for sectors outside of health, and requires skills in effective communication (7, 8). In addition, barriers to achieving a HiAP approach include lack of funding, lack of clear objectives and performance indicators to measure health outcomes (7, 8), lack of ownership and accountability for HiAP at a local level (8), lack of staff expertise, and siloed organizational structures (7).

Whilst the themes identified across these two reviews identify a range of distinctive enablers and challenges to the policy process, more recent health promotion discourse proposes that understanding decision-making processes could be better understood by exploring the policymaking environment through application of theories of the policy process (9, 10). By understanding the factors that influence the policymaking environment, practitioners could better navigate policy decision-making, regardless of the unique LG contexts, whether that be within or between countries, rural and city locations or legislative arrangements (10, 11). However, it seems that whilst health promotion policy research is increasing, few are informed by theories of the policy process, or continue to rely on simplified and outdated stages heuristic models (10, 12, 13). The stages heuristic model, whilst easy to understand for health promotion practitioners, does not reflect the messiness and interrelatedness of the complexity of factors influencing the policy process (9, 14). Theories of the policy process, however, give meaning to the interaction of many factors, such as political environments, policy actor beliefs and interests, public opinions, events, political ideologies and power to name a few (15, 16).

Informed by theories of the policy process, this scoping review identifies a more in-depth perspective of the policy process, by capturing the most recently available research on factors that influence the policy process (inclusive of enablers and challenges), including an exploration of how the research gives consideration to different legislative and geographical LG contexts. Alongside this, the review determines the extent that current research explicitly applies theories of the policy process when exploring the role of HiAP in the LG policymaking environment. It extends upon previous findings to identify gaps in the literature and provide discussion on future directions for research in HiAP in the LG policymaking environment.

HiAP remains an emerging topic and advancing our knowledge could be enhanced by incorporation of evidence from both empirical and gray literature (17). Therefore a scoping review was deemed an appropriate approach for advancing the field. Scoping reviews are valuable in health as the method collates, organizes and interprets large volumes of evidence on a specific topic (18) and the exploratory nature of the research questions aligns with the value of scoping reviews in synthesizing and mapping concepts, types of evidence, and research gaps (18).

The research question proposed for this review was:

“What are the factors in the policy process that enable and/or challenge LG in initiating, implementing or evaluating a HiAP approach to achieve population health and wellbeing outcomes?”

Additional sub-questions of interest included:

- How does the literature related to a HiAP approach in LG apply theories of the policy process?
- Are policy factors related to a HiAP approach different across various LG contexts and jurisdictions?

## Methods

The scoping review method was conducted in accordance with Joanna Briggs Institute (JBI) methodology for scoping reviews (19) and recommendations for conducting scoping reviews (18). A full outline of the protocol is provided open access (20). The research question guided the process to identify all relevant literature (18). The initial step included a search of relevant literature from 2001 to January 2021, reflecting 20 years of health promotion policy research, across Scopus, Proquest and EBSCO. The databases were selected for their multidisciplinary focus across health, politics and humanities, with Proquest including gray literature sources. Included terms were considered based on the goal of obtaining sources of evidence that address population health and wellbeing, rather than those with a focus on health care, health services, or individual approaches to health and wellbeing. The research team have content expertise required to guide the review (18), and in this case it assisted in determining appropriate terminology to include in the search strategy. Based on knowledge and extensive experience in health promotion by several authors (KL, JH, LS), and HiAP being a relatively new term in health promotion, it was deemed necessary to include both the concept “HiAP” in the search terms, as well as additional relevant concepts, such as structural determinants of health [political, social, environmental (built or natural)] or concepts such as health equity. The search strings are outlined in Table 1.

Sources needed to address any factor related to the policy process, be positioned in the LG context and address HiAP or a related concept. A full list of inclusion and exclusion criteria are summarized in Table 2.

An initial list of possible factors influencing the policy process were available to all reviewers to assist in the assessment of articles for inclusion, particularly as one reviewer was less familiar with the theories of the policy process. However, the reviewers were not bound to only these initial factors. Any sources that presented research of factors influencing the policy process were discussed and included if they otherwise met the criteria. The initial factors were informed by a deconstruction of concepts related to theories of the policy process, in specific reference to the Multiple Streams Framework (MSF) (21), Advocacy Coalition Framework (ACF) (22), Punctuated Equilibrium Framework (PEF) (23) and Analysis of Determinant of Policy Impact (ADEPT) (24). The first three frameworks were chosen to inform the inclusion criteria as they are considered three of the most established and rigorously tested frameworks in the policy sciences, albeit largely focussed on policy agenda setting (15). The ADEPT framework, initiated from and adapted from health promotion behavior change models, aimed to address the gaps in factors related to policy implementation and evaluation (25). A mind map of the policy process concepts deconstructed from these theories

**TABLE 1** Database search, including search strings, limits and number of sources (after removing duplicates within databases).

Database	Search string used	Limits	Number of sources
Proquest	("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health inequit*" OR "health equit*") AND ("policy process")	<b>Year:</b> 1 Jan 2001–1 Jan 2021 <b>Language:</b> English <b>Sources:</b> Dissertations and Theses, Scholarly Journals and Reports	593
Scopus	("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health *equit*" AND ("polic*"))	<b>Year:</b> 2001–12 March 2021 <b>Language:</b> English <b>Sources:</b> Articles and Reviews	208
EBSCO	("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health *equit*" AND ("polic*"))	<b>Year:</b> 2001–Jan 2021 <b>Language:</b> English <b>Sources:</b> Academic Journals, Journals, Dissertations	234

is available in the scoping review protocol (e.g., is available in the scoping review protocol (see [Supplementary material](#)).

Articles obtained in the search were assessed for inclusion by two blind reviewers (KL, BK) at title/abstract level using Rayyan software (26). If it was not clear whether the article referred to population or individual health and wellbeing, LG or other tiers of government or a HiAP related concept the article was included at full-text review. The reference lists of sources that met inclusion criteria were scanned to identify any additional sources. Two authors [initials removed for peer review] reviewed all articles at full text and discussed any discrepancies during regular reviewer meetings (18). In one instance where the context remained unclear, the primary author was contacted to clarify. All evidence sources were included that met the criteria, excluding reviews of the literature.

Data from articles included at full text review were extracted for further analysis. Data extraction included key concept, nation of article, use of theory and key findings of the study (see [Supplementary material](#)). Data extraction also included commentary on how findings were compared across different LG contexts, for example size of LG or different legislative environments. Two authors conducted this process for approximately 10% of the included articles, checking the data extracted for consistency (18). The first author completed this process for the remaining articles included at full-text review.

**TABLE 2** Summary of inclusion and exclusion criteria applied to the sourcing of evidence.

	Inclusion criteria	Exclusion criteria
Context	LG context; Multiple tiers of government involved, although only if the role of LG was clear.	Set in state or federal tiers of government. Set in local healthcare settings or community-based organizations. Not in any particular context.
Concept 1	Address HiAP or a related concept such as determinants of health, health equity.	Address health with reference to biomedical or healthcare approach or a focus on individual health (including urban planning environment and built environment related to individual health risk factors).
Concept 2	Discuss any factor related to the policy process.	Discuss policy content or policy impacts/outcomes.

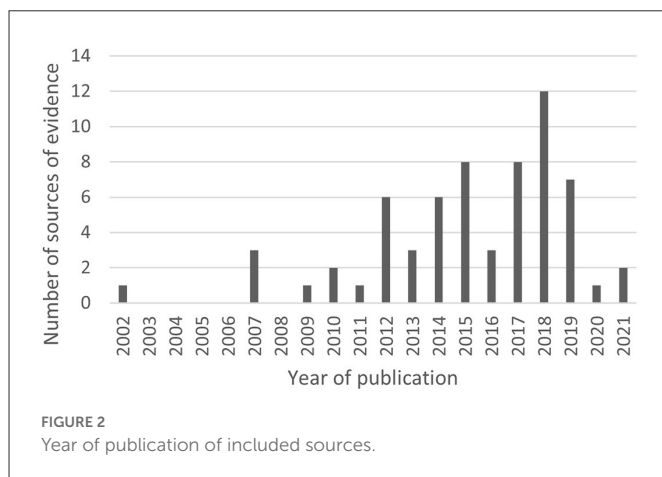
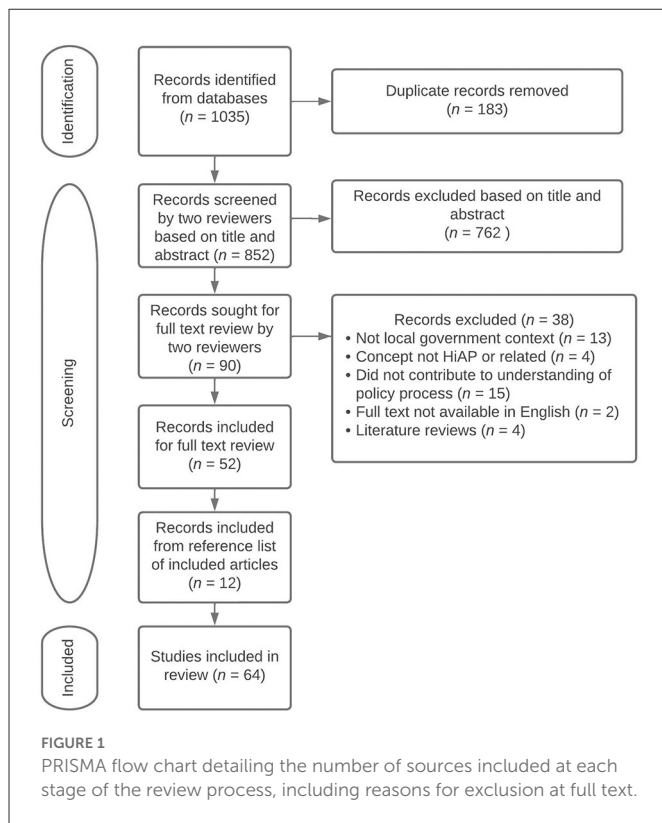
The final stage of the scoping review involved an inductive, qualitative thematic analysis of the key findings, completed by two authors (KL, BK). The first author (KL) conducted a first pass of the data manually and developed initial codes through an inductive approach. Using these initial codes as a guide, two of the authors coded from all datasets. Following blind data analysis, the two authors discussed the coded dataset and continued the qualitative data analysis using NVivo 12 software [QSR International Pty Ltd. (2018) NVivo (Version 12), <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>] to build a consensus of themes that represented key factors of the policy process (27). Through this process, factors of the policy process and their relationships to one another were critically discussed. Other aspects of the literature critically discussed in depth during this process were: (1) the use of theory to inform study design and interpretation of findings across the body of literature, (2) inconsistencies with terminology, and (3) how to capture the interconnectedness of themes.

## Results

The initial database search yielded 1,035 sources for possible inclusion in the review. After removing duplicates, 852 sources were assessed for inclusion based on title and abstract, resulting in 90 sources read in full text. Of these, 52 sources were deemed to meet the inclusion criteria. A scan of the references of sources that met the inclusion criteria identified another 12 sources eligible for the review. A total of 64 sources were included in the final review (Figure 1).

Of the included sources, 56 (87%) were published since 2012, and 30 (47%) since 2017 (Figure 2).

Sources represented a range of countries, including Norway (15, 23%), followed by Australia (10, 15%), Netherlands (8, 12.5%), Denmark (6, 9%), England (6, 9%), Sweden (4, 6%) and United States of America (4, 6%). Other countries less represented in the



literature were the United Kingdom (3, 5%), Canada (3, 5%), Brazil (2, 3%) and single studies from Cuba, Finland, Hungary, Slovakia, Spain, Turkey, Europe and one not an empirical study. A majority were exclusively undertaken within the LG context (59, 92%) and did not address other tiers of government. Twenty-one sources of evidence were focussed on HiAP as a concept (33%), with others exploring relevant concepts such as determinants of health (17, 27%), health equity (13, 20%), or less defined concepts such as health promotion, public health or healthy planning (13, 20%).

## Factors identified in the policy process

Amongst the included sources, there were 16 factors identified as influencing the policy process (Table 3). Some sources focussed on a single factor (e.g., intersectoral collaboration), whilst others included a range of factors. The 16 identified factors influencing the policy process are summarized in Table 3 and the next section reports in more detail on the novel findings of the review, including any insight into contextual variances of LG based on size, geographical location or legislative environment.

## Understanding and framing of health

It is evident from the findings that there is not a unanimous understanding of HiAP or related concepts such as health equity within a LG context. HiAP is reported as complex and difficult to define (84). In terms of understanding, there was evidence of LG staff knowing the impact of policies on health (5, 28, 29, 82), as well as examples of LG staff and decision-makers conversely regarding health as the responsibility of individuals (30–32, 83).

The broader terminology of HiAP (inclusive of social determinants of health and health inequities) was perceived to gain little policy attention in LG (28, 30–34). Whilst LG appeared to address health determinants, some of the findings suggested health was not the prominent reason for action that led to better health outcomes (31, 35–39). Alternative framing of the issue, namely as liveability, wellbeing (36) or living conditions (31, 84) was more accepted, although recognized as shifting the focus away from health (31, 33). Synnevåg et al. (84) suggest the term “public health” should be used to gain support, though concede it may need to be reframed during the process to be more relevant to different contexts.

## Level of policy priority

Health inequalities or health determinants were consistently regarded as a high policy priority (30, 40, 82), despite competing with other LG responsibilities (29, 41). Some studies reported that only a select few LGs regarded health determinants a high priority (5, 42). Behavioral and lifestyle programs were perceived to be of higher priority in LG compared to addressing determinants of health (43, 44, 71, 83). The level of policy priority for addressing determinants of health was challenged by a range of factors including the political attraction to lifestyle programs (82), the perceived lack of urgency (45) and competing with priorities such as healthcare, food safety or other nationally determined priorities (44, 46, 72, 83). Larger municipalities in Norway were more likely to prioritize policies regarding living conditions, while smaller municipalities prioritized lifestyle issues (44, 47).

## Political ideology and decision making

Politicized decision-making was also a challenge faced in the LG context, recognizing that population health outcomes extend beyond short term political election timeframes (36, 72) and misalign with political ideologies for those seeking economic growth (48). Commitment to health inequities was higher if it aligned to the values and ideologies of decision-makers (34). Commitment was

TABLE 3 Outline of the 16 identified factors influencing HiAP within LG, with a summary of the key findings (review, global, 2011–2021).

Theme	Frequency (n, %)	Key findings	References
Cross-sector relationships	44, 69%	Collaboration across sectors was regularly reported as necessary for HiAP, though challenging to achieve. There was more focus on horizontal collaboration across departments, than vertical collaboration between staff and decision-makers.	(5, 28–70)
Evidence	34, 53%	LG utilizes a wide range of evidence sources. Local data, including community input, was consistently reported as more important than academic sources of evidence.	(30, 32–37, 40, 42–44, 47, 49–52, 55, 57–60, 66, 67, 71–81)
Level of policy priority	26, 40%	Addressing health determinants was reported as a priority for LG, though not always the highest priority, amongst more politically favorable lifestyle programs and other competing LG interests.	(5, 29, 30, 36, 38–48, 51, 53, 54, 59, 64, 68, 70–72, 82, 83)
Understanding of health	24, 38%	The definition and understanding of the term “health” was perceived as ambiguous and complex, and varied amongst decision-makers.	(5, 28–32, 35, 40, 42–44, 46, 51, 60, 62, 65, 68, 69, 71, 72, 82–85)
Funding	23, 36%	Many sources highlighted the challenge of financial constraints, or reliance on higher tiers of government for funding.	(5, 29, 30, 32, 35, 37, 40, 42, 46, 48, 49, 51, 58, 59, 61, 63, 64, 68, 70–72, 75, 82)
Leadership/Political commitment	18, 30%	Support from local management and politicians was reported as a key contributor to local policy success.	(29, 32, 34–36, 38, 39, 46, 49, 53, 59, 60, 62, 64–66, 68, 86)
Champions and policy entrepreneurs	16, 25%	Champions were reported as important in initiating HiAP, although not necessarily existing in LG.	(29, 30, 34–36, 39, 42, 45, 52–54, 58, 63, 71, 81, 86)
Framing	15, 23%	LG decision-makers often referred to “health” as another concept such as liveability, or wellbeing. Rarely was “health” the reason for action on addressing determinants of health.	(28, 30–39, 53, 57, 65, 84)
Role of community	14, 22%	Community input is a key influence in local level policy decision-making. There is some debate over the level of comfort by planners in trust that community will focus on determinants of health, if engaged in the process.	(28, 32, 34, 36, 37, 40, 46, 49, 51, 54, 59, 60, 82, 87)
Role of legislation	14, 22%	Legislation was reported as a contributor to successful initiation and implementation of HiAP, although LG did not always adhere to the mandate, and required sufficient resourcing.	(35, 36, 44–49, 52, 60, 69, 71, 75, 82)
Staff capacity	12, 19%	Capacity of staff time and expertise was reported as a challenge to a HiAP approach.	(29, 32, 36, 46, 49, 53, 59, 61, 67, 73, 78, 88)
Use of tools (e.g., Health impact assessment)	11, 17%	Health impact assessments were reported as useful to assessing possible health impacts across sectors and raising awareness of health determinants amongst policy decision-makers, although challenged by lack of legislation and adequate resourcing.	(33, 43, 48, 54, 57, 61, 62, 66, 69, 71, 89)
Political ideology and decision making	10, 16%	Broader political ideologies, and individual values and beliefs, influenced the commitment to addressing health equity at a local level.	(29, 32, 34, 36, 48, 49, 69, 72, 73, 80)
Responsibility of local government	9, 14%	Health inequalities is accepted as a responsibility of LG, although there is a perceived lack of power or authority to take action.	(5, 39, 40, 43, 44, 51, 53, 69, 72)
Performance measures	9, 14%	Several sources note the lack of, or use of vague performance indicators, contributing to a lack of urgency to address health inequities.	(33, 35, 43, 45, 49, 55, 59, 60, 90)
Organizational structures	5, 8%	There is ongoing debate on a successful governance structure for HiAP in LG, between a centralized unit and cross-department collaborations.	(28, 37, 41, 53, 55)

lower where values conflicted or where political reputations were seen to be at risk (48, 49, 73).

## Evidence

The review found that local data, such as anecdotal experiences and knowledge, is considered more important than academic sources of evidence in the LG context (49, 72, 74), although accessing relevant local data is acknowledged as difficult (36, 49, 50, 75–77). Browne et al. (76) found that academic research was the least utilized evidence input was the most commonly used and influential type of

cited amongst public health plans in Australian LG. Community evidence (49, 72, 73, 76, 77), along with anecdote (73, 74), networks (30, 76, 77), media (30, 77) or government reports (30, 36, 51, 76, 77).

Evidence was more likely to support policy action if it highlighted health inequities (34, 40), included a cost effectiveness argument (33, 73, 78), was free of jargon (73), was already synthesized (78), was politically acceptable and viable (74, 78), and appealed to values of doing the “right thing” (78). However, some authors caution that even where local level data is available, it may not be used to inform policy (52). Sources reported some key challenges for LG utilizing



evidence, such as the limited time of staff (76–79) and availability of evidence (77, 79).

## Champions and policy entrepreneurs

Findings from this scoping review confirms the importance of the role of a policy entrepreneur, or individual in a similar role such as a champion or knowledge broker (35, 45, 53, 86). However, whilst the potential value of a policy entrepreneur was consistently identified, few studies reported on either the presence of, or role of such entrepreneurs in the LG context (29, 54).

## Organizational structures

The review unveiled a debate on the influence of organizational structures that support collaboration across sectors. There was no conclusive agreement on the ideal governance structure. Holt et al. (41) report that a central unit was difficult for public health staff to engage other sectors, whilst Von Heimbürg et al. (55) found the contrary. Other organizational structures that support formal communication across departments are proposed as useful, such as intersectoral committees (56, 57), or formal structures such as strategic planning and health impact assessments (57). Additional findings suggest that beyond formal communication and structures, intersectoral collaboration requires a range of interpersonal skills to be effective, such as the development of trust between sectors (53, 55), conflict management (37) and communication skills (28).

## Funding

The literature highlighted the challenge of financial constraints (29, 32, 40, 51, 58, 59). However, whilst agreeing funding is an important component, it is debatable whether the size of LG has an influence on the level of resources and capacity to address health inequities. Bekken et al. (75) report that larger Norwegian municipalities are more likely to be sufficiently resourced compared to smaller municipalities, which is in alignment with results by Lilly et al. (29) that city councils were better resourced than regional and rural counterparts. However, Bagley et al. (46) found no difference in the approach to municipal public health planning between Australian LGs in relation to their level of wealth.

## Use of theory in literature

A sub-question in the review was to explore the application of theories of the policy process in the literature. A third ( $n = 23$ ) of the included sources utilized any type of theory, varying between social, organizational or political science theories (see [Supplementary material](#)). There were 11 sources that applied or referred to theories of the policy process. Of these, nine applied the MSF, or referenced an aspect of the framework relevant to the research. For example, Hoeijmakers et al. (54) applied only the policy entrepreneur component of the MSF. Five sources applied the MSF explicitly to inform or interpret the research findings (29, 36, 45, 66, 86), while others mention the MSF, but do not discuss how it informed the study design, results or interpretation of findings (33, 35, 55). Other frameworks that were applied included network analysis (54), or other conceptual frameworks adapted for

exploration of the policy process (34, 44). For example, Fosse et al. (44) applied the Gradient Evaluation Framework, which had been adapted from the stages heuristic policy framework to evaluate the extent to which policies considered health inequities. The use of multiple theories was applied by three sources (29, 35, 54).

## Discussion

This review served two purposes: (1) identify the factors in the policy process that enable and/or challenge a HiAP approach in LG, including across different jurisdictions and (2) explore how literature exploring HiAP approaches in LG applied theories of the policy process.

## Factors in the policy process

The recent literature, up to 2021, confirms many findings previously reported in scoping reviews up to 2016, including influencing factors such as funding, leadership, intersectoral collaboration, clear objectives and performance indicators (7, 8). The wide range of factors demonstrate the complexity of the policy process. Some factors were clearly enabling the process, such as the level of priority given to health and wellbeing and strong leadership within LG. Key challenges in the LG policymaking environment were lack of key champions, limited funding and staff capacity, difficulty collaborating across sectors, the ambiguous responsibility of LG to respond to HiAP, and the lack of performance measures for health and wellbeing indicators. Finally, there were many factors that were recognized as influential, however, neither a clear enabler nor challenge to the policy process. This is consistent with findings from other authors who suggest that factors of the policy process influencing social determinants of health inequities instead be referred to as “increasing (or decreasing) the “probability”” of influencing the policy process (91) [p. 108].

This scoping review added new themes not previously captured in published reviews on this topic, such as framing, level of policy priority, the role of evidence and political ideologies. Additional insights were identified for the role of policy entrepreneurs or champions, organizational structures and possible contextual considerations regarding funding. The theoretical lens adopted in this scoping review may have contributed to the identification of additional themes in the policy process, not previously reported. Also, it is likely the additional themes were a result of the emerging literature exploring HiAP in LG. For example, the theme related to use of evidence was predominantly identified in literature post 2015. None of the themes identified in this review contradict previous findings, rather extend upon our understanding that the role of HiAP in the LG policy environment is multifactorial, supporting the call for the application of theories of the policy process to understand the complexity and scope of factors related to the policy process.

## Use of theory

This review explored how theories of the policy process were applied in the literature, finding that most of the sources did not apply any type of theory. Whilst the lack of theory did not prohibit the

sources from identifying a wide scope of factors in the policy process being identified, the use of theory can provide a way to understand the complexity of how factors are interconnected.

The scoping review identified only 11 sources that applied theories of the policy process, but very few that had applied the theories explicitly and comprehensively in the communication of the research methodology and findings. Given the MSF was the most commonly applied framework in the review studies, an attempt was made to synthesize the findings to demonstrate how this framework could explain the interconnectedness of policy factors. The MSF claims that three streams must align for policy action to be realized (21). To understand this in the policymaking environment requires exploration of how policy issues were raised on the LG policy agenda, referring to factors such as the role of evidence, framing or policy actor involvement (problem stream), and then in regard to how these same factors influence action on health determinants (policy stream) and under what type of political, legislative and governance contexts (politics). For example, whilst the term health was not explicitly discussed amongst LG decision-makers, there is not the broader understanding of whether this impacts on policy solutions to address health determinants, or what other influences within the political environment enable or constrict these decisions from reaching the policy agenda given “health” *per se* may never be discussed. Most of the studies did not comprehensively assess the policymaking environment to make the connections across the three streams of the MSF. In fact, this was the case regardless of whether the framework was applied or not. Despite attempts, a comprehensive synthesis was not achievable given the limited number of studies, the different concepts that were being studied (healthy planning, health inequalities, health impact assessment and health determinants) and across three different countries, with varied governance structures. Even where findings could potentially be synthesized, it was apparent the MSF was applied in slightly different ways or raised different considerations within each of the theoretical streams. For example, the cooperation across sectors and LG departments was often interpreted similarly within the policy stream (29, 36, 45, 66), all agreeing that this was limited and challenging the policy process. In contrast, the influence of higher tiers of government was referred to in either the policy stream (36) or in the politics stream (29). Until there is a sufficient volume of empirical studies that effectively and explicitly apply these theories, it remains difficult to synthesize the interrelatedness of factors that influence the policy process in a meaningful way. Accordingly, it is impractical to propose any evidence-informed suggestions on how to change the practices of health promotion to influence the policy process. This supports both the need for health promotion practitioners and academics to further embrace the political nature of health promotion to inform future practice and collaborate with experts in political science for a more accurate and consistent application of the theories (13, 92). Accordingly, findings from this review support the call for health promotion to apply theories of the policy process to effectively inform practice and research in navigating the policy process. As previously highlighted by experts in health promotion, the globally recognized professional knowledge and skill competencies to achieve this are currently insufficient (9). These professional competencies for health promotion require updating to support international health promotion practitioner registration, along with a contemporary curriculum focussed on politics within related tertiary education degrees (11, 93).

## Contextual differences

The scoping review extended upon previous reviews to explore differences across various LG contexts. However, across the literature very few sources reported findings based on the context within LG e.g., size, rurality or responsibilities. Within the limited existing literature, larger, metropolitan settings appear to have a greater understanding and prioritization of health determinants as a policy issue, and the resource capacity for a HiAP approach.

Furthermore, it is important to note sources were predominantly located in countries where there are legislative environments and existing governance structures to support action on addressing health determinants at a local level. However, often the description of the governance structures was not comprehensive, resulting in difficulty in making comparisons based on geographical locations. Based on this review, it is recommended that future research provides a comprehensive overview of the size, location and any other key descriptors of LG settings to enable findings to be better contextualized. Further research is needed to disaggregate and communicate findings based on these different contexts, rather than combining the findings together as a whole. In terms of geographical spread, the majority of the research was located in European countries, which limits the scoping review from providing a global perspective. More research is required to contribute to this research gap in other countries not represented, particularly countries where there is no legislative requirement for HiAP within LG.

## Limitations

There were several limitations in the conduct of this scoping review. It is acknowledged that the method taken for the scoping literature review meant that some sources that were not intentionally addressing the comprehensiveness of the policy process may have been included. For example, some sources focussed on a single factor such as evidence or health impact assessments. However, across the body of literature, most sources identified an extensive range of factors influencing the policy process, as opposed to narrowing in on one specific factor. However, the sources did not analyse or present factors in a similar or comparative way.

Only studies published in English were included. Given the higher volume of sources from Scandinavian countries, this may have restricted the volume of existing literature on this topic. Given LGs in countries such as Norway have legislative requirements for HiAP, there may be more relevant and in-depth studies available in non-English language sources not accessible to the authors of this review. The range of sources, including gray literature, may also have been expanded if more databases were included in the search (e.g., PubMed, Google Scholar).

The search terms were broadened to attempt to incorporate all sources related to HiAP as well as terms that are often used interchangeably with the concept. Whilst the use of different terminology may have broadened the research scope, in some instances the terminology of the key concept used by authors was not clear (e.g., health promotion) and these sources were included. However, our interpretation of these concepts may have differed to the original source intent. This

highlights the need to be clearer in the terminology used, as determined more broadly in public health discourse (94). The different governance structures of LG across countries were sometimes difficult to ascertain. However, all action was taken to minimize the exclusion of articles as a result of not knowing the political structures, including contacting primary authors to clarify.

In addition, whilst policy science researchers recognize there is no “ideal” framework (15), the inclusion of sources was initially guided by factors of the policy process as deconstructed from only four frameworks, and as is the case with the MSF and ACF, mostly tested in national tiers of government (95, 96). Therefore, these frameworks may not explain all of the factors of the policy process, or all those relevant to local tiers of government.

Whilst all measures were taken to identify all relevant sources of evidence, there were several sources identified from scanning reference lists, which suggests some other relevant literature may have been inadvertently excluded.

## Conclusion

This scoping review identified a range of factors to the policy process influencing LG adopting a HiAP approach, including newly reported factors such as understanding and framing of health, use of evidence, policy priority, and influence of political ideology. The study concludes that whilst practitioners can learn from the factors that influence the LG policy process to encourage a HiAP approach, it would be more useful to build the evidence-base through the use of theoretical foundations, such as theories of the policy process. Many have previously called for the use of theory to guide the complex policy process, though the actual application in health promotion has been slow in uptake. This scoping review reinforces that this is also the case for studies exploring a HiAP process within the LG setting. Future research exploring HiAP in LG should apply theories of the policy process to be able to comprehensively and meaningfully explain the otherwise messy policy process. A more consistent theoretical application will also allow for further comparison of findings across different LG contexts, including LG size or broader legislative environments.

## Author contributions

KL developed the scoping review protocol, undertook the literature search and was one of the peer reviewers through the review

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process, led the drafting, writing, and finalization of the manuscript. BK contributed to the finalization of the protocol and methodology for the review, co-wrote the manuscript, contributed feedback and suggestions for clarity, and was a second reviewer in the scoping review process. JH and SR provided input on the peer review process where decisions could not be agreed by KL and BK. SR provided feedback on the initial scoping review methodology. JH read drafts, contributed feedback on the scoping review methodology, and an initial draft of the manuscript. LS contributed by providing feedback on the scoping review protocol, contributing feedback on manuscript drafts, proofreading, and suggestions for amendments for finalizing the manuscript. All authors contributed to the article and approved the submitted version.

## Funding

This research was supported by an Australian Government Research Training Program (RTP) Scholarship.

## Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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## Supplementary material

The Supplementary Material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpubh.2023.1010335/full#supplementary-material>



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