Public Health Agency of Canada
Agence de santé publique du Canada

Crossing Sectors

– Experiences in intersectoral action, public policy and health

Canada

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Crossing Sectors

– Experiences in intersectoral action, public policy and health

Public Health Agency of Canada
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Commission on Social Determinants of Health

EQUINET

CHP
CENTRE FOR HEALTH POLICY

London School of Hygiene & Tropical Medicine

Prepared by the Public Health Agency of Canada in collaboration with the Health Systems Knowledge Network of the World Health Organisation's Commission on Social Determinants of Health and the Regional Network for Equity in Health in East and Southern Africa (EQUINET).

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Preface

This paper was written for the Health Systems Knowledge Network (HSKN)[1] established as part of the WHO Commission on the Social Determinants of Health, and was reviewed by at least one reviewer from within the HSKN and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

1 The work of the HSKN was funded by a grant from the International Development Research Centre (IDRC), Ottawa, Canada. The views presented in this paper are those of the authors and do not necessarily represent the decisions, policy or views of the IDRC, World Health Organisation and/or its Commissioners, the HSKN, EQUINET or the reviewers.

Executive Summary

This paper represents the first phase of a Canadian initiative on intersectoral action for health and provides an overview of approaches to intersectoral action at the global, sub-regional, national, sub-national, and community levels. It is intended to contribute to the World Health Organisation's Commission on Social Determinants of Health (SDH) and is the result of collaboration between EQUINET, the Health Systems Knowledge Network of the Commission on SDH and the Public Health Agency of Canada.

Experiences documented by academics, policy-makers and practitioners in more than 15 countries are examined in an attempt to improve understanding of questions relating to:

- the types of problems addressed through intersectoral action (IA);
- the conditions that shape horizontal and interjurisdictional collaboration;
- tools, mechanisms and approaches to support IA; and
- roles played by the health sector and other actors.

As evidenced in this paper, the experience of intersectoral action offers significant lessons to draw upon:

- ***Context matters.*** The broader context for decision-making (political, economic and socio-cultural) affects how issues are framed and the choice of approaches (including intersectoral action), mechanisms and tools to address the problem. Variables include the stability of the socio-political environment, national income level of the country, decision-making styles and timing (*e.g.,* pre- versus post-election). Political and civil society actors are key drivers of intersectoral action.
- ***IA is a strategy that can address a wide range of health problems.*** IA has been used to address a wide range of health and socio-economic public policy challenges, including action on specific determinant(s) of health, populations, communities, diseases and health behaviours, and risk factors. To a lesser extent, broad policy frameworks that explicitly address health equity (*e.g.,* UK, Sweden) have outlined IA as a key strategy. The use of health equity as an explicit goal varies considerably. Issues have been framed as health promotion, disease prevention, health protection, public health, primary care, community development, crime prevention, public security, economic development, social cohesion, education, employment and sustainable development.
- ***Intersectoral action is both dynamic and resource-intensive.*** Experience in acting across sectors demonstrates

that the nature of IA efforts changes throughout the policy development, implementation, and evaluation phases. The roles, actors, skills and resources required to initiate IA are very different from those required to implement the action and to assess its impact. IA has been extremely resource-intensive, in terms of people, money and time. Skills required in the development stage—*e.g.,* negotiation and resource identification—vary considerably from those needed for implementation and assessing impacts. Defining objectives and roles, sustaining momentum, and evaluating results represent three key challenges. With these considerations in mind, a critical assessment of when, where and how to act across sectors is required.

- ***IA becomes more difficult in more complex policy environments.*** As the number of partners and interests increases, logistical challenges make it more difficult to initiate and sustain intersectoral action. More documented success stories of IA appear at the community level than at the national and global levels, and many sources acknowledge the problem of increasing complexity at higher levels of governance. The number of partners and complexity of decision-making models are likely contributing factors: a healthy community is easier to achieve than a healthy world. Yet many of the levers needed to influence large-scale improvements in health equity require intersectoral action at and between the local, sub-national, national, and global levels. To be effective, IA requires a thorough understanding of the context. The complexity of decision-making needs to be viewed as an opportunity rather than a risk.

The experiences reviewed in this paper demonstrate some successes in working vertically and horizontally for health gains. Given the resource implications of intersectoral efforts, however, a critical assessment of when, where and how to act is required. While a range of approaches have been used, at different levels of governance, there does not appear to be a "one size fits all" model.

Many questions remain. The information gleaned from this paper will help shape questions to be explored in the next phase of this initiative, involving subsequent case studies and analyses and a report of country and regional experiences in IA. This paper is also expected to inform the final report of the Health System Knowledge Network (HSKN) to the WHO Commission on Social Determinants of Health.

1 Introduction

In 1997, the World Health Organisation (WHO)'s Conference on Intersectoral Action for Health explained why there is a need to advance intersectoral action for health (WHO 1997):

- We need a new vision for health that establishes the health sector as one of a number of intersectoral players in a "web" that makes use of new kinds of leadership, skills, information and intelligence.
- We need new systems of governance to manage partnerships and alliances, leading to new roles and responsibilities, delivery and financing methods, and monitoring, accountability and outcome tools and measures.
- We need improved evidence demonstrating the impact of intersectoral action on health and health interventions.
- We must strengthen understanding and use of health and social indicators, which are often narrow and skewed toward economic factors, to inform and strengthen policy and program decisions.
- We need to capture health opportunities as well as burdens.

In the ten years since the Conference, many regions, nations and communities have embarked on intersectoral action. Results have been mixed. While there is ample documentation of the need to work across sectors, there has been less exploration of experiences in initiating, sustaining and evaluating the impact of intersectoral efforts for health in a variety of decision-making contexts.

The purpose of this paper is to synthesize and analyse documented experiences and learnings in intersectoral action (IA) for health. The paper draws from a range of different social and political contexts, and where possible, examines intersectoral action addressing social determinants of health toward the goal of health equity. It attempts to respond to the following key questions:

- What public problems have been addressed through IA?
- What tools, mechanisms and strategies were used to facilitate IA?
- What role(s) did the health sector and other sectors play in initiating and sustaining IA?
- What has been learned?

This paper, the first phase of a Canadian initiative on intersectoral action for health, is intended to contribute to the World Health Organisation's Commission on Social Determinants of Health (SDH). It is the result of collaboration between the Health Systems Knowledge Network of the Commission on SDH and the Public Health Agency of Canada. Information gleaned from this paper will shape questions to be explored in subsequent case studies and analyses and a report of country and regional experiences in IA. It is also expected to inform the final report of the Health System Knowledge Network (HSKN) of the WHO Commission on Social Determinants of Health.

The paper is organised as follows:

- Section One: Introduction;
- Section Two: Defining the Terms and Describing the Methodology;
- Section Three: Intersectoral Action for Health: A Broad Spectrum of Approaches;
- Section Four: Intersectoral Action: Navigating Barriers and Enablers;
- Section Five: Approaches to Facilitate Joint Action;
- Section Six: Roles and Responsibilities;
- Section Seven: Issues Arising from Intersectoral Action; and
- Section Eight: Spotlight on the Future.

2 Defining Key Terms and Describing the Methodology

Definitions

The following definitions are derived from the work of the WHO Commission on Social Determinants of Health.

Intersectoral action for health

Drawing from the work of the 1997 Conference, this paper adopts the following definition of Intersectoral Action for Health:

> A recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone. (WHO Health 1997, p. 3)

For the purposes of this synthesis, the following sectors are considered to fall within the broad public sector (or government) category: health, environment, education, finance/ treasuries, defence, and natural resources. The non-government sector includes actors from the private sector, including professional and media organisations.

Social determinants of health

Social determinants of health (SDH) are understood as "the social conditions in which people live and work" (WHO Commission on SDH 2005a, p. 4), which may have an impact on population or individual health. Frequently-cited social determinants of health include education, socio-economic status, early childhood development, physical and social environments, gender, and culture.

Health equity

Health equity is defined as "the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically." (WHO Commission on SDH 2005a, p. 5)

While all three of these terms are considered central to the discussion of IA within the context of the WHO Commission on Social Determinants of Health, this synthesis focuses primarily on IA. It should be noted, however, that while many of the experiences dealt with in this synthesis are not explicitly directed toward addressing SDH or health equity, they could potentially be applied to the advancement of health equity goals.

For working definitions of other related terms used throughout the paper, see Appendix A – Glossary of Terms.

Methodology

This paper examines experiences documented by academics, policy-makers and practitioners in more than 15 countries. Sources, which date from the mid-1990's to the present, include more than 100 articles, government and non-government

publications, presentations, and commissioned papers, as well as work under way for the WHO Commission on Social Determinants of Health. Primarily, experiences have been drawn from high-income countries. Materials relating to European and Canadian initiatives predominate, although the paper also addresses significant IA initiatives in Australia, New Zealand, Sri Lanka and Brazil.

The search for materials was a collaborative effort among EQUINET, the Health Systems Knowledge Network (HSKN) hub, and the Public Health Agency of Canada. Keywords included: "intersectoral action for health"; "health equity"; "health inequalities"; "health impact assessment"; "health action zones"; "social security"; "social development"; "social exclusion"; "strengthening/implementing initiatives, actions and mechanisms: government"; and, "public sector". EQUINET searched all internet-accessible databases, all United Nations sites, a range of research institution and civil society sites commonly tapped by EQUINET, and Google. The HSKN hub selectively accessed additional materials through WHO Commission on SDH contacts and manually checked reference lists of important documents. All three collaborating organisations provided additional documents. Source types included articles, reports of government and non-government organisations, consultants and donor organisations.

While the scope of this paper was fairly extensive, there were three main limitations:

1. The keywords used in selecting sources may have limited the scope of the paper to experiences with a clear health sector lead or partner role. This paper did not systematically explore broader public policy literature sources on intersectoral and inter-jurisdictional collaboration. Because of this limitation, documented experiences in intersectoral action for broader social policy objectives—an area where health is an important indicator of progress—may have been missed.
2. As a paper-based review, the scope of the synthesis is limited to documented, readily-available experiences. In most countries, the confidential nature of formal decision documents, such as Cabinet and Treasury documents, restricts access to information providing details on issue framing, intersectoral collaboration mechanisms and accountability arrangements.
3. Information on process and outcome evaluation related to intersectoral efforts is relatively limited. The questions explored in this paper can be answered, in part, by documented experiences. Phase two of the project, which will involve context-specific case studies, is expected to supply additional answers to these questions.

3 Intersectoral Action for Health: A Broad Spectrum of Approaches

The concept of intersectoral action was introduced at the International Conference on Primary Health Care in Alma-Ata, Kazakhstan in 1978. The primary health care model explicitly stated the need for "a comprehensive health strategy that not only provided health services but also addressed the underlying social economic and political causes of poor health" (WHO 2005b, p. 11). In the 1980's, conferences related to IA and the Ottawa Charter further underscored the need to work between sectors to realise health gains. WHO notes, "A formal commitment to IA became part of many countries' official health policy frameworks in the 1980s. However, the track record of actual results from national implementation of IA was feeble... . IA to address social and environmental health determinants generally proved, in practice, to be the weakest component of the strategies associated with Health for All" (WHO 2005b, p. 15). In the 1990s, with the growth of knowledge on determinants of health, efforts to work across sectors also expanded. In 1997, the WHO hosted a special conference on IA (noted in the introductory comments of this paper). In 2000, the Bangkok Charter for Health Promotion confirmed the need to work across sectoral boundaries. Specific policies to address health disparities were subsequently developed in a number of OECD countries. The United Kingdom and Swedish policies are often cited.

In 2006, the European Union introduced *Health in All Policies,* a broad-reaching directive with implications for intersectoral policy development, implementation and evaluation (Evans & Vega 2006, slide 6). A "Health in all Policies" conference was held by the European Union in September 2006, for which the Finnish Ministry of Social Affairs and Health produced a book entitled *Health in all Policies – Prospects and Potentials.* The book describes Sectoral experiences in health in all policies on, for example, heart health or health at the workplace. One part is also dedicated to opportunities and challenges of health governance, another on health impact assessment. The conclusions recognize that even if in many policies, the combined strategy of other policies with health will be a "mutual gain", in some cases the values and objectives of the various policy intentions can be incompatible. In such cases, it is suggested that aims and objectives need to be negotiated and compromises sought (Ståhl, T. *et al.* 2006).

Key developments related to intersectoral action for health

- 1970s: Alma Ata, Primary Health Care
- 1980s: IA Conferences, Ottawa Charter for Health Promotion
- 1990s: WHO Intersectoral Action for Health for the 21st Century (Halifax Conference)
- 2000s: Bangkok Charter for Health Promotion, Health disparity policies in OECD countries; Health in All Policies – EU (2006)

(Evans & Vega 2006)

This paper examines recent efforts,—*i.e.,* those undertaken within the past decade—to identify variables and patterns in order to gain a better understanding of IA developments in different socio-political contexts. Specifically, it addresses the following questions:

- What types of problems has intersectoral action been used to address?
- What are some of the different intersectoral action approaches that have been used?
- How have these different forms of collaboration been categorized?
- How can intersectoral action be strengthened?

The following sections identify a range of public policy challenges, along with specific intersectoral approaches to addressing them.

Intersectoral action at different levels of decision-making

Intersectoral approaches for health have been employed at many different levels of governance or jurisdiction: for example, through internationally-promoted programmes initiated by the World Health Organisation or other United Nations agencies, regional and national policy frameworks, sub-national initiatives, and community-based and settings-based policy development and implementation.

At the *global level,* examples of intersectoral action for health include:

- the 2002 World Summit on Sustainable Development, which brought together a wide range of actors, including health sector representatives;
- the Healthy Environments for Children Alliance, which was established as an implementation platform to facilitate intersectoral work on issues related to children's health and the environment (van Schirnding 2005);
- the Health for All movement; and
- the United Nations Environment Program (UNEP)'s Sustainable Cities Movement. (Huchzermayer, Burton & Harpham 2001).

At the *global/regional* level, the European Union has used the implementation of health impact assessment (HIA) as a tool to identify linkages between health and other sectoral policies. Discussion relates to the use of health impact assessment as well as legislative bases for undertaking HIAs on policies deemed to influence health. The WHO Regional Centre for Environmental Health Activities, which promotes environmental health through technical support in 23 member countries, is an example of how such collaboration has been institutionalized. This collaboration stemmed from the need for sustainable development and

natural resource management issues to address the complexity of environmental and health considerations at play alongside development issues (Lock & McKee 2005, pp. 356-60).

At the *national level,* intersectoral approaches have been used to address complex, multifaceted issues by combining the efforts of the relevant government departments and agencies into a single coordinated strategy:

- In the United Kingdom and Sweden, broad policy frameworks or whole-of-government approaches address inequalities or inequities through intersectoral action and related strategies.
- In Canada and Australia, intersectoral action experiences depicted in the literature reviewed focus on specific populations, such as children, or on settings (low-income communities, schools and workplaces).

At the *sub-national level,* intersectoral action has been used to address a range of policy challenges related to health equity:

- Quebec's 2001 *Public Health Act* "acknowledges that various laws and regulations of other government agencies can affect population health and well-being. Thus, it empowers the Ministry of Health and Social Services to undertake intersectoral action to support public policy development favourable to health" (Bernier 2006, p. 26). Two strategies support its implementation: the creation of an intra-governmental health impact assessment process, and contributions to the development of research. The research dimension includes "financial support to design new tools for assessing effects of public policy on health. A knowledge transfer program includes reviews and briefs to inform government ministries about the possible health impacts of laws and regulations being developed" (Bernier 2006, p. 32).

At the *community level,* networks often bring together a wide range of actors, such as clinicians, researchers, sectoral policy makers (*e.g.,* health, education, social services, and environment), as well as civil society and private sector actors. These networks provide a vehicle for discrete groups, such as health professionals, community health organisations or community-based services, to work together in addressing areas of mutual interest. Examples include:

- Australia's Here for Life Networking Project (Queensland), and the High Street Community Linkage (Sydney) and Connexions (Melbourne) projects.
- The New Zealand Ministry of Health's identification of three types of action (New Zealand Ministry of Health 2001) in community-based intersectoral action for health:
  - overarching area, or settings-based initiatives: Health Action Zones, Healthy Cities, and Healthy Schools;
  - issue-based initiatives: community-based programs related to alcohol, injury prevention, nutrition, health and housing; and
  - case-management services: strengthening families, collaborative case management, social workers in schools, family service centres, and comprehensive services for children experiencing emotional, mental, and behavioural disturbances, and/or for children with multiple difficulties and needs.

Working between levels

Horizontal collaboration occurs across sectors (or across sub-sectors within a single sector). Generally, this type of collaboration involves individuals or groups from the same level of decision-making or jurisdiction, working toward a defined set of goals.

Vertical collaboration is working across jurisdictional boundaries to address policy challenges that require decisions by more than one level of government. It can refer to global institutions working with regions and national governments, or national governments working with state, provincial or municipal governments to address complex policy challenges. Vertical collaboration "brings together partners with unique characteristics and requirements related to their public sector role...it must respect the jurisdictional mandates and responsibilities of partners at different levels of government, while building on common values, interests and purposes" [Canadian] Federal/Provincial/Territorial Advisory Committee [F/P/T] on AIDS 1999, p. 4). It is often complemented by horizontal engagement of other parties, such as non-government organisations and private donors in low- and middle-income nations.

Observations on working across organisational boundaries in HIV/AIDS note that intersectoral action is strongest, and outcomes are best, when the collaboration is both vertical and horizontal:

> IA is most successful when it includes vertical as well as horizontal collaboration. Combining both dimensions maximizes the likelihood of reinforcing and synergizing effects ([Canadian] Federal/Provincial/Territorial Advisory Committee on AIDS 1999, p. 4).

Weaving these elements together yields a resilient and durable end product, and provides a shield against inaction, flagging interest, or disintegration. At the same time, because of the wide range of interests involved, additional effort and negotiation may be required to reach a shared understanding of goals, approaches, respective roles, and accountability for outcomes.

Problems addressed through IA: Framing public policy issues

Intersectoral action is a strategy used to deal with complex policy problems that cannot be solved by a single country, region, government, department, or sector. Intersectoral action has been brought to bear on specific determinants of health, diseases, populations (e.g. indigenous peoples, children), geographic communities, health behaviours, and risk factors.

The literature reviewed also indicates that intersectoral action has been used to bolster community development, crime prevention, disease prevention, economic development, sustainable development, education and employment, health promotion, health protection, primary care, public health, public security, and social cohesion.

Each of these policy "entry points" brings with it a particular conceptual base; related assumptions, vocabulary, and measurement approaches; a set of institutional actors; and, commonly used policy instruments. The way in which an issue is framed often determines which government agency or agencies and other organisations will lead efforts to address the policy challenge. The impact of issue-framing is discussed further in Section 5: Approaches to facilitate joint action.

4 Intersectoral Action: Navigating Barriers and Enablers

Drivers of intersectoral action

The need to act is a core driver for IA efforts. Additional drivers for intersectoral action have included:

- lobbying and political pressure from the public, opposition parties, non-government organisations, the media, or coalitions of interested groups to address a significant policy challenge;
- favourable economic conditions supporting intersectoral action to address complex policy challenges. Since IA often costs more in the short-term than simpler, "quick-fix" responses, strong economies may offer the resources for sustained investment in intersectoral work. In periods of fiscal constraint, innovative approaches to cross-sectoral actions may be undertaken as a means of addressing overlapping and intersecting organisational mandates;
- the existence of a "feedback" loop between citizens and government, to drive, define and respond to the issues. Timely information-sharing between citizens and government is required;
- strong central agencies that oversee and guide approaches to ensure that organisational mandates, authorities and reporting are respected. While central agencies do not necessarily lead these approaches, they often play a strong support role in ensuring adequate resources for initiatives; guiding policies through formal decision-making avenues; and, designing and monitoring compliance with accountability frameworks; and
- negative data from reports of commissions and/or task forces, studies, statistics, poll results. Bad news sometimes attracts more public and political attention than success stories. Comparing nations' health status and conditions for health can spark interest in intersectoral efforts to address shared problems and promote equitable conditions for health and social development.

The documented experiences clearly demonstrate that context and culture are critical to the success of intersectoral initiatives. Conditions or approaches that obtain results in one sector, or one environment, may not necessarily prevail in another. The literature suggests that while there is no universally "correct" way to proceed with IA efforts, adhering to certain principles promotes IA success.

Presentation materials related to health promotion in schools (Rowling & Jeffreys 2005) illustrate this point. Challenges in achieving collaboration between the health and education sectors included: "vertical funding; professional diversity of paradigms and views; competing priorities

and decision-making processes; and complex processes of engagement." While health research relied on the assumption that health promotion strategies have the potential to work equally well in all schools, educational research captured the critical point that schools have vastly different cultures [e.g. compare rural with inner-city schools]—cultures which depend on a variety of shifting factors. Effective collaboration between the sectors could only be achieved if the partners are able to see "mutually beneficial outcomes, feasible implementation strategies and compatible monitoring and evaluation methods."

In conflict-driven and politically fragile states, intersectoral actions have proved vital in restoring security and promoting health equity. The breakdown of government has, in some circumstances, yielded an opportunity to establish IA as an accepted way of working—an outcome that is not always possible in more established environments (WHO: Health Systems Knowledge Network 2006).

The literature demonstrates that good intentions do not always translate into successful intersectoral initiatives. Australia's National Youth Suicide Prevention Strategy fell short of stated objectives due to a host of unintended factors: lack of consultation with states and territories; insufficient networking; inexperienced project staff; and, inadequate government planning processes. Australia's experiences with the Strategy teach a valuable lesson on the importance of advance planning to avoid pitfalls and mitigate risks.

Conditions for success

Many sources provide advice on conditions for IA success at local, national, and regional levels, and across jurisdictions (F/P/T Advisory Committee on HIV/AIDS 1999; WHO 1997; Swedish International Development Co-operation Agency, 1999, Rychetnik & Wise 2004, Canadian Public Health Association 1997). "Working together: intersectoral action for health" (Harris *et al.* 1995) provides a comprehensive list of these enabling factors, or conditions of success.

Other readings and checklists offer additional variations and considerations (Rachlis 1999; FPT 1999; Bauld 2005 and Goumans 1997). Many lists of "enablers" include some of the elements listed below:

1. ***Create a philosophical framework and approach to health that is conducive to IA.*** For example, favouring health determinants over a disease-driven approach automatically builds connections with other sectors and allows them to see a role for themselves in addressing the problem.

Conditions for effective intersectoral action

- The parties have identified a ***need*** to work together in order to achieve their goals. This requires clarity on individual organisational goals, as well as joint goals.
- In the broader operating environment, there are ***opportunities*** that promote intersectoral collaboration, e.g., the community understands and is supportive.
- Organisations have the ***capacity***—the required resources, skills, and knowledge—to take action.
- The parties have developed a ***relationship*** on which to base cooperative, planned action. The relationship is clearly defined and is based on trust and respect.
- The ***planned action*** is well-conceived and can be implemented and evaluated. The action is clear and there is agreement to undertake it. Roles and responsibilities are clear.
- There are plans to ***monitor*** and ***sustain outcomes.***

(Adapted from: Harris *et al.* 1995)

2. ***Emphasize shared values, interests, and objectives among partners and potential partners.*** Many writers have emphasized the importance of seeking trust and shared values: individuals engaged in IA must be like-minded. Personal values, for individuals, are more significant indicators than association with organisational values. Societal values that align with the objectives of IA can also be influential.
3. ***Ensure political support; build on positive factors in the policy environment.*** Often, politicians lead or champion progressive IA initiatives, both within and beyond the health sector. Strong connections with political leaders, administrators and the media are key to securing their support.

   A clear mandate and a supportive policy environment are equally desirable in fostering a sense of solidarity, facilitating collective action, acknowledging the requirement for long-term investment in IA, and boosting a favourable economic climate. Alternatively, the intersectoral initiatives themselves may identify the creation of a more supportive policy environment for the future as a specific goal. A proactive stance is encouraged. This means, for example, assisting senior decision-makers and policy-makers in all sectors to understand the benefits of IA, and encouraging them to foster intersectoral action in research, policy and practice.
4. ***Engage key partners at the very beginning: be inclusive.*** Strong, dedicated partners are critical to the success of intersectoral action. Involving the right people and institutions, and reaching beyond government to involve civil society and the voluntary sector, are vital steps.
5. ***Ensure appropriate horizontal linking across sectors, as well as vertical linking of levels within sectors.*** When links are drawn across sectors and between levels of government, the resulting "fabric" is stronger. However, it is essential to recognize the potential for failure due to inadequate communication or consultation, lack of policy coherence, lack of clarity on respective roles, and/or lack of sensitivity to power imbalances.
6. ***Invest in the alliance-building process by working toward consensus at the planning stage.*** Ensuring that the action is well-planned, or that there is a good relationship between the parties, does not guarantee success. Efforts can be strengthened by engaging all players at the outset, confronting differences, and inviting collaboration in the planning process.
7. ***Focus on concrete objectives and visible results.*** The act of establishing health goals, on its own, has done little to promote intersectoral action. Some Canadian provinces have chosen to set overarching, whole-of-government goals, but it is too early to determine whether this approach has been effective. It is also difficult to monitor achievement toward such goals.

   While short-term gains may be highly motivating, they can also be counter-productive, as in the case of the United Kingdom's Health Action Zones.
8. ***Ensure leadership, accountability and rewards are shared among partners.*** Increasingly, people and organisations in the health sector play different roles in IA. Partners must learn to be effective, whether they are acting as catalysts, leaders, partners or supporters. All partners in intersectoral work must be able to perceive that the process is mutually beneficial and that responsibilities and rewards are distributed appropriately.
9. ***Build stable teams of people who work well together, with appropriate support systems.*** Goumans (1997) draws a distinction between "core group" and "peripheral group" participants. Core group participants are committed ideologically to the concept of IA, while peripheral group participants are

involved because the activity relates to their particular interests. This observation highlights the important role that individual participants play in effective intersectoral action. Adequate capacity and resources, shared goals, mutual respect, and trust make it easier for individuals to make long-term commitments to working across sectors.

10. ***Develop practical models, tools and mechanisms to support the implementation of intersectoral action.*** A lack of appropriate support mechanisms can serve as a barrier to intersectoral action. Collaborative planning models, evaluation frameworks that assess multiple indicators, shared accountability models and innovative governance structures are examples of tangible support.

11. ***Ensure public participation; educate the public and raise awareness about health determinants and intersectoral action.*** The existence of a clear channel of communication between citizens and government is needed – to give and receive feedback; to properly evaluate the success of intersectoral action; and to take corrective measures, as necessary.

Whole-of-government approaches create additional imperatives for successful intersectoral action. Once there has been a decision that it is necessary to work together, care must be taken in determining how to do so. Suggested actions to create conditions for success include (National Audit Office 2001, Exworthy, Berney & Powell 2002, Bauld 2005):

- reinforcing the policy direction with a statutory duty to collaborate, where appropriate;
- ensuring that partner organisations align their vision and policy objectives, and that central agencies (while providing appropriate guidance) avoid undue interference in partnerships;
- providing incentives for joint working (*e.g.,* financial incentives, flexible decision-making, or appropriate performance assessment). Reducing the variety of funding streams, using pooled budgets, and reducing administrative and reporting burdens are also effective incentives;
- setting realistic time frames to achieve results; and
- ensuring that there are clear lines of redress for citizens, as well as a clear accountability framework.

5 Approaches to Facilitate Joint Action

This review of experience in intersectoral approaches reveals a range of interrelated tools, mechanisms and strategies. This paper defines *tools* as catalysts that have facilitated IA; *mechanisms* as institutional structures and arrangements; and *processes* and *strategies* as a broader combination of planned actions or initiatives toward a specific goal(s).

Supports for intersectoral action

Information tools

Information—ranging from anecdotal evidence of the impact of social determinants of health on health inequities, to more formal information and knowledge-based tools—has served as a catalyst to involve multiple parties in developing healthy public policies, both within and beyond the health sector. The documents reviewed focused primarily on impact assessment tools, which were presented as a means of capturing information that may focus on or include a health dimension. Examples include Health Impact Assessments, Environmental Impact Assessments, Integrated Impact Assessments, and Geographic Information Systems. Each is briefly described below.

Health impact assessment (HIA) has been described as "a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population" (WHO European Centre for Health Policy 1999). It can be applied prospectively, concurrently or retrospectively. Lock and McKee note that in situations where there has been a decision, for political reasons, to proceed with a policy that has negative health impacts, IA contributed to awareness and made the decision-making process clearer (2005). Observed benefits of HIA include strengthening policy-makers' understanding of how health is affected by different policy areas, subsequent development of a shared policy agenda, and improvement in intersectoral relations (Lock & MacKee 2005). HIA has been used as a mechanism to involve multiple stakeholders from within and outside of government.

An equity-focused HIA "uses HIA methodology to determine the potential differential and distributional impacts of a policy, program or project on the health of the population, as well as specific group within that population, and assess whether the differential impacts are inequitable" (Harris-Roxas, Simpson & Harris 2004, p. 1). The Harris-Roxas, Simpson and Harris review analysed four models: the Merseyside Guidelines; the Bro Taf Health Inequalities Impact Assessment; the Equity Audit; and, the Equity Gauge. They note that there is a "lack of clearly and systematically consolidated guidance on how to assess both the health impacts and health equity impacts of a proposal" (2004, p. 43), and conclude,

> Many of those behind the increased international interest in HIA are also promoting a health equity agenda, and there is increasing interest in how the two may be

> combined. Despite suggestions that equity should be considered in every HIA there is little enabling guidance available. There is a need, particularly in contexts where an explicit commitment to reducing health inequalities does not exist, for clearly structured, practical guidance on how to incorporate equity in HIA (2004, p. ix).

Other forms of impact assessment include environmental impact assessments (EIA), which include a human health dimension, and integrated impact assessments (IIA). IIAs attempt to capture a range of complex factors and these factors' relationship with the policy intervention under consideration. IIAs bring together knowledge and perspectives from a range of social and economic areas to assess the multiple impacts of proposals or policy decisions. The UK's Health Development Agency notes that since IIA "deals specifically with education, housing, transport and other determinants, it can be useful to think of IIA as a health determinants impact appraisal tool" (NHS Health Development Agency 2004, p. 4).

Geographic information systems (GIS) are used increasingly by a wide range of sectors to map variables such as demographic information, employment, income, health and disease patterns. The visual nature of GIS maps assists in identifying the distribution and degree of concentration of multiple variables. GIS is recognized as a valuable tool to facilitate dialogue between sectors on shared areas of concern and to initiate collaboration, with resulting impacts on health, education, housing and other indicators of social or economic development.

Other examples of types of information that have facilitated intersectoral action include natural disaster profiles in both developed and developing nations; surveillance information on hazards to human health; evaluation results; and, shared platforms for electronic networks.

There appears to be agreement that the health sector requires a broad spectrum of information tools to translate information and knowledge into evidence that will permit linkages to be drawn between sectoral policies, and health. In reviewing rural services innovations related to Health Action Zones in the UK, Asthana and Halliday noted the need to distinguish between information for professionals [within and outside the health sector] and information for users (2004, pp. 462-463). Beyond specific users, other audiences include the public, media, decision-makers, and other non-government organisations. The information tools highlighted in these examples help to explain the relationship between a proposed or implemented policy and human health, health equity, and the equitable distribution of determinants of health.

Institutional arrangements

The creation of new organisational entities or institutional arrangements to support intersectoral action has been documented at many decision-making levels. At the global level, the 2002 UN Summit on Sustainable Development is an example of an event that brought together institutional actors from the environmental, energy, health, and industrial sectors to address the complex, long-term policy challenges of sustainable development (von Schirnding 2005).

At the regional level, EuroHealthNet is a not-for-profit organisation with the goal of contributing to a healthier Europe through promoting greater health equity between and within European countries and facilitating networking and cooperation among relevant and accountable national, regional, and local agencies in European Union (EU) Member States, Accession and EEA countries (Welsh Assembly Government 2003). While its members are health and social services agencies of national governments, active partnerships with other sectors are critical to advancing its priorities.

At the national level, the UK's Social Exclusion Unit promotes multi-agency approaches for Health Action Zones, Education Action Zones, and Young Offender teams. In Canada, there are a number of existing cross-sectoral, interjurisdictional policy-making *fora,* including the Federal Provincial Territorial (FPT) Ministers of Health and the Environment, and FPT Ministers Responsible for Sport, Recreation and Physical Activity. These *fora* are used to discuss and reach decisions on policy issues of interest to participating sectors. Brazil recently established the Comissao Nacional sobre Determinantes Sicuaks da Saude (National Commission on the Social Determinants of Health), which is mandated to create equal and fair health opportunities for all (WHO Commission on Social Determinants of Health 2006a).

Focus: SRI LANKA

A national framework for health

Sri Lanka has proven to be fertile territory for intersectoral action for health. In 1980, the Charter for Health Development was signed by the Prime Minister and the World Health Organisation. The Government of Sri Lanka committed to attaining acceptable levels of health for all its citizens by 2000, and embraced primary health care as the key approach. The National Health Development Network, driven by the National Health Council (NHC) (chaired by the Prime Minister), was established to ensure political commitment to intersectoral action for health.

The NHC sets government policies regarding health care and mobilization of non-health sectors; coordinates multisectoral action; and, encourages participation in health care. Ministers of Health; Agriculture Development and Research; Higher Education; Finance and Planning; Local Government, Housing and Construction; Home Affairs; Labour; and Rural Development serve on the Council.

The role of decentralization in IA

Decentralization provided a strong impetus for IA. District Health Councils were established in 1981 to promote multisectoral action and intersectoral coordination in 24 administrative districts in Sri Lanka. Four key interventions had an impact on equity during these years: investment in human development, through access to education, health services and food supplements; development of health infrastructure; access to essential medicines; and, continued provision of medical supplies and food during periods of armed conflict (Perera 2006, p. 40).

Provincial Health Councils were established by constitutional amendment in 1987, and health administration was totally devolved. The line Ministry is responsible for policy formulation, hospital management, specialized campaigns, technical training institutions, and bulk purchases of medical supplies. The latest effort to decentralize occurred in 1992, when Divisional Directorates of Health Services were created.

Key developments related to health and equity have included the first poverty elimination program (1989); social marketing for leprosy elimination (1990); the establishment of Divisional Directorates for Health (1992); a population and reproductive health policy (1998); an intersectoral implementation approach for policy for the aged. A National Commission on Macroeconomics and Health (2002) was struck to reinforce national-level commitments to sustainable investment in health, particularly for the poor.

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A master plan for health and development

In 2002, a ten-year master plan for health development was initiated. Five strategic objectives were established: to ensure delivery of comprehensive health services to reduce disease burden and promotion; to empower communities toward more active participation in maintaining their health; to strengthen stewardship and management functions of the health system; to improve human resources for health development and management; and, to improve health financing, resource allocation and utilization.

Although the plan lacks a specific strategic objective on intersectoral action, it is expected that IA will be explored under the second and third objectives. Plans include enhancing the participation of civil society and non-governmental organisations in promoting behavioural and lifestyle changes. To strengthen health stewardship, enhanced coordination and partnerships with other sectors is envisioned. The Health Sector Development Project, established in 2004, aims to strengthen the health sector's capacity to fulfil this stewardship role.

Improvements due to factors within and beyond the health sector

Sri Lanka's significant improvements in health indicators have stemmed from performance within the health sector itself, as well as major socio-economic developments in education, agriculture and other sectors. Education is now universally accessible and heavily promoted, and there are strong links with the health sector. Government (both national and local), the community, and non-governmental organisations play consistently strong roles in promoting intersectoral action for health and equity.

Strong political leadership and positive intersectoral synergies between health and other sectors appear to be key features of IA action in Sri Lanka. Free education since 1945, leading to high levels of female literacy, have promoted attitudinal changes and created a knowledge base that has weathered periods of economic decline. Nutritional status of poor families, mortality rates, and a host of social services (including water and sanitation systems) have improved dramatically, in tandem with the health system.

There are multiple challenges associated with further improvements to health equity and intersectoral action. Conflict in the North East (the 20 Year War) led to a deterioration of health status, infrastructure and human resources in the region. As a nation, the epidemiological transition to non-communicable diseases has taken place, with associated challenges for the quality of health services. While Sri Lanka is currently a low HIV-prevalence country, many of the risk factors are present. Intersectoral responses are included in a draft HIV/AIDS policy.

(For further detail, refer to Perera 2006, *Intersectoral action for health in Sri Lanka,* Institute for Health Policy, Sri Lanka).

Documents reviewed for this paper highlight a breadth of *new* institutional mechanisms. Although evaluation results demonstrating the impact of these relatively new institutions were not available, two observations are of note:

1. The organisational titles of these institutions are not necessarily specific to health. While the health sector is an active participant, it is not necessarily the lead.
2. Few of the sources reviewed referred to *existing* intersectoral decision-making *fora* at either the political or bureaucratic level. While the new mechanisms appear to have been designed to fill gaps that were not addressed by existing decision-making *fora,* the interaction between the new and existing machinery needs to be taken into account. The literature reviewed did not examine or provide insights into these dynamics.

Financial mechanisms

The lack of financial mechanisms to support intersectoral action has been identified as a common barrier to IA. However, examples drawn from source documents highlight financial tools and mechanisms that may hold promise:

- *Financial allocations* exclusively for intersectoral action, with clear criteria on what does or does not constitute IA, can be combined with *regulations* that provide legal instruments to enforce intersectoral action in certain situations (WHO 2004, p. 19).
- Intersectoral action as a *condition of funding* is used by international financing institutions to require sectors to work collaboratively in addressing difficult issues (WHO 2004, p. 19). This incentives-based approach provides parameters that support cross-boundary work. The Government of Canada uses this approach for its Population Health Fund, which provides grants and contributions to academic, community, and voluntary sector organisations to advance policy and program objectives related to children, seniors and other population groups and issues. Alternatively, a penalty-based approach has been used in some countries, with government sanctions for lack of transparency and bias against intersectoral collaboration (WHO 2004, pp. 19-20).
- *Cost-sharing or resource pooling* involves financial contributions by a range of government and non-government organisations for a specific population or issue that aligns with the organisations' mandates.
- *In-kind resources* have been used by sectors that are constrained by the limitations of funding agreements to contribute non-financial resources (*e.g.,* people, information, expertise, physical space and technology) to support shared objectives. The accountability requirements associated with in-kind resources are often less stringent than those for investments of financial resources. In-kind arrangements between organisations can offer greater flexibility to adapt to the changing needs of intersectoral work in the different stages of policy development, implementation, and evaluation.

The documentation did not elaborate on the details of these fiscal tools and mechanisms in the context of health information or institutional arrangements. However, financial incentives and disincentives are considered to have a strong influence on the behaviours of organisations and individuals in intersectoral action.

Legislation and regulations

Legislation and regulations, combined with other tools and mechanisms, may have implications for intersectoral action. The World Health Organisation's International Health Regulations influence the health policies of all nations, with implications beyond the health sector (*e.g.,* on the travel, food, and tourism sectors). However, the regulations do not necessarily require intersectoral collaboration.

Legislation has been used to formalise the establishment of intersectoral institutional arrangements. This has occurred, for instance, in the European Union (EU), with the establishment of the EU Health Commission and regulations governing the application of HIA to policy proposals initiated within and outside the health sector (Lock & McKee 2005, p. 357). Lock and McKee note, however, that despite the legal basis for HIA in the EU, capacity concerns often limit effective implementation.

Accountability frameworks

Accountability requirements for public and private sector organisations vary considerably. In many nations, there is a growing expectation that organisations will demonstrate value for money and attribute outcomes to policy interventions. Accounting for joint initiatives that involve more than one government may lead to tension between compliance accounting (with established rules and principles) and results-based accounting. Fox and Lenihan

note that "today, citizens care at least as much about the 'what' as the 'how'...they care about the outcomes of results achieved" (2006, p. 3):

> Most joint initiatives do not seem to involve the kind of shared decision-making sketched in the community development example. On the contrary, much of the real work still happens in silos ... most of the real collaboration happens in the early stages when the partners are still trying to decide what they want to do together. While it may not be possible to give a full accounting of how those decisions were made, we probably don't need one ... if there is a loss of transparency, it is likely marginal and we are quite willing to live with it to get a partnerships that leads to measurably better results (Fox & Lenihan 2006, p. 7).

Challenges related to accountability are particularly evident in initiatives where there is both horizontal and vertical collaboration. In Canada, the Vancouver Agreement is an example of a socio-economic initiative that brings together three levels of government, multiple departments, and community and private sector organisations to revitalise Vancouver's downtown east side. Within this complex web of organisations, mandates and efforts, joint evaluation frameworks have been negotiated to assess both process and outcomes.

Planning and priority-setting

The literature provides little information on the use of ongoing planning and priority-setting processes. The documentation tends to focus on *innovative* rather than *existing* mechanisms, perhaps assuming that health and health equity themes are accepted components of regular government-wide planning and priority-setting cycles. The materials reviewed pay little attention to the degree to which, and how, IA is institutionalised within regular planning and priority-setting mechanisms or machinery of government.

Most socio-political contexts require major policy directions and related funding allocations to be determined through established decision-making processes. Treasuries play a leading or significant role in government-wide budget planning and priority-setting. The nature of their role, relative to health and other government sectors, is explored further in Section 6: Roles and Responsibilities.

Intersectoral action approaches

In addition to a range of tools and mechanisms to support intersectoral action, this review of experiences also revealed a range of IA approaches to address health and equity challenges – including place-based, staged and targeted approaches, as well as broad policy frameworks.

Place-based or settings approaches

Healthy Communities/Healthy Cities is a World Health Organisation initiative that focuses on implementation at the local level. This broad concept uses "settings" as structures that provide methods of reaching defined populations. Since its inception, Healthy Cities has included cities, municipalities, villages, islands, communities, schools, and places of work (Werna *et al.* 1998, p. 74 in Huchzemeyer *et al.* 2001, p. 12).

The UK's Health Action Zones (HAZ) initiative built upon the Healthy Cities Movement model, and provides an example of locally-managed approaches to improving health equity. Under the Labour government, national redistributive efforts were complemented by local action in disadvantaged areas that had been identified as communities in critical need. Zones were considered a key means

of "tackl[ing] root causes of ill health – poverty, unemployment, homelessness and family breakdown. They followed government initiatives in other social areas – education action zones, employment action zones and young offender teams ... [and] Ministers hope [they] will lead to closer cooperation at the local level to tackle social deprivation (Dean 1998, p. 1111). Initiatives involving income, employment, education, early childhood development and [community] regeneration were combined, and partnerships among government, the private sector, and communities were established (WHO Commission on Social Determinants of Health 2006c).

Dahlgren and Whitehead comment that the settings approach "has been used to tackle health hazards at work and focuses on major determinants of health in a certain workplace, rather than on a single risk factor." However, they caution that "the equity in health dimension of these programmes – Healthy Workplaces, Healthy Schools and Healthy Hospitals – has sometimes been weak". They also note "the need within this approach to identify the determinants of social inequities in health ... special efforts should be made to initiate setting based initiatives in disadvantaged communities" (2006, p. 101).

The scale of place-based approaches may vary significantly, and a range of sectors and jurisdictions may be involved. However, the setting provides a shared platform for action. Place-based IA has the advantage of tangibility and visibility: it is conducive to site visits for decision-makers, the media, and stakeholders to examine the public policy problem and related interventions.

Staged approaches

Other global, national and local examples use staged approaches through joint planning and policy workups to develop options, recommendations and action plans. At the global level, in deliberations related to Water, Sanitation, and Health Protection of the Human Environment, there are participants from the health, agriculture, environmental, natural resources and economic sectors, including multilateral government and non-government organisations. Through the Development Policy Forum, senior-level officials hold informal dialogues on cross-cutting public policy issues related to water, sanitation and health protection. Established in 2001, the initiative brought together sectors with shared interests and impacts, and reported to the World Water Forum in Mexico in 2006.

Bos (2006) noted two essential elements in this approach:

- undertaking a *joint review of all sectoral policies* to foster harmonisation and incorporate health issues into sectoral policy development, where useful; and
- establishing institutional arrangements within a strengthened policy framework to identify the potential of existing arrangements; establishing specific institutional arrangements on health issues in development; identifying partners and the content of collaboration; and, putting the mechanisms in place with resources. Experience has shown that without adequate resources, intersectoral actions seldom have lasting impact. Finally, Bos recommends developing clear Memoranda of Understanding to formalise more permanent arrangements, provide clearer links to intersectoral bodies, establish clear mandates, and provide adequate resources.

Three process steps were noted: situation analysis of institutional arrangements; identification of obstacles to intersectoral collaboration; and, the development of ideas to bridge intersectoral gaps (WHO 2004, p. 18).

Focus: NORWAY

In 2005, the Norwegian Directorate for Health and Social Affairs initiated a staged approach to reduce social inequalities in health.

Phase One

Phase One involved increasing knowledge on social inequalities in health by strengthening expertise, research, and documentation. Impact assessment was used as a tool to measure the impact of policies, programs and projects on social inequalities in health. The organisation ensured that the Directorate's own policies took social inequalities into account, and prepared a professional basis for a national strategy involving all sectors.

Phase Two

In Spring 2007, the Norwegian government submitted a report to the Stortling [the National Budget] presenting its strategy to reduce social inequalities in health.

The Norwegian government has given priority to strengthening the responsibilities and role of the public sector within key welfare areas such as health, care services and education. The strategy to reduce social inequalities in health establishes guidelines for the government and central administration's focus on and promotion of social equalisation of the most important determinants of health over 10 years (2007-2017).

(For further detail, refer to Directorate for Health and Social Affairs 2005 and The Ministry of Health and Care Services 2006).

These staged approaches appear to be employed where the need for sectors to act in concert to improve health and health equity is recognized, and where there is a strong push for evidence to support choices about where and when to act collaboratively. Risks associated with this approach include potential loss of support between developing the evidence base, options development, and making decisions. Advantages associated with this approach include developing stronger evidence across a broad spectrum of determinants of health and equity, reaching better-informed decisions, and making more effective, efficient use of resources.

Targeted approaches

Given resource constraints and the desire for timely and visible results, decision-makers may choose to focus or *target* efforts on a specific population or issue. The literature reviewed includes two main types of targeted approaches: population or group-based; and, disease or risk factor approaches.

Population-based

In Chile, the Ministry of Planning and Coordination established the Solidarity and Social Investment Fund, Programa Puente (Bridge Program), which targets families in extreme poverty. The program involves all policy-making sectors that influence health, and uses selective interventions to tackle inequities. Counsellors work with families to link and facilitate access to services. Financial incentives are in place for employers who hire unemployed heads of households covered by the program. The number of families served by the program has increased substantially. Results on the health, social and economic impacts of the program were not available (WHO Commission on Social Determinants of Health 2006b).

The poor health status of indigenous peoples in many countries is well-recognised. New Zealand, Australia and Canada are among the nations that have used targeted intersectoral approaches to address the complex social and economic challenges of indigenous peoples. Aboriginal community, regional, national, and international organisations are exploring ways to reduce inequities. Government partners include education, health, social services, economic development, natural resources, environment, and population-specific departments, *e.g.,* Indian and Northern Affairs Canada.

Disease or risk factor-specific

Strategies focusing on a specific disease, risk factor, or groups of risk factors have been used by many countries. Dahlgren and Whitehead note that disease-specific approaches focus on the downstream factors in the causal chain, but they acknowledge that "sometimes, a coordinated systematic approach that focuses on a specific disease is effective in mobilizing public action" (2006, p. 101). Common risks associated with this approach include duplication of efforts and a narrow focus on downstream effects.

These targeted approaches may be useful in situations where there is a strong public and stakeholder perception of the need to address a specific population group, disease or risk factor, *e.g.,* Low-income families, Severe Acute Respiratory Syndrome (SARS), HIV/AIDS, and tobacco use.

Broad policy frameworks

Examples of broad policy frameworks with health implications are the UN's Agenda 21: A Plan to Achieve Sustainable Development and Europe's National Environment and Health Action Plan. The United Kingdom (UK) and Swedish cases are the more frequently-cited examples of broad policy frameworks with a central health equity focus. Highlights of these approaches are included in text boxes on this and the pages that follow.

New Zealand's approach to addressing health inequalities encompasses four levels of intervention (Crombie *et al.* pp. 22-23). Structural elements include education, social security, and labour market policies favouring those at the highest risk of unemployment. Health professionals advocate for other sectors to introduce policies that will improve health and reduce inequalities in health. Actions to address intermediary pathways include policies to improve living and working conditions and community and school-based programs, complemented by health and disability services to ensure equitable access and elimination of barriers. These actions are designed to minimise the impact of disability and illness on socio-economic position.

Focus: UNITED KINGDOM

In 1980, *The Black Report,* which identified health inequalities in the UK population, ignited debate on the extent of the inequalities and contributing determinants. The Wanless Report, a cross-cutting review of national policy and evaluation reports on inequalities that explored child poverty and transportation, also prompted action. However, despite acknowledgment of, and ongoing discussion about the situation, it was not until the Labour Party came to power in 1997 that the UK produced a dedicated national policy on addressing health inequities. Until 2005, it remained the only country to have taken such an approach.

Joined-up government adopts IA as a key strategy

The policy places the responsibility for dealing with health on government as a whole. Within that framework, IA is recognised as a key strategy for addressing health inequity. Further, the concept of "joined up government", defined as "the bringing together of a number of public, private and voluntary

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sector bodies to work across organisational boundaries towards a common goal" (National Audit Office 2001), emerged as a mechanism to facilitate the implementation of IA. The push toward IA was viewed as part of the process of modernizing government. The Cabinet Office and Treasury were made responsible for promotion and monitoring. Related national policies on children and neighbourhood renewal were introduced during the same time frame.

Numerous challenges impeded progress

Politics represented the greatest barrier to achieving IA in the UK. Until a Labour government was in place, IA was not a priority. The establishment of Health Action Zones is one of the government's best-documented examples of IA. Twenty-six Health Action Zones (HAZ) were established to organise area-based action around the social determinants of health. They were linked to the Social Exclusion Unit responsible for promoting multi-agency approaches for Health Action Zones, Education Action Zones and Young Offender teams. Intended to foster inter-agency and intersectoral collaboration, as well as harness community-based resources and experience, these Health Action Zones were scheduled to operate for at least seven years. After a high profile start accompanied by considerable enthusiasm for the concept, most of the Zones were shut down after three years, due to shifting government priorities.

Bauld (2005) observes that the experience of each Zone was highly context-specific, and there is evidence of long-lasting benefit in terms of learning about intersectoral ways of working. In short, Zones made a "good start in difficult circumstances", which included unrealistic objectives; inadequate funding; constantly shifting objectives and partnership arrangements; performance management systems that provided few rewards for IA; shortfalls in organisational capacity; and, tension between effecting local change while identifying structural causes of inequity nationally.

Obstacles and positive outcomes

Most Health Action Zones were shut down before their impact could be properly evaluated. However, some evaluators, while acknowledging the ambiguous nature of the data gathered from the Zones, have argued that there is evidence of long-lasting benefits in terms of learning about intersectoral work. These benefits include: introducing an improved service delivery model for previously overlooked population groups; and, creating a context that supported new and more constructive ways of working together (Bauld *et al.,* 2005, p. 438). Additionally, the Zones gave health inequalities a greater political profile, at least locally.

While cross-departmental working groups have emerged on thematic issues, and Ministers for different departments jointly sign strategy documents, there is evidence that departments may continue to work in individual "silos", and that they lack a sense of collective ownership of intersectoral policies (Exworthy, Berney & Powell 2002). The UK government remains dedicated to the concepts of joined-up government and intersectoral action, seeking to build on past experience to enhance intersectoral and interagency working both nationally and locally.

Lessons from experience

Documented lessons learned on IA under the Labour government in the UK (National Audit Office 2001), (Exworthy, Berney & Powell 2002), and (Bauld 2002) include the need to:

- design the most appropriate form of working together;
- reinforce this with a statutory duty to collaborate, where appropriate;

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- ensure that partners align their vision and policy objectives, and that central government avoids undue interference, while providing appropriate guidance;
- provide incentives for joint working, *e.g.* financial incentives, decision-making flexibility, and appropriate performance assessment;
- minimise administrative burden on departments and local partnerships;
- set realistic timescales (the benefits of IA may require several years to materialise);
- develop strong leaders and build organisational capacity;
- put in place monitoring and evaluation systems;
- ensure that there are clear lines of redress for citizens; and
- ensure that there is a clear accountability framework.

(For further information, refer to the National Audit Office 2001, Exworthy, Berney and Powell 2002 and Bauld 2005).

Dahlgren and Whitehead discuss "integrated determinants of health strategies", indicating that one of the most effective approaches is to "integrate health equity objectives into existing social and economic policies and programmes for economic growth, taxes, employment, education, housing, social protection, transport and health services" (2006, p. 100). The authors note "a high priority must be placed on the development and use of health equity impact analyses ... health equity impact assessment – as with environmental health impact analyses – be considered a normal part of any assessment of public and commercial policies and programmes that are likely to have positive or negative effects on health. It may be necessary to make such health impact analyses compulsory by law or regulation."

Focus: SWEDEN

Intersectoral action for health linked to social determinants by a proactive government

Intersectoral approaches were used by national and local governments in Sweden well before the release of the *Black Report.* Sweden's current national public health strategy has emerged out of a social welfare model and recognition of health inequities identified in the 1980s. Significant research into the nature of these inequities and related intervention approaches provided evidence to support broad-based public health objectives. Ultimately, this focus was linked to a social determinants framework, with an overarching intersectoral action component.

Factors that contributed to the development of national public health goals included: a history of social democratic government; a strong relationship with the labour movement; a highly developed welfare system; a call from municipalities for national public health goals; involvement of politicians from across the political spectrum; strong civic literacy; a highly democratic process; political commitment to equity; a high level oversight body; intersectoral goal-setting; a strong evidence base; and, a preference for collective, systemic approaches (Östlin 2003).

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A comprehensive national strategy

The National Public Health Commission asserts that "we consider that responsibility for individual health is divided between the individual and society, whilst the responsibility for injustice in the distribution of health between groups is first and foremost a matter for society" (National Committee for Public Health 2001).

Sweden's *Health on Equal Terms* public health goals and strategy provided a philosophical and practical framework for cooperation among multiple sectors and actors in relation to major health determinants. The goals, based on strong scientific evidence and developed in a democratic process, identified roles and established targets related to determinants of health.

The national policy governs intersectoral actions at the county council and municipal levels, which makes public health a shared responsibility among several central agencies, Sweden's 21 county councils and its 290 municipalities. In addition, the policy embraces non-government organisations, trade unions and universities. The breadth of this approach offers a unique model for governing intersectoral action for health and equity.

Overcoming barriers through solid research, consultation, and inclusion

Initially, Sweden lacked a long-term comprehensive strategy to overcome health inequities. The process of goal development included three key steps: framework development and discussion; ethical values, scientific facts and priority setting; and, finalising the strategy. Experts were commissioned to gather scientific data pinpointing needs. Multidisciplinary research into health determinants was undertaken and analysed. Active participation of all seven political parties was a critical element in shaping policy directions.

The inclusive nature of the process—i.e., ensuring that opposition parties, the public, and other stakeholders took "ownership"—is of particular note. Public consultations heightened citizen awareness and involvement. Key documents were made available to the public in a variety of formats, including Braille. The public health goals process initiated in 1998 led to the adoption of *The Public Health Objectives Act (2003),* Sweden's first formal public health policy and one of the world's first formalized health strategies employing a health determinants approach. Through this Act, Parliament endorsed the broad goal of "provid[ing] societal conditions for good health on equal terms for the entire population". Eleven public health goals under three categories (social structures and living conditions; settings and environments; and, lifestyles and health behaviours) support this overarching goal.

Specific, measurable targets were established for each of the 11 goals. Rather than imposing new goals on other sectors, there was a decision to integrate the goals relating to employment and social supports from other sectors into public health goals (Östlin 2003).

Health leads the way

The health sector drove the initial stages, and facilitated the process throughout, by calling for research into health inequities and providing the expertise required to generate hard evidence to enable the political sphere to lead the process. Other sectors also participated: multisectoral and multidisciplinary research into the issues highlighted the inequities present in the system. The involvement of government, non-government organisations, experts and the public throughout the process was instrumental to the approval and early implementation of the public health goals and strategy. A Steering Committee chaired by the Minister of Public Health, with Ministers from other sectors participating, oversees the ongoing implementation of public health goals that fall outside the health sector.

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Monitoring and evaluation techniques under development

Though it is too early to assess the impact of the new policy, the Swedish National Institute of Public Health has been tasked with monitoring and evaluation on behalf of the Steering Committee. Developing the methodology to monitor and evaluate the intersectoral components of Sweden's public health policy is challenging.

(For further detail refer to: Östlin, P. & Diderichsen, F. 2001, 'Equity-oriented national strategy for public health in Sweden: A case study', *Policy Learning Curve Series Number 1,* WHO European Centre for Health Policy, Brussels. [On-line] Available at: *http://www.who.dk/Document/E69911.pdf*).

Evidence of the effectiveness of these broader policy frameworks was not provided in the materials reviewed. While frameworks offer the advantage of integrating knowledge and efforts toward shared objectives, they may also present challenges in developing, implementing and evaluating policy, due to the large numbers of participants and the differing perspectives involved: for instance, sustaining interest among the wide range of stakeholders; measuring impact; and, providing timely evidence for decisions in a dynamic environment. Risks may include a perceived loss of focus on the health sector's work to ensure equitable policies. Clearly, a strong analytical capacity within participating sectors is required to identify areas for assessment and to advise on options in a timely manner.

Combining approaches

In many cases, a combination of these approaches is employed. At the national level, governments may select a targeted approach for a specific population, combined with a staged approach for a particular emerging issue. Evaluation results of combined approaches were provided, where available, but generally, there is little evidence of the effectiveness of intersectoral versus intrasectoral action for equity goals. Attribution challenges are significant. In many cases, decades may pass between implementation and the achievement of outcomes.

Experience demonstrates that working across sectors places heavy demands on resources. The resource limitations of an individual sector may mean that it cannot afford to work on all issues, at all times, with all of the relevant stakeholders. Choices must be made on which issues to address, with which sectors, at which time. While health gains are not necessarily an explicit priority for other sectors, health is a critical indicator of social and economic development. Equity may serve as the common ground for stakeholders in moving toward more equitable distribution of health and determinants of disparities in health.

Within the context of this paper, it is difficult to assess the appropriateness of each of these approaches for a specific decision-making context. However, the range of examples cited provides some insight into the scope of IA approaches. Clearly, context and culture matter in selecting an approach, and will also influence the effectiveness of the approach that is chosen.

6 Roles and Responsibilities

The roots of IA stretch back to the Alma-Ata Declaration of 1978 and the concept of *Health for All,* a global strategy that brought all governments and the world community together to acknowledge the social and economic dimensions of health and to collaborate in addressing health inequities. There is now broader recognition that individual determinants and their interactions exercise a powerful influence over population health. Many sectors have engaged in IA, and much has been written about their successes, near-successes, and disappointments. A concept that cast the public sector as a principal force has evolved into a strategy that embraces a range of public and private sector institutions and civil society.

Although many countries have formally committed to IA, and many sectors have risen to the challenge of working collaboratively, implementation has often been flawed or neglected. Overarching goals have sometimes given way to concerns about resources, governance, and organisational mandates:

> Intersectoral collaboration is not a self-generating or even a self-sustaining phenomenon. As a concept, it goes against the grain of most government systems, particularly at the national level. Ministers, usually representing specific disciplinary areas and professional groups, must defend their sector's (vested) interests and compete with each other over limited budgets. At lower levels of government, the competitive characteristics are taken over by a perception that collaboration may actually be favourable, and at the district level the intersectoral barriers are usually non-existent. At this level, good intentions may, however, be hampered by restrictive national policies or limitations in the way earmarked funds can be spent (Bos 1998, p. 1).

Departments and sectors traditionally involved in IA

There are certain sectors with which the health sector has traditionally and most frequently joined forces to achieve health gains. Collaborations with the education, social services, agriculture, and environmental (including water and sanitation authorities) sectors are most commonly documented in the IA literature reviewed. The justice sector may also play a role, for example, in efforts such as Australia's National Youth Suicide Prevention Strategy.

Other sectors are noticeable by their absence. IA literature reviewed for the purposes of this paper provides little evidence of collaboration with the finance, information and communications, employment, manufacturing, transportation, and technology sectors. This may be due to the absence of intersectoral initiatives, to the keywords used in identifying materials to review, or to the limited involvement of the health sector in some intersectoral initiatives where health and health equity outcomes are identified as secondary, rather than primary, objectives.

For example, the cultural sector is increasingly viewed as a strong contributor to the health and vibrancy of cities. Cultural strategies are

frequently used as instruments of social cohesion in minority or vulnerable communities. However, such initiatives may not be cited in the health literature, because they may not have an explicit health sector component. Similarly, housing initiatives in Canada, Europe and Australia, led by sectors other than health, were not captured within the scope of the IA literature reviewed for this paper. Crombie *et al.* offer useful commentary on this observation:

> Most countries have separate policies on poverty, social inclusion and social justice. Unlike policy on inequalities in health, these policies seldom emanate from departments of health, the social inclusion/ social justice policies are motivated by a general concern for human rights and dignity, of which health is only a small part. However, as they deal with the underlying causes of inequalities in health ... they are directly related to health (2005, p. 40).

Political partners

The IA literature emphasises the critical role played by political leaders in prompting and sustaining intersectoral action, either through direct involvement or liaison with senior officials assigned to the task. Most collaborations address issues or problems that are political in nature; political commitment provides both the motivation to act and the resources and structures necessary to support the action. Politicians often set the tone, at senior decision-making levels, on matters of policy direction and resource allocation. They direct and lead central agencies and line departments, which, in turn, deliver on political commitments to the electorate.

In situations where the government has clear priorities and generally supports IA, political leadership makes all the difference. But the engagement of politicians in IA also presents challenges. Conflicts may arise between Ministers about the objectives, management, and ownership of initiatives. There can be awkwardness about who takes the credit for new programs or successful interventions. These tensions may be mirrored in conflicts between departments that are expected to work together.

Other problems arise when ministers or central agencies try to dictate local priorities, or set agendas for community-based action. As a variety of sources have demonstrated, intersectoral initiatives are most successful in less complex decision-making environments, often at the community level. While politicians and ministers at the national level may be involved in supporting an initiative, planning for community-based efforts should take place “on the ground” to reflect citizens’ needs. The stability of the Health Action Zones in the UK was threatened by this type of interference. Those reviewing the New Zealand experience have noted that a combination of “‘top down’ support with ‘bottom up’ planning and management” (New Zealand Ministry of Health 2001) is required.

The health sector as leader, partner, supporter and defender

Strengthened intrasectoral action *within* the health sector has been identified by the WHO as an important component of leadership by the sector. Stahl et al. offer insights into the internal capacity that the health sector requires in order to effectively lead, influence, partner with and support other sectors:

> In order to have a significant role in identifying policies and policy proposals with potential impacts on health, the health sector needs to have sufficient capacity in terms of public health personnel at the various levels of administration and this personnel needs to have adequate public health training and sufficient mandates and responsibilities allotted to them. Even if health considerations have become an intrinsic part of policy-making in some sectors, such as that of environmental policies, in general other sectors need input from the health sector

> in order to be able to take health implications into account. This is the case especially in areas without a strong tradition of considering health implications and in the cases of new or emerging issues or potential problems (2006, p. 276).

The health sector's role in assessing the health impacts of policies led by other sectors may require it to defend health and health equity. The tensions associated with this role have been well documented in the development of anti-tobacco legislation, where conflict arose between economic and social partners. The health sector's role as a defender of health, advocate of health equity, and negotiator for broader societal objectives is apparent in recent literature on health impact assessments in the EU and in the Norwegian and Finnish strategies.

At a community level, New Zealand has outlined health sector roles as follows:

- a *funder* of IA projects, as well as evaluations and pilot programs;
- a *supporter* of community-based initiatives, demonstrating leadership and securing high-level political support;
- a *partner among partners,* ensuring that planning remains locally-based and that more senior levels do not undermine trust by interfering with local priorities and program management; and
- a *developer of guidelines* for community-based initiatives (New Zealand Ministry of Health 2001, pp. 140-141).

Rachlis comments on the health sector's role at the community level in connecting to community organisations:

> It is at the community level that intersectoral action can be most successfully initiated and the health sector has the most influence on the decision-making process. The health sector can promote local action as well as stimulate political pressure to act on higher levels. A key step in this process is to link public health personnel with community groups. Linking public health agencies to their communities is like plugging intersectoral action into an electrical outlet. These connections provide the energy to make intersectoral action for health happen (1999, p. 21).

Working on the assumption that the most complex social problems are best resolved through intersectoral approaches, it is to be expected that the health sector will play a variety of roles in the context of different initiatives. There is, at least potentially, wide scope for intervention in areas beyond the traditional provision of health services, including research; education (of health professionals and other sectors); facilitation (community empowerment or reinforcement of positive impacts on health from other sectors); advocacy; monitoring and evaluation (of health status, impact of policies, etc.) and mediation (between conflicting interests). The sector itself is diverse, with many players in different quarters, including politicians, bureaucrats, and voluntary and private sector participants.

While the health sector must be open to working in concert with others—in fact, it often leads the charge—it must also take care not to impose its leadership in every instance. Sectors "compete" against each other because each reflects a vested interest, a certain degree of political clout, and specific territory and resources. This underlying competitiveness also exists between line departments in government.

Ministries of health play different roles depending on their governments' stance on the matter of social determinants and the level of government support for equity goals and intersectoral action. The extent of the challenges faced by health ministers varies, depending on how divergent the views are and how supportive the climate is. In cases where the health sector must "go it alone" within government, its interactions with non-governmental organisations, civil society and private sector actors are critical to its ability to make a positive impact on health equity.

Other government actors

Line departments

Government actors outside of the health sector hold many of the policy levers for determinants of health and health equity. Line departments responsible for environment, education, social services, housing, community and economic development are commonly cited as participants in intersectoral action for health. The sources reviewed did not provide detailed commentary on the role of these other participants in intersectoral action for health. However, it should be noted that in many of the examples, such as initiatives to address homelessness, community revitalisation efforts were led by line departments other than health. It appears that these line departments may lead, partner in, support and defend initiatives germane to their mandates.

Equity, quality of life, social and economic development are broad, cross-cutting policy goals that require collaboration among multiple line departments, central agencies, political officials, non-government and civil society in order to achieve results.

Central agencies

Central agencies, such as departments of finance or treasuries, play a critical role in generating and sustaining IA. Public service culture and accountability frameworks often work against collaboration and coordination. In addition to initiating horizontal initiatives on complex issues requiring the involvement of multiple departments, central agencies may play a coordination and oversight role to support intersectoral or horizontal action (Fox & Lenihan 2006).

Experience shows that there is a discrepancy between central agencies' potential and actual roles. Central agencies have the authority and perspective to choose between competing priorities and bring different parties together. However, there is scepticism about their ability to support horizontal collaboration and facilitate the work rather than judge its results. Engaging in process may require central agencies to engage in substance—a role for which they may lack the required knowledge and capacity.

Central agencies could enhance the likelihood of success by providing greater clarity and detail on the mandate of new initiatives, the authority vested in departments or structures assigned to manage them, and the level of decision-makers to which they report. In terms of ongoing support of intersectoral projects, central agencies could play a more effective role by getting more involved in policy substance; by instituting better, more strategic financial and management procedures; and, by putting in place new accountability frameworks that reduce the reporting burden (Bakvis & Juillet 2004, pp. 64-65).

It is not evident, from the literature consulted, how central agencies view the question of health expenditures. In countries where health is uppermost on the political agenda, the primary focus is on health care delivery financing; very little attention is paid to health expenditures. Research examining the extent to which health expenditures are viewed as an investment (as opposed to a drain on the treasury) would provide useful insights.

While there are obvious tensions between line departments and central agencies over implementation and management of horizontal initiatives, Fox and Lenihan (2006) note that complex policy files demand horizontal action. Line departments and central agencies need to commit to greater understanding of the relevant dynamics, to improve the fulfilment of their respective roles. Because central agencies are viewed as playing an important role in managing the overall corporate framework, setting out incentives, and creating a supportive climate for promoting the government's priorities, their strong commitment is required.

Non-government actors

Non-governmental organisations (NGOs) and actors play a vital role in IA. Their growing voice and influence helps to leverage political change and action on social determinants

of health. In more robust economies, their lobbying efforts can prompt governments to act. In low-income countries and fragile states, they often spearhead important initiatives and influence decision-makers. Countries such as Sri Lanka have created structures to liaise with non-governmental actors and assist in coordinating their efforts. NGOs may be the primary delivery vehicle for critical health services, or a vehicle to implement policies developed through intersectoral approaches (WHO Commission on Social Determinants of Health 2006c).

Canada's National Homelessness Initiative, which was launched in 1999 and renewed in 2003, stands as an example of how pressure from local government and non-government actors eventually moved the federal government to act. This demonstrates the important role that actors outside government (including voluntary sector groups) can play (Canada School of Public Service 2006).

The health literature reviewed for the purposes of this paper includes little mention of the role of non-governmental organisations. The role of NGOs is explored more fully in sources dealing with international development and sustainable development. The proliferation of organisations involved in crisis response, health promotion, education, and community activism signals their growing importance as potential partners in addressing social determinants and promoting health equity. Intersectoral initiatives must take account of governance differences between NGOs and government institutions.

The degree to which NGOs' advice and collaboration is sought by government varies from country to country; it depends, among other things, on the political climate and on their capacity to offer substantive input. The off-loading of programs and services in many western democracies has led to a growing recognition of the importance of a vibrant voluntary sector. The watchdog role played by organisations in that sector could be an interesting question to explore, as a mechanism for tracking whether, how, and by whom IA is used to address social determinants.

Private sector organisations

On a global level, the impact of private donor organisations, such as the Gates Foundation, on approaches to health and health equity is recognised. Targeted funding strategies that are disease-focused have had important impacts on patterns of health investments; in some cases, these strategies may have increased inequalities in health. The pharmaceutical industry is recognised as a significant player, but was not discussed significantly in the IA experiences reviewed.

While the importance of private sector actors is acknowledged, examples of active strategies to collaborate were not evident. The onus appears to lie with the public health sector, civil society and other actors to draw linkages between private sector interests and the benefits of health and equity.

Media

While the media is acknowledged as playing a critical role in communicating and influencing public policy and public opinion, its role was not fully explored in the sources reviewed. This is an area that warrants further exploration.

7 Issues Arising from Intersectoral Action

Increasingly, departments, agencies, and other actors recognise the need to work across sectoral and organisational boundaries to achieve results. Experiences reviewed demonstrate two major lessons emerging from horizontal work:

1. Horizontal work is resource-intensive: it demands time and paperwork, as well as human, financial, and information resources; and
2. Management of policy and operations requires a careful balancing of competing interests and objectives.

Intersectoral initiatives do not necessarily save time or money. Governments and other organisations should think carefully before embarking on such initiatives, and be prepared to see them through when they do proceed. While different nations and levels of government have taken various approaches to intersectoral action, the literature has yielded some broad implications. Six issues are discussed below: achieving policy coherence, focusing intersectoral efforts, sustaining commitment, strengthening capacity, balancing competing objectives and interests, and accounting for results.

Achieving policy coherence

As many sectors engage in IA, there is a corresponding need to ensure that government policies are aligned with broad, shared objectives. This requires sensitivity to the range of actors, policy options, and opportunities for collaboration, with significant implications for organisational or initiative design and resource allocations within the health sector.

The formulation of coherent policies involving multiple sectors may include incentives for IA collaboration, articulated by the highest levels. Such incentives have a greater chance of succeeding and overcoming competition among sectors when they are accompanied by active financial support and clear-cut budget appropriation for IA (Rachlis 1999). Government policy reviews aimed at harmonising policies, while cumbersome, could yield a sustainable process with long-lasting impacts. Such reviews may also identify policies that are working at cross-purposes.

Witness the Millennium Development Declaration, adopted by 170 heads of state in 2000, which has produced Millennium Development Goals (MDGs). These goals represent the first global policy framework for poverty reduction adopted at a level where “sectoral divides can be overcome and opportunities for collaborative approaches enforced”. However, Bos concludes that success is still limited despite the presence of the framework (2006).

Focusing intersectoral efforts

Given the resources and time required to support many intersectoral efforts, and the challenges associated with measuring their impact, the literature appears to advocate selective, pragmatic approaches to IA. Both New Zealand and the Netherlands have identified feasibility assessments as a means of assessing and prioritising proposals for new intersectoral initiatives or policies (New Zealand Ministry of Health 2001, p. 139), (van Herten *et al.* 2001, pp. 343-345). Van Herten *et al.* note that the “feasibility of [intersectoral

health] policy depends of the availability of evidence, the degree of support and the availability of tools for implementation" (2001, p. 345). Consciously choosing when, where, and how to work across sectors is a way to ensure that resources are focussed where they are likely to have the most impact, and where conditions for success exist.

The level of engagement that is selected may range from monitoring of opportunities to joint programming or shared evaluation models. Collaboration may be appropriate only at the policy development and evaluation stages; implementation of sectoral elements of a shared policy framework may be sector-specific. This refinement—*i.e.,* thinking about where, when and how to engage—may represent a natural evolution building on the experiences of past intersectoral work. A cautionary note is required, however. Some of the most difficult policy challenges, such as health equity, may require sustained efforts by multiple actors over long timeframes to realise results. Intersectoral action needs to be directed toward objectives; it should not be determined by the ease of working with specific sectors. Tangible results, in the short- and medium-terms, toward overarching goals may depend on collaboration with sectors that share interests with the health sector.

Sustaining commitment

Garnering shared support and sustaining commitment for intersectoral initiatives are important factors in the success of such plans. Because IA tends to cost more and take longer than other approaches to yield results, it is essential to secure the commitment of sectors and stakeholders. The vertical orientation of most organisational reporting relationships may create tensions regarding horizontal or multi-jurisdictional action and reporting.

Sustaining commitment to IA may be problematic because there may be considerable political and bureaucratic turnover during the length of time required to complete a project. The terms of elected and unelected officials or other sectoral leaders may end before IA initiatives succeed, and changes in leadership may threaten the continuation of the collaborative work. Policies may change along with leaders, organisations may be restructured, and emergencies may arise.

The literature reviewed sets out the following methods for ensuring sustained commitment:

- involving appropriate stakeholders in identifying priorities, toward a shared vision;
- articulating benefits for each sector;
- encouraging decentralization of decision-making and bolstering local autonomy;
- heightening awareness of IA through an increased international profile, which may be established through summits and national or international declarations; and
- linking pay to performance in achieving results.

Strengthening capacity

Although governments and academics have generally acknowledged, over the past two decades, that intersectoral action is appropriate in complex situations, implementation is lagging. A different skill set is required for inter-sectoral action. Various authors have suggested organisational capacity to initiate and implement cross-organisational initiatives as a criterion for proceeding with IA. Fulfilment of the health sector roles of leadership, partnership, support and defence requires knowledge and skills that extend beyond health issues. Health sector organisations require an enhanced and more systematic approach to understanding the social and economic environment, policy drivers, and related opportunities and risks. As noted by Stahl *et al.,* health organisations also require the mandate and support to influence other sectors (2006).

Appropriate planning is crucial. Interdisciplinary and interorganisational planning approaches may be required to strengthen workers' skills in developing plans that acknowledge multiple

> **"While an assessment of the costs and benefits is necessary, in most horizontal projects there will be serious measurement problems."**
>
> (Bakvis & Juillet 2004)

sectors. Experience underscores the importance of communications and negotiation as fundamental skills for IA. Environment and health collaborations demonstrated success in moving away from theoretical approaches toward problem-based approaches to learning. Workshops were developed, drawing on a mixture of disciplines and a range of approaches to address complex, practical policy challenges. The shift from discipline- and sector-specific theoretical approaches to problem-based learning has had a positive influence on IA professional development and training programs.

Balancing competing objectives and interests

Managing policy and operations involving more than one sector requires a careful balancing of competing interests and objectives. To sustain IA, those in the health sector must think beyond their own goals, and take into account other objectives. Identifying links between health policy objectives and other sectors' objectives is key to successful collaboration.

The health sector should strengthen its capacity to recognize the objectives of, and work more efficiently with, other sectors. Bos comments, "the parts of the health sector that would need to work directly with the agriculture sector are frequently under funded *[sic],* have no formal arrangements for intersectoral roles and responsibilities, and have staff with inadequate skills for intersectoral negotiation and decision-making *[sic]*" (2006, p. 2).

Accounting for results

In many nations, and at many levels of decision-making, there is a heightened emphasis on demonstrating results. There are growing expectations from citizens, non-government actors and international donors that governments will be accountable for the results of their policy decisions.

Honest reporting of intersectoral actions, both successes and failures, is critical. In complex horizontal actions, it can be difficult to attribute accountability or credit success or failure. Complex files need clear goals, and should attempt to measure process and outcome. Traditionally, in government, lines of accountability run vertically, and a culture of "business as usual" can make interdepartmental, intersectoral collaboration difficult.

Designating a lead organisation for horizontal initiatives is necessary in order to clarify authority, instil accountability, and allocate adequate financing (Bakvis & Juillet 2004).

Many questions regarding accountability relationships in intersectoral action remain to be explored. Who receives credit for success or blame for failure? Should lines of accountability flow through individual partners, or is it possible to establish systems in which stakeholders collectively share risk and reward? Clearly, joint initiatives push the limits of conventional accountability practices. Must compliance be compromised in order to work with partners? Probably not. Governments have become more sophisticated in recent years about planning and implementing horizontal approaches; they are still learning to incorporate checks and balances. Still, it seems that [they] are getting better and better at partnering, and at coming up with creative ways and means for reliable reporting (Fox & Lenihan 2006, p. 15).

8 Spotlight on the Future

Remaining questions

While this paper does not conclusively identify appropriate models of categorising IA, it notes the benefits of using global, regional, national, sub-national, and community or local levels of governance as a useful entry point for undertaking intersectoral action. It introduces broad descriptions of approaches – staged, targeted, broad, and combined – as a practical way to approach the challenge of health equity, address the social determinants of health, and, where appropriate, act across sectors to realise health gains.

Questions arising from this paper include:

What arguments were most/least persuasive in making the case for intersectoral action? Cabinet discussions are held *in camera* in many countries, so the "inside story" on what was most persuasive is not usually captured in government documents outlining lessons learned, evaluations, or the academic literature.

Which policy levers were most effective, efficient and equitable in advancing health equity? In addressing public policy problems, policy levers are typically tested for *effectiveness, i.e.,* will the intervention work within the specific context in question? The *efficiency* test examines whether value is received for the resources that were invested: *i.e.,* do the benefits warrant the investment costs? Finally, what impacts does the intervention have on *equity, i.e.,* the equitable distribution of social determinants? The health sector may raise the equity test in contributing to the development and implementation of policy proposals for other sectors.

What roles did other actors play? How can the health sector refine its role in the absence of other key partners' (*e.g.,* the public, the media, central decision-makers, other social sector actors, and the economic sector actors) consideration and awareness? A better understanding of which sectors did not engage- and why not- may assist in refining approaches to effective intersectoral action for shared objectives.

How was commitment sustained over time? Examples are provided in some of the literature, with an emphasis on leaders from health and other sectors. In developing health sector organisations, attention should focus on the types of leadership and other contributions required to work both within organisational boundaries, and with other key sectors.

How can the health sector strengthen its capacity for intersectoral action? If the health sector is calling on other sectors for equitable distribution of determinants of health, it must sustain a focus within the health sector to lead efforts in equitable access to health services for which it is directly responsible. This requirement, coupled with the growing complexity and interdependence of sectors and social problems, poses considerable challenges to the health sector.

The role of the health sector is no longer straightforward. It must be able to shift and adapt. It must know when to lead, when to follow, and what type of input to seek. It must also be vigilant in ensuring that the health aspects of complex files led by other sectors are identified and addressed. It must be sensitive to timing, able to distinguish among short-, medium-, and long-term gains, and prepared to make decisions on appropriate entry points and strategies.

What tools, models or resources are needed to support IA? Developing a well-planned, systematic approach to intersectoral action that will yield

both health and broader socio-economic benefits requires considerable support. Much of the literature outlined barriers and enablers to intersectoral action, and some tools to support intersectoral action were identified. Further work is needed to assess the needs of a range of actors and the fit with available tools and resources. Collaboration with other sectors may uncover a host of existing tools, such as integrated planning and evaluation models, which could serve as useful examples.

Conclusion

Just as the concept of health has evolved over the past decades, the concept of intersectoral action for health appears to be shifting. Experiences reviewed in this paper demonstrate some successes in working vertically and horizontally for health gains. Given the resource implications of intersectoral efforts, however, a critical assessment of when, where and how to act is required. While a range of approaches has been used, at different levels of governance, there does not appear to be a "one size fits all" model.

There is an emerging need to shift from *IA for health* to *IA for shared societal goals.* Equity, with health as one important indicator, offers an entry point that may hold promise in many political contexts. This shift requires a health sector that balances determinants within which it holds the policy levers, and those for which other sectors are the lead.

This paper provided a high-level overview of approaches to intersectoral action at the global, sub-regional, national, sub-national, and community levels. In the ten years since the 1997 WHO Conference on Intersectoral Action for Health took place, there has been some progress in exploring the health sector's new role, as a partner among partners. New kinds of leadership, skills, information, and intelligence are being applied around the globe. New systems of governance to manage partnerships and alliances are being considered and tested. Some progress has been made in strengthening the understanding the health impacts of interventions. Yet, in this paper, solid evidence demonstrating the effectiveness of intersectoral action for health was difficult to locate.

Many questions remain. It is our hope that as the tenth anniversary of the 1997 conference approaches, this paper and subsequent case studies will contribute to a more refined understanding of intersectoral approaches that is adapted to specific contextual needs.

Appendix A
Glossary of Terms and Abbreviations

Terms

Unless otherwise indicated, these terms are drawn from Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security 2004, Reducing Health Disparities-Roles of the Health Sector: Discussion Paper, Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, Ottawa.

Determinants of health: the range of personal, social, economic and environmental factors that determine the health status of individuals or populations (WHO, Health Promotion Glossary, 1998). The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services.

Disadvantaged populations: populations that share a characteristic associated with a high risk of adverse health outcomes (*e.g.,* Aboriginal peoples, single mothers in poverty, women, homeless people, refugees). One approach to assisting disadvantaged populations is to use specific strategies targeted at that particular population. This is distinct from approaches aimed at reducing the range of underlying determinants of health that affect health (*e.g.* income, education).

Health care: the programs, services, procedures, therapies and interventions that treat and care for individuals with diseases, injuries and disabilities. Health care is the largest subset of the health sector.

Health disparities: differences in health status that occur among population groups defined by specific characteristics. For policy purposes, the most useful characteristics are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socio-economic status (SES), Aboriginal identity, gender, and geographic location.

Health inequality: "...is the generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups...that need not imply moral judgment...[and may result from] a personal choice that would not necessarily evoke moral concern" (Kawachi, Subramanian & Almeida-Filho 2002, p. 647). Some inequalities reflect random variations (i.e., unexplained causes), while others result from individual biology, the consequences of personal choices, social organisation, economic opportunity, or access to health care. Public policy addresses health inequalities attributable to modifiable factors, especially those that are perceived as inequitable.

Health inequity: "...refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice....The crux of the distinction between equality and equity is that the identification of health inequities entails normative judgment premised upon (a) one's theories of justice; (b) one's theories of society; and (c) one's reasoning underlying the genesis of health inequalities. Because identifying health inequities involves

normative judgment, science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair" (Kawachi, Subramanian & Almeida 2002, pp. 647-648).

Health sector: the policies, laws, resources, programs and services that fall under the jurisdiction of health ministries. This sector encompasses health promotion and preventive health, public health, community health services such as home care, drugs and devices, mental health, long-term residential care, hospitals, and the services generally provided by health care professionals (doctors, nurses, therapists, pharmacists, etc.).

Population health: Population health is both a description and a concept that underlies the discussion of health disparities. "Population health strategy focuses on factors that enhance the health and well-being of the overall population. It is concerned with the living and working environments that affect people's health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health" (Federal/Provincial/Territorial Advisory Committee on Population Health 1994). It is concerned with collective, rather than individual health status and risk factors, as well as policies and strategies that address non-medical determinants affecting health throughout the life course.

Primary health care: The World Health Organisation defines primary health care as "the principal vehicle for the delivery of health care at the most local level of a country's health system. It is essential health care, made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Besides an appropriate treatment of common diseases and injuries, provision of essential drugs, maternal and child health, and prevention and control of locally endemic diseases and immunization, it should also include at least education of the community on prevalent health problems and methods of preventing them, promotion of proper nutrition, safe water and sanitation."

Public health: "Public health is the combination of science, practical skills, and values directed to the maintenance and improvement of the health of all the people. It is a set of efforts organised by society to protect, promote, and restore the people's health through collective and social action. ...Public health activities change with changing technology and values, but the goal remains the same – to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the populations" (Last 1994).

This broad definition is closely aligned with the definition of "population health", and should be distinguished from the definition of the five core "public health" programs and services aimed at primary prevention: population health assessment, surveillance, disease prevention, health protection, and health promotion. These programs and services are provided by health departments, regional health authorities, and local units.

Socio-economic status (SES): a term that describes the position of an individual group in a population or society, reflecting the overall hierarchy. The most frequently used indicators of SES are income, education and occupational categories. The conceptual cousin of this term is class, which originated in social theories that attempt to *explain* rather than simply *describe* the structure and functioning of society. To be consistent with previous national documents on health status and their determinants, SES is used and is intended to be interpreted broadly.

Appendix B

The World Health Organisation Commission on the Social Determinants of Health

The Commission on Social Determinants of Health (Commission) was launched in March 2005 and will complete its initial work in May 2008. It is chaired by Sir Michael Marmot of the University College, London and has twenty Commissioners. The Commission brings together leading scientists and practitioners to provide evidence on policies that improve health by addressing the social conditions which people live and work. It collaborates with countries to support policy change and monitor results.

Main Goals of the Commission:

- To support policy change in countries by promoting models and practices that effectively address the social determinants of health.
- To support countries in placing health as a shared goal to which many government departments and sectors of society contribute.
- To help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

Appendix C
The Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see *http://www.who.int/social_determinants/map/en*) and also commissioned a number of systematic reviews and case studies (see *www.wits.ac.za/chp/*).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Regional network in east and southern Africa devoted to promoting health equity (*www.equinetafrica.org*), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (*www.lshtm.ac.uk/hpu*). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social determinants of health at global, regional and country level.

Abbreviations

These abbreviations are drawn from WHO Commission on Social Determinants of Health 2005, Action on the Social Determinants of Health: Learning from Previous Experiences, WHO, Geneva.

CMH: Commission on Macroeconomics and Health

CSDH: Commission on Social Determinants of Health

HAZ: Health Action Zones (United Kingdom)

HFA: Health for All

HIA: Health impact assessment

IA: Intersectoral action

IA: Intersectoral action for health

IIA: Integrated impact assessment

MDGs: Millennium Development Goals

NGO: Non-government organisation

PHC: Primary health care

SDH: Social determinants of health

UK: United Kingdom

UN: United Nations

WHO: World Health Organisation

Sources

Amery, J. 2000, 'Interprofessional working in health action zones: How can this be fostered and sustained', *Journal of Interprofessional Care* vol. 14, no. 1, pp. 27-30.

Appleby, J. & Harrison, A. 2006, *Spending on Health Care: How much is enough?* King's Fund, London.

Asthana, S. & Halliday, J. 2004, 'What can rural agencies do to address the additional costs of rural services? A typology of rural service innovation', *Health and Social Care in the Community,* vol. 12, no. 6, pp. 457-465.

Australian Institute of Family Studies 2000, 'Networking and intersectoral collaboration', in *Building capacity for life promotion: Technical Report Volume 1 Evaluation of the National Youth Suicide Prevention Strategy,* Australian Institute of Family Studies, Canberra. [On-line] Available at: *http://www.aifs.gov.au/*

Baird, H. & Cantwell, M. 2006, 'Abstract for presentation at National Medicines Symposium 2006 Partnerships in action: National Prescribing Service and Consumers' Health Forum of Australia', *National Prescribing Service,* Australia & Consumers' Health Forum of Australia, Australia. [On-line] Available at: *http://www.icms.com.au/nms2006/abstract/125.htm*

Bakvis, H. & Julliet, L. 2004, Basic Research *The horizontal challenge: line departments, central agencies and leadership,* Canada School of Public Service. [On-line] Available at: *http://www.myschool-monecole.gc.ca/Research/publications/pdfs/hc_e.pdf*

Banken, R. 2001, *Strategies for Institutionalizing HIA.* European Centre for Health Policy, Health Impact Assessment Discussion Papers, No. 1. World Health Organisation Regional Office for Europe, Copenhagen. [On-line] Available at: *http://www.euro.who.int/document/e75552.pdf*

Bauld, L. *et al.* 2005, 'Promoting Social Change: The Experience of Health Action Zones in England', *Journal of Social Policy,* vol. 34, no. 3, pp. 427-445.

Bennett, J. 2003, 'OECD Health Working Papers No. 2 Investment in Population Health in Five OECD Countries', OECD, Paris. [On-line] Available at: *http://www.oecd.org/dataoecd/30/39/2510907.pdf*

Bernier, N. 2006, 'Quebec's Approach to Population Health: An Overview of Policy Content and Organisation', *Journal of Public Health Policy,* vol. 27, pp. 22-37.

Bos, R. 1998, 'Health opportunities in water resources development: Capacity building in the domain of intersectoral collaboration', *International Conference on Water and Sustainable Development,* Paris, France. [On-line] Available at: *http://www.oieau.fr/ciedd/contributions/at2/contribution/BOS.html*

Bos, R. 2006, *Understanding the links between agriculture and health,* International Food Policy Research Institute. [On-line] Available at: *http://www.ifpri.org/2020/focus/focus13/focus13_16.pdf#search=%22intersectoral%20action%20for%20health%22*

Canadian Public Health Association 1997, *The Canadian Experience of Intersectoral Collaboration for Health Gains,* Canadian Public Health Association, Ottawa.

Canada School of Public Service 2006, *Policy development and implementation in complex files Lessons from the National Homelessness Initiative* by Ralph Smith & *Lessons from Vibrant Communities* by Sherri Torjman, Canada School of Public Service and the National Secretariat on Homelessness, Ottawa.

Crawshaw, P., Bunton, R. & Gillen, K. 2003, 'Health Action Zones and the problem of community', *Health and Social Care in the Community,* vol. 11, no. 1, pp. 36-44.

Crawshaw, P. & Simpson, D. 2002, 'Comprehensive Community Initiatives: Addressing a 'Problem' in Local Governance or Creating One?', *Sociological Research Online,* vol. 7, no. 1. [On-line] Available at: *http://www.socresonline.org.uk/7/1/crawshaw.html*

Crombie, I.K. *et al.* 2005, *Closing the Health Inequalities Gap: An International Perspective,* World Health Organisation Europe, Copenhagen.

Dahlgren, G. & Whitehead, M. 2006, 'Levelling up (part 2): a discussion paper on European strategies for tackling social inequities in health', *Studies on social and economic determinants of population health, No. 3,* WHO Regional Office for Europe, Copenhagen.

Dean, M. 1998, 'UK government announces first "health action zones"', *The Lancet,* vol. 351, p. 1111.

Directorate for Health and Social Affairs 2005, *The Norwegian Directorate for Health and Social Affairs' Plan of Action to Reduce Social Inequalities in Health: The Challenge of the Gradient,* Directorate for Health and Social Affairs, Oslo.

Eklundh, B. & Pettersson, B. 1987, 'Health promotion policy in Sweden: means and methods in intersectoral action', *Health Promotion,* vol. 2, no. 2, pp. 177-194.

Evans, T. & Vega, J. 2006, *Making the Case for Financing the Social Determinants of Health* (presentation deck) October 29, 2006, London, World Health Organisation.

Exworthy, M., Berney, L. & Powell, M. 2002, ' "How great expectations in Westminster may be dashed locally": the local implementation of national policy on health inequalities', *Policy & Politics,* vol. 30, no.1, pp. 79-96.

Federal/Provincial/Territorial Advisory Committee on AIDS, a sub-committee of the Federal/Provincial/Territorial Advisory Committee on Population Health 1999, *Intergovernmental collaboration on HIV/AIDS... A Discussion Paper,* Minister of Supply and Services, Ottawa.

Federal/Provincial/Territorial Advisory Committee on Population Health 1994, *Strategies for Population Health: Investing in the Health of Canadians,* Minister of Health, Ottawa.

Federal/Provincial/Territorial Advisory Committee on Population Health 1999, *Intersectoral Action... Towards Population Health,* Minister of Supply and Services, Ottawa. [On-line] Available at: *http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/inters_eng.pdf*

Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security 2003, *Building an Early Childhood Development System Utilizing A Population Health Perspective A Tool for Reviewing Current Approaches:* Report of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, Minister of Public Works and Government Services Canada, Ottawa. [On-line] Available at: *http://publications.gov.sk.ca/details.cfm?p=12081*

Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security Canada 2005a, *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper,* Minister of Health, Ottawa. [On-line] Available at: *http://www.phac-aspc.gc.ca/ph-sp/disparities/ddp_e.html*

Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security Canada 2005b, *Reducing Health Disparities – Roles of the Health Sector: Recommended Policy Directions and Activities,* Minister of Health, Ottawa. [On-line] Available at: *http://www.phac-aspc.gc.ca/ph-sp/disparities/dr_policy_e.html*

Fox, G. & Lenihan, D. 2006, *Where Does the Buck Stop? Accountability and Joint Initiatives Discussion Paper,* Public Policy Forum & Crossing Boundaries National Council, Ottawa.[On-line] Available at: *http://www.ppforum.com*

General Practice Divisions – Victoria Ltd (GPDV) 1995, *Planning and Evaluation of Links Projects or Intersectoral Collaboration A Checklist,* based on the work of Harris et al in Working Together-Intersectoral Action for Health, 1995, [On-line] Available at: *http://www.gpdv.com.au/gpdv/documents/060701_checklist4workingwithdivisions.pdf#search=%22intersectoral%20action%20for%20health%22*

Goumans, M. & Springett, J. 1997, 'From projects to policy: "Healthy Cities" as a mechanism for policy change for health?', *Health Promotion International,* vol. 12, no. 4, pp. 311-322.

Great Britain Working Group on Inequalities in Health 1980, *The Black Report, Inequalities in health: report of a Research Working Group,* Department of Health and Social Services, London.

Harris, E *et al.* 1995, *Working together: intersectoral action for health,* Government Publishing Service, Canberra.

Harris-Roxas, B., Simpson S. & Harris E. 2004, *Equity Focused Health Impact Assessment: a literature review,* Australasian Collaboration for Health Equity Impact Assessment (ACHEIA), Sydney.

Health Canada 1998, *Building Partnerships for Health: Lessons Learned Nutrition for Health An Agenda for Action,* Minister of Public Works and Government Services Canada, Ottawa. [On-line] Available at: *http://www.hc-sc.gc.ca/fn-an/alt_formats/hpfb-dgpsa/pdf/nutrition/building_partnerships-creation_partenariats_e.pdf*

Health Canada Alberta/Northwest Territories Region 2002, *The Cloverleaf Model for Success – A Toolkit for Intersectoral Action,* Health Canada Alberta/Northwest Territories Region, Edmonton, Alberta. [On-line] Available at: *http://www.dietitians.ca/resources/ISA-TOOLKIT-eng.pdf*

Health Canada & Alberta Health and Wellness 2002, *Preventing Chronic Disease: Working Together in an Integrated Approach March 20-21, 2002 Edmonton, Alberta,* [On-line] Available at: *http://www.diabetes.ca*

Health Systems Trust 1998, 'Intersectoral Working', *HST Update,* Issue No. 32. [On-line] Available at: *http://www.hst.org.za*

Huchzermeyer, M., Burton, S. & Harpham,T. 2001, *Health and Environment in Development Policy and Planning: Strengthening the Basis of Intersectoral Collaboration,* Department of Health and Sustainable Development, WHO, Geneva.

Implementing action for sustainability (toolkit) 2003, North West Regional Assembly, Liverpool.

Intersectoral Community Action for Health (ICAH) (webpage) 2006, New Zealand Ministry of Health. [On-line] Available at *http://www.moh.govt.nz/icah*

Joffe, M. & Mindell, J. 2002, 'A framework for the evidence base to support Health Impact Assessment', *Journal of Epidemiology and Community Health,* vol. 56, pp. 132-138. [On-line] Available at: *http://jech.bmj.com/*

Kawachi, I., Subramanian, S.V. & Almeida-Filho, N. 2002, 'A glossary for health inequalities,' *Journal of Epidemiology and Community Health,* 56, pp. 647-652.

Krieger, N. *et al.* 2003, 'Assessing health impact assessment: multidisciplinary and international perspectives,' *Journal of Epidemiology and Community Health,* vol. 57, pp. 659-662. [On-line] Available at: *http://jech.bmj.com/*

Last, J.M. 1995, *A Dictionary of Epidemiology,* Oxford University Press, New York.

Lock, K. & McKee, M. 2005, 'Health impact assessment: assessing opportunities and barriers to intersectoral health improvement in an expanded European Union', *Journal of Epidemiology and Community Health,* vol. 59, pp. 356-360. [On-line] Available at: *http://jech.bmj.com/*

LSE Health and Social Care 2004, 'Health challenges in South Eastern Europe', *Eurohealth,* vol. 10, no. 3-4, London.

Mindell, J. *et al.* 2004, 'Enhancing the evidence base for health impact assessment', *Journal of Epidemiology and Community Health,* vol. 58, pp. 546-551. [On-line] Available at: *http://jech.bmj.com/*

Mindell, J. *et al.* 2004, 'Health impact assessment as an agent of policy change: improving the health impacts of the mayor of London's draft transport strategy', *Journal of Epidemiology and Community Health,* vol. 58, pp. 169-174. [On-line] Available at: *http://jech.bmj.com/*

Mindell, J., Ison, E. & Joffe,M. 2003, 'A glossary for health impact assessment', *Journal of Epidemiology and Community Health,* vol. 57, pp. 647-651. [On-line] Available at: *http://jech.bmj.com/*

Mittelmark, M.B. 2001, *Promoting Social Responsibility for Health: Health Impact Assessment and Healthy Public Policy at the Community Level,* Research Centre for Health Promotion, University of Bergen, Bergen, Norway.

National Audit Office London 2001, *Joining Up to Improve Public Services,* Report by the Comptroller and Auditor-General, HC 383, Session 2001-2002, HMSO, London. [On-line] Available at: *http://www.nao.org.uk/publications/nao_reports/01-02/0102383.pdf*

New Zealand Ministry of Health 2001, *Intersectoral Initiatives for Improving the Health of Local Communities – A Literature Review,* Wellington. [On-line] Available at: *http://www.moh.govt.nz*

NHS Health Development Agency 2004, *Clarifying health impact assessment, integrated impact assessment and health needs assessment,* NHS Health Development Agency, Wetherby, Yorkshire.

O'Byrne, D., Health Promotion [On-line] Available at: *http://www.goinginternational.org/english/pdf/archive/Byrne1_e.pdf#search=%22intersectoral%20action%20for%20health%22*

O'Keefe, E. & Scott-Samuel, A. 2002, 'Human Rights and Wrongs: Could Health Impact Assessment Help?' *Journal of Law, Medicine & Ethics,* vol. 30, no. 4, pp. 734-738.

Östlin, P. & Diderichsen,F. 2001, 'Equity-oriented national strategy for public health in Sweden: A case study', *Policy Learning Curve Series Number 1,* WHO European Centre for Health Policy, Brussels. [On-line] Available at: *http://www.who.dk/Document/E69911.pdf*

Painter, C. & Clarence, E. 2001, 'UK Local Action Zones and Changing Urban Governance', *Urban Studies,* vol. 38, no. 8, pp. 1215-1232.

Partnerships for Better Health. Intersectoral Community Action for Health Initiatives (PowerPoint presentation), New Zealand Ministry of Health. [On-line] Available at: *http://www.arts.auckland.ac.nz/lpg/docs/InterSectoral%20Community%20Action%20for%20Health%20-%20Partnerships%20for%20better%20health.pdf*

Pemba, S. & Ndeki, S. 1994, 'Continuing education. The experience of Tanzania', *Health Action',* vol. 8, pp. 6-7.

Perera, M.A.L.R. 2006, *Intersectoral action for health in Sri Lanka,* Institute for Health Policy, Sri Lanka.

Pleasence, P. *et al.* 2004, 'Civil law problems and morbidity', *Journal of Epidemiology and Community Health,* vol. 58, pp. 552-557. [On-line] Available at: *http://jech.bmj.com/*

Powell, M. & Moon, G. 2001, 'Health Action Zones: the 'third way' of a new area-based policy?,' *Health and Social Care in the Community,* vol. 9, no. 1, pp. 43-50.

Rachlis, M. 1999, *Intersectoral Action and Health (paper presented at workshop* sponsored by Health Canada (Alberta and NWT) in partnership with Alberta Health and Alberta Community Development)

Radnor, Z. & Lovell, B. 2003, 'Success Factors for implementation of the balanced scorecard in a NHS multi-agency setting', *International Journal of Health Care Quality Assurance,* vol. 16, no. 2, pp. 99-108. [On-line] Available at: *http://emeraldinsight.com/0952-6862.htm*

Ramduny, V. 1998, 'Intersectoral Working In Practice', *HST Update,* Issue No. 32, p. 3. [On-line] Available at: *http://www.hst.org.za*

Ramduny, V. 1998, 'Policy in Progress Intersectoral Collaboration-An Overview', *HST Update,* Issue No. 32, pp. 5-8. [On-line] Available at: *http://www.hst.org.za*

Resource Centre: Intersectoral Action for Health Toolkit (webpage) 2004, Health Canada and Dieticians of Canada [On-line] Available at: *www.dietitians.ca/resources/resourcesearch.asp?fn=view&contentid=2480*

Rowling, L. & Jeffreys, V. 2005, *Intersectoral action in health promoting schools: Whose evidence should shape practice?* (PowerPoint presentation) University of Sydney, Sydney. [On-line] Available at: *http://www.aracy.org.au/pdf/events/2005ConferenceSpeakers/2005%20ARACY%20Conference%20P25Louise%20Rowling%20220705.pdf*

Rychetnik, L. & Wise, M. 2004, 'Advocating evidence-based health promotion: reflections and a way forward', *Health Promotion International,* vol. 19, no. 2, pp. 247-257. [On-line] [Accessed January 18, 2007] Available at: *http://heapro.oxfordjournals.org/cgi/reprint/19/2/247?ijkey=cef8d37df67db443fd40a5f6ebc2380c9feac3fc*

Sanchez, L. *et al.* 2005, 'Intersectoral coordination in Aedes aegypti control. A pilot project in Havana City, Cuba', *Tropical Medicine and International Health,* vol. 10, no. 1, pp. 82-91.

Ståhl, T. *et al.* 2006, *Health in All Policies Prospects and potentials,* Ministry of Social Affairs and Health, Health Department, Finland & European Observatory on Health Systems and Policies, Helsinki.

Sullivan, H., Judge, K., & Sewell, K. 2004, 'In the eye of the beholder: perceptions of local impact in English Health Action Zones', *Social Science & Medicine,* vol. 59, pp. 1603-1612.

Swedish International Development Co-operation Agency, 1999, *Reaching the Goals in the S-21: Gender Equality and Health Volume II* (reference document submitted to the Organisation for Economic Co-operation and Development)

Tackling Health Inequalities – The UK Situation (meeting summary) 2006, European Commission Expert Working Group on the Social Determinants of Health Inequalities.

The Swedish Public Health Policy – Principles and Process (summary of presentation) Dr. Piroska Östlin, Director of the National Institute of Public Health, May 14, 2003, Observatoire montréalaise des inégalités sociales et de la santé (OMISS), Montreal.

Usmani, A. *Primary Health Care* (PowerPoint presentation) [On-line] Available at: *www.publichealth.pitt.edu/supercourse/SupercoursePPT/9011-10001/9471.ppt#287,13,Comprehensive PHC*

van Herten, L.M., Reijneveld, S.A. & Gunning-Schepers, L.J. 2001, 'Rationalising chances of success in intersectoral health policy making,' *Journal of Epidemiology and Community Health,* vol. 55, pp. 342-347. [On-line] Available at: *http://jech.bmj.com/*

von Schirnding, Y. 2005, 'Short report The World Summit on Sustainable Development: reaffirming the centrality of health', *Globalization and Health,* vol. 1, no. 8, pp. 1-6. [On-line] Available at: *http://www.globalizationandhealth.com/content/1/1/8*

Wanless, D. 2002, *Securing our Future Health: Taking a Long-Term View,* U.K. Treasury, London.

Wanless, D. 2004, *Securing Good Health for the Whole Population,* U.K. Treasury, London.

WEHAB Working Group 2002, *A framework for action on health and the environment,* World Summit on Sustainable Development (WSSD), Johannesburg. [On-line] Available at: *http://www.un.org/jsummit/html/documents/summit_docs/wehab_papers/wehab_health.pdf#search=%22intersectoral%20action%20for%20health%22*

Welsh Assembly Government 2003, *Health impact assessment and government policymaking in European countries: A position report,* Welsh Assembly Government, Cardiff, Wales.

Whitehead, M. & Dahlgren, G. 2006, 'Levelling up (Part 1): a discussion paper on concepts and principles for tackling social inequalities in health', *Studies on social and economic determinants of population health, No. 2,* WHO Regional Office for Europe, Copenhagen.

WHO 1997, *Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-First Century Report to the International Conference 20-23 April 1997 Halifax, Nova Scotia, Canada,* World Health Organisation, Geneva.

WHO 2004, *Health as a Cross-cutting Issue in Dialogues on Water for Food and the Environment Report of an International Workshop Jointly organized by WHO and InWEnt (Capacity Building International) Amman, Jordan 15-18 December 2003,* World Health Organisation, Geneva. [On-line] Available at: *www.iwmi.cgiar.org/dialogue/files/pdf/Activities/Jordanworkshop/WSH04.02.pdf*

WHO Commission on Social Determinants of Health 2005a, *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health* (Discussion paper for the Commission on Social Determinants of Health) Draft 5 May 2005, WHO Commission on Social Determinants of Health, Geneva.

WHO Commission on Social Determinants of Health 2005b, *Action on the social determinants of health: Learning from previous experiences* (a background paper prepared for the Commission on Social Determinants of Health) March 2005, WHO Secretariat of the Commission on Social Determinants of Health, Geneva. [On-line] Available at: *http://www.who.int/social_determinants/en/*

WHO Commission on Social Determinants of Health 2006a, *WHO Commission on Social Determinants of Health: Brazil* (webpage) 2006 [On-line] Available at: *http://www.who.int/social_determinants/country_action/brazil/en/index.html*

WHO Commission on Social Determinants of Health 2006b, Health Pamphlet, [On-line] [Accessed November 27, 2006] Available at: *http://www.who.int/social_determinants/resources/csdh_brochure.pdf*

WHO Commission on Social Determinants of Health 2006c, *Proposed areas of investigation for the KN: An initial scoping of the literature,* (prepared for the first meeting of the Health Systems Knowledge Network of the WHO's Commission on Social Determinants of Health by the Health Systems Knowledge Network Hub) Discussion Document No.1 Draft February 2006.

WHO, 'Country Health Profile Sri Lanka', [On-line] Available at: *http://www.searo.who.int/LinkFiles/Sri_lanka_srilanka.pdf*

WHO Regional Office for Europe (eds.) 1999, *Health Impact Assessment Main concepts and suggested approach Gothenburg Consensus Paper,* WHO Regional Office for Europe, Copenhagen.

WHO, *Working with civil society. Tapping civil society potentials* (webpage), World Health Organisation in collaboration with the Training and Research Support Centre (TARSC), Zimbabwe. [On-line] available at: *http://www.tarsc.org/who/4002.html*

Woods, S. E., Lake, J. R. & Springett, J. 2003, 'Tackling health inequalities and the HAZ Smoking Cessation Programme: the perfect match?,' *Critical Public Health,* vol. 13, no. 1, pp. 61-76.