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Intersectoral models to build healthy public policy: A review of the evidence

Produced for Wellbeing SA

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make history.

Stretton Health Equity has prepared this evidence review on intersectoral models of healthy public policy for Wellbeing SA.

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Executive summary

Introduction

This review is intended to inform the ongoing work of Wellbeing SA on intersectoral approaches, including different models of Health in All Policies, designed to build healthy public policy in South Australia.

Healthy public policy

- Healthy public policy is concerned with health in its broadest sense and with ensuring that the public policy impacts on health and wellbeing are considered in policy decisions in all sectors of government, including through the equitable distribution of income, accessible quality housing and meaningful employment.
- The development of the concept of healthy public policy has been underpinned by recognition of the link between health outcomes and the social determinants of health and health equity.
- Examples of healthy public policy include policies on urban planning that promote active transport and are pedestrian and cycle friendly, and economic policies that address income distribution, employment and affordable housing.

Social determinants of health and health equity

- The social determinants of health are the "non-medical factors that influence health outcomes".[1] They are the conditions in which people are born, live, work and age, and the wider set of forces and systems that shape the conditions of daily life which include economic policies and systems, social policies and political systems. Addressing the social determinants of health and health equity requires an intersectoral collaborative approach because most of these factors are outside of the responsibility of the health sector.
- Despite evidence that the influence of social determinants is at least double that of health systems on population health, there is a continued focus on targeting health systems and individual behaviours.[2, 3] Without a social determinants of health perspective, the focus of intersectoral collaboration remains on lifestyle and behavioural factors and does not address the underlying causes of ill-health.
- The influence of the commercial determinants of health – the practices of transnational corporations and their dominance of global trade – on population health is increasingly being recognised. This influence occurs through transnational corporations' production methods, influence on regulatory structures governing their activities, and results in shaping the social determinants of health.

Enablers and barriers for successful intersectoral collaboration

- The key factors that support successful intersectoral collaboration include:
  - Political will for intersectoral collaboration
  - Governance structures that support intersectoral collaboration, giving a mandate and creating an authorising environment. Intersectoral collaboration advances most with coordination from the head of the jurisdiction (e.g. Prime Minister's/ Premier's department)
  - Leaders and champions that promote intersectoral collaboration
  - Resources to undertake collaboration
  - A shared plan and agreed common goals between participating agencies
  - Trust between partners

- The key barriers to intersectoral collaboration identified in the literature include:
  - Changing political priorities
  - Changing organisational structures
  - Funding cuts
  - Changing staff and loss of leaders/champions
  - When led by health, intersectoral collaboration can be viewed as health imperialism by other sectors, creating resistance to perceived health dominance.

Models of intersectoral collaboration for healthy public policy

- The variety of models for intersectoral collaboration range across a continuum of relationships – from strong partnerships to softer forms of cooperation and approaches. Some models have a top-down approach, relying on government authority, while others involve bottom-up collaboration with the community. Models can involve local, state, and/or federal governments.
- Complementary, strategic, evidence-based intersectoral collaboration at local, regional, and national levels was found to be important to addressing the social determinants of health. Despite the many different approaches to intersectoral collaboration internationally, there are consistent aims across the continuum of models including: bringing sectors together to find shared solutions to complex and persistent multisectoral problems, addressing social determinants of health, and producing healthy public policy.
- The models identified in the literature include:
  - Healthy Cities – implemented locally with a focus on local government, community participation, and urban planning and design
  - Health in All Policies (HiAP) – a collaborative approach that integrates and articulates health considerations into policymaking across sectors with a focus on achieving participating sectors' goals and co-benefits
  - Other similar models and initiatives, including:
    - Models that build local and regional action for healthy built environments
    - Issues-centred approaches located in municipal governments.
- There were limitations to municipal intersectoral collaboration, which mainly had an emphasis on smaller-scale interventions intended to change intermediary determinants such as health behaviour, rather than addressing the structural determinants of health, for example poverty, race, and level of education.
- The HiAP model in South Australia has been identified as an exemplar of a centralised model of HiAP. Nordic countries are exemplars of decentralised or 'community' HiAP models in which central governments provide the strategy and legislation, funding, and research support, but local governments are responsible for implementation. While Nordic countries have been identified as exemplars, this is for scenarios in which HiAP leadership has been shown, and there is a conducive context with high welfare state provision. However, rising rhetorical commitment to HiAP in these Nordic countries has been undermined by political and economic changes.

- All the models of intersectoral collaboration identified in this review are mechanisms to progress intersectoral collaboration to produce healthy public policy.

There is no 'one size fits all' model. Context is important in determining which model is suitable and appropriate for producing healthy public policy.

The role of community participation

- Evidence supports the role of community participation in improving policy, planning and services, and health outcomes. There is a spectrum of community participation which ranges from consultation (seeking community opinions on proposed plans) to structural participation (community participation as an engaged, developmental and empowering process).
- Aboriginal Community Controlled Health Services (ACCHSs) are exemplars of community participation in Australia that provide a model of participation for health services seeking to embed participatory mechanisms in their practices. They include a formal mechanism for community participation through community-controlled boards of governance.
- The primary purpose of engaging communities from a policy perspective is to promote more responsive public services and to improve service quality. However, while commitment to community action in policy terms is common (at least in rhetoric), the practice of effectively engaging with communities has proven to be complex.
- Community consultation is understood to widen the knowledge base and experience incorporated into policy considerations, to test new policy proposals, and to assist governments to identify the needs and expectations of consumers and interest groups more accurately. Community consultation is often more episodic than the structural participation approach of community empowerment that suggests a more ongoing and active relationship.
- In Australia there has been a retreat from more empowering, collective structural participation and concepts of citizen power to an individualised focus on consumer consultation.

Skills for intersectoral collaboration

- Effective intersectoral collaboration relies on the capacity of organisations to devote meaningful resources to a collaborative initiative; the recognition of common or converging values and objectives and agreed solutions to identified problems; and on acceptable compromises where there are conflicting interests between the organisations.
- Within organisations, leadership and championing by senior decision makers has a key role in establishing the case for change, securing resources, and providing a supportive authorising environment. Without the organisational support of leadership within the partner organisations, this work will remain marginalised.
- Boundary spanners seek to negotiate agreements between systems and create links and networks to align activities and produce shared outcomes. They seek to develop a shared vision, shared goals, and a shared approach, and to foster coordination across organisational boundaries.
- Maintaining trust within partnerships through fulfilling commitments and maintaining open communication assists in developing credibility.
- Intersectoral collaboration depends on the knowledge, skills, personal characteristics, and experience of individuals. The literature identifies the necessary skills and competencies that reflect collegiality, such as respect, diplomacy, and regard for others. Other capabilities include the capacity for big picture thinking, problem-solving skills, coordination, and engagement skills (bringing people together), brokering skills (seeing what needs to happen), flexibility, and the ability to negotiate shared practices and outcomes.
- Although technical skills were recognised as important, greater emphasis was placed on the need for the 'softer' influencing and negotiating skills to raise awareness of the potential health impacts of other sectors' policies, to influence other sectors to act, and to resolve differences.
- Communities of Practice (CoP) can be used to develop skills for intersectoral collaboration for health. Factors that influence their effectiveness include having leadership, reciprocity, and trust, identified strategic objectives and commitment to these objectives, clear and defined measures of success, relevance to context, and appropriate technological support.
- Challenges associated with CoP include managing contrasting expectations from members about roles, actions, outputs, and outcomes, establishing a natural leader and/or core group, low level of interaction between members, gaps in skills/competencies and lack of identification with the CoP. The creation and maintenance of a shared vision that is relevant to local communities is important for fostering commitment to objectives and enthusiasm for the work of the CoP.
- CoP can support implementation of evidence-based strategies to improve health within and across communities and can be a valuable strategy to support staff implementing intersectoral collaboration.

Section 1
Background to the concept of healthy public policy

Healthy public policy is concerned with health in its broadest sense and with ensuring that the public policy impacts on health and wellbeing are considered in policy decisions in all sectors of government.

The concept of healthy public policy has links back to the community-based social movements of the 1960s and 1970s with their understanding that health is created outside the health system and their arguments for the need for social reform and action at the system level to achieve change. The WHO Alma Ata Declaration of 1978 first acknowledged the important role of intersectoral collaboration for health.[4] It recognised that health and wellbeing is influenced by the decisions and policies of other sectors and that to achieve significant health gains the health sector needs to work in partnership with other sectors. This provided the foundations for the Ottawa Charter for Health Promotion in 1986 which made building healthy public policy the first of its five key action areas to provide a framework for health promotion action.[5] The five action areas are to:

1. Build healthy public policy to ensure that policy developed by all sectors contributes to health-promoting conditions (e.g. healthier choices of goods and services, equitable distribution of income).

2. Create supportive environments (physical, social, economic, cultural, spiritual) that recognise the rapidly changing nature of society, particularly in the areas of technology and the organisation of work, and that ensure positive impacts on the health of the people (e.g. healthier workplaces, clean air and water).

3. Strengthen community action so that communities have the capacity to set priorities and make decisions on issues that affect their health.

4. Develop personal skills to enable people to have the knowledge and skills to meet life's challenges and to contribute to society (e.g. life-long learning, health literacy).

5. Reorient health services to create systems which focus on the needs of the whole person and invite a true partnership among the providers and users of the services.[5]

The Ottawa Charter sought to put health on the agenda of policy makers in all sectors and to identify obstacles to the adoption of healthy public policies in non-health sectors, and ways of overcoming these obstacles. It was underpinned by the ideas and values of social justice and equity, ecosystem health, empowerment, a whole-of-government approach and the settings approach. Box 1 provides examples of healthy public policy outcomes.

Box 1: Examples of healthy public policy

Healthy public policy examples include:

- Mandated wearing of seatbelts in cars and helmets on bicycles
- Regulation of healthy foods and food safety
- Policies on urban planning that support active lifestyles and are pedestrian and cycle friendly
- Economic policies that address income distribution, employment, affordable housing
- Policies to reduce greenhouse gas emissions to reduce catastrophic climate change impacts

Law has recently become a focus of public health as a tool of healthy public policy. It can be a powerful instrument to address the social determinants of health and reduce health inequities.[6]

The WHO Commission on the Social Determinants of Health in 2008 documented the evidence for action on the social determinants of health and health equity and highlighted the need for intersectoral collaboration and cooperation to address them.[7] This was followed in 2015 by the adoption by UN Member States of the 17 Sustainable Development Goals[8] which have a strong focus on intersectoral collaboration and include a focus on addressing climate change and working to preserve and protect our environment.

Section 2
Introduction to Social Determinants of Health

There has been a growing awareness over the past four decades of the role of social factors in influencing health outcomes and inequalities, commencing with the publication of the UK Black report in 1980.[9]

The Black report provided detailed evidence that health inequalities were increasing in the United Kingdom and concluded that these inequalities were mainly attributable to the influence of social inequalities including income, education, housing, employment and working conditions.[9] The World Health Organisation Commission on Social Determinants of Health (CSDH) (2005-2008) gathered evidence on what needed to be done to reduce health inequalities within and between countries.[7] The CSDH report reinforced the findings of the UK Black report that avoidable health inequalities both between countries and within countries arise from the circumstances in which people "grow, work, and age, and the systems put in place to deal with illness".[7] These circumstances were noted to be shaped by political, social, commercial, and economic forces.[7]

Figure 1 presents the CSDH conceptual framework which shows how social, economic, and political mechanisms result in stratification of populations into socioeconomic positions by income, education, occupation, gender, and race/ethnicity. Box 2 provides the WHO description of social determinants of health that is drawn from the evidence presented in the CSDH.

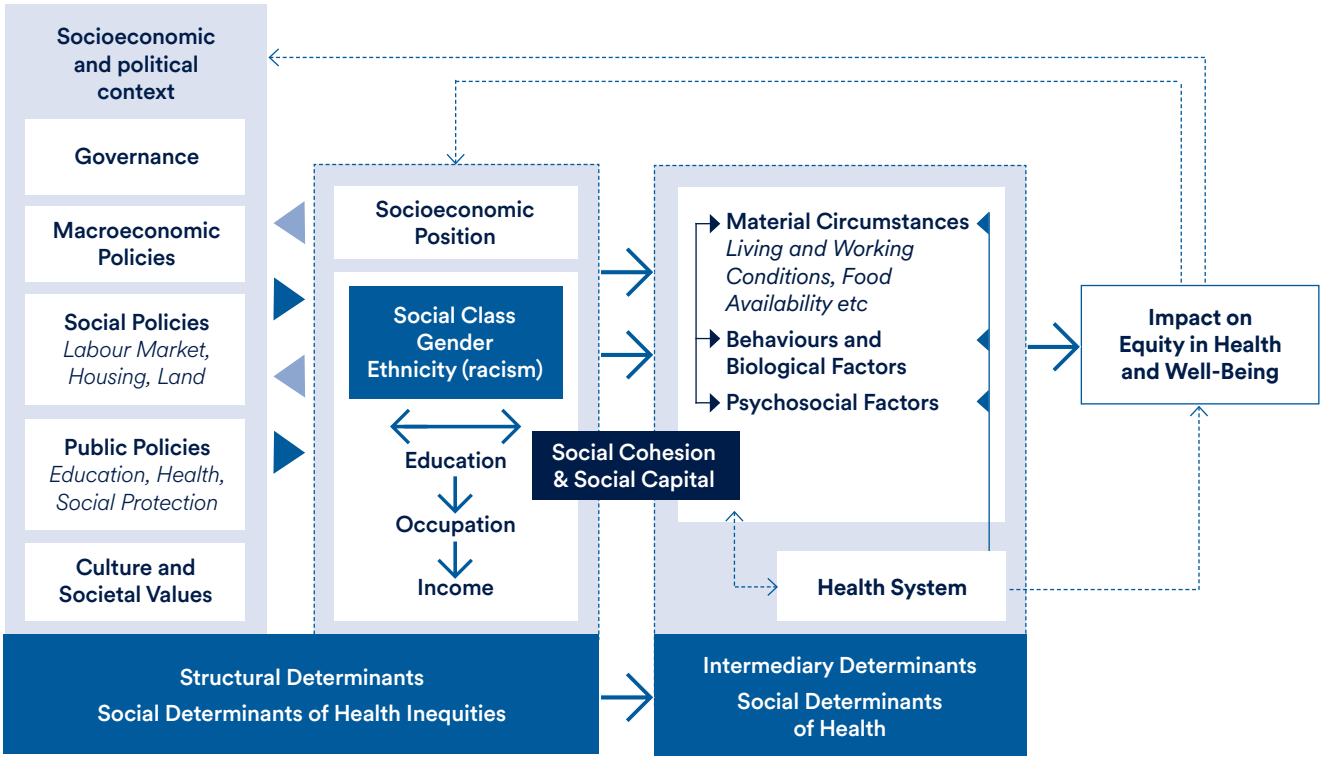


Figure 1: Commission on Social Determinants of Health conceptual framework

There is a growing international literature that has built on the findings of the CSDH report, providing evidence on the social determinants of health as drivers of population health outcomes and health equity.[10-13] This literature has also compared the contribution of health systems and social determinants to population health and found that the influence of social determinants is at least double that of health systems.[14] Despite this evidence, there is a continued focus on targeting of health systems and individual behaviours.[2, 3] Without a social determinants of health perspective, the focus of intersectoral collaboration is all too often on lifestyle factors.

There are two central views in public health policy as to how population health may be improved: a focus on unhealthy behaviour (behavioural health promotion), and views that underlying social and economic determinants produce health outcomes. Behavioural health promotion that focuses on lifestyle factors is dominant in policies developed by contemporary governments despite the considerable information and evidence on social determinants of health.[15]

Many background or policy papers on health promotion are subject to lifestyle drift, the 'tendency for policy to start off recognising the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors.'[16] Behavioural health promotion is an inadequate strategy for addressing social inequities in health. Accumulating evidence on social determinants of health is clear that achieving health equity requires policies that change the conditions in which people live.[15]

Box 2: WHO description of social determinants of health

'The social determinants of health are "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."[17]

The commercial determinants of health – practices of the private sector – are also increasingly acknowledged to influence population health through production methods, influence on regulatory structures governing business activities, and through shaping social determinants of health.[18, 19] Examples include extractive industry transnational corporations (mining) and the fast food corporate sector. In particular transnational corporations have grown in power and influence in the past three decades due to substantial tax breaks and subsidies.[20]

> The growth in the power and influence of transnational corporations and their domination of global trade and investment have resulted in their practices having fundamental influences on public health.[21]

They have the capacity to influence the regulatory environment, aspects of their outputs harm health, and there is a power disparity between transnational corporations and local communities that oppose their operations.[18, 19] There is growing recognition of the role commercial factors play in conjunction with social, environment and economic factors to shape diet and physical activity.[22] These determinants of obesity are outside of the health system, highlighting the importance of intersectoral responses.[22]

Health in all Policies (HiAP) is one approach to developing healthy public policy across sectors that emphasises the consequences of public policies on determinants of health, and aims to improve accountability of policymakers for health impacts.[12] There are few examples of HiAP that have a strong equity focus.[23] A review of the literature on opportunities and barriers for implementation of HiAP in EU countries found that this is partly because a greater understanding is needed of the differences between health inequity and health inequality (see Box 3), and better national and local

data are needed to understand health inequalities.[23] Health equity was not the dominant focus of the HiAP initiative in South Australia at its establishment but there was still an evident focus on equity as an underpinning principle.[24] Increased emphasis on economic priorities in 2014 in response to a worsening economy shifted the policy focus away from equity.[24] Rhetorical commitments to equity in HiAP have also been undermined by economic changes in Nordic countries.[25]

Lack of success in incorporating health equity into intersectoral collaboration was noted to be a feature in the literature on both HiAP and Health Impact Assessment (discussed in Section 4 below).[23]

Figure 2 shows the links between the concepts of social determinants of health and health equity, intersectoral collaboration (the mechanism), healthy public policy (the output), and an equitable and healthy population (the desired outcome).

Without a social determinants of health perspective, the focus of the adopted approaches will be on individualised lifestyle factors and behaviour change, and so the policy output will not address the underlying causes of ill health and will not achieve health equity.

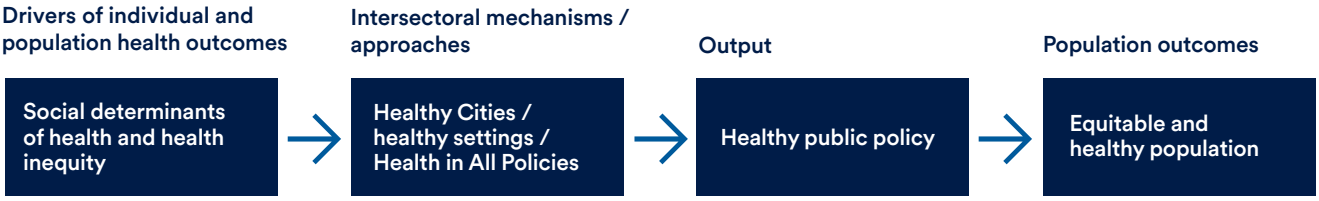
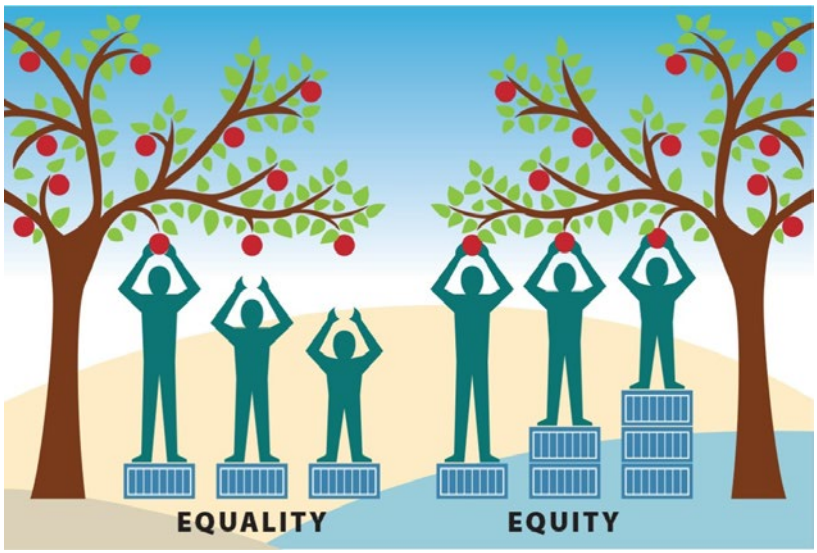


Figure 2: Links between the concepts of social determinants of health, Health in All Policies and healthy public policy



Box 3: Defining health equity

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health—such as poverty and discrimination and their consequences, which include powerlessness and lack of access to good jobs with fair pay; quality education, housing, and health care; and safe environments.

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and in the determinants of health that adversely affect excluded or marginalized groups."[26]

Health equity is not about treating everyone the same (equality). It is not just about a focus on disadvantaged groups. It is also about levelling the social gradient whereby those who are less advantaged in terms of socioeconomic position have worse health and shorter lives than those who are more advantaged.[27] Achieving health equity requires levelling the social gradient across all of society.

Section 3

Key factors for and barriers to success in intersectoral collaboration

There is a large literature on intersectoral collaboration for health. The implementation of intersectoral collaboration in a growing number of countries has increased interest in how to maximise effectiveness of intersectoral approaches.[28]

A theme identified in many papers is the key factors for and barriers to success.[23, 28-32] These feature heavily in lessons learned from implementing intersectoral collaboration in different countries around the world and are framed positively in the literature as providing opportunities for implementing successful intersectoral collaboration.[23, 28, 32] Many factors associated with the success of intersectoral collaboration are dependent on context, but similar key factors are identified consistently throughout the literature on specific approaches to intersectoral collaboration[23, 28, 33] and intersectoral collaboration more generally.[29, 31, 32] The commonly identified factors for success are summarised in Box 4 and include political will, governance, leaders and champions, resources, shared plans and common goals, and trust.

These factors are often interdependent in influencing outcomes of intersectoral collaboration.[34] A transparent, shared plan and agreed common goals contribute to stronger working relationships and building trust. Absence or lack of the identified factors can be barriers to success. While all the factors in Box 4 contribute to successful outcomes, some of these conditions are more powerful determinants of success than others.[34] Resources to undertake a collaboration are crucial and without them intersectoral collaboration cannot be implemented or sustained.[34] Although the factors for success are important, the key to getting started with intersectoral collaboration is finding appropriate entry points.[35] The "win-win" approach adopted by HiAP focuses on identifying co-benefits so that the intersectoral policy approaches contribute to improved health outcomes but also contribute to outcomes desired by other sectors in the collaboration (e.g. education, environment or transportation).[35]

Box 4: Summary of key factors for successful intersectoral collaboration identified in literature

Political will
Political commitment to intersectoral collaboration is a pre-requisite for success, particularly in the development phase but also throughout implementation. High-level political support is one of the most frequent triggers for initiating intersectoral collaboration.

Governance
An overarching high-level strategy can help overcome divisions arising from conflicting objectives across sectors and different levels of government, particularly if it specifically endorses intersectoral collaboration. A clear mandate for intersectoral collaboration from a central agency can facilitate implementation and departmental commitment.

Leaders and champions
Collaborative leadership and identifying a champion from each sector are important for fostering reliable collaboration. Identification of champions is facilitated through commitment of people working at policy level and in the field. Support from the head of the jurisdiction is also important – this was evident in South Australia.

Resources
Allocation of sufficient joint resources, both human and financial, is vital to support implementation and make intersectoral collaboration feasible.

Shared plan and agreed common goals
A common framework and defining shared objectives can facilitate development of a shared plan. A strategic plan that sets out common goals can also assist in identifying common ground and developing common agendas. Leaders can set an example through sharing responsibilities and agreeing to work towards a common goal.

Trust
Intersectoral collaboration works best when it builds on trust and partnership. Good collaborations are based on trust however this can take time to build. Collaborative leadership can assist in establishing a climate of trust.

Similar barriers to success are consistently identified in the literature on intersectoral collaboration as well. The commonly identified barriers are summarised in Box 5. Many of the barriers to intersectoral collaboration are the flip side of the success factors.[32] The lack of success in incorporating a health equity focus in intersectoral collaboration was identified in many papers.[23, 24] Barriers to success were also interdependent. The longer duration of projects involving intersectoral collaboration was identified as a threat to success, particularly if there was lack of clarity about the plan or political priorities changed.[28] Health departments also need to adopt new capabilities to work effectively across sectors.[30] Success or failure in building health department and other sector capacity can influence outcomes of intersectoral collaboration.[30]

Another challenge to intersectoral collaboration is where it is only supported by rhetoric and there is a lack of concrete investment in implementation.[32] This issue of rhetorical commitment has been observed in relation to healthy equity,[24] preventive public health, and social determinants.[25] Permanent structures for intersectoral collaboration on health and wellbeing have an improved chance of longevity compared with electoral mandates.[32] A change in government can challenge continuity of intersectoral collaboration in the absence of permanent structures.[32] Adequate resources and dedicated staff, particularly leaders and champions for intersectoral collaboration, are important for intersectoral collaboration to be feasible.[28, 36]

Box 5: Summary of barriers to successful intersectoral collaboration identified in literature

Changing political priorities and context
Initiatives involving intersectoral collaboration can be lengthy. If departmental or Government priorities shift during the project work or there are economic changes this can undermine commitment to intersectoral collaboration.

Changing organisational structures
A change in organisational structure can slow implementation of actions and lead to missed opportunities for intersectoral collaboration. It can also undermine intersectoral collaboration by changing workloads across sectors and changing responsibilities of key staff, including leaders and champions.

Funding cuts
Political context impacts on intersectoral collaboration: short-term investment of resources (to align with political terms) or funding cuts prevent sustainable intersectoral collaboration.

Changing staff and loss of leaders/champions
Lengthy intersectoral collaborations (and even those which are not lengthy) can be undermined by staff turnover. Loss of key staff and particularly loss of leaders and champions can impede collaboration and reduce commitment both within and across sectors.

Can be viewed as health imperialism
If sectors are told about problems and necessary actions in a way that is too focused on health, it can be viewed as health imperialism rather than true collaboration. Tactics used when approaching intersectoral collaboration are vital to avoid health actors coming across as outsiders with vested interests in an environment where staff in each sector work in silos with their own core concerns.

Section 4
Models of intersectoral collaboration

There are a variety of models for intersectoral collaboration and these range across a continuum of approaches.

Models also range across a continuum of relationships, from strong partnerships to softer forms of cooperation such as providing data, research, analysis, or other forms of information and cooperation .[35] Models also differ in the ways they join up health and other sectors. Some models have a top-down approach relying on government authority while others involve a bottom-up collaboration from the community.[35] Intersectoral collaboration can also take place at different levels of government: local, state, or federal. Despite the many different approaches to intersectoral collaboration internationally, there are similar aims across the continuum of models. These aims include bringing sectors together to find shared solutions, addressing social determinants of health, solving complex, interrelated and persistent 'wicked' problems, and production of healthy public policy.[35, 37]

Approaches to intersectoral collaboration to address healthy public policy include Healthy Cities and Health in All Policies (HiAP), as well as other models in different countries, regions, and cities, which vary these approaches.

Healthy Cities

Healthy Cities is an approach used for intersectoral collaboration at local government level. The Healthy Cities Movement began in 1984 with the "Beyond Health Care" conference held in Toronto and an aim to grow awareness of the need to move away from a focus on individualised lifestyle focused health promotion and instead move towards healthy public policy initiatives.[33] The Healthy Cities approach has a commitment to intersectoral collaboration and community participation and focuses on health as a social concept rather than a medical one.[33] It entails a local political commitment to the project, a city health plan based on community diagnosis, a commitment to develop specific Healthy City entry point strategies, obtaining the necessary funding and willingness to report back on agreed core indicators and on experiences of implementation.[33] Healthy Cities draws on urban planning, an ecological view of health, community-based work, and innovations in health promotion.[33, 37] In Australia the three original Healthy Cities – Canberra, Noarlunga and the Illawarra were funded through a Federal grant for three years. In 2022, Illawarra and Noarlunga (renamed Onkaparinga) are still active albeit in a model that differs from the original WHO prescription. Box 6 describes the Onkaparinga example of Healthy Cities.

> Healthy Cities mobilises stakeholders through a participatory approach, and has been described as a framework for a participatory process to respond to health issues emerging due to urbanisation.[38]

The objectives of Healthy Cities are to strengthen urban governance, reduce health inequities, ensure policy coherence for health, and promote continuous innovation for health.[38] The WHO European Healthy Cities Network has been strong for more than three decades and has brought together 100 flagship cities interacting directly with WHO.[39] The Network also comprises almost 30 national networks which bring together cities within Healthy Cities Member States.[39] WHO provides political, strategic and technical support and capacity building to flagship cities and national networks.[39] There is also a Western Pacific Alliance for Healthy Cities, established in 2004.[40] Box 7 describes Changwon Healthy Cities, a member of the Alliance for Healthy Cities.

Belfast Healthy Cities is one of the longest running examples of Healthy Cities. Belfast was first designated to the WHO European Healthy Cities Network in 1988 with phase I (1988 to 1992) involving a partnership model based on community participation, intersectoral collaboration and reducing inequalities in health.[41] Belfast Healthy Cities is now in Phase VII and works with stakeholders from local and regional government departments, universities, and from private, public and community sectors. Phase VII work on WHO core themes is informed by an overarching regional framework, the Northern Ireland Programme for Government, which is a cross departmental framework.[42]

Box 6: Case study example of Healthy Cities in Noarlunga, South Australia

A current Australian example of Healthy Cities is Healthy Cities Onkaparinga, a community led bi-partisan coalition of agencies and community members in South Australia which originated from an Australian Government three year pilot of Healthy Cities in Noarlunga, Canberra and Illawarra (1987 to 1989).[43, 44] Healthy Cities Onkaparinga no longer has government funding but as a community-led initiative it provides community members with the opportunity to raise health issues of concern and to work to address these issues using the Ottawa Charter for Health Promotion as its primary reference.[43]

Vancouver City Council unanimously approved a Healthy City Strategy in 2014 focused on three areas of intervention: healthy people, healthy communities, and healthy environments. Vancouver's Healthy City Strategy (2014-2025) represents the social sustainability pillar of the City's sustainable development framework and complements the pillars of economic and ecological sustainability. The Strategy commenced with a four year action plan (2015-2018) that contained 19 actions and managing and monitoring is undertaken by 30 members from public institutions, provincial and federal agencies, foundations and the private sector and is co-chaired by the City Manager and Chief Medical Health Officer.[31]

Box 7: Case study example of Changwon Healthy Cities, South Korea

Changwon, South Korea, was a founding member of the Alliance for Healthy Cities in 2004.[40] Members of the Alliance for Healthy Cities follow WHO guidelines, along with national and regional recommendations.[40] Changwon was the first planned city in South Korea and the fourth in the world, and through Healthy Cities has integrated concern for sustainable public health into the cities' approach to social and economic development.[40] Changwon declared itself a 'cycling city' in response to an increase in emissions from motorised vehicle use and has also committed to health as a human rights issue and a development responsibility.[40] Changwon Healthy Cities re-framed development so that economic development is used to improve health and welfare, rather than development being an end in itself.[40]

Healthy Cities and the role of local governments have gained new attention and significant prominence in the context of the implementation of the Sustainable Development Goals (SDGs).[45]

Nine factors have been identified as central to the sustainability of Healthy Cities, drawn from the example of Healthy Cities Noarlunga. These factors are 1) a social health vision; 2) inspirational leadership; 3) model adapted for local conditions; 4) juggling competing demands; 5) strongly supported community involvement; 6) recognition by those involved that Healthy Cities is a relatively neutral space in which to achieve goals; 7) university links and research focus; 8) international links and WHO leadership; and 9) transition from project to approach.[46] A sustainable Healthy Cities initiative provides a base for success in achieving health promotion outcomes over time.[46]

A sustainable Healthy Cities initiative provides a base for success in achieving health promotion outcomes over time.

There are many factors that have a direct or indirect impact on the health of the community at the local level, and context and local politics are central to any Healthy Cities project. Because of this complexity, it is not easy to demonstrate a direct causal link between a Healthy Cities project and a health outcome.[46] However, the literature suggests that evidence can show that a Healthy Cities initiative can lead to activities that can be reasonably linked to expected health outcomes based on program logic.[46] For example, supporting evidence for the outcomes of Healthy Cities approaches can be deduced from research into urban design and environmental health,[47] where for example there is evidence that urban design, access to green space, and transport have a direct impact on people's health in cities.[48] It can also be found in relation to the role of intersectoral action between policy makers, researchers and community representatives, which has been shown to lead to better health action and health outcomes, with networking itself found to be an important contributor to initiating and maintaining health action.[47]

Health in All Policies

HiAP and Healthy Cities share consistent aims, but the focus of most use of HiAP has been at federal or state/provincial level[49] whereas Healthy Cities is implemented at local level. HiAP has been adopted by many cities, regions and countries and has been defined by the WHO as 'an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity'.[50] Cairney, St Denny and Mitchell[25] identified five elements of HiAP: 1) treat health as a human right; 2) identify evidence of the 'social determinants' of health inequalities; 3) recognise that the ability to affect health is predominantly held by other sectors rather than by health departments; 4) promote intersectoral policymaking and collaboration inside and outside of government; and 5) generate political will to develop healthy public policy.[25] A HiAP approach has also been described as focusing on the development of partnerships for healthy public policy through identifying 'win-win', coproduction and 'co-benefits' from intersectoral collaboration.[36]

The governance structures for a HiAP approach are formal and sustained structures, mechanisms managed outside the health sector to ensure policies have at least neutral or positive impacts on population health.[51]

HiAP has been suggested as an approach to addressing policy problems that are complex and intractable, where cause and effect have not been clear, and solutions require interdependent effort[35]. The attempt to implement joined-up government in the 1990s in the UK and Nordic countries was motivated by the need to develop new strategies to address persistent social and health challenges.[35] By 2010, HiAP approaches had been reported from at least 16 countries and regions around the world, nearly all of which undertook a mixture of universal and targeted HiAP approaches to improve health for all and address health inequities.[35] Measuring success from implementing HiAP is difficult, but the literature does highlight key factors for success (discussed in section 3), and examples of successful models of HiAP. Box 8 describes an Australian example of HiAP.

Box 8: Case study example of HiAP in South Australia

The HiAP model in South Australia has been identified as a best case centralised model and as an exemplar of a HiAP model.[25] It was established by the state government, backed by a whole-of-government strategic plan and with strong rhetorical political support and was introduced with a clear supportive mandate and in a supportive context.[25] The South Australian approach developed and applied a Health Lens Analysis process to support HiAP.[52] The Health Lens Analysis provided a rapid, policy relevant assessment of the impact of policies outside the health sector, highlighting connections and interactions between health and core business of other sectors.[53] HiAP sought to engage early in policy development processes in South Australia and the Health Lens Analysis contributed to agenda setting and provided practical processes for undertaking intersectoral action.[52, 53]

A five-year NHMRC funded evaluation of the South Australian model of HiAP identified five key lessons: 1) context is vital and can help and hinder implementation; 2) South Australian HiAP focused on win-win strategies to achieve a high degree of consensus and implementation of initiatives to change daily living conditions but had few avenues for community involvement. Actions to change social determinants of health and redistribute resources require strong citizen involvement, and a strong advocacy approach, and may require other approaches to intersectoral action; 3) regional HiAP initiatives need to be complemented by HiAP in national governments where there are more powerful levers to change the distribution of power, money and resources; 4) not all HiAP initiatives were successful however this is not surprising with an innovative approach that must be allowed to experiment to learn; 5) HiAP was successful at keeping focus on whole populations and initiatives that required small shifts to have a significant positive impact across the population. There was some evidence of reversion to a focus on lifestyle factors but it was minor compared with success in focusing on population wide policies.[54]

Nordic countries have been identified as exemplars of decentralised or 'community' HiAP models in which central governments provide the strategy and legislation, funding, and research support, but local governments are responsible for implementation.[25] While Nordic countries have been noted to represent exemplars, this is for scenarios in which HiAP leadership has been shown, and there is a relatively conducive context with high welfare state provision, however rhetorical commitment to HiAP in Nordic countries has been undermined by recent political and economic changes.[25]

While HiAP has mostly been a central government approach to developing healthy public policy through intersectoral collaboration and co-benefits, there is potential for it to be strengthened through approaches such as that adopted in Nordic countries, and to build the role of local government and a strong focus on community engagement and self-determination.[49] Currently Wellbeing SA has established a Cultural Determinants of Health Aboriginal

Health Promotion team with the intent of combining community insights with the bureaucratic authority to make change.[55] This is an example of the nutcracker effect by which the problem of health inequities is tackled both by bottom up and top down action to "crack" the problem.[56]

Aboriginal Community Controlled Health Services (ACCHSs) are exemplars of community participation in Australia that provide a model of participation for health services seeking to embed participatory mechanisms in their practices and to address local social determinants of Aboriginal health.

Since the 1970s, ACCHSs have provided accessible, effective, appropriate, needs-based health care with a strong focus on prevention and social justice. Findings from a study of comprehensive primary health care in Australia found that as a model for comprehensive primary health care, ACCHSs demonstrate strong outcomes in relation to multidisciplinary work, community participation, cultural respect and accessibility strategies, prevention and health promotion, and advocacy and intersectoral collaboration on social determinants of health, compared to the other participating state-managed and non-government services.[57] ACCHSs have a formal mechanism for community participation by way of community representation on boards of governance.[58-60]

Models of HiAP have been implemented in developed and developing countries and regions. HiAP models were formally adopted by 2010 in Australia, Brazil, Cuba, England, Finland, Iran, Ireland, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales.[35] Other global examples of HiAP include the Philippines, Fiji, Mongolia, Ecuador, El Salvador, California.[35] New and emerging case studies of HiAP have also been identified in China, Sudan, Suriname, Namibia and Zambia.[61] The variety of models for interaction between health and other sectors and the continuum of relationships is illustrated in Table 1 with examples of countries that have adopted these models.

Other models of intersectoral collaboration for healthy public policy

Other models of intersectoral collaboration have been implemented at local and regional levels. These include the healthy built environments initiative in Saskatoon, Saskatchewan, regional intersectoral round tables in Quebec, the Mobile Food Market Initiative in the Halifax region of Nova Scotia, collaborative action in social sectors in Waitakere City in New Zealand, and intersectoral policymaking in Danish municipalities.[29, 31, 62, 63] The Waitakere City example is based on a long history of community activism and interagency collaboration in regional and local areas.[62] Regional and local authorities established processes involving combined community sector and interagency forums, a series of which were held to promote wellbeing.[62] Community forum and government agency representatives met at community-wide Wellbeing Summits and developed a wellbeing collaboration strategy process.[62]

Table 1 Models of intersectoral interaction

Information	Cooperation	Cooperation and coordination	Coordination	Coordination and integration	Integration
Many countries	Brazil New Zealand	England Sri Lanka Wales	Malaysia N. Ireland Quebec Scotland S. Australia Sweden	Cuba Finland Thailand	Iran, Islamic Rep. Norway

Source: National Collaborating Centre for Determinants of Health 2012 in Lin V, Jones C, Wang S, Baris E. Health in all Policies as a Strategic Policy Response to NCDs. Health, Nutrition, and Population (HNP) Discussion Paper. The International Bank for Reconstruction and Development/ The World Bank. 2014, p21.[35]

There are several approaches to implementing intersectoral collaboration, one of which is a more issue-centred approach that aims to integrate a specific health concern into other sectors' policies.[29] This issue-centred approach is the Danish municipality experience which has similarities to a HiAP approach at local government level.[29] There were limitations to municipal level intersectoral collaboration, with emphasis on smaller-scale interventions intended to change intermediary determinants such as health behaviour, and this can be attributed to the defining of structural social determinants of health by national governments.[63] Complementary, strategic, evidence-based intersectoral collaboration at municipal, provincial, territorial and federal levels have an important role.[31] National implementation of intersectoral policymaking for health can overcome the limitations of decentralisation.[63]

The examples of intersectoral collaboration in Canada include multiple different models. Vancouver implemented a Healthy City strategy, and the Grey Bruce Health Unit in Ontario developed a HiAP approach that was also complemented by the Grey Bruce Healthy Communities partnership which was created in 2010 so that municipalities could partner with public health actors and community stakeholders. There are also examples of other models initiated as local and regional levels in Saskatchewan, Quebec, and Nova Scotia. The Quebec region created the first regional intersectoral round table on healthy lifestyles in 2004, and between 2004 and 2009 the 17 administrative regions in Quebec established regional intersectoral round tables. These were consultative and had the main objective of working toward healthy living environments.[31] The Mobile Food Market initiative in Halifax, Nova Scotia is an initiative involving residents, local businesses, the public sector and community organisations and was created in 2015 to improve access to fresh, high quality fruit and vegetables in the Halifax area. It operates at 13 sites and sells fruit and vegetables at a reduced price.[31]

The healthy built environment initiative in Saskatoon, Saskatchewan, built on several years of activity on active transportation led by the Health Promotion Department of the Population and Public Health Division. In late 2015 and early 2016, this activity was taken a step further with the decision to focus on the issue of health equity. The healthy built environment initiative was a partnership between departments in the Population and Public Health Division in the Saskatoon Health Region, the Transportation Division and Planning and Development Division of the City of Saskatoon, the University of Saskatchewan, and a group of associations that included a non-profit, a cycling association, and a community initiative.[31] These other models of intersectoral collaboration in Canada were not driven by a policy or mandate requiring collaboration on health issues, but rather by the political will of municipalities (in the example of the Mobile Food Market), incentive policies in the cases of the Quebec example, support from the heads of the Population and Public Health Division in the example of Saskatchewan, and forms of encouragement such as memorandum of understanding and Vancouver's Social Sustainability Strategy.[31]

> Health Impact Assessments (HIAs) are discussed in the literature on intersectoral collaboration but are not a model or approach, they are a tool to assess potential health effects of a policy, program or project.[64]

Involvement in HIA can promote intersectoral collaboration,[65] and HIA is commonly used as a tool for implementing HiAP.[66, 67] HIA is a predictive policy tool to minimise possible negative health impacts and maximise positive health impacts of a policy, plan, or program by informing decision makers of its health impacts.[68] There has been significant growth in the number of HIAs conducted and reported in developed and developing countries, including formal assessments that are compulsory for projects with large environmental impacts and HIAs used as a basis in urban planning.[12] Wales has mandated HIAs for public bodies such as the Welsh Government through its Well Being of Future Generations (Wales) Act 2015.[67, 69] The Wales Health Impact Assessment Support Unit provides support, training, and information about HIA.[69] The Well Being of Future Generations (Wales) Act also provides a strategic framework for Wales' HiAP approach.[69]

There is strong support for evidence of win-win mechanisms at local and state/provincial levels when using HIA as a decision support tool.[70] HIAs are typically introduced after a draft proposal has been developed but before implementation.[52] The Health Lens Analysis used in the South Australian HiAP is a similar technique to HIA, but Health Lens Analysis is able to be used much earlier in the process, at the conceptual stage or agenda setting stage where Health Lens Analysis can shape policy priorities.[52, 71] This is facilitated by those implementing HiAP working from inside the government system.[52]

Evidence on models of intersectoral collaboration in Wellbeing SA's priority focus areas

Wellbeing SA's strategic plan identifies the following priority focus areas: early life, chronic disease, injury prevention, Aboriginal health promotion, and mental health and wellbeing. The literature on models of intersectoral collaboration commonly discusses intersectoral collaboration broadly rather than for specific health priorities, but there are case studies that provide examples of models that have addressed one or more of the Wellbeing SA priorities. A search of Wellbeing SA priorities and intersectoral collaboration or collaboration identified literature relevant to chronic disease,[30, 72, 73] early childhood/early life,[74, 75] injury prevention (specifically road safety).[73, 76, 77]

Early life

Community-based intersectoral collaboration focused on aspects of early life has been implemented in rural communities in Tasmania.[74] One case study from the HiAP work in South Australia was also relevant to early life: a project with the education sector to increase parental engagement in children's literacy particularly in low socioeconomic status families.[75] HiAP was able to encourage change in South Australia through conceptualising education as a social determinant of health.[75] A desktop analysis of Australian early childhood education policy current in 2019 found that all jurisdictions' policies proposed an integrated approach to early childhood education and care, with child and family health and wellbeing services provided through intersectoral collaboration between government and public and private sectors, and through integrated services.[78] The integrated services were largely found to draw together health, family support and early childhood education and included universal, targeted and intensive services.[78]

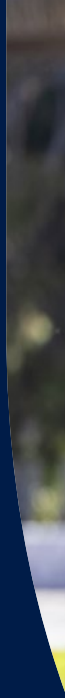
Chronic disease

Two reports that described where intersectoral collaboration has been applied to chronic disease provide examples that fall within HiAP approaches to non-communicable disease (NCD) prevention and control.[30, 73] Intersectoral collaboration and healthy public policy were noted to have been long recognised as essential for controlling NCD risk factors,[30] and these explicitly include mental health and wellbeing, another of the Wellbeing SA priorities. An EU funded 3 year project forged cross-sector alliances including regional and municipal authorities, community-based social organisations, civil society groups and organised volunteer networks to identify and enrol hard to reach population groups with chronic conditions into a self care program across 5 European countries.[79] In another approach, the Public Health Agency of Canada introduced a novel funding program that required applicants to secure matched funding from private sources to support large scale interventions for chronic disease prevention.[80] This co-funding model enabled government bodies to leverage funding from private sector sources. Challenges identified included partner capacity, and concerns about trust and the alignment of motivations and interests between partners.[80] The Alberta Healthy Living Network took a different approach to intersectoral collaboration focused on chronic disease risk factors and underlying determinants of health, forming an intersectoral network that consisted of 93 organisations by 2008 and included federal and provincial governments, regional health authorities, non-profit organisations, Aboriginal groups, the research community and member organisations outside the sector.[72]

The relationship between the social determinants of health and chronic disease is well established and relates to factors such as sex and gender identification, race and ethnicity, income and educational level, as well as systemic factors including the political and social conditions that support life chances in education, employment, housing, and social inclusion.[81] Addressing the social determinants to act on chronic disease has been identified as including: 1) intervening in the health care system to reduce the consequences of illness among those who are disadvantaged or vulnerable; 2) reducing the vulnerability of disadvantaged people to health-damaging factors; 3) decreasing exposure to health-damaging factors associated with lower socio-economic position, and 4) decreasing social stratification.[81]

Injury prevention

The most prominent injury prevention focused examples of intersectoral collaboration relate to road safety, including the WHO supported Russian and Mexican implementation of intersectoral road safety initiatives that arose from the Decade of Action for Road Safety 2011-2020.[76, 77] These initiatives involved collaboration at national and regional level in Russia[77] and at national, state and local level in Mexico.[76] Intersectoral collaboration on road safety in Vietnam was a transport sector-led initiative to introduce a helmet law that illustrated the health impacts of intervening in social determinants despite it not being introduced to tackle a health issue per se. [73]



Successful partnership with Aboriginal organisations requires considerable time and effort to develop, is more than consultation or engagement in an advisory capacity and should occur from initiation stage through to evaluation.

The Global Network on Safer Cities (GNSC) is another intersectoral initiative focused on injury prevention, specifically crime and violence prevention. The GNSC is a UN-Habitat initiative that equips local authorities and stakeholders to deliver urban safety and stimulates exchange between policymakers, institutions and NGOs working on urban development and crime prevention on prioritisation of safety.[82] The GNSC was launched in 2012 and its beneficiaries are local authorities in more than 100 cities that are involved in the safer cities programme of UN-Habitat.[82] There is also a Local Government Safe Cities Network in Australia. The Council of Capital City Lord Mayors and Australian Local Government Association formed the Local Government Safe Cities Network in 2004 (formerly named the National Local Government Drug and Alcohol Committee) to reduce harm and create safe spaces and places through urban design and planning.[83] The International Safe Community Certifying Centre leads the International Safe Community movement and designates International Safe Communities.[84] WHO has recognised the important mechanism of Safe Communities for coordination of evidence based action for prevention of violence and injuries.[84] Safe Communities are collaborations between local governments and communities.[84]

Aboriginal health promotion

The 1989 National Aboriginal Health Strategy criticised the ad hoc approaches to Aboriginal health that were prevalent in Australia at that time and reinforced the important role of Aboriginal Community Controlled Health Services.[85] The National Aboriginal Health Strategy also forcefully and repeatedly emphasised the importance of a need for intersectoral collaboration in Australia and better collaboration between Commonwealth and state governments, and between Aboriginal community, Aboriginal Community Controlled Health Organisations and government at all levels.[85, 86] The Achievements in Aboriginal and Torres Strait Islander Health project was commissioned in 2001 and found that partnerships between a range of government, non-government, and academic institutions in Australia, whilst not without difficulty or cost, contributed to successful programs and require strong policy support.[87] The project report noted that increased collaboration between organisations strengthened intersectoral collaborations but liaisons between Aboriginal community-controlled health services and government departments and organisations within both Aboriginal and Torres Strait Islander and non-Indigenous communities had been impeded by conflict.[87] Issues leading to conflict involved avoidance or suppression of meanings given to terms such as community-control in relation to the role of Aboriginal and Torres Strait Islander Health Workers which were unresolved barriers to progress.[87] Tensions between the Aboriginal community-controlled sector and governments was noted as likely to continue to play out in Australia.[87]

A decade later it was re-emphasised that partnerships between Aboriginal organisations and government are far more likely to be successful if the principle of self-determination for Aboriginal people and their organisations is honoured.[86] Successful partnership with Aboriginal organisations requires considerable time and effort to develop, is more than consultation or engagement in an advisory capacity and should occur from initiation stage through to evaluation.[86]

The South Australian HiAP health lens analysis of Aboriginal mobility, road safety and wellbeing straddles two of Wellbeing SA's priorities: Aboriginal health promotion and injury prevention.[73] This South Australian project aimed to identify ways of increasing Aboriginal life expectancy by increasing safe mobility options and improving road safety.[73] It was a multi-sectoral project that contributed to an outcome of legislative and policy changes to make the licensing system fairer for Aboriginal people living in one remote South Australian Aboriginal community. While HiAP was the first of multiple initiatives seeking to address Aboriginal road safety, recommendations from the HiAP project influenced the work, and the eventual changes increased driver training for some Aboriginal people.[54]

All the models of intersectoral collaboration described above are mechanisms to progress intersectoral collaboration to produce healthy public policy.

It is important to note that while some models may receive more focus in published literature than others, there is no 'one size fits all' model.

The context is important in considering which model of intersectoral collaboration is suitable as a mechanism for producing healthy public policy.

Section 5

The role of community participation

The original South Australian HiAP approach has focused on the role of central government agencies in intersectoral collaboration for policy to address the social determinants of health. This HiAP model has had limited engagement at the local level, or with the community.[54] Some other HiAP models have had a greater focus on community participation, for example the Grey Bruce Health Unit HiAP approach in Ontario includes the Grey Bruce Healthy Communities Partnership which works towards policies to improve health of residents in the region[31] (as discussed in section 4).

Community participation is a core principle of comprehensive primary health care.[4] In the Alma Ata Declaration, participation covers a spectrum of ideas, including individual participation in clinical decision making, the mobilisation of community resources in the delivery of health care, and collective participation in the planning and implementation of health services.[59] It has been found to result in improved health outcomes, equity, access, quality and responsiveness and to increase people's control and ownership of services and of decision making processes.[88]

The International Association for Public Participation (IAP2) advances the practice of public participation through professional development, standards of practice, advocacy and initiatives with strategic partners around the world.[89] It has three pillars for public participation processes which include core values, a code of ethics and a spectrum of public participation.[89]

There is a strong evidence base demonstrating that the level of control an individual has over their life circumstances is a significant determinant of health outcomes.[90] There is also a growing evidence base on the role of 'collective control' as a mechanism to enhance population health and address the social determinants of health inequities.[91]

Community participation can be divided between utilitarian and empowerment models. In the utilitarian model of community participation, an organisation uses participation as a means to achieve its project aims. In contrast, the focus of the empowerment model is on community ownership and control. The empowerment model uses participation as an end, where local communities take responsibility for diagnosing and working to solve their own health and development issues and exercise collective control to address inequities.[91, 92]

A synthesis of lessons about community participation from the literature found that:[93]

- The terms 'community' and 'participation' mean different things to different people in different circumstances. There is no standard definition of community participation.
- Context is important. Participation cannot be considered outside the political context. Effective participation encounters issues of power and control over decisions, particularly those related to resource utilization.
- It is not possible to create broad, self-sustaining community participation through health services alone. People and communities have other priorities beyond their health, such as food, shelter, education and income.
- History and culture are defining elements of the value, structure and sustainability of community health programs, with or without community participation.

Typologies of community participation

Typologies of community participation provide tools to understand the extent and purpose of participation. A recent typology of community participation provides a conceptual framework for understanding participation and the degree of power and control that may be redistributed through the participative process:[10]

- *Structural participation*: participation as an engaged and developmental process, for example through an elected board of governance, community control predominates, co-production and co-governance, ongoing, potentially empowering
- *Substantive participation*: community actively involved in determining priorities and implementation, for example through community meetings, steering committees or collaborative relationships and joint planning, but external control remains, may lead to shift in power over time
- *Participation as a means*: using participation to achieve a defined end such as increased participation and compliance within a health intervention, for example through a community meeting or local advisory group or community education group, no shift in power, driven by organisation
- *Consultation*: asking for people's opinions and reactions to policy plans, for example, through feedback surveys or focus groups, limited one-off and controlled by consulting organisation.

Evidence supports the role of community participation in improving policy, planning and services, and health outcomes[58, 59] (although more evidence is required on the link between community participation and health outcomes).[94] While participation and inclusion are necessary conditions for empowerment and collective control, there is also a need for attention to the breadth (inclusion) and depth of participation (the extent to which it enables the exercise of collective control).[60]

Challenges for implementation of community participation

The primary purpose of engaging communities from a policy perspective is to promote more responsive public services and to improve service quality. However, while commitment to community level action in policy terms is common (at least in rhetoric), the practice of how to engage effectively with communities has proven to be complex.[95] Box 9 presents challenges for the implementation of community participation, and factors affecting the forms of participation that are achievable. These can be related to power, transferability, support and resources, and representation.

Pre-conditions for effective community consultation

Community consultation is understood to widen the knowledge base and experience incorporated into policy considerations, to test new policy proposals, and to assist governments to identify the needs and expectations of consumers and interest groups more accurately. However, community consultation is often more episodic than the structural participation approach of community empowerment that suggests a more ongoing and active relationship. Effective engagement with the community can benefit the community participants through increased knowledge and understanding, solidarity and trust.[88, 97]

In Australia there has been a retreat from more empowering, collective structural participation and concepts of citizen power to an individualised focus on consumer consultation which would be classified lower in the participation typology.[59, 98] For example, in South Australia, government public policy consultation evolved over the last decade from direct consultation with the community to an invitation to individuals to contribute their views through an online consultation hub, YourSAy.

There are a number of key pre-conditions in government departments that support community participation and consultation:

- a mandate and official endorsement at senior levels of government
- staff with expertise, experience and skills in community participation
- decentralised and devolved decision-making allowing for greater responsiveness and flexibility
- simple, clear and consistent structures and procedures
- stability in functional responsibilities and continuity of staff with local knowledge in program areas
- balanced requirements for economic efficiency and social justice
- presence of pre-existing and ongoing constructive relationships with communities
- valuing the knowledge and experience of community members
- representative mechanisms in a diverse community that respect difference.[88]

Box 9: Challenges for implementation of community participation and factors affecting achievable forms of participation

Power

- tension between centralised decision making and control, and local participation and empowerment
- removing barriers between professionals and community members promotes alliances and partnerships
- shared ownership leads to greater understanding and commitment, empowerment and shared decision making

Transferability

- different issues emerge at the local level from state, national or international spheres, and what is useful at one level is not necessarily easily transferable to another

Supports and resources

- budget constraints, competing priorities, short timeframes and a focus on quick wins rather than building long term relationships and trust
- the need to build leadership skills, and staff knowledge and skills in community participation, and to build the capacity of and empower community members

Representation

- major challenges can arise from the diversity of stakeholder groups and interests
- extending participation beyond existing service users to hear a multitude of community voices in planning and decision making to build trust and enhance partnership with the community
- strategies are required to support the involvement of marginalised population groups
- need for community representation on boards of governance
- collaboration with community organisations.[59, 96, 97]

Section 6

Building skills that support intersectoral collaboration for healthy public policy

There is an extensive literature on intersectoral collaboration, much of which identifies facilitators and barriers to collaboration, including the organisational culture and capacities and the staff skills required to support effective collaboration between sectors. While the skills of individuals are important to make intersectoral collaboration work, effective intersectoral collaboration also requires the active support of organisations. Box 10 summarises the key organisational and individual skills identified in the literature as supporting intersectoral collaboration.

Box 10 – Organisational capacities and staff skills that support intersectoral collaboration

Organisational capacities

- adequate and meaningful resourcing, including financial resources and dedicated staff
- recognition of shared values and objectives
- identification of shared solutions and acceptable compromises where organisational interests conflict
- presence of leadership and change champions creating an authorising environment for staff to work across sectors and an agenda for change
- presence of boundary spanners developing a shared vision and approach, and fostering coordination across organisational boundaries
- trust based on previous positive collaboration experiences and presence of long term relationships and networks

Staff skills and competencies

- respect, diplomacy and regard for others, capacity for big picture thinking, problem-solving skills, coordination and engagement skills, brokering skills, flexibility, ability to negotiate shared practices and outcomes
- knowledge of strategic priorities and of the issues on which action is sought, the issues' history and potential health impacts
- knowledge of wider context and understanding of institutional, policy and political contexts operating within collaborating sectors
- supportive 'soft skills' such as negotiation, collaboration, partnership and trust building skills
- supportive attitudes such as willingness to learn and try new ways of working, ability to work in teams, and valuing innovation

Organisational capacities and culture

Research has found that effective intersectoral collaboration relies on the capacity of organisations to devote meaningful resources to a collaborative initiative, including the allocation of sufficient financial resources and dedicated staff.[99, 100] Effective intersectoral collaboration also relies on the recognition of common or converging values and objectives, on solutions to identified problems and on acceptable compromises where there are conflicting interests between the organisations.[99]

Leadership and championing

Leadership and championing by senior decision makers have a key role within the participating organisations. Senior decision makers can establish the case for change and secure the resources required to support collaboration. A supportive management provides the authorising environment and allows the flexibility that is critical to support and enable staff to work collaboratively across sectors.[28, 101] Senior decision maker leadership can bring together the commitment of individual staff members with the power of the organisation, creating an authorising environment that mandates and supports collaborative initiatives to address complex multisectoral policy problems.[28, 100] This has been found to be strengthened by a central mandate for intersectoral collaboration to develop healthy public policy.[54] Change champions across each level of the collaborating organisations can nurture the right skills and attitudes among staff, undertake creative problem solving and harness collaborative opportunities.[28, 54, 102]

Organisational leadership that provides a supportive environment for intersectoral collaboration as well as setting a clear agenda for change is central to the success and sustainability of collaborative initiatives.

As well as having strong leadership from the top, leaders at all levels that actively champion collaboration and facilitate collective processes are essential.

Without the organisational support of leadership within the partner organisations, this work will inevitably remain marginalised.[101]

Boundary spanning

Individual staff who undertake networking tasks and work in a coordinating way across boundaries within or between organisations are described in the literature as boundary spanners.[103] Boundary spanners seek to negotiate agreements between systems and create links and networks to align activities and produce shared outcomes. They seek to develop a shared vision, shared goals and a shared approach, and to foster coordination across organisational boundaries. Research has shown that when undertaken effectively, interactions between boundary spanners create social relationships that reveal interdependencies between the systems.[103, 104]

Boundary spanners have a particular set of skills that enable partnerships to function more effectively. These include negotiating skills, network management, personal communication, strategic brokering, policy entrepreneurship and being able to identify new opportunities. Boundary spanners establish a climate of trust in which collaboration can work and have been found to be essential for effective partnerships.[103, 105, 106]

Trust

The importance of trust to effective collaborative relationships is highlighted in the literature. Maintaining trust within partnerships through fulfilling commitments and maintaining open communication assists in developing credibility. It enables stakeholders to deal constructively with differences as they emerge, and supports jointly owned decisions and mutually agreed ways of working together. A supportive authorising environment and mandate can enable collaborative action to commence while trust between partners is still developing, but positive experiences of collaboration and the development of long term relationships and networks are essential to trust developing and being sustained, and to the future of collaborative partnerships.[28, 107] The development of networks, shared power and trust-based relationships are important to the effectiveness of partnerships and of staff working as boundary spanners.

The social environment in which boundary spanners function, in organisations and the space between them, means that they need to develop special skills and practices. The literature suggests that these skills are specifically about working effectively with people who have different perspectives, priorities, interests, or cultural or professional backgrounds. Skills are required to transcend these differences and find the common ground upon which collaboration can be developed to achieve shared goals. People manifesting these skills are characteristically described as acting with integrity and inspiring trust.[101, 104] Even where trust has not developed or there is mutual distrust between the partner organisations, boundary spanners may be able to operate effectively as a result of the trust placed in them as individuals with credibility because of their skills and ways of working, although mistrust between partner organisations may limit their potential impact and capacity to achieve significant positive outcomes.[103, 107]

Staff skills and capabilities

While organisational culture, leadership and support and a positive context are essential to effective intersectoral collaborative partnerships, individuals make intersectoral collaboration work. They work within and can be constrained by the organisational culture. They have the vision, initiate the action, communicate with others, decide on the direction of action and the resources required. Intersectoral collaboration depends on the knowledge, skills, personal characteristics and experience of individuals.[100] The literature identifies the necessary skills and competencies that reflect collegiality, such as respect, diplomacy and regard for others. Other capabilities include the capacity for big picture thinking, problem-solving skills, coordination and engagement skills (bringing people together), brokering skills (seeing what needs to happen), flexibility, and the ability to negotiate shared practices and outcomes.[101, 108]

The following principles of partnership underpin the skills required for staff to work collaboratively across sectors:

- Recognise and accept the need for partnership
- Develop clarity and a realistic purpose
- Ensure commitment and ownership
- Develop and maintain trust
- Create robust and clear collaborative working arrangements
- Monitor, measure and learn.[109]

The attributes, skills and capabilities identified in the literature as being required by staff to effectively lead intersectoral collaboration and build partnerships for healthy public policy have been succinctly summarised by Harris et al[100] within the categories of knowledge, 'soft skills' and attitudes. We have further developed these attributes and skills based on current literature:

Knowledge

- Knowledge of the strategic priorities, activities and workings of their organisation and of those with whom they are working
- Understanding of the issues around which they are taking action and the strategies shown to be effective, including having the knowledge to be able to identify the potential health impacts of proposed plans[28]
- Understanding of the previous history of the proposed action, including any past dealings between the organisations and how these have been perceived
- Knowledge of the wider context in which they are working and understanding the institutional, policy and political contexts that operate within the collaborating sectors.[28, 100]

This knowledge may already be possessed by staff as a result of previous experience or may be acquired through interactions with others from their own and partner organisations.

The 'soft skills' needed for effective collaboration

'Soft skills' include negotiation, collaboration, partnership and trust building skills,[23] supported by the following capabilities:

- Interpersonal skills that support the development of good relationships and help build alliances[23]
- High verbal and written communication skills – communication is intricately related to the flow of information, role clarity, ownership, visibility and transparency issues, as well as perceptions of equal power between partners[96]
- Ability to work effectively in small and large group settings to maximise participation, promote consensus decision making and achieve action-oriented closure of discussions
- Ability to think innovatively and beyond one's own policy areas, for both health and other sectors[23]
- Knowing how to package information, brief senior decision makers, access relevant information networks
- Ability to identify 'win-win' solutions where there are evidence-based co-benefits for health and other sectors[23]
- Mediation, negotiation and conflict resolution skills, and ability to find positions of compromise[23]
- Ability to translate information so that it is clear for different professional groups and sectors
- Ability to listen to and value others' contributions, and to be inclusive, flexible and adaptable
- Skilled at reflective practice.[100, 102]

Attitudes

- Promoting creativity and risk taking among stakeholders
- Willingness to learn and try new ways of working
- Valuing innovation at all levels of the organisation
- Ability to work in teams, a clear sense of their own role in relation to others and sharing rewards and recognition for participation with the participating partners on the task.[100]

Although technical skills were recognised in the literature as important[23], greater emphasis was placed on the need for the 'softer' influencing and negotiating skills to raise awareness of the potential health impacts of other sectors' policies, to influence other sectors to act, and to resolve differences.[23, 102]

The way that this is done is critical, to ensure that the health sector is not perceived by other sectors as being 'health imperialist' with vested interests and its own agenda, but rather is genuinely collaborating for the mutual benefit of all partners.[23, 53]

The health sector predominantly has strong biomedical and clinical technical skills rather than being focused on addressing population health and health inequity. Other sectors struggle also to understand health equity beyond addressing the needs of disadvantaged groups. There is little understanding across all sectors of the need to flatten the social gradient across the whole of society to address the causes of the social determinants of health.[24]

Communities of Practice

Communities of Practice (CoPs) can be used as a workforce development strategy to develop staff skills for intersectoral collaboration for health. CoPs have been implemented in many fields to engage a group of people in intersectoral collaboration to address common issues of community concern.[110] A CoP has previously been described as 'groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis'.[111] Members of an intersectoral CoP take part in mutual exchange of information and resources which can enhance collaborators' capacity to develop, adapt, implement, and evaluate strategies to address an issue.[110]

The literature on CoPs consistently identifies certain factors that enable success. These include having leadership, reciprocity and trust, identified strategic objectives and commitment to these objectives, clear and defined measures of success, relevance to context, and appropriate technological support.[110, 112, 113] Challenges associated with CoPs include managing contrasting expectations from members about roles, actions, outputs and outcomes, establishing a natural leader and/or core group, low level of interaction between members, gaps in skills/competencies and lack of identification with the CoP.[72, 113, 114] The creation and maintenance of a shared vision that is relevant to local communities is important for fostering commitment to objectives and enthusiasm for the work of the CoP.[113]

A CoP can promote development of expertise in contexts where there is general agreement about a common purpose but understanding of the means to achieve that purpose is lacking.[112] CoPs can engender social learning to enhance practice.[112] A facilitator is required as a key leadership role to support a CoP and maintain momentum during the launch phase and beyond.[110, 114] A champion or advocate (either an individual or a group) is another key leadership role to support the development and ongoing promotion of the CoP with both existing and new collaborators.[110] Face to face interactions facilitate building of trust and strengthen relationships,[112] but there are also advantages to virtual CoPs with accessible technology which can facilitate information sharing among participants[113, 115] and use common social software to increase the reach of the CoP.[114]

> A model of CoP can be a means of developing intersectoral working that can both promote partnerships and move towards sustainable change that has a positive influence.[113]

Expertise is an outcome of interaction within a CoP, and results from a "common set of experiences, attitudes and passions".[112] Communities of practice can support implementation of evidence-based strategies to improve health within and across communities.[110] They can therefore be a valuable strategy in implementing intersectoral collaboration.

Section 7

Conclusion

This evidence review has found that there is significant intersectoral action for health in many different forms occurring in many countries around the world.

Despite the different approaches to intersectoral collaboration internationally, there are consistent aims across the continuum of models including: bringing sectors together to find shared solutions to complex and persistent multisectoral problems, addressing social determinants of health, and producing healthy public policy.

Evidence supports the role of community participation in improving policy, planning and services, and health outcomes. Democratic processes that are inclusive and support citizen and community participation need to be refined and developed so these benefits can be realised. Equity requires the involvement of those whose health is most compromised, and this is especially the case for Aboriginal and Torres Strait Islander peoples given their history of dispossession and colonialism.

This review has identified the organisational capacities and staff development needs required for effective intersectoral action. It has also identified Communities of Practice as a strategy to assist in developing intersectoral ways of working to both promote partnerships for health and equity and in order to enhance the processes that lead to healthy public policy and then, in turn, improved health and equity.

A very clear message from the variety of strategies and approaches evident in intersectoral models of healthy public policy is that one size does not fit all, and that context is important in determining which model is most suitable and appropriate for producing healthy public policy.

There is an increased need for governments to act on the social and commercial determinants of health. Healthy public policy which does this is vital to improving both population health and health equity. Addressing the social and commercial determinants of health requires an intersectoral collaborative approach because most of these factors are outside of the responsibility and control of the health sector.

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We acknowledge and pay our respects to the Kaurna people, the original custodians of the Adelaide Plains and the land on which the University of Adelaide's campuses at North Terrace, Waite, and Roseworthy are built. We acknowledge the deep feelings of attachment and relationship of the Kaurna people to country and we respect and value their past, present and ongoing connection to the land and cultural beliefs. The University continues to develop respectful and reciprocal relationships with all Indigenous peoples in Australia, and with other Indigenous peoples throughout the world.