Moving Forward to Equity In Health

What kind of intersectoral action is needed? An approach to an intersectoral typology.

Partnership and Intersectoral Action

Conference Working Document

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1. INTRODUCTION

Historically in public health, a systematic approach to the problems of a population's health has frequently been advocated, in particular, one which considers the different social, administrative and economic sectors, as well as the diversity of cultures and values that organize and stratify societies. Health problems in a broad sense have diffuse boundaries and health determinants are largely outside the direct scope of the health sector, allowing for the assertion that problems can hardly be solved by exclusive actions of the health, or any other sector. This is even more relevant if health aims to effectively reduce health inequities, as addressing health inequities necessarily involves addressing social determinants of health. This is one of the central arguments for working "together" with other sectors or having health impacts considered in other sectors' actions, the so-called "intersectoral action" for health.

Intersectorality is one of the recurring issues in public health management, however there is very little documentation and systematization of its practice, especially within the health field. Nor is there an explicit theory on which to build a framework for analysis of which types of intersectoral action are more feasible under different scenarios. The notion of intersectorality refers in principle to the integration of various sectors with a view to solving social problems. But the term has different connotations depending on the assumptions adopted, and even, according to what is meant by "sector". At the same time, implementing this integrated approach involves actions related to planning and implementation that may bring to the fore contradictions between the interests of various sectors and social groups such as professional bodies, trade unions and employer organizations, neighbourhood associations, consumer groups, among others. This implies that it is necessary to include in the debate the distribution of power among the various groups behind intersectoral action. There are various definitions of an intersectoral approach; some are more general, and others are specifically related to the health system. We would like to highlight a few of them:

> *"Convergence of efforts of different governmental and nongovernmental sectors to produce comprehensive and integrated policies that provide answers to general needs "*
>
> (Fernandez and Mendes, 2003).

> *"Articulation of knowledge and experience in planning, implementation and evaluation of actions with the objective of achieving integrated results in complex situations, looking for a synergistic effect on social development"*
>
> (Junqueira & Inojosa, 1997).

> *"Coordinated intervention of institutions representing more than one social sector, in actions designed, totally or partially, to address issues related to health, welfare and quality of life "*
>
> (Castells M, 2004).

In line with these definitions, since the early 1980s, the Pan American Health Organization has defined intersectorality as the process in which the objectives, strategies, activities and resources of each sector are considered in terms of their implications and impact on objectives, strategies, activities and resources of other sectors (WHO/PAHO, 1982)

All of these definitions take into account not only public administration, but also the different social actors. These definitions imply two assumptions that are highlighted by N. Cunill. The first is that integration between sectors enables the search for comprehensive solutions. This premise **expressly assigns a political basis** to intersectorality and translates into the assumption that all public policies pursuing global development strategies such as changing the quality of life of the population should be planned and implemented across sectors. The second premise that is behind part of the discourse on intersectorality is that integration between sectors allows for differences between them to be used productively to solve social problems. This premise refers **to a technical basis** of intersectorality consistent with the idea of creating better solutions (at sectoral level) because it allows sharing of resources and knowledge that are specific to each sector.

Existing at the country level are a variety of intersectoral practices, related to national and local contexts with different conceptions of intersectorality. These result in technical and political arguments associated with the countries' development. However, we wish to emphasize in this paper the specific aspects of the health sector, both in its conceptualization and practice, which influence the development of intersectorality. The first is the health sector's vision and the pattern of health actions that prevails within the sector (health). The second is the vision of health present in the other sectors (as health is seen by other sectors and actors). Third is the presence or absence of health in all other social policies (health in all policies). We explore these aspects of intersectorality in order to gain a better understanding of a typology of intersectoral work in practice.

2. PRELIMINARY PROPOSAL FOR A TYPOLOGY OF INTERSECTORAL WORK IN HEALTH PRACTICE

We understand by typology the different patterns of how practice leads to intersectoral action or "intersectoral work". This is based in part on the theoretical frameworks underpinning intersectorality and health, and the objectives that gave rise to such initiatives, but also in the nature and framing of the public policy in question. The typology might provide clues to understanding entry points for action on the social determinants of health, that could eventually be tracked to more sustained ways of working within and across government and society.

When the conceptualization of the problem is predominantly associated with the social production of health and disease and quality of life of our societies, intersectoral work by health and other sectors becomes a technical and political mandate. At the same time, when the agenda is concerned with the confluence of factors that cause health inequities, its genesis is understood and associated with social determinants, and in this way the health sector cannot avoid looking to other social and governmental sectors to design, plan and/or run policies, programs or actions. This is in contrast to the situation where health is seen as a process associated primarily with access to curative and preventive medical services, where the relationship of health with other sectors is not a priority goal.

In this paper we will discuss intersectorality as a new rationale for management that seeks to overcome the fragmentation of policies, considering the concept "health" as a whole, and which offers a new way to plan, implement and monitor service delivery. These aspects have a direct relationship with the concept of governance, mainly at national and organizational levels, as defined by Graham and colleagues (2003). This requires consideration of some features identified by Stoker (1998), such as: those which include a complex set of institutions and actors beyond the government; recognizing that the limits and responsibilities of each

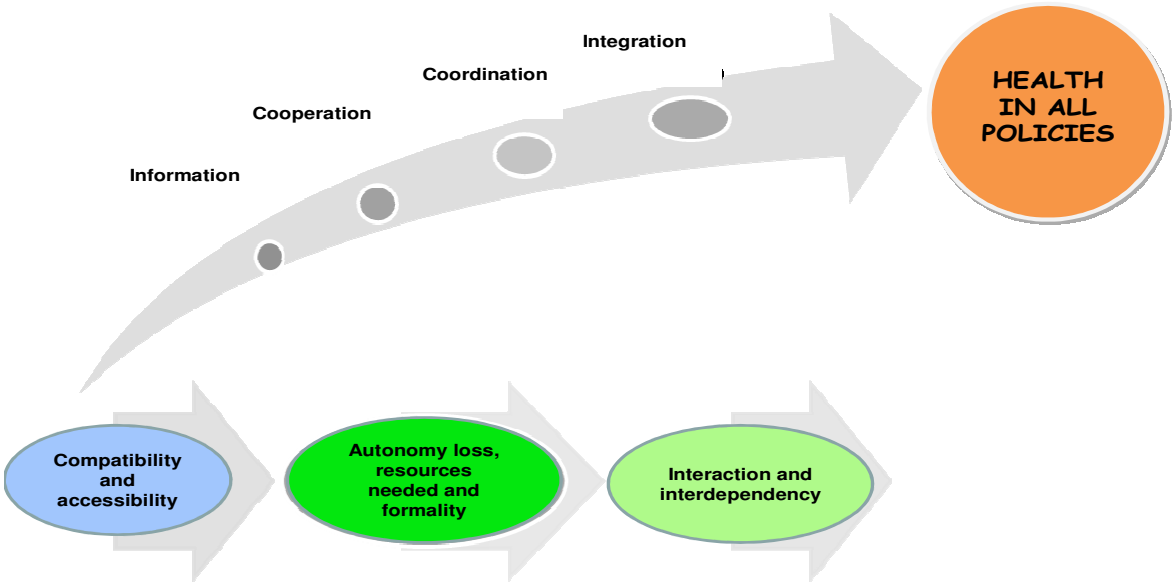
sector to reduce inequities are not clear, which implies a joint responsibility; involving a collective action powered by units organized to support the relationships between institutions; and that the distribution of power is part of the exercise of intersectorality, but this does not mean removal of authority from contributing parties and driving capacity but rather "using new tools to steer and guide".

For the construction of the typology, we have considered three dimensions. We start with the observed **pattern of relationship of health with other sectors**. This results in part from the type of structure given to the work by the process and the trajectory of the development of the working relationship and process, which defines the use of "governance tools to promote coherence, collaboration and partnership at work" as noted by Louise St-Pierre and collaborators (2009). The second dimension is the **vision of health and society that supports health and health action.** We argue that this second dimension largely defines the type of relationship with other sectors as well as the type of participation and involvement of civil society and the community as a whole. The third dimension is **the entry levels for implementation of intersectoral work**, at national, regional, organizational, local and community levels. We will develop the first two dimensions and will only give a few examples of the third; we plan that in a future release of this paper, each dimension will be developed in more detail associated with cases and practical experiences, with the aim of having a more robust way of articulating entry point and enabling country stakeholders to assess which situation they are in with respect to these dimensions of intersectoral work. In addition, there are important aspects to consider in the construction of the typology that have also not been included in this first version, which are related to funding mechanisms, the mechanism(s) for exercising influence in other sectors and the time and other resource requirements for supporting sustainability and intersectoral work, which is preliminarily described by St-Pierre et al (1999) in the framework used to analyse the six case studies commissioned by the Dutch Council for Public Health and Health Care.

2.1. PATTERN OF RELATING WITH OTHER SECTORS:

In the following diagram, we have tried to systematize the level or type of relationship with other sectors, that frames the intersectoral approach as part of a developmental process where each state is characterized by the level of inclusion with other sectors, leading to the "ideal" integration of health into all policies.

FIGURE 1: POSSIBLE MODES TO ENGAGE WITH OTHER SECTORS



Source: Own compilation based on Netherland Policy Integration E. Meijers. Adapted by 0. Solar.

First, it is noted that in order for working with other sectors to be possible, there must be some kind of evidence (or consciousness) that the solution to the problem in question cannot be achieved through a single sector. It must be perceived that the benefits of cooperation or coordination outweigh their costs. Intersectorality, applied to the development of policy and/or program planning, requires ad hoc institutional arrangements. These institutional changes can occur in the structural or management scope of work. It is important to note that coordination results in a relative loss of organizational autonomy, hence, it can generate strategies of resistance.

The diagram is based on work by E. Meijers related to the integration of policies for addressing environmental issues. Below we will briefly discuss each of the patterns of relationship, of the health sector with other sectors:

A. RELATIONSHIP WITH OTHER SECTORS: INFORMATIVE.

This is based on the information exchange with other sectors, whether the results of a study, analysis or problem in the sector. It relates to the areas identified as relevant to this issue, and it is a one-way relationship. It is usually associated with instructions from the health sector, involving a problem where the other sector plays a passive reception. On the other hand, it can be viewed from another perspective, as a first step in a process of intersectoral information that is part of the process of building a common language for achieving dialogue and understanding. In pursuit of this, one is striving to instil in the other sector a greater knowledge of the logic or business of the health sector, but also crucially the health sector is expected to be more aware of the logic and priorities of other sectors, in order to identify commonalities and key aspects for a joint work process.

B. RELATIONSHIP WITH OTHER SECTORS: COOPERATION.

This refers to interaction between sectors to achieve greater efficiency in the actions of each sector. This would essentially convert an incidental, casual or reactive cooperation into actions strategically oriented to those problems where the activities of other sectors may be decisive; this means that on many occasions it is public health who leads them. Generally it prevails through aiming at optimizing the resources of different sectors, laying down some formality in the relationship of work and results in a certain loss of autonomy for each of the sectors. The issue implies interest and benefits for involved sectors. This type of intersectorality is basically present in the field of enforcement or implementation of programs or policies, not in its formulation.

C. RELATIONSHIP WITH OTHER SECTORS: COORDINATION.

This involves a joint work effort involving the adjustment of policies and programs of each sector in search of greater efficiency and effectiveness, and points to a more horizontal networking among sectors. There is also usually a shared financing source. This is of great importance, since to create synergies (or at least avoid anti-synergies) within public administration it is necessary to take a broader view of the issues or problems at hand, especially when it comes to developing a new inclusive rationality as the one offered by intersectorality. It is not enough for there to be planning and definition of joint responsibilities between the involved sectors. It is also essential that this understanding be reaffirmed in the plans and budgets of each one of them. This translates into greater dependence between sectors and hence a loss of autonomy of each one of them. These aspects are crucial to recognise when analysing the barriers to intersectoral work, that are related to the new work logic and distribution of power, in order to develop coordination with other sectors.

D. RELATIONSHIP WITH OTHER SECTORS: INTEGRATION.

Integrated work involves defining a policy or program together with other sectors, where there is a new policy that represents more than the work of one sector. In this regard, some key elements that define a relationship of policy integration are those pointed out by UNESCO in its definition **of integrated social policies** (UNESCO, 1990). *"The sectorization",* it says, *" is a reordering of reality necessary to act on it with a criterion of technical division of labour, but only an integrated, associative, intersectoral vision can control the demands of a global strategy for development".* Understood in this way, the intersectorality challenge involves a conceptual integration of objectives, the administrative integration of certain processes and the collapsing (at least hypothetically) of "closed fiefdoms" or "fiefs" of each sector. Cunill and colleagues also emphasize that integration affects the full spectrum, from the design to the evaluation of actions. This is important because the concept of intersectorality represents not only a conceptual question for social policies, but a way of responding to policy implementation. Another element is that intersectorality is supposed *to share resources, responsibilities and actions* (Mendes and Fernandez, 2004), which therefore, necessarily calls for solidarity or power. If we stop on this last point, it becomes clear that intersectorality **is a political process** that involves confrontation of contradictions, limitations and resistance, let alone justification as the standing alternative to sectorality. Moreover, the predominance of a professional corporate ethos makes intersectorality also **a cultural problem**. One of the expressions of this limitation outlined by Ruffian and Palma (1990) indicates that: *"it is necessary to "think" intersectorally to implement intersectoral policies ..."*. Thus it defines not only the execution or implementation of policies but also their formulation. From this perspective the integration of policies can be simultaneously accompanied by autonomy of the

sectors, since its formulation, design, and financing are agreed and adapted on the basis of a common social goal rather than on particular sectoral requirements. Therefore sectoral performance is able to have a greater autonomy since its genesis and implementation of integration is present. Integrated intersectoral work frequently requires some "cross-sectoral" management function.

E. HEALTH IN ALL POLICIES

We see this as an additional or complementary step to integration, where intersectorality is present not only as a strategy for solving problems but also as an area of development and production of new programs and policies with a strong focus on higher level aims, generally formulated in terms of quality of life. Here there is not only integration in the formulation, design and implementation of health policies with other sectors, but health is considered one of the axes of all policies, especially social policies. All the other sectors include the impact of their efforts on health, and simultaneously include as one of their strategic objectives, better health for the whole population, whether explicitly or implicitly in terms of its association with one of the higher level objectives associated with development and quality of life. This does not necessarily imply health leadership of each of the sectoral processes, but it means that there is a leadership within the sector of this vision of work and on how responsibilities for population health outcomes are not only of the Health Ministry or Health Sector.

It is important to point out that there is coexistence in time of these different forms of relationship and intersectorality, both within the sector, and in various organizational and governmental levels (national, regional, local and community). Also, they do not necessarily represent progressive stages of development. There may be political windows of opportunity and conditions that allow a jump to the integration and/or health in all policies stages, for example, from a form of cooperation.

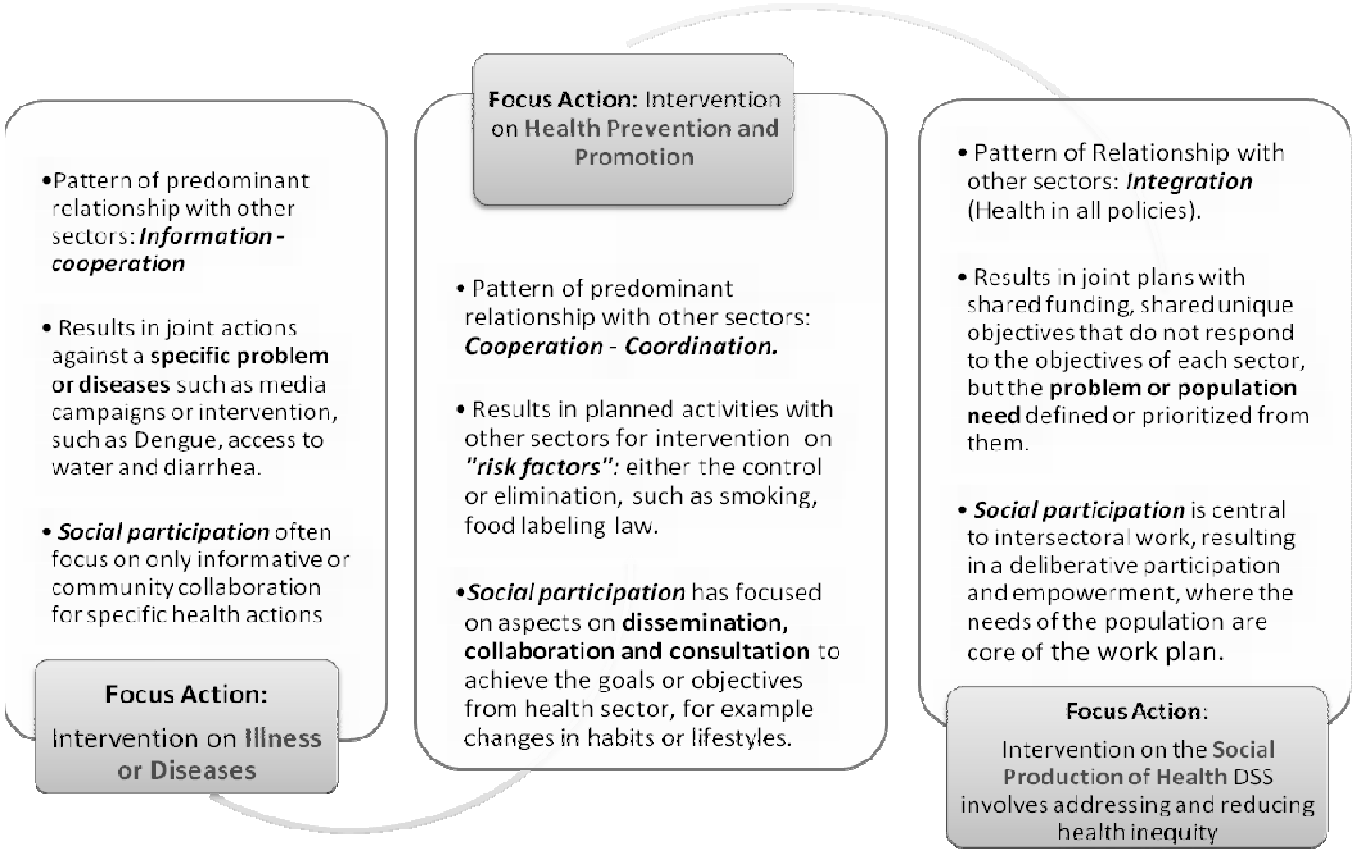
2.2 HEALTH AND SOCIETAL VISION THAT UNDERPINS PUBLIC HEALTH ACTION, INTER-SECTORAL DEVELOPMENT AND SOCIAL PARTICIPATION

We would like to discuss briefly some reflections on the practice of intersectorality and its relation to the health and societal vision of public health, as well the pattern of social participation that accompanies it. As with any classification that attempts to summarize "practices" it has the limitation of artificially streamlining processes or not properly including different contexts. However, it is also helpful to identify certain patterns that may help us to better understand and at the same time improve the practice of intersectorality. In the attached diagram we have tried to reflect the three major currents compelling public health action, one that has its focus on disease interventions, one on health prevention and promotion, and one that focuses on the social production of health. These three major trends co-exist in both the health sector, and in other sectors. Out of this vision of health, and the prioritization of interventions that emerges from it, arises a logical construction of different sectoral tasks. This influences the type of relationship established with other sectors, ranging from information and instruction, through to coordination, cooperation and integration. Similarly it facilitates or limits the arrangements of social participation in the sector.

In the first box of the Figure 2 we can see the action of intersectorality associated with a vision of health that is oriented towards disease interventions, ranging from a passive reporting relationship, and even of instruction in some cases. This is because the prevailing view in this situation relates to knowledge and responsibility, and therefore the task of everything related to health is in the health sector and this logic is built into the relationships with other sectors. We argue that this informative logic also prevails in relation to population and civil society,

and thus defines a purely informational pattern of social participation and therefore an absence of social control.

FIGURE 2: OVERVIEW OF HEALTH AND SOCIETY AND ITS FOCUS ACTION.



Source: Adapted by O. Solar

In the second box, we can see a health vision focused on eliminating or reducing risk factors associated with promoting measures to change life styles and habits, primarily dominated by individual strategies, but they may also include strategies for addressing populations. Here it is not explicitly founded on a priority to reduce inequities, and there is a predominance of the overall objectives of the health sector. This means that most of the time, establishing a relationship with the other sectors is based on health's sectoral objectives prevailing over the "broader" needs of the people, such as reducing consumption of tobacco focused only on information campaigns and individual strategies rather than on living and working conditions that minimize opportunities and needs for tobacco consumption. The logic of participation here is basically built on dissemination, information and advisory assistance, and seeks as a central objective to change behaviours and habits of the population.

In the last box we speak of a vision of health as a socially produced pattern of health and illness. It necessarily involves an analysis of the causes of the distribution of health problems and therefore includes an analysis of social determinants. From this logic, working together with other sectors has implicit structural interventions, as is so-called by Blankenship et al (2008). Structural interventions permit modifying the context of these groups, including the generation of social participation spaces, in which the actors and most vulnerable groups have voice and channels of social control over the policies and programs that directly affect them.

In turn, this leads to the situation where the work of the sector(s) is ordered by the needs of people, as perceived by people, and not by the sectoral objectives, since needs are captured by a new policy or integrated program, which provides answers to the social determinants that need to be addressed. From this vision the construction of social participation is linked to the deliberation and the structural changes that enable the alteration of the contexts in which these problems arise. This involves specific mechanisms for redistribution of power and thus empowerment of people.

It is important to note that developing intersectoral pro-equity policies involves questioning three core aspects of the public administration, on the one hand the structure of public administration itself, as characterized by ministries serving a sectoral specialization with power distributed among them; secondly it questions allocation of resources according to items and mechanisms and lastly ," *it suggests a tendency to design instances of inter-sectoral coordination in such a way that not only enables the "conversation" between concerned sectors but also with society by giving explicit space to the participation of citizenship* ", as noted by Cunill (2005), which means that the" *State generates and facilitates "real" spaces of participation and social control"*.

2.3. ENTRY POINTS FOR INTERSECTORAL WORK: SOME EXAMPLES FOCUSING ON "INTEGRATION"

There are various alternatives for the implementation of intersectoral work, ranging according to various national and local contexts, that can occur during the whole process of work, (in other words, from the formulation of a policy to its implementation) or only in a portion of it. At the same time, intersectoral action can be developed through the use of integrated management strategies based on local geographic areas, a social group, the family, or an issue, in a prioritized axis or through a structural reorganization of systems. This implies that there maybe entry points at different levels of government: national, local and/or community. Another important aspect to stress here is the financial management of intersectorality. This is key and, under certain circumstances, the *budget* can even act as another important "producer" mechanism giving rise to intersectorality. We will try to explain briefly some of the entry points with examples of cases that have been documented. Unfortunately in the literature there is no systematized diversity of experiences that are published and a more thorough search takes longer. We will briefly review three examples.

A. INTEGRATED MANAGEMENT STRATEGIES, BASED ON GEOGRAPHIC AREAS AND POPULATION.

This occurs when municipalities (or cities) take on global projects or goals such as improving the quality of life of citizens, sustainable development or the fight against exclusion. They tend to emerge with integrated approaches. As highlighted by Junqueira (1998) *"the town is a prime area for the integration of public policies, particularly social policy"*. This situation is enhanced when the municipalities have decision making powers and resources to undertake programs and policies. Thus, the geographic area itself becomes a field of social policy integration, and can overcome the bureaucratic dismantling of the social field. This process has burst onto the Latin American scene in the last twenty years, giving more viability to intersectorality. All cases documented in this sense have a clear spatial delimitation, and come mainly from Brazil, for example the experiences of the Municipal Mayor of Fortaleza of Ceara State; the State of Maranhão and supposedly there are also experiences in Belo Horizonte and Minas Gerais. These documented experiences have come from local governments that have political autonomy (their governments are elected) and also administrative autonomy, empowering them to introduce substantive changes to the governmental structure. Two common bases can be recognized in these examples:

- An effort to change the logic of public policy, and in particular, social policies, moving towards proactive action for a life of dignity and value as a right of citizenship . It is what we have called the political basis of intersectorality.

- An attempt to reduce or restructure the government bureaucracy to make it more flexible, while ensuring integrated management in resolving collective problems, which is more relevant to the technical basis of intersectorality.

B. INTEGRATED MANAGEMENT STRATEGIES BASED ON GEOGRAPHIC AREAS AND THE FAMILY.

This refers to the approach used with vulnerable groups associated to a particular geographic area or district. As an example we use the program “Chile Crece Contigo” (Chile Grows with You). This is a comprehensive protection system for children which aims to meet the needs and support the development of each stage of early childhood (from pregnancy to 4 years), promoting the basic conditions required for children to flourish in this period, with the understanding that child development is multidimensional and therefore it simultaneously affects the biological, physical, psychological and social aspects of child and its environment. The implementation and start up of this comprehensive protection system required the development of a network of public services and programs properly coordinated, particularly at the local level, working closely with the final recipients of intervention - children and their families - so as to ensure a set of benefits and basic social services. This system is run by a decentralized management system that is locally based and deep-seated in the municipality. Chile Grows With You is a system that is under the direct responsibility of the Government of Chile, coordinated through a Committee of Ministers, including the Ministry of Education; Ministry of Finance; Ministry of Health; Ministry of Labor and Social Welfare; Ministry of Justice, Ministry of Housing and Urban Development and the National Women’s Service, and chaired by the Ministry of Planning. The Committee's role is to ensure the appropriate design, installation and execution of the system. As a support to the Committee of Ministers, a Technical Committee was created to represent the legal and technical teams of the ministries and their associated services. The technical secretariat of the Committee of Ministers, as well as the Technical Committee is under the responsibility of the Ministry of Planning, who are in charge of coordinating and articulating the implementation of the comprehensive protection

system of early childhood. We can summarize the principles governing planning and management of this program as:

- One image - several ministries;
- Planning based on rights and guarantees above the programmatic offer;
- A shared background -several executors;
- Population approach with emphasis on the most vulnerable
- Geographic area / district /local government-based management.

In a nutshell we may say that the two experiences described are developed in specific local areas in *which the governmental structure is organized so that attention is moving from the "sectors" to the "problem".* Under this approach, priorities cannot be sectoral but are defined on the basis of population problems, to which the solution involves integrated activities in various sectors. Thus, the intersectoral logic of action relates to the population and the space where these groups are placed, assuming that this geographical and population base allows the identification of problems. The intention is that *"school is not limited to education; the health service is not limited to the care of disease or preventive action, nor the sport gym to offer their space and equipment. Each service located in a given community should be composed by a social action network"* (Junqueira [et al], 1998).

C. INTEGRATED MANAGEMENT STRATEGIES BASED ON A SPECIFIC ISSUE THAT CROSSES THE AREAS OF A SECTOR

Another example is the "Pan American Alliance for Nutrition, Health and Development" created in July 2009 by the regional directors of the United Nations agencies meeting at PAHO. This Allliance aimed to propose and implement comprehensive, sustainable, cross-sectoral programs, within the framework of a gender-equity and intercultural approach, to speed up the process towards the achievement of the Millennium Development Goals. The Alliance is further charactersied by its approach (based on social determinants), its strategy (intersectoral) and its targeting criteria (towards vulnerable geo-demographic spaces). The initiative behind creating the Alliance recognizes that malnutrition and overall health are the result of the interaction of many factors, some of them with a level of individual anchor, but with many others directly related to socio-economic conditions in which we live. Traditional approaches to address the problem of malnutrition have been focused on individual factors through food programs and vertical health programs, downplaying or simply ignoring the social determinants, which include among others: food security, conditions in the physical and social environment, education, access to information, the health condition of the mother, family planning, access to health services, the exercise of human rights and fundamental freedoms, family income and working conditions. Efforts to correct these reductionist approaches require coordinated, simultaneous and complementary technical cooperation across all United Nations agencies and other actors committed to the development and welfare of the population.

3. SOME THOUGHTS, DOUBTS AND UNANSWERED QUESTIONS, TO EXPLORE AND INVESTIGATE

Intersectorality and especially its management are still matters of which we have little knowledge and where there are few practical tools. There are different reasons for that. One reason is the prevailing theoretical and practical tendency is to build up concepts that fragment and reduce the complex character of the health-disease process, the development of health practice and the organized social response towards heath problems. Critics of intersectoral action practices to date have also focused on the imperialistic nature of the culture within the health sector which has prevented health from having a consistent vision of the need for working with other sectors and thereby limiting the opportunity to develop practical tools for doing so through practice and experience (Norway Case Study). The other general conclusion is that intersectorality in terms of integration is an irreplaceable component of policies and programs to reduce inequities. It is not possible to reduce inequities if intersectorality does not generate or facilitate opportunities for participation, allowing the exercise of full rights.

To manage intersectorality better, greater analysis and even more theory is needed to clarify certain questions. What situations lead to intersectorality? What are the integrative mechanisms? What elements are necessary to build political and technical feasibility for intersectorality? What are the aspects or catalytic agents of the process? What forms of financing and transfer mechanisms are needed? How can the sectoral culture that predominates be addressed? How does intersectorality build and facilitate social participation spaces? What are key elements to give sustainability to its regulatory support, monitoring and evaluation? What skills are needed to develop intersectoral work? And what associated investments and redirection of training and research resources are needed across professional accreditation bodies, and public health institutions and agencies/initiatives?

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Republic of Kenya

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