

Intersectoral Action for Health: Challenges, Opportunities, and Future
Directions in the WHO European Region

Juha Mikkonen

A Dissertation submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy

Graduate Program in Health, York University
Toronto, Ontario

May, 2018

© Juha Mikkonen 2018

Abstract

Human health is shaped by public policy decisions made not only by the health sector, but numerous other sectors and actors that influence people's social, economic, and cultural conditions. Therefore, national health ministries cannot solve the root causes of many health problems without also engaging non-health sectors to implement health-promoting public policies. For over three decades, the World Health Organization (WHO) has actively endorsed the concept of "intersectoral action for health" as a key approach to address the most pressing health challenges at the national and international levels. At the international level, the need to engage non-health sectors in health promotion activities has been repeated in nine outcome documents of the global health promotion conferences organized by WHO between 1986 and 2016. However, calls to promote health through greater intersectoral action have not led to wide-scale and systematic implementation by national governments and jurisdictions.

The challenges and opportunities to intersectoral action for health are rarely identified in a systematic way in the existing research literature. To address the current gap in knowledge, this dissertation was based on three key research questions: (1) How do the expert informants within the WHO Regional Office for Europe understand the concepts of "intersectoral action for health" and "governance for health?", (2) What do the academic literature and key informants identify as the challenges and barriers to intersectoral action for health?, and (3) Which factors facilitate the implementation of the intersectoral action for health and what are the opportunities to promote health through such action in the future?

The methods of this study included an in-depth review of literature and primary data collection that involved 28 semi-structured interviews with WHO Programme Managers, Unit Leaders, Directors, and Technical Officers working at the WHO Regional Office for Europe in Copenhagen. A thematic analysis of the key informant interviews focused on the challenges and opportunities to intersectoral action for health. The aim of this analysis is to shed light on the factors that are relevant to the policy process and dynamics of intersectoral policymaking. The findings of this study draw on the perspectives that the informants had gained by working with many of the 53 countries that comprise the WHO European region. The analysis involved a computer-assisted coding process with NVivo software and led to ten thematic challenges/barriers and to ten thematic opportunities/facilitators.

Overall, this dissertation increases understanding of the political, technical, institutional, and managerial barriers to intersectoral action for health. In addition, it presents a systematic analysis of the factors that can facilitate intersectoral action for health and considers the future of intersectoral approaches in health promotion. Based on the empirical findings, the concluding section includes eighteen recommendations for strategies to overcome the challenges and barriers to the implementation of intersectoral

action for health in the future. These recommendations include various strategies such as ensuring high-level political support and a mandate for intersectoral action, mapping out co-benefits among sectoral partners, establishing permanent intersectoral mechanisms, ensuring adequate resources for implementation and monitoring, and increasing the capacity of the health sector to work with non-health sectors.

Dedication

To my son and the memory of my father.

Acknowledgements

One should not promote the false belief that personal success comes about only through a person's own efforts. In fact, our successes and failures are greatly influenced by our social relationships and socioeconomic conditions during our life course. In most cases, success requires a lot of persistence, good luck, and supportive people. Similarly, my PhD studies were completed with the direct and indirect support of many persons at the various stages of the process. In the following, I will mention a few key people but acknowledge that there are many more. Thank you all.

First, my supervisor and colleague, Dr. Dennis Raphael, made it possible for me to complete my PhD degree in Canada. Without his continuous support, this project would not have seen fruition. I met Dennis in 2009 when I visited York University for the first time. Our shared interest has been to educate the general public on the social determinants of health. For this purpose, we produced the report "Social Determinants of Health: The Canadian Facts" (2010), which has been a great success with over 700,000 downloads from the project's website.

My second supervisor, Dr. Vappu Tyyskä, Professor of Sociology at Ryerson University, has been of a great assistance during my stay in Canada. As a Finnish-Canadian immigrant herself, Vappu has always been ready to help and talk about academic, cultural, and political matters. She has been irreplaceable, and I am happy that she found time to supervise me even on the eve of her retirement. In addition, I would like to thank my other committee members: Dr. Joel Lexchin, Dr. Liette Gilbert, and Dr. Carlos Quinonez. Similarly, thanks to my fellow students at York University for all the peer support I have gotten: Candice Christmas, Danielle Bishop, Monica Abdelkader, Vanessa Knight, and Julia Brassolotto.

I am thankful to people at WHO for providing me with an opportunity to work as an international health policy consultant and supporting my academic work by providing me access to the informants of this study. The WHO Division of Policy and Governance for Health and Well-being (PCR) and its former and current staff made the data collection possible: Agis Tsouros, Piroska Östlin, Monika Kosinska, Snezhana Chichevalieva, Francesco Zambon, and Donna Zilstorff. In addition, I would like to give special thanks to Katharina Beyer for all the fun times when we shared an office together during my stay in Copenhagen. Most importantly, this study would have not been possible without its knowledgeable key informants at the WHO Regional Office for Europe.

As a native Finn, there are a number of people in Finland who have provided their support and assistance over the years. In an academic context, I would like to thank all my fellow students in the Faculty of Social Sciences at the University of Helsinki who studied with me in the beginning of the 2000s and several other people who were senior to me, especially Anna-Maija Pirttilä-Backman, Anna Bäckström, Nelli Hankonen, and Ari Haukkala from the discipline of social psychology. Special thanks go to Nelli for giving me

a great introduction to academic life when I was a university freshman. Our humorous men's peer support group "PÄKSÄ" has been important over the course of many years, so special thanks to Antti, Mikael, Janne, Otto, Markus, and Jarkko.

For the past three years, I have been an Associate of Demos Helsinki, the Finland's leading independent think tank. Demos has formed one important home base for me in my native country, and I wish to especially thank Aleksi Neuvonen, Tuuli Kaskinen, Antti Hautamäki, Airi Lampinen, and Johanna Lampinen. Furthermore, I have had important discussions with a number of people about health and social policies. In addition, I would like to mention the importance of discussions with several other Finns who are the leading experts in their own separate fields: Juho Saari, Pekka Puska, Anna-Maria Isola, Lauri Vuorenkoski, Rinna Kullaa, Kristian Wahlbeck, and Heikki Hiilamo.

In my professional history, there are many important organizations and people that should be mentioned in this context as well. First, I need to thank Ms. Riitta Pakaslahti for offering me work in a Finnish health NGO in 2002. This was an opportunity that has directed my career ever since. As an organization, the European Anti-Poverty Network taught me a lot about how to work at the international level.

There are also a number of important people and mentors who have sadly passed away too early. I want to thank Dr. Jukka Tontti for influencing my decision to become a student of social psychology, Mr. Markku Soikkeli for being an inspiring person and making me think in new ways and Dr. Bob Gardner from the Wellesley Institute for all the discussions about Nordic and Canadian public policies. Dr. Kimmo Leppo, a former Director General of the Health Department at the Ministry of Social Affairs and Health in Finland, provided me with important background information on the history of Finnish health policymaking.

It is not always easy to settle in a new country on the other side of the globe. The Finnish community in Toronto has been very important to me in many ways, and I co-chaired the Canadian Friends of Finland for a short time. Thanks to Paula and Samantha Glass for offering invaluable help in settling in Toronto. They have always been there, both in good times and bad times. Moreover, thanks to all the people who have stayed or visited the Glass house over the years, especially Heini, Mari, Annika, Visa, Paavo, and Joonas, just to mention a few. I have had good times with many former Finns who worked at Kanadan Sanomat, the Finnish consulate, and the Finpro office. I would like to thank the former professor of Finnish Studies at the University of Toronto, Dr. Börje Vähämäki, for being an inspiring person and showing how one can turn old with style and charm. A few additional friends need to be mentioned who have all been important in different ways. Thanks to Karen, Liisa, Teemu, Kaisa, Jani, and Keshra for their support and good times in Toronto.

In Finland, there are a number of friends who have indirectly contributed to my development as a person and researcher. I would like to mention Pia, Elisa, Tuomo, Päivi,

Eekku, Anna, Janne, and Johannes as well as friends from my childhood, Visa and Kasse, who I have known for over three decades.

Most importantly I want to express my gratitude to my family. My mother deserves a medal of honour for working so hard to provide her children with opportunities. I want to thank my late father Kari for spending so much quality time with me when I was a child and preschooler. My sister Anu has always been on my side, and her importance has even increased over the years. Lastly, I want to thank my partner Vilja for taking my good and bad rants during this PhD process as well as for taking good care of our son.

This dissertation would not come to fruition without external financial support throughout my PhD studies. I am very grateful for receiving a Vanier Graduate Scholarship from the Canadian Institutes for Health Research, a Susan Mann dissertation scholarship from York University, and a dissertation grant from the Alfred Kordelin Foundation.

Although my PhD project is now finished, I will continue being a student for life. Many years ago, at the time when I graduated from high school in Finland, I celebrated by sketching a signboard with a Latin phrase *non scholæ sed vitæ discimus* [we do not learn for school, but for life]. Years may have passed, but I still agree with that statement.

Abstract.....	ii
Dedication.....	iv
Acknowledgements.....	v
Table of Contents.....	viii
List of Abbreviations.....	xii
List of Tables.....	xiii
List of Figures.....	xiii
List of Boxes.....	xiii
 CHAPTER 1: INTRODUCTION	 1
1.1 Background to the study and key concepts	4
1.2 Original contribution to knowledge	15
1.3 Overview of the research questions	16
1.4 Outline of the dissertation	18
 CHAPTER 2: REVIEW OF THE LITERATURE	 20
2.1 Introduction to the literature review	20
2.2 Promoting health equity through public policy	22
2.2.1 <i>Defining health equity</i>	27
2.2.2 <i>Causes of health inequity and health inequalities</i>	28
2.2.3 <i>Implementing healthy public policy</i>	40
2.3 Health, human rights, and the justification for action.....	49
2.4 Understanding policy change.....	55
2.4.1 <i>Governance</i>	58
2.4.2 <i>Policy actors and interests</i>	63
2.4.3 <i>Ideas and ideologies</i>	67
2.5 Intersectoral action through the decades.....	72

2.5.1 <i>Intersectoral action for health</i>	73
2.5.4 <i>Health in All Policies</i>	95
2.5.5 <i>Other intersectoral approaches to health</i>	100
2.6 Concluding remarks	102
CHAPTER 3: RESEARCH CONTEXT	105
3.1 World Health Organization in the European region	110
3.2 WHO statements on health promotion	119
CHAPTER 4: RESEARCH QUESTIONS, DATA, AND METHODS	127
4.1 Research questions.....	127
4.2 Research design	128
4.2.1 <i>Methodological considerations</i>	129
4.2.2 <i>Planning the study</i>	131
4.3 Data collection	132
4.3.1 <i>Purposive sampling</i>	132
4.3.2 <i>Key informant interviews</i>	133
4.3.2 <i>Process</i>	134
4.4 Analysis of the qualitative data	136
4.4.1 <i>Content analysis</i>	137
4.4.2 <i>Thematic analysis</i>	138
4.4.3 <i>Process of organizing qualitative data</i>	140
4.4.4 <i>Limitations</i>	143
4.4.5 <i>Ethics</i>	145
CHAPTER 5: FINDINGS	147
5.1 Understanding of the key concepts	148
5.1.1 <i>Intersectoral action for health</i>	148
5.1.2 <i>Governance for health</i>	155

5.2 Implementation challenge: thematic analysis	159
5.2.1 Challenges and barriers	160
5.2.1.1 <i>Narrow view of health and its determinants.....</i>	<i>161</i>
5.2.1.2 <i>Low level of political leadership and commitment</i>	<i>165</i>
5.2.1.3 <i>Competing interests and competition for resources.....</i>	<i>168</i>
5.2.1.4 <i>Lack of permanent implementation mechanisms.....</i>	<i>171</i>
5.2.1.5 <i>Lack of resources for implementation</i>	<i>174</i>
5.2.1.6 <i>Complexity of the policymaking processes.....</i>	<i>176</i>
5.2.1.7 <i>Not sharing the same language and concepts.....</i>	<i>179</i>
5.2.1.8 <i>Limited authority and mandate of the health sector</i>	<i>182</i>
5.2.1.9 <i>Lack of ownership and management</i>	<i>185</i>
5.2.1.10 <i>Potential conflicts of interest.....</i>	<i>187</i>
5.2.2 Opportunities and facilitating factors	191
5.2.2.1 <i>Establishing permanent intersectoral structures.....</i>	<i>192</i>
5.2.2.2 <i>Identifying and utilizing the windows of opportunity.....</i>	<i>196</i>
5.2.2.3 <i>Identifying co-benefits, mutual gains, and win-win situations.....</i>	<i>198</i>
5.2.2.4 <i>Placing more focus on long-term returns and investments.....</i>	<i>201</i>
5.2.2.5 <i>Increasing the skills and credibility of the health sector</i>	<i>204</i>
5.2.2.6 <i>Linking to existing processes.....</i>	<i>209</i>
5.2.2.7 <i>Making budgets differently</i>	<i>211</i>
5.2.2.8 <i>Increasing focus on policy development within WHO.....</i>	<i>213</i>
5.2.2.9 <i>Strengthening and clarifying the WHO's role and mandate</i>	<i>216</i>
5.2.2.10 <i>Working through other UN agencies and non-state actors.....</i>	<i>219</i>
 CHAPTER 6: DISCUSSION AND CONCLUSIONS	 226
6.1 Reflections on challenges and barriers.....	230
6.2 Reflections on opportunities and facilitators.....	240
6.4 Conclusions and recommendations	248
6.4.1 <i>Theoretical implications</i>	<i>250</i>

6.4.2 Practical implications.....	255
6.4.3 Final conclusions	262
References	266
APPENDIX A. Review of human rights documents relevant to this study	305
APPENDIX B. Interview guide.....	315
APPENDIX C. List of key informants	320
APPENDIX D. List of case studies mentioned by the key informants.....	322

List of Abbreviations

AMR	Antimicrobial resistance
APHA	American Public Health Association
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRICH	Centre for Research on Inner City Health
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
ECOSOC	United Nations Economic and Social Council
EU	European Union
FCTC	WHO Framework Convention on Tobacco Control
FENSA	WHO Framework of Engagement with Non-State Actors
HIA	Health Impact Assessment
HiAP	Health in All Policies
IAH	Intersectoral Action for Health
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
IHR	International Health Regulations
ISA	Intersectoral Action
MDGs	Millennium Development Goals
NCDs	Non-communicable diseases
NGOs	Non-governmental organizations
OECD	Organisation for Economic Co-operation and Development
SDGs	Sustainable Development Goals
SDH	Social determinants of health
SEP	Socioeconomic position
SES	Socioeconomic status
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

List of Tables

Table 1. Explanations for the health inequalities between socioeconomic groups.....	33
Table 2. Three types of intersectoral interventions.....	78
Table 3. Intersectoral governance structures and actions.....	93
Table 4. WHO declarations, statements, and charters on health promotion, 1986-2016.....	126
Table 5. Number of informants discussing specific challenges and barriers.....	161
Table 6. Number of informants discussing specific opportunities and facilitators.....	192

List of Figures

Figure 1. Key rationale for intersectoral action for health in the interviews.....	153
--	-----

List of Boxes

Box 1. Classification of the rights outlined in the UDHR.....	52
Box 2. Interest groups in health policymaking.....	63
Box 3. The Preamble of the Constitution of the World Health Organization.....	109
Box 4. Research-based recommendations on how to facilitate the implementation of intersectoral action for health.....	258
Box 5. Rights and Freedoms covered in the ICCPR.....	311

CHAPTER 1: INTRODUCTION

No one is 'outside society'; the question is where each stands within it.
(Mills, 1959, p. 184)

Leaders in public health are generally driven by a profound and fundamental sense of mission. A sense of purpose motivates them to leave the comfort of the sidelines and wade into controversy, despite the uncertainty of outcomes. Many are 'wounded healers' who have suffered greatly but channel their pain into power for the common good. Their souls swell with both the passion and compassion of those who have seen suffering and want to stop it.
(Koh & Jacobson, 2009, pp. 199-200)

In the simplest terms, this PhD dissertation is about the challenges and opportunities of promoting health through public policy. This study is based on the human rights perspective that recognizes that every human being has the right to the enjoyment of the highest attainable standard of health. The special interest of the dissertation lies in policies aimed to promote health through intersectoral action by engaging a number of actors, including different sectors of government, civil society, and the private sector. In many cases, the health sector is a collaborator and initiator but does not necessarily lead the implementation of various health-promoting policies. Intersectoral action for health has been suggested as a key strategy in health promotion since the late 1970s through various conceptual frameworks and approaches. Despite good intentions, the results of intersectoral collaboration for health have been varied at the international and national levels. The core question that the dissertation aims to answer is: What are the key facilitators and barriers to intersectoral action for health?

This dissertation has a special focus on the work of the World Health Organization (WHO), which is one of the specialized agencies of the United Nations (UN). Established on April 7, 1948, WHO acts as a global directing and coordinating authority on health such that it has significant power to shape the ideational base of global health. Currently

WHO has six regional offices and is headquartered in Geneva, Switzerland. The data of this dissertation comes from 28 key informant interviews with current and former WHO staff members from the WHO Regional Office for Europe in Copenhagen as well as from literature sources that include academic papers and international policy documents.¹

Numerous international and national policy recommendations that call for intersectoral action for health stand on the notion that the health of a population is largely determined by their living conditions that are influenced by public policy decisions (Marmot et al., 2010; WHO, 1986a, 1986b, 1988, 2008a). Therefore, the health care system can often cure diseases but cannot alone solve the root causes of the most pressing health challenges. The conditions in which people live and work are the result of complex social, economic, cultural, and institutional arrangements. Many of these conditions, called “social determinants of health” (Marmot & Wilkinson, 2006; Raphael, 2016; WHO, 2008a) are resistant to planned change. However, collective and goal-oriented decision-making has shown its power throughout human history to effect such change. Convincing evidence between and within countries shows that living conditions have improved and so has the health status of the population. The intrinsic value of physical and psychological health is one of the core values shared globally across cultural and regional borders.

In my dissertation, I argue that while many of the well-intended WHO policy documents that call for intersectoral action for health are supported by solid scientific evidence, the actual implementation of these recommendations is, and will, remain challenging because the field of politics and policymaking is encompassed by multiple

¹ WHO works with national governments and its key partners are the Ministries of Health. The Preamble to the WHO Constitution states that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” (WHO, 1946). Due to the nature of WHO’s work, this dissertation has its main focus on intersectoral action as it occurs between different sectors within a government. This type of action usually involves inter-ministerial and interdepartmental work within and between the Ministry of Health and other ministries.

actors with conflicting interests and values – a dynamic which is sometimes ignored in the health policy literature. I argue that the magnitude of institutional and organizational challenges to the implementation of intersectoral action for health has been greatly underestimated in health policy research as well as in policy recommendations. In this larger sphere of politics and policymaking, promoting health and well-being is only one objective that is constantly contrasted with other policy objectives, such as economic growth, security, private interests, as well as with a set of values that favour individualism over collectivism. Addressing the fundamental determinants of health requires public policy action that will always go beyond the mandate of the health sector. This action is political by its nature, and in order to effectively implement health-promoting public policies, health advocates should put more focus on increasing their understanding of policymaking processes, conflicting interests, and institutional barriers.

At the same time, having a focus on a system of ideas and ideologies is necessary for understanding many of the contextual factors that shape public policy decisions and influence health.² However, a sole focus on ideologies and values is not sufficient because there are numerous meso- and micro-level factors that influence policymaking and policy outcomes.³ I argue that the most important of these factors are institutional arrangements, policy actors and their interests, and policy processes. Nevertheless,

² By ideologies, I generally refer to a set of ideas and ideals of a good society. However, there are multiple definitions of ideology. For instance, Eagleton lists sixteen meanings in his introductory chapter to reflect the fluidity of the “ideology” as a concept (Eagleton, 1991). In a sociological encyclopedia, Silbey (2006) writes that ideology is “generally used to point to the ability of ideas to affect social circumstances, the function of ideology has thus been described as the capacity to advance the political and economic interests of groups or social classes, or, alternatively, the capacity to produce cohesion and resolve social strain” (Silbey, 2006, p. 278).

³ In this study, multi-level analysis refers to the following three layers: (1) Macro-level of political economy, such as prevailing ideologies and values; (2) meso-level of organizational factors, such as existing structures and processes within and between policy actors; and (3) micro-level of individual and group behavior, such as social interaction between civil servants and government departments. The macro-meso-micro frame is also widely used in numerous other areas, for example in the developmental psychology literature (Bronfenbrenner, 1979).

ideologies are important because they set the overall political and social context where policy decisions are formulated and implemented. These ideas and ideologies certainly shape elements of policymaking but this relationship is rarely linear and predictable.

1.1 Background to the study and key concepts

The background of this study consists of a number of international policy documents that include high-level and normative statements regarding the goals of health promotion and means to attain these goals (WHO, 2009a). The WHO Constitution is one of the key international documents that form the normative base for health promotion at the global level (WHO, 1946).⁴ The Constitution states that the overarching objective of the organization is the attainment of the highest possible level of health for all. The WHO Constitution and its Preamble have been seen to present groundbreaking thinking that has withstood the test of time. In the current globalized world, the pledge of WHO member states to advance the health of their own citizens is as timely ever (Grad, 2002).

As a leading global health authority, WHO has produced a body of statements, declarations and charters on health promotion during the past decades. The declaration of Alma-Ata was released in 1978 and highlighted the important role of primary health care in population health but also presented health as “a fundamental human right” and stated that “the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (WHO, 1978). Between 1986-2016, WHO organized nine international conferences on health promotion, each of which led to a final outcome document. To date, the most influential of these documents is the

⁴ The Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Ottawa Charter, which was presented at the First International Conference on Health Promotion in Ottawa on November 21, 1986 (WHO, 1986b). The conference statement endorsed the concept of “health public policy” that refers to the need to bring health on a wider socio-political agenda. The general conclusion is that effective health promotion requires coordinated action, not only by the health sector, but by all the sectors that have an impact on people’s living conditions.

This dissertation uses the outcome documents of these international WHO conferences to provide a context for the research questions and findings of this study (WHO, 1988, 1991, 1997b, 2000, 2005a, 2009b, 2013c, 2016e). Other relevant international policy initiatives that will be considered in this dissertation are the Health 2020 policy platform for the WHO European Region (WHO, 2013b) and the United Nations Sustainable Development Goals (SDGs). These SDGs are officially titled “Transforming our World: The 2030 Agenda for Sustainable Development” and consist of 17 goals and 169 targets (UN General Assembly, 2015).

This study utilizes several sensitizing concepts as background ideas and interpretative devices to inform the research process from beginning to end (Bowen, 2006).⁵ In contrast to “definite concepts”, sensitizing concepts suggests a starting point and direction for a qualitative study. The interpretation of the findings of this study has been guided by several concepts that are derived from the academic literature and WHO policy documents. These include “health”, “the social determinants of health”, “the right to health”, “health promotion”, “intersectoral action for health”, and “governance for

⁵ According to Charmaz (2003), sensitizing concepts are “those background ideas that inform the overall research problem”, and they “offer ways of seeing, organizing, and understanding experience; they are embedded in our disciplinary emphases and perspectival proclivities. Although sensitizing concepts may deepen perception, they provide starting points for building analysis, not ending points for evading it. We may use sensitizing concepts *only* as points of departure from which to study the data” (Charmaz, 2003, p. 259).

health.”⁶ In the following, I review these sensitizing concepts, which provided me with a starting point as well as a line of inquiry for the analysis and interpretation of my findings.

Key concept 1: Health

Since this dissertation is about promoting health, it is therefore important to consider the concept of health as key to the understanding of the subject matter. According to Aggleton (1990, p. 5), official definitions of health can be categorized in two main types. The first type is to define health negatively as the absence of disease and illness. The second type is to define health in positive terms, for instance seeing health as an ideal state that also includes a person’s ability to function. For instance, the Preamble to the Constitution of the WHO (WHO, 1946) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The WHO definition has since been supplemented with many clarifications, for instance, the word “complete” has raised critical comments because it can unintentionally contribute to the medicalization of daily life, as no one is “completely healthy.” In addition, disease patterns have changed since 1948 and the incidence of chronic diseases has increased significantly, which means that according to the WHO definition a large portion of people should be seen as permanently ill. In addition, health as complete well-being cannot be operationalized and measured effectively.

There are multiple ways of looking at health and multiple different perspectives that are applied alongside each other. From a sociological perspective, it can be concluded that an individualized biomedical understanding of health is able to deliver only a very limited perspective on the complexity of health and its determinants. Huber et al. (2011) have suggested that the contemporary definition of health should be dynamic and include a person’s capacity to cope, maintain, and restore a sense of well-

⁶ The concepts “intersectoral action for health” and “governance for health” guided my research and were also the direct focus of my inquiry.

being in the face of adversity. Based on the existing definitions, Sartorius (2006) has made a summary of three main perspectives for understanding health: (1) The absence of diseases or impairments; (2) the ability to adequately cope with the demands of daily life; (3) a state of balance that an individual maintains within him or herself and the surrounding social and physical environment. I acknowledge these views and see health as a dynamic pursuit of the ideals of the WHO definition yet always tied to prevailing cultural and social contexts.

Key concept 2: The social determinants of health

The concept of the social determinants of health is another key notion of this dissertation. The social determinants of health (SDH) approach has its focus on improving our understanding of how everyday living and working conditions shape our health (Braveman, Egerter, & Williams, 2011; Marmot & Wilkinson, 2006; WHO, 2008a). In other words, the social determinants of health are understood as economic and social living conditions that people experience in their daily life and which have an influence on their health. There are varying conceptualizations and theoretical frameworks for social determinants of health, which emphasize different social factors and their pathways in terms of producing health outcomes (CCSDH, 2015; Lucyk & McLaren, 2017). In the academic literature, the concept of social determinants of health has seen to have a dual meaning as it is used to refer to (1) the social factors influencing the health of individuals and larger populations, and (2) the social processes that underlie the unequal distribution of social factors among different socioeconomic groups (Graham, 2004a, p. 102).⁷

Since the early 2000s, WHO has been the key actor raising awareness on the social determinants of health and bringing them onto political and research agendas

⁷ Graham (2004a) sees that it is important to make a distinction between "health determinants" and "health inequality determinants." This dissertation has its main focus on social determinants of health as "determinants of health inequality."

globally. WHO has proposed a global monitoring system of action on the social determinants of health in a recent consultation paper, in which the following definition is used:

The social determinants of health (SDH) are the conditions in which people are born, work, and grow old, and the power and resources that shape these daily living conditions. The inequitable distribution of the underlying SDH is the root cause of inequities in health. Action on the SDH, especially among the most disadvantaged populations is therefore required to improve health equity. (WHO, 2016d, p. 1)

Proponents of the social determinants of health approach suggest that national and local governments have the key responsibility to increase the quality of the social determinants of health through redistributive measures and providing social safety nets for citizens (Raphael & Bryant, 2006b). The amount and quality of social and economic resources (e.g. money, social support) are distributed unequally, and being deprived of these resources has a negative impact on health and well-being (Raphael, 2009b). From this perspective, intersectoral action is required to address the social determinants of health because they are influenced by numerous decisions in the various spheres of public policymaking.

The academic literature on the social determinants of health considers the social causes of these inequalities (Braveman et al., 2011; Marmot & Wilkinson, 2006; Raphael, 2009c). The main research focus of the social determinants of health research is to understand the causes of health inequalities and identify ways to reduce them (Bartley, 2004). There are various listings of the social determinants of health, such as lists by Wilkinson & Marmot (2003) and Mikkonen & Raphael (2010), which include societal factors such as the level and distribution of income, education, employment status, working conditions, gender, housing, and the availability of health care and social safety nets. Various conceptualizations of the social determinants of health highlight different

perspectives but they also have clear similarities. For instance, income, education, housing, and employment are almost always listed as important determinants of health (Raphael, 2011, p. 224).

In 2008, the WHO Commission on Social Determinants of Health (CSDH) published its influential final report that focused on the role of structural determinants and daily living conditions in determining people's health status (WHO, 2008a). The structural determinants of health refer to a wide range of social and economic settings, such as investments or under-investments in public infrastructure, including various domains such as social security, education, health care services, employment opportunities, quality of housing, and transportation, among many other factors that are linked to a person's socioeconomic status (Solar & Irwin, 2010). An often-quoted excerpt from the WHO Commission's report highlights how inequities in these structural determinants lead to inequities in health: "Social injustice is killing people on a grand scale" (WHO, 2008a, p. 26). The Commission asserts that avoidable health inequalities are unjust and therefore should not be tolerated. Similarly, the report argues that improving people's daily living conditions and tackling the inequitable distribution of power, money, and resources are plausible ways to promote greater health equity. These recommendations cannot be implemented only by the health sector; they require intersectoral action and political commitment from the highest levels of decision-makers. Moreover, the role of the political cannot be neglected, since many of these structural arrangements are a result of public policy decisions made by governing authorities.

Key concept 3: The right to health

Human rights are defined as freedoms and entitlements that concern the protection of the well-being, dignity, and equality of every human being (Hunt et al., 2015). These rights are protected by national laws and constitutions as well as international human rights treaties that are ratified in the context of the United Nations. According to the UN

human rights framework, national governments have the responsibility to promote, protect, and fulfill human rights (CESCR, 2000: para. 33). The principle of progressive realization refers to the obligation of states to “take steps” to the maximum of their available resources to achieve the full realization of human rights. In other words, there is a real difference between whether the state is unable or unwilling to guarantee human rights. This may be visible especially in developing countries that may not have working social and legal institutions for an effective implementation of international human rights agreements. However, the binding human rights treaties presume that states take all reasonable measures towards the realization of their human rights obligations within the resources available (Hunt, 2007, p.11). Human rights obligations are violated when a national government is unwilling to use a reasonable amount of resources to fulfill the economic, social, and cultural rights defined in these international treaties (CESCR, 2000: para. 47).

The WHO Constitution states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” and that governments have a responsibility for providing adequate health and social measures to fulfill the right to health (WHO, 1946). Hunt (2007, p. 9) summarizes the above responsibility as a requirement that a country has an effective and integrated health system that encompasses health care services and policies to address the underlying determinants of health. By adopting the UN definition, I use the concept of human rights to refer to internationally recognized norms and moral principles that are recognized as inalienable and are articulated in international human rights agreements, of which the Universal Declaration of Human Rights (UN General Assembly, 1948) is the most influential despite its non-binding nature. A review of UN human rights documents relevant to this dissertation can be found in Appendix A.

In this study, I do not interpret human rights only as abstract ideals but as notions that construct the fundamental values of our human civilization (Nickel, 2014; Taket, 2012;

WHO, 2002). Many of the current achievements in human development, such as modern welfare states, are related to the notion of inalienable human rights. For example, we may consider various ways to reduce human suffering, e.g. efforts to tackle absolute and relative poverty, using taxation to redistribute wealth in order to provide social safety nets and universal health coverage for all, and a judicial system that is based on everyone's equality before the law. In other words, the fulfillment of human rights is not based on voluntary efforts but on the rights-based principles that are institutionalized in our social institutions in a way that it makes their existence or absence not immediately visible.⁸ The recognition of everyone's right to health is the core value of this study.

Key concept 4: Health promotion

WHO has defined health promotion as a comprehensive social and political process to improve the health of a population (WHO, 1998b, p. 1-2). A narrower perspective is to understand health promotion as enhancing the skills and capacities of an individual towards a healthier lifestyle. The origins of a more holistic approach to health promotion can be at least partly located at the WHO Regional Office for Europe, which established a new programme in health promotion in 1984 – the first programme of its kind in WHO (WHO, 2009a, p. 29-32). A number of interdisciplinary expert meetings were organized related to this pioneering work, and one of these meeting produced a discussion document on the concept and principles of health promotion that states: "Health promotion has come to represent a unifying concept for those who recognize the need for change in the ways and conditions of living, in order to promote health" (WHO, 1984).

The above work preceded the First International Conference on Health Promotion held in Ottawa in 1986, which produced probably the single most influential document

⁸ For instance, in everyday discourse, it may be easier to recognize a situation where human rights are blatantly violated (e.g. unlawful arrests of citizens) than to identify a situation where human rights are fulfilled (e.g. providing a living income to everyone).

on health promotion – the Ottawa Charter (WHO, 1986b), recognizing three main strategies to carry out health-promotion activities. The first strategy is advocating for political, social, economic, and other conditions that are favourable to good health; the second is enabling people to have equal opportunities and resources to take control of the determinants of their health; and the third is mediating between different interests in society in order to attain good health outcomes by also engaging actors also outside of the health sector. The Ottawa Charter summarizes strategies under five action areas: (1) building healthy public policy, (2) strengthening community action, (3) developing personal skills, (4) creating supportive environments, and (5) reorienting health services towards prevention and health promotion. None of these areas can stand on its own because action is needed in all of them in order to attain desirable health outcomes at the population level. For this dissertation, I adopt a definition based on the Ottawa Charter that describes health promotion as “the process of enabling people to increase control over the determinants of health and thereby improve their health” (Nutbeam, 1998; WHO, 1986b).

This dissertation has its main focus on the first action area of the Ottawa Charter, i.e. promoting health through public policy. A seminal role for this conceptualization should be attributed to Nancy Milio’s book, “Promoting health through public policy”, which was published five years before the Ottawa conference (Milio, 1981). Despite this work, many public health researchers have repeatedly argued that too often the implementation of the principles of the Ottawa Charter focuses only on health behaviours and reducing individual risk factors (Hancock, 2011; Legowski & McKay, 2000). Individual- and community-level risk factors, such as health behaviours, have been referred to as downstream determinants, in contrast to upstream determinants such as government interventions and other public policies (Braveman et al., 2011).

At the population level, upstream interventions are seen to be more effective because they focus on the root causes of poor health, such as poverty, limited

educational opportunities, and health-threatening living and working conditions (WHO, 2008a). Since the WHO Alma-Ata Declaration (1978) and the subsequent Health for All movement (WHO, 1981), there has been increasing calls for public health to work with the upstream determinants of health in contrast to the proximal downstream determinants.

Key concept 5: Intersectoral action for health

Yet another central concept of this dissertation is “intersectoral action”, which does not have one established definition. The term has been used by WHO, especially since the mid-1980s (WHO, 1986a). A recent literature review concluded that in most definitions, intersectoral action is depicted as a process, a practice, a collaboration, a coordination, or an interaction (Dubois, St-Pierre, & Veras, 2015). In this dissertation, I will use an integrative conceptual definition of intersectoral action that was proposed by Dubois et al. (2015):

Working with more than one sector of society to take action on an area of shared interest to achieve better results than those obtained working in isolation. Sectors may include government departments such as health, education, environment, justice, etc.; ordinary citizens; non-profit societies or organizations; and business. (Dubois et al., 2015, p. 2939)

Based on the above definition, “intersectoral action for health” can be understood as collaborative relationships and actions between different sectors to “achieve health outcomes or intermediate health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone” (Dubois et al., 2015, p. 2939). It can entail collaboration within and/or between the public sector, civil society, and the private sector.

A WHO conference report on intersectoral action for health stated that intersectoral action for health includes the involvement of the health sector itself (WHO,

1997a, p. 3). However, more recent definitions have added that the health sector does not necessarily need to be involved; it is sufficient if the goal is to promote health (PHAC & WHO, 2008).⁹ A widely recognized goal of intersectoral action for health is the achievement of greater health equity by influencing the decisions and actions in other sectors (de Leeuw, 2017). Examples of sectors that can have major health impacts include agriculture and food production, education, environmental and infrastructure planning, social services, and finance, among others. The overarching aim of intersectoral action for health is to promote greater awareness of the health consequences and impacts of policy decisions as well as to move towards healthy public policies in general.

Key concept 6: Governance for health

The concept of governance does not have a single and exhaustive definition. It generally refers to a wide system of actors, mechanisms, processes, and interests that influence how power is used to manage resources at the local, national, or global level (McQueen, Wismar, Lin, & Jones, 2012). Governance arrangements define who has power and who makes decisions (IOG, 2014). The governance for health perspective calls for the use of broad and intersectoral strategies to promote the health of the population through interactions among the government, civil society, and the private sector (Kickbusch & Gleicher, 2012). These strategies go beyond the health sector's mandate as governance for health requires directing and coordinating a number of non-health actors that make decisions and implement policies that have health impacts.

There are also many other interconnected concepts that are also relevant to this study, including institutions, policy actors, interests, ideas, and policy processes. Many of

⁹ A collaborative report by WHO and the Public Health Agency of Canada (PHAC) concludes: "We understand 'intersectoral action for health' to refer to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity" (PHAC & WHO, 2008, p.2).

these notions originated in the literature on political science or public administration and are described in more detail in Chapter 2. Later, the sensitizing concepts are tied to my empirical analysis in the conclusion and discussion sections of this dissertation.

1.2 Original contribution to knowledge

There are several original contributions that this dissertation aims to make. First, it provides a historical background to the development of intersectoral policymaking. Second, it produces a systematic analysis of the current challenges and opportunities related to the implementation of intersectoral initiatives to promote health. Third, it informs these questions by presenting findings based on a unique qualitative data source, i.e. the key informant interviews of WHO experts whose views are not widely studied because they are traditionally hard to access. The role and subjective experiences of health experts can provide new insights into the implementation of intersectoral action for health that are directly linked to the practice of policymaking. Fourth, the dissertation utilizes a “policy analysis lens” that is still rarely used in the research focused on the social determinants of health and achieving health equity.

Regarding the use of a policy analysis lens, I argue that raising public awareness and generating political will to address health issues is important but never sufficient to induce a policy change. This dissertation will consider many of the important contextual factors that can hinder the implementation of healthy public policy, such as institutional arrangements, interests, policy actors, ideas, and the nature of the policy process in general.

Many of the current health challenges require intersectoral responses because adequate responses to them are beyond the health sector’s sole and direct influence. There is solid and convincing evidence that supports the implementation of intersectoral initiatives to promote health (Leppo et al., 2013a; PHAC & WHO, 2008; WHO, 1986a, 1997a, 2015d). However, repeated policy recommendations by WHO and many policy

experts have not led to wide-scale implementation of intersectoral action for health at the global and national levels. As a global authority in health, WHO shapes the global health agenda by advising national governments and providing high-level recommendations that can be expected to have a significant impact on future developments in health. This dissertation will respond to the urgent need to gather more information about the political, technical, and institutional barriers that make this implementation process difficult. Similarly, it is important to increase knowledge of the opportunities that are arising to promote health through intersectoral initiatives and mechanisms (e.g. see case studies in WHO, 2016b).

1.3 Overview of the research questions

This dissertation has three overarching aims and a set of guiding research questions. In terms of its methodology, it is a qualitative public policy study and utilizes methodologies derived from content and thematic analyses (Ayres, 2008; Clarke & Braun, 2013; Julien, 2008; Mayring, 2000; Saldaña, 2016). The data consist of international policy documents and 28 key informant interviews that were carried out with WHO experts in Copenhagen, Denmark. The methods and data of this study are described in more in detail in Chapter 4. The overarching aims of this dissertation are:

1. To explore the historical and conceptual development of intersectoral action for health equity by reviewing international policy documents and the academic literature;
2. To shed light on the challenges and opportunities to the implementation of intersectoral action for health by interviewing WHO experts; and

3. To consider the future of intersectoral action in health promotion and give propositions for a more effective collaboration between sectors.

The following three research questions have guided my research:

1. How do the expert informants within the WHO Regional Office for Europe understand the concepts of “intersectoral action for health” and “governance for health”?
2. What do the academic literature and key informants identify as the main challenges/barriers to intersectoral action for health?
3. Which factors facilitate the implementation of the intersectoral action for health and what are the opportunities to promote health through such action in the future?

A number of hypothetical propositions have guided this work. The main one is the view that intersectoral action for health is difficult to implement because there are numerous political, technical, and institutional barriers to the implementation of health-promoting public policy that are not often systematically explored in the academic literature. A lack of political will is one important factor that explains the scarcity of comprehensive intersectoral initiatives for health. However, it is not a sufficient explanation for the reoccurring difficulties of governments to follow the WHO recommendations in the area. The hypothetical proposition is that the challenges to healthy public policy are very nuanced and many of these challenges should be explored in detail, paying attention to specific dynamics between organizations, bodies, and actors

in order to understand the complexities related to the initiation and implementation of intersectoral action for health.

1.4 Outline of the dissertation

After this introduction, Chapter 2 ("Review of the Literature") of the dissertation gives an overview of the key concepts and relevant literature by considering various intersectoral approaches to health and health equity. In order to better understand policy change, I provide an overview of various factors that shape the policymaking process, which include governance arrangements, institutions, policy actors, interests, ideas and ideologies. My argument is that efforts to promote equity in health are fundamentally based on the human rights approach. In the UN context, the normative human rights documents are based on the understanding of health as a basic human right. In Appendix A, I review key United Nations documents from a health perspective, including the Universal Declaration of Human Rights (UN General Assembly, 1948) and other international covenants (UN General Assembly, 1966a, 1966b).

In Chapter 3 ("Research Context"), I provide a descriptive history of the WHO Regional Office for Europe and review some of its milestone policy documents. The majority of key informants in this study built their professional careers in in the European Region of the WHO, which currently consists of 53 Member States. Especially since the 1980s, the WHO Regional Office for Europe has been an important global actor in defining many of the key concepts related to health promotion, health equity, and intersectoral action for health.

In Chapter 4 ("Research Design and Data"), I provide a description of the methods of data collection and analysis. I utilized purposive sampling to collect key informant interviews. The full interview guide used in this study is in Appendix B. I analyzed my interview-based qualitative data by applying content and thematic analysis.

A qualitative data analysis (QDA) computer software package was used to code the data (NVivo 11 for Mac). The analysis involved a computer-assisted coding process of the detailed notes from the key informant interviews.

Chapter 5 ("Findings") presents my analysis of the key informant interviews. In its main section, I provide an analysis of how the key informants understand the concepts of "intersectoral action for health" and "governance for health"; how they see the challenges and opportunities of intersectoral approaches to health; and what suggestions they make for future work. In addition, I reflect on the implications of this study for policy and practice by outlining the main contributions to the current debates on health equity and intersectoral approaches.

Chapter 6 ("Conclusions and Future Directions") focuses on the future prospects of intersectoral action and summarizes some of the key strategies and requirements for overcoming the challenges and barriers that currently hinder the implementation of intersectoral initiatives for health and well-being. In addition, the section includes propositions for strategies to overcome the challenges and barriers to the implementation of intersectoral action for health in the future.

CHAPTER 2: REVIEW OF THE LITERATURE

2.1 Introduction to the literature review

The overall aim of this chapter is to review the relevant literature and describe the wider context of the study. As the first section, this introduction summarizes the content of my literature review. The second section (2.2: “Promoting health equity through public policy”) gives an overview of the key concepts of my study. I explain what health equity is and what factors are seen to cause health inequalities between socioeconomic groups. It also shows the connections between health equity and public policy. The understanding of these connections is important in order to realize why intersectoral action for health has been recommended as a key strategy to solve complex public health challenges and promote greater health equity.

The third section of this chapter (2.3: “Health, Human Rights and the Justification for Action”) lays out a short history of human rights and their relevance to the promotion of health. I have a special focus on human rights documents produced in the context of the United Nations (UN), as I consider these documents as key to my thinking about a “universal moral commitment” to health equity. I also believe it is important to study the original human rights documents because they are the defining documents for all the members states of the UN and its specialized agencies, including WHO. A list of the most significant international human rights conventions and treaties can be found in Appendix A.¹⁰ International conventions are important, since they have been ratified by most of the countries in the world. In addition, the right to health is mentioned in at least in 115 national constitutions (Brown et al., 2014, p. 14).

¹⁰ The following three documents comprise the International Bill of Human Rights (IBHR): the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

My key argument is that the UN human rights framework provides a solid value base that justifies intersectoral action for health. Advancing health equity and protecting the right to health are closely related concepts that support each other. In other words, actions to promote health equity derive their key justifications from the right to the highest attainable standard of health. This right is highlighted in numerous international human rights documents that are signed by most developed countries. One of the reoccurring arguments is that health advocates and citizens should make decision-makers and elected representatives more accountable for their commitment to promote health and to respect health-related obligations under international law. After reading this section, the reader should have a basic understanding of how human rights are defined in contemporary international discourse.

The fourth section (2.4: “Understanding Policy Change”) focuses on the governance structures, actors, ideas, and processes that can constitute significant barriers to the implementation of intersectoral policies to promote health. A vast amount of literature has been produced on the importance of intersectoral action for health. All of these strategies suggest that health promoters should involve other sectors to become advocates of their goals. A simplistic understanding of public policy might lead to an assumption that other sectors start to value health only when they gain an understanding that their actions might have significant health impacts. However, the political reality is that the awareness of the social determinants of health does not automatically lead to the adoption of health-promoting public policies and setting “health” (and its equitable distribution) as the government’s top priority. Explanations to these barriers should be sought elsewhere. The section considers these political and administrative factors that influence population health, such as priority setting, governance structures, and resource distribution.

The fifth section (2.5: “Intersectoral Action for Health through the Decades”) gives an overview of conceptual developments related to intersectoral action in health and its

implementation by providing a historical outlook of the development of various intersectoral approaches. The concluding section (2.6: "Concluding Remarks") summarizes key insights based on the literature and highlights some of the ways health researchers and advocates can reorient their focus in order to effect public policies to be more supportive of intersectoral action for health.

2.2 Promoting health equity through public policy

The classical definition of politics refers to resource allocation: "who gets what, when and how" (Lasswell, 1958).¹¹ The sphere of politics is intrinsic to policymaking, and there is no public governance free from power relations. A government can formulate action plans and set priorities on the use of public resources in order to take action on a certain collective issue. However, along with publicly stated policy goals, there can be many underlying values and implicit objectives that drive the policymaking processes. For instance, non-decision-making or the lack of clear priorities can form a policy in the same way that a publicly stated plan of action does. In other words, a wide understanding of public policy acknowledges that policies can be practiced without a clear and explicit intention to implement a certain policy, i.e. lack of priority can be also seen as a priority setting.

Public policies are implemented in changing socio-political contexts (Buse, Mays, & Walt, 2012). In the process of forming public policies, some of the central questions are: (1) What is the problem we want to address? (2) what action would fix the problem and how can it be implemented? and (3) how can we measure, monitor, and evaluate the effects of the chosen policy? (Hill, 2013). In terms of health equity, defining the problem

¹¹ The term "policy" has multiple definitions. One influential definition of "policy" is: "A set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve." (Jenkins, 1978).

is clear, since the aim is to reduce avoidable and unjust health inequalities through public policy action. However, things become more complicated when the second question on the ways to tackle these inequalities is considered. The importance of having a comprehensive public health policy has increasingly been recognized since the 1970s (Irvine et al., 2006).

Persistent health inequalities between socioeconomic groups have been described as a “wicked problem” with a complex nature that cannot be solved by using only one strategy (Kickbusch & Gleicher, 2012). In the context of the work of WHO, health policy researchers and the international policy community have come to the consensus that action across multiple sectors is required for improving equity in health (WHO, 1986b, 2008a, 2013b, 2013c). The rationale for this consensus is based on the finding that population health is influenced by factors that lie largely outside of the health care sector. In the academic research community, there are debates on how deeply the public health sector should be involved in political processes that extend its focus towards the wider social determinants of health. For instance, as a supporter of a narrow view of public health, Rothstein argues that public health officials should limit their actions to predefined core functions that have a legal or constitutional basis, such as immunization, quarantine, contact tracing, and environmental regulations (Rothstein, 2002, 2009). He sees that public health officials lack “the resources, expertise, legal authority and political and public support” to address the root causes of ill health (Rothstein, 2009, p. 87). This view has been criticized (see Goldberg, 2009), and many international actors in health, such as WHO, see their institutional mandate as promoting health throughout all sectors of society.

The social determinants of health perspective includes a wide variety of social, economic, environmental, and political factors that constitute people’s living and working conditions (Raphael, 2016). From this perspective, population health cannot be promoted effectively solely through the actions of the health sector. In the context of WHO, the Rio

Political Declaration on the Social Determinants of Health (WHO, 2011) was endorsed by all 194 Member States of WHO in the 65th World Health Assembly in 2012. The declaration has five action areas: (1) Adopt better governance for health and development; (2) promote participation in policymaking and implementation; (3) further reorient the health sector towards reducing health inequities; (4) strengthen global governance and collaboration; and (5) monitor progress and increase accountability (WHO, 2011).

Since the Ottawa Charter (WHO, 1986b) was introduced in 1986, there has been growing calls to tackle health inequities with intersectoral approaches such as the Whole-of-Government (WG) approach, the Health in All Policies (HiAP) approach, the Social Determinants of Health (SDH) approach, and the Healthy Public Policy (HPP) approach. However, the implementation of health-promoting action in multiple sectors, within and outside of government, has proved to be challenging. In terms of implementation, some of the key questions include: Why is it so difficult to implement health-promoting public policies to address the wider social determinants of health? What are the processes, structures, and values that hinder the opportunities for effective intersectoral action and cooperation?

This literature review will address these questions and aim to clarify significant barriers that advocates for health equity are likely to experience. Policymakers and advocates can expect numerous obstacles at the macro, meso, and micro levels of implementation. Policy actors and institutions outside of health can have numerous reasons for resisting policies that could potentially promote health equity. Moreover, ideological factors and individualistic values can discourage policy actors from seeing health promotion as a shared responsibility of multiple sectors. In short, intersectoral action to promote health equity can be described as a great idea but one that is hard to implement.

One of my arguments in this dissertation is that public health advocates should turn their analytical focus to policy processes, structures, and values that hinder their opportunities for implementing intersectoral action for health. Public policy analysis and political science can provide important tools for health researchers that can advance the understanding of the complex politics of health. By increasing understanding of these barriers and their mechanisms, health advocates can help to develop more effective strategies to promote health equity and social justice.

In order to promote health equity more effectively, researchers have recommended carrying out Health Impact Assessments (Harris-Roxas et al., 2012), setting up intersectoral governing bodies, and implementing health-promoting policies at multiple levels and sectors (Kickbusch & Buckett, 2010; WHO, 2013c). These recommendations to tackle health problems through intersectoral action seem to be well-articulated and based on a large amount of research evidence. However, as stated earlier, the most pressing question is: Why have these calls not lead to wide-scale implementation, and why do so few outside of the health field seem to listen to these suggestions?

To understand the lack of implementation of these well-intentioned recommendations, we need to have a stronger focus on the politics of health (see Bambra, Fox, & Scott-Samuel, 2005). A comprehensive perspective on policy formulation acknowledges that policy change takes place through a complex interaction of ideas, institutions, actors, and interests (e.g. Howlett, Ramesh, & Perl, 2009). Embrett and Randall (2014) argue that advocacy on health equity is rarely sufficient in terms of achieving significant policy changes. Instead, they call for linking policy problems to policy solutions, increasing intersectoral cooperation, and improving administrative capacities to implement changes. They conclude that: "What seems clear from the social determinants of health and health equity literature is that there is a general lack of appreciation for the role of policy analysis and a misguided belief that advocacy based on

evidence alone is sufficient to move an issue onto the policy agenda” (Embrett & Randall, 2014, p. 154). In other words, merely showing the evidence on policies that would most likely to promote people's health is not enough to attain policy change and to gain policymakers’ support.

My main rationale for this dissertation is that it is increasingly important for researchers to direct more attention to political and institutional factors that make the implementation of equity-related policies difficult. This means analyzing the influence of different policy actors, interest groups, ideas, and governance arrangements. In terms of governance, it has been proposed that measures to reduce health inequalities need to be wide-ranging, and intersectoral action should be taken at multiple levels (Leppo et al., 2013a; Ndumbe-Eyoh & Moffatt, 2013).

The concepts of health equity and social determinants of health are central in the contemporary academic debates related to attaining a more equal distribution of health by reducing avoidable and unfair socioeconomic health inequalities. The basic premise is that this improvement should come about by improving the average level of health or the situation of the worst off, without compromising the health of the most advantaged. A large body of research has shown that health inequalities prevail across the socioeconomic spectrum by forming a “social gradient”, which means that health inequalities do not consider only the most disadvantaged but all social groups from the bottom to the top (NCCHPP, 2016).

In contemporary discussions, the focus of the action has more and more shifted to the structural determinants of health, which are also referred to as “the causes of the causes”. Intersectoral action for health has been suggested as a policy remedy because these fundamental causes generally are outside the health sector’s direct influence or mandate (Marmot, 2007; McQueen, Wismar, Lin, Jones, et al., 2012; WHO, 2008a). In the following, I consider various conceptual definitions as well as explanations for the existence of health inequalities.

2.2.1 Defining health equity

Equity refers to the quality of being fair and just. Chang (2002, p. 491) states: "Equity, unlike equality, is perceived as a normative concept based on the ethical principle of distributive justice at all levels and all domains." Health equity means justice in health, which can be defined more specifically as equal access to various resources that influence health (Braveman, 2010, 2014a). In addition, Braveman and Gruskin (2003) argue that it is important to have a clear definition of health equity. They see that an unambiguous concept is needed to guide its operationalization and measurement. They define equity in health as "the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage" (Braveman & Gruskin, 2003, p. 256).

Solar and Irwin (2010, p. 12) define health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically." Many health researchers share the view that in order to achieve equity in health, we are required to look at the social determinants of health that lie mainly outside of the health care sector (Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010). Because health inequity has its roots in living and working conditions, they can be defined as avoidable and unjust (i.e. social conditions can be improved through collective action) (Braveman & Gottlieb, 2014).¹²

It is widely acknowledged that ensuring equal access to health care is very important, but it is not a sufficient measure to promote greater health equity (Marmot, 2004). To achieve equity in health, we are required to look at the social determinants of health that lie outside of the health care sector (Marmot & Wilkinson, 2006). Furthermore, coordinated action on the social determinants of health requires that different sectors

¹² It should be noted that genetic variation can contribute to the existence of health inequities; but in general, various social determinants have been considered to be more important (Townsend, Davidson, & Whitehead, 1986).

within a government are able to work in a coherent way towards the same goals. The opportunities and challenges of such coordinated and intersectoral action is also the core question of this dissertation.

2.2.2 Causes of health inequity and health inequalities

The final report of the WHO Commission on Social Determinants of Health states that "social injustice is killing people on a grand scale," and continues to assert that health inequalities are caused by "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (WHO, 2008a). The report refers to the unequal distribution of social, material, and environmental conditions that influence the health of a population, which are probably the most powerful determinants of population health (Marmot & Wilkinson, 2006; Whitehead & Dahlgren, 2006). Whitehead (1992) has defined socioeconomic health inequalities as systematic differences that are avoidable, unnecessary, and unjust. However, not all health differences are related to inequality, e.g. the differences between young and old. Braveman (2014a) notes that the research on health inequality points to differences in social justice between advantaged and less advantaged socioeconomic groups.¹³ Lower socioeconomic groups suffer from economic, social, and environmental disadvantages that cause avoidable illness, disability, suffering, and premature death (Braveman, 2014a, p. 6). In addition, there are numerous analyses that focus on health inequalities experienced by particular groups, such as children, women, and immigrants (for example, see Raphael, 2009c).

Numerous conceptual models have been presented to outline how social conditions and health are associated with each other. One of the most cited model is the Dahlgren-Whitehead model that is presented in many WHO reports (Dahlgren &

¹³ For instance, Anand (2004, p. 19) concludes that "group inequalities give rise to the suspicion that they derive from social rather than natural (e.g. genetic) factors – and may thus be avoidable through public intervention."

Whitehead, 1991). Other similar models have been also presented that refer to similar concepts but highlight slightly different aspects (Brunner & Marmot, 2006; Evans & Stoddart, 1990; IOM, 2000; Solar & Irwin, 2010). Graham (2004a) notes that these type of models “represent health as the outcome of causal processes that originate in the social structure, in which social position is embedded” (Graham, 2004a, p. 2007). All these models suggest that social factors (e.g. living conditions) produce health inequalities. However, Graham (2004a) suggests that some of these models should be modified to better capture the link between structural inequalities and health. These deeper-level structural determinants have been referred as “fundamental social causes” of health inequality (Phelan, Link, & Tehranifar, 2010). These fundamental social causes include structural inequalities in resources such as money, knowledge, power, prestige, and social support (Link & Phelan, 1995). All the above factors are beyond the mandate of the health sector, which further provides a rationale of why intersectoral action for health is needed.

Explanations for health inequalities

The observation that living conditions and health are associated is not at all new. This connection can be found in ancient Greek philosophy (Tountas, 2009). Probably the first title on public health was the treatise “On Airs, Waters, and Places,” by Hippocrates, who is considered to be the founder of western medicine. Hippocrates wrote about the occurrence of diseases depending on the location of where people lived, the quality of drinking water, and the winds to which people were exposed (Hippocrates, 460-354 B.C.). The historical roots of social epidemiology stem from early studies of the 19th century. A French physician and free market supporter Louis-René Villermé (1782-1863) used Parisian census data to show that mortality rates were patterned by poverty and wealth (Krieger, 2001b). In his studies on the working class in England, Friedrich Engels (1820-1895) noted that the poor suffered notably higher mortality rates than the non-

poor (Engels, 1845/1993).¹⁴ As one of the founders of modern social medicine, Rudolf Virchow (1821-1902) was a pioneer in defining the physician's role in alleviating poverty by turning focus on the connection between social conditions and health.¹⁵ Virchow asserted that medical doctors should be "the natural advocates of the poor" (Birn, 2009; White, 2001). Later, Thomas McKeown (1979) argued that the decline in mortality rates from the mid-nineteenth century onward was not caused by medical advances, but improvements in the overall living conditions of people.¹⁶ In particular, improved nutrition and sanitation made people more resistant to infections and reduced the spread of diseases. Furthermore, the post-World War II era was the time when the Western welfare states started to develop (Esping-Andersen, 1990). It is without question that the increased collective responsibility of social and health affairs has had a significant positive effect to the population health. The social security system with a number of benefits and services have decreased the negative effects of various social risks, such as child birth, retirement, unemployment, sickness, or disability.

The WHO Commission on Social Determinants of Health (2005-2008) released its final report in 2008 (WHO, 2008a) as a call to action in order to build a global movement for health equity. The work of the commission was based on two concerns: "a passion for

¹⁴ In his book "The Condition of the Working Class in England", Friedrich Engels paid special attention to the early childhood conditions and health: "The great mortality among children of the working-class, and especially among those of the factory operatives, is proof enough of the unwholesome conditions under which they pass their first year. These influences are at work, of course, among the children who survive, but not quite so powerfully as upon those who succumb" (Engels, 1845/1993, p. 150).

¹⁵ Rudolf Virchow has stated in his article published in 1848: "Medicine is a social science, and politics is nothing but medicine on a large scale" (White, 2001, p. x).

¹⁶ However, McKeown's interpretation of the data has been contested by several researchers (see Colgrove, 2002). Despite the flaws in the analysis, McKeown's key premise has been generally accepted: "A large and growing body of research suggesting that broad social conditions must be addressed in order to effect meaningful and long-term improvements in the health of populations has validated the underlying premise of McKeown's inquiries" (Colgrove, 2002, p. 729).

social justice” and “a respect for evidence” (WHO, 2008a, Note from the Chair section, para. 2). The aim was to “advance health equity through action on the social determinants of health” by laying out the evidence and current knowledge on the connections between health and social conditions (WHO, 2008a, Note from the Chair section, para. 4). Since the Commission’s report, the social determinants of health approach has been increasingly used to describe the linkage between living conditions and health. From the early 1990s, the term “social determinants of health” has become more common in the English literature.¹⁷

However, long before the WHO Commission’s work, in 1980, a milestone paper was published, which has become widely known as the Black Report (Black, 1980). It made an important distinction between two primary mechanisms causing health inequalities: cultural-behavioral and materialist-structuralist. Also, two other explanations were suggested in the report, of which the first one was the artefact explanation (i.e. health inequalities as an artefact of data collection) and the second was the natural/social selection explanation (i.e. health status is a direct consequence of innate characteristics or genetic predispositions). However, the natural/social selection hypothesis was not seen to provide sufficient explanation about the extent of health inequalities (Blane, 1985). Later, researchers have focused on many potential and overlapping explanations for health inequalities, such as neo-material (Lynch et al., 2000), psycho-social (Brunner & Marmot, 2006; Wilkinson & Pickett, 2006, 2009), behavioural-cultural (Bartley, 2004), life-course

¹⁷ See the results from Google Ngram Viewer on the search term “the social determinants of health” at: https://books.google.com/ngrams/graph?content=social+determinants+of+health&year_start=1940&year_end=2008&corpus=15&smoothing=3&share=&direct_url=t1%3B%2Csocial%20determinants%20of%20health%3B%2Cc0

(Braveman, 2014b; Hertzman & Power, 2003), and political (Raphael, 2012b; Raphael & Bryant, 2006a).¹⁸

From a structural perspective, especially four of the above theories can be highlighted in more detail (Mackenbach, 2012, p. 763).¹⁹ First, the neo-material explanation focuses on the unequal distribution of material resources that leads to different exposures to factors that are beneficial or harmful to health (Lynch et al., 2000). Second, the fundamental causes explanation highlights the link between an individual's socioeconomic position and access to a greater variety of cultural, material, and social resources, such as wealth, knowledge, power, and social support (Link & Phelan, 1995). Third, the life-course perspective outlines the socioeconomic differences in accumulating exposures to biological and social factors through the life-course (Hertzman & Power, 2003). Fourth, the psychosocial explanation focuses on the health-harming effects of psychosocial stress that is experienced more in lower socioeconomic groups (Marmot & Wilkinson, 2001; Wilkinson & Pickett, 2009). In the psychosocial model, a higher incidence of stressful experiences is associated with a lower social status and increased by the extent of income inequalities, relative deprivation, and demand-control imbalances.

¹⁸ Bouchard et al. (2015) carried out a bibliometric analysis to identify the most cited academic articles on health inequalities between 1966-2014. They identified Marmot's article on health inequalities among British civil servants as the one of the five most cited articles (Marmot et al., 1991). The paper was based on the so-called Whitehall II study, which showed a clear association between lower socioeconomic position with increased mortality. According to Marmot et al. (1991), low job control explained a significant portion of higher morbidity among lower socioeconomic groups and this variation was concluded to be unrelated to health behaviors.

¹⁹ Mackenbach (2012) has outlined nine different theoretical approaches that may explain the persistence of health inequalities in well-developed welfare states. These approaches have varying focus areas, which include: (1) 'neo-material' factors, (2) cultural capital, (3) diffusion of innovations, (4) fundamental causes, (5) life course perspective, (6) mathematical artifact, (7) personal characteristics, (8) psychosocial pathways, and (9) social selection.

Table 1. Explanations for the health inequalities between socioeconomic groups	
Explanation	Factors
Materialist	Socioeconomic differences in income and working and living conditions
Psychosocial	Relatively higher levels of stress and other psychosocial risk factors experienced by people with a lower socioeconomic status
Behavioural-cultural	Socioeconomic differences in health behaviours and their cultural acceptance (e.g. alcohol consumption, smoking, diet, and exercise)
Lifecourse	Accumulation of various types of disadvantage over the life-course (social, psychological, and biological)
Genetic	Genetic/biological/epigenetic differences influencing the health status of individuals
Intersectionality	Health effects resulting from multiple intersecting forms of discrimination and oppression related to factors such as gender, race, ethnicity, disability, and sexual orientation
Political economy	Indirect effects from the lower levels of power and influence among lower socioeconomic groups

The explanations presented in Table 1 provide different perspectives on health inequalities, but they do not exclude each other. Similarly, due to the complexity of phenomena, many researchers hold the view that the measures to reduce health inequalities need to be wide-ranging and action should be taken at multiple levels (Leppo et al., 2013a; Ndumbe-Eyoh & Moffatt, 2013). The complexity of the causal factors that influence the level of health inequalities make it evident that the delivery of health services or the health sector alone cannot solve the problem and therefore intersectoral action for health is needed.

In relation to the debate on the causes of health inequalities, Joyce and Bamba (2010) argue that focus on behavioural interventions can stigmatize already disadvantaged populations. They assert that the root causes of health inequalities are not behavioural but structural. From this perspective, policymakers should address health inequalities by developing macro-level strategies and complementing them with more targeted interventions (Marmot et al., 2010). In other words, understanding and responding to key challenges for reducing health inequalities requires developing clearer policy responses (Smith, Bamba, & Hill, 2015). According to Smith et al. (2015), it is crucial to generate and maintain concern for health inequalities, which means having public, political, and professional concern for strengthening the evidence base, producing solid policy alternatives, and ensuring political will that lead to intersectoral implementation of health-promoting public policies.

On the other hand, Braveman and Gottlieb (2014, p. 26) argue that the complexity of the causal pathways and the long time frames make research on the social determinants of health and health equity particularly challenging. As many other researchers, they assert that to tackle the health equity puzzle we would need more intersectoral action, which, however, faces multiple barriers “including differing priorities, funding streams, and timelines across agencies” (Braveman & Gottlieb, 2014, p. 27). Their view is that a considerable shift in financial and political incentives is needed to overcome these barriers. Based on the multitude of these explanations, it can be concluded that actions by multiple sectors are needed to influence the broad areas of social determinants of health that are associated with health inequalities.

Intersectionality and health

The concept of intersectionality provides yet another perspective why the health sector alone cannot influence on the wider social determinants of health. Along with “traditional” socioeconomic variables such as income, education, and occupation, there

are policy analyses on health equity that focus on particular groups. The term intersectionality refers to multiple intersecting and interacting factors that shape an individual's social position (Hill, 2015). The main focus of intersectionality is often beyond the traditional socioeconomic variables of income, education, and occupation, for instance ethno-racial explanations focus on the health effects that result from various forms of racial discrimination (Reitz & Banerjee, 2007) and feminist and other critical scholars highlight how factors such as sex, gender, disabilities, immigration status, and race have many intersecting impacts on health (Hankivsky et al., 2010). In addition, intersectionality encourages the examination of the role that power and privilege in health inequalities play by moving beyond a descriptive analysis to investigating the social processes and structures that create and sustain power inequalities within society (Hill, 2015).

Gender is one of the intersecting factors that divides the population and has health consequences, not least for the reason that men have held greater privilege throughout human history. Doyal defines gender equity in health as a "equitable distribution of health-related resources" (Doyal, 2000). Doyal argues that it is important to understand the similarities and differences in the health needs of women and men in order to address them effectively. Gender roles and differences in living and working conditions can systematically expose men and women to various risk factors to different degrees. These underlying determinants include social and economic disadvantages, income, employment, education, housing, reproductive health needs, among others (Östlin et al., 2006). Intersecting factors can decrease the quality of life by increasing the likelihood of experiencing adverse living conditions.

For instance, a racialized woman with an immigrant status has much a greater risk of poverty than a non-immigrant male. Moreover, poverty manifested as lack of material and financial resources has been linked to depression and high levels of stress. McGibbon and McPherson (2013) argue that many of women's mental health struggles

are the result of oppression that takes place in multiple domains of everyday life. These intersecting impacts increase stress and make women susceptible to many negative health outcomes. They argue that the recently implemented neo-liberal policies place more and more responsibility on individual women, even though there are many structural and societal reasons that contribute to the risk of mental and other health problems (McGibbon & McPherson, 2013, p. 64).²⁰ For instance, neo-liberalism has been associated with an increasingly precarious job market where women face more difficulties in finding well-paid full-time employment. At best, public policies can address many of these differing needs from micro to macro levels and reduce gender inequities in health (Östlin et al., 2006). A rational conclusion can be drawn with an implication that health considerations should be included on policy agendas of non-health sectors because it is evident that a multitude of factors have intersecting impacts on health.

Three general approaches to promote health equity

Policy measures to promote health equity by tackling health inequalities can be very varied in terms of their focus and targets. Researchers have identified three ways of considering health inequalities that have varying policy implications (Graham, 2004a, p. 114-118; Graham, 2004b, p. 118-128; NCCHPP, 2016, p. 2-3). These three approaches are (1) improving the health of the most disadvantaged groups, (2) reducing the gap between the most disadvantaged and other socioeconomic groups, and (3) addressing

²⁰ Coburn (2000) describes the tenets of neo-liberalism as follows: "Neo-liberalism refers to the dominance of markets and the market model. Though composed of a complex combination of characteristics the basic assumptions of neo-liberalism, the 'philosophy' of the new right are: (1) that markets are the best and most efficient allocators of resources in production and distribution; (2) that societies are composed of autonomous individuals (producers and consumers) motivated chiefly or entirely by material or economic considerations; (3) that competition is the major market vehicle for innovations. Neo-liberalism is distinguished from neo-conservatism by the fact that the latter contains a particular social component supportive of traditional family values, particular religious traditions etc and not only a 'free-enterprise' economic doctrine." (Coburn, 2000, p. 138)

health inequalities across the whole population. There are significant national differences in the use of these strategies in terms of what is seen as a main approach (Raphael, 2012c). It should be noted that each of these three general strategies can apply the principles of intersectoral policymaking, i.e. engage more than one sector. In the following, I will briefly discuss each of these strategies.

Focusing on the most disadvantaged. The first strategy is to target the most disadvantaged populations and therefore is limited to a fairly small group of people (Graham, 2004b, p. 118-120; NCCHPP, 2016). In some cases, this strategy can be very beneficial to the worst off but does not have an impact on other groups. For instance, improving health and well-being of homeless people by providing them income, shelter, and access to health care can be all very effective strategies to improve the living conditions of a very disadvantaged group. However, this strategy does not address the root causes that can increase people's likelihood to become homeless in the first place, such as a lack of affordable housing, joblessness, and the absence of social safety nets in general. Similarly, having a sole focus on a disadvantaged group can stigmatize the targeted population and legitimize their disadvantage as a normal social condition that should be made more tolerable for more well-off citizens (Solar & Irwin, 2010). Similarly, policies that target only the most vulnerable can conceal the need to address social structures that originally gave rise to health inequalities. In addition, there is a danger that some disadvantaged groups are "hidden" (i.e. whose needs are not recognized) and therefore they are not targeted at all within a focused strategy.

In other words, the focus on the most disadvantaged can pose a danger of ignoring the root causes of the problem. For instance, people's reliance of food banks cannot be solved by providing food banks more resources in order for them to work more efficiently. This solution would not address the root problem that makes food banks and "breadlines" exist in the first place, e.g. the issues of poverty and unemployment. An

alternative perspective might come about from seeing food banks as a clear failure of public policy.

Focusing on the health gap. The second strategy focuses on the relational aspect of health inequalities, i.e. the gaps between the most worst off and the more advantaged groups (Graham, 2004b, p. 120-123; NCCHPP, 2016). This way to pursue health equity means reducing health inequalities by improving the health of disadvantaged populations to attain a more equal distribution of health amongst the overall population (Braveman, 2014a). More specifically, it is often argued that reducing poverty and income inequality is probably the most efficient way to tackle global health inequalities (Wilson, 2009). In a recent review on the relationship between income inequality and health, Wilkinson and Pickett conclude in a quite straightforward way that “narrowing the [income] gap will improve the health and wellbeing of populations” (Pickett & Wilkinson, 2015). Furthermore, improving the overall quality of the social determinants of health among the most disadvantaged populations is needed to attain greater levels of health equity (Braveman, 2006; Vågerö, 1995).

However, only reducing the health gap does not necessarily influence the overall distribution of health. At first, both strategies — focus on the most disadvantaged and focus on the health gap — might seem to be cost-effective and offer benefits that can be easily understood. Economic arguments, such as the need to channel resources to the people who are in the most need, can be easily grasped. In addition, these strategies can offer a publicity value as policymakers can give a clear message to the media and general public that they have a clear strategy to address health challenges among the disadvantaged. Despite the benefits of these two strategies, it has been proposed that a more universalistic strategy would lead to the best overall results in terms of population health.

Shaping the overall distribution. The third strategy has its focus on the health gradient, i.e. how health is distributed across the whole population (Graham, 2004b, p.

123-126; NCCHPP, 2016). The first two strategies focus on the most disadvantaged and therefore they tend to ignore everyone above the least well off. Socioeconomic position and health are interconnected in every nation, and in all societies there are hierarchies based on income, occupation, and education (WHO, 2008a). One's position on this hierarchy constitutes an individual's socioeconomic position (Krieger, 2001a). A social gradient in health refers to a linear correlation between health status and socioeconomic position, i.e. the higher the social position, the better the health (Marmot, 2006).

The health gradient is visible in every society including developed and developing countries. In the context of developed countries, differing mortality rates between socioeconomic groups can be seen in an example from Washington DC. At the distance of 12 miles, life expectancy varies from 57 years for the most underprivileged group, black men, to 76.6 years for the group of the wealthiest, white males (Marmot, 2006). Similar disparities between lower and higher socioeconomic groups can also be observed in more egalitarian nations such as Canada (Raphael, 2012a) and the Nordic countries (Mikkonen, 2012).

Each of the above strategies aim to address health inequalities, but the third strategy that focuses on the overall distribution of health is the only universalistic approach by focusing on the distribution of health from the most disadvantaged to the most advantaged populations.²¹ Similarly, one limitation of intersectionality can come about from its focus on specific groups at the expense of a more universalist focus. In other words, intersectionality has a tendency to focus on the most disadvantaged groups rather than dealing with the overall distribution of health (cf. three approaches to health inequalities presented above). This can be positive in the sense that individual needs are met effectively but also has a negative aspect if the element of distribution is neglected.

²¹ In terms of national health policies, Norway is a rare example of a country that has explicitly taken the universalistic approach to tackle health inequalities and reoriented its national policy in order to address the health gradient (van der Wel, Dahl, & Bergsli, 2016).

One analogue to the strategy of shaping the overall distribution of health can be found from epidemiological studies that have concluded that shifting various risk factors (e.g. high blood pressure) is significantly more effective when the focus is, not on individuals, but on the whole population. For instance, Rose (2008) has made a strong case indicating that population-level strategies are significantly more effective than targeted strategies because population -evel change can effectively shift the normal (or Gaussian) distribution of health-related determinants. In comparison to targeted strategies, this change at the population level will lead to greater improvements in population health on average as well as to better health in the most disadvantaged groups (Rose, 2008). To summarize, shaping the overall distribution is likely to lead to more significant improvements than having a focus on a limited target group.

2.2.3 Implementing healthy public policy

The term healthy public policy has its roots in the pioneering work of Nancy Milio. In her book "Promoting health through public policy" (1981), Milio provided an extensive set of evidence to show how agriculture, finance, transportation, and social policy sectors influence population health. According to Clavier and de Leeuw (2013a), Milio's term "healthy public policy" summarizes the idea that "health is the product of social and political forces, many of which are under the control of political action in various policy sectors" (Clavier & de Leeuw, 2013a, p.2).²² A Canadian key figure in health promotion, Trevor Hancock, argued for moving from "public health policy" to "healthy public policy"

²² de Leeuw & Clavier (2011) highlight the significance both of these two persons for the health promotion movement: "Both Nancy Milio, Trevor Hancock and the aggregate authorship of the Ottawa Charter clearly believed that Healthy Public Policy was an irrefutable necessity for health promotion. The 'evidence' had been established with great assertiveness; Milio included over 1000 references in her Healthy Public Policy work. Hancock spoke with the authority of the Canadian Public Health Association and with superb rhetorical power" (De Leeuw & Clavier, 2011, p. ii240).

in his 1985 paper.²³ Hancock referred to physicians Johann Peter Frank (1745-1821), Rudolf Virchow (1821-1902), and Benjamin Ward Richardson (1828-1896) as pioneers who acknowledged the importance of environmental and social factors to health. Hancock sees that the 1974 Lalonde report ("A new perspective on the health of Canadians") as the first Western document that made a strong argument for public policymakers to look for health promotion measures beyond the health care system. Halfdan Mahler (1923-2016) was the Director-General of WHO from 1973 to 1988 and delivered the keynote address at the Second International Conference on Health Promotion held in 1988 in Adelaide, South Australia. In his keynote, Mahler referred to the following definition of healthy public policy:

Healthy public policy is the policy challenge set by a new vision of public health. It refers to policy decisions in any sector or level of government that are characterized by an explicit concern for health and an accountability for health impact. It is expressed through horizontal strategies such as intersectoral cooperation and public participation. (Mahler, 1988a, p. 134)

The Health for All movement and the WHO's global strategy (WHO, 1981) were strong expressions of a more holistic understanding of health (Hancock, 1985, p. 10). Overall, WHO was an instrumental actor in making the term healthy public policy more widely known. The Ottawa Charter (WHO, 1986b) was developed for the First

²³ Hancock's earliest documented formulation of the term and the concept of "healthy public policy" was in 1982, in an article for the *Futurist*, titled "Beyond health care. Creating a healthy future." He recalls reading Nancy Milio's work in the late 1970s and expresses that he was also much influenced by the work of Peter Draper (1933-2016), who led the Unit for the Study of Health Policy at Guy's Hospital on London. In addition to Milio's contribution, Trevor Hancock credits Peter Draper for being "years ahead of the field in thinking about these issues" (Source: personal communication, September 27, 2016).

International Conference on Health Promotion in Ottawa on November 21, 1986.²⁴ The Charter states that health consequences of decisions should be considered in all sectors and at all levels. It calls for decision makers to have a greater awareness and responsibility for health. In addition, the Ottawa Charter urges health promoters to identify the obstacles to implementing healthy public policies outside of the health sector and to find new ways to remove those obstacles (WHO, 1986b). The roots of the Ottawa Charter can be traced to the Lalonde report in Canada (1974), the Alma Ata Declaration (1978), and the “Health for All” philosophy of WHO that arose in the beginning of the 1980s (Kickbusch, 2003).²⁵ Over the past few decades, the Ottawa Charter has become one of the most influential documents in health promotion and still has the potential for action and relevance in today’s world (Hancock, 2011).

Hancock has listed a set of basic principles that can be associated with successful action on healthy public policies (Hancock, 1990, p. 9). These principles include having a long-term view, secured political commitment, the existence of intersectoral processes and structures, community participation, and public support. In addition, Hancock states that multifaceted strategies are usually required and the initiators of action need to be credible and equipped with adequate resources. Confrontations that can easily lead to

²⁴ Under the section on Healthy Public Policy, the Ottawa Charter states: “Health promotion goes beyond health care. It puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. [...] Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policymakers as well” (WHO, 1986b).

²⁵ The first Director-General of Health Canada's Health Promotion Directorate, Dr. Ron Draper, was the key person in the process of organizing the First International Conference on Health Promotion that was held in Ottawa in 1986. His work has been acknowledged to be especially important to the development of health promotion globally (Catford, 1998). In support of Dr. Halfdan Mahler, who was the Director-General of WHO (1973-1988), Dr. Draper’s collaborated closely with Dr. Ilona Kickbusch to organize the Ottawa conference. Kickbusch was then leading the health promotion program at the WHO Regional Office for Europe.

win-lose situations should be avoided, with the focus instead being on finding win-win solutions through coalition building (Hancock, 1990, p. 9). Along with Hancock's notions, the move towards cooperation and less compartmentalized approaches has been seen to require public health actors who have adequate skills to carry out effective advocacy, mediating, and negotiating (Kickbusch, Draper, & O'Neill, 1990, p. 4). One of the leading figures in public health for seven decades, Dr. Lester Breslow (1915-2012), has expressed the view that the Ottawa Charter is the document that was able to best capture the essence of the third public health revolution by focusing on "capacity building for health" (instead of disease prevention) and seeing health as an everyday "resource for living" (Kickbusch, 2003, p. 384).

On the other hand, healthy public policy, in the way it was endorsed by the Ottawa Charter, has not become an integral part of the public discourse in the WHO members states. Some authors have concluded that health promoters may have failed to understand the policy processes and conditions that must preside over the implementation of healthy public policy (Bernier & Clavier, 2011; De Leeuw & Clavier, 2011). According to de Leeuw & Clavier (2011), there are a number of specific factors and conditions that can act as facilitators or barriers to the implementation of health-promoting public policies, such as the level of political commitment, the role of different interest groups, and the political structures of a country. Many of these challenges are discussed in the following sections.

Barriers to implementation of policies for health equity

There are multiple barriers to the implementation of public policies that promote health. In the following section, I focus especially on the implementation of wider public policies with an aim to reduce health inequalities. Exworthy (2008) has categorized seven general challenges that demonstrate the difficulty of the task: (1) the root causes of health inequalities are multidimensional and there are many policy solutions that might be

effective but their influence is difficult to prove; (2) implementing effective policies requires a long time span but everyday electoral politics is overwhelmingly based on short time spans; (3) multisectoral action that includes multiple governmental sectors, non-governmental organizations, and the corporate sector is very challenging even when there is a will to develop it; (4) other policy goals and priorities (e.g. economic goals) are sometimes seen as more important than promoting public health; (5) the cause and effect relationships are complicated and often it is hard to predict the outcomes of actual political decisions, (6) there is lack of extensive and reliable long-term data about health inequalities and their development, and (7) globalization and decentralization have decreased the ability of individual nations to tackle complex and global policy problems.

The above list highlights challenges such as the multidimensional nature of health inequalities, long time spans that are needed to implement policies that would address health inequalities, other policy priorities than health, and the decreased ability of individual nations to tackle global policy problems. These challenges reflect the complexity of the problem and the struggles of finding effective solutions. In addition to Exworthy's list, solving the health inequality puzzle is even more challenging when the influence of different ideologies and power relations is taken into consideration. Health and its distribution can be seen as deeply political issues because (1) different socioeconomic groups have more health than others due to avoidable reasons, (2) the presence or absence of health is dependent on political action or inaction, and (3) the right to health is not accepted as a basic human right (Bambra et al., 2005, p. 187).

Some studies have indicated that public health professionals are not sufficiently aware of structural and political determinants of health (Collins, 2012). In addition to the lack of awareness, many public health workers hold the view that they do not have the authority, political mandate, or skills to address the upstream determinants of health; it is easier and more convenient to work with lifestyle interventions at the individual level. For instance, McIntyre et al. (2013, p. 1) studied the views of Canadian public professionals

on the social determinants of health and concluded that “two groups with different affiliations to formal public health could discuss the social determinants of health without acknowledging the inequitable distribution of power and resources that lies at its root.” Many similar studies have showed that public health professionals generally find it hard to move beyond a focus on individual actions to one of influencing upstream factors.

The term “lifestyle drift” is used to describe the reoccurring challenge of maintaining focus on the upstream determinants of health. Carey et al. (2016) summarize that lifestyle drift has been used to refer to “(1) policy initiatives for tackling ‘inequalities in health that start off with a broad social determinants (upstream) approach but drift downstream to largely individual lifestyle factors’ and (2) the general trend of investing in individual behavioral interventions” (Carey et al., 2016, p. 1). Often policymakers feel that it is easier to focus on proximal health behaviours such as alcohol, smoking, diet, and exercise than to aim at influencing the fundamental drivers of these behaviours, i.e., “the causes of the causes” (Marmot & Allen, 2014). To overcome the lifestyle drift is by no means easy and would require that policymakers have and are able to sustain a clear vision of the importance of the social determinants of health in determining the health of the population. In addition, there are important barriers related to political and institutional mandates that are seen to limit the possibility to influence the broader public policies that lie mainly outside of the health sector itself. Intersectoral action for health tends to provide one possible solution to decrease the power of lifestyle drift. Sustainable changes cannot be achieved without altering policies and therefore the following section considers the role of public policy action in promoting health equity.

In the research literature, a number of additional explanations have been identified to describe the limited take-up of health inequalities research in real life policymaking (Smith, 2013; Smith, Stewart, et al., 2015). Based on over 140 interviews with policymakers, Smith (2013) listed several factors explaining the lack of adoption of policy recommendations made by health inequality researchers: (1) a lack of political will

to implement upstream policies that have been recommended based on the available evidence, (2) policymakers do not believe they own a sufficient public mandate to implement these recommendations, (3) other policy issues have generally had a higher priority than reducing health inequalities, (4) the scope of available policy responses has been considered to be limited to the actions taken by departments of health, and (5) actors seeking to reduce health inequalities have been “out-lobbied” by other interests and actors, such as the alcohol, food, and beverage industry (Smith, 2013; Smith, Stewart, et al., 2015).

The above challenges reflect the complexity of the problem and difficulties with finding effective solutions. As indicated earlier, even the most well-developed and affluent welfare states have not been able to eradicate health inequalities both within and between their countries (Mackenbach et al., 2008). Raphael (2012b) states that health inequalities originate from the deepest structures of society and are related to the unequal distribution of economic, political, and social resources. In countries that have placed health inequality on the policy agenda, the predominant way to tackle the unequal distribution of health has been through incremental changes in public policy.²⁶ Graham (2004a, p. 116) asserts that “mainstream economic and social policies lie at the heart” when assessing national differences in social determinants of health. However, in many countries socioeconomic health inequalities are still not visible in mainstream policy discourse (Bryant, 2012; Bryant et al., 2012). At the global level, the influential final report of the WHO Commission on Social Determinants of Health (2008) called for global action

²⁶ Siu (2014) defines public policy as follows: “A public policy is an embodiment of both formal and informal actions (or inactions) carried out by the government on specific issues that have significant social, economic, political, and/or environmental impact on specific population groups or the public at large. It is usually carried out in the name of the public good and represents the government’s position. This position is often, but not necessarily, supported by human and financial resources, organizational structures and processes, ideological justifications, or legal, financial, and/or military sanctions.” (Siu, 2014, p. 3).

to tackle health inequities, however, steps towards the progressive realization of health equity have been halting (Marmot et al., 2012; WHO, 2008a).

Raphael (2009a) identifies two main approaches that can help to formulate health-promoting public policies: (1) professionally-oriented rational or knowledge-based approaches and (2) social and political movement-based materialist or political economy-oriented approaches. Raphael argues that, in a market-dominated political economy, adopting a social-movement-based approach might be essential to force jurisdictions to implement equity-oriented policies. Similarly, from a political economy perspective, Bryant (2010) considers how political, economic, and social forces shape the health of a population in various jurisdictions. In the Western context, liberal, conservative, and social democratic welfare states have different strategies for addressing social and health challenges (Esping-Andersen, 1990). Bryant (2010) argues that economic and social inequalities also lead to health inequalities. Therefore, in order to reduce health inequalities, the focus should be put on health-promoting public policies that reduce economic and social inequalities.

Mackenbach (2012) introduced a hypothesis proposing that the failure of modern European welfare states to eliminate health inequalities can be explained “partly because of a failure to implement more radical redistribution measures, partly because of concurrent developments which have changed the composition of socioeconomic groups and made health inequalities more sensitive to immaterial factors” (Mackenbach, 2012, p. 767). He asserts that a substantial reduction of health inequalities “can only be achieved with more radical redistribution measures, and/or a direct attack on the personal, psychosocial and cultural determinants of health inequalities” (Mackenbach, 2012, p. 767). However, Mackenbach’s conclusion is that only small steps in the reduction of health inequalities are likely because there is insufficient political support for radical redistribution of (material) resources and also a lack of effective interventions on the non-material determinants of health.

As one way forward, Baum (2007a) points out the importance of the “nutcracker” effect which means that both top down and bottom up action is needed in the promotion of health equity. Politicians and senior policymakers can carry out top down action while bottom up action refers to political pressure built through community and civil society action. In terms of specific actions, however, there is only very limited evidence available on the effects of specific interventions that aim to tackle health inequalities (Bambra et al., 2010).

From a wider perspective, Blas et al. (2008) analyzed what role the state and civil society can have in promoting health equity. They summarized the evidence collected by nine knowledge networks which supported the WHO Commission’s work. The findings point out that individual states and their governments can promote health equity in at least three main ways (Blas et al., 2008, p. 1684). First, governments can provide and guarantee human rights and essential services. Second, they can facilitate policies that provide the basis for equitable health status among different social groups. Third, governments can collect and monitor data about the population by using various indicators such as mortality, morbidity, and the level of equitable distribution of health. These indicators are essential in order to have an accurate view at the level of health inequalities because without effective monitoring tools it is impossible to know whether any changes are taking place and to know what the effects are of these implemented policies.

The 2008 report of the WHO Commission on the social determinants of health gave a number of recommendations to promote health equity at regional, national, and global levels (WHO, 2008a). On behalf of the commission, Marmot (2007) wrote just before the report was published, “the Commission for the first time brings together at a global scale actors, experiences, and evidence concerned with social determinants of health and health equity.” Later, in the 2012 evaluation of the results of the Commission’s work, Marmot et al. (2012) concluded that many minor developments have taken place

since 2008, yet equity in health and its determinants had barely risen on the global agenda, as they stated:

Health equity is hardly a consideration in trade talks; governments are too diverted by the global financial crisis and their domestic economic problems to give focus to health equity; and the default position of people in the health sector is to focus on health services and prevention of specific diseases. (Marmot et al., 2012, p. 187)

The work to tackle health inequalities needs to continue throughout the world, but one might ask what is required for success? If we presume that the causes of health inequalities can be found in social conditions, and that everyone has the right to health, then it is easier to agree that equity in health should be promoted through improving living conditions and the prerequisites for health (i.e. social determinants). Marmot and Allen (2013) summarize that “concerted and coordinated action on the social determinants of health requires strong political leadership and ambition – locally, nationally and internationally.” Moreover, in addition to equity-oriented leadership, fulfilling these goals requires good governance as well as a strong institutional and public support (Ottersen et al., 2014). In this dissertation, I argue that it should be clearly acknowledged that the core justification for action derives from the human rights perspective to health. In the following section, the importance of health as a human right will be reviewed in greater detail.

2.3 Health, human rights, and the justification for action

The history of moral thought is long; however, the modern conception of human rights is relatively new. Ethical considerations of the nature of human rights have been an essential part of the Christian tradition as well as other religious and cultural traditions throughout history. In the eighteenth century, Anglo-Saxon writers outlined “natural rights” and French philosophers spoke of “rights of man” (Hunt, 2008, p. 113-145). The term “human

rights” was used sporadically but it was understood in a more limited perspective than today. During the eighteenth century, human rights were not seen as “universal rights” as they did not include the rights of women, slaves, and racial minorities. The predecessors of modern human rights declarations and conventions include documents such as the Magna Carta (1215), the English Bill of Rights (1689), the French Declaration on the Rights of Man and Citizen (1789), and the US Constitution and Bill of Rights (1791) (Flowers, 1998).

Public health and health promotion have an ethical and moral dimension that is related to the notion of health as a basic human right (CESCR, 2000; Riedel, 2009; UN General Assembly, 1948). Socioeconomic-related health inequalities can be considered avoidable and therefore unjust (WHO, 2008a). Braveman and Gruskin (2003) assert that human rights principles and health equity are closely related by their both having an ethical imperative to improve the health and well-being of a population. Health equity should be measured by comparing the differences between the most advantaged and disadvantaged social groups. This comparison should be made by looking at health status and the social determinants of health among people in different socioeconomic positions. Rioux (2010) states that the UN agreements highlight many essential prerequisites of health, such as income, housing, and health care. In this sense, the human rights framework can offer a valuable and complementary perspective in the work to improve a population’s health.

There is a body of international human rights documents emanating from the United Nations and ratified by most United Nation member states (Dominguez-Redondo, 2010). These declarations and conventions place the responsibility for ensuring human rights upon national states. In the United Nations context, the collection of the most significant human rights documents is known as the International Bill of Human Rights (IBHR). The IBHR comprises three key documents: the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Economic, Social and Cultural Rights

(ICESCR, 1966),²⁷ and the International Covenant on Civil and Political Rights (ICCPR, 1966).²⁸ The ICESCR and the ICCPR are two binding covenants while the UDHR is a non-binding declaration. In addition, the UN Committee on Economic, Social and Cultural Rights (CESCR, 2000) has issued “General Comment No. 14: The Right to the Highest Attainable Standard of Health”, which is seen as one of the key international documents that specifies the position of the ICESCR on health and human rights.

From a wider perspective, the provision of the right to health can be measured in terms of availability and accessibility of various social determinants of health (Raphael, 2012b). Box 1 outlines how the Universal Declaration of Human Rights (UDHR) classifies different human rights into six categories (Nickel, 2014; UN General Assembly, 1948). This categorization clearly shows that the fulfillment of human rights is closely linked to a number of social determinants of health. For instance, protecting people against violence, following the principle of nondiscrimination, protecting people from poverty, or provision of education to all are the key social determinants of health. In Appendix A, I provide a more detailed review on how the right to health (which is highly relevant for academic researchers and health advocates (Fox & Meier, 2009; Rioux, 2010)) is defined in the key human rights documents released after the Second World War.²⁹

²⁷ The ICESCR was adopted by United Nations GA resolution 220 A (XXI) on December 16, 1966, and entered into force on January 3, 1976.

²⁸ The ICCPR was adopted by United Nations GA resolution 220 A (XXI) on December 16, 1966, and entered into force on March 23, 1976.

²⁹ On the history of human rights before the UN documents, see Hunt, L. (2008). *Inventing Human Rights: A History*. New York: Norton.

Box 1. Classification of the rights outlined in the UDHR (Nickel, 2014).

Security rights – Protect people against crimes such as murder, massacre, torture, and rape.

Due process rights – Protect against abuses of the legal system such as imprisonment without trial, secret trials, and excessive punishments.

Liberty rights – Protect freedoms in areas such as belief, expression, association, assembly, and movement.

Political rights – Protect the liberty to participate in politics through actions such as communicating, assembling, protesting, voting, and serving in public office.

Equality rights – Guarantee equal citizenship, equality before the law, and nondiscrimination.

Social/welfare rights – Require provision of education to all children and protections against severe poverty and starvation.

Source: Nickel, J. (2014). Human rights. Stanford: Stanford Encyclopedia of Philosophy, Metaphysics Research Lab, Stanford University. Retrieved June 28, 2017, from <http://plato.stanford.edu/entries/rights-human/>

During the past two decades, the health and human rights movement has grown stronger in terms of research and advocacy (Mpinga et al., 2011). If we take the right to “the highest attainable standard of health” seriously, then nations should be committed to reducing the health gap between the least and the most disadvantaged socioeconomic groups within a society. To date, there are no official international agreements that focus explicitly on health equity. However, many of the current agreements can be used to advocate for stronger arguments in the promotion of health equity.

For instance, Braveman (2010) discusses the connections between human rights and health equity. She clarifies how rights-based approaches to health and to health equity are perspectives that support each other. Braveman focuses her conceptual analysis on equity in social conditions and the right to a living standard that is adequate for health. Her analysis shows that the international declarations and covenants (namely the UDHR, ICESCR, and ICCPR) are supportive in terms of promoting health equity. Braveman's (2010) main argument is that the human rights perspective and health equity go well together. For instance, the unified perspective gives a better opportunity to improve the measurement of the prerequisites of health and build consensus on shared values that promote health and defend human rights. Similarly, Rodriguez-Garcia and Akhter (2000) argue that public health professionals should take on two major challenges. First, human rights should be adopted as the core of public health practice, research, and policy; and second, the Universal Declaration of Human Rights and other human rights documents should be used as the guiding principles for the protection and promotion of the public's health (Rodriguez-Garcia & Akhter, 2000, p. 694).

In 2001, Whitehead et al. (2001) called for a global response to the challenge of unavoidable and unacceptable health inequalities. They argued that macroeconomic and social policies do matter when tackling health inequalities; however, they suggested that not much action had been taken.³⁰ In terms of taking action, it is important to consider different accountability mechanisms that help to monitor action, or in many cases, inaction. Yamin (2008) highlights three aspects of accountability that should be considered in terms of promoting, protecting, and fulfilling health as a human right: (1) What the state is doing; (2) how much effort the state is expending; and (3) how the state is going about the process (Yamin, 2008).

³⁰ "In essence, our contention is that it is possible to challenge health inequities with purposeful public policy. Such a challenge is long overdue." (Whitehead, et al., 2001, p. 209).

While I am of the belief that the human rights approach is a powerful means of providing justification for an intersectoral approach to promoting health equity, there is a critique of the approach that argues it individualizes the problem of rights by diverting attention from the state's responsibility for their provision. One form of this individualization of collective problems can be associated with the use of the legal system to attain particular rights. For instance, Gloppen (2008) has suggested that in some cases it can be problematic to use litigation as a strategy to hold governments accountable for implementing the right to health. The argument is that there can be significant financial and social implications that have not been extensively studied. More specifically, Gloppen (2008, p. 21) has raised the question of who actually benefits from using litigation as a strategy by asking: "Is litigation primarily used by marginalized persons to gain fair access to medical services, or is it in seeking assistance pursue access to treatment that is not otherwise provided due to expense?"

Raphael (2012b) concludes that there is a moral imperative to tackle health inequalities and this approach is justified by understanding health as a human right as the UN human rights documents assert. He concludes that health inequalities are largely caused by economic and political structures, and the ideologies behind these structures. Raphael argues that the most effective way to tackle health inequalities is through public policy that promotes equity. In a similar manner, Braveman (2014a) provides three responses to the question "why should we care about health inequalities?" First, there is a massive body of evidence showing that economic and social disadvantage are associated with lower health status that is manifested as increased morbidity and premature deaths. Second, both economic and social disadvantage can be relieved by public policies, such as labour laws, progressive taxation, and reducing discrimination in society. Third, ethics and human rights principles give us an obligation to ameliorate the situation, as "[h]uman rights agreements require that countries demonstrate 'progressive

realization’; i.e., they are making gradual progress toward realizing the rights of their populations” (Braveman, 2014a, p. 7).

In conclusion, promoting, protecting, and fulfilling the right to the highest attainable standard of health requires coordinated action by all relevant governmental sectors. However, the actual implementation of intersectoral action is a highly complex process that requires understanding a wide variety of factors that influence policy change. In this dissertation, my purpose to use the above approaches as contextual background for my empirical analysis, i.e. they set the scene in which calls for greater intersectoral action for health are presented. In the next section, I will review the essential roles of governance mechanisms, policy actors, interests, and ideas in the policymaking process.

2.4 Understanding policy change

Many public health researchers focus on providing evidence and information to decisions makers about impacts of policy decisions on health. Evidence is important and research findings can greatly extend people’s understanding on the complex relationships between health and public policy.³¹ Dunn (2012) points out that the call for evidence-based policymaking in the UK, the US, and the European Union can be seen as a response to the challenge posed to governments that try to manage the increasing complexity of today’s problems. Moreover, Dunn sees that the concept of evidence-based policymaking signals “a recognition that ideological, religious, and political influences – usually hidden and lacking in transparency – have exerted a harmful effect on policymaking in areas ranging from health, education, and welfare to national security and the environment” (Dunn, 2012, p. 41). On the other hand, he also acknowledges that

³¹ Policy analysis can be divided into two different approaches: “analysis of policy” (descriptive) and “analysis for policy” (prescriptive). Analysis of policy is retrospective and explanatory and aims to increase understanding of policy content and development. Analysis for policy is prospective and aims at recognizing and defining suitable policy options for the future. (Buse et al., 2012, p. 18; Hill, 2013, p.5).

some see “the movement toward evidence-based policymaking as a continuation of an ostensibly harmful logical positivist (scientistic) approach to questions of public policy and democracy” (Dunn, 2012, p. 42).

Other authors have also concluded that it would be a mistake to assume that evidence in itself could provide the sole basis for policymaking (Clavier & de Leeuw, 2013b; Smith, Stewart, et al., 2015). Political scientists generally acknowledge that evidence is just one factor that can influence policy decisions. Many institutional and contextual factors, including a mix of political and personal beliefs and ideas, are more important than evidence for shaping the policy landscape.³² Many health researchers acknowledge these complexities of policymaking. For instance, WHO has traditionally divided its work into technical and political spheres, recognizing that technical evidence by itself is never enough without the political will to use it.³³

Embrett & Randall (2014) have argued that policy analysis is rarely used in research into social determinants of health and health equity. They speculate that this absence comes about because of researchers’ general lack of appreciation of the political factors that act as barriers to policy adoption. In addition, they conclude that simply “raising public awareness to generate political will” is rarely a sufficient strategy to induce political change. Instead, they suggest “linking specific problems to policy solutions, improvement of political environments to encourage intersectoral cooperation and an increase in administrative capacity to implement change” (Embrett & Randall, 2014, p. 153).

Walt and Gilson (1994) claimed over two decades ago that health policy research has focused too much on the content of policy while actors, context, and processes have

³² For instance, Kickbusch (2010b) suggests that the research community should use the term “evidence-informed policy” instead of the unrealistic term “evidence-based policy” (p. 263).

³³ Naturally, this also applies the other way around, i.e. political will itself is never sufficient if there are no technical means for successful implementation (governance mechanisms, institutions, resources, organizational capacity, etc.).

been neglected. They argued that contextual and procedural factors are very important in health policymaking as policies are formulated through complex interactions between actors, content, context, and processes. For instance, the context of policymaking is influenced by many factors such as political ideology, culture, and governance structures (Walt, 1994; Walt et al., 2008).³⁴ Others have highlighted in greater detail how public policy decisions come about through a complex interplay between policy actors, institutional structures, processes, and ideas (Howlett et al., 2009). Policy analysis can be either focused on understanding the formulation of certain policies or finding the best policy alternatives for the future.

The extent of intersectoral action on health equity is determined through public policy decisions. First, we can ask: are equity goals supported by the surrounding culture and ideology? Second, who are the actors promoting health equity and what is their position in terms of power and influence within society? Third, are equity-promoting policy actors able to formulate concrete policy alternatives, and are they able to feed them to the actual policy processes within the government? For example, the implementation of equity promoting public policies is unlikely if the prevailing culture promotes individualistic solutions and values, policy actors who propose alternatives do not have power, and the government processes are not influenced by equity-related ideas. On the other hand, elected representatives and government officials are also influenced by political ideologies, cultural factors, voters' decisions, and the advocacy of a multitude of interest groups.

In the next section, I will focus on the above factors that can have a significant influence on how, why, and when different health-promoting or health-threatening policies are implemented. I will focus my attention on governance mechanisms, policy

³⁴The framework is closely related to a political economy perspective because it also acknowledges the varying levels of power and influence among different actors that influence the policy formulation process.

actors, and interests as well as on ideas and ideologies. My purpose in presenting these perspectives is to outline the significant complexity of policy change. Moreover, the governance perspective is relevant to this dissertation as it provides new insights to understand the challenges and barriers to the implementation of intersectoral initiatives.

2.4.1 Governance

Governance refers to the processes and structures by which collective decision-making takes place. The term has many definitions that highlight different aspects of governing. Some of the definitions highlight the use of power in managing resources, and other definitions give prominence to the structural and institutional arrangements within which the power is exercised (McQueen, Wismar, Lin, & Jones, 2012, p. 9). The Institute of Governance summarizes these complexities by defining that “governance determines who has power, who makes decisions, how other players make their voice heard and how account is rendered” (IOG, 2014). In the field of global development, governance has been defined as “the formation and stewardship of the rules that regulate the public realm – the space where state as well as economic and societal actors interact to make decisions” (Hyden, Court, & Mease, 2003, p. 5). According to Greer et al. (2016, p. 4), governance is “the systematic, patterned way in which decisions are made and implemented.” In this wider sense, governance can be understood as structures, processes, and power relations of a governing body (i.e. the context), such as a nation-state or organization.³⁵

The five principles of good/fair governance have been formulated based on the work of the United Nations (UNDP, 2011; UNESCAP, 2006). According to these principles, good governance must acknowledge the importance of (1) legitimacy and participation;

³⁵ Kickbusch and Gleicher (2012) define “governance for health” as “the attempts of governments or other actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches.”

(2) strategic vision and a long-term perspective; (3) performance in terms of responsiveness and efficiency; (4) accountability and transparency; and (5) fairness and equity (see Graham, Amos, & Plumptre, 2003). Sometimes the term “fair governance” is used to highlight the democratic need to respect the rights and interests of involved parties.

Stoker (1998) proposes that governance should be seen to refer to a set of institutions that are within but also beyond government. In other words, he points out that governance is a multifaceted concept and the contemporary meaning of governance is much more than “government action” through the formal institutions of the state (Stoker, 1998). According to the Stoker’s proposals, the concept of governance can be useful to identify the power relations but also the blurred boundaries and responsibilities between different institutions for addressing social and economic issues. As an analytical concept, governance can be useful in gaining new insights into how the government (or the state) can use new tools and techniques to steer and guide other institutions and actors towards its policy objectives.

Institutions as tools of governance

Governance can take place through formal or informal institutions. In a simple form, formal institutions refer to laws and formally agreed procedures and informal institutions refer to values, norms, and belief systems. In the institutionalist tradition, institutions are understood more broadly, not only as bureaucratic structures, but also as recurrent social practices and ideologies.³⁶ Institutionalism can provide a helpful perspective to understand the contextual factors that influence the implementation of intersectoral

³⁶ In this context, a broad definition of institutions is adopted: “An institution is a relatively enduring collection of rules and organized practices, embedded in structures of meaning and resources that are relatively invariant in the face of turnover of individuals and relatively resilient to the idiosyncratic preferences and expectations of individuals and changing external circumstances” (March & Olsen, 2008, p. 3, as cited in Farard, 2012).

action for health. It can be assumed that in order for intersectoral action to take place, there needs to be a strong idea about the benefits of solving health challenges through intersectoral collaboration. In addition, it can be assumed that intersectoral structures need to be institutionalized to make the implementation of intersectoral initiatives more efficient and sustainable. Deep institutional silos in bureaucratic structures or in everyday social practices are likely to make intersectoral work difficult. In the following, I will briefly outline the key ideas of the institutionalist tradition.

Since the 1980s, historical institutionalism and other institutional traditions have dominated the study of welfare state politics (Schmidt, 2008) and the approach has produced a strong body of research (Thelen & Steinmo, 1992). The merits of the institutionalist approach are in its ability to shed light on how policy development is closely linked to institutions that can constrain or significantly slow the policy change. The most well-known authors in the field of historical institutionalism include scholars such as Paul Pierson (2007), Theda Skocpol (Pierson & Skocpol, 2002), Peter Hall (1993), and Kathleen Thelen (Thelen & Steinmo, 1992).

With regard to historical institutionalism (HI), Pierson (2004, p. 1-2) argues that most contemporary social scientists typically carry out their studies by taking a “snapshot” view of political life but often ignore historical developments and temporal contexts. For instance, a political scientist could focus on the measurement of certain variables that are expected to predict various political outcomes. Pierson argues that the significance of these “variables” can be distorted when they are removed from their context and to overcome this problem requires a shift “from snapshots to moving pictures.” His solution to this methodological problem is to place politics in time, which he explains as “systematically situating particular moments (including the present) in a temporal sequence of events and processes stretching over extended periods” (Pierson, 2004, p. 2). Historical institutionalism makes a strong argument to show that history matters, and as in other institutionalism traditions, the role of institutions is emphasized in

order to understand policy change and policymaking processes (Pierson & Skocpol, 2002). Institutions, with their unique histories and backgrounds, constrain and shape the behaviour of political actors and interest groups (Béland, 2005). Policy processes both influence and are influenced by institutions. Historical institutional research looks at the sequences of policy change across time through analyzing institutions (Pierson & Skocpol, 2002) and institutionalist scholars often use case studies as a base of their analysis (e.g. Pierson, 2007; Tuohy, 1999).

The understanding of institutional dynamics can provide insights into why intersectoral action for health is difficult to implement and why planned changes in institutional arrangements are often difficult to attain. Especially the concept of “path dependence” is central to understanding how past institutional developments can shape current policy options. Another key concept is a “critical juncture”, which can be defined as a period of significant change that produces distinct and long-lasting legacies (see Collier & Collier, 1991, p. 27-39). For instance, a moment of a crisis can act as a critical juncture that allows policymakers to make decisions that have significant impact upon future developments. Critical junctures are always contextual and therefore have distinct characteristics depending on the surrounding political environments.³⁷

Scholars such as Hall (1993) have also focused on the importance of ideas in institutional change (see Campbell, 2002). One example of institutionalist research that has an explicit focus on the interplay of ideas and institutions is Schmidt’s discursive institutionalism (DI). Schmidt (2008) provides a new institutionalist framework that pays attention to ideas and discourse in institutional change in contrast to three older institutionalist traditions.³⁸ Schmidt understands ideas as “the substantive content of

³⁷ Critical junctures can be understood as moments when a window of opportunity opens (see Kingdon, 1984; Leppo et al., 2013a)

³⁸ These traditions are rational choice institutionalism (RI), historical institutionalism (HI), and sociological institutionalism (SI).

discourse” (Schmidt, 2008, p. 303). In Schmidt’s categorization there are two types of ideas (cognitive and normative) which exist at three levels: policies, programs, and philosophies (also Mehta, 2011). Cognitive ideas describe the nature of what the world is, and what kinds of underlying causal laws exist, i.e. the question of “how change happens.” Normative ideas consider our values and attitudes, i.e. questions of “what is good or bad” and “what ought to be.” These normative beliefs can sometimes override the self-interests of policymakers (Campbell, 2002, p. 24-25). In discursive institutionalism, Schmidt (2008) identifies two forms of discourse: (1) the coordinative discourse between policy actors and (2) the communicative discourse between political actors and the public. The discursive interaction between policy actors is different compared to the interactions between politicians and the general public; for instance, many of the themes debated among policy actors never rise on the wider political agenda that is followed by the general public.

In this dissertation, I take some key ideas from the institutionalist tradition including the importance of ideas, bureaucratic structures, and critical junctures. First, there needs to be a widely accepted idea that intersectoral action for health is a viable solution to tackle complex health challenges. Second, bureaucratic structures are needed to implement intersectoral action for health in a sustainable manner. Third, critical junctures are closely related to seizing the windows of opportunity that can provide a moment to gain strong political support for the implementation of intersectoral initiatives (see Leppo et al., 2013a).

Institutions and governance structures form the context where different policy actors, in health as well as in other sectors, try to advance their interests. These structures can enable or prevent actions or make certain developments more likely. However, from a policy perspective, it is not enough to analyze structures; it is equally important to consider different policy actors and their power in pursuit of reforming policies and governing structures.

2.4.2 Policy actors and interests

The field of public policymaking involves a wide array of actors with different interests, strategies, and levels of power. The diversity of these actors and their interests make the policy formulation process very complicated and sometimes unpredictable. On a general level, the state can be seen as a mediator of different interests through governmental decision-making.³⁹ As one possible categorization, Box 2 represents a list of the most important actors and organized groups that have an interest in influencing the formulation of health policy.

Box 2. Interest groups in health policymaking

- Political parties
- Elected representatives at local and national levels
- Government officials and civil servants
- Experts and scholars
- Workers' organizations and unions
- Employers' organizations
- Health care providers and clinics
- Public health and community organizations
- Private health care industry
- Professions and their advocacy organizations (e.g. medical associations)
- Pharmaceutical companies
- Instrument manufacturing industry
- Business and corporate sector (incl. alcohol and tobacco industries)
- Other non-governmental and non-profit organizations
- International/supranational organizations (e.g. UN, WHO, WTO, World Bank)
- Citizens and social movements

³⁹ From a legal perspective, the state has three functions: legislative, executive, and judicial (Deber, 2014, p. 3-5). First, the legislative aspect refers to the law-making process that is conducted by representatives chosen in elections to make decisions on their electorate's behalf. The electoral system can have a significant impact on how political dynamics play out with different political parties (e.g. the first-past-the-post system or proportional representation). Second, the state has the executive power to implement laws and use its power to direct resources accordingly. Third, the state and its judicial system interpret laws and set penalties for situations where the law is not obeyed.

The power relations between these actors influence what kinds of policy initiatives are produced, supported, and implemented at different levels of governance. Similarly, intersectoral action for health cannot be implemented without having sufficient power to influence the governmental decision-making processes. There are a number of theories that explain the policy change process (Buse et al., 2012). In the following, I will consider four approaches to understanding the policy change process: pluralism, rational choice, and “the streams model.”

Pluralism

Pluralism was the dominant school of thought from the 1950s to the 1970s in political science. Classical pluralism suggested that all interest groups have an equal chance to influence public policy, i.e. the approach highlights the plurality of actors and interests that influence decision-making processes (Hill, 2013, p. 27-30). As a related concept, incrementalism refers to decision-making that takes place through small and politically feasible adjustments to the current system (Lindblom, 1959, 1979). The pluralist approach assumes that everyone has equal opportunities to raise proposals on the public policy agenda, and so it is likely that the most useful ideas are supported and implemented by governing authorities through incremental change (Hill, 2013, p. 25-37).

Later, the pluralist view was criticized for its naivety and ignorance of inequalities that prevent some interest groups from having their voices heard (Stone, 2011, p. 232-234). The approach can be seen to be based on misguided assumptions such as (1) resources to gain influence would be widely spread throughout society, (2) these resources would be equally available to different actors, and (3) the amount of potential power would always exceed the governing power. Lindblom (1979) revised the pluralistic argument by recognizing the influence of strong business interests in policymaking. This type of neo-pluralism acknowledged the uneven distribution of power among interest

groups by arguing that there is “disproportionate political power and influence of business in politics” (Lindblom, 1979, p. 525).

Similarly, pluralism can be criticized based on its contextual limitations; for instance, in many nations decision-making is greatly influenced by a few selected interest groups representing workers and employers. For instance, in corporatism, the political parties can be assumed to have less influence and decisions are made through tripartite processes where the state acts as a mediator between the interests represented by trade unions and business associations (Hill, 2013, p. 54-57). Similarly, the elitist view of policymaking assumes that there is a small but influential political elite that possesses the top positions in business, government, civic organizations, and the media. According to the elite theory, this relatively small group of people often share the same values and hold the power to determine the basic directions of public policy (Dye, 2008, p. 21-23). Individuals can move from non-elite groups to elite positions but it is always a gradual process and usually requires conformity with the values of the governing elite. On a more general level, the incrementalist model of decision-making can be criticized for its lack of long-term planning and goals. Therefore, many incremental steps can lead to unwanted outcomes because there is no overall strategy or a strong sense of direction.

Rational choice

Rational choice theory can be contrasted almost as a mirror image of pluralism (Stone, 2011, p. 234-236). Rational choice theorists presume that the main motivation of individuals is to maximize their self-interests and for this reason collective mobilization of interests is not a rule but an exception. From this view, humans in general do not prefer collective action that would allow others to be “free riders” who unfairly benefit from other people's efforts. Pierson (2004, p. 9) has commented that rational choice theory should not be necessarily rejected but the critics should point out the theory's “restricted range of application” and therefore “its scope should be placed in proper perspective.”

As a later development, a theory of bounded rationality put its focus on the constraints of optimal decision-making, which are, most importantly: limited and unreliable information on which to base decisions, the limited cognitive capacity of the human mind, and the finite amount of time for decision-making (Jones, 2003). On the other hand, bounded rationality can be seen as an approach that ignores many of the political struggles and conflicting interests that play an essential role in policymaking.

Many political scientists have concluded that it is not sufficient to describe policy change as a rational process that takes place through gradual stages (Hill, 2013; Howlett et al., 2009; Sabatier, 1999). As outlined earlier in this section, governance structures, policy actors, and ideas have a significant influence on the formulation of the policy agenda. The complexities of these factors make the policymaking process non-linear and less logical than is sometimes assumed by health advocates (Clavier & de Leeuw, 2013b).

The streams model: problems, policies, and politics

In contrast to seeing policy change based on gradual stages, alternative models such as “the streams model” hold promise in analyzing policy changes that are relevant to promoting health and its just distribution (de Leeuw & Breton, 2013; Exworthy, 2008).⁴⁰ The streams model proposes that a policy is formulated only when the three policy streams of *problems*, *policies*, and *politics* come together (Kingdon, 1984). In other words, the problem needs to be identified, there needs to be a policy-based solution to the problem, and governing authorities must have the political will to implement the proposed policy.

Kingdon’s streams model is especially useful in order to understand the difficulties of implementing intersectoral action for health (Leppo et al., 2013a; Ollila, 2011). The first

⁴⁰ Mark Exworthy (2008) states: “A sensitive application of models such as ‘streams’ and ‘networks’ offers significant insights into the nature of SDH policy [social determinants of health] and the opportunities/constraints facing policymakers.”

stream (problems), can be understood as the acknowledgement of complex and multi-sectoral health problems. The second stream (policies) considers the identification of a macro-level solution, which in this case is intersectoral policymaking. Unfortunately, many of the micro- and meso-level challenges and barriers to intersectoral action have received more limited attention. Therefore, the main purpose of this dissertation is to focus on the micro- and macro-level factors that influence the policymaking process. The third stream (politics) is also one of the key consideration of this dissertation as it is evident that intersectoral action for health cannot be implemented without high-level political support and leadership. A general hypothesis can be made that intersectoral policymaking for health has not gained mainstream status because there is a constant lack of political support that would prioritize health concerns within governmental decision-making. In politics, many competing interests generally have higher priority than the question of tackling the health problems of the population.

However, only considering actors and their interests is not sufficient to understand policy development. Therefore, ideas and ideologies need to be considered as well because they ultimately shape the multiple interests that different actors hold.

2.4.3 Ideas and ideologies

The history and study of different political ideologies is long and winding. Ideologies such as liberalism, conservatism, socialism, and social democracy are consistent systems of ideas and ideals. These ideological views are normative and are committed to a set of values that suggest how our collective life should be organized and how we can get there most efficiently. Ideologies (as systems of values, attitudes and beliefs) can highlight the primacy of the individual or the primacy of the collective (Berman, 2006).

Individualistic and collectivistic approaches can lead to very different conclusions to questions such as how we should distribute limited resources among the population

and what the relationship is between individual agency and social structure. A political ideology based on the primacy of individual agency and freedom can be contrasted to an ideology that highlights the role of social structure and collective social arrangements. These political beliefs consist of causal and normative ideas about society and collective life (Campbell, 2002). Ideas shape our understanding of all collective problems and their root causes. For instance, if the existence of poor health is individualized and seen to be caused by individual behaviours, then it can be argued that the solutions need to be implemented at the same individual level. On the other hand, if poor health is seen as connected with social arrangements, then solutions need to be implemented at the structural and social levels.

An ideational perspective recognizes the non-rationalist, nonlinear, and uncertain nature of policymaking. Ideas have been described as “causal beliefs held by individuals or adopted by institutions that influence their attitudes and actions” (Béland & Cox, 2010a). To expand this general definition, Mehta (2011, p. 27) describes ideas as (1) problem definitions, (2) policy solutions, and (3) public philosophies or zeitgeist. Mehta draws on Kingdon’s (1984) classical work on “three policy streams” of problems, policies, and politics, all of which are needed to come together for an idea to rise on the political agenda and to become a policy. As stated earlier, we cannot form a policy to address a problem that does not have a workable solution; similarly, a policy that does not address any problem cannot gain political support (Kingdon, 1984). Ideas are important because they have a substantial power to shape what policy actors see as appropriate, legitimate, and proper solutions (Béland & Cox, 2010b, p. 3). In a similar manner, ideas have the power to define issues as problems, even if they would not have been considered as problems in the past. Moreover, ideas should be studied over time to understand how present-day ideas have been shaped by older ideas (Carstensen, 2010).

Another key concept in ideational research is framing. Frames refer to the way in which policies are presented and described in order to “make them politically acceptable

and legitimate” (Campbell, 2002, p. 26-28). A frame consists of a set of ideas, i.e. it is a wider concept than an idea (Mehta, 2011). Frames can contain both cognitive and normative ideas that form a basis for policy action. Political elites can have an interest in strategically crafting new frames to gather more public support for their political goals. On the other hand, opposing political parties can try to reframe questions differently to canvass support for their aims. Policy goals can be framed from many different perspectives. Ideational researchers argue that the chosen frames have significant influence on how different policy goals resonate among the general public and policymakers (Fafard, 2012).

Furthermore, researchers argue that positive and negative framing can lead to radically different outcomes (Saari & Kananen, 2009). Usually, positive framing increases the likelihood that people will support a certain policy, while negative framing decreases the support (Kangas, Niemelä, & Varjonen, 2013). However, little is known about how ideas and policy frames can influence the support of equity-related policies. Campbell (2002) argues that researchers have not been very clear in their analyses of how ideas turn to policies and what the causal mechanisms are behind those processes. More empirical research is needed to increase our understanding of framing and its influence on policy development.

Although ideational research has attracted increasing interest among social scientists, the study of ideas cannot, and should not, substitute for institutionalist and structural approaches. Along with the understanding of institutions, an ideational approach provides one piece of a larger puzzle as it can expand our understanding about how and why policy change occurs within institutions (Béland, 2009). In terms of intersectoral action, it is critical that policy advocates are able to present clear and uncomplicated arguments regarding what are the benefits of taking an intersectoral approach to health.

Related to the ideational perspective, Schrecker (2014) points out that framing and problem definition have a major influence on how we understand the causes and consequences of “the inequality machine” and whether we think that ongoing developments can be turned to a more equitable direction. As one example, Schrecker asserts that we are not defenseless against globalization. He sees that countries can still have a significant influence at the national level through their public policies such that it is misleading to claim that inequality would increase regardless of national policies. In addition, Schrecker (2014) argues that we should consider issues related to ideas and framing such as “how conceptions of competence in economic policy are shaped, and why the ‘pattern of discourse’ has become impoverished and inhospitable to redistributive policies” (Schrecker, 2014, p. 6). Ideas matter because they shape our perception of the world. Ideas embody causal beliefs and different ideas that will lead to the implementation of different problem solutions (Béland & Cox, 2010b). Ideational assumptions of causal relationships are not necessarily based on any empirical evidence.

Critical and engaged civil society actors and researchers can have a significant role in raising awareness of long-term consequences of political decisions, introducing new ideas, and reframing debates. Professional lobbyists and think tanks across the political spectrum produce materials to influence decision makers. These interest groups can influence the policymaking process by formal statements, position papers, media releases, advocacy campaigns, and lobbying through personal and private channels. The actions of different interest groups can be better understood if one is able to recognize the specific values and goals that drive a certain interest group. Governmental and non-governmental actors can influence public policy decisions by contributing to policy processes. In addition, to promote certain policies, it is crucial to understand what are the factors that influence policy formulation processes before an actual decision is made or action is taken.

Acknowledging power relations and hierarchies is essential to understanding the policy process. Decisions are very rarely based only on rational consideration that does not embody a struggle between competing actors and interests (Buse et al., 2012, p. 20-22). It is important to understand how policy processes evolve and what the struggles are behind public policymaking. Exworthy (2008) has argued that there has been a limited number of studies that focus on public health by analyzing policy processes. He sees that this gap in research originates in the epidemiological focus of public health and its lack of interaction with political science. Walt (1994) suggests analyzing policy as an interaction between policy context (e.g. social and economic conditions), content of policy (e.g. a concrete policy proposal), and power (e.g. relations between different stakeholders).

In terms of intersectoral action for health, one should ask how equity-related policy goals are acknowledged in different institutional contexts, and who supports or opposes them. For instance, researchers can consider how intersectoral action for health could be institutionalized in organizational processes and which groups of actors might oppose such attempts. Identifying the actual barriers can make it easier to overcome them.

Provided that health researchers and advocates truly want to promote health equity successfully, they are compelled to evaluate how issues can be raised on the political agenda and how the policy processes can be influenced more effectively. In terms of implementing intersectoral action for health, an absolute first step is that a number of sectoral policy actors should agree that “the idea of intersectorality” provides a solid foundation to promote health in the first place. In this dissertation, I will use the above theoretical concepts as background to my empirical analysis. The existing discussion outlined in this section indicates that policymaking processes are complex and this should be clearly acknowledged by everyone who aims to promote intersectoral initiatives. To provide a more in-depth background for my empirical analysis, the

following section reviews the historical developments of intersectoral approaches to health.

2.5 Intersectoral action through the decades

As an early milestone, which also influenced WHO's work, the Lalonde report "New Perspective on the Health of Canadians" (1974) has been credited with being the first government report that identified the health care system as only a rather minor force driving population health (Graham, 2004a). In 1977, the WHO's World Health Assembly (WHA) presented a resolution stating that all people of the world should "attain a level of health that will permit them to lead a socially and economically productive life by the year 2000" (Mahler, 1988b, p.72). The target was derived from the WHO's Constitution that had an objective of "the attainment by all peoples of the highest possible level of health." This was seen to mean that people should have a level of health which makes them capable to work productively and participate actively in their surrounding social community. A year later, the 1978 WHO declaration of Alma-Ata was published as one of the first truly international recognitions that highlight the importance of intersectoral action for health.⁴¹ The Alma-Ata conference was co-organized by WHO and the United Nations Children's Fund (UNICEF) and the declaration was endorsed on September 12, 1978. The attendees included delegates from 134 governments and representatives of 67 NGOs and UN agencies (Mahler, 1988b, p. 72). As a seminal document, the conference declaration highlighted the role of primary health care in attaining "Health for All by the year 2000" and it has inspired many subsequent declarations. Baum (2007b)

⁴¹ The first section of the declaration of International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 states: "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." (WHO, 1978)

concludes that the Alma-Ata declaration is “a quite remarkable document and has made an impact that few other before or since have had” (Baum, 2007b, p. 34). According to Lee (2008, p. 75), the conference “called for a revolution in thinking about health development, rejecting top-down, high-tech and vertical (disease-focused) approaches in favour of accessible, integrated, care that recognized the key role of local communities, affordable and appropriate technologies, and the need to address the underlying political, social and economic causes of poor health” (Lee, 2008, p. 75).

Despite the fact that almost four decades have passed from the Alma-Ata conference, many health researchers argue that legitimacy to engage other sectors in health promotion is still in its infancy and needs to be built (e.g. Clavier & de Leeuw, 2013a). In the following, I contextualize the key intersectoral approaches since the end of 1970s by reviewing their core ideas and intellectual roots.

2.5.1 Intersectoral action for health

Starting from the late-1970s, the idea of intersectoral cooperation has had a significant role in the development of the WHO’s Health-for-All philosophy (WHO, 1986c), and the approach has been the starting point for numerous other health programs and projects across the world both at national and local levels (PHAC & WHO, 2008). The WHO’s global strategy for Health for All (HFA) was adopted by the World Health Assembly in 1981 as the “Global Strategy for Health for All by the year 2000” (WHO, 1981).⁴²

⁴² In addition to WHO’s Health for All strategy and health promotion declarations, intersectoral action for health is visible in a number of other high-level WHO documents. For instance, the 2011 UN Resolution on the Prevention and Control of Non-Communicable Diseases (NCDs) calls on countries to “recognize that the rising prevalence, morbidity and mortality of non-communicable diseases worldwide can be largely prevented and controlled through collective and multisectoral action by all Member States and other relevant stakeholders at local, national, regional, and global levels, and by raising the priority accorded to non-communicable diseases in development cooperation by enhancing such cooperation in this regard” (UN General Assembly, 2011).

Mahler (1988b) has summarized the goals of HFA by stating that the strategy set health as a fundamental human right and a worldwide social goal. It urged states to make a political commitment to improve the health of their population by coordinated efforts that involve multiple spheres of government, such as social and economic sectors. The goal was to improve the overall level of health and target a more equitable distribution of health resources both within and among countries. Community involvement was seen as an important part of the work by making citizens active actors in shaping their own health and socioeconomic future. At the international level, the Health for All strategy called for technical and economic cooperation among countries to promote health. In 1984, member states of the WHO European region adopted 38 Health for All targets that have later been considered as “the most important avenue for the spread and recognition of a broad understanding of health promotion” within the context of WHO (Kickbusch, 2003, p. 384).

In 1986, as part of the implementation of HFA, a report “Intersectoral action for health: The role of intersectoral cooperation in national strategies for Health-for-All” (WHO, 1986a) was published. The report put a strong emphasis on equity considerations in national health policies and focused on various actions outside of the health sector that may have significant health impacts. The report used “intersectoral action” as an umbrella concept to refer to all the actions that go beyond the health sector’s direct mandate but did not suggest one clear definition for the concept.

As an update to Health for All strategy, the HEALTH21 policy was adopted at the Fifty-first World Health Assembly in May 1998 (WHO, 1998a). The document “HEALTH21: The health for all policy framework for the WHO European Region” endorses a multisectoral strategy for sustainable health through shaping physical, economic, social and cultural environments. The strategy concludes that: “Vital gains, both in health and in economic advancement, can be made through well designed policies for education, employment, industrial structure, taxation and social policy” (WHO, 1998a, p. 20). In

addition, the HEALTH21 strategy highlights the need to address health problems in people's everyday living environments, i.e. "systematically on the places where people live, work and play" (WHO, 1998a, p. 22). For WHO, a "settings approach" to health action has meant activities such as WHO networks for healthy cities, health-promoting schools, health-promoting workplaces, health in prisons, healthy universities, and health-promoting hospitals.⁴³ In addition to bringing health into everyday contexts, another key idea behind these initiatives has been to increase the commitment to health as a systems goal instead of focusing only on the role of the health sector (Kickbusch, 2003). In other words, the settings approach to health has always entailed an intersectoral element at its core.⁴⁴

The third update of the Health for All policy framework for the WHO European Region was adopted in September 2005 (WHO, 2005b). The update was based on broad consultations with country representatives and relevant expert agencies. The new perspective in the update was a "values-based governance" rooted in the three key values of equity, solidarity and participation. The 2005 HFA update document also provided a checklist for policymakers and a toolbox for practical ways to implement HFA values (WHO, 2005b, p. 53-80). The WHO member states were urged to build their own national implementation strategies for the HFA framework that would reflect its core values towards greater health equity. In conclusions, these historical developments

⁴³ Kickbusch has stated that: "In all of these [settings-based] projects, the key intention has been to gain a 'political' commitment to improving the health of the entire organization (a systems approach) and developing strategies that allow all parts of the organization to work together to improve the health of the setting" (Kickbusch, 2003).

⁴⁴ The WHO's current website describes the settings approach in the following way: "Healthy Settings, the settings-based approaches to health promotion, involve a holistic and multi-disciplinary method which integrates action across risk factors. The goal is to maximize disease prevention via a 'whole system' approach. The settings approach has roots in the WHO Health for All strategy and, more specifically, the Ottawa Charter for Health Promotion. Healthy Settings key principles include community participation, partnership, empowerment and equity" (WHO, 2017b).

indicate that intersectoral action for health has been one of the key elements of WHO's work on Health for All strategies already for several decades.

Definitions of intersectoral action for health

In the literature, intersectoral action has been defined in multiple ways with clear similarities and some differences. Dubois et al. (2015) conducted a scoping review of definitions and frameworks of intersectoral action that indicated there is a lack of consensus on the definition. In the literature, definitions such as "intersectoral action for health" and "intersectoral collaboration for health" are often used interchangeably. Generally, the definitions of intersectoral action were found to refer to "a process, a practice, a collaboration, a coordination, and an interaction" [emphasis added] (Dubois et al., 2015, p. 2937).^{45 46} One especially influential definition of intersectoral action can be traced to the report "Working together: intersectoral action for health" (Harris et al., 1995) published by the Australian Government in 1995, which defined effective intersectoral action as:

⁴⁵ Collaboration can be defined as "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions which go beyond their own limited vision of what is possible." (Harris et al., 1995, p. 23).

⁴⁶ Begun & Malcolm (2014, p. 134) have presented the following continuum to outline different levels of collaboration, from the least involved (communicating) to most involved (collaboration):

1. Communicating: willing to share information, likely because of share interests in the external environment and desire to be "good neighbors."
2. Consulting: asking for opinions, advice that may or may not be followed.
3. Cooperating: starting to take joint actions, like lobbying together.
4. Coordinating: starting to plan and make decisions influenced by each other, like agreeing to increase referrals among programs.
5. Collaborating: decisions made by the group; shared ownership and responsibility; mutual risks and rewards.

A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone. (Harris et al., 1995, p. 2)

Dubois et al. (2015) refer to the above as the 1995 Harris definition, which later informed the 1997 WHO definition presented in an international meeting in Halifax (WHO, 1997a).⁴⁷ The Public Health Agency of Canada (PHAC) and WHO published a joint-report in 2008 in which the definition of intersectoral action for health was extended to health-promoting actions also taken by sectors other than health. The report also states that intersectoral action can be vertical by linking sectors at different levels, such as local, regional, and national governments (PHAC & WHO, 2008). Generally, intersectoral action is typified by collaboration between multiple stakeholders from different policy sectors, coordination of actions, and joint efforts aimed at policy development and implementation. The collaboration can take place within the public sector only or among the public sector, civil society and the private sector. Intersectoral action has been understood as an organized and strategic process that requires the ability to negotiate and manage conflicts (Dubois et al., 2015, p. 2936). Based on several earlier definitions, Dubois et al. (2015) propose an integrative conceptual definition for “intersectoral action”:

Working with more than one sector of society to take action on an area of shared interest to achieve better results than those obtained working in isolation. Sectors may include government departments such as health, education, environment,

⁴⁷ The following WHO definition of intersectoral action for health was presented in the report of an international conference held on April, 20-23, 1997 in Halifax, Nova Scotia, Canada: “A recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.” (WHO, 1997a, p. 3)

justice, etc.; ordinary citizens; non-profit societies or organizations; and business. (Dubois et al., 2015, p. 2939).⁴⁸

In the process of implementation intersectoral initiatives (or interventions), the role of the health sector can vary in terms of its leadership. As presented in Table 2, WHO has categorized this involvement into three different types by referring to interventions (1) led by the health sector only; (2) led by the health sector but in cross-sectoral collaboration with others; and (3) led by the non-health sectors (WHO, 2013a, p. 9). For example, intersectoral action for health can be naturally led by non-health sectors in many areas such as education, social protection, transportation, and urban development as they fall beyond the health sector’s direct mandate. However, the health sector can have a major role in motivating non-health sectors to take action and to evaluate the possible health impacts of different policies.

Table 2. Three types of intersectoral interventions (WHO, 2013a, p. 9)	
Type 1: Health sector led	Interventions that involve different sectors but fall within the explicit domain of health sector work, and where health policy practitioners generally lead the decision-making process; examples of this kind of intervention include nutritional supplementation programmes.

⁴⁸ In public administration, “cross-sector collaboration” has been defined in a similar way as “the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately.” (Bryson et al., 2006, p. 44)

Table 2. Three types of intersectoral interventions (WHO, 2013a, p. 9)	
Type 2: Cross-sectoral with health	Interventions with potential health impacts that do not fall under the health sector space but where intersectoral collaboration is most often present, and where health policy practitioners would thus need to identify and make the case for specific interventions at the expense of others; for instance, a comprehensive early child development intervention.
Type 3: Other sectors lead	Measures that can have an effect on health but where the health sector and potential health outcomes are not considered in general, and therefore where health sector policymakers would be more in need of theoretical and evidence-based support as outcomes relate to other sectors, as well as health, in order to enter a potential dialogue with the leading sectors; for instance, measures to expand education at different levels or parental benefits.

Prerequisites for effective intersectoral action for health

The engagement of multiple sectors toward shared health goals has been seen to have many merits compared to one sector working alone (PHAC, 2007; PHAC & WHO, 2008). Harris et al. (1995, p. 14) have summarized some of the advantages for taking an intersectoral approach to health, such as better use of resources, reduced duplication of services, better ability to address the issues outside of the health sector, finding more effective solutions to complex problems, a possibility to implement new ways to address health inequalities, and the development of sustainable solutions. In other words, intersectoral action can effectively address the social determinants of health and multiply

the impact of interventions. They conclude that “working with other sectors is effective, efficient, sustainable, and able to address equity issues” (Harris et al., 1995, p. 30).

However, many conditions should be met before intersectoral action for health can fit into the above description of its effectiveness. This section reviews the barriers and facilitators to intersectoral action for health in the light of existing research literature.

There are numerous proposals for intersectoral action and cooperation (Freiler et al., 2013; McQueen, Wismar, Lin, Jones, et al., 2012; Ndumbe-Eyoh & Moffatt, 2013; PHAC & WHO, 2008; St. Pierre & Gauvin, 2010; Whitehead, Povall, & Loring, 2014; WHO, 1997a). Mostly these proposals refer to intersectoral action that is led by the health sector (i.e. type 1 in Table 2) and include making intersectoral structures a part of an institutional mandate and creating win-win situations through various incentives that would increase the motivation to cooperate across the sectors (PHAC, 2009). These incentives and co-benefits can be financial, social, and cultural. Similarly, there can be disincentives to unisectoral action. Supportive structural arrangements and a cooperative culture are more likely to encourage intersectoral action than internally competing departments. Also a clear accountability framework should be enforced when the intersectoral structures are created.

Facilitators of intersectoral action for health

In what follows, I will review grey and empirical literature on the various factors that are likely to influence the implementation of intersectoral action for health. My aim is to give a general overview on what is currently known about the barriers and facilitators of intersectoral policymaking.

In government structures, intersectoral action for health requires cooperation between actors and agreeing on shared goals (de Leeuw & Peters, 2014). Intersectoral action itself is rarely anyone’s direct responsibility, and often there are no resources channeled to cooperation across the sectors. Lack of coordination and short-term

decision-making have been identified as key factors that increase the difficulty of establishing intersectoral governance. Greer and Lillvis (2014) suggest that the challenges of coordination and durability can be addressed with three different strategies: (1) Political leadership, (2) bureaucratic change, and (3) indirect strategies, such as awareness raising, interest group empowerment, and citizen involvement. Establishing durable intersectoral structures with clear roles and responsibilities requires a strong political and institutional commitment. Moreover, it is important to consider which actors and groups are likely to either endorse or oppose the deepening intersectoral collaboration and why that might be the case (i.e., departments are worried that cooperation can decrease their resources and/or increase their workload). Some of the suggested solutions include having a strong and determined leadership (i.e. political will) and providing meaningful incentives for collaborative actions. Adequate resources, skills, and knowledge are important requirements, but need to be complemented with leadership and strategic thinking that support intersectoral work. However, ideal conditions for intersectoral action rarely apply in real-life policy formulation (Kickbusch, 2010a). More realistically it can be expected that some conditions apply and some do not. The complexities of the policy environment and conflicting interests often make outcomes unpredictable and not a result of careful planning. Moreover, it is important to acknowledge that many interest groups do not necessarily have any explicit goals directly related to health, but they may have strong interests that contradict health-related goals. For instance, economic growth or corporate profits can be said to have a greater importance than health-related concerns.

Furthermore, effective intersectoral action requires a strong mandate, commitment, and skills. At a general level, Harris et al. (1995, p. 18) identify two main difficulties as to why sectoral organizations might be reluctant to engage in collaboration with other sectors. The first reason is the unavoidable fact that they might lose some freedom and autonomy. The second reason is related to the requirement to engage and

put resources into activities that are not seen as their “core activity.” Returns of possible investments (e.g. time, funding, knowledge) from intersectoral collaboration can in many cases be unclear and difficult to measure.

Intersectoral coalitions and partnerships

Coalition formation is a key strategy for promoting intersectoral action (Harris et al., 1995, p. 15-16). This requires that the partners have identified a need for collaboration as well as having clarity on individual and joint goals (Harris et al., 1995; PHAC, 2007). According to von Schirnding (1997; 2015), key ingredients for successful partnerships include valuing the contributions of all partners, protecting the core interests of individual organizations, having a clear mandate, and the existence of a clearly defined decision-making process. Similarly, having true opportunities and capacities for action accompanied with sufficient resources, skills, knowledge, and legitimacy are some preconditions for effective implementation (von Schirnding, 1997; von Schirnding, 2015).⁴⁹ The collaborative relationship should be clearly defined and be based on mutual trust and respect (PHAC, 2007). Monitoring mechanisms and plans to sustain outcomes are important in order to have a long-term impact (Harris et al., 1995).

Other authors have highlighted the importance of building trust and creating sustainable power-sharing mechanisms from the early stage of the collaboration (Jones & Barry, 2016, p. 7). Trust can be built by taking sufficient time to agree on the shared goals, which also means letting collaborators have real influence on the decision-making process, and not letting participants undermine joint-commitments at a later stage.

⁴⁹ Also Harris et al. (1995, p. 17) list factors that are likely to promote successful intersectoral partnerships: “Openness and honesty, mutual respect, flexible dynamic relationships, secure funding, adequate resources, flexible funding, providing adequate training, having a program champion (someone who does not have immediate involvement with the program and who is an advocate for the program at high levels in the organisation), patience and encouragement, as well as creating an organisational climate where risk-taking and innovation are encouraged and failure is not punished.”

According to Jones & Barry (2016, p. 7), shared power means “sharing the credit for partnership activities, keeping promises, being consistent and contributing expertise freely when that expertise would benefit the partnership.” They see intersectoral trust-building and power-sharing as skills that can be taught. However, the above naturally requires that different partners, or collaborating sectors, are truly willing to share power to achieve objectives that go beyond their own sectoral mandate. Some health promoters might be naive in terms of seeing this willingness to share power as natural or a default mode of action. A more realistic approach is probably to acknowledge the political and institutional barriers and be serious in finding efficient ways to negotiate the way forward towards joint-agreements and action.

Mahmood et al. (2015) have developed a checklist for effective intersectoral partnerships. Their checklist can be used at the various stages of the partnership process to assess its strengths and weaknesses. The nine domains of the checklist are (1) the perceived need for partnership; (2) the mission and purpose of the collaboration; (3) the context, including economic, political, social, and cultural factors that influence partnership functioning; (4), the partners’ profile, including overall skills and expertise as well as partners’ willingness to share resources; (5) resources such as time, skills, expertise, reputation, personal networks and connections; (6) leadership in terms of individuals and teams to provide strategic direction towards the partnerships’ mission; (7) roles and structures related to the formalization of the partnership; (8) internal and external communication; and (9) functioning in terms of tasks and activities to fulfill the mission of the partnership. The above list gives a comprehensive view of the prerequisites of building and maintaining effective intersectoral collaboration between different actors. In terms of empirical validation of the checklist, a very similar list was formulated in a narrative synthesis of 26 studies that focused on factors influencing partnership functioning (Corbin, Jones, & Barry, 2016). The understanding of the above

factors can increase the understanding of facilitators and barriers to intersectoral action for health.

Empirical studies on intersectoral initiatives

Empirical studies can provide insights into what is needed for the successful implementation of intersectoral action for health. Furthermore, these studies are used to contextualize the results of this dissertation. Generally, it should be noted that empirical evidence on the effectiveness of intersectoral initiatives is still very limited. One of the obvious challenge is related to the difficulty of evaluating complex and multi-level interventions that involve many stakeholders and measuring health outcomes that can be expected to be visible after an extended period of time (Bauman, King, & Nutbeam, 2014). To date, reviews and empirical evaluations have clearly showed that there is a need for more systematic and rigorous evaluations of intersectoral initiatives (Berkeley & Springett, 2006; Carey & Crammond, 2015; Chircop, Bassett, & Taylor, 2015; Lawless et al., 2012; Ndumbe-Eyoh & Moffatt, 2013; Shankardass et al., 2012).

Berkeley and Springett (2006) examined real life obstacles to intersectoral action for health, especially in the context of Health for All initiatives. In their study, the main categorization was made between cultural barriers and political barriers. Cultural barriers included differences in multiple spheres, including varying conceptions and understandings of health (broad/narrow; societal/biomedical), differing organizational cultures and practices, and differing professional cultures on an interpersonal level, including differences in professional identity, status, accountability, and discretion.⁵⁰ Political barriers were generally related to the fact that many intersectoral initiatives were driven by political and other imperatives rather than their possible health gains. For

⁵⁰ According to the Oxford English Dictionary "discretion" refers to "the quality of behaving or speaking in such a way as to avoid causing offence or revealing confidential information."⁵⁰ (Source: <https://en.oxforddictionaries.com/definition/discretion>)

instance, often politicians and other decision-makers were seen to have a health care financing agenda rather than a health agenda. In this case, the driving force can be the goal of cutting health care expenditure rather than investing in the future. Furthermore, political barriers included short-term election cycles in which politicians wanted to prove that they have “delivered” and left their own mark in a short period of time, whereas effective intersectoral initiatives would require sustainability and commitment that goes beyond election cycles (Berkeley & Springett, 2006).

Lawless et al. (2012) reviewed the outcomes of the implementation of the HiAP approach in South Australia. The implementation was carried out by utilizing “health lens analysis” (HLA) that was described as a process of intersectoral partnerships involving a systematic examination of connections between policies, strategies, and health combined with an aim to deliver evidence-based recommendations for health-promoting policies. The authors outlined three independent projects that utilized the HLA: water sustainability, regional migrant settlement, and digital technology. The foundation of the approach lies in the notion of mutual benefit, which is described as placing equal emphasis “on achieving the objectives of other sectors as well as improving health” (Lawless et al., 2012, p. S16). Their general finding was that the HLA increased policymakers’ understanding of the health impacts of their work, produced changes in policy direction, increased policy-relevant research; and strengthened partnerships between health and other sectors. Based on these experiences, they conclude that the HLA is a promising tool to facilitate change from policy rhetoric to policy action.

Carey et al. (2014) use the term “supportive architecture” to describe the preconditions for effective intersectoral action for health.⁵¹ Based on a review of 17 studies, they differentiate between “hard” and “soft” elements of a supportive

⁵¹ To refer to the umbrella concept of this dissertation (i.e. intersectoral action for health), Carey et al. (2014) use the terms “joined up government”, “Whole-of-Government”, and “Health in All Policies.”

architecture, where hard elements are related to structural arrangements and soft elements describe the process of creating cultural and institutional changes for effective collaboration across the sectors (Carey & Crammond, 2015; Carey et al., 2014). In their conceptualization, hard elements include having a mandate for change, decentralized control, accountability mechanisms, incentives, and dedicated resources that can be used in a flexible way. Soft elements include deliberate and strategic focus on collaboration, training and skill development, a clear call to action, and information sharing between sectoral partners. Furthermore, they highlight that the effectiveness of specific interventions is always contextual and therefore multiple instruments are needed in order for intersectoral collaboration to be effective (Carey & Crammond, 2015; Carey et al., 2014).

Shankardass et al. (2012) carried out a scoping review on case studies of intersectoral action for health equity. With a focus on cases that featured a central role for governments, they were able to identify 128 articles describing intersectoral action across 43 countries. However, based on this extensive search, their key finding was that many of the case studies were largely described in a superficial way and it was rather difficult to formulate a comprehensive view on how intersectoral action was implemented and how different sectoral actors interacted with each other. They concluded that: "A particularly high proportion of case articles did not contain sufficiently rich information to confirm the period of initiation of initiatives, the involvement of various non-governmental sectors, whether or not evaluations were carried out to assess the various impacts of intersectoral initiatives (particularly in terms of economic assessments), and processes of intersectoral engagement between government sectors" (Shankardass et al., 2012, p. 30). Ending up with similar conclusions, Chircop et al. (2015) carried out a scoping review that identified 64 articles that considered the role of intersectoral collaboration in addressing public policy problems. Their general finding was that the majority of the reviewed research articles stated that intersectoral collaboration was used as a "strategy" but

simultaneously failed to report the details on how the process of collaboration unfolded in practice. On that account, one of their main conclusions was that “the day-to-day practice of intersectoral collaboration for public policy and its successes and failures remain largely unexamined. Further, the concept of intersectoral collaboration itself remains unclear and contested and warrants further critical analysis” (Chircop et al., 2015, p. 187).

Ndumbe-Eyoh and Moffatt (2013) conducted a systematic review on intersectoral action for health equity that critically appraised 10,235 research articles of which 886 were chosen for full-text screening. Despite the high-number of articles, their review resulted in only 16 studies and one systematic review which met the inclusion criteria. Based on the included articles, their general conclusion was that there was only a very limited number of studies that indicate that intersectoral action has been successful in promoting health equity, although they also emphasize that “the lack of evidence should not be interpreted as a lack of effect” (Ndumbe-Eyoh & Moffatt, 2013, p. 1). Most of the reviewed studies were setting-specific interventions at a local level (e.g. schools and workplaces) and the literature was mainly descriptive. Similarly, mechanisms that link intersectoral processes to observed outcomes were rarely studied. The authors identified one systematic review concluding that “the current evidence-base on the effects of public health partnerships on health outcomes is partial and methodologically limited” (see Smith et al., 2009, p. 219-220). In their conclusions, Ndumbe-Eyoh and Moffatt (2013) call for the development of better methods and tools to improve the evaluation of intersectoral initiatives in order to build a stronger evidence base.

In the field of public administration, cross-sector collaboration (used interchangeably with intersectoral collaboration) has been suggested as one strategy to solve complex public problems. In the literature, collaboration across sectors is seen as necessary and desirable but at the same time very difficult to implement in the real-life context. Bryson et al. (2006) have summarized 22 propositions for research and

implementation of cross-sector collaboration, which consider a range of factors such as the initial conditions in the environments in which collaboration takes place, (e.g. preconditions affecting the collaboration, such as the level of agreement on the problem definition), process components (e.g. leadership, legitimacy, trust, ways to manage conflict, and planning processes), structural aspects (e.g. goals, division of labour, rules, operating procedures, and authority relationships), governance mechanisms (e.g. coordinating and monitoring activities), and other contingencies affecting the cross-sector collaboration (e.g. collaboration type, power imbalances, and competing institutional logics). In addition, Bryson et al. (2006) conclude that cross-sector collaborations are more likely to create public value when they are aimed at minimizing each sector's characteristic weaknesses and build to maximize each sector's characteristic strengths. However, to highlight the difficulty of the overall task, their last proposition concludes that in the implementation of cross-sector collaborations "the normal expectation ought to be that success will be very difficult to achieve" (Bryson et al., 2006, p. 52).

Generally, empirical studies focused on intersectoral action for health indicate that cross-sectoral collaboration is considered effective and desirable in terms of producing positive health outcomes but at the same time the rigorous evaluation of these positive effects is very challenging as they take place at multiple levels over an extensive time period (Chircop et al., 2015; Ndumbe-Eyoh & Moffatt, 2013). In summary, unifying themes in empirical studies have been the existence of structural, cultural and political barriers (Berkeley & Springett, 2006; Carey & Crammond, 2015), the need to identify mutual benefits (Lawless et al., 2012), and the general conclusion that collaboration between sectors should be expected to be difficult and to require thoughtful planning (Bryson et al., 2006). However, it should be noted that one of the limitations of the studies reviewed in this section is that they have focused only on initiatives and interventions led by the health sector.

Leadership and intersectoral action

Leading public health work is never only a technical exercise. A set of values have been characteristic of effective public health leaders, including a belief in social justice, reliance on evidence, interdependence, respect, and transparency (Begun & Malcolm, 2014, p. 58). Similarly, there is a set of traits that have been associated with effective public health leaders, including integrity, initiative, empathy, comfort with ambiguity, passion, courage, and persistence (Begun & Malcolm, 2014, p. 69). Koh and Jacobson (2009, p. 200) highlight the importance of passion and personal commitment to social justice but also state that successful leaders have to move beyond passion towards strategic thinking:

In regularly tapping the realms of social strategy, political will and interpersonal skill, these individuals must also develop sophisticated, tactical leadership techniques that extend beyond running any single organization. The artful public health leader will be one who can function in an ambiguous arena without clear boundaries or hierarchies, using a chaotic context as a starting point for change. (Koh & Jacobson, 2009, p. 200)

A conceptual division has been made between “management” and “leadership.” According to Begun and Malcolm (2014, p. 22-23), management is used to refer to realism and execution (i.e. doing things right), whereas leadership is used to refer to an ability to inspire with a combination of idealism, realism, and execution (i.e. doing the right things). Management can be seen to have a focus on short-term efficiency, whereas leadership focuses on long-term effectiveness. Leaders in public health should be prepared to actively work for their share of resources because the allocation of resources is ultimately a political decision. Similarly, in most cases, it is a political decision to establish various intersectoral mechanisms to tackle health problems.

Major leadership and management challenges are likely to arise when actors are asked to engage in intersectoral action. As previously mentioned, intersectoral

collaboration can pose a risk to the core task of engaged partners and cause power struggles that are related to potential fears about losing autonomy and independence. In a case where potential results are unclear, it would be a non-rational decision to invest scarce resources in intersectoral initiatives. Therefore, the leadership challenge is to create conditions and convince actors that working together is “more effective, efficient, and sustainable than working alone” (Harris et al., 1995, p. 30). Naturally this requires an environment where intersectoral mechanisms can provide true advantages and benefits. Similarly, it is important to make certain that the potential loss of resources and independence among sectoral actors is necessary for the achievement of broader goals that provide greater benefits for the society as a whole.

At the interpersonal level, there are many leadership and management skills that can facilitate effective intersectoral action. Harris et al. (1995, p. 18) see that an effective actor in promoting intersectoral action needs a skill set that includes at least three different types of expertise: (1) expert skills, such as scientific knowledge and evidence, (2) skills for advocacy, such as an ability to convince and motivate others, (3) skills to enable action, such as project management skills and proficiency in group leadership.

The implementation of intersectoral initiatives is likely to require an innovative social strategy that cultivates a sense of interdependence among stakeholders and renews a sense of community by invoking health as a shared responsibility (Koh & Nowinski, 2010). Acknowledging the importance of social determinants of health is one of the core requirements in engaging a diverse set of partners from different sectors. A shared understanding of the causes of health problems can lead to long-term collaboration and genuine partnerships that facilitate co-learning and effective joint action. In order to tackle leadership challenges in public health, Koh & Nowinski (2010) emphasize the role of communication and framing of health issues: “Effective communication can motivate understanding and action. In particular, for inequities affecting some to be viewed as unacceptable for all, reframing can not only change the

mental structures that shape the way we see the world but also redefine what constitutes common sense” (p. 10).

Along with the traditional leadership and management challenges described in the literature, special attention should be paid to the process of negotiation between different sectoral interests.⁵² In order to attain sustainable results, WHO (2015c, p. 117-120) recommends using a cooperative negotiating strategy that focuses on “win-win” solutions through exchanging information about needs and priorities in an open and collaborative way. Cooperative negotiators usually do not state fixed positions but highlight their objectives and interests in a concise way. The interests that drive different stakeholders should be carefully listened and responded to in an assertive way. Generally, it can be concluded that the ability to identify, negotiate, and coordinate a number of interests appears to be an essential success factor in intersectoral policymaking. Being successful in this process requires many of the leadership and management skills described earlier.⁵³

Governance perspectives on intersectoral action

Interpersonal leadership and management skills influence but are also constrained by the surrounding governance structures. From a large body of literature, Greer et al. (2016) identified five desirable aspects of health governance that included transparency,

⁵² “Negotiation may be defined as a process whereby two or more parties seek an agreement to establish what each shall give or take, or perform and receive in a transaction between them. Alternatively, it is an act of discussing an issue between two or more parties with competing interests, with an aim to identify acceptable trade-offs for coming to an agreement” (WHO, 2015c, p. 115).

⁵³ The informants in this study can be viewed as public health leaders, not in the political, but in the technical sphere. In other words, WHO is the global coordinating authority on health and its Programme Managers are in a position to show international leadership in their specific programmatic areas.

accountability, participation, integrity, and capacity.⁵⁴ These structural qualities shape health-related decision-making and policy implementation and can explain policy successes and failures in different contexts including international, national, regional, and local policy environments. Similarly, Brown et al. (2014) have listed a set of general functions that are needed to improve governance for health equity. Their list include domains such as political commitment, evidence, accountability structures, policy coherence, local participation, capacity development, and modernization of public health training (Brown et al., 2014, p. 47-50).

More specifically related to intersectoral policymaking, McQueen et al. (2012) have proposed an analytical framework to analyze intersectoral governance for health. Their framework can be used to evaluate the extent of different governance mechanisms to promote intersectoral action (McQueen, Wismar, Lin, & Jones, 2012, p. 11). Their model separated intersectoral governance structures from actions that can be implemented through those structures (Table 3).⁵⁵ For this dissertation, the framework that separates intersectoral structures and actions provides a useful analytical tool to review possible ways to institutionalize intersectoral governance within a government.

⁵⁴ The authors refer to these key aspects by naming them as the “TAPIC” framework (Greer, Wismar, & Figueras, 2016).

⁵⁵ Kickbusch has used the umbrella term “horizontal health governance” to describe various intersectoral strategies within a single government (Kickbusch, 2010a).

Table 3. Intersectoral governance structures and actions (adapted from McQueen et al., 2012, p. 11)	
Intersectoral governance structures	Governance actions
Cabinet committees and secretaries	Financial support
Parliamentary committees	Advocacy
Delegated financing	Coordination
Industry engagement	Evidence support
Interdepartmental committees and units	Implementation and management
Joint budgeting	Monitoring and evaluation
Mega-ministries and mergers	Policy guidance
Ministerial linkages	Providing legal mandate
Public engagement	Setting goals and targets
Public health ministers	
Stakeholder engagement	

Along with structural and non-structural engagement strategies (many of which were listed in Table 3), such as intersectoral committees or public engagement, there is an additional way to facilitate intersectoral action which could be portrayed as a “budgetary strategy.” It is common that financial planning and budgeting is predominantly sectoral without pursuing the combination of funding streams towards intersectoral action. A budget silo refers to common budgetary planning where financial resources can be used only within a specific sector or programme (McDaid, 2012). These tightly constrained budgets constitute one key challenge to intersectoral action as sectors do have less flexibility to channel their financial resources towards challenges that require coordinated and simultaneous action by two or more sectors.

McDaid and Park (2016) have reviewed financing mechanisms for intersectoral action for health. Through a literature search, they identified three principal financing approaches: discretionary earmarked funding, recurring delegated financing to independent organizations or bodies, and mechanisms for joint budgeting between sectors. First, earmarked funding signifies a practice where government sets aside funds

for an intersectoral collaboration between sectors to address a specific health issue. In this case, the activities normally stay under the control of the Ministry of Health. Second, delegated financing refers to the allocation of funds from governmental sources to independent bodies, such as health promotion agencies or non-governmental actors. The reallocation of funds involves a transfer of power to organizations that are, at least to some extent, independent from the government. Third, joint budgeting refers to a practice in which different sectors share their financial resources to tackle a specific health issue by working together. This type of resources pooling may be established on a mandatory or voluntary basis and can take place at various levels of depth from aligned budgets to fully integrated budgets between two or more sectors (McDaid & Park, 2016). The authors conclude that there are positive examples of all three financing mechanisms described above, however, the effectiveness of each strategy depends also on numerous additional factors, such as organizational culture and structures, management efficiency, and the level of trust between sectoral partners. Similarly, a sense of ownership and the balance in the financial contributions provided by different sectors can have a profound impact on the success or failure of jointly financed intersectoral collaboration.

To conclude, the planning process of intersectoral initiatives should involve careful consideration of the expected challenges and ways to overcome them. For instance, there should be a clear understanding how conflicting interests between the sectors are being negotiated and mediated. In the context of reducing health inequalities, Lynch (2017) has summarized the multiplicity of the challenges by stating:

The standard policy remedy, multisectoral policymaking, is in fact extremely difficult, requiring clarity about goals; capacities for joint action; relationships on which to base cooperative action; well-conceived policies that can be implemented and evaluated; clear roles and responsibilities; and plans to monitor and sustain outcomes. Barriers to cross-sectoral action include coordination problems, issues of sustainability, political power-plays and the need to negotiate the roles and resources of (public) health versus medical actors and health versus other sectors. (Lynch, 2017, p. 4-5)

Although the task is challenging, it is evident that a number of governance structures and mechanisms can be created to support or prevent the implementation of intersectoral initiatives. As a recent conceptualization of intersectoral action for health, the literature on the HiAP approach provides important insights that are very relevant to this dissertation. In addition, the HiAP approach has been actively endorsed by WHO after its emergence in 2006 (WHO, 2013c, 2014b, 2015c). The origins and principles of HiAP are considered in the following section in a greater detail.

2.5.4 Health in All Policies

The Health in All Policies (HiAP) approach gained its first official recognition during the Finnish presidency of the European Union in 2006. In that year, Finland aimed at mainstreaming the HiAP approach at the European level and involved senior-level policymakers to recognize the importance of horizontal governance for health (Puska & Ståhl, 2010; Ståhl et al., 2006). Previously, Finland has had a long history of applying intersectoral governance structures in health policymaking (Leppo & Melkas, 1988; Melkas, 2013; Mikkonen, 2012). However, the concept “Health in All Policies” [In Finnish: “Terveys kaikissa politiikoissa”] was not publicly used before the Finnish EU Presidency in 2006. The first notable publication that used the HiAP terminology was the book “Health in All Policies: Prospects and potentials” published in the year of presidency (Ståhl et al., 2006).

The underlying idea behind the invention of the term “HiAP” was to direct more attention to policy implementation and more explicitly highlight the health impacts of the decisions made in non-health sectors. The Finnish health policy experts and civil servants who were planning the theme for the EU presidency year had recognized that the key challenge in intersectoral approaches to health often lay in poor implementation due to lack of political will and uncertainty about the implementation of concrete measures. It

was hoped that a new conceptualization would reorient the focus more towards the implementation of intersectoral action for health nationally and regionally (Timo Ståhl, personal communication, May 24, 2017).

The significance of the efforts by a rather small group of Finnish experts and civil servants has become more evident after a decade as the HiAP approach has spread globally to many different jurisdictions and governments (Kickbusch, Williams, & Lawless, 2014; Pinto et al., 2015; Rudolph et al., 2013). WHO, especially its Geneva Headquarters, has acted as a major proponent and authority that has provided a global communication channel to raise greater awareness about the HiAP approach (WHO, 2015c). In addition, there is an increasing amount academic research carried out that utilizes the HiAP framework, even to the extent that there are debates about possible conceptual inconsistencies related to the use of the HiAP concept in general. These inconsistencies can arise from mixing “policy development” to “policy action” (see de Leeuw & Peters, 2014, 990-991).

The current authoritative definition of the approach can be found in the WHO Helsinki Statement (2013d); it defines HiAP 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. It improves accountability of policymakers for health impacts at all levels of policymaking” (WHO, 2013d). The ability to quickly recognize and seize the window of opportunity for intersectoral action is an integral part of the HiAP approach (Leppo et al., 2013a).

In order to facilitate the use of the HiAP approach, WHO has published a framework for country action that outlines key components of HiAP (WHO, 2014b). The framework is intended to serve as a starter’s kit for applying the HiAP approach at national and subnational levels. It outlines six components that can be adopted and adjusted to changing governance, economic, and social contexts. The HiAP framework

suggests taking action on the following six areas: (1) Establish the need and priorities for HiAP; (2) frame planned action; (3) identify supportive structures and processes; (4) facilitate assessment and engagement; (5) ensure monitoring, evaluation, and reporting; and (6) build capacity. It is noted that these components are not presented in order or priority, as action should be taken based on what is feasible in a specific context. The HiAP framework for country action acknowledges the aspirational nature of the HiAP approach towards a transformative change that entails perceiving health from a more holistic perspective and is well-aligned with the current UN Social Development Goals (UN General Assembly, 2015). The framework document states that it is “a contribution to achieving that policy coherence for health and health equity, and thus reinforcing the broader development agenda” (WHO, 2014b, p. 19).

From a more theoretical perspective, it has been noted the HiAP approach is more than just intersectoral action; for instance, de Leeuw and Peters (2014) see intersectoral action as a function of HiAP. The concept of HiAP does not refer only to intersectoral action, but is more of a way of thinking about policymaking processes and governance structures (McQueen, Wismar, Lin, Jones, et al., 2012). The HiAP approach can be implemented by utilizing Health Impact Assessments (HIA). However, that is just one part of the approach and HiAP itself is more than assessing the health impacts of decisions. The governance structures, policy processes, and underlying ideas and ideologies have a great influence on how the HiAP approach is actually implemented in a real-life situation. For instance, some of the different ways to implement HiAP come from Finland (Melkas, 2013), South Australia (SA Health, 2010), and California (Rudolph et al., 2013). Evaluating HiAP initiatives is challenging and requires a comprehensive understanding of the complexity of policymaking processes (Baum et al., 2014). From a conceptual perspective, the HiAP approach makes health an explicit value in all areas of public policy. It can be argued that in some cases this can be strategically a poor choice and increase resistance in other sectors to adopt goals and values of the health sector.

Moreover, when implementing the HiAP approach, it is important to focus on “co-benefits” and “win-win-situations.” This would not mean “selling health” but highlighting the possible beneficial effects for other sectors. De Leeuw and Peters (2014) have developed a Health in All Policies checklist that approaches the challenges of implementation from a political science perspective. Their list includes the following nine key questions (de Leeuw & Peters, 2014, p. 991-996):

- (1) How has the problem been framed and by whom?
- (2) Within the problem definition and tentative policy logic, which policies are already in force or in development? Are there any measures of success?
- (3) What information is there about the problem, its magnitude and consequences, and relevant stakeholder positions, now and in the future?
- (4) What facts, ideas and assumptions constitute the policy logic in relation to the problem?
- (5) What evidence, experience and opportunity exist to develop winning alternative approaches?
- (6) What social, economic and institutional ‘win-wins’ can be established? What gains can be identified?
- (7) What are the power, priority and support positions of all stakeholders in a particular policy proposal?
- (8) What politics are involved in the initiation and final stages of policy development and adoption?
- (9) Have policy implementation barriers and facilitators been considered and integrated in policy formulation?

In addition to the above questions, the authors provide more detailed checklist items for each of the nine themes. They argue that anyone formulating and implementing HiAP initiatives should consider the above perspectives because the answers can make the possible political barriers and challenges more visible, which is required in order to address them in an appropriate and effective way (de Leeuw & Peters, 2014). Monitoring of HiAP related actions is equally important in order to evaluate their effectiveness. Based

on the Finnish experiences of monitoring HiAP activities at the local level, Ståhl (2016) has suggested that HiAP indicators should be objectively measurable (i.e. no self-assessments), interpretable and of good quality, and explicit enough to allow clear auditing. It has been underlined that HiAP evaluation and measurement is a complex process that should pay attention to numerous intervening factors (Bauman et al., 2014). Despite the challenging nature of the work, the effort should be extended towards a rigorous evaluation of successes and failures of the implementation of HiAP related initiatives. As proponents of complex evaluations, Bauman et al. (2014, p. i150) have stated: "Without extending evaluation and measurement beyond this stage, the evidence base for HiAP will remain limited, and its potential for demonstrably improving population health will remain speculative. [...] In the absence of this kind of scaled-up evaluation work, many policymakers and governments will remain unconvinced of the effects and value of HiAP in progressing a cross-agency health promotion agenda."

Health impact assessment (HIA) is seen as a tool that could facilitate the implementation of HiAP and increase the efforts of non-health sectors to consider the health impacts of their decisions (Falvo, Regina Cubas, & Gulis, 2015; Frankish et al., 1996). HIA is a process of identifying how policy changes might influence health and these assessments can also include human rights indicators. A widely cited definition of HIA describes it as "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population" (ECHP, 1999, p. 4). Proponents of various intersectoral approaches have recommended the use of HIA to inform decision-making and implementation (APHA, 2012, p. 2936; Kemm, 2001). In an ideal situation, HIAs aim at maximizing positive health impacts and to minimize negative health impacts by considering the evidence and providing informed understanding

regarding the anticipated health effects of a policy or programme (EHP, 1999, p. 5).⁵⁶ Health equity impact assessments (HEIA) are based on the principles of HIA but have a specialized focus on the unintended potential positive or negative impacts on health equity (MOHLTC, 2012). Although the conceptualization of HIA provides a promising tool to identify and consider the health impacts of different policies, there are multiple barriers to its systematic use in policymaking, such as having sufficient resources and skills to carry out HIAs as well as having policymakers prioritize health impacts when other powerful interests might intervene in the policy process.

During the past decade, the implementation of HiAP has been strongly supported by WHO, which has also developed comprehensive training materials and courses for national experts and policymakers (WHO, 2015c). Despite the promising development and increased interest in the HiAP approach, it is yet to be seen whether its implementation will lead to substantial and sustained changes towards intersectoral policymaking at the global, national and sub-national levels. The empirical part of this dissertation provides a systematic analysis of the barriers and facilitators that apply to the implementation of HiAP.

2.5.5 Other intersectoral approaches to health

Besides the intersectoral approaches already dealt in the earlier section of this dissertation, there are a few other approaches that are well-established in the literature. In terms of health-related action, a few additional perspectives with different historical roots can be highlighted: Whole-of-Government, Whole-of-Society, and One Health approaches.

⁵⁶ "Health impacts are the overall effects, direct or indirect, of a policy, strategy, programme or project on the health of a population" (EHP, 1999, p. 4).

Whole-of-Government and Whole-of-Society

In its definition Whole-of-Government (WoG) “denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery” (Management Advisory Committee, 2004, p. 4). The WoG approach was a reaction to the New Public Management (NPM) reforms implemented since the 1980s (Hood, 1991). The NPM reforms highlighted the importance of organizational goal setting and performance management. According to Christensen and Lægreid (2007), the WoG approach tried to respond to the negative side of these reforms and they explain the concept of WoG as “an umbrella term describing a group of responses to the problem of increased fragmentation of the public sector and public services and a wish to increase integration, coordination, and capacity” (Christensen & Lægreid, 2007, p. 1060). Horizontal and vertical coordination were seen to be necessary to avoid phenomena such as “departmentalism” and “vertical silos” that can exist inside the government structure. From this perspective, different government bodies have specialized responsibilities but also a wider responsibility for good governance as a whole. Therefore, cooperation and coordination provide the road to effective public service.

Since the late 1990s, the WoG approach has been applied in a wide array of policy sectors. The health sector is only one of many areas of governance that has applied the WoG approach and its terminology. Especially in the UK, the term joined-up government is sometimes used to refer to intersectoral collaboration (Carey & Crammond, 2015). Later, the WoG approach has been complemented with a Whole-of-Society approach, which refers, not only to the engagement of different sectors within government, but also to the need to engage and collaborate with the civil society and private sector as well. In the health context, the WHO Regional Office for Europe has

used both HiAP and WoG/WoS terminology in its policy papers and strategies in recent years (Brown et al., 2014; Jakab, 2014; WHO, 2013b, 2015d).

One Health

The concept of One Health was originally coined by veterinary epidemiologist Dr. Calvin Schwabe in the 1960s to present a holistic and ecological approach to health that recognized the interconnectedness of humans, animals, and wider ecosystems (Lueddeke, 2015, p. 211). Later the One Health Initiative has been promoted by veterinarians and scientists working with animal health and zoonotic diseases, i.e. pathogens that can be transmitted to humans. These include viruses, bacteria, fungi, and parasites, of which the most commonly known are influenza, Ebola virus, and a number of food borne illnesses. It has been estimated that 61% (N=868) of all identified pathogen species (N=1415) causing disease in humans are zoonotic (Taylor, Latham, & Woolhouse, 2001). To date, the One Health approach has been formally endorsed by numerous international organizations such as the Food and Agriculture Organization of the United Nations (FAO), European Commission, World Bank, WHO, and many NGOs (Lueddeke, 2015, p. 211).

In the end, Whole-of-Government, Whole-of-Society, and One Health approaches generally represent the same idea that highlight the importance and necessity of intersectoral action for health. The general tenet is that the health sector cannot solve the most pressing public health problems as the determinants of health are influenced by many other sectors within and outside of government (de Leeuw, 2017).

2.6 Concluding remarks

The implementation of intersectoral action for health is influenced by a complex set of actors, ideas, processes, and contextual factors that have been outlined in the four

sections of this literature review. First, I described what is meant by health equity and why it is important. This is relevant as the promotion of health equity is the adjoining goal of the contemporary WHO in its pursuit to promote intersectoral action for health. Second, I reviewed the role of the human rights framework as a normative base that gives justification to the pursuit of greater health equity.⁵⁷ This is important because WHO as well as the informants of this study have built their professionalism on the notion of health as a human right. Third, I examined factors that influence the implementation of health-promoting and intersectoral policies including governance structures, policy actors, interests, and ideas that shape policy processes. The understanding of the contextual factors that influence policymaking processes in general is important in order to understand the possible barriers and facilitators. Fourth, I reviewed various intersectoral approaches for health that have been introduced over the past three decades, such as the Health in All Policies approach. This historical background is important as it provides a backdrop to contextualize my empirical analysis.

Based on the literature review, it can be concluded that it is not sufficient for health researchers and advocates to focus only on the content of policy. My main argument is that *the idea of improving health through intersectoral action cannot have a significant impact without changes in governance structures and political priorities*. Intersectoral action for health is difficult to implement because the world is complex and the politics of health involve many different actors and conflicting interests. In terms of Kingdon's (1984) three streams (problems, policies, politics), I argue that the emphasis should put on formulating policies that effectively solve complex health challenges through intersectoral action as well as on generating political will that has to provide adequate mandates and resources to address the complex health problems.

Similarly, to change the policy scene in favour of health equity, it is necessary to focus on the complexity of policymaking processes, ideological presumptions, and the

⁵⁷ The human rights documents relevant to this study are reviewed in Appendix A.

ways in which political power is used to shape our living and working conditions. For this purpose, the concept of governance can be applied to make better sense of the complexities of different policymaking environments. The governance for health perspective demands paying greater attention to mechanisms, structures, and relationships between different actors that shape the health of the population.

The capacity of policy actors to promote intersectoral approaches to health is often limited. Adequate capacity refers to skills, knowledge, and resources to collaborate efficiently with other sectors and organizations. Frequently people working in the health sector do not have the skills nor power to engage other sectors or they do not carry an ability to recognize the co-benefits that intersectoral approaches to health could provide to a society at large. Effective collaboration would very often mean engaging in two parallel processes: promoting health *and* contributing towards the goals of non-health sectors. In the future, finding and clearly expressing these co-benefits is an important task for all health advocates who are promoting intersectoral action for health equity.

Based on this literature review, my conclusion is that producing and disseminating evidence and information about the benefits of intersectoral action for health is unlikely to be sufficient to produce major political shifts towards getting health higher on the political agenda. There is a need for educated citizens and health advocates who demand evidence-informed action from their elected representatives. On the other hand, redistributive policies in terms of economic and social resources are important prerequisites for greater health equity. The current evidence on the engagement of non-health sectors in health promotion can be summarized by stating that intersectoral action for health is not easy but it is still a necessity. In order to formulate an analytical response to these challenges, the findings section of this dissertation focuses on the barriers and facilitators of intersectoral action.

CHAPTER 3: RESEARCH CONTEXT

The United Nations was founded in 1945⁵⁸ and its health agency, the World Health Organization (WHO), adopted its Constitution in 1946. WHO has six regional offices that are geared to address the particular needs of countries in the region and it is the most significant health agency at the global level (Clift, 2013; Lee, 2008).⁵⁹ The WHO's Twelfth General Programme of Work for 2014-2019 (WHO, 2014d) lists six core functions for the organization: (1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; (2) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; (3) setting norms and standards, and promoting and monitoring their implementation; (4) articulating ethical and evidence-based policy options; (5) providing technical support, catalyzing change, and building sustainable institutional capacity; and (6) monitoring the health situation and assessing health trends. Grad (2002) has suggested that increased globalization can make the WHO's role even more central in the future, although critics note that there are rising nationalistic tendencies globally that can endanger current global governance systems and international organizations in particular.

⁵⁸ Article 55 of the United Nations Charter defines the purpose of the organization by stating: "The United Nations shall promote: a) higher standards of living, full employment, and conditions of economic and social progress and development; b) solutions of international economic, social, health, and related problems; c) international cultural and educational cooperation; d) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion" (United Nations, 1945).

⁵⁹ WHO has 194 Member States (2017). WHO headquarters is located in Geneva, Switzerland. The six regional offices are Africa (AFRO), the Americas (PAHO), South-East Asia (SEARO), Europe (EURO), the Eastern Mediterranean (EMRO), and the Western Pacific (WPRO). The total number of WHO staff is around 7,000 people in 149 offices worldwide. Source: <http://www.who.int/about/regions/en/>

This chapter explores the context of this study by describing the *stated history* of the European Region of WHO.⁶⁰ The region consists of 53 countries in a geographical region that ranges from the Atlantic to the Pacific oceans. The WHO staff in the region is composed of around 550 public health experts located in the main office in Copenhagen, in three technical centres, and in 29 country offices. Approximately 70% of the regional staff work in the regional office and the rest are dispersed across the smaller country offices and technical centres. The two-year budget of the WHO European office is about US\$240 million, which includes regular and voluntary contributions by the Member States and private actors (WHO, 2016f). In the current biennial, the regional budget is divided into six categories: (1) communicable diseases (17%); (2) non-communicable diseases (12%); (3) promoting health through the life-course (15%); (4) health systems (20%); (5) preparedness, surveillance and response (14%); and (6) corporate services/enabling functions (22%) (WHO, 2016f, p. 24).⁶¹ The organizational structure of the WHO European office generally resembles these budgetary distributions.

After the widespread outbreak of the Ebola virus in West Africa (2013-2016), WHO was publicly criticized for its slow response (AP, 2015; see Section 2.4.1 in this dissertation). It was argued that the slowness was due to the WHO's bureaucracy, poor

⁶⁰ This dissertation has its main focus on challenges and opportunities for the implementation of intersectoral action for health and therefore it leaves the historical analyses of the political and technical evolution of WHO to other researchers (see Lee, 2008).

⁶¹ For the current 2-year period, the total WHO budget is about US\$4 billion, of which approximately 25% consists of regular contributions from the Member States and 75% is made up of voluntary contributions from countries and other donors (WHO, 2016f, p. 24).

internal communication, and inability to be decisive.⁶² Partly because of the criticism, WHO's work in health emergencies and communicable diseases has been prioritized in the most recent budgetary allocation (see Moon et al., 2015).⁶³ WHO's proposed budget for the 2018-2019 biennial (WHO, 2017e) contains a significant budget increase of US\$69.1 million for the WHO health emergencies programme and a US\$21.9 million increase for communicable diseases whereas the budget is reduced by US\$24.6 million for non-communicable diseases and by US\$18 million for enabling and administrative functions. In addition, WHO created a new programme area for the 2018-2019 biennial entitled "equity, social determinants, gender equality and human rights" through a merger of two former programme areas ("social determinants of health" and "gender, equity and human rights"). Despite the merger, the budgetary allocation for these two areas was not significantly changed (WHO, 2017e, p. 9).

The WHO Regional offices are mandated by the WHO Constitution and other basic documents, which include governance principles, such as financial and staff regulations, and a number of agreements with other intergovernmental organizations

⁶² The criticisms of the work of international health organizations has been revolving around the same issues for a long time. For instance, Jakovljević (2008, p. 806) writes: "Analysts criticize international health agencies for their bureaucracy, lack of coordination, and waste of resources, often leading to increased inequities and inequalities in health care (inequity in health, inequality in health) for the world's most vulnerable populations, instead of improving health. Furthermore, international health agencies are said to be neglecting the new global health challenges, not only new emerging diseases and health risks, but also issues regarding the development of new medical technologies, interventions and research, the design and implementation of information systems, the status and reforms of national health systems, consumers' health protection, etc. [...] Due to the short-term funding of public health programs and rapid staff turnover in governments, donors and international agencies, and technical assistance groups, health interventions often have low coverage and do not contribute to the building of sustainable health systems" (Jakovljević, 2008).

⁶³ The Harvard Global Health Institute and the London School of Hygiene and Tropical Medicine jointly launched the Independent Panel on the Global Response to Ebola that gave 10 recommendations to reform WHO's work in global health to address the current "system weaknesses" (Moon et al., 2015).

(WHO, 2014a). The Preamble to the WHO Constitution states the foundational principles of the organization (Box 3).⁶⁴ The Constitution (WHO, 1946) identifies health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” In addition, the Preamble to the Constitution explicitly declares that (national) governments have a responsibility to fulfill the right to health “by the provision of adequate health and social measures.” As a document first drafted in 1946, many have considered the WHO Constitution as a remarkably progressive document that has withstood the test of time (Grad, 2002).

⁶⁴ The WHO Constitution was originally adopted in 1946 and entered into force on 7 April 1948. The most recent version has incorporated the amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth, and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23). These amendments came into force on 3 February 1977, 20 January 1984, 11 July 1994, and 15 September 2005.

Box 3. The Preamble to the Constitution of the World Health Organization (1948/2014).

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

In the following, I will focus on the stated history of the WHO Regional Office for Europe as the key informants of this dissertation work exclusively in Europe, and therefore their experiences in intersectoral action for health are predominantly based on the work carried out within the 53 countries of the European region. A knowledge of the historical developments of the WHO's European office contextualizes this research on a

continuum and uncovers some of the circumstances from where the foundations of the intersectoral approach to health have emerged.

3.1 World Health Organization in the European region

The WHO Special Office for Europe was first opened in Geneva on January 1, 1949 in the aftermath of the Second World War. The war had left many European countries with a destroyed public infrastructure, including severely damaged health systems (WHO, 2010c, p. 4-5). Epidemics such as tuberculosis spread rapidly in Europe and it was estimated that the continent had 15 million internal refugees and displaced people.

In the early years, the newly established WHO Special Office for Europe was located within the WHO headquarters in Geneva's Palais des Nations. In 1952, the European office changed its name to the WHO Regional Office for Europe and a process was started to find a new location for the office. It was argued that moving from Geneva would help to establish the Regional Office for Europe as a separate unit within the organizational structure of WHO. Nine European cities offered space to the regional office.⁶⁵ The final decision was voted on May 21, 1954, in Geneva by representatives from 21 Member States. The final vote was between Nice and Copenhagen of which the latter won with 11 votes to 10. The regional office in Copenhagen was opened in 1957 in a residential neighborhood and it was mostly surrounded by family houses. The first WHO Regional Director for Europe was Dr. Norman Begg, who was one of the strongest advocates for Europe's own head office. He did not live to see the opening in Denmark, having died a year before at the age of 50.

⁶⁵ The following countries offered space for the WHO Regional Office for Europe in the beginning of the 1950s: Nice, Florence, Vienna, Frankfurt, The Hague, Geneva, Rennes, Montreux, and Copenhagen.

Early Years of WHO Europe (1952-1966)

The first four-year plan of the WHO Regional Office for Europe (1952-1956) included three programmes (WHO, 2010c, p. 12). The first programmatic area was focused on capacity building activities such as information exchange, providing professional education and training, as well as encouraging the Member States to be involved in inter-country work. The purpose of the second programme was to provide technical assistance to Member States related to communicable diseases, maternal and child health, occupational health, and nursing. As a third programmatic area, there were cooperative activities to facilitate collaboration between the WHO European Office and other United Nations agencies as well as non-governmental organizations. The WHO Regional Office for Europe organized “travelling seminars” that were seen as a successful way to spread knowledge and good practices across the European region.

The second Regional Director, Dr. Paul Van Calseyde, started his term in 1957 and held the post until 1966 (WHO, 2010c, p. 17-21). During his tenure, Europe went through rapid economic growth, and the period was marked by a significant reduction in communicable diseases. The European Region was declared free of malaria in 1962. In contrast to infectious diseases, many non-communicable diseases, mental health problems, and increased pollution contributed increasingly to Europe’s disease burden. In the WHO context, the early origins of an intersectoral approach to health can be traced to the late 1950s and early 1960s. It was acknowledged that health is influenced by many policy decisions made outside of the health sector, and the focus of activities was slowly shifted from cure to prevention. The importance of prevention has been reflected in work of the WHO Regional Office for Europe to the present day.

Many new partnerships with other UN agencies were established before the end of the 1960s. Of these, the most important were efforts to provide training facilities in maternal and child health with the United Nations Children’s Fund (UNICEF), improve occupational health in collaboration with the International Labour Organization (ILO), and

control zoonotic diseases with the Food and Agricultural Organization (FAO). Along with developing partnerships, new units were formed within the Regional Office, such as a chronic disease and gerontology unit as well as an epidemiology and health statistics unit.

Long-term Planning and New Programmes (1966-1985)

The third Regional Director was a Finnish physician, Dr. Leo A. Kaprio, who held the post for almost two decades from 1966 until 1985. He earned his medical degree from the University of Helsinki (1936-1945) and completed his postdoctoral training in the United States at Johns Hopkins University. Dr. Kaprio highlighted the need for long-term planning in the field of health and improving managerial leadership (WHO, 2010c, p. 25-28). The idea of national health planning in collaboration with WHO was developed during his tenure. Three long-term programmes were established in the WHO Regional Office for Europe: cardiovascular diseases (1968-1980), mental health (1970-1978), and environmental health (1971-1980). These programmes strengthened the preventative approach to health in the European region. One of the most significant legacies from Dr. Kaprio's term was the global health policy later known as "Health for All", which had a notable influence on WHO policies for many decades. The founding document was adopted at the World Health Assembly in 1977, and the principles were affirmed at the International Conference on Primary Health Care in Alma-Ata, USSR, in 1978.

The Declaration of Alma-Ata (WHO, 1978) acknowledged health as a fundamental human right and emphasized the role of primary health care in attaining health for all. In addition, the attainment of the highest possible level of health was stated as a goal "whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO, 1978, p. 1). A few years later, in 1984, an expert panel focused on the development of health promotion within the WHO context, concluded that "the group is fully aware that the development of priorities and practices

for health promotion depends upon the prevailing economic and cultural conditions” (WHO, 1984).⁶⁶

In the beginning, many developed countries saw the Health for All policy as something that was targeted to developing countries and therefore less relevant to them. As a regional director, Dr. Kaprio directed a significant effort to involve developed countries in strategic processes and highlighted the importance of addressing health gaps and health problems of vulnerable populations within more developed countries as well. The first Health for All policy document for the European region was adopted in 1984 and it included 38 targets and 65 indicators to monitor progress. Dr. Kaprio retired in 1985 and the implementation of the strategy was left to his successor Dr. Jo E. Asvall.

From the 1980s to the Millennium: Implementing Health for All (1985-2000)

The fourth Regional Director (1985-2000), Dr. Jo E. Asvall, was a Norwegian physician with a background in working for malaria eradication in a number of countries in South America and Africa (WHO, 2010c, p. 32-37). Later he worked for the Norwegian government and was involved in developing a new Norwegian national health policy. In the late 1970s, he joined the WHO Regional Office for Europe, first as an Officer for Country Health Planning and later as took a post as a Director of Programme Management. In 1985, Dr. Asvall was seen as a natural successor to Dr. Kaprio for continuing the implementation of the Health for All policy as a Regional Director.

The Health for All work was to a great extent about awareness-raising and mobilizing different actors to promote the health of all. Targets and indicators were seen as important tools to place the question of health and its distribution on the political agenda in the WHO Member States. The lessons and professional networks developed from several “leadership through advocacy” meetings were used to promote the Health

⁶⁶ Also in 1984, the WHO’s first programme in “health promotion” was established in the European office. (WHO, 1984)

for All strategy across the region. The WHO Regional Office for Europe assisted member states in formulating their national health policies to acknowledge the principles of the Health for All strategy (Mahler, 1988b).

The major health emergency of the 1980s was the accident at the Chernobyl nuclear plant on April 26, 1986. The WHO Regional Office provided its expertise on environmental health and ionizing radiation to the region in the wake of this cross-border emergency. The Chernobyl accident highlighted the importance of emergency preparedness through global alert and response (GAR) networks. Later some of the lessons were used in the preparation of the 2005 version of the International Health Regulations (IHR), which is a legally binding agreement including all the WHO Member States (WHO, 2008b).

One of the highlights of Dr. Asvall's term as Regional Director was the first International Conference on Health Promotion held in Ottawa in 1986. The conference was organized by the WHO Regional Office for Europe, and it became a significant milestone for the international health promotion movement through its outcome charter. To date, the Ottawa Charter for Health Promotion (WHO, 1986b) has become one of the most influential international policy document to define the aims and scope of health promotion.⁶⁷ Subsequent to the Ottawa conference additional initiatives were launched to apply the Health for All principles to specific settings. The most important of these were the WHO Healthy Cities network (de Leeuw, 2001; Hancock, 1993; WHO, 2014c) and the Health Promoting Schools (WHO, 1998c, 2006) initiative.

Two major societal challenges took place in Europe in the 1990s. The first was the collapse of the Soviet Union in 1991, which meant that many of the former Warsaw Pact

⁶⁷ The Ottawa Charter for Health Promotion (WHO, 1986) set forth an idea that people's health can be best improved by enabling people's control over the underlying factors that influence their health. The Charter focused on health promotion action in key five areas: 1) building healthy public policy; 2) creating supportive environments; 3) strengthening community action; 4) developing personal skills; and 5) reorienting health services towards prevention and health promotion.

countries in the eastern part of the European region had to reconstruct their political and economic systems. These changes led to the almost doubling of the number of Member States in the WHO European region, from 31 to 50. The EUROHEALTH programme was established to address the needs of the new Member States, and 13 country-specific liaison offices were established by 1993.⁶⁸ The second regional challenge was the armed conflict in the Balkans after the dissolution of Yugoslavia. The result was a humanitarian crisis that created the need to address the immediate question of refugee health and long-term health needs in the Balkans. The WHO Regional Office for Europe established a network of offices whose first leader was the renowned public health expert, Sir Donald Acheson (Acheson, 1999). The process of creating structures for the aid work took a considerable amount of time. By liaising with the Overseas Development Agency in London, Acheson was able to guarantee a large quantity of emergency drugs and surgical supplies to the region. WHO continued to actively work in the area after the conflict throughout the 1990s.⁶⁹

The next milestone in the region was the launch of the revised Health for All policy framework in 1998. The new strategy was called Health21, as it was based on 21 targets to promote and protect health (WHO, 1998a). In comparison to the previous Health for All policy, some of the new elements in the strategy increased the focus on quality-of-life measures and sustainable economic growth. Dr. Jo E. Asvall ended his 15-year long career as the Regional Director for the WHO European office in 2000 (WHO, 2010b). His legacy included a successful expansion of WHO activities in the expanded

⁶⁸ Later many of these liaison offices were established as WHO Country Offices.

⁶⁹ The situation in the summer of 1992 was described as follows: "Sir Donald's resources consisted of a tiny office containing a packing case table and two chairs and the 'enthusiastic and cheerful support' of a personal assistant and interpreter called Sanja Viscovic and a driver, Branco Pelko. Being Croatian, neither of them could cross the border into Bosnia. Sir Donald quickly ascertained that he would need to establish a number of other offices in various cities if he were going to really get a handle on the level of public health problems that were fast arising." (Acheson, 1999).

European region as well as implementing new working methods in regard to the WHO Members States, including in-country liaison offices for the purpose of better adapting the WHO programmes to differing country contexts (WHO, 2010b).⁷⁰

Focus on National Health Policies (2000-2010)

The fifth Regional Director (2000-2010), Dr. Marc Danzon, a French medical doctor, had a background with the French Health Education Committee and at various positions at the WHO Regional Office for Europe (WHO, 2010c, p. 40-43). Dr. Danzon established new working methods to better address the needs of WHO Member States. The Regional Office's new country strategy, "Matching Services to New Needs", was adopted in 2000.⁷¹ Its core was in shifting the focus of WHO to tailoring partnerships with countries where the WHO's European office would be better prepared to provide expert advice and services based on the needs of its Member States. In addition, the expertise of the WHO country offices was strengthened, and they were given a more independent role.

⁷⁰ In 2010, WHO published a tribute book titled "Jo Eirik Asvall's Memorial Guide", which draws up ten rules for successful public health leadership based on Dr. Asvall's work as a Regional Director:

1. Be there, where and when you are needed.
2. Put international health first.
3. Aim to influence systems and policies.
4. Turn vision into action.
5. Opt for evidence over eminence.
6. Blend ethics and science with political know-how.
7. Build movements for change — let a thousand flowers bloom.
8. Hire talented people and give them space to move.
9. Be courageous.
10. Lead by example, spread the glow.

⁷¹ In the new Country Strategy, adopted in September 2002, the core mission of the WHO Regional Office for Europe was defined as: "To support Member States in developing their own health policies, health systems and public health programmes; preventing and overcoming threats to health; anticipating future challenges; and advocating public health." (WHO, 2010c, p. 41).

The implementation of the new Country Strategy included upgrading the collaborative agreements between WHO and individual countries. The strategic documents called “Biennial Collaborative Agreements” (BCAs) are signed between WHO and national health ministers. BCAs lay out the top priority issues within a country and include an implementation strategy to address the most pressing national health challenges in collaboration with WHO. BCAs were seen as a tool to promote the principles of good governance, especially in terms of transparency, efficiency, and accountability. Many of the BCAs were signed with eastern European countries that are not members of the European Union.⁷² In 2016, BCAs are still considered an important tool for the WHO’s collaboration with Member States and the Regional Office allocates various amounts of financial assistance to countries for the implementation of these biennial agreements.

The armed conflict in Kosovo ended in 1999, and an agreement was made for a Stability Pact for South East Europe. The European Union, the United States, and other G8 countries were involved in the process of negotiating the pact to provide support for the region’s development. Later, in 2001, the WHO Regional Office for Europe published its proposal to address the pressing health-related challenges in South-eastern Europe. The process led to the signing of the Dubrovnik Pledge: Meeting the Needs of Vulnerable Populations in South East Europe, which focused on restructuring health services to provide universal and high-quality health care, improving public health infrastructure, and developing capacity-building for health professionals.⁷³ In May 2002, the Dubrovnik Pledge led to establishing a permanent mechanism to implement its commitments, which is known as the South-eastern Europe Health Network (SEEHN).

⁷² For instance, in 2008, there were 33 BCAs of which 3 were negotiated with Western European countries.

⁷³ The signatory countries of the Dubrovnik Pledge in September 2001 were Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, the former Yugoslav Republic of Macedonia, and Yugoslavia.

Health 2020 and Governance for Health (2010-)

The sixth Regional Director (2010-) is Dr. Zsuzsanna Jakab (b. 1951), who had held various senior management roles at the WHO Regional Office for Europe and was the founding director of the European Centre for Disease Prevention and Control (ECDC). Dr. Jakab is a native Hungarian and has worked at the Hungarian Ministry of Health as a State Secretary and in various other roles before her career at WHO.⁷⁴ During Dr. Jakab's first term, the European Health 2020 policy framework (WHO, 2013b) was developed as a strategic tool to steer Regional Office work as well as to provide countries with a comprehensive but flexible framework for their health policy development.⁷⁵ In the early 2010s, some of the other priorities of the Regional Office under Dr. Jakab's leadership have been to strengthen an evidence base in health policy as well as to provide increased support for the Member States in addressing health inequalities and social determinants of health. One of the important changes has been shifting the focus from programmatic silos to governance for health by applying whole-of-government and whole-of-society approaches (Brown et al., 2014; Kickbusch & Behrendt, 2013; Kickbusch & Gleicher, 2012). This change can be seen to reflect the renewed focus on the importance of intersectoral approaches in the WHO European region in the beginning of the 2010s.

In February 2015, Dr. Jakab started her second five-year term as Regional Director. The interrelatedness of health and sustainable development has been outlined as one of the new priority areas of the Regional Office for the period of 2015-2020.⁷⁶ The

⁷⁴ <http://www.euro.who.int/en/about-us/regional-director/biography>

⁷⁵ Dr. Jakab's PhD dissertation focused on the Health 2020 policy framework and its implementation process: Jakab, Z. (2014). The European policy framework and strategy for health and well-being (Health 2020): From vision to implementation (PhD dissertation), University of Debrecen, Debrecen, Hungary.

⁷⁶ See the press release available at: <http://www.euro.who.int/en/media-centre/sections/press-releases/2014/zsuzsanna-jakab-nominated-for-second-term-as-who-regional-director-for-europe> (Accessed on January 30, 2016).

WHO Regional Office for Europe has continued organizing ministerial conferences on different themes based on the requests from Member States. In addition, collaboration with various international organizations such as the European Union, OECD, the World Bank, and other UN agencies such as UNICEF has continued during the 2010s.

3.2 WHO statements on health promotion

The WHO global health promotion conferences have been an important forum where intersectoral approaches to health have been articulated and conceptualized over decades. In the following, I provide a descriptive history of these conferences in order to offer a general outlook on how WHO has acted as a global authority in health promotion.

The First International Conference on Health Promotion was held in Ottawa, Canada on November 17-21, 1986, and there have been eight subsequent conferences of which the latest was held in Shanghai, China, on November, 21-24, 2016. The global conferences have produced declarations and statements with a specific focus on various aspects of health promotion. These declarations, charters, and statements are non-binding, and there are no enforcement or monitoring processes to follow-up on their impact. The influence of these policy declarations in terms of their ability to shape priorities and national health policies is almost impossible to measure objectively. Some documents such as the Ottawa Charter can be seen to have a significant impact on health promotion practices, debates, and academic research globally. However, it is very difficult to demonstrate causal links from high-level international declarations to policies implemented at the national level. Leger (2007) has summarized the principal value of international declarations in health promotion by stating: “Whatever their strengths and weaknesses, they provide many people, organizations and governments with a common and consistent set of beliefs, principles, arguments and actions about why it is essential to promote the health and well-being of everybody” (Leger, 2007, p. 181). Similarly, the authoritative policy statements provide support and direction for health promotion

practitioners in the field. In terms of concrete guidance, the need to engage and collaborate with non-health sectors has been one underlying element of all nine health promotion conferences from 1986 to 2016. In the following section, I briefly review the conference statements and their key themes.

The First International Conference on Health Promotion (1986) produced the Ottawa Charter for Health Promotion (WHO, 1986b). The key focus of the Charter was briefly summarized in the introduction of this dissertation. The preparations for the conference were started a few years earlier; and the important conceptualization of health promotion can be found in the paper, "A Discussion Document on the Concept and Principles of Health Promotion" (WHO, 1984), which was based on a meeting organized by the WHO Regional Office for Europe on July 9-13, 1984. The WHO Health for All strategies also influenced the planning of the first health promotion conference, and a series of background papers were written on various aspects of health promotion.⁷⁷ Probably the most influential of these papers was Nancy Milio's 5-page paper titled "Building healthy public policies: Focus for a new public health" (Milio, 1986).⁷⁸ In her paper, Milio summarizes some of the key arguments of her book on promoting health through public policy (Milio, 1981) and calls for a more systematic assessment of the health impacts of policy decisions by stating:

Public policy has thus become inextricably linked to the prospects for human health. It must now be used in the health interests of the public. This does not

⁷⁷ I would like to offer my special thanks to Dr. Trevor Hancock for providing me with the background papers of the Ottawa conference.

⁷⁸ In her seminal 1981 book, Milio considered that almost all policy sectors have an influence on the health of the population. Several decades later, de Leeuw (2017) noted that some sectors seem to have greater importance and have received more attention than others: "Although Milio has demonstrated that virtually every walk of life, public policy, and civil society impacts on individual and population health, the sectors that have been identified persistently are education, housing and urban planning, transport and mobility, social protection and welfare support systems, and energy and sustainable development." (de Leeuw, 2017, p. 334).

mean that health should be the sole or determining criterion for policy choices. It does mean that the health impacts of policy options, direct and indirect, intended or not, be brought to the attention of policymakers and be taken into account in public discourse within governments, the media, and elsewhere as policy decisions are made. (Milio, 1986)

The Second International Conference on Health Promotion was held in Adelaide, South Australia, on April 5-9, 1988. The conference has been considered as a major milestone in the Health for All movement. The Adelaide Recommendations on Healthy Public Policy (WHO, 1988) built on the Alma-Ata Declaration and the Ottawa Charter by highlighting their principles and putting further focus on equity and human rights as areas of governments' accountability for health. Several action areas are given special attention, such as women's health, food and nutrition, tobacco and alcohol, and environmental hazards. The need for collaboration and coordinated intersectoral efforts is highlighted throughout the document.

The Third International Conference on Health Promotion was held in Sundsvall, Sweden, on June 9-15, 1991. The Sundsvall Statement on Supportive Environments for Health (WHO, 1991) emphasizes the role of physical, social, economic, and political environments in damaging or supporting health. The conference statement calls for health, environment, and social justice advocates of all relevant sectors at all levels to work together towards the goal of Health for All. It also sets out two basic principles that should act as a basis for all work in health promotion: (1) Aiming towards greater equity, accountability, and sustainability and (2) recognizing the interdependence of all living beings and taking into account future generations. Promoting community action and empowerment of people were seen as defining factors in a "democratic health promotion approach" endorsed by the statement. In addition, the statement urges WHO and the United Nations Environment Programme (UNEP) to strengthen their collaboration to tackle conditions and products harmful to health and the environment.

The Fourth International Conference on Health Promotion was held in Jakarta, Indonesia, on July 21-25, 1997. It was also the first one of the health promotion conferences to involve the private sector and the first to be held in a developing country. The Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997b) reaffirmed the conclusions of the previous conferences and highlights health as a key investment that is linked to the global economy, financial markets, and trade policies. The conference declaration called for new collaborative responses that would break through traditional boundaries within and between the public and private sectors as well as engage NGOs. The participants endorsed the formation of a global health promotion alliance with seven priorities, which included raising awareness of the changing determinants of health, supporting collaboration for health, mobilizing resources for health promotion, collecting knowledge on best practices, and increasing transparency and accountability in health promotion. WHO was called on to take the lead in engaging different stakeholders to advance the above priorities in health promotion.

The Fifth Global Conference on Health Promotion was held in Mexico City on June 5-9, 2000. The Mexico Ministerial Statement for the Promotion of Health (WHO, 2000) restated the attainment of the highest possible standard of health as a positive asset and a necessary factor for equity and development. The conference statement called on governments to tackle health problems that hinder social and economic development. In addition, intersectoral action for health was emphasized by stating that there is an urgent need to address the social, economic, and environmental determinants of health through implementing "strengthened mechanisms of collaboration for the promotion of health across all sectors and at all levels of society."

The Sixth Global Conference on Health Promotion was held in Bangkok, Thailand, on August 7-11, 2005. The Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005a) asserts that the global context for health has changed markedly since the Ottawa Charter. The charter builds on the earlier statements on health promotion but sets

a special focus on critical factors, including increasing inequalities, new patterns of consumption and communication, commercialization, global environmental change, and urbanization. It also states that new opportunities have arisen with the development of new information and communications technology. The Bangkok Charter lists four key commitments that consider making health promotion (1) central to the global development agenda, (2) a core responsibility for all governments at all levels, (3) a key focus of communities and civil society, and (4) a requirement for good corporate governance.

The Seventh Global Conference on Health Promotion was held in Nairobi, Kenya on October 26-30, 2009. The Nairobi Call to Action (WHO, 2009b) set out five priority responsibilities for governments and other stakeholders in health promotion: (1) Strengthen leadership and workforces, (2) mainstream health promotion, (3) empower communities and individuals, (4) enhance participatory processes, and (5) build and apply the evidence base. In addition, the call for action endorsed the implementation of the recommendations of the WHO Commission on Social Determinants of Health (WHO, 2008a). Intersectoral action for health was also highlighted in the statement stressing that “effectively addressing the determinants of health and achieving health equity requires actions and partnerships that extend beyond the health sector to implement forms of collaboration, cooperation, and integration between sectors” (WHO, 2009b, p. 5).

The Eight Global Conference on Health Promotion was held in Helsinki, Finland, on June 10-14, 2013. The Helsinki Statement on Health in All Policies (WHO, 2013c) calls on governments to “commit to health and health equity as a political priority by adopting the principles of Health in All Policies and taking action on the social determinants of health” (p. 2). The statement acknowledges that it is inspired by “the rich heritage of ideas, actions and evidence” that originated with the Alma-Ata Declaration (1978) and the Ottawa Charter (1986). It concludes that the previous WHO statements on health promotion “identified intersectoral action and healthy public policy as central elements

for the promotion of health, the achievement of health equity, and the realization of health as a human right” (WHO, 2013c, p. 1). The actions of the Helsinki Statement include ensuring effective structures, processes, and resources at all levels of government to promote health. The statement states that the health sector’s capacity to engage other sectors will require building institutional capacity and skills in leadership, partnership, advocacy, and mediation. Transparent audit and accountability mechanisms for health and health equity are highlighted as important measures to monitor these developments. Furthermore, governments are called on to establish conflict of interest measures to safeguard and protect policies from being distorted by commercial and vested interests.

The Ninth Global Conference on Health Promotion was held in Shanghai, China, on November 21-24, 2016. The Shanghai Declaration on Health Promotion (WHO, 2016e) states that the UN Sustainable Development Goals (SDGs) “establish a duty to invest in health, ensure universal health coverage and reduce health inequities for people of all ages.”⁷⁹ In the context of achieving the United Nations Development Agenda 2030 and the SDGs, the declaration calls for integrated and intersectoral responses to health challenges in a situation where economic growth alone does not guarantee improvements in population health. Three priority areas are highlighted in the declaration: (1) Good governance as a crucial factor for health, including mechanisms to protect health through public policies (e.g. legislation, regulation, taxation, and fiscal policies in general); (2) cities and communities as critical settings for health, including policies that promote equity and create co-benefits between the health sector and other

⁷⁹ A recent major development in global health, the Sustainable Development Goals (SDGs), were adopted on September 25, 2015 by the 193 countries of the United Nations General Assembly. The SDGs are officially known as “*Transforming our world: The 2030 Agenda for Sustainable Development*”, and they consist of 17 goals and 169 targets. The SDGs are the successor to the Millennium Development Goals (MDGs) that were adopted in 2000. In terms of health, the SDGs are important because they have an explicit focus on health, articulated in Goal 3 and its targets, and because they promote intersectoral collaboration to address many of the social determinants of health.

city policies; and (3) health literacy as a factor that empowers and drives equity, including investments in the strengthening of health literacy in all populations and in all educational settings. The Shanghai Declaration urges political leaders from different sectors and from different levels of governance to promote health and well-being in all SDGs. This work is expressed as a shared responsibility and demands coordinated action by all concerned. The declaration ends with a statement where the participants pledge “to accelerate the implementation of the SDGs through increased political commitment and financial investment in health promotion.”⁸⁰

The purpose of this section was to provide a descriptive outline of how WHO has worked through international health promotion conferences since 1986 (see Table 4). In terms of promoting intersectoral policymaking, the most significant health promotion conferences were Ottawa (1986), Adelaide (1988), and Helsinki (2013). The final statements from these conferences clearly asserted the importance of intersectoral action for health with slightly varied emphases. In the next chapter, I will move on to my research questions, data collection procedure, and method of analysis.

⁸⁰ As articulated in the Shanghai Declaration (WHO, 2016e), the promotion of sustainable development has many linkages to health and especially to intersectoral approaches. One important aspect is that the SDGs are not directed only to developing nations; well-developed nations are encouraged to produce their own national implementation plans. To date, many countries have produced documents that consider the implementation of the SDGs at the national level.

Table 4. WHO Global Conferences on Health Promotion, 1986-2016	
Year	WHO Conference Statements on Health Promotion
1986	Ottawa Charter for Health Promotion. First international conference on health promotion, Ottawa, Canada, November 17-21, 1986.
1988	Adelaide Recommendations on Healthy Public Policy. Second international conference on health promotion, Adelaide, South Australia, April 5-9, 1988.
1991	Sundsvall Statement on Supportive Environments for Health. Third international conference on health promotion, Sundsvall, Sweden, June 9-16, 1991.
1997	Jakarta Declaration on Leading Health Promotion into the 21st Century. Fourth international conference on health promotion, Jakarta, Indonesia, July 21-25, 1997.
2000	Mexico Ministerial Statement for the Promotion of Health. Fifth global conference on health promotion, Mexico City, June 5-9, 2000.
2005	The Bangkok Charter for Health Promotion in a Globalized World. Sixth global conference on health promotion, Bangkok, Thailand, August 7-11, 2005.
2009	Nairobi Call to Action. Seventh global conference on health promotion, Nairobi, Kenya, October 26-30, 2009.
2013	Helsinki Statement on Health in All Policies. Eight global conference on health promotion, Helsinki, Finland, June 10-14, 2013.
2016	Shanghai Declaration on Health Promotion. Ninth global conference on health promotion, Shanghai, China, November 21-24, 2016.

CHAPTER 4: RESEARCH QUESTIONS, DATA, AND METHODS

4.1 Research questions

The main rationale for this dissertation stems from the perceived difficulty in implementing intersectoral action for health, even though the idea has been strongly promoted by WHO, health policy experts, and health advocates since the late 1970s. In my literature review, I showed (especially in the context of WHO) that there is a strong consensus that intersectoral action for health is necessary to address the most pressing health challenges in an effective and comprehensive way. Similarly, my review indicated that the health sector alone cannot address many of the social determinants of health that are crucial to the health of the population. Fundamentally, the need to take action on health is based on international human rights agreements, which form the normative base and justification for governments to promote the health of their citizens. Based on the above perspectives, I have defined three general aims and three guiding research questions for my dissertation.

The three main aims of this dissertation are:

1. To explore the historical and conceptual development of intersectoral action for health equity by reviewing international policy documents and the academic literature;
2. To shed light on the challenges to, and opportunities for, the implementation of intersectoral action for health; and
3. To consider the future of intersectoral collaboration in health promotion.

I used three guiding research questions:

1. How do the expert informants within the WHO Regional Office for Europe understand the concepts of “intersectoral action for health” and “governance for health”?
2. What factors do the academic literature and key informants identify as the main challenges/barriers to intersectoral action for health?
3. Which factors facilitate the implementation of intersectoral action for health and what type of opportunities can be identified to promote health through intersectoral collaboration in the future?

4.2 Research design

This study is a qualitative study based on semi-structured interviews with key informants, who consisted of WHO Programme Managers, Unit Leaders, Technical Officers, and two Directors. These WHO experts exert significant influence over the implementation of WHO programs in Europe and act as normative agents in shaping the health policy landscape internationally. The study utilized strategies and principles derived from content analysis and thematic analysis to examine the key challenges and opportunities for the implementation of intersectoral action for health. Computer-assisted qualitative data analysis software (NVivo 11) was used as a tool to assist sorting and coding the collected data.

One of the aims of this study is to systematically explore and identify ways by which intersectoral action for health could be better facilitated in the future. Before

describing my data and methods in more detail, I will look into some general methodological considerations related to social science research.

4.2.1 Methodological considerations

There are numerous qualitative, quantitative, and mixed-methods approaches available to study policy contexts and processes (Bryman, Bell, & Teevan, 2012). The data sources for qualitative studies can include existing policy documents, key informants, on-site observations, and many other forms of non-numerical data (e.g. verbal, written, and visual). Quantitative policy studies use existing statistics, surveys, and other forms of quantified data.

In general, a data analysis can be carried out in many different ways, and it also depends on the type of the data that is being analyzed. Qualitative data analysis relies largely on interpretative techniques, which can include identification, categorization, coding, and many other ways of interpreting the data (Given, 2008; Mason, 2002; Silverman & Marvarsti, 2008). There are many approaches to qualitative research, but there are still no universal rules, and the “fluidity” of the process is almost always an essential part of qualitative research. In some cases, qualitative researchers can utilize content analysis and other methods that turn qualitative findings into numerical form (Mayring, 2000). Some approaches, such as grounded theory, aim to make qualitative research more rigorous by highlighting a certain set of steps that a researcher should follow (Charmaz, 2006; Glaser, 1998; Strauss & Corbin, 1990).

In contrast to qualitative methods, quantitative analysis is based on statistical rules and other mathematical models. These methods can include various statistical tests to test hypotheses and form models that show statistical correlations between the measured factors (VanderStoep & Johnston, 2009). There are numerous computer programs available to help the analysis of qualitative data (e.g. NVivo, Atlas.ti) and quantitative data (e.g. SPSS, Stata). Researchers should be reflective in their choice of methods and

what they can claim based on the findings. In qualitative studies, one should reflect on whether another researcher would interpret and code the studied subject matter in a similar way (inter-rater reliability) and how the researcher's own cultural or contextual presumptions (or biases) might influence the interpretative processes and the validity of results. In quantitative studies, many challenges are related to the method of statistical analysis as well as to the data collection, e.g. how a certain phenomenon has been operationalized to measurable variables and the quality of data in terms of its statistical significance.

A mixed-method approach can aim to combine both qualitative and quantitative data sources. For instance, Baum (1995) argues that health researchers should be willing to apply diverse methodologies that are suited to the problem being investigated. This perspective highlights that both epidemiological and interpretive research methods have their place in studying public health problems because these problems result from complex causes and interactions between social, economic, biological, and environmental factors.

Regardless of the chosen method, the role of theory and existing academic research is important to contextualize the study, understand the studied phenomena, and convince other researchers who might be examining the results. New studies need to link themselves to existing and published knowledge and through those linkages academic papers can further contribute to academic discourses and debates. In terms of methodological awareness, two terms are important: validity and reliability (Silverman & Marvasti, 2008, p. 257-276). Validity can be understood as a synonym for truth, i.e., are the results logically and factually sound? If the validity is high, then the research findings represent the phenomena in a truthful way. Reliability refers to the degree of consistency in the interpretation of the findings, i.e., would different researchers end up with similar results with the same data? In qualitative research, strategies to attain validity and reliability include prolonged engagement with the subject matter, systematic

observations, using multiple methods, and triangulation of sources (Lincoln & Guba, 1985, p. 289-331).

The point of saturation is an important concept in terms of evaluating the validity of the findings (Firmin, 2008). For instance, the results can be assessed to be more valid when it is evident that continuing interviews, or collecting other data, will provide little new information. In other words, informants keep reporting ideas that were already brought up and continuing data collection does not produce any new and meaningful results. Similarly, triangulation of sources by using existing literature and documents can increase the validity of research. If some themes or ideas that were identified in the literature seem to be missing from the data, the researcher should pay special attention to explain the results. Lincoln and Guba (1985, p. 289-331) use the term “trustworthiness” to refer to a researcher’s ability to give a detailed and credible description of the contextual factors, methods, and the process of analysis in order to increase the reliability and validity of qualitative research. In the following section, I will describe my choice of methods and the process of data collection.

4.2.2 Planning the study

The idea for this dissertation was born from the reading of academic policy debates and international policy documents considering the unwillingness of governments to forcefully take an intersectoral approach to health. Since the 1970s, the reoccurring policy suggestion by WHO has been to engage non-health sectors in health promotion. Despite the recommendations by the WHO Regional Office for Europe, many governments still do not consider the health impacts of policies implemented by non-health sectors in a systematic way. Interviewing officials across European governments would have been one possible strategy to gain new insights into the challenges and opportunities for intersectoral action for health. However, due to time and resource constraints, in this study a decision was made to limit the data collection to WHO staff. As a researcher, I

was provided an opportunity to interview WHO experts to seek answers to the question of why the implementation of intersectoral initiatives has been challenging and what success factors could be identified that could facilitate further intersectoral action for health.

4.3 Data collection

The data collection of this dissertation was based on purposive sampling with 28 key informants at the WHO Regional Office for Europe in Copenhagen. In what follows, I will summarize my rationale for the use of interview data and provide details of the data collection process.

4.3.1 Purposive sampling

The informants for this study were recruited through purposive sampling, i.e. their professional role is associated with having expert knowledge that is relevant to this dissertation. Palys (2008) describes purposive sampling as a series of strategic choices that tie the sample to the objectives of the study. The general principle of purposive sampling can be illustrated by the statement: “Think of the person or place or situation that has the largest potential for advancing your understanding and look there” (Palys, 2008, p. 698).

In this dissertation, the purposive sampling could be described as “stakeholder sampling”, as WHO experts are the key actors involved in designing and implementing international health programs.⁸¹ WHO is probably the most significant normative actor in global health, and its experts aim at influencing national decision-makers and policies by

⁸¹ The sampling in this study could be also understood as “paradigmatic case sampling” in the sense that all the informants were running or otherwise involved with WHO programmes and activities. They could be seen as exemplars of a certain class and sharing many similar values and other qualities (see Palys, 2008).

providing recommendations and other technical advice in the health arena. In terms of promoting health equity, the WHO Regional Office for Europe in Copenhagen has been a lead actor shaping the health policy landscape and many of the widely used concepts related to health equity originated in the Regional Office and its publications. (See Whitehead, 1990 as one example).

4.3.2 Key informant interviews

I utilized the key informant method where expert informants were asked to answer questions in an interview (Marshall, 1996; Weiss, 1994). The interviews were semi-structured and based mainly on open-ended questions. I considered the WHO experts to present Tremblay's classical characteristics of ideal informants (Tremblay, 1957).⁸² In terms of my study, it was important that my informants were well aware of the developments of health policy in the WHO European region and globally. Expert informants might have been involved in the processes that lead to the implementation of a certain policy and therefore can provide greater insights into policymaking processes in a way that cannot be known by only analyzing published policy documents. Expert informants are also capable of providing the essential information in a concise format with a focus on the descriptive in-depth information of the studied phenomenon (Marshall, 1996). My aim was to include highly knowledgeable informants who have been involved in the process of producing and implementing WHO strategies and policy papers during the past years. The informants worked mainly with national-level focal points (e.g. national ministries and WHO country offices) and less with local-level and non-governmental actors. Most of the

⁸² According to Tremblay (1957) the ideal key informant has the following characteristics: (1) Role in community: the informant has access to relevant information, (2) knowledge: the informant has gained meaningful understanding in his or her field, (3) willingness: the informant wants to cooperate with the researcher, (3) communicability: the informant is able to communicate effectively, and (4) impartiality: the informant is "unbiased", or biases are made visible (Marshall, 1996; Tremblay, 1957).

informants considered that the main type of intersectoral action is collaboration between different health and non-health ministries, whereas some informants also highlighted intersectoral action as an interplay and collaboration between the public sector, non-governmental organizations, and the private sector.

Before the interviews, I familiarized myself with the literature on interviewing elites and leading decisions-makers. The best interview strategy depends on the context. However, some general guidelines should be considered prior to the actual interviews. Harvey (2011) gives some practical tips specifically for elite interviews. For instance, elites might avoid answering the question asked. In those cases, it is a good strategy to be persistent and ask again but give up if it is clear that the person is not going to answer. Usually, it might be beneficial to place difficult questions in the middle of an interview and say something like "this is not a question I would ask you if we met socially but my purposes here are quite different" (Harvey, 2011). Maintaining silence can lead to more detailed answers. In addition, the researcher can openly ask for feedback, comments, and criticism, which may make the informant less defensive as well as improve the quality of the research. Furthermore, Marshall (1996) states that the researcher should respect the informant's interests, sensitivities, and position. The informants should not be exploited, and the researchers should not have any hidden agendas.

4.3.2 Process

The data collection was preceded by a planning process carried out by a project group within the Division for Policy and Governance for Health (PCR) at the WHO Regional Office for Europe. The core project team involved the director of the division and a Programme Manager and the author of this dissertation. In addition to this PhD study, it was concluded that the project would be aimed at benefiting the work of WHO. Concrete internal outputs were specified as (1) raw data and notes, (2) a set of case studies, and (3)

an internal report summarizing the results.⁸³ Based on multiple discussions within the project team, I formulated the first draft of the interview guide. The draft version was later commented on and revised several times (see Appendix B).

After the interview guide was formulated and approved by the project team, the next step involved identifying the WHO Program Managers, Unit Leaders, and Technical Officers who could act as the key informants through interviews. First, I searched the WHO internal directory to identify everyone with a “Programme Manager” title at the WHO Regional Office in Copenhagen. Later the project team made additional suggestions about Technical Officers and Team Leaders who could provide essential information. In total, 30 informants were identified and contacted by email.⁸⁴ The email described the purpose of the project and briefly outlined its focus on intersectoral action for health. The email contact was accompanied with a kind wish to everyone to participate and to schedule 30 to 60 minutes for an interview. The data collection resulted in 28 interviews that took place either in-person (N=24) or via Skype (N=4). Only 2 of 30 identified informants did not participate in the process due to scheduling issues beyond the control of the researcher or the project team. A total of 28 interviews were

⁸³ An internal WHO working paper titled “Mapping exercise to support intersectoral action: Results of the in-house consultation with Program Managers, Unit Leaders, and Technical Officers at the WHO Regional Office for Europe” (18 pages and a 25-page annex) was completed in November 2015.

⁸⁴ The email that was sent to the informants included the following short description: “In your programmatic area, we are interested to know of country experiences and good practices of intersectoral action for health. In particular we are looking for high-level mechanisms that were introduced to develop and/or implement policies, strategies or plans in your area of expertise.

Key themes of the consultation

1. Intersectoral action for health: mechanisms, structures, and instruments
2. Opportunities and barriers to intersectoral action for health
3. Policy development and support for taking action
4. Case studies and good practices from the European region.”

carried out, which included 17 Program Managers, 4 Technical Officers, 4 Unit Leaders, 1 Director, 1 Consultant, and 1 Director of a WHO Collaborating Centre (see Appendix C).

The length of individual interviews varied from approximately 30 minutes to one hour, and the duration of all recorded interviews was 23 hours and 23 minutes. All interviews were digitally recorded with the consent of the informants. At the beginning of each interview, I explained that the process will contribute to the WHO's internal development as well as to my personal PhD dissertation. The informants were informed that they will get an internal report that summarizes the results and that they will be provided with an opportunity to comment on its draft version before it is made final. A consent form was also provided at the face-to-face interviews and emailed to those who were interviewed via Skype.

I wrote notes during the interviews and prepared a detailed written summary, usually within a few days following the interview. The preparation of written summaries involved listening to the recordings and identifying the key inputs and highlights that were seen to answer the questions presented in the interview guide. These detailed notes were later imported to NVivo for content and thematic analysis. Along with interview notes, I wrote short notes (memos) during the research process. The process of memoing has been defined as "the act of recording reflective notes about what the researcher (fieldworker, data coder, and/or analyst) is learning from the data. Memos accumulate as written ideas or records about concepts and their relationships" (Groenewald, 2008, p. 505).

4.4 Analysis of the qualitative data

Qualitative methods can be especially useful in gaining a deeper understanding of a phenomenon by utilizing detailed descriptions and an in-depth analysis (Flick, 2009). In addition to providing answers to research questions, one of the related objectives of a qualitative researcher is to tell a convincing story about the data (Glesne, 2006).

I utilized content analysis as the first preliminary method to analyze expert interviews, which was later followed by thematic analysis to produce higher-level thematic categories and interpretations (Ayres, 2008; Braun & Clarke, 2006; Mayring, 2000). In the following, I review the general aspects of how these two methods have been used to analyze various types of qualitative data across academic disciplines.

4.4.1 Content analysis

Content analysis aims at analyzing the data by quantifying it as well as finding meanings and connections. Julien (2008, p. 120) defines qualitative content analysis as: "the intellectual process of categorizing qualitative textual data into clusters of similar entities or conceptual categories and to identify consistent patterns and relationships between variables or themes." In a qualitative content analysis, one can utilize inductive or deductive category development (Mayring, 2000). In contrast, a quantitative approach to content analysis is deductive in the sense that the researcher applies preselected categories to quantify the frequencies of those variables in the data.

A qualitative approach to content analysis is usually inductive and it starts with a close reading of the material in order to derive new categories and meanings from the data. However, the division between inductive and deductive approaches in social research is the focus of many debates, especially in relation to qualitative approaches such as grounded theory. An idealized version of grounded theory would argue that various themes "emerge" from the data when the data is approached without any pre-existing theories or preconceptions. A more realistic approach is to recognize that there are always some existing knowledge and cognitive processes that drive the analytical process and influence the analysis of qualitative data. As an alternative to "a purely inductive approach", it has been suggested that this pre-existing knowledge should be made explicit in qualitative research, for instance by utilizing "sensitizing concepts" that

can provide starting points for the analysis and interpretation of the data (Bowen, 2006).⁸⁵ Qualitative analysis is almost always an iterative process where the researcher revises previously identified categories during the entire length of the research process (Julien, 2008). Qualitative content analysis itself is not tied to any theoretical perspective or framework and the data is open to subjective interpretation and reflects multiple contextual meanings (Julien, 2008, p. 120).

4.4.2 Thematic analysis

Thematic analysis is a qualitative method used to identify, analyze, and report patterns within the research data (Braun & Clarke, 2006). It is used to organize and describe a rich data set by organizing and describing the key topics and ideas. Ideally, a theme captures important aspects of the data to address the research questions and provides a patterned response or meaningful interpretation (Braun & Clarke, 2006, p. 82). Thematic analysis is seen as a particularly flexible approach, and it can be used to produce both data-driven and theory-driven analyses (Clarke & Braun, 2013). Thematic analysis is often not only descriptive but aims at an interpretation of the data.⁸⁶ A division has been made between semantic and latent themes, of which semantic themes are constructed from the explicit

⁸⁵ The term “sensitizing concept” was introduced by sociologist Herbert Blumer (1954, p. 7) who contrasted it with “definitive concepts” by writing: “A definitive concept refers precisely to what is common to a class of objects, by the aid of a clear definition in terms of attributes or fixed bench marks. . . . A sensitizing concept lacks such specification of attributes or bench marks and consequently it does not enable the user to move directly to the instance and its relevant content. Instead, it gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look. (Blumer, 1954, p. 7; cited in Bowen, 2006).

⁸⁶ According to Merton (1975), political scientists concluded that content analysis was not a sufficient method to analyze communications and especially propaganda; therefore, thematic analysis was developed to better “identify implicit as well as explicit themes in order to infer states of mind of the communicator and to interpret responses to the communication” (Merton, 1975, p. 336).

and surface meanings of the data, i.e. what is being actually said.⁸⁷ On the other hand, the analysis of latent themes involves an interpretive process to identify the “underlying ideas, assumptions, and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). In contrast to content analysis, thematic analysis involves making contextual linkages and reintegrating the analysis to its source whereas content analysis can involve coding the data without connecting the findings to the original account and its context (Ayres, 2008, p. 867).

There are no universal, step-by-step guidelines for conducting a thematic analysis, however, on a more general level, Braun and Clarke (2006) have outlined the six phases of thematic analysis:

- (1) Familiarization with the data;
- (2) Generating initial codes;
- (3) Searching for themes;
- (4) Reviewing themes;
- (5) Defining and naming themes;
- (6) Producing the report.

Similarly, Ryan and Bernard (2003) suggest that thematic analysis consist of at least four separate tasks: (1) Discovering themes and subthemes, (2) winnowing themes to a manageable few, (3) building hierarchies of themes or code books, and (4) linking themes to theoretical models (Ryan & Bernard, 2003, p. 85). In addition, Ryan and Bernard (2003) share useful strategies on how to induce themes from empirical data. These strategies can be briefly listed as identifying features such as repetition, indigenous

⁸⁷ Saldaña (2016, p. 297) describes a theme as “an extended phrase or sentence that identified what a unit of data is about and/or what it means. A theme may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon). Themes can consist of such ideas as descriptions of behavior within a culture; explanations for why something happens; iconic statements; and morals from participant stories.”

categories⁸⁸, metaphors or analogies, transitions, similarities and differences, linguistic connectors, missing data, and theory-related material (Ryan & Bernard, 2003). Ayres (2008) outlines thematic analysis as a data reduction and analysis strategy to categorize, summarize, and reconstruct the data to capture the important concepts within it (Ayres, 2008, p. 867). In contrast to various open coding strategies (e.g. grounded theory), thematic coding aims at data reduction by providing only the essential and condensed descriptions and interpretations. An essential part of the coding process in qualitative research is writing memos and notes based on the codes. In general, memos can assist the researcher by providing insights and summaries that can be later organized into subcategories and themes.

Through content and theme analyses, this study aimed at gaining an insight into underlying factors that have had a negative or positive influence on the implementation of intersectoral action for health.

4.4.3 Process of organizing qualitative data

The process of organizing qualitative interview data normally involves extracting the data from personal notes and/or audio recordings. With regard to recorded interviews, there are several transcription levels, where the most accurate is a word-for-word transcription that includes elements such tone of voice, body language, and pauses. These factors are relevant when applying some specific methodologies such as conversation analysis. However, depending on the research approach, it is often sufficient to transcribe only the key messages and themes. For instance, Saldaña writes that probably a majority of researchers “feel that only the most salient portions of the corpus related to the research

⁸⁸ Ryan and Bernard (2003, p. 89) explain the term “indigenous categories” in relation to unfamiliarity: “Another way to find themes is to look for local terms that may sound unfamiliar or are used in unfamiliar ways. Patton (1990:306, 393–400) referred to these as ‘indigenous categories’ and contrasted them with ‘analyst-constructed typologies’.”

questions merit examination, and that even up to one-half to two-thirds of the total record can be summarized or 'deleted', leaving the remainder for intensive data analysis" (Saldaña, 2016, p. 17).

As an alternative to full verbatim transcription of interview data, Halcomb & Davidson (2006) have suggested an alternative method of data management, which they describe as "a cost-effective, constructive, and theoretically sound process through which to manage verbal interview data" (Halcomb & Davidson, 2006, p. 42). Their suggested process of data management comes with six steps: (1) Audiotaping of interview and concurrent note taking, (2) reflective journalizing immediately after an interview, (3) listening to the audiotape and amending/revising field notes and observations, (4) preliminary content analysis, (5) secondary content analysis, and (6) thematic review (Halcomb & Davidson 2006, p. 41-42).

The above process also resembles the method utilized in this study. In addition, I imported interview recordings to NVivo, and they were available to me during the whole research process. The first stage of my analysis consisted of writing detailed summaries of the interviews on text-processing software. The second stage involved constructing summary tables that were categorized based on the research problem (e.g. "what is intersectoral action for health", "challenges", "opportunities"). The third stage entailed importing the transcribed documents to NVivo for further analysis.

My analysis involved listening to the interview recordings, writing detailed memos of the interviews, and later closely reading the memos.⁸⁹ There were multiple rounds of

⁸⁹ Maietta (2008) describes the purpose of codes in qualitative research: "Codes are used to organize sections of text into key topics defined by researchers. A review of text by codes is a key component of diagnosing patterns of discussion within qualitative data" (Maietta, 2008, p. 105).

coding and producing higher-level categories based on the sub-codes.⁹⁰ The interpretive process was guided by a group of sensitizing concepts that were derived from the existing literature. These concepts included “health”, “the social determinants of health”, “the right to health”, “health promotion”, “intersectoral action for health”, and “governance for health”. Through the understanding of the above concepts, I obtained an interpretative framework for answering my research questions: (1) The understanding of intersectoral approaches to health (what it involves, why, and how), (2) challenges and barriers related to the implementation of intersectoral action for health, and (3) facilitating factors and opportunities related to the implementation of intersectoral action for health.

While conducting the coding with NVivo, I repeatedly listened again to the interviews to make sure that I did not fail to catch any important viewpoints. As suggested by Firmin (2008), I looked for repeated statements and ideas in the interview data and wrote a number of short memos to summarize the key points raised by the informants. These reoccurring ideas led me to a number of themes concerning the barriers and opportunities for intersectoral action for health. The evolution of my themes followed the description by Ayres (2008, p. 867), who writes that in thematic coding, “coding categories are reconceptualized, renamed, reorganized, merged, or separated as the analysis progresses; categories are seldom static and never inviolate, as they are subject throughout the analysis to the search for alternative interpretations or disconfirming evidence.” Although the data was collected through semi-structured interviews, I did not intentionally raise specific challenges or opportunities during the interviews that I would have expected the informants to talk about. From this perspective,

⁹⁰ Qualitative analysis can be carried out in a traditional way “by hand”, which involves using pen and paper. Another option is to use a word processor and spreadsheet software, such as Microsoft Word and Excel. However, there are many specialized computer programs available that can facilitate the analysis and help to sort out qualitative data (Maietta, 2008). In this study, the choice for a computer-assisted qualitative data analysis software was NVivo 9 by QSR International (<http://www.qsrinternational.com>). NVivo has become a widely used academic standard and it is available for both Windows and Mac computers.

the final themes resulted from a data-driven inductive process. The process of formulating my themes involved de-contextualizing data from the interviews to represent a more generalized phenomenon, which was later followed by re-contextualizing these ideas into themes. The process resulted in ten key challenges/barriers and ten key opportunities/facilitators for intersectoral action for health, which are examined in the findings section of this dissertation.

4.4.4 Limitations

A few important limitations apply to this study. In this PhD project, it was not possible to assess inter-coder (or inter-rater) reliability. The term inter-coder reliability refers to the extent to which independent coders reach the same conclusions when analyzing the same material (Lombard, Snyder-Duch, & Bracken, 2010). A higher level of reliability and consistency can be achieved when two or more coders end up with the same categories or reach an inter-coder agreement. This study was carried out by one researcher, and therefore an inter-coder evaluation of codes and themes was not possible.

Another limitation of this study is related to the homogeneity of the informants. The use of a sample embedded within the WHO limited the potential for identifying alternative voices that might question the value of an intersectoral approach to health. The informants of this study were “insiders” within WHO with a particular understanding of intersectoral action for health. In addition, in their professional position they were strongly expected to support the overall strategy of their organization where commitment to intersectoral action for health plays a major role.

Many of the expert informants shared similar educational and professional backgrounds and worked in the same organization. This was considered a strength because it provides deeper insights into the views of the selected expert group, but it can also be seen as a weakness. In other words, some important and relevant insights into the studied phenomenon might not occur if the informants are too similar to each

other. In this study, a thematic analysis indicated that saturation of the data took place because not many new themes occurred after approximately twenty interviews. In the future, the above limitations could be avoided by involving multiple researchers in the coding process and expanding the scope of informants to include other organizations and/or other sectors besides the health sector.

As a researcher, I explained that the data will be used in my PhD dissertation, which focuses on the barriers and facilitators to the implementation of intersectoral action for health. The relationship of the researcher to some subjects was collegial, but in most cases they met for the first time at the interview. The Director of the Division of Policy and Governance for Health and Well-being at the WHO Regional Office for Europe had informally encouraged the informants to participate in the data collection of this study. It is likely that this encouragement contributed to the high participation rate, as only 2 of 30 identified informants did not give an interview. However, it is unlikely that the endorsement from the senior management would have caused any major coercion in terms of the key findings of this study. However, two perspectives could be considered in this context: (1) An assumption can be made that the informants were less likely to openly criticize their supervisors or the management structure of WHO, and (2) due to strong organizational support for intersectoral approaches, the informants were likely to voice the importance of the project. The core focus of the interviews was on the barriers and facilitators of intersectoral action, of which many are at a very general level. In this context, the limitation could be that the informants may have become hesitant to speak about internal inefficiencies in relation to the WHO structures, management, or working methods in general. However, as a researcher, I did not see this as posing a significant risk that would distort my findings as my main focus was not on the WHO's internal work, but on the universal barriers and facilitators to intersectoral action for health that are generally located outside of WHO structures.

4.4.5 Ethics

From the ethical perspective, the risks of my study were considered to be minimal, as great care was taken to maintain confidentiality and high ethical standards. The interviewees in this study did not form a disadvantaged and vulnerable group of people, but were rather the opposite by being high-status individuals. Some of the risks included informants disclosing confidential information and not being aware of doing so at the time of their interview. In addition, they could have shared politically contested ideas and opinions that could have endangered their professional position. However, the challenge was minimal, as it was more likely that the informants' high positions gave them experience in sharing only information filtered for political acceptability. As a benefit to the participants, it was highlighted that they are provided with an opportunity to reflect upon their activities in working in health policy and perhaps gain new insights into their work.

After my dissertation proposal was approved by my supervisory committee, it was submitted to York University's Ethics Review Committee for approval. As part of the process, I obtained a training certificate that is issued after successful completion of the "Tri-Council Policy Statement 2 (TCPS 2) Course on Research Ethics." Three guiding principles of the TCPS 2 on Ethical Conduct for Research Involving Humans are (1) respect for persons, (2) concern for welfare, and (3) justice (CIHR, NSERC, & SSHRC, 2010). The above principles guided my dissertation research.

The informants for this study were asked to sign an informed consent form and a copy of the form was provided to them. During the research process, the data (recorded interviews and notes) were securely stored on a personal computer protected with a password. Hardcopy data (e.g. transcripts) were securely stored in a researcher's personal locked storage cabinet and the print-outs will be destroyed upon the completion of the dissertation. In addition, after the final submission of the dissertation, the electronic data

were encrypted with a strong Advanced Encryption Standard (AES) algorithm for long-term storage and archived to an external hard disk.

CHAPTER 5: FINDINGS

This chapter reports the key findings based on a thematic analysis of the key informant interviews. First, the informants' understanding of the key concepts is summarized in order to gain insights into how they understand intersectoral collaboration and governance for health. Second, the key challenges and barriers to intersectoral action are presented in ten thematic areas that were derived through content and thematic analyses of the interview data. The foundation of this categorization lies in the perspectives that key informants brought up when they were specifically asked to discuss challenges and barriers to intersectoral action for health. Third, the key opportunities and facilitating factors are organized under ten main themes that reflected the perspectives of the informants.

It is important to note that the following categorization highlights the priorities of informants. However, it should also be noted that very often challenges and opportunities are the opposite sides of the same coin, and their interpretation depends on the chosen perspective, as the following informant states:

I mean what has facilitated intersectoral action and what has made it more difficult are often the same things in the sense that the presence of something has facilitated it and the absence of it has been the barrier. (Interview 2)

The focus of this study was on the factors that were highlighted by the expert informants and ensuring that their professional as well as subjective perspectives are respected when presenting the research findings. Direct quotations from the informants are used to exemplify some of the key findings as well as give informants their own voice to describe the important factors that can influence intersectoral policymaking and related policy processes. In summary, the following thematic analysis aims at a comprehensive review of the specific factors that are seen as having a negative or

positive effect on the implementation of intersectoral mechanisms and initiatives at the local, regional, national, and global levels of governance.

5.1 Understanding of the key concepts

At the beginning of each interview, a research informant was asked a direct question on how he or she understands the concepts of “intersectoral action for health” and “governance for health.” In this study, this clarification of the key concepts was seen to be important before the informants were asked any further questions about possible challenges and opportunities that can influence the implementation of intersectoral mechanisms and initiatives. The following two sections focus on the conceptual understanding of the key terms of the study.

5.1.1 Intersectoral action for health

The key informants were asked how they understand the concept of intersectoral action for health in light of their own programmatic area and professional experience. In general, informants expressed that intersectoral action for health is nothing new but it is gaining in importance and the rhetoric justifying intersectoral collaboration is getting stronger. A number of informants highlighted that the European health policy framework, Health 2020, is the key strategic vehicle for promoting intersectoral action in the WHO European Region (WHO, 2013b).⁹¹ In addition, the current UN Social Development Goals (SDGs) were seen as providing support for engaging a wider array of sectoral actors in promoting health (UN General Assembly, 2015). The work of the Commission on Social

⁹¹ The Health 2020 policy framework has four priority areas: (1) Invest in health through a life-course approach and empower citizens, (2) tackle Europe’s major disease burdens of non-communicable and communicable diseases, 3) strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies, and (4) create supportive environments and resilient communities (WHO, 2013b).

Determinants of Health (2005-2008) and its final report (WHO, 2008a) were seen as important milestones that have increased the awareness of the complexity of the determinants of health. For example, one informant said, “During the past 10 years there has been a huge shift towards intersectoral action in my area; previously the perspective was narrower” (Interview 18). Another informant reflected the evolution of the concept in the following way:

Intersectoral action is a concept that has been around in public health for many years. It goes back to *Health for All* and even before, so it has at least thirty-five years of history. It was always known that to achieve certain health outcomes, you cannot do it alone in the health sector. But as our evidence accumulated over the years, we have much stronger arguments to demonstrate why intersectoral action, Whole-of-Government approaches, Health in All Policies and so on, are compelling if we are to address health properly. (Interview 20)

All key informants expressed the view that the health sector by itself can never fully promote the health and well-being of the population. The informants shared the view that collaboration and cooperation across sectors is needed if a government wants health promotion to be truly successful. In every programmatic area, there are health challenges that require intersectoral action to tackle them effectively. The shared understanding was that factors and policies influencing health go far beyond the health sector itself. Similarly, informants stated that intersectoral action is a very relevant approach for them. One informant working with vulnerable groups’ health issues said, “This work would not be possible without different sectors working together” (Interview 3). Another informant similarly said, “In my area, we cannot improve health without involving other sectors outside of the health sector, especially sectors such as education, legal sector, and social welfare, just to mention a few” (Interview 1). The recurring rationale that justifies and also demands intersectoral policymaking was expressed in the following way:

Intersectoral action for health means that in order to achieve meaningful health outcomes you need to involve sectors beyond the health sector; therefore you need joint efforts from different sectors, or in some cases even just one [non-health] sector to have a health impact. (Interview 9)

The idea of sectors working together was seen to be a more holistic approach to health and its determinants. The increased awareness of the drivers of health, or “causes of the causes”, was seen to result in a more comprehensive but more complex understanding of health in general. This wider approach to health was seen to be based on compelling arguments with a solid base in scientific evidence. The form and concrete examples of intersectoral action varied depending on the professional area of the informant. The concrete meaning was reflected through different programmatic actions, implementation structures, and partnerships. The titles of specific case studies that were mentioned in the interviews can be found in Appendix D.

These case studies were considered to exemplify intersectoral action in different areas and levels of action. Due to the nature of the work of the informants, many of these case studies were implemented at the international level. As a more comprehensive data collection effort, the WHO Regional Office for Europe has carried out a mapping exercise to collect intersectoral initiatives from the countries across the European region, and those results have been published elsewhere (WHO, 2016a).

One of the core features of intersectoral action for health was identified as formal and informal collaboration between sectors towards health goals. In concrete terms, this was seen as ministries or organizations with different mandates working together, horizontally or vertically, to attain specific health goals. The type of collaboration was seen to be dependent on the nature of action, for instance, whether it was technical or political. Technical collaboration could involve experts from the various fields working on shared health-related goals, such as preparing guidelines, recommendations, and

standards to address health issues in policy areas that were not directly under the guidance of the health sector. Political collaboration could mean political decision-makers negotiating on national or regional priorities and finding ways to distribute resources to address health problems.

The cooperative approach was seen as necessary as well as cost-efficient, since coordinated efforts are able to produce more sustainable outcomes. In terms of coordination, an interesting difference was seen between the terms “multisectoral” and “intersectoral”, in the sense that multisectoral action did not necessarily indicate that sectors collaborate and communicate in a coordinated way. One informant described this difference by stating:

Intersectoral action for health is about the collaboration of different sectors that are working together to achieve specific health-related outcomes. Intersectoral implies that they are working together. Multisectoral, on the other hand, is another term that is more about a number of sectors working for certain area of health, but not necessarily collaborating together. (Interview 20)

In other words, “multisectoral action for health” might be aimed at the same goals, but without intersectoral coordination. The question of coordination is closely linked to the need to attain policy coherence in the government’s action and strategies.⁹²

Generally, informants expressed two views on the question of who is leading intersectoral work for health. Some informants highlighted the role of the health sector by

⁹² According to OECD (2002), policy coherence means “different policy communities working together in ways that result in more powerful tools and products for all concerned. It means looking for synergies and complementarities, and filling gaps, between different policy areas to meet common and shared objectives” (OECD, 2002, p. 34). A similar but a more concrete description defines policy coherence as “the systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the agreed objectives. Within national governments, policy coherence issues arise between different types of public policies, between different levels of government, between different stakeholders and at an international level” (TCD, 2010).

saying that in intersectoral action, other sectors should coordinate their efforts with leadership provided by the health sector. On the other hand, several informants saw the role of the health sector more as a flexible facilitator. From this perspective, it should not be expected that the health sector can easily impose its own goals on other sectors (cf. the discussion on health imperialism). The informants called for a more sensitive and “politically savvy” approach to get collaborators and partners committed over sectoral boundaries. In some cases this was seen to require adapting and learning the culture and language of the other sectors. Furthermore, it was seen to be important to understand the inner logic that drives the work in other sectors, especially their values and modes of operation.

Numerous informants emphasized the importance of seeing win-win situations and finding co-benefits across sectors (see Section 4.2.2.4). The co-benefits approach requires paying close attention to actions that can have two separate effects: (1) promote the health of the population, and (2) benefit all the sectors or partners involved. It was stated that not enough attention has been paid to carrying out a systematic mapping of health-related co-benefits. The results of such a mapping could be used strategically to establish a new intersectoral collaboration. One informant wanted to highlight that other sectors continually promote health and do it effectively without any involvement of the health ministries or departments.

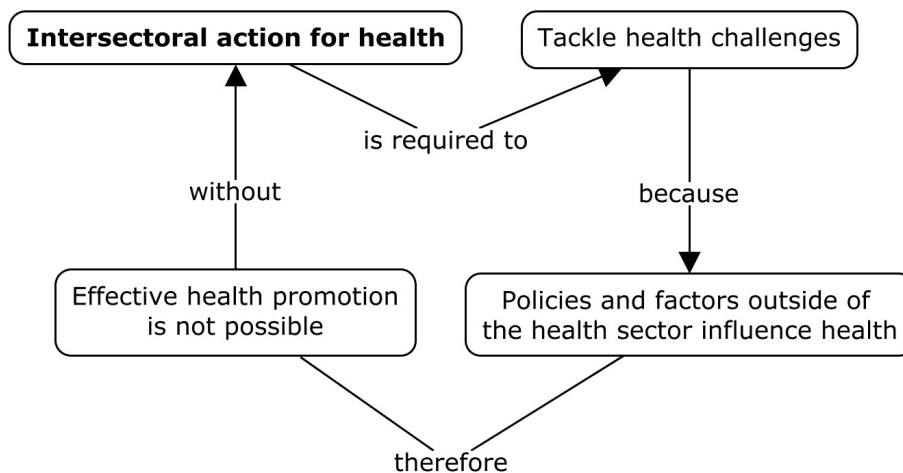
Discussion and implications

During the interviews, it became clear that the question “what is intersectoral action for health” should be discussed together with questions such as “why is intersectoral action important?” and “why should health be promoted through intersectoral collaboration?” Many informants wanted to emphasize that intersectoral action is absolutely necessary for their work and health cannot be effectively promoted without engaging non-health actors. As one informant said, “If we restrict our work to the health sector, nothing will

change” (Interview 10). This brought up a key rationale for intersectoral action for health that was reoccurring throughout the interviews (Figure 1).

The idea presented in Figure 1 can be summarized by concluding that intersectoral action for health is required to tackle health challenges because policies and factors outside of the health sector can have a significant influence on the health of a population, and therefore, effective health promotion is not possible without engaging non-health sectors in health promotion activities.

Figure 1. Key rationale for intersectoral action for health in the interviews



A small number of informants reflected on the history of intersectoral collaboration and the terminology it has produced. However, no one expressed the view that some terms would be better than others, although they might have slightly different meanings in different contexts. With clear similarities to the framing of this dissertation, one informant suggested the use of intersectoral action for health as an umbrella concept for approaches that focus on intersectoral collaboration for health:

Intersectoral action, Healthy Public Policy, Health in All Policies, Whole-of-Government, and Whole-of-Society, they are all part of the same continuum. What

is different is the fact that those terms were used at different times, when the political context and the evidence were different from what it is, for example, today. So we have to understand that, and second, there are some differences between them. Depends on how you look at them, and I personally think that it is dangerous to try to over-intellectualize these definitions. And that is the reason why this year in our paper, we speak about intersectoral action for health as a proxy to cover all of them. (Interview 20)

The terminology referring to collaboration across sectors has changed and evolved during the past four decades. This can be seen as a natural adaptation to surrounding political and cultural realities. Most likely for this reason, the informant expressed the view that scholarly research can provide new insights, but it is equally important to respect the conceptual evolution of different intersectoral approaches:

It would be nice to have a scholar to identify those differences, and of course there are people who have preferences, so there are some colleagues who prefer to hear Health in All Policies rather than Whole-of-Government. But when we talk in detail we talk more or less about the same thing. [...] However, we also have to be also respectful of the evolution of these concepts and how they emerged. So I would not be dismissive. (Interview 20)

Generally, it can be concluded that how informants defined “intersectoral action for health” was aligned with the literature definitions reviewed for this study. The informants highlighted different aspects of intersectoral collaboration and saw that often the health sector leads these efforts but acknowledged that sometimes the primary leader and implementer of policies can come from a non-health sector. For instance, one can consider significant improvements in road safety. The introduction of speed limits, seat belts, safer vehicles, and many other factors have been implemented and enforced by the non-health sector. These sectoral actions have had positive health implications, as they have decreased the number of traffic accidents. A similar example can be easily found in the field of food safety where regulations in food production and storage have

decreased the number of food poisonings. Probably the most important finding was that all informants held the view that their work could not be carried out effectively without engaging actors outside of the health sector. Intersectoral collaboration was seen to stand as a necessity for the promotion of health in all policy domains.

5.1.2 Governance for health

Governance for health is one of the key concepts in the Health 2020 policy framework, which acts as a guiding high-level strategy for the work of the WHO Regional Office for Europe. An increased focus on governance mechanisms has been used to direct attention to the political, social, and economic contexts where health-related policies are implemented. In this study, the key informants were asked what the concept of “governance for health” means for them and how it is applied to their own programmatic area. Governance for health can be understood as a result of collaboration that goes beyond sectoral boundaries, i.e. governance is something that makes intersectoral action for health possible through a number of governing mechanisms, practices, processes, and institutions. As defined in the literature section, governance itself is a wide concept that considers the relationships between different sectors within and outside of the government. The key questions are related to the use of power, mechanisms of governing, and ways in which interests are mediated. During the research process, it became apparent that there was not a single definition of governance for health that recurred throughout the interviews.

The informants used “governance for health” to refer to contextual dimensions such as structural arrangements as well as accountability and regulatory frameworks. Similarly, governance was seen to refer to the way in which governments implement and monitor policies, laws, and regulations. Intersectoral action was considered as more self-explanatory and also as a more commonly used term than governance, although a few informants expressed the view that they favour the use of the term “governance for

health” over “intersectoral action for health.” For instance, the following informant preferred the use of the term governance because it provides a broader perspective on factors that influence health:

I like the term governance much more than intersectoral action, to be honest, because for many people intersectoral action for health means that it is enough when you have these ministries and people from different sectors working together. I mean governance is something else. Governance is something where you have common objectives and a framework for monitoring, evaluation, and accountability. This type of governance is of course based on intersectoral collaboration. But for me governance is always something more than intersectoral action. (Interview 10)

Governance for health was associated with the definition of “good governance”, which entails factors such as accountability, cooperation, transparency, leadership, and sustainability. One informant who worked in the prevention of infectious diseases expressed the view that good governance for health means that the work is organized “according to internationally accepted best practices, standards, and guidelines” (Interview 13). The same informant highlighted that regular reviews and the existence of credible monitoring mechanisms have to be an essential part of good governance. According to another informant, making accountability relationships clearer is one of the main programmatic goals in improving governance for health:

At least in our program, we define governance as providing the regulatory and legal framework but also accountability relationships: who is accountable and for what, which roles and responsibilities there are, what policies that are in place, and so on. And this is what we target in the program, to change the accountability relationships or clarify them. (Interview 8)

If you think of the Alma-Ata declaration or Health in All Policies, I think that the idea of working together has always been there, it is just how you do it. I think that the barriers are always the same: you need to get people on board to work together, you need to create win-win situations, you need to have shared

understanding and common goals. I think that everyone can agree on the concept, it is just how to make different sectors work together and to organize the governance on this. I think we do not have the golden bullet yet, but we have to think how to make governance around this better. (Interview 24)

Moreover, promoting good governance for health was seen to require identifying and strengthening mechanisms and structures that have an influence on the determinants of health. One informant referred to governance for health as an outcome of successful intersectoral collaboration, whereas another saw it as an umbrella structure that makes intersectoral action for health work. Another informant described governance as the way work to promote health is managed and structured by pointing out that governance is not “what” but “how”:

Governance for health is very much about how you build mechanisms and infrastructure for public health work. It is about relations, it is about engaging other sectors, it is about how you build trust. It is very much how you manage this work, for example, what kind of mechanisms you have and how you involve institutions. So governance is not ‘what’ but ‘how’. (Interview 3)

Creating and increasing policy coherence for health was seen as an important policy objective that refers to the process of getting different sectors and stakeholders to work harmoniously to advance health-promoting policies. It was considered to be essential that health-promoting and intersectoral structures are coherent but also sustainable so that they do not cease to exist more quickly after a change of government.

The implementation of accountability and monitoring frameworks was seen to be difficult or sometimes impossible if there is no commitment to these goals at the highest political level. In other words, political will and commitment to health-related goals was considered to be an essential part of governance for health. The scope of the WHO’s mandate was one of the themes that informants frequently mentioned. A number of informants expressed the view that a clear framework for health governance could give a

more definite mandate to work across sectors, which also makes it easier to engage non-health actors.

The informants focused on the work of national governments and ministries. They did not provide in-depth reflections on the role of the state as an entity or questions on the relationship between the public, private, and non-governmental sectors. In other words, challenges and opportunities were not specifically considered in the light of power relationships between these sectors. The general focus in the interviews was on intersectoral action as it occurs within national governments. In the next two sections, I will provide a thematic analysis of the challenges and opportunities for the implementation of intersectoral action for health.

5.2 Implementation challenge: thematic analysis

The literature review for this study showed that intersectoral action for health is a policy idea that has a long history, but its implementation at different levels of governance has proved to be challenging. Probably the most significant shortcoming is the scarcity of permanent intersectoral mechanisms and structures for coordinated efforts for health. The question is how to attain better policy coherence at the horizontal and vertical levels of governance, i.e. sectoral policies that are mutually supportive and do not act against each other's objectives.

The following thematic analysis focuses on the key challenges and barriers as well as the opportunities and facilitating factors that were highlighted by the informants. The thematic division of challenges and opportunities follows the prime concerns and priorities expressed by the key informants themselves. The discussion of these impeding and facilitating factors was in most cases carried out on the separate parts of the research interviews. However, it is important to note that the separation of challenges and opportunities is more or less artificial, since each factor can be looked at from the opposite side, i.e. the opposite of not having political will (as a barrier) is the existence of political will (as a facilitator). By combining both perspectives, one can construct a taxonomy of key factors that have an impact on the implementation of intersectoral action for health. Analyzing these factors is necessary in order to identify the preconditions for effective governance for health.

The aim of the following section is to answer the key questions of this study, more specifically, this means reviewing in a systematic way two core questions: (1) Which factors act as the main challenges and barriers to intersectoral action for health?; and (2) which factors facilitate the implementation of intersectoral action for health? The WHO informants for this study form an experienced group of knowledgeable professionals in health policy who can be expected to provide a comprehensive picture of the above research questions.

In the beginning of each section, I identify the main theme and provide an analysis of its contextual meaning. In addition, I provide illustrative quotations from the key informant interviews to provide the reader with further insights into how these themes were actually discussed by the informants. To conclude each section, I make a brief reference to whether the findings were relevant in light of my literature review. My closing statement in each thematic section aims to answer the question of whether the specific theme can be seen as expected or unexpected in relation to the current academic and policy literature that was reviewed in Chapter 2. The general importance of my findings is not examined as part of the analysis section but will be further considered in Chapter 6, which provides the discussion and summarizing conclusions of this dissertation.

5.2.1 Challenges and barriers

A barrier can be understood as a circumstance or obstacle that prevents progress in some field, whereas a challenge can be defined as a competitive situation or task that tests someone's abilities.⁹³ In terms of intersectoral action for health, these barriers and challenges can exist on various levels, including the institutional, political, informational, and cultural, among others.

This section identifies the reoccurring challenges and barriers to intersectoral action for health by thematic categorization. Table 5 outlines how many informants highlighted specific thematic challenges and barriers. Almost every theme has a connection to another theme. These links will be dealt with in more in detail in the discussion and conclusion sections of the study.

⁹³ See the Oxford Dictionary of English (3rd Edition, 2010), available online via Oxford Dictionaries Online: <https://www.oxforddictionaries.com/>

Table 5. Number of informants discussing specific challenges and barriers (N=28)	
Theme (challenge/barrier)	Number of interviews where theme was discussed
1. Narrow view of health and its determinants	13
2. Low level of political leadership and commitment	14
3. Competing interests and competition for resources	17
4. Lack of permanent implementation mechanisms	21
5. Lack of resources for implementation	9
6. Complexity of the policymaking processes	5
7. Not sharing the same language and concepts	6
8. Limited authority and mandate of the health sector	9
9. Lack of ownership and management	5
10. Potential conflicts of interest	3

5.2.1.1 Narrow view of health and its determinants

A narrow view of health and its determinants was mentioned as one key barrier that can hinder the support for intersectoral action for health. This narrow view was seen to be manifested both inside and outside of the health sector. In this context, the narrowness refers to seeing health and its determinants from individualistic and biomedical perspectives. As shown in the literature review of this study, throughout its history and especially after the Ottawa Charter (1986), WHO has promoted socio-environmental approaches to health challenges, and none of the informants of this study argued for a narrow limiting of health-related work to only biomedical or behavioural interventions.

One of the challenges is that politicians and civil servants do not necessarily share WHO's broad view of health.

This narrow thinking is always a contextual phenomenon and can be better understood through concrete examples. The following four examples from different programmatic areas can provide insights into what the narrow perspective to health can mean and how the chosen perspective can influence the proposed solutions. The first example considers sexual and reproductive health. Here, the informant stated that "the biggest barrier is that there is a lack of understanding and a lack of knowledge of these intersectoral connections" (Interview 1). In addition, the informant brought up that there are certain cultural barriers that might hinder the opportunities to promote sexual health because the area is often considered a private matter, and therefore outside involvement is not seen as appropriate. Although the informant also argued that sometimes non-professionals might easily understand the need for intersectoral action:

A key barrier is misunderstanding, or not understanding, why another sector should be involved in an area of health; especially when we mention sexual and reproductive health. In some countries, the term "sexual health" scares people, and the meaning of it does not translate easily. This can be a very private matter for many, and we have to work hard to advocate on these issues. There is a lack of understanding of the importance of intersectoral collaboration in sexual and reproductive health in general among professionals. When it comes to a private person, then it can be much easier to understand. Everybody agrees with the statements: "I want my children to be healthy" and "I want my grandchild to be born healthy". One of the biggest barriers to us is that there is a lack of understanding and a lack of knowledge of these intersectoral connections. (Interview 1)

Another informant, specializing in food safety, stated that sometimes the representatives of the health sector are not open to or do not understand why there should be intersectoral engagement. These national counterparts representing the Ministry of Health need to be encouraged to invite representatives from other sectors:

I very much emphasize the importance of working across sectors, but I do see that sometimes there is resistance in the counterparts in several countries. Just recently we organized a training course on antimicrobial resistance in food-borne pathogens. We had an in-country training course with international professionals from various relevant sectors to present. However, we had to repeat to the national counterpart many times that we would like to see them inviting people from the veterinary sector as well, not just representatives from the Ministry of Health. So it was challenging to get them to understand why these professionals from the other sector should be invited. (Interview 4)

Similar challenges were met by an informant working on gender and health. In this case the challenge was to get the health sector to understand that gender issues should be on their agenda and that non-action can have significant health consequences. One example was that the health sector deals with the symptoms of domestic violence experienced by women but does not necessarily have referral mechanisms and other means to address the core root of the problem, i.e. violence at home, by engaging social and law enforcement professionals. Another example was related to the socioeconomic inequalities manifested in cases where women do not have real opportunities to receive good care because they do not have access to the financial resources needed to access health care:

One main challenge is to get the health sector to understand and perceive that gender is part of their agenda as well. In many cases, the ministries of health are happy to leave gender issues to other ministries and other sectors. Because in many countries the health sector does not perceive that gender issues are among their responsibilities. For instance, women do not come to prenatal care in countries with rural areas. But the health sector says that services are there, women just do not come. One of the reasons we have seen in rural areas, especially in Central Asia, is that women do not come because they have to make out-of-pocket payments and women do not have control over the economic resources. They do not get to go to the doctor when they have to because women's health is not valued. So those are barriers that are determined by

socioeconomic inequalities associated with gender norms and values. So the health sector may say that there is nothing we can do about it. (Interview 9)

An informant working with antimicrobial resistance (AMR) stated that the problem in his field is deeply rooted in the practices within the agricultural and health systems. A lack of awareness of the wider determinants of health is combined with the challenging nature of the problem, as cost-benefit analyses related to AMR are difficult to carry out. In many cases, it is not easy to say when people have died because of antimicrobial resistance. However, the intersectoral connections behind the growing resistance to antibiotics have gained more attention in recent years, and now it is more widely recognized as a serious problem that might become a global threat facing the whole human civilization. Multiple informants suggested that there is a need to act by multiple sectors, even when there rarely is complete indisputable scientific evidence of the effectiveness of these actions. An informant working on the environment and health stated the question of evidence in public health in the following way:

In general, we know that intersectoral action for health is effective, but we know less about the effectiveness of very specific interventions. [...] It is also a methodological question as we cannot do randomized controlled trials. Sometimes we limited our actions too much because of a lack of evidence. (Interview 2)

The narrow view of health is closely linked to the silo thinking in institutions and government structures. One informant stated that thinking in silos is very embedded within institutions and the existing silos could be influenced by increasing people's awareness of the intersectoral nature of health. The mandate to work across sectors is also related to the perspective of health as well as of institutional silos. A too-limited mandate does not allow the health sector to cross these sectoral boundaries to engage other actors even if it might be clear that their actions have clear health implications. The

questions related to silos and mandates are considered in more detail in the later sections of this chapter.

To conclude, it is not very surprising that a narrow view of health was highlighted in the interviews as one of the key barriers. Biomedical and behavioural models have been dominant paradigms to understand and conceptualize health throughout the past century (Blaxter, 2010). It is difficult to justify the need for intersectoral action for health if individual lifestyle choices and genetic predispositions are seen as the most influential determinants of health. But as this thesis has argued, since the Alma-Ata declaration (WHO, 1978), the role of socio-environmental and structural paradigms has been more widely recognized. However, the dominant understanding of health has relied on seeing health as an individualized phenomena that is strongly associated with lifestyle choices (Labonte, 1993; Raphael, 2008). I will further explore these paradigms and their linkages to intersectoral action for health in the discussion section of this dissertation.

5.2.1.2 Low level of political leadership and commitment

The informants for this study were working mainly with national governments. One of the key barriers expressed in the interviews was related to a lack of political commitment and leadership. Several factors can be seen as influencing the willingness and capacity to implement intersectoral mechanisms for health. It was mentioned in multiple interviews that the Ministry of Health is often a relatively weak actor, for instance, in comparison to the Ministry of Finance, which has a significant amount of power to set the budgetary limits of other ministries. A weak ministry or Minister of Health usually has a negative impact on how health-related matters are valued and supported by other sectors within national governments, as the following informant states:

The first barrier is a lack of leadership from the side of the Ministry of Health. Here is a practitioner speaking who sees this from a very practical perspective. I think it

doesn't help the country if the Ministry of Health or the Minister of Health is weak, has different interests or is lobbied, either politically or based on some other agenda. So I think that if the minister is not showing leadership, I would argue it is difficult to be credible vis-a-vis the other key ministers as well. If you have a strong Minister of Health who wants to push things through, then I think it would help you to show this leadership and get others on board. (Interview 18)

The natural dynamics of political systems in general were seen to be one factor that can reduce the commitment to long-term planning towards intersectoral mechanisms. Electoral cycles were fixed-term and politicians are normally worried about their credibility and support inside of their own political party as well as their support among potential voters. For example, some politicians were hesitant to engage in intersectoral work because there is a danger of sectoral and interpersonal conflicts that can have a negative impact on their future career in politics:

The way the political system is organized can be a barrier because many times these people who are ministers are worried about the situation inside their political party, but not outside of it. They are thinking more about the situation they will have after the next election and they prefer to work in a way that is practical for themselves and for their political ambitions. In my opinion, it can be quite practical for them to avoid conflicts with other ministers and to work in separated areas. (Interview 23)

Another informant states that it can be a courageous act for a politician to start something he or she cannot take the glory for, i.e. the results would be visible after a longer time period that exceeds the normal electoral cycle. Similarly, various ways to avoid the leadership role can act as a barrier, as the different sectors can blame the other sectors and urge them to take responsibility instead of taking a collaborative approach to the given health-related problem.

In terms of political barriers, it takes a lot of courage for a politician, who is working from one election to another, to put something in motion for which he or

she cannot take the glory. There is a much bigger time investment, and I guess it is a politically difficult issue because you have different sectors that should play a role but do not have a tradition of working together. There can be a lot of finger-pointing and blame games because different sectors can say the problem is caused by another sector. (Interview 22)

Similarly, the high-level involvement and commitment to health promotion was seen to be key to policy coherence as otherwise different sectors might implement a number of policies that fundamentally contradict each other:

You need high-level involvement because policy coherence is not a theoretical word. Under the Prime Minister you have the possibility to make sure that the policies of different sectors do not pull in different directions. That is the issue. (Interview, 20)

In the end, one of the key questions related to political leadership and commitment is also the perceived value of health as well as other interests that compete with health interests when public resources are allocated. Equally important is to have competent, knowledgeable, and politically skillful individuals as health ministers and civil servants within the Ministry of Health. These committed individual champions for health can at best make a huge difference if they are able to use successful tactics to promote the value and role of health matters within the government.

The importance of political leadership and commitment has been identified as one of the prerequisites to intersectoral action for health in the WHO statements on health promotion (WHO, 2009a). Along with WHO, health policy researchers have identified the role of high-level leadership as key to the successful implementation of health promotion initiatives (Begun & Malcolm, 2014; Koh & Jacobson, 2009; Rowitz, 2013). In addition, the political dynamics of short electoral cycles have been recognized as a barrier that applies to health policymaking in general (Exworthy, 2008; Howlett et al.,

2009). For the above reasons, the emphasis on the essential role of leadership was an expected result of the key informant interviews and is in line with the existing literature.

5.2.1.3 Competing interests and competition for resources

Competing interests can hinder the willingness of different actors to carry out intersectoral work. In the interviews, one reoccurring perspective was that there is constant competition for resources and recognition between sectors and disciplines at different levels. Short-term economic gains can be seen as considerably more valuable than long-term health benefits that would affect the whole population. The health of the population is not necessarily acknowledged as one of the key drivers behind social and economic development. In terms of values, equity manifested as an equitable distribution of resources is rarely given the highest priority in politics. In addition, it was seen to be too optimistic to expect that different sectoral representatives and stakeholders would get together, as there are significant barriers to such activity. The following informant had come to a conclusion that intersectoral collaboration in many cases does not come about without careful planning and coordination:

Intersectoral collaboration does not happen naturally and it is a tough walk for some countries. They look at some of these other stakeholders and there is fighting, there are jobs on the line, there is funding on the line, so they see competition. So there is not always that 'oh, would it be nice if we just hold hands and work together' feeling. In essence, people might think that 'I do not know you, I do not know what you do, you have a different work plan, you have a different funding pool.' So actually getting partners together can be very tough. (Interview 27)

The Health Minister can take action to get different stakeholders together to formulate strategies and action plans to tackle health challenges. However, the distribution of power among different sector ministries can hinder opportunities to tackle

health problems effectively through intersectoral collaboration. Positive results might require that the Minister of Health be very powerful or that the Prime Minister has a special interest in a specific health problem, as expressed by this informant:

The problem is that in many countries, the Ministry of Health is not often very powerful, and unless you have a very powerful Minister, or you have a Prime Minister with a special interest in this area, then it is sometimes difficult to achieve good results. (Interview 21)

Several informants indicated that different sectors have their own goals and objectives that are normally given priority. In other words, the sectors are required to focus on their core mission and they are unwilling to channel their resources to activities that do not help them to attain their sectoral objectives. In addition, there are conflicting interests between sectors that are also directly related to the use of power within a society. It can be concluded that these issues are related to the key questions in politics: who gets what, why, and how. However, the informants did not very often address the issues of power as directly as this informant:

Professions, disciplines, and sectors tend to work in isolation. They have their own networks, there is competition, fighting for resources, recognition, possibilities, and also a pure lack of awareness. (Interview 4)

A handful of informants highlighted how different sectors may have more or less fundamental conflicts in their core activities. As an example, one informant expressed the insight about how the alcohol industry is a powerful player and is actively lobbying against effective policies to tackle harms caused by alcohol. These policies considered effective by WHO include limiting marketing and strengthening regulations to control the pricing and availability of alcohol. Another informant, working in the field of nutrition and physical activity, asserted that sometimes the representatives of health interests are not taken seriously by others unless they threaten the interests of other sectors:

I would say that one barrier comes from the differences and opposed objectives of the sectors, and to reconcile different interests can be extremely difficult. For example, you can think of business and health interests in the field of diet and physical activity. [...] I also feel that the weakness of the health sector is a handicap in comparison to other sectors. Power and influence is really an issue. Unless you really create a reputation, you are perceived seriously; and it is only when you occasionally pose a threat to others are you then taken seriously for doing business with. (Interview 10)

Based on the interviews, it was evident that the process of managing and negotiating between opposing and conflicting interests should be one of the key concerns of anyone who plans intersectoral action for health. In many cases, these conflicts can be expected and are inherent in the dynamics of intersectoral collaboration that engages multiple actors with different core objectives. Therefore, different mediation strategies could be helpful in order to avoid the dramatically escalated conflicts that would end the collaborative process.

Within a government, different sectoral ministries depend on a certain amount of limited resources that are allocated among them. Therefore, it is expected that competition for these resources does not naturally support the tendency towards working together. Competition and collaboration have a different logics that are not normally mutually reinforcing. The role of the highest decision-makers (e.g. the Prime Minister) is critical in setting governmental priorities for allocating resources among different sectoral ministries. The recent literature on HiAP and intersectoral approaches in general have increasingly highlighted the fact that conflicting interests and competition for resources should naturally be expected (de Leeuw, Clavier, & Breton, 2014). In 2015, the WHO Regional Office for Europe published a working document on intersectoral action for health that stated: "Health is a political choice, and today many governments give priority to economic, trade and industrial policies rather than health" (WHO, 2015d). A recent WHO training manual on HiAP pays considerable attention to various mediation

strategies that health actors can use to raise health higher on the political agenda (WHO, 2015c). It is likely that health promoters would greatly benefit from increasing their skills and capacities to carry out negotiations with actors whose main interest is not health.

5.2.1.4 Lack of permanent implementation mechanisms

Multiple informants mentioned that a lack of sustainability is a major challenge that influences the scope of intersectoral action for health. In concrete terms, this means that intersectoral work is frequently not institutionalized, which means that there are no established permanent intersectoral implementation and coordination mechanisms. A change of government can lead to intersectoral collaboration having to start from scratch. Short-term working groups and other initiatives are useful, but they often do not help to attain long-term goals that require breaking down sectoral silos. This breaking down would change the work culture towards greater collaboration among different sectoral actors within a government. Similarly, it might be very difficult to see the long-term outcomes of those initiatives. One informant highlighted how sometimes a working group can create a spinoff that becomes a recognized intersectoral platform which continues its work on a long-term basis. Another informant highlighted the importance of permanent intersectoral structures that would last beyond electoral cycles:

People are changing, governments are changing, knowledge is missing because often you have invested in one minister, or a group of ministers, or one government. And when the government changes, of course you are to start all over again. (Interview 1)

In addition, the lack of coordination can lead to situations where data and knowledge are kept in organizational silos, as expressed by an informant working with health information and statistics:

I do see over and over again that there is a huge problem with coordination, especially in the East. The data can be seen as very valuable and not easily shared. There is a lack of coordination and, for different reasons, the Ministry of Health does not talk to other agencies. There could either be old laws in place that are barriers to sharing information or there could be a lack of data protection laws that are there to facilitate data sharing. (Interview 19)

Silo thinking can be deeply embedded in institutions and the change towards increased collaboration can require significant structural adjustments. One of the important questions is who should lead the intersectoral work and how different coordination mechanisms are created. Many of the informants for this study had a role in advising governments in health policy, and they felt that support from the highest level of government was an essential requirement to achieve good results through intersectoral collaboration. Any changes in the prevailing power structures can lead to varying levels of hostility. Therefore, the actors willing to change the current conditions should be prepared to address the resistance they might encounter. The participants in the intersectoral structures should feel that the work is beneficial and based on a long-term commitment. As one informant expressed, there are no quick fixes:

The ability of these committees is limited when they are seen as quick fixes. Sometimes the committees come and go, as the minister goes, the committee goes. We have seen this happen too many times. And also I think that it is important to find ways how countries can really feel that these intersectoral committees, once they have been established, are really good tools that can help the ministry to implement better policies. I think this is the best reward and the best objective for WHO. (Interview 18)

Many informants indicated that the health sector does not need to lead all the time, even when the main goal would be to change the determinants of health. For example, the major improvements in road safety were implemented not by the health sector, but by the ministries of transportation and monitored by law enforcement officers. Therefore, different kinds of capacities and actions are needed to implement intersectoral

action for health at different horizontal and vertical levels of governance. Ministerial committees at the national level have very different working methods and goals compared to working groups at the local level. In terms of achieving measurable outcomes, several informants highlighted that intersectoral collaboration at the local level is often much easier than at the national level.

At the local level, a lack of intersectoral response mechanisms can have a negative impact on efforts to prevent and solve social and health problems. There are many cases when the health sector deals with the symptoms of a bigger social problem, which could be acted on effectively only through an intersectoral response. For instance, an informant working for women's health brought up an example concerning women who are victims of domestic violence. In this case, an emergency physician representing the health sector cannot always ask women to leave their family situation if there are no adequate referral and support systems in place. At worst, the representative of the health sector could put a victim of domestic abuse at further risk by encouraging her to go to law officers in a situation where other referrals cannot be made due to a lack of supporting intersectoral structures:

We are very cautious when we work with countries that want, for instance, to start a big campaign on preventing violence against women. I might say that you do not have these support systems in place. You cannot ask women to come out with their problems if you are not going to have shelters, police response, psychological support, and support for the children. So there is a huge challenge and you cannot put those women at further risk. (Interview 9)

Nevertheless, just establishing intersectoral mechanisms was not seen to be enough. Within the intersectoral mechanisms, different actors should have clearly defined and agreed-upon goals that are understood by everyone involved. Similarly, it is important that people working in intersectoral committees, teams, and other groups have agreed on shared working methods. Different kinds of tools, such as health impact

assessments, can be used to facilitate the collaboration and to expand the knowledge base related to a specific health challenge.

The emphasis on the importance of permanent intersectoral mechanisms was an expected finding in light of the existing literature. However, many informants were also critical about setting up new intersectoral structures, as they argued that the structure itself does not solve anything. An increased focus should be put on what takes place inside of the structure and how influential it is, e.g. what kind of mandate it has, does it have clear goals, and how clear are the roles of its members. The general conclusion is that having an intersectoral committee is a good start but does not define success. In the literature, a division has been made between intersectoral structures and actions (McQueen, Wismar, Lin, & Jones, 2012). The key informants of this study confirmed the suggestion that intersectoral governance structures and actions should always be considered together.

5.2.1.5 Lack of resources for implementation

A wide set of resources, such as money, time, and knowledge are needed to implement intersectoral initiatives. Often financial resources and allocated funding for intersectoral action is one of the core requirements that can enable a long-term focus. However, the informants referred to many other resources and capacities, such as evidence, knowledge, skills, and influence. In order to implement something in a successful way, a set of these resources needs to come together at the right time and in the right context. Knowledge, skills, and action plans are not sufficient if there is not the power to obtain the necessary resources for actual implementation. In other words, just having good ideas is not enough if there is no political will, commitment, and power to implement those ideas.

The intention to increase collaboration across sectors can often clash with the core task and objectives of each sector in terms of resource allocation. For instance, an

informant expressed that sectoral actors can feel “starved” in the sense that they do not have sufficient resources even to manage their core tasks, and therefore calls for more intersectoral engagement can be seen as more of a threat than an opportunity:

One barrier is really an issue of investment. There is a lot of money which is utilized for keeping the current wheels turning but not for creating capacity and growth. And being starved without funding means that it is then very difficult to walk the talk of intersectoral action. Different sectoral actors can very easily argue that “I barely have enough money for keeping the system running every day. How on earth would you expect me to spend more money for engaging other partners?” So the whole funding debate, different funding models, and the sustainability of funding is actually a big factor. (Interview 27)

A capacity to formulate intersectoral action plans and use the available financial resources for their implementation is always a complex process. The involvement of multiple sectors that encompass different cultures and working methods will increase these complexities. In addition to money, some of the essential resources in policymaking include technical knowledge, management expertise, communication skills, and many other capacities at the organizational and individual levels. On the other hand, the same factors can act as facilitators, as will be evident when considering opportunities for intersectoral action for health (see Section 5.2.2 of this dissertation).

One informant said, “We do not have people who are skillful and have the competency to apply intersectoral approaches” (Interview 15). This statement was used to refer to the scarcity of undergraduate and graduate training programs that explicitly focus on health from an intersectoral perspective. People coming to work in the health sector cannot be expected to have a solid understanding of the intersectoral nature of health if it is not taught in universities and other institutions.

To some extent, a lack of key resources, such as money and time, was seen as an inevitable constraint. The finding is not unexpected, and this might explain why the informants did not engage in very deep analytical thinking about the resource issue.

Informants generally stated that a lack of resources is a problem that is connected to other challenges or barriers. From a more theoretical perspective, a lack of resources and investment can be considered as a political challenge. In the literature, Kingdon's (1984) three streams approach (problems-policies-politics) asserts that the first two prerequisites for effective policy implementation are the existence of a recognized problem and a realistic policy response. However, these two "streams" are not sufficient for policy implementation because there also needs to be real political will to address the problem (i.e. a politics stream).

Based on these findings, it can be concluded that political will has to be shown in ways that go beyond political rhetoric. Concretely, this has to mean political decisions to channel resources for the implementation of intersectoral action for health. Therefore, one of the key issues is related to the priority setting; when intersectoral mechanisms are not seen as a political priority within a government, then the planning and implementation of these actions are rarely granted resources. As an informant stated, "Everyone thinks that intersectoral action is important, but it is not everyone's priority" (Interview 7).

5.2.1.6 Complexity of the policymaking processes

Policymaking processes are rarely linear and straightforward; they are more often non-linear and complex with a large number of contextual variables. Ideas, institutions, actors, and interests form a complex network in which a policymaker has to operate. An expectation that setting a policy goal and defining certain implementation measures would effortlessly lead to the fulfillment of a policy is certainly a simplistic view of policy processes. A few informants for this study paid attention to these complexities and long time spans that are often needed to achieve sustainable policy changes. For instance, it was expressed that many sectors and their challenges can be very technical, and it is not always easy to understand the needs and logic of other sectors, which also makes it

harder to understand the underlying policymaking processes. To be influential, it is crucial to know whom and when to influence in order to have an impact and to shape ongoing processes before final decisions are made.

One informant indicated that politicians who do not understand the nature of the policy process can be a barrier in terms of formulating and implementing intersectoral policies. The informant said that sometimes he sees a high-level civil servant or a minister suggesting that a complex policy problem at a structural level could be solved through a campaign or increasing the provision of health education. According to another informant, the limited understanding of policy processes can be associated with a narrow understanding of health in general (see Section 5.2.1.1):

I feel is that there is a lack of understanding of issues around diet and physical activity. Sometimes even ministers do not really understand how it is to work in this field and how they can make a difference. They do not understand the process. For example, sometimes there is a director general or minister saying that we are going to do something about this. They propose giving more education in schools and some campaigns, and that's it. (Interview, 10)

The above informant saw that often simplistic and non-structural solutions can be a sign that a policymaker does not understand the underlying issue and the complexity of health determinants. On the other hand, the concept of “lifestyle drift” can provide one explanation to the situations where policymakers’ focus moves from the wider social and structural determinants of health to individual lifestyles. Initiatives that focus on lifestyle factors, for instance by providing health education, usually have clear visibility and are much easier to implement than structural interventions that require strong political support and intersectoral collaboration across ministries. Similarly, it is much easier to show that a certain health promotion campaign has been carried out and has reached its target group. A health minister can take the credit for a visible campaign even if its effectiveness has not been properly evaluated. On the contrary, even in an ideal situation,

the implementation of intersectoral initiatives can take a long time before there are changes in the social determinants of health that can lead to improved health outcomes. It was expressed that some politicians do not necessarily engage in long-term thinking but rather want to “leave their mark” by doing something in the short term.

A lack of understanding of policy processes can, although only to a limited extent, explain the lack of implementation of policy papers and strategies. A successful implementation of strategic goals requires that essential policy processes are first identified, and then there is a concrete and detailed plan on how to support them. However, understanding the policy processes is only one factor (and not the definitive factor) in terms of outcomes. In many cases, political barriers (such as not prioritizing health) are significantly more important. However, when a political agreement has been reached, the technical understanding of policy processes can become a more decisive factor. In terms of policy development, one informant expressed the view that sometimes the processes are more important than the actual policy outcomes:

In the end, most of the policy papers are not implemented and are not enforced. Sometimes I feel that the process of how you get to this decision and the process of how you get to the establishment of a certain committee is more important than having a committee itself. (Interview 18)

The above informant highlighted the importance of collaborative processes as such. New collaborative structures can build trust across the sectors as well as facilitate and provide mutual learning experiences that can be important regardless of the actual outcomes. Another perspective related to policy processes, was related to the training and capacities of people working in the health sector. Health workers are not very often trained to understand the political complexities, especially if their training has focused chiefly on clinical settings. Although the understanding of policy processes was brought up by several informants, the informants did not engage in a deeper reflection on the

complexities policy processes and how ideas, ideologies, interest, and institutions might shape the policy formulation processes.

Health policy researchers have argued that in health promotion, the central role of the policy process has not been sufficiently acknowledged (Clavier & de Leeuw, 2013b). Similarly, the informants for this study called for paying more attention to the policy process. Based on these findings, it can be argued that health advocates within and outside of government could benefit from gaining deeper insights into the complexity of policymaking processes in order to be able to promote health more effectively. This becomes especially relevant when considering intersectoral initiatives that are implemented in a complex web of stakeholders with a number of different interests. Similarly, the governance perspective requires understanding how different actors, interests, institutions, and ideas interact over time as part of the policy process.

5.2.1.7 Not sharing the same language and concepts

In multiple interviews, language and terminology used by health actors was mentioned as a barrier to intersectoral action for health. One informant indicated that the so-called “health jargon” might distance the health sector from the other sectors and decrease its political influence. According to another informant, it can be counterproductive to use terms that are not clearly understood by non-health actors. It was suggested that health actors should aim to be more convincing by learning the language of the sector they want to collaborate with:

We have a problem that we are not very convincing when talking to other sectors; we do not speak the same language. So they do not understand us, and we do not understand them. So basically, we want to understand the economics and to have the language to be able talk to the Ministry of Economic Affairs. I think it is starting to be better, but I still think we have those silos and all the different reasons I am giving you now. (Interview 15)

Another informant stated that sometimes it seems that new concepts create almost a parallel language that is not easily understood by people who are not directly working with the same issues. There is also an added challenge for international organizations, such as WHO, that work with countries that can have very different social and political cultures. UN organizations should aim to use terms that are understood in a similar way and represent the same meanings. The informant reflected the polysemic⁹⁴ nature of the terminology as follows:

You know, the more you work with these kind of concepts, the more you start creating a sort of parallel language that is difficult for others to understand. Of course you need good terms, but many times these terms are so polysemic that I am not sure that everybody understands those in the same way we do. It also depends on the political reasoning in a country; for some people, certain terms are very clear, but for others, those can mean completely different things. Empowerment and so on... Or let's say social inclusion, it is so polysemic, that if you ask people, they might understand it in completely different ways.
(Interview 23)

One informant saw the challenge of understanding different languages from a knowledge translation perspective. The informant stated that different "sectoral cultures" and languages can create clashes that are often based on misunderstandings. These communication barriers could be a cause for mistrust and hostility and therefore hinder opportunities for intersectoral collaboration. Nevertheless, the same informant also shared an optimistic belief that these barriers can be reduced by highlighting the mutual benefits and adjusting the communication efforts to different cultures and ways of thinking:

⁹⁴ The term "polysemy" refers to "the coexistence of many possible meanings for a word or phrase." (Source: Oxford Dictionary)

Related to these knowledge translation platforms, we talk about a two-community approach that highlights that every community has a different way of thinking and a different culture and a different language, and that creates clashes. I used to work with food safety, and I have seen this very much there as well. Depending on the discipline that you enter, you enter with a certain way of thinking, and you enter with a certain lingua as well, and that makes it very difficult to communicate and exchange between the two different communities. And essential to that is trust-building and understanding that the interaction is mutually beneficial. (Interview 28)

A specific example are the language challenges brought up related to the International Health Regulations (IHR). The IHR is an international and legally binding instrument for almost two hundred countries, including all the WHO Member States. It lays out a set of procedures that countries and WHO must follow to prevent acute public health risks that can pose a risk across national borders. An informant working with alert and response operations expressed the view that sometimes the language and terms of the IHR, such as “a notification” can be understood, not as neutral terms, but very negatively. In some cultural contexts, it is considered a failure if one needs to notify someone, else and the negative involvement of other sectors is not considered desirable. This can risk transparent communication because the purpose of a notification can be understood as part of an action that aims to “punish the guilty ones.”

In the literature, a lack of uniform language has been identified as one barrier to intersectoral action whereas learning the “language” of other sectors has been identified as a facilitator (WHO, 2015c, p. 176). The emphasis on the need to have shared language and terminology is not entirely new. However, it is likely that more attention should be paid to effective communication where “being understandable” is one of the central factors. In addition, persuasive communication is key to being able to lead public health work in general (Begun & Malcolm, 2014).

5.2.1.8 Limited authority and mandate of the health sector

The health sector's limited authority and mandate was seen to be one of the major challenges in intersectoral work. As an international organization, the core mission of WHO is to advise and serve its member states and more specifically their Ministries of Health (MoH). WHO has its national counterpoints in the health ministries, and its explicit organizational mandate is to work with them. This can pose a significant challenge when WHO wants to promote intersectoral action for health in a stronger way. The informants expressed varying views of the WHO's mandate, as some saw it very much limited to MoHs, and others considered it to be wider and dependent on the health question being considered. The following informant saw that the health sector's mandate can be very limited in general:

We know that it is better to implement preventative measures upstream; however, very often the health sector does not have the authority or mandate for this.
(Interview 4)

Sometimes WHO experts are able to find a person from the Ministry of Health who can facilitate and start to work across sectors. However, this strategy can often fail if intersectoral collaboration has not been started earlier. Multiple informants highlighted that often an interagency collaboration with another UN organization can provide a way to approach non-health sectors. For instance, it was stated that UNICEF has a cross-cutting mandate with children. These collaborative efforts within "the UN family" were brought up several times by different informants and seemed to be important for many WHO experts, as the following quote signifies:

If the Ministry of Health says that we do not know anyone in the Ministry of Education working with this topic, then that's it. Then we usually go through some other UN agency, through UNFPA, through UNICEF, through other partners we know to have been working in other areas of that specific interest we have. We

ask whether they can communicate with the Ministry of Education, Ministry of Labour and so on. (Interview 1)

WHO works at the international level and tackles the problem of reaching out to non-health sectors. Naturally, similar challenges related to a limited mandate can be observed at the national level. In some countries, the officials at the Ministry of Health feel that they are bound by legal barriers and organizational culture, which makes them unable to contact non-health sectors even though the collaboration seems to be necessary to solve a health problem that has strong intersectoral roots. The following informant highlighted the embeddedness of silo thinking within institutions:

In some countries the silo thinking is very embedded in the institutions. Some countries tell us: "We need changes in laws, we need to be mandated legally to work with the other ministries; otherwise we are not even allowed to call them. We need a strong mandate and legal barriers need to be removed." In some other countries this is of course very different, and intersectoral collaboration is encouraged. Then it is more about providing specific actions that they can actually do. We do a lot of work just in raising awareness and encouraging countries to integrate their policymaking to include more than one sector. (Interview 2)

According to one informant, sometimes national experts working with the same health-related challenge met for the first time in an international meeting organized by WHO. These two experts from different ministries had never met in their home country and now had the first opportunity to discuss these issues:

That was the first time those two experts working in the same field met, not in their country but outside of their country. They met and had a possibility to discuss. (Interview 1)

Another informant highlighted the question of mandate in terms of accountability and responsibility. When a ministry or organization perceives that a certain health

problem is not clearly under their responsibility, they can easily conclude that they do not have a mandate to take action on it:

One of the challenges related to intersectoral approaches is the question of who is accountable and who is responsible for a certain action. [...] And sometimes the organizations and institutions that we want to work with say that they do not have the mandate. (Interview 15)

It was stated that proponents of a wide mandate could argue that as long as the health sector can make the case that intersectoral policy is relevant to health, there is a mandate to work on the determinants of health across the sectors. In addition to political mandates, there are professional boundaries that can often limit the activity. Non-health actors may fear that someone is taking over some of their activities. Therefore, the representatives of the health sector should avoid taking a “we know better” attitude that could be interpreted as “health imperialism” but try to approach intersectoral health challenges through collaboration and encourage other sectoral actors to provide their expertise for mutual benefit.

The focus on the limitations of the health sector’s mandate is an expected finding. The importance of having legal as well as “softer” mandates has been clearly argued in the literature (Harris et al., 1995; Ollila et al., 2006)⁹⁵ and this can be seen as one of the reasons why there have been considerable efforts to promote the view that intersectoral initiatives have to be supported by the decision-makers at the highest level of government who are in a position to provide an intersectoral mandate (WHO, 1986b, 1988, 2013c, 2015d). The mandate of WHO in relation to national governments and its other stakeholders will be considered later in this dissertation.

⁹⁵ “Legal mandates for the assessment of health implications of policies, as well as legal responsibilities to follow up and report population health trends and policies affecting them, are important instruments in institutionalizing health in other policies.” (Ollila et al., 2006, p. 275)

5.2.1.9 Lack of ownership and management

A number of informants stated that the implementation of intersectoral initiatives can be weak because of a lack of clear ownership. One informant used the term “intersectoral gap” to demonstrate the situation where intersectoral initiatives seem to be everyone’s responsibility but at the same time no one’s responsibility. The informant proposed the question: “Who is responsible when everyone is responsible?” Political decisions about increasing intersectoral collaboration for health are often made by high-level decision-making bodies or between different sectoral ministries. In an ideal situation, high-level decisions lead to the formulation of an action plan that guides the implementation. However, as intersectoral initiatives do not have “a natural owner”, they might fall into a gap, which means that the implementation measures are not clear and concrete action is not taken:

For instance, in the areas like violence prevention, it is not very clear who should lead: Is it health? Is it justice? Is it education? In those cases, there is a clear danger that policy proposals will fall into an intersectoral gap, or that the people are not working through a collaborative mechanism. What we need is cross-sectoral action with coordination mechanisms that will enable it. The health sector does not necessarily need to be leading the work, but certainly it has to have a responsibility to make sure that something happens. (Interview 16)

The challenge of ownership can also be seen as a management challenge. Some of the key questions are: How is the resource allocation done? Who uses the resources and how? Are the roles clear? Who coordinates the day-to-day implementation? Are there monitoring and accountability mechanisms? Who does the follow-up and makes adjustments if needed? It was seen that ownership does not build automatically and rapidly. As the following informant tells, the building of ownership is a process and can take a long time:

The process of ownership is essential. Especially, I think that the process of building the ownership and justifying why you should do certain things is important. (Interview 18)

Ministers and other high-level decision-makers can facilitate the processes of ownership and coordination, but sometimes they can also create obstacles. These obstacles can be unintended or sometimes intended if the ministers perceive that their own interests are in conflict with another minister or sector. One informant expressed the view that high-level discussions themselves do not automatically lead to implementation, and there is a great need to pay attention to “the people on the ground” who take ownership of coordination and management:

Sometimes you can have ministers talking together, but that means nothing because no one will move it from there. It is sometimes essential because if they do not talk together, they will create obstacles. At least they will facilitate, or enable it, or permit it, but it won't happen just because of that; you need to have people on the ground. (Interview 7)

In other words, leadership requires technical and managerial capacities that are used for concrete implementation. The whole idea of intersectoral action carries a significant risk that the planning and coordination is not carried out in an optimal way due to a lack of clear ownership and management structures. In some cases, the health sector might have an important role as an initiator of action even if the implementation would be carried out by some other sector. However, the health sector normally does not have the power to plan and decide on the implementation structures of a non-health sector. The responsibility to increase ownership often rests on the shoulders of a limited number of people who initiated and established the intersectoral collaborative structures. If they fail to transfer the ownership to a new and sometimes larger group of actors, then there is a real danger that the good intentions of intersectoral work will fall into an intersectoral gap and not lead to actual implementation.

The questions of efficient management have not generally been the main focus of the literature considering intersectoral action for health. It is likely that actors involved in the implementation of intersectoral action would benefit from having skills that are usually considered in the literature on organization management and development (Begun & Malcolm, 2014; Rowitz, 2013). Based on the interviews, it can be concluded that there is the danger that calls for intersectoral action for health often stay at the rhetorical level. Therefore, more attention should be paid to the process of creating an ownership and management of intersectoral initiatives.

5.2.1.10 Potential conflicts of interest

Although potential conflicts of interest were mentioned by only three informants, they should still be carefully considered, as they can form significant barriers to the implementation of health-promoting policies. In comparison to “competing interests”, conflicts of interest can lead individual actors to promote interests that are fundamentally against health. Therefore, these conflicts are not only a question of giving or not giving priority to health.. In many cases, personal and industrial financial interests can be found at the core of these conflicts. The conflict of interest issue was raised by three informants who worked in separate fields – alcohol, tobacco, and nutrition.⁹⁶ An informant working in nutrition described the situation in the following way:

Another problem is dealing with conflicts of interest, inside and outside of governments. These conflicts can be a barrier to working across sectors. For example, if you think about the highest level, you could have a Minister of Economy who was a CEO of a food and beverage company until recently. There

⁹⁶ It should be noted that conflict of interests can also be a significant problem with pharmaceuticals. The drug industry can exert significant influence on laws and regulations, try to change the prescription behaviour of physicians, produce biases in clinical research, and engage in aggressive drug marketing. However, WHO staff members working directly with pharmaceuticals were not interviewed for this study.

can be a problematic connection between private sector funding and academic research. And even with health professionals, like in pharmaceuticals or even in nutrition, it is the same. In many countries, pediatricians are known for being very close to the formula and milk industry. Of course, there are always independent people and you cannot generalize. But the issue of conflict of interest, at all levels, I think is extremely important. And it is one issue that can undermine serious constructive dialogues because there are lots of people playing double games. (Interview 10)

As an example of how conflicts can undermine serious policy dialogue, industry can forcefully lobby conflicted policymakers against excise taxes (e.g. a sugar tax) or marketing restrictions on unhealthy products. Similarly, the relationship between researchers and industry can be problematic and at worst, produce biased research. The industry does not necessarily try to exert direct influence or guidance on the research; however, it can fund only research that will produce “favourable” results or steer the research focus to questions that are harmless to the industry’s profit-making motive. The informant saw that the solution is to increase transparency and to have a clear and shared vision on how to address the potential conflict of interest through guidelines, laws, and regulations.

The second example of potential conflicts was raised by an informant working in tobacco control. One of the traditional lobbying strategies has been the industry’s effort to produce biased information and to question the reliability of data and existing evidence. In terms of more direct conflicts of interest, the informant expressed the view that the tobacco industry is still a very strong force, especially in the Eastern European region. It is not unheard of that monetary benefits (i.e. corruption) is being used to turn the attention of policymakers away from stricter tobacco control measures:

In our region, the industry is very strong, not that much in the Western European countries, where they are much weaker and working in a more transparent way. But when moving to the east, everything is possible, from monetary benefits to moral benefits. (Interview 18)

As a more recent global development, the field of international trade policy can create new obstacles to the implementation of health-promoting policies. For example, industry lobbyists might raise an argument that a bilateral trade agreement does not allow a national government to implement a certain policy based solely on health arguments. In many cases, the health sector is unprepared to respond to the questions and complexities associated with the international trade:

And I think that the industry can be sort of threatening and work against any bold health actions. And they are sort of changing the agenda, or taking it down, and bringing with them also the Ministry of Economy, Finance, and Trade, those hardcore ministries in the government. So I think this is something we see more and more, as a part of globalization as well. And the health ministries are not capable of dealing with those arguments and areas, as they are completely on a learning curve. You can have an industry representative coming and saying: "If you do this bold policy decision, you will be threatened by a bilateral trade agreement with another country." They say that it means that I sue you, and then the officials in the Ministry of Health need to try to deal with this new situation. (Interview 18)

The same informant indicated that sometimes the trade partners can be genuinely happy that intersectoral approaches "do not work, because they might pose a threat to certain financial interests. The industry can take bold action by influencing the finance ministers who hold a powerful role within the government. The Ministry of Finance can have a strong impact on the whole government's agenda through having the ability to influence sectoral budgets.

The third area that was mentioned in relation to conflict of interest was alcohol policy. The informant stated that the alcohol industry cannot be a good partner for the health sector because their aim is to sell a product that is harmful and contributes significantly to the avoidable disease burden globally. In other words, health interests and the alcohol industry's profit-making interest are fundamentally in conflict. The informant

stated that the alcohol industry itself is a very well-connected and powerful lobbyist in the European region:

The alcohol industry is a very powerful actor, and I even find it being increasingly powerful. And the industry is very well-connected, and they have very huge so-called research institutions behind them that produce the research they want. So they have a lot of staff, and they lobby heavily against what we are saying. And the industry mainly promotes approaches targeted to individuals, arguing that we need to find those who drink too much. I would say that our approach is a combination of population-based and individual-based approaches. But it has to be balanced, and if we really want to reduce harms caused by alcohol we have to focus on the three best buys at the population level: availability, pricing, and marketing. (Interview 21)

The informant suggested that the alcohol industry promotes an individualistic view on alcohol problems, i.e. turning the focus on problem drinkers and supporting campaigns on responsible drinking, but at the same time disregarding policy measures that would influence the whole population, such as restricting availability or increasing excise taxes on alcohol. Public health research and WHO recommendations support the strategies targeting the whole population; and population-level strategies appear to be much more effective in reducing alcohol consumption as well as the harm caused by alcohol than measures targeted at individuals.

Conflicting and opposing interests might become more visible in specific situations. For example, these can include situations where political advisers have ties to the alcohol industry. The Ministry of Agriculture wants to support wine production, or the Ministry of Economic Affairs wants to support the alcohol industry without considering the possible health and social impacts due to increased alcohol consumption. These conflicts were considered to pose a threat to health-promoting policies and were seen to require awareness that is actualized in guidelines as well as in laws and regulations.

To conclude, an important aspect of intersectoral action for health is to have mechanisms to address potential conflicts of interest. Concretely, these mechanisms can include guidelines, procedural rules, laws, and regulations. The informants noted that often there is a lack of these mechanisms in many WHO Member States. On the other hand, critics from civil society and academic institutions have also argued that the current WHO Framework of Engagement with Non-State Actors, known as FENSA (WHO, 2016c) does not contain sufficient safeguards against conflicts of interest (Buse & Hawkes, 2016; CSS, 2016; Khayatzaheh-Mahani, Ruckert, & Labonté, 2017). FENSA itself highlights the role of due diligence and risk assessments that are carried out by WHO (WHO, 2016c). The framework was recently adopted in 2016 and it is yet to be seen how successful WHO will be in preventing and managing possible conflicts of interest.

5.2.2 Opportunities and facilitating factors

In this study, opportunities and facilitators are understood as factors and circumstances that can make intersectoral action for health more likely to occur. Naturally, the focus of this analysis is on the factors that were seen to promote intersectoral collaboration and lead to improved health outcomes. Facilitating factors refer to things that can make intersectoral action easier or are prerequisites for it. Various opportunities can arise from contextual developments and are often related to wider processes, such as political changes, or international strategic commitments such as the UN Sustainable Development Goals. These opportunities can be understood as various ways to overcome the thematic challenges that were considered in the previous section of this dissertation.

The qualitative analysis of opportunities and facilitators in the interviews led to ten key thematic areas. The informants shared the view that intersectoral action for health needs to be strengthened, and they were mainly optimistic and enthusiastic about future opportunities. Generally, informants saw that there is no single magic bullet for complex

problems. Similarly, addressing the multitude of challenges related to intersectoral collaboration will require wide-ranging responses at different levels of governance. The following themes are mostly broad-level factors, and their concrete implementation will always depend on the surrounding institutional and political context. Table 6 outlines how many informants highlighted specific thematic opportunities and facilitating factors.

Table 6. Number of informants discussing specific opportunities and facilitators (N=28)	
Theme (opportunity/facilitating factor)	Number of interviews where theme was discussed
1. Establishing permanent intersectoral structures	16
2. Identifying and utilizing the windows of opportunity	16
3. Identifying co-benefits, mutual gains, and win-win situations	12
4. Placing more focus on long-term returns and investments	13
5. Increasing the skills and credibility of the health sector	22
6. Linking to existing processes	14
7. Making budgets differently	6
8. Increasing focus on policy development within WHO	9
9. Strengthening and clarifying the WHO's role and mandate	15
10. Working through other UN agencies and non-state actors	15

5.2.2.1 Establishing permanent intersectoral structures

In the interviews, one of the most frequently mentioned factors that could advance intersectoral action for health was the existence of permanent intersectoral structures at different levels of governance. Several informants suggested that there should be more

intersectoral implementation and monitoring mechanisms that would be independent of changing governments, civil servants, and politicians. Wider and international policy frameworks such as Health 2020 or the SDGs could be utilized in the process of establishing these permanent structures. It was expressed that intersectoral action for health can be significantly more effective when the actors have a long-term focus and an intersectoral way of working is institutionalized in the organizational structures:

There is a lack of sustainability, and that is why the most important suggestion for the future is establishing permanent intersectoral mechanisms. The Health 2020 policy framework is one ideal entry point for this, and I hope that the SDGs will be also used. (Interview 1)

Another key facilitator relates to the nature of these permanent structures. Numerous informants highlighted the need to have health-related intersectoral structures (e.g. committees or working groups), namely at the highest level of power. In this context, the national level was referred to as the highest level of decision-making. High-level involvement was seen to be crucial to attain the required political support for these intersectoral activities for health. In addition, it was considered to be similarly important to have action-oriented intersectoral teams at the lower levels of governance, which were generally understood as regional and local-level structures. However, having established structures were not seen as sufficient in themselves, as an intersectoral team or other mechanism needs to have an actual capacity to formulate action plans and implement them. In other words, intersectoral mechanisms need to be endowed with effective methods and tools to carry out intersectoral work. For instance, the following two informants highlighted that committees have to be action-oriented and have clear objectives:

There should be an intersectoral team or committee with the highest level of power that can really take a decision, not just having a committee for its own sake,

but to have an action-oriented committee with possibilities to take these decisions, to start with small but end in big. (Interview 1)

You rarely see good outcomes when you have a committee of people who come together for one meeting and then leave again. But when you have planned very clear objectives for a committee and you follow that through, then it can be very effective. (Interview 7)

Another informant gave two concrete examples on intersectoral committees. The first example considered a committee that was led by the Minister of Health, and other ministers were invited to the group to discuss various health challenges and to explore how they could collaborate to address those challenges in an effective way. The second example was a group of Director Generals from different governmental agencies who were invited to meet regularly to talk about health issues at the National Institute of Public Health:

There needs to be mechanisms for this collaboration, like intersectoral committees or working groups that can facilitate communication and joint planning. I think these should be at a high level and chaired, for example, by the Minister of Health, with the involvement of other ministers. In my previous work, when I worked at the country level, we had a committee that was chaired by the Minister of Health, who invited the other ministries to join this working group to talk about health issues. Interestingly, the Health Minister received a lot of interest from other sectors. This of course can be done at different levels. Another example can be found from one national public health institute that had convened a group of Director Generals to discuss health issues. So it was all kinds of directors, from agriculture, from education, and so on. They met regularly to discuss how their work can contribute to better health. (Interview 3)

As another concrete example, the healthy cities model can provide lessons on the importance of permanent intersectoral structures. The idea of healthy cities is to establish a settings-based and intersectoral approach for health promotion at the city level. This model has been considered a successful model to promote health by engaging multiple

actors in collaborative efforts in an action-oriented way. An informant who had worked with the project for years highlighted three main facilitators that he considered to be essential for success: (1) strong political leadership, (2) established intersectoral committees, and (3) a coordinating body close to the highest decision-makers. The informant describes the first success factor as follows:

The healthy cities movement was based on strong political leadership and putting health high on the social and political agenda of cities, because this immediately set the tone for the scope of the work of healthy cities. It was not something to be led by the health departments, but it was to be a project for the whole city. So this helped to get the political commitment. (Interview 20)

The model for healthy cities introduced a necessary requirement that there has to be an intersectoral group and committee to steer the project that is close to the city's decision-makers:

Very importantly, it made it a requirement that healthy cities should have a coordinator and office to facilitate and coordinate the processes, including intersectoral action. I think that this is a great lesson to be learnt from the healthy cities movement; that from the start, it addressed the issue of capacity. So it is not enough to set up a committee, but it was also important to have resources—a secretariat, a unit, an office—that will help and support the work. Who is going to contact these people, who is going to prepare agendas, who is going to organize the meetings, who is going to feed these committees with information and feedback. You see what I mean, you need someone. And the closer those units were to the mayor's offices, the most strategic role they had. (Interview 20)

In the healthy cities model, a separation can be made between high-level strategic committees and operational bodies. The latter have the role of coordination and implementation, i.e. running the day-to-day activities and turning the high-level commitments and strategies into concrete actions. According to the informant, clear

high-level strategic goals linked with designated ownership and management structures have been crucial in the success of the healthy cities model.

The importance of permanent intersectoral structures in the implementation of intersectoral action for health is an expected finding in light of the literature (McQueen, Wismar, Lin, Jones, et al., 2012). As outlined earlier in the thematic analysis of challenges, the lack of permanent structures was seen as a major barrier to intersectoral action (see also Section 5.2.1.4). The informants emphasized the recommendation that efficient management structures and implementation mechanisms should be directly linked to high-level committees. It was considered as a common shortcoming that an intersectoral committee does not have measures and sufficient resources to translate high-level discussions and agreements to the level of implementation. In summary, the existence of established intersectoral structures is definitely an important facilitating factor, especially when these structures are combined with clear implementation and monitoring mechanisms.

5.2.2.2 Identifying and utilizing the windows of opportunity

The ability to identify and utilize the windows of opportunity was considered as an essential skill for everyone who is working to advance intersectoral policymaking. Several informants mentioned that changing governments and new political platforms can provide new opportunities for policymakers and health advocates. For instance, newly elected governments usually shape their political priorities soon after elections, which makes this often a good time for advocates and lobbyists to influence the strategic priorities of the government. Another opportunity might arise through a crisis that forces people to work together across sectors. Probably the most recent public health examples are related to the spread of infectious diseases such as Ebola, SARS, and pandemic influenzas. Increased public awareness and media scrutiny can force politicians to address

the public health risks that would otherwise not have been considered as political priorities.

One informant raised an interesting perspective by highlighting the difference between policy generalists and public health experts. This informant saw herself more as a policy generalist who is skilled in spotting new opportunities by looking at health from the wider system's perspective rather than from a problem-focused perspective with an emphasis on certain health-related phenomena:

People like me, who are more policy generalists than public health experts, find it easy to spot opportunities because we look at this from a system's perspective, from a policy, political science perspective rather than from a narrow topic perspective that can sometimes close your vision. I am not critical of my colleagues because I think you need a balance. However, to spot some of the existing opportunities may require some further awareness-raising. We have some really good colleagues in mental health, NCDs, nutrition, tobacco, TB, and migration. They are doing really good stuff that requires intersectoral work. So we see the opportunities, and my colleagues are generally moving in that direction, but we still have a long way to go. (Interview 19)

A concrete example of an opportunity can also be related to a country's international commitments. For instance, the ratification of an international agreement can provide an opportunity for establishing new intersectoral mechanisms. One informant stated that signing a UN convention or monitoring protocol is usually an indication that there is also high-level political support for its implementation:

When a country signs a UN convention or especially a monitoring protocol, then there is pressure from the highest level of the state to implement it, because it is what the country is committed to at the international level. Then you have this pressure from different ministries, from the president, or whoever is the leading authority in the country and has the most power. Then you have a lot of pressure to do something and then people at least try to do it, there is a commitment. Otherwise it is very difficult. (Interview 25)

New windows of opportunity can also open through non-formal global or national trends and discussions. For example, these can include a heightened focus on social and health inequalities or concerns about climate change. These discussions can induce politicians to reshape their priorities, as there can be growing demands from the public to address the newly perceived problems. The identification of this political momentum can be crucial for actors promoting greater health equity through intersectoral action.

In general, this theme is not surprising, especially since the recent literature on the HiAP approach has highlighted the importance of actively seizing the windows of opportunity (Leppo et al., 2013a). The informants for this study mainly focused only on opportunities that can be noticed at the international level. The type of opportunities that are more directly associated with national processes was not considered in the interviews.

5.2.2.3 Identifying co-benefits, mutual gains, and win-win situations

Numerous informants spoke about the need to identify co-benefits, mutual gains, and win-win situations to all sectoral actors whose collaboration is encouraged. In other words, other sectors do not have an intrinsic motive to promote health, as they have their own core mission. One informant raised a perspective that people should not forget the question of “how other sectors influence the health sector.” For instance, if the “Health in All Policies” approach is perceived as one-sided promotion of health-related interests, then other sectoral actors could think of why initiatives such as “education in all policies”, “environment in all policies”, or “security in all policies” are not promoted. The multitude of various sectoral interests makes it clear that intersectoral collaboration turns out to be significantly easier when the mutual gains are clearly identified, as the following informant expresses:

I think the main issue there is to make it clear to all participating actors what are their benefits, what is in it for me. [...] It needs to be clear what the benefits for individual sectors are. (Interview 27)

On the other hand, the importance of co-benefits was seen as deriving from the fact that the health sector itself does not have the power or mandate over other governmental sectors. One informant referred to the need to find win-win situations in concluding that: "When your access to a stick is very limited, it is better to find a carrot" (Interview 27). The same informant added that even if you find a good "carrot", you still have to explain to others why this specific carrot is good and desirable, as it might not be evident in all situations. Another informant highlighted the importance of building a case that there are benefits for everyone involved:

It was very difficult as long as we said that we have to do more in the transport sector to help health. The Transport Minister says: "What's in it for me?" So to do that, you have to first build the case that there is something in it for everyone. And even with the health benefits alone. (Interview 2)

Another informant stated that sometimes the best situation occurs when co-benefits come naturally on the agenda and not necessarily as health initiatives promoted by the health sector:

I think that it is a great opportunity when health promotion naturally emerges on the agenda. For instance, in the education sector this can mean that increasing physical activity among children is seen as one means to get better educated people. (Interview 10)

Moreover, the above informant concluded later in the interview that sometimes just focusing on "sectoral benefits" provides too narrow a perspective, as many of the benefits manifest themselves at a cross-cutting level that entails the whole society:

The real benefits of improved health of the population are not just visible for the ministries of health. It is not only about reducing health care costs. It is really about improving the liveability of our environments, even increasing productivity, having less absenteeism from work, and of course beyond all of that. The benefits really only manifest themselves at the Whole-of-Government level. So that is why it is very difficult to argue from a very sectoral point of view, because you do not catch all the benefits if you have just that limited view. (Interview 2)

An informant working in environment and health stated that sometimes interventions with clear co-benefits can be very cheap and simple. For instance, a bike lane costs much less than many other road construction projects. In addition, increased cycling, walking, and use of public transportation can produce environmental benefits by reducing greenhouse gas emissions.

On the other hand, also showing how cheap and simple some of the interventions can be. A bike line costs nothing compared to some other road construction projects. And we see now even a change in big international funding institutes, like the World Bank. For a very long time, one of the main framing concepts in the field of transport for development has been "let's build freeways to connect cities", and there has been a lot of road construction. Now we see changes also in this regard towards more sustainable transport being supported and encouraging cities to really have sustainable transport plans in place. And of course, this is around the world, and in Europe it is pushed by the European Commission. (Interview 2)

Another informant highlighted mutual benefits related to the collaboration of the health and education sectors. Schools are the central social and physical environments where children spend a significant amount of their time. Therefore setting-based initiatives such as health promotion in schools can be very effective. Related to the school context, the informants mentioned interventions such as making healthier diets more available, increasing physical activity in curricula, reducing bullying, and implementing various models for mental health promotion.

A few informants stated that the health sector should focus more on the systematic mapping of the co-benefits and win-win situations. This could be carried out by analyzing the key entry points of other sectors in a structured fashion. During this process, the health sector could deepen its strategic understanding of the ways in which various sectoral actions have an impact on health. To summarize, the health sector's engagement through taking a more proactive role in finding possible co-benefits was considered as a clear opportunity for the future.

The important role of win-win situations or co-benefits has been recognized earlier in the literature and been a suggested policy recommendation in WHO statements (Howard & Gunther, 2012; Molnar et al., 2016).⁹⁷ The informants did not place any emphasis on the possible shortcomings of the win-win approach, of which one of the clearest is the danger of limiting intersectoral action for health only to the areas where it is not contested and can be easily initiated (Koivusalo, 2010). To summarize, an increased tendency to avoid conflicts and political disagreements might be expected if the focus of intersectoral initiatives is predominantly on the areas where win-win situations can be clearly identified. In the worst case, this might not increase but decrease the overall political power and influence of the health sector. Seeking win-win situations and co-benefits is probably one of the most efficient strategies to promote the implementation of intersectoral initiatives; but at the same the health sector should be aware of the possible risk of excessive conflict avoidance.

5.2.2.4 Placing more focus on long-term returns and investments

A number of informants stated that one way to strengthen intersectoral action for health is to value and focus more on long-term benefits. It was suggested that health-related

⁹⁷ For instance, the Helsinki Statement on Health in All Policies (WHO, 2013c) calls on governments "to ensure that health considerations are transparently taken into account in policy-making, and to open up opportunities for co-benefits across sectors and society at large."

actions should be seen as investments that will provide clear returns later. Often the benefits do not manifest themselves as short-term gains but as improvements that become visible over many years. One informant emphasized that many long-term benefits often become visible on the Whole-of-Government level over a longer time period, and therefore those benefits can be difficult to measure from a purely sectoral perspective.

As an example, one informant highlighted that antimicrobial resistance (AMR) is a serious threat to public health that can be tackled only through intersectoral action and partnerships. Preventing resistance from developing is a much cheaper option than providing treatments such as last-resort antibiotics or intensive care. An increased resistance to last resort antimicrobial drugs can make even minor infections life-threatening. An informant working with AMR stated that:

Political barriers have really prevented us from making any big progress in the past. I think that as a public health risk, antimicrobial resistance has been a very difficult sell. People have been optimistic about new antibiotics being developed and that then we can sort of reset the clock on resistance because we will always find new treatments. But then realizing that during the last two to three decades nothing new has come, and now I think that people start to realize that this is a serious problem. (Interview 22)

In this case, a long-term perspective would mean that policymakers would take a strong and intersectoral response to prevent or delay the increasing resistance by truly acknowledging that prevention is better than a cure. Along with the health sector itself, collaborative actions are needed from all sectors involved with drug regulation and the use of antimicrobial drugs in humans, animals and the environment. For instance, the ban on antibiotic growth promoters in agriculture has been one concrete way to delay the development of antimicrobial resistance.

A life-course perspective on health recognizes the importance of acting early, starting with prenatal to neonatal care, as well as supporting human development in early childhood and adolescence. Informants suggested that having a long-term perspective requires patience combined with a vision of the future:

We need to manage our expectations, and I think that Health 2020 with its emphasis on intersectorality is the right way to go. It will not happen overnight, but some countries already have best practices. And I think the more we can show them and the more we can keep this high on the agenda, eventually other countries will follow suit. (Interview 14)

As another example, it was mentioned that investments in schools and early childhood education can give returns after many decades. Acting early and supporting children's development will lead to healthier and more productive people who contribute to social and economic development. It was suggested that one key message could be that there is no prosperity and productivity without good health, and healthy people also give companies a competitive advantage:

I would like to see Europe as a region where things such as a healthy diet are linked with prosperity, competitiveness, better business, and better health and well-being. And I think that is possible. (Interview 10)

Similarly, one informant highlighted that insurers should have a strong incentive to keep their clients, in this case pensioners, healthy by investing in health promotion and prevention:

For instance, when you have pension insurers that actually see the merits of making sure that pensioners are kept healthy. And then they do actually contribute to health promotion and disease prevention. (Interview 15)

The calls for a long-term perspective are closely linked to wider discussions on sustainable development and the UN Sustainable Development Goals. In terms of AMR, it has been repeatedly stated that increased political commitment and global intersectoral governance mechanisms are needed (Wernli et al., 2017). The adoption of binding targets to limit unnecessary antimicrobial use and creating a global AMR monitoring mechanism are among the concrete proposals by WHO and other international actors.⁹⁸

The informants also noted that there are multiple barriers to really having a long-term perspective. Generally it has been identified that the cyclical nature of politics makes it challenging to address complex or difficult problems such as socioeconomic health inequalities (Exworthy, 2008). In terms of national policymaking, it is likely that having a shared long-term agenda that runs across the political spectrum makes it much easier to implement intersectoral initiatives.

5.2.2.5 Increasing the skills and credibility of the health sector

A wide-ranging set of skills and other competencies is required from the health sector to establish intersectoral initiatives and mechanisms. The work to develop these competencies can be understood as capacity-building for intersectoral action. One informant expressed the view that being credible requires putting one's own house in order:

⁹⁸ On tackling antimicrobial resistance, Wernli et al. (2017, p. 7) conclude: "Fostering a global transformation to deal with AMR requires political commitment and relevant governance mechanisms. An effective mechanism to curb AMR globally would be the adoption of binding targets limiting antimicrobial use. While it may take a long time for states to adopt these targets, expanding monitoring of AMR control will reduce information gaps and help governments maintain their commitments to tackle the problem."

We still need to put our own house in order, which means that the health sector in my particular area is really lagging behind because if you think what capacity we have and are we doing the right things. We should increase the credibility of the health sector; in my own area the health sector needs to do better. Better means capacity-building, curricula development, in-service training, health workforce development, and everything else our colleagues in the health systems used to talk a lot about. (Interview 10)

Besides basic training and curriculum development in higher education institutes, there are also many other factors that can be strengthened to advance an intersectoral approach to health. The following informant summarized that gathering and showing the evidence as well as learning to use language that is better understood in other sectors can provide a key to the future:

Intersectoral mechanisms require a lot of persuasion, building case studies, and building evidence. I think that evidence is a key thing; people need evidence to show that there will be an impact and there will be change. And how to make this in a way understandable to non-health sectors is also important. Because sectors have certain terminologies that they use that are not understandable to other sectors. For example, we use the concept of burden of disease. But this is a concept that is not necessarily understood by others. So we need to speak their language in order to address some of these gaps. (Interview 24)

The above informant also expressed the view that learning how other sectors talk is a skill that can be taught. In other words, being an influential actor requires persuasion skills and the ability to convince others. The importance of effective communication was also highlighted by many other informants. However, these communication efforts should be combined into a clear vision of what is being done, why, and how. One informant working with service integration concluded that in many successful cases, the actors have a shared vision that gives them a purpose and contextualizes their work:

One of the key things is definitely to have leaders for this change process and the integration of services. And you need to have a common narrative or a vision about where you want to go. And then something that is very often underestimated is the time that you need not only to prepare but also to convince people, to communicate with people, to get everyone involved. This leads to the next point which is communication. Often the problem is that there is no coherent communication strategy. In successful initiatives, they communicate the vision, why this is important, what the stakeholders gain, and they can answer the question "why should I do this?" (Interview 8)

It was also expressed that some of the specific success factors can be recognized more easily by analyzing intersectoral initiatives at the local level. The key facilitators included clearly defined goals, indicators to measure and monitor the progress, an ability to revise implementation plans if needed, and sufficient resources. However, an informant highlighting the above facilitators also noted that sometimes the question is not that much about getting more resources but allocating the existing resources in an effective and purposeful way:

Very often the successful local initiatives shared the same success factors: they very clearly defined their aims from the start, had quantifiable aims so that you can measure your key milestones and you can prove that you are changing something, and then with that you can go to a policymaker and say "OK, here is what we did so far, and we want to go there; can you support us?" Also it is shocking how often people cannot tell why they do what they do. So it is time, communication, leadership, top-down and bottom-up approaches, and then definitely resources. But here we are always very careful to say it is not always that you need new resources, sometimes it is more about reallocating the existing resources. (Interview 8)

In light of the interviews, it can be concluded that there is a need to increase the skills and capacities of the health sector to be better prepared to work across the other sectors. One of the ways forward could be increased engagement and recruitment of experts who have received their basic training in non-health areas to work with

intersectoral health initiatives. Similarly, the informants saw that the training of health experts and civil servants could be further developed to include more specific competencies that are needed for intersectoral work.

Another reoccurring opportunity was related to the need to increase the skills of the health sector in making the case that many public policies have health impacts even if the linkages are not always evident. The following informant reflected the differences between different policy areas by stating that in areas such as air pollution and road safety the health impacts are perceived to be much more evident in comparison to other areas such as social or educational policies:

There are obvious facts on ways to engage another sector. If you speak to someone about pollution in the environment and its effects on people's lungs and the health of children, nobody is going to dispute that. If you talk about accidents, you talk about how our roads are built, and the effects of speed limits, or this and that, and nobody is going to disagree that road safety is an issue where police have to be involved, etc. Where matters get more complex is when you begin to relate health outcomes to the social determinants and social policies in general. Because when you do that, although you provide the evidence that it is the cumulative effect of interventions and the roles of different sectors in creating a health promoting situation, the interventions themselves are not as obviously connected in people's minds to health. The connections might be obvious, but they are not as clear. (Interview 20)

Also, several other informants expressed the view that the health sector would need to do a better job in explaining many of the intersectoral connections and their relevancy in terms of health. This was seen to imply the health sector itself as well. One informant stated that sometimes the civil servants at the Ministry of Health are the most difficult partners to convince of the benefits of taking an intersectoral approach and that WHO should do more to get them engaged:

In all of this, the health sector is often the most difficult to convince to get engaged in this. And since we are WHO, we have a bit more homework to do in this field. (Interview 2)

Moreover, the same informant identified two central areas: values and evidence. Population health is often seen to have less societal value than other objectives such as short-term economic gains. The informant contrasted the value of health to the value of money:

We need to understand all the mechanisms that are relevant for building, destroying, and maintaining the health of the population and use this across all the sectors. Money is something that speaks to everybody and everybody across all sectors refers to that, but health should have the same currency, the same status. (Interview 2)

In terms of evidence, the informant acknowledged that there is not always very precise evidence about the effectiveness of health interventions but also expressed the view that public health should not limit itself too much to situations where there is a basis to make evidence-informed policy recommendations:

We know a lot about why we should take action and what is the potential for health. We know definitely less about the effectiveness of very specific interventions. [...] Sometimes we are limiting ourselves by being very strict with regards to the scrutiny we put on evidence in this field. But that is not limited just to my field but to public health generally. (Interview 2)

Based on the interviews, the ways to increase the influence of the health sector can be summarized as skills development through formal and informal training with a focus on advocacy, strengthening the evidence base by collecting and presenting information in a credible way, and presenting a stronger case for intersectoral policymaking and its benefits in general. These challenges have been addressed in the

literature. For instance, WHO has produced an extensive manual on the implementation of the HiAP approach to build the capacity of the health sector (WHO, 2015c).

5.2.2.6 Linking to existing processes

Multiple informants stated that existing national and global processes can provide opportunities that can be used to advance intersectoral action for health. The UN Sustainable Development Goals (SDGs) were mentioned a number of times as a global process that can be utilized to strengthen an intersectoral approach to health. In the WHO European Region, the Health 2020 policy platform was seen as a vehicle that promotes intersectoral policymaking. As a more specific opportunity, the Framework Convention on Tobacco Control (FCTC) is a binding convention that can, and already has, greatly helped national governments in the implementation of tobacco control measures across different sectors. In addition, the WHO's global and regional strategies were naturally seen to be helpful in advancing intersectoral action. For instance, the 2011 UN Political Declaration on NCDs and the 2014 UN Outcome Document on NCDs in the context of the SDGs provide new global opportunities for promoting intersectoral collaboration to tackle non-communicable diseases.

On the other hand, one informant emphasized that governments already have many processes that are intersectoral, and therefore one of the key opportunities for WHO is to link health to the existing processes:

There are already processes as part of government policymaking that are intersectoral, so our opportunities are to identify those and link with them, and not to duplicate them. (Interview 19)

Another informant pointed out that it is not necessarily an effective strategy to focus on the development of new action plans or strategies. There are many existing national action plans and strategies in which the health component can be linked:

These other processes where we can link to are certainly enablers. And the health sector can push these processes forward, and at the same time, it can be pulled forward to them as well. In my field, there has always been a clear understanding that you do not have to always create a new action plan from scratch; maybe you already have an action plan you can use. So it is really making use of the existing processes as far as they are out there. (Interview 2)

In addition to the national-level plans, a few informants referred to regional and global strategies that could be used more effectively to promote an intersectoral approach to health. For instance, one informant stated that the integration of health services is “a hot topic” within many international organizations, including the OECD, the EU, and WHO. These international organizations can put forward processes that also advance intersectoral action at the national level:

What we definitely see is that the whole topic of integration of service delivery has become very high-level. You have the EU working on it; the WHO headquarters is working on it. Many of the national governments have picked it up as a part of their health reforms. So it has become a hot topic on most levels; and many international institutions, the OECD for example, is also working on a performance indicator framework for integrated care. So there are a lot of actors pushing towards integration of services. And that is definitely a big opportunity. (Interview 8)

Lastly, it was mentioned that the collaboration between the health sector and the foreign affairs sector can provide opportunities that should not be underestimated. As a consequence of globalization, international health diplomacy has become a relevant but often neglected area (see Faid, 2012). Many international agreements, such as trade deals, can have significant health impacts, which makes the involvement of the health sector important in terms of avoiding the plausible negative effects on health.

The recommendation to link to existing policy processes that might be international (SDGs) or national strategies is not unexpected in itself. However, some

informants suggested that policymakers might often forget this option before they have already started a new process. In day-to-day policymaking, there is not necessarily enough time and competencies to map out the opportunities for these linkages.

5.2.2.7 Making budgets differently

A few informants pointed out that budgets can largely determine the scope of intersectoral action by setting limits on the available resources. Usually the budgets are planned from a sectoral perspective and money is allocated to different sectors. As an example, one informant said that it is a practical challenge when two ministries cannot combine their funding streams for joint action.

It was suggested that intersectoral action can be promoted and supported through various financing mechanisms. For instance, joint budgeting or pooled budgets can be used to get two or more sectors to share their financial resources to tackle a specific health challenge. The following informant stated that the new ways of financing can provide an opportunity to promote an intersectoral approach:

I think that the very promising development is that budgets, and also investments, are being progressively planned in a different way. In some ways, money always determines what we are doing. (Interview 15)

The informants did not go into much detail when they were discussing different funding mechanisms to advance intersectoral action for health. However, a couple of informants mentioned that austerity policies and reduced health budgets pose a challenge, whereas an opportunity lies within a new kind of thinking that focuses on long-term returns and benefits. It was expressed that austerity policies can become very expensive in the long run.

In terms of financing, one of the dangers was seen to be related to cost-shifting within one sector or between different sectors. The sectoral actors may have an incentive

to transfer costs to another payer if there is a possibility to do it. This kind of cost-shifting can reduce the effectiveness of the public sector and is not generally seen as a desirable thing. Structural and institutional arrangements can be used to reduce the value of unnecessary cost-shifting, for instance by enacting policies that disincentivize cost-shifting tendencies. With regard to health-related budgeting, one informant wanted to highlight the discussions related to the greater integration of health services and stated that the integration of these services should not be seen as a cost-cutting tool because it does not necessarily reduce the costs. The informant asserted that greater integration should be promoted as one approach to cost-efficiency and cost-effectiveness but not to cost-reduction:

Sooner or later you need fresh money, you need investments. What is also very important is that all of these initiatives are to improve quality, they are not for cost-cutting. You cannot cut costs with an integration of services, or it should not be your main goal. You maybe shift costs for example, sometimes you can see that because you reduce hospital admissions, you have fewer costs in the hospital sector, but then of course the costs may rise in the primary care sector because there you need more GPs or you need more nurses, et cetera. It is a very ambiguous topic. (Interview 8).

Although the informants did not describe various funding mechanisms in detail, it can be concluded that planning budgets to support and facilitate intersectoral collaboration is a clear opportunity in terms of advancing intersectoral action for health at the national, regional, and local levels. At a minimum, some of the budgetary barriers should be removed in order for them not to disincentivize intersectoral collaboration in cases where the potential benefits can be clearly perceived.

In my literature review, three key financing approaches were identified to support intersectoral action for health: earmarked funding, delegated financing to independent bodies, and joint budgeting between sectors (McDaid, 2012; McDaid & Park, 2016).

Although there are recognized ways for intersectoral budgeting, the use of these mechanisms seems to be more sporadic than systematic.

5.2.2.8 Increasing focus on policy development within WHO

The informants for this study reflected options and directions for policy development to further advance intersectoral policymaking in their programmatic area(s). One recurring topic was related to the desire to increase inter-program collaboration within WHO itself. A number of informants expressed the view that increasing joint-work and communication between WHO programs can also be an opportunity to promote intersectoral action with other stakeholders and country representatives. Some of the concrete interorganizational ways that were mentioned included joint high-level missions to countries, collaboration to produce intersectoral policy briefs, organizing inter-program trainings, and developing new tools to address health challenges through an intersectoral approach.

Some examples of concrete tools were mentioned (see also Appendix D). One informant gave a detailed description of a step-by-step manual intended to help policymakers to develop national action plans on transport, health and the environment.⁹⁹ The manual is directed to national governments who wish to formulate an intersectoral action plan to address intersectoral challenges. The informant described the purpose of the manual in the following way:

It is sort of a step-by-step manual on how to develop intersectoral action plans. That is something that has been asked for by the Member States, and we developed that for them. Now France and Serbia are piloting the application of

⁹⁹ WHO. (2014). Developing national action plans on transport, health and environment. A step-by-step manual for policy-makers and planners. Copenhagen: WHO Regional Office for Europe.

this manual and using it in the development of their national action plans in this field. (Interview 2)

With regard to WHO's work, a number of informants expressed a wish to have more inter-programmatic and inter-agency high-level missions to countries. The first "inter-programmatic" area considers the programs within the WHO Regional Office for Europe and the second "inter-agency" area refers to joint missions between different UN agencies. However, it was stated that the same barriers that limit the intersectoral work elsewhere, and thoroughly examined in this study, apply also to WHO and limit the collaboration between different programmatic areas, as expressed by the following informant:

What I would like to see in the future is much more country-level collaboration, for example, to have more joint missions that include multiple WHO programmes. I think it is vital that WHO programmes do leadership training now together and start with joint activities at the beginning of each biennium. [...] We are trying to work together in-house, but it is just difficult in the way we are programmed. Those planning processes are putting us a bit in a box. And this is also about global planning processes; we are not working in country teams and that is also a problem. (Interview 15)

Another informant indicated that very often the countries want practical guidance and examples of policies that have been effective in tackling health challenges. Also for this reason, the informant stated that it could be beneficial to have multiple WHO programmes join with each other to organize a joint mission to a country. At best, this could combine the political and technical expertise within WHO in an optimal way:

We all are serving the countries, and the countries most of the time are very practical. So instead of doing this solo exercise in countries, we [WHO programmes] could go there together to have a joint mission. Often I am going alone to my missions. Maybe we could go to some countries and see if it works to have an intersectoral workshop or meeting and to bring some technical

programmes in. So you could illustrate your talk about intersectoral cooperation and the need for it through concrete benefits or entry points. This could be genuine teamwork to make our message heard more at the country level and make it more practical. This could be something, but of course, then we are talking about barriers, and why it is not happening, and there are many objective barriers why it is not happening. But we could aim for it. (Interview 18)

Several informants stated that collecting and reporting concrete case studies can be one way to demonstrate the benefits of intersectoral action. However, the contextual nature of policymaking was seen as a challenge, because in intersectoral policymaking WHO cannot recommend any one-size-fits-all model that could be directly implemented in different national contexts. For this reason, WHO's guidance on intersectoral action consists more of recommendations at a general level rather than aiming to give detailed policy prescriptions.

In terms of intersectoral action, one implicit perspective among the informants seemed to be that, as an organization, WHO should pay more attention to making sure that it really "practices what it preaches." The Programme Managers were not always very well aware of what the other programmes are doing and how the work might relate to their own work. In addition, very few informants referred to the work of WHO headquarters and its relevancy to their own programme.

The need to focus on internal policy development within WHO is well-recognized, and there is an ongoing policy reform currently being implemented (WHO, 2017c, 2017d). In 2012, reform proposals were placed under three categories: programmes and priority setting, governance, and management. An extensive list of reform proposals was introduced to make WHO a more effective organization (for historical context, see Clift, 2013; Lee, 2008). The interviews seemed to provide support for the suggestion that WHO suffers from a lack of information flow between its Geneva headquarters and its regional offices. On the other hand, programmatic budgets very much define what WHO does; and if the level of earmarked funding is very high, it might weaken the internal

collaboration between different WHO programmes and its offices. Based on the interviews, it can be suggested that WHO should pay attention to ensuring efficient management structures that facilitate the collaboration between different programmatic areas in order to have an organization that makes a greater overall impact.

5.2.2.9 Strengthening and clarifying the WHO's role and mandate

A number of informants indicated that widening the WHO's mandate can act as an opportunity in terms of promoting intersectoral policymaking. However, there were varying views on how wide or narrow the WHO's current mandate is. The key difference was in the question of whether WHO can approach and work with ministries other than the Ministry of Health. The following informant saw that the mandate is quite strictly limited to health ministries:

It is a difficult issue because our main partner in a country is the Ministry of Health; we do not have even a mandate to approach the ministry of something else. So we are always entering the door of the Ministry of Health. (Interview 1)

One interesting finding was that the informants gave different characterizations about the scope of the WHO's mandate. To some extent, this can be understood through the different programmatic areas that informants work in. For instance, health and environment is naturally a more intersectoral field than vaccination. One informant working in an area that has a strong intersectoral focus stated:

Formally we have written to other ministries. So I do not see myself limited to writing only to the Minister of Health. The only practical problem there is that all our guidance on how to communicate with other ministries is relatively limited. But we have worked with the relevant internal bodies to overcome that. So, I actually see my mandate as very broad and not limiting at all. Because as long as we can make the case that a sectoral policy is relevant to health, the WHO

mandate sort of gives us an opportunity to act in that field. So I do not feel limited at all in this regard. (Interview 2)

However, the varied responses indicated that the informants did not seem to have received an organization-wide clarification on their “intersectoral” mandates or these mandates were, at least to some extent, defined and negotiated within individual programmatic areas. In terms of a mandate, the WHO Constitution was referred as the core document that defines the role of WHO. The following informant highlighted that even the Ministries of Health are not always able to take action on some specific issue; they still might have the power to bring others together to convince them:

Our main partners are the Ministries of Health, and this is linked with the WHO Constitution. I mean they are normally friends, allies, good people we like to work with, and that should be kept as such. Even in practical terms they are the entry points. So, I think they should not be underestimated, they should be supported, scaled up as much as possible. We need to support them so that they are relevant in their countries and things like that. I see them as my entry points. Sometimes the Ministry of Health is not extremely powerful but they have convening power. We can and should use them. I see myself working with other sectors as well because if I do not work with them, nothing meaningful will happen. (Interview 10)

In 2012, the Health 2020 strategy was accepted as an official framework by the Member States of the WHO European region to guide work and set priorities in the region. Several informants stated that Health 2020 can be understood as a tool to increase the understanding of the intersectoral nature of health and its determinants. For WHO, it does not provide a direct mandate to contact ministries other than the Ministries of Health. However, as a wide policy framework promoting the Whole-of-Government approach, it gives strategic and political support for national Health Ministries in order for them to engage more non-health partners at the country level. Naturally, all health-related UN resolutions can also strengthen the mandate of WHO, as expressed by this informant working on road safety:

I think generally speaking for road safety, there is the UN General Assembly resolution that gives us a mandate; but in the other areas we do not have the mandate. We can only work with the Ministries of Health; however, it would be useful to have a wider mandate for another areas. (Interview 16)

In relation to road safety, an informant commented on a situation where there was some willingness inside of WHO to work with a specific company representing the car manufacturing industry. The project did not go further because the internal legal advice was that as an organization, WHO cannot give one manufacturer a competitive advantage:

The project was on road safety, of course you need industry to develop road safety measures if you want to have safer vehicles. But the legal advice from the WHO office was that the project would put this particular commercial company at an unfair advantage, and therefore it would not be aligned with WHO policies. (Interview 16)

One special issue that was brought up related to the WHO mandate was about media relations. The current situation within WHO is that all media and public relations have been centralized to designated media and communication departments, i.e. individual experts, and other staff members are not normally allowed to give direct media commentary. One informant understood the justification for this practice, as it is aimed at protecting WHO's credibility and ensuring that only reliable information is communicated to the media, but also noted that the practice used to be different in the past:

WHO had quite an interesting history here; at one point we all were allowed to talk to the media and write press releases, and we all had training in doing press releases and interviews, et cetera. And then that was stopped and only certain people are allowed to do those, which is the case at the moment. So we have had relationships with the media, but they are filtered through official channels within WHO. (Interview 19)

Naturally, this kind of media and communications strategy limits the possibilities for individual WHO experts to communicate and do advocacy work through the media. It was expressed that WHO could communicate more about the health benefits and achievements of intersectoral policymaking and also actively use social media (e.g. Facebook, Twitter, and YouTube), besides traditional media channels.

Discussion about the mandate can be expected when the focus is on intersectoral action that fundamentally can be seen to suggest that other sectors should work on the goals that are another sector's core responsibility. WHO works side-by-side with governments with focal points at the Ministries of Health. There are two broad ways how WHO can increase the scope of its mandate: (1) to collaborate with other UN agencies, or (2) to work directly with heads of government at the highest political level. The emphasis on the level of the mandate was not an unexpected finding itself; however, the varying views on the scope of the mandate can be seen as surprising to some extent. This finding could be explained by the fact that the WHO informants interviewed for this study worked in different programmatic areas that often have different dynamics and working methods; i.e., in some programmatic areas, having a wide mandate could be a more politically contested question than in others.

5.2.2.10 Working through other UN agencies and non-state actors

The informants for this study put a considerable amount of time reflecting on the challenges and opportunities for intersectoral action for health in the context of the national Ministries of Health. Along with national focal points within countries, WHO works at the international level through a number of partners. One of the key ways WHO can work across sectors is by engaging with other UN organizations and well-established international partners. At best, this interorganizational and international collaboration was seen to be able to provide great benefits to all stakeholders internationally as well as at

the country level. In the interviews, the WHO informants mentioned a large number of organizations that they actively collaborate with. Generally, these partners varied, depending on the specialized area of the WHO expert.

In the field of food safety, the informant highlighted the importance of organizations such as the Food and Agriculture Organization of the United Nations (FAO), World Organisation for Animal Health (OIE), EU Commission, European Food Safety Authority (EFSA), and European Medicines Agency (EMA). In addition, the informant expressed the view that it is not possible to work without the food industry, as it is the key player in policy implementation and also has a strong shared interest in ensuring the safety of food.

The informant working in sexual and reproductive health considered her main partners to be the United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF), United Nations International Children's Emergency Fund (UNICEF), Gesellschaft für Internationale Zusammenarbeit (GIZ), and United States Agency for International Development (USAID). The informant indicated that the involvement of the private sector is a complicated and sensitive issue, especially in the area of reproductive health. To date, cooperation between WHO and the private sector has been very limited. According to the informant, there has been much more collaboration with NGOs at the country level. However, the informant also noted that this collaboration can be very difficult in some countries where civil society is not very strong, and it is hard to find credible actors to participate in joint meetings between WHO and national counterparts.

In the area of promoting the health of ethnic minorities, the key UN partners of WHO include the United Nations Development Programme (UNDP), Office of the High Commissioner for Human Rights (OHCHR), UN Women, and UNICEF. In addition, the informant mentioned the Council of Europe and the International Organization for Migration (IOM). WHO has also worked indirectly with Roma NGOs by asking

governments to nominate a civil society organization to present Roma people in country-level training. The informant saw that civil society is a significant partner with WHO, which should not only be involved but also strengthened.

The Programme Manager working to strengthen public health services stated that, along with the in-country focal points, her most important partners include WHO Collaborating Centres, the European Observatory on Health Systems and Policies, several academic institutions, European Public Health Association (EPHA), and the network of health-promoting hospitals. The Programme Manager for nutrition and physical activity highlighted the importance of UNICEF as a partner that has opened many doors to in-country work. The OECD was mentioned as an important collaborator in the work to analyze economic drivers of health promotion, and this cooperation has also led to several joint publications.

Similarly, the Food and Agriculture Organization of the United Nations (FAO) has been an important collaborator, especially in industry-oriented work. The European Union and its Commission, especially DG Health and Food Safety and DG Agriculture and Rural Development, have collaborated actively with WHO in food and physical activity. There are also many relevant European NGOs such as the European Association for the Study of Obesity (EASO) and the European Heart Network (EHN). However, the informant stated that collaboration with NGOs is often based more on informal knowledge exchange rather than on formalized and structured work.

The Programme Manager for injury prevention and road safety mentioned that due to the limitations in WHO rules the program has very little involvement with the private sector. The organizational restrictions are related to conflict of interest and to the risk of giving an unfair competitive advantage to one company. This particular Programme Manager highlighted the existence of good collaborative relationships with WHO Collaborating Centres, UNICEF, and the United Nations Economic Commission for Europe (UNECE). The Programme Manager for the social determinants of health stated

that intersectoral partnerships constitute one core area of the programmatic work and highlighted collaborative work, especially between WHO, UNDP, UNESCO, UNICEF, and the International Labour Organization (ILO). These UN agencies share a strong interest in reducing inequalities and increasing social cohesion.

The two informants working in the area of integrated care mentioned that the World Bank and OECD are important partners in information exchange. The Programme Manager for antimicrobial resistance highlighted the European Medicines Agency (EMA), European Commission, World Organisation for Animal Health (OIE), and Food and Agriculture Organization of the United Nations (FAO) as his core collaborators. The Programme Manager for tobacco control stated that collaboration between the UNDP and WHO has been strong and very successful in taking the agenda forward regarding non-communicable diseases. The same informant also mentioned that the role of the European Commission has grown bigger and that WHO is actively engaged in information exchange and meetings with EU institutions such as DG Sante. Moreover, the informant stated that there are gaps related to the collaboration between WHO and the trade sector in general.

The Programme Manager for alcohol and illicit drugs stated that WHO has engaged in a joint project with the European Commission with a focus on a shared database and monitoring system. As a specialized agency of the EU, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was emphasized as being an important partner of WHO. In addition, the informant stated that the European Alcohol Policy Alliance (Eurocare) is an important non-governmental partner that represents a number of European public health organizations that aim to reduce alcohol-related harm. The Programme Manager for human resources for health emphasized good collaboration with the World Federation for Medical Education, nursing associations, and medical education organizations in general. Within the field of human resources for health, other relevant international organizations that the informant mentioned included the World

Bank, EU, ILO, OECD, and UNESCO. The Technical Officer for vulnerable groups, gender, and human rights specifically mentioned that there have been joint conferences and capacity building efforts with the Council of Europe, UN Women, UNFPA, IPPF, and the European Institute of Women's Health (EIWH). The Technical Officer for environment and health highlighted the good collaboration between WHO, the United Nations Economic Commission for Europe (UNECE), the United Nations Environment Programme (UNEP), academic institutions, and a number of NGOs. The informant stated that in health and environment, the most active collaborators from his perspective have been transport-oriented NGOs, whereas health NGOs have had much weaker representation. However, the informant stated that the relative weak engagement of the health sector is not necessarily a negative thing. The active engagement of other sectors in health-related matters can be considered as a good development in terms of promoting intersectoral action for health.

Based on the interviews, at least three general conclusions can be drawn from the WHO's collaboration with other UN agencies and non-state actors. First, international partners are important to WHO because they can provide significant assistance with the country-level work by connecting WHO with other sectoral ministries and non-health actors. This type of collaboration among UN agencies can be considered as an expected finding and WHO's key partners are also listed in public sources (WHO, 2017g). The following two informants emphasized the positive aspects of this type of collaborative approach by stating:

If the Ministry of Health says that we do not know anyone from the Ministry of Education who is working on this topic, then we usually go through UNFPA, UNICEF, or another partner we already know. (Interview 1)

Intersectoral action for health can also be promoted through other agencies. For example, FAO can contact the Ministry of Agriculture. In any case, a coordinated

approach is needed, and we can also use the WHO's own country offices.
(Interview 4)

Second, the collaboration and coordination with other agencies is not always smooth, and there can be competition between UN agencies within countries. It was expressed that the coordinated approach should be strengthened because sometimes different UN agencies may be engaged in overlapping work and are not well aware of each others' actions. Third, the relationship between WHO and non-governmental organizations within countries is often challenging. At the country level, WHO has to consider which NGOs it should invite to meetings in order to facilitate civil society engagement. However, this leads to the question of why some NGOs are invited but others are not; and often in these cases, the practical solution has been that no NGOs were invited at all. The general expectation is that as a framework, FENSA (WHO, 2016c) will provide clearer guidelines on the nature and mechanisms for WHO on how to collaborate with NGOs and other non-state actors. Third, the WHO's collaboration with the private sector is very limited. In addition, the informants of this study did not have direct media contacts, as those are channeled through the communications department of WHO.

A few informants indicated that there should be more resources channeled to the inter-agency work between WHO and other UN agencies. One recurring statement was that informants do not have time to attend multi-agency meetings because their core programmatic tasks require most of their time. One informant stated that additional staff for intersectoral work would be very valuable in facilitating inter-program work within WHO as well as with other UN agencies, NGOs, and academic research institutions. Similarly, joint action related to the SDGs was seen to provide a solid framework and predefined goals for the WHO's collaboration with UN agencies and non-state actors (UN General Assembly, 2015). In conclusion, strengthening the inter-agency and inter-

organizational collaboration and using it more effectively was considered a clear opportunity by the majority of the informants.

In the interviews, the informants were also asked about concrete projects or other activities that could exemplify intersectoral action for health in the WHO European Region. Many of these “case studies” included an element of inter-organizational or inter-agency collaboration. A list of these examples can be found in Appendix D, but an in-depth analysis of the cases is outside the scope of this dissertation.

CHAPTER 6: DISCUSSION AND CONCLUSIONS

The empirical part of this dissertation focused on the challenges and opportunities for the implementation of intersectoral action for health by analyzing the data from 28 key informant interviews. The informants for this study held expert roles at the WHO Regional Office for Europe in a number of different programmatic areas (see Appendix C). The thematic analysis revealed ten key challenges/barriers and ten key opportunities/facilitators for intersectoral action for health.

The aim of this dissertation was to uncover the challenges and opportunities for implementing intersectoral action for health as experienced by WHO experts. Many of the theoretical approaches outlined in my literature review focused more on the context of policy change and less on the real-life implementation process and its challenges. In general, the contemporary literature on the social determinants of health and health equity (e.g. Marmot & Wilkinson, 2006; Raphael, 2016; WHO, 2008a) extensively describes the contextual environment where policies are implemented but is less concerned with the policy process that eventually leads to different outcomes. My literature review on the social determinants of health, human rights, governance and policy ideas provided me with a general sense of reference in approaching my empirical interview data (i.e. sensitizing concepts). Through a thematic analysis, this dissertation produced new information on the actual challenges and opportunities experienced by policy experts who work to promote the implementation of intersectoral action for health within the WHO context. To my knowledge, the experiences of WHO staff members on this subject matter have not been systematically studied before, despite the fact that WHO has promoted intersectoral action for health since the 1970s.

In this discussion section, I will compare and contrast my research outcomes to the literature sources by reviewing the findings in light of what could be expected based on the existing literature and by considering whether my study revealed any findings that

were unexpected or previously unknown. In addition, I will reflect on the added value of this study regarding the implementation of intersectoral action for health.

Intersectoral action for health

My first research question considered the conceptual understanding of “intersectoral action for health.” The literature review of this dissertation revealed that intersectoral action has been used to refer to a *process*, a *practice*, a *collaboration*, a *coordination*, and an *interaction* (Dubois et al., 2015). In the interviews, the most frequently used term to describe intersectoral action was “collaboration”, whereas the informants generally did not use the terms “process” or “practice” to describe intersectoral action for health. It is interesting that descriptions of intersectoral action as a process were less common; i.e., the need for collaboration was highlighted, but the informants talked much less about collaboration as a process that usually requires a long-term commitment and determination from all stakeholders. This finding could be contrasted to the arguments claiming that one of the shortcomings in intersectoral approaches is that the actual process of policy implementation has gotten too little attention, i.e., intersectoral action for health is offered as a standard policy remedy without acknowledging the inherent complexity of its implementation (Clavier & de Leeuw, 2013b; Lynch, 2017).

A thoughtful focus on the policy process could lead to improved policy prescriptions. Similarly, it can be argued that a full and realistic acknowledgement of policy barriers would be helpful in addressing them more efficiently. A degree of humility would be also required, along the lines suggested by Bryson et al. (2006), who concluded that the normal expectation should be that success in the implementation of cross-sectoral/intersectoral action is very difficult to achieve. Despite the challenging nature of the task, the informants of this study considered intersectoral action as an essential prerequisite for effective health promotion. This finding reflects the relatively strong consensus that can be observed by a close reading of WHO documents in general, and

especially conference statements on health promotion (see Chapter 3). Multiple informants stated that in their programmatic areas, there has been a positive shift towards intersectoral approaches during the past decade. To some extent, these positive appraisals can be seen to reflect the strong intersectoral aspect in the Health 2020 policy framework, which is the core document steering the work of the WHO Regional Office for Europe (WHO, 2013b).

However, as my literature review showed, intersectoral action has already been strongly promoted by WHO since the late 1970s through the milestones of the Alma-Ata Declaration (WHO, 1978), Health for All strategy (WHO, 1981), the Ottawa Charter (WHO, 1986b), and more recently the Health in All Policies approach (WHO, 2013c, 2014b, 2015c). In 1978, the Alma-Ata Declaration stated that the attainment of the highest possible level of health “requires the action of many other social and economic sectors in addition to the health sector” (WHO, 1978). The informants did not generally refer to the historical developments in a detailed way and only a few informants referred to the statements or declarations released in the 1980s or 1990s regarding intersectoral action for health. This might be explained by the fact that these historical developments were not the key focus of the interviews. However, the Health 2020 policy framework (WHO, 2013b) and the work of WHO Commission on Social Determinants of Health (WHO, 2008a) were mentioned spontaneously by multiple informants.

Governance for health

The second part of my first research question focused on the understanding of governance for health. The informants for this study understood the concept “governance for health” as covering a considerably wider area than intersectoral action for health. Governance was seen as referring to mechanisms and structures where intersectoral action can happen and which can make it possible. As one informant stated, “governance is something where you have common objectives and a framework for

monitoring, evaluation, and accountability" (Interview 10). The governance perspective was seen to include interaction, interests, and power relations within and between the public sector, the private sector, and civil society. This definition is similarly stated in the literature review of this dissertation as "the formation and stewardship of the rules that regulate the public realm" (Hyden et al., 2003, p. 5) or "the systematic, patterned way in which decisions are made and implemented" (Greer, Wismar, & Figueras, 2016, p. 4). According to Greer et al. (2016), health governance includes transparency, accountability, participation, integrity, and capacity. Generally, all these elements were discussed in the interviews, with the only exception being "participation", which was not discussed in great detail by any of the informants. Some informants highlighted the importance of civil society engagement, but they also stated that they do not work directly to engage citizen groups or individual actors. I will reflect on this absence and the limited role of civil society in my conclusions (Section 6.4.2).

An unexpected finding is how little the informants addressed the issues of power and politics. The direct references to power were made mainly when the interviewees spoke about the potential conflicts of interest and the industry influence in relation to alcohol, food, and tobacco. However, the informants generally did not use any direct references to political ideologies and ideas that shape power relations within a society. There might be several explanations for this observation. It is unlikely that the WHO experts would not see the importance of political ideas and ideologies in shaping health-related public policies. Therefore, the lack of explicit discussion about political ideas more likely stems from the position of the informants as WHO representatives who perceive that their professional role implies focusing on the technical aspects of health promotion. In addition, it would be against the norm to bring strong political beliefs into an interview that very much resembles a professional consultation. It can be assumed that in an environment such as WHO, health experts have also learned to be cautious in

bringing political statements to the table because their role is to assist WHO Member States regardless of the political situation in the country.

Within WHO and other UN agencies, a division is made between political and technical levels of the work. Programme Managers, Team Leaders, and Technical Officers in this study work on the technical issues, whereas political decisions and statements take place in official decision-making bodies. However, it should be noted that the division between technical and political work is never absolutely clear, with a significant grey area between them. In the WHO European region, the Regional Committee and its Standing Committee consist of country representatives and are the core decision-making bodies. The roles of the Regional Director and other executive managers can be seen to be more political, as the directors often have to liaise with national governments and politicians to gain support and traction for the evidence-informed policy recommendations produced by WHO.

6.1 Reflections on challenges and barriers

My second research question considered the factors that key informants identified as the main challenges and barriers to intersectoral action for health. In the following, I will review the ten thematic areas by outlining links to the existing literature and reflect on the relevance of my findings to the implementation of intersectoral action for health in the future.

The informants associated *the narrow view of health and its determinants* (theme in Section 5.2.1.1) with unwillingness to engage multiple sectors in health promotion through intersectoral collaboration. Blaxter (2010) has concluded that it is important to understand that the biomedical and social models conceptualize health in very different

ways.¹⁰⁰ Throughout the 20th century, a biomedical perspective on health has provided the most dominant paradigm for understanding health and its determinants. From a health promotion perspective, Labonte (1993) has outlined three general frameworks for the concept of health. First, a traditional and paradigmatic medical approach sees health as an individualized phenomenon that is manifested in the absence of disease or disability. From this perspective, health promotion activities are conducted by physicians and other medical professionals who apply various strategies on an individual patient, including surgical interventions, drug therapies, screenings, and management of behavioural risk factors.

Second, a behavioural approach to health provides a somewhat wider conceptualization that highlights health as the functional ability of an individual. Unhealthy lifestyles manifested in poor nutrition, lack of exercise, smoking, alcohol use, and ineffective coping skills are seen to lead to poor health. Health promotion is understood as an activity of health workers and advocates who provide health education and try to promote behavioural change towards healthier lifestyles by influencing psychosocial and behavioural risk factors.

Third, a socio-environmental approach sees health as a positive state that is fundamentally linked to the surrounding social and physical environment. Supportive social relationships and inclusive communities can promote health, whereas risk conditions such as hazardous living conditions and poverty can be significant threats to

¹⁰⁰ In addition, Blaxter (2010) has reviewed the concept of health by highlighting five different perspectives: (1) health as the absence of illness; (2) disease as deviance from the norm; (3) health as balance and homeostasis; (4) health as an ability to function; and (5) health as a state or status.

health.¹⁰¹ Fourth, a “structural-critical” approach refers to an analysis of economic and social relations and their influence on the health of a population, i.e. the political economy of health. Power imbalances and inequitable distribution of resources within a society among socioeconomic groups are at the heart of the structural-critical approach (see Raphael, 2012b, p. 14; Raphael & Bryant, 2006a).

The different perspectives on health lead to different problem definitions and strategies to solve health problems. The multiple streams theory (Kingdon, 1984) presumes that successful policy implementation always has to entail a definition of the problem and a policy proposal to tackle it. In terms of problem definitions, the traditional biomedical approach to health is unlikely to lead to a strong call for intersectoral action, as health is seen as an individualized medical problem that should be tackled through medical interventions carried out by the medical profession. In other words, the understanding of health is important in terms of the solutions to promote health. For instance, if the lay understanding of health inequalities is individualized as “making healthy lifestyles choices, it may become difficult to gain popular support for solutions that would tackle health inequalities by social and structural measures (e.g. Blaxter, 1997). The key informants for this study expressed the view that non-health sectors have a strong impact on the health of the population. Consequently, a theoretical conclusion from this finding is that intersectoral action for health should be based on a socio-environmental and structural-critical understanding of health.

¹⁰¹ For instance, the final report of the WHO Commission on Social Determinants of Health (WHO, 2008a) took a step towards a structural analysis by stating that “inequities are killing people on a grand scale”. However, the same report has been also criticized for not clearly acknowledging the role of unequal power relationships in producing these inequities (see Birn, 2009; Navarro, 2009). Link and Phelan (1995) have developed “the theory of fundamental causes” to explain how privilege is associated with resources such as “knowledge, money, power, prestige, and social connectedness” that are unequally distributed and affect the health of individuals (p. 87).

A wider understanding of health and its determinants can be promoted through various forms of advocacy, such as producing evidence-based information in an accessible form (e.g. policy briefs and other materials) as well as preparing more detailed background papers for policymakers and politicians. Similarly, raising public awareness through the media is important for having an educated public that understands the interconnections between health and public policy. In addition, professional training and education as well as curriculum development within universities and other educational institutions are important in order to have a new generation of experts who are aware of the intersectoral nature of the social determinants of health. Close attention should be paid to promoting interaction between research, policy, and practice, for instance through policy dialogues that bring researchers, practitioners, and politicians together for policy development. Politicians should be held accountable for the health effects of their decisions and their willingness or unwillingness to support evidence-informed policies, which is a task that requires active citizens and an active civil society in general.

A low level of political leadership and commitment (5.2.1.2) to intersectoral action for health was associated with the weakness of the Ministry of Health and short electoral cycles where politicians focus on short-term gains at the expense of a long-term commitment to health promotion. Similarly, the informants for this study reflected on the perceived low political value of health in comparison to short-term economic objectives and other competing interests. These findings support the view of health as a fundamentally political issue in a similar vein to that stated by Bambra et al. (2005, p. 187) when they write that “ultimately, health is political because power is exercised over it as part of a wider economic, social and political system.” Moreover, the explicit recognition of the political determinants of health and their influence on population health is an important starting point for developing sustainable structures and mechanisms for intersectoral action for health.

WHO strongly endorses the view that a commitment to and support for intersectoral action for health from the highest political level is one of the key success factors for successful implementation (WHO, 2015d). High-level political support is important to actors in the lower level of governance for having a strong mandate for engaging in intersectoral collaboration. A strong and determined leadership needs to be combined with resources, skills, and knowledge as well as strategic thinking to support intersectoral work (Greer & Lillvis, 2014). In the governmental context, it is important that the Ministries of Health are politically savvy in a way that they can successfully engage other ministries and systematically map co-benefits and mutual gains for other sectors, which could be achieved through intersectoral collaboration. This means working actively and efficiently to raise health higher on the political agenda.

Competing interests and competition for resources (5.2.1.3) is another theme that was raised by the informants. In the context of governmental decision-making, health and its promotion is only one priority among many other priorities. From a governance perspective, it should be clearly recognized that every sector or ministry has a core objective that is not directly related to health. Within the national context, officials in the Ministry of Health and in governmental health agencies should have adequate skills to mediate and negotiate interests with representatives from non-health sectors. Government officials can be trained in the use of various tools and frameworks. For instance, in the WHO context, one recent example of training materials focused on intersectoral approaches is the WHO Health in All Policies training manual (WHO, 2015c).

On the other hand, several informants mentioned that economic growth, security, and many other policy priorities are often higher on the policy agenda than health promotion. These interests are promoted by a number of interest groups that were discussed in the literature review of this dissertation. In terms of policymaking, classical pluralism suggests that all interest groups have an equal chance to influence public policy (Lindblom, 1959). Later, the pluralist view has been complemented with neo-pluralist

arguments that acknowledge that there is an uneven distribution of power among different interest groups, among which the corporate and business sector is often very powerful in shaping public policymaking (Lindblom, 1979). However, policies that benefit corporate and business interests are rarely the same policies that promote the population's health (Raphael, 2014).

When the political nature of health is accepted as a premise, competing interests and competition for resources is something that should be naturally expected. The political economy approach suggests that the distribution of power and resources within a society strongly influences policy agendas and policymaking processes (Bryant, 2012). In the context of this study, it can be argued that if the power balance is strongly inclined towards market interests, the Ministries of Health are likely to meet difficulties in the promotion of their health-related interests, and this also entails the implementation of intersectoral action for health. It is clear that health advocates should have sufficient skills to place health on the policy agenda, but at the same time, their work is unlikely to be very successful if the surrounding ideological and political climate gravitates strongly towards market and corporate interests. As discussed earlier in this section, the informants for this study discussed the power of the market sector when they reflected on potential conflicts of interest, but they did not explicitly refer to the power relationships between the market sector and the public sector.

In the Western context, some welfare theorists propose a general hypothesis that intersectoral action for health can be easier to implement in social-democratic welfare states than in liberal welfare states that are more market-oriented in providing a social safety net to their citizens (see Esping-Andersen, 1990; Saint-Arnaud & Bernard, 2003). However, there are many intervening factors, such as the existence of efficient implementation and accountability mechanisms and various other indicators associated with the principles of good governance (UNESCAP, 2006; see Section 2.4.1 in this dissertation). However, these questions are outside of the scope of this dissertation and

therefore it remains a task for other researchers to explore the linkages between welfare state typologies and facilitators of intersectoral action for health. Instead, the main focus of this study is to utilize a wider governance perspective in order to understand the policymaking process more clearly.

Lack of permanent implementation mechanisms (5.2.1.4) has a major impact on the initiation and sustainability of intersectoral action for health. The collaboration of multiple sectors is unlikely to be sustainable without permanent mechanisms and coordination structures. In other words, my findings suggest that intersectoral action for health should be institutionalized to be sustainable. Along the lines suggested by Fafard (2012), in order to understand the practical steps to “institutionalized intersectoral action”, the broad use of the term “institution” should be narrowed to consider mainly bureaucratic structures (e.g. ministries) and the rules and practices that influence those structures (e.g. legal mandates). According to Greer and Lillvis (2014), bureaucratic changes are one way to tackle the challenges of coordination and durability of intersectoral action for health. From a governance perspective, McQueen et al. (2012, p. 11) have produced a list of intersectoral governance structures and governance actions that can inspire governments in finding concrete ways to implement intersectoral action for health. (See Table 3 in this dissertation.) The most effective solutions are always contextual but one of their key structural ideas is the establishment of intersectoral and interdepartmental committees with a strong (legal) mandate for implementation (McQueen, Wismar, Lin, & Jones, 2012).

Lack of resources for implementation (5.2.1.5) is a rather obvious condition that makes the initiation of intersectoral action for health less likely. As stated earlier in this dissertation, the key question of politics is “who gets what, when and how” (Lasswell, 1958). The lack of resources for health-related intersectoral initiatives can be seen to reflect the fact that intersectoral action for health is not high enough on the policy agenda to lead to clear changes in government priorities and resource allocation.

Kingdon (1984) suggested that a policy is formulated and implemented only when three policy streams come together: problems, policies, and politics (Ollila, Baum, & Peña, 2013). The problem stream refers to the identification of a problem that can be clearly defined (e.g. a specific health challenge that needs to be tackled through intersectoral action), the policy stream considers the need to have practical policy-based solutions (e.g. establishment of an intersectoral committee with a clear mandate and resources), and the politics stream refers to the requirement of having sufficient political will to implement the proposed policy. In other words, practical policy ideas are rarely enough if there is no political will that would lead to the implementation of those ideas. Recently, Kingdon's multiple streams theory has been applied in the theoretical literature considering the implementation of the Health in All Policies approach (Kickbusch, 2010b; Ollila, 2011; Ollila et al., 2013; WHO, 2015c). In terms of implementing intersectoral action for health, the significance of the multiple streams theory has been in its ability to emphasize that it is not sufficient to identify a problem and formulate a policy proposal if these two elements are not accompanied by a strong and sustainable political commitment.

Complexity of the policymaking processes (5.2.1.6) refers to the non-linear and unpredictable nature of policymaking. Intersectoral policymaking requires commitment from a number of actors, which also increases the uncertainty of the process because of sometime contradicting ideas on how to achieve the defined policy goals and varying levels of commitment towards health-related goals. As stated earlier, many intervening interests influence the policymaking process and make actors prioritize other non-health goals. This complexity and challenges of intersectoral policymaking is an overarching concern of this study. Increasing the understanding of ideas, interests, institutions, and governance structures that shape the policy environment is important in raising health higher on the policy agenda. For this purpose, the utilization of training materials and

case studies can provide new insights on how to facilitate the implementation of intersectoral approaches to health in different policy contexts (WHO, 2015c, 2016b).

Not sharing the same language and culture (5.2.1.7) was seen as a major barrier to effective collaboration between health and non-health sectors. The reoccurring statement was that the language and terminology used by the health ministries and agencies is often not easily understood by others. This can lead non-health partners to misunderstand health-related goals and the means to achieve them. Similarly, different professional and organizational cultures among sectoral partners can increase the risk of misconceptions and misinterpretations. The risk of clashes can be decreased by allocating a sufficient amount of time to building the conceptual and cultural base for intersectoral partnerships. These factors are also key to building trust among the partners (Jones & Barry, 2016).

Limited authority and mandate of the health sector (5.2.1.8) poses a challenge to intersectoral work, as the engagement of multiple partners often requires a mandated authority to be involved in policy implementation." A claim can be made that it is particularly important to have a strong mandate from the highest level of government, and therefore the involvement of the Prime Minister as the most prominent political decision-maker has been suggested as one success factor towards the implementation of health-related intersectoral initiatives (McQueen, Wismar, Lin, & Jones, 2012; WHO, 2015d). Similarly, getting health high on the policy agenda among sectoral ministers and ministries would likely strengthen the health sector's mandate to establish intersectoral structures within a government.

Lack of ownership and management (5.2.1.9) was identified as a major barrier that makes the successful implementation of intersectoral initiatives less likely. For instance, if a government decides to address a specific problem through intersectoral action by engaging multiple sectors and partners, there is an evident risk that the actual implementation falls into an "intersectoral gap" in those cases where no one is taking the

core coordinating responsibility. As one informant of this study stated, there is a danger that when everyone is supposed to take responsibility then no one actually takes it. From this perspective, the core success factor is the existence of an assigned coordinating body that carries the ownership of a specific intersectoral initiative. This body should be equipped with efficient management structures for day-to-day activities that include monitoring and evaluation mechanisms to promote accountability and transparency. In other words, leaders cannot succeed without management that is efficient in transforming high-level strategic goals into action. This distinction has been described by the aphorism that “managers focus on efficiency (doing the most with the least), while leaders focus on effectiveness (goal attainment)” (Begun & Malcolm, 2014, p. 23).

Potential conflicts of interest (5.2.1.10) were only talked about extensively by three informants but can act as significant barriers to intersectoral action for health. Specifically alcohol, tobacco, and food industries can act in a way that are in clear conflict with the goals of health promotion and therefore there should be institutionalized ways to address the potential conflicts of interest. Specifically, a clear decision can be made not to collaborate with industries that have a fundamental conflict with the goals and values of health promotion (e.g. the tobacco and alcohol industries). Even limited collaborative actions can lead to a grey area where health interests are endangered. At the global level, the Framework Convention on Tobacco Control (FCTC) is a binding international convention for its signatories. As the first global public health treaty, the FCTC has been highlighted as a significant achievement of the international public health community.¹⁰² Related to alcohol, WHO has a non-binding global alcohol strategy (WHO, 2010a) and

¹⁰² The WHO Framework Convention on Tobacco Control (FCTC) was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. Regarding conflicts of interest, the preamble of the FCTC states that the parties to the convention are determined to give priority to their right to protect public health by “recognizing the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts” (FCTC, 2003).

there have been calls to formulate a binding convention on alcohol modeled after the FCTC. However, their efforts have been strongly opposed by the alcohol industry and have not gained enough support to lead to preparation of a treaty (Schmitz, 2016).

6.2 Reflections on opportunities and facilitators

My third research question considered the factors that facilitate the implementation of intersectoral action for health as well as the opportunities to promote health through such action in the future. In the following, I will consider each of these factors in more detail and compare my findings to literature sources.

Establishing permanent intersectoral structures (5.2.2.1) can make the implementation of intersectoral action for health more likely and sustainable. In the literature, Greer and Lillvis (2014) refer to bureaucratic change as one key strategy to make intersectoral action for health less dependent on political cycles and/or individual politicians.¹⁰³ They highlight three different approaches to an increased sustainability of intersectoral initiatives: (1) Appointing individual bureaucrats or government officials who are sympathetic to intersectoral approaches; (2) changing the structure of bureaucracy through reorganization or inserting new units (e.g. committees, specialist agencies, or secretariats) into the bureaucracy; (3) inserting new health-related requirements into existing procedures and structures (e.g. mandatory Health Impact Assessments) (Greer & Lillvis, 2014). Of the above strategies, the informants of this study focused mainly on the second approach, i.e. establishing intersectoral and interdepartmental committees. Health Impact Assessments (HIAs) were mentioned, but there were several informants who seemed to be discouraged by the limited impact of HIAs over the past decades. In addition, a few informants spoke about the need to have “the right people in the right

¹⁰³ Greer and Lillvis (2014) focus on the coordination of intersectoral action for health by referring specifically to the “Health in All Policies” approach.

positions”; however, this was not suggested as an explicit strategy for institutionalizing the intersectoral approach to health.

In this study, a number of informants suggested creating intersectoral governance structures within institutions. They see that specialized sectoral “silos” do not move very easily towards intersectoral action. Separate structures and “the silo mentality” can make it difficult to initiate and coordinate comprehensive initiatives that would engage different sectors. In addition, there is rarely a strong will or sufficient resources to support intersectoral and horizontal initiatives. Organizational culture might not recognize the importance of cooperation, and horizontal actions might be seen to be outside of a specific organization’s mandate.

Similarly, different government departments have their own budgets and they have an intrinsic goal to safeguard their resources for the future. Intersectoral cooperation might be seen as a threat to the existence of a certain department or unit. On the other hand, intersectoral bodies might cause more harm if they do not have a true mandate to change things and truly influence the policy process. For instance, demoralization and cynicism might result if the members of such groups do not believe that their recommendations can lead to actual implementation. Privatization and outsourcing may increase fragmentation and further exacerbate difficulties in forming horizontal governance structures.

Identifying and utilizing the windows of opportunity (5.2.2.2) for intersectoral initiatives was a reoccurring theme in the interviews. From this perspective, the health sector should actively aim to recognize the windows of opportunity that might arise through changes in economic, social, and political realities (Ollila et al., 2013, p.

15-18).¹⁰⁴ There are a number of facilitating conditions that can lead to desired outcomes regarding the utilization of windows of opportunity. For instance, Leppo et al. (2013b, p. 333) suggest that policymakers need to be prepared and have to act swiftly when an opportunity arises. In this context, the preparation can mean long-term processes of evidence-gathering, awareness-raising, building coalitions, and strengthening technical capacity. A usual window of opportunity arises when political parties are preparing for elections and when newly elected governments prepare their strategic programmes and other plans for the parliamentary term. In those moments, it would be beneficial for health advocates to have the capacity to move from awareness-raising to concrete policy proposals that can be incorporated into strategies and action plans.

Identifying co-benefits, mutual gains, and win-win situations (5.2.2.3) was considered especially important in order to motivate non-health collaborators to work with the health sector. For this purpose, it was suggested that health actors should proactively carry out systematic mapping processes to identify these co-benefits. A clear identification of win-win situations can also steer the health sector's own strategy towards the intersectoral initiatives that are most likely to succeed. In the literature, win-win approaches have been suggested as a solution to "what works" (Molnar et al., 2016; Ståhl et al., 2006). However, the tendency to emphasize only win-win strategies can lead to a high level of conflict avoidance and does not contribute to the knowledge of how the health sector could proceed when its partners are reluctant to consider any kind of health impacts of their work (Equity Action, 2012; Koivusalo, 2010).

¹⁰⁴ For instance, the book "Health in All Policies - Seizing opportunities, implementing policies" (Leppo et al., 2013a) bases its analytical framework on the successful utilization of windows of opportunity. The work is inspired by Kingdon's multiple streams theory of problems, solutions, and politics that need to converge to move an issue towards policy implementation (Kingdon, 1984). The moment when the window of opportunity is open has been described as "a short period of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for change" (Ollila et al., 2013, p. 18).

Placing more focus on long-term returns and investments (5.2.2.4) was seen as one strategy that can be employed in order to gain more support for intersectoral approaches. Intersectoral approaches to health should be an integral part of a long-term vision for health policymaking, as coordinated collaboration is likely to produce better health outcomes than working in sectoral silos. For health advocates, a long-term vision can provide a sense of optimism and resilience in the face of setbacks that can result when politicians make a decision to implement policies that are unlikely to promote health.

Increasing the skills and credibility of the health sector (5.2.2.5) through various forms of capacity building, such as attending training, learning to use tools to facilitate the policy process, engaging in professional networks, and producing evidence synthesis. In this study, one of the core aims of these activities was seen to be making the health sector a more credible and influential collaborator that can shape the governmental policy priorities to better acknowledge health concerns. There are examples of materials such as the WHO HiAP training manual (WHO, 2015c), a review tool to strengthen Health in All Policies (Equity Action, 2012), and intersectoral policy briefs (WHO, 2017f).

Linking to existing processes (5.2.2.6) that are aligned with the goal of promoting health through intersectoral action was another opportunity mentioned by several informants. The informants stated that often it is not effective to start creating intersectoral structures from scratch, as there are many existing processes (e.g. structures and strategies) at the international, national, and sub-national levels that can be utilized to promote health by engaging non-health sectors. At the national level, many countries have periodically updated governmental action plans and programmes that could be linked to health-related goals without the need to start a new process solely for health concerns. At the international level, the UN 2030 Agenda for Sustainable Development was highlighted as an existing process that has broad health implications. Many of the SDG targets are very relevant to WHO, as they are also the key social determinants of

health, such as education, income, and environmental conditions. As an organization, WHO has purposefully sought alignment and interlinkages with its strategies and the SDG Agenda (WHO, 2015a, 2016d).

Making budgets differently (5.2.2.7) by utilizing various strategies, such as joint budgeting, earmarked funding, and delegated financing, was mentioned as a way to facilitate and encourage intersectoral action. These strategies have been discussed in the literature, although there is no gold standard for intersectoral budgeting, as solutions are tied to the surrounding policy context and its actors (McDaid, 2012; McDaid & Park, 2016). However, it is clear that financial resources can be used to incentivize certain actions and discourage others. Therefore, budgetary options for joint financing should be considered when the aim is to reduce sectoral silos and encourage different actors to work together towards a shared goal.

Increasing focus on policy development within WHO (5.2.2.8) was brought up as a way to increase the WHO's internal capacity to promote intersectoral action through improved inter-programmatic collaboration. This theme was highlighted by some informants with concrete suggestions to produce intersectoral policy briefs, organize more joint missions to countries that would include experts from multiple technical areas, and further develop internal communication practices within WHO. The interviewees in this study indicated that WHO experts were not always very well aware of what their colleagues were working on and what linkages their own work might have with their colleague's programmatic area. These findings can be contrasted with the general critique of international organizations and their internal inefficiencies related to unnecessary bureaucracy and coordination problems (Jakovljević, 2008; Moon et al., 2015). However, many similar challenges can be found in any large organization that would benefit from the implementation of more streamlined management and leadership structures. However, the political nature of UN organizations can make these challenges more difficult to solve, as the UN decision-making bodies involve a large number of

countries with different political priorities and cultures. In addition, the WHO Regional Office for Europe is strongly dependent on the priorities set by its Member States as only 25% of its funding consists of regular contributions and 75% of its budget is made up of voluntary contributions that shape its programmatic focus (WHO, 2016f). Programmatic budgets define what WHO does, and a heavy and uncoordinated reliance on voluntary contributions poses the danger that different programmatic areas are not being integrated.

Strengthening and clarifying the WHO's role and mandate (5.2.2.9) might assist its staff in better realizing their opportunities and limitations in terms of taking an intersectoral approach. The provision of general guidelines on intersectoral work in different programmatic areas and national contexts could make WHO staff members better equipped to carry out their work. The question of the WHO's mandate is also related to the discussion of the technical and political aspects of its work. The key question is how well WHO can fulfill its constitutional mission and "act as the directing and coordinating authority on international health work" without political interests, which can interfere with the aim of having WHO's work based on the best available scientific evidence on health-promoting policies.

Some authors, such as Hoffman and Rottingen (2014), have suggested that WHO should be divided into two separate entities: technical and political. The rationale behind the suggestion is that the existence of two separate but collaborating entities would better secure independent scientific advice and strengthen political decision-making in a way that does not mix science and politics. However, this type of bold suggestion is unlikely to gain sufficient support from countries, and it carries the risk of creating two new silos, which can take scientific evidence even further away from political decision-makers.

WHO started its internal reform work in 2011, and a large body of background documentation has been produced to support the implementation of WHO reform.¹⁰⁵ The reform was directed at improving the internal governance and coordination within WHO but also at strengthening the organization's capacity for better resource mobilization in order to maintain the relevance of WHO in the future.¹⁰⁶ The most recent internal evaluation report asserts that WHO has made significant progress towards being "a more effective, transparent, and accountable organization" (WHO, 2017d). WHO is a unique organization in terms of its normative role and in bringing countries together at the global and regional levels. Private foundations or NGOs cannot undertake a similar role with national governments on a large scale. However, it is quite evident that WHO needs moral and political support from its Member States in order to continue its leadership role in global health.

Working through other UN agencies and non-state actors (5.2.2.10) was underlined as a concrete way to create and foster intersectoral partnerships for health. The informants for this study gave the greatest prominence to other UN agencies, the OECD, and bodies and agencies of the European Union. The collaboration with other UN agencies was seen to be especially relevant in terms of the UN Sustainable Development Goals, which provide an unifying umbrella to all partnering organizations. The informants considered that their engagement with civil society organizations was mainly limited to information exchange and joint meetings or events. The WHO's active collaboration with

¹⁰⁵ http://www.who.int/about/who_reform/documents/en/ (Accessed August 8, 2017)

¹⁰⁶ Six main challenges were identified at the beginning of the WHO reform process: (1) The need for better internal governance and alignment between global and regional bodies; (2) difficulty in allocating resources across various layers of governance structures; (3) lack of predictability of funding and associated challenges with priority-setting; (4) weak resource mobilization capacity at all levels of the organization, (5) increasing administrative and management costs, and (6) rise of other global health actors and the role of WHO in a changing environment (WHO, 2017c).

the private sector was not brought up in any of the interviews, which reflected the fact that the informants did not work directly with private entities in their programmatic areas.

The need to create a framework for collaboration with non-state actors has been on the WHO's internal agenda for a long time. This process led to the adoption of the WHO Framework of Engagement with Non-State Actors (FENSA) at the Sixty-ninth World Health Assembly held in May 2016 (WHO, 2016c). The framework divides non-state actors in four categories: NGOs, private sector entities, philanthropic foundations, and academic institutions. At best, FENSA can provide opportunities for WHO to work effectively with organizations outside of the UN system by applying an intersectoral approach to health. Through the framework, potential partners of WHO are provided an opportunity to move from knowledge-exchange to partnerships, which are more collaborative in their nature. However, a number of civil society organizations have stated that the possible collaboration with private industries and foundations carries a clear risk of conflicts of interest (CSS, 2016). FENSA explicitly forbids collaboration with the tobacco and arms industries but recommends only caution regarding multinational alcohol, food, and beverage industries whose financial interests can contradict the goal of promoting various aspects of human health.

One of the key questions is related to the level and depth of partnerships between WHO and non-state actors, i.e. how WHO should collaborate with private industries and philanthropic foundations without weakening its safeguards against conflicts of interest. Critics claim that FENSA puts private sector entities on an equal footing with other non-state actors and allows them to participate in policy development and standards-setting without setting clear procedures to avoid and manage the conflicts that are likely to arise (CSS, 2016). The WHO Director General has stated, about FENSA, that "management of conflict of interest and other risks of engagement are addressed through a process of due diligence, risk assessment and risk management, with increased transparency through the creation of a register of non-State actors" (WHO, 2017a, p. 1).

However, researchers have raised their concern about whether internal due diligence processes and risk management are sufficient measures to avoid conflicts of interest especially regarding the prevention of non-communicable diseases (Buse & Hawkes, 2016; Khayatzadeh-Mahani et al., 2017; Rached & Ventura, 2017).

At the moment, it is too early to say in which direction WHO's collaboration with non-state actors will develop. For instance, Kickbusch et al. (2016) have concluded in their recent report that "it remains to be seen whether FENSA opens and clarifies the political space in which WHO is able to engage with non-state actors, or whether it has the effect of closing it down" (Kickbusch et al., 2016, p. 25). In conclusion, there is a great deal of uncertainty whether WHO can successfully build new intersectoral partnerships that are beneficial to health and lead to concrete action at the country level.

Generally, this dissertation has validated many of the earlier findings of the challenges and opportunities for intersectoral action for health and was able to provide a nuanced view of these factors in the contemporary WHO context. In the following concluding section, I will review and summarize the most important theoretical and practical implications of this study.

6.4 Conclusions and recommendations

In this dissertation, I provided a systematic analysis of the challenges to and opportunities for intersectoral action for health based on interviews with 28 WHO experts. I carried out a thematic analysis of the interview data, which resulted in ten key challenges/barriers and ten key opportunities/facilitators for intersectoral action for health. In the findings section of this dissertation, I provided an in-depth analysis of these themes complemented with a number of direct interview quotations to exemplify my thematic categories.

My dissertation confirmed many of the findings that are already known from previous research and policy documents. The unique contribution of this study included

an analysis of the subjective experiences of these hard-to-access key informants. The perspectives of these informants are particularly valuable, as their employer is the global directing and coordinating authority in health policy. Although the role of WHO is in transition, it still remains in an influential position to steer the conceptual development of health policy and serve its Member States globally.

There are a few general findings that can be considered to be both expected or unexpected, depending on the point of view. First, the informants generally did not reflect on the role of political organizations in the interviews. In this context, a political organization refers to political parties, labour unions, business associations, or other actors that represent organized interests. It is very likely that the WHO experts have a clear understanding of the central role of political parties and their agendas in policymaking. A lack of ideological talk is not necessarily unexpected, as one interpretation of this finding is that the informants approached the interview situation as a form of professional communication where there is no place for politics or other forms of ideological talk. In other words, direct references to liberal and conservative perspectives or left-wing and right-wing ideologies may be perceived as a contested terrain that has no place in the professional role of an international policy expert. At the same time, it should be acknowledged that my main interest was not in looking for political views but to understand the policy process and its challenges. It remains as a task for other researchers to study how experts working for a UN agency would respond to a more direct question on political ideologies and the role of party politics in determining preconditions for intersectoral action for health and health promotion in general.

WHO recommendations and policy documents focus on technical expertise without discussion of different political perspectives. This is one of the reasons why governance terminology can be seen to be better suited for WHO. Governance terminology can be also used without an explicit focus on power relations, which of course can lead to a very limited analysis of policy problems and their solutions, as it can

be seen as “speaking of policies without touching on politics.”¹⁰⁷ From a positive perspective, a more general focus on governance mechanisms allows discussions on health challenges across countries that have a great variety of political realities and histories. Another reason behind the use of non-ideological (e.g. liberal/conservative, left/right) terminology is that WHO has a role of serving all its Member States equally and without intervening in national day-to-day politics. This generalist approach can be seen in the WHO statements on health promotion (see Section 3.2) as well as in policy documents that provide guidance for the implementation of intersectoral action for health, such as “Health in All Policies: Framework for Country Action” (WHO, 2014b).

In terms of future action, this study has several implications for theorizing and practicing intersectoral action of health. In the following two sections, before drawing my final conclusions, I will briefly consider the main theoretical and practical implications of this study.

6.4.1 Theoretical implications

Many of the broad perspectives on health, such as the social determinants of health approach, are descriptive but not generally used to analyze the contextual factors that influence the policy process. The theories of governance and various organizational theories can better capture how the actual implementation process takes place and what

¹⁰⁷ For example, Navarro (2009) has voiced criticism that the final report of the WHO Commission on SDHs did not address the question of power in a very explicit way and this shortcoming left its analysis on an apolitical level: “It is not *inequalities* that kill, but *those who benefit from the inequalities that kill*. The Commission’s studious avoidance of the category of power (class power, as well as gender, race, and national power) and how power is produced and reproduced in political institutions is the greatest weakness of the report. It reproduces a widely held practice in international agencies that speaks of policies without touching on politics. It does emphasize, in generic terms, the need to redistribute resources, but it is silent on the topic of whose resources, and how and through what instruments. *It is profoundly apolitical, and therein lies the weakness of the report* [emphasis in original]” (Navarro, 2009, p. 440).

kind of challenges can be expected at the micro level, i.e. the everyday work of policymakers. In this dissertation, sensitizing concepts were derived from the existing literature and utilized as a background to conduct a thematic analysis of the interview data collected from WHO informants.

In terms of theorizing intersectoral policymaking, this dissertation confirms many of the issues that have been previously been identified as key challenges to the implementation of intersectoral action for health. It also indicates that the analysis of intersectoral policymaking can benefit from research that applies the concepts of ideas, interests, institutions, and governance mechanisms. The added value of this study is that it successfully validated previous concerns and challenges in the context of current WHO activity around health promotion. As the author of this study, I am not aware of any studies where WHO experts would have systematically reflected on challenges and opportunities for intersectoral policymaking by participating in an academic study as informants. These hard-to-access experts have practice-based knowledge in contrast to more theoretically oriented literature that is currently available on intersectoral action for health.

Recently, some concerns have been raised that the focus on intersectoral action might make collaborators favour small-scale interventions in contrast to addressing the broader social determinants of health at the local level (Holt et al., 2016). The phenomenon is similar to “lifestyle drift”, where the focus of interventions tends to drift from addressing broad policies towards the downstream, e.g. individual lifestyle interventions (Carey, 2016). Two perspectives on this type of drift can be drawn from the findings of this dissertation. First, local-level policymakers often do not have a clear vision about what concrete actions they could undertake to address the broader determinants of health, i.e., often there is a need for capacity-building, tools, and inspirational leadership. Second, especially at the local level, the actors do not necessarily believe that they have either the mandate or the power to address any of the wider policies, and

therefore the focus naturally shifts toward small-scale interventions. An analysis of contextual governance mechanisms and structures can help in understanding the possibilities for finding the best ways to have a maximal focus on the broad social determinants of health, even for actors who work at the local level (Greer, Wismar, Figueras, et al., 2016). The key is to engage in thorough planning and be conscious of the challenges and barriers in order to overcome them strategically. Later I will present eighteen recommendations on how the implementation of intersectoral action for health can be facilitated in light of my empirical findings.

More generally, this dissertation provided unique insights into the factors influencing the process of intersectoral policymaking in the health context. My aim was to give a comprehensive overview of the factors that promote or hinder the opportunities to implement health-related intersectoral initiatives. Based on the findings, I present three main suggestions to further continue studying intersectoral action for health. The first line of research could be to conduct in-depth analyses of each theme identified in this study from a governance perspective. In other words, every theme of this study, either a barrier or a facilitator of intersectoral policymaking, could be further studied through a policy analysis lens. For example, this could mean studying governance mechanisms, interests, and policy actors in changing contexts by utilizing real-life case studies from the local and national levels. The second line of research would be to study the interaction between different thematic factors identified in the findings section. For instance, many of the barriers and facilitators of intersectoral action for health usually cluster together, and one of the theoretical questions in the future could be related to the question of how different barriers (or facilitators) interact and intersect. This would mean analyzing not only static

structures and policy outcomes but also policymaking processes.¹⁰⁸ This type of a relational perspective could provide a more dynamic view of the whole process of intersectoral policymaking. The third line of research could be the analysis of different barriers and facilitators from the political economy of health perspective. This could involve analyses of the impact of different political ideologies, governance mechanisms, power relations, and welfare state arrangements related to a government's willingness to initiate governance structures for intersectoral policymaking.

In relation to the political economy perspective, it should be noted that a large bulk of welfare theorizing has been produced about different typologies of welfare regimes, rooted in the seminal work of Esping-Andersen (1990).¹⁰⁹ However, this dissertation was not an extension of that theorizing because the WHO European region includes countries that are not a standard part of research that is carried out on welfare state development. For instance, post-Soviet states in Central Asia, Eastern Europe, Transcaucasia, and the Baltic regions cannot be placed in traditional welfare state

¹⁰⁸ A recent paper by Lawless et al. (2017) takes steps towards a more interactive analysis of intersectoral policies by providing an evaluation framework drawn from relevant policy literature and experiences from the South Australian HiAP initiative. The authors state: "Despite the importance of such inter-sectoral work it has been difficult to evaluate given the complexity of the task, the wide range of sectors and people involved, and the difficulties of attributing long-term outcomes to policy changes. This paper describes development of a framework for evaluation that allows examination of both the policy-making processes and the health outcomes of the resulting policies" (Lawless et al., 2017, p. 1).

¹⁰⁹ In Esping-Andersen's original typology (1990), liberal welfare states are classified as societies that rely heavily on market-based and individualistic solutions, whereas social democratic welfare states place substantial reliance on the centralized state that provides tax-funded social safety nets for citizens. Conservative welfare states rely on traditions in which the family has a central role in sustaining welfare. Dominant market-oriented ideologies can make it difficult to implement solutions that would increase the citizens' feelings of collective responsibility. Redistributive measures, such as taxation to fund public services, are not likely to gain political support if the voters believe that the state or government should play a minimal role in people's everyday lives.

typologies.¹¹⁰ Therefore, it remains the task of other welfare theorists to compare the challenges of intersectoral policymaking across different (welfare) state regimes. At a global level, another perspective on the role of state is related to the importance of good governance, as it goes beyond “West-centric” welfare state theories. Generally, the informants for this study referred to the role of national governments and sometimes referred to countries that “are not doing that well.” Moreover, nation states can be oppressive and undemocratic, and therefore the principles of good governance and human rights provide a more comprehensive analytical lens to look at the varying country contexts than the theories of the welfare state.¹¹¹

In conclusion, I argue that future attempts to theorize intersectoral action for health could benefit from paying closer attention to the contextual governance structures as well as to the internal dynamics of the intersectoral process in terms of how different barriers and facilitators interact and cluster together.

¹¹⁰ These include the following 12 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

¹¹¹ From first-hand experience, the author of this dissertation had to consider this issue while working as a policy consultant in a country in Central Asia. This specific country was questioned by multiple international organizations about its human rights situation, media freedom, and the status of civil society. In this situation, the ethical question that can be posed is whether an international organization is taking part in whitewashing and sugarcoating repressive governments, or can be unwillingly used to present an oppressive government in a good light. Another perspective is that even the limited presence of an international organization is better than not being present at all. International influences can produce incremental changes in the long term, and authoritarian governments do not last forever. Therefore, it can be argued that it is important that international organizations do not limit their scope and actively try to also work with governments that are less receptive to many widely accepted goals, such as equity and human rights. At best, and with careful consideration, this involvement can improve the quality of life among ordinary citizens despite the repressive nature of a country's prevailing governance system.

6.4.2 Practical implications

The ability to provide research-based guidance and recommendations to policymakers is one important aim of policy studies. Based on this study, I have summarized eighteen key factors that are likely to facilitate the implementation of intersectoral action for health under micro-, meso-, and macro-levels (Box 4). This guidance is derived from the findings section of this dissertation by combining a set of challenges and opportunities highlighted by the WHO informants who were interviewed during the research process.

These recommendations can be directly linked to my theoretical foundations. First, political and social context (macro level) refers to the political economy level including the ruling ideologies, ideas, welfare state arrangements, and the distribution of power between different interest groups (Esping-Andersen, 1990; Raphael & Bryant, 2006a). These factors influence the extent of political support and commitment to address health challenges through intersectoral action. At the ideational level, the conceptual understanding of health is associated with the willingness of government to take intersectoral action. For example, seeing health only from a narrow biomedical and individualized frame does not support the involvement of non-health sectors in health promotion. Therefore, understanding health as socially and politically determined can be seen as a prerequisite for taking an intersectoral approach. Social and political explanations for different health outcomes was extensively discussed in my literature review (Dahlgren & Whitehead, 1991; Link & Phelan, 1995; Raphael, 2016; Solar & Irwin, 2010). In my literature review, I also showed that institutional arrangements and policy actors influence the implementation of health-related initiatives by increasing or reducing their acceptability and feasibility (Howlett et al., 2009). Similarly, understanding health as a human right increases the likelihood that high-level policymakers are willing to implement health-promoting public policies. The first set of my recommendations (1-5) focuses on advocacy that is needed to change the political and social climate to be more supportive of intersectoral action for health. Conceptually this is close to Kingdon's

concept of agenda-setting and the notion that political will is an essential prerequisite for policy implementation (Kingdon, 1984). Concrete efforts can focus on generating public and electoral pressure, raising awareness of the social determinants of health through social and traditional media, and utilizing the windows of opportunity when they arise.

Second, governance structures and actions (meso level) refer to a number of factors that can be observed at the sectoral and organizational level (recommendations 7-15). These findings directly link and are quite similar to the conclusions in the existing literature. My recommendations are aligned with the earlier suggestions of ways to promote more effective intersectoral governance. For instance, the listed recommendations have a significant overlap with the analytical framework proposed by McQueen et al. (2012), which was outlined in Table 3 in this dissertation. In addition, the importance of identifying co-benefits and win-win situations among sectors has been brought up throughout the literature on the HiAP approach (Leppo et al., 2013a; Molnar et al., 2016; Rudolph et al., 2013; WHO, 2015b).

Third, leadership and capacity-building (micro level) refers to social interactions between individual people and groups (recommendations 16-18). Leadership and management skills are needed for organizational effectiveness but also to build trust and collaborative relationships among different sectoral actors. Interpersonal skills have been identified as a core competency and a prerequisite in order to get different partners to work together in an effective and goal-oriented way (Begun & Malcolm, 2014). In the literature, one of the key success factors is the ability to build relationships with a high level of trust (Jones & Barry, 2016). One way to promote intersectoral trust-building is to ensure that sectoral partners have sufficient skills to recognize their differences and to acknowledge varied interests as a natural starting point of a collaborative process. Moreover, negotiation and conflict resolution takes place at the interpersonal level among individuals. For instance, WHO has provided training in order to address the need

to equip civil servants and health experts with negotiation skills in the context of implementing the Health in All Policies approach (WHO, 2015b).

An understanding of the above factors is especially relevant to policymakers, civil servants, and health advocates who are in a position to plan or implement various intersectoral policies. The factors in Box 4 are listed in the form of a recommendation, and their nature is “programmatic” in the sense that they cannot be addressed by only a single actor within a government. In addition, it should be noted that these recommendations are not listed in any particular order that would indicate their relative importance. Generally, all the listed factors are important, but their relative importance varies depending on the context. It should be taken into account that these are the most important recommendations based on the findings of this study, and other researchers may end up with slightly different results.

Box 4. Research-based recommendations on how to facilitate the implementation of intersectoral action for health

I. Political and social context (macro level)

1. Raise awareness of the social determinants of health to promote a broad understanding of health.
2. Ensure explicit high-level political support and commitment to intersectoral action
3. Utilize public and electoral pressure to shape the policy agenda towards greater intersectoral action for health.
4. Involve local and national media to report the successes of intersectoral initiatives.
5. Identify the windows of opportunity that can enable intersectoral policies for health to move forward (e.g. a change of government).
6. Have a vision about long-term policy outcomes in the context of sustainable development.

II. Governance structures and actions (meso level)

7. Map out co-benefits and win-win situations among/with sectoral partners.
8. Attain a clear top-down mandate when possible (e.g. legal mandate).
9. Link health goals to existing processes, if appropriate (e.g. national strategies in non-health sectors).
10. Establish permanent intersectoral governance mechanisms, if appropriate.
11. Utilize financing and budgeting mechanisms to support intersectoral action for health.
12. Ensure adequate resources for implementation and monitoring.
13. Engage civil society and other relevant stakeholders, if appropriate.
14. Set clear and measurable goals and targets for intersectoral action for health.
15. Establish monitoring and evaluation mechanisms to ensure accountability.

III. Leadership and capacity building (micro level)

16. Foster effective leadership and management that supports collaboration beyond sectoral silos.
17. Foster cross-sectoral relationships based on trust and a shared understanding of the problems throughout the collaborative process.
18. Increase the capacity of the health sector to work with and to reach out to other sectors (e.g. negotiation and conflict resolution skills).

Based on my findings, I argue that the capacity of the health sector to efficiently engage and motivate non-health sectors to take action is one of the most important action areas. As an example, the initiation of intersectoral and inter-ministerial policy dialogues can be an effective way to approach non-health sectors. My findings indicate that there is a need to develop more nuanced collaborative methodologies for intersectoral dialogues to avoid situations where health-motivated initiatives would be perceived as “health imperialism”, i.e. imposing the health sector’s own sectoral goals on non-health sectors. Open policy dialogues can be one way to proceed if they aim at concrete action plans and are motivational in terms of proposing open-ended questions to non-health collaborators. The questions could be formulated without imposing solutions to allow room for creative problem-solving. For instance, non-health collaborators could be approached by asking: “What could your sector do to promote health and welfare?”; “What happens if intersectoral action is not taken?”; “Who pays the costs of inaction?”; and “What are the mutual benefits and win-win situations that can be identified?” The participants in these dialogues can include technical and political representatives from different sectoral ministries. From a whole-of-society perspective, it would be important that the civil society organizations can have their voices heard as participants or be offered a consulting role. In some cases, it might be beneficial to use external professional facilitators to lead intersectoral policy dialogues to avoid situations that resemble a zero-sum game in which each sector’s gain is another sector’s loss. Nonetheless, the health sector itself should focus on continuous capacity-building to strengthen its institutional and expert capacity to engage and work with non-health sectors.

For health promoters in general, one of the core challenges is to be credible in uniting research evidence with normative statements, which are moral and political in their very nature. If politicians do not agree with the normative statements and their implications (e.g. the need to pursue health equity for all), then they are unlikely to care

about any research evidence about the policies that would advance health equity. Therefore, it becomes obvious that health promoters cannot diminish the importance of the politics of health while considering the recommendations of this study or any other guidance on the implementation of intersectoral action for health. For instance, in-depth analyses of real-life case stories by looking at the successes and failures throughout the policy process are likely to be helpful in advancing an understanding of how and why intersectoral action for health has succeeded in different contextual environments.

The implementation of intersectoral initiatives does not necessarily require substantial financial investments. What is needed more is an openness to new ways of thinking by focusing on the positive results that can be attained through a whole-of-government level, in contrast to developments that take place only in sectoral silos. In the long run, there is enough evidence to indicate that thoughtfully planned intersectoral action for health can reduce the societal burden caused by health problems and be cost-effective. However, as shown in this dissertation, there are a number of political, institutional, cultural, and financial barriers to greater intersectoral collaboration that need to be taken seriously. Many times the existing governance structures do not incentivize intersectoral action for health. Along with getting health higher on the agenda, bureaucratic restructuring, legislative mandates, and intersectoral financing can be ways to reduce sectoral silos, although there is no single strategy that would provide a quick fix for complex governance challenges. Sufficient political will and determination at the highest level of government form the starting point for success. In those cases where political leadership cannot be found at the national level, there still might be an avenue for regional and local level action to promote intersectoral initiatives and innovations. At best, these local or regional level initiatives can prove themselves by successful outcomes and have an influence on other actors on both the vertical and horizontal levels. At the level of implementation, it is crucial that different actors have clearly defined roles and responsibilities. Moreover, there needs to be adequate skills as well as financial and

human resources for implementation, monitoring, and reorienting the policies if there is a recognized need to do so. In conclusion, strengthening the evidence base and other capacities related to effective policy implementation is a continuous task of the health sector.

The findings of this dissertation should be viewed as part of the historical continuum of health promotion activities in the context of WHO. As reviewed in Section 3.2, there are nine statements from the WHO Global Conferences on Health Promotion, which have included a reoccurring call for greater intersectoral action for health (WHO, 1986b, 1988, 1991, 1997b, 2000, 2005a, 2009b, 2013c, 2016e). These conference statements, released between 1986 and 2016, have changed the understanding of health towards a more comprehensive perspective that acknowledges the importance of social, economic, and environmental determinants of health. Similarly, all these statements have made strong recommendations for engaging non-health sectors in health promotion. However, it is very difficult to evaluate the impact of the statements in the content of national policies in WHO Member States. The general challenge of global statements and their recommendations is that they have to be universal rather than context- or country-specific. The real proof of a policy lies in its implementation in a policy environment that is always unique in terms of its actors, governance structures, dominant interests, and a number of other factors. By utilizing the knowledge of WHO experts, this dissertation provides a wide set of general themes that should be considered when national or local governments wish to work across sectors to promote health.

Regarding the need to raise health higher on the agenda, it should be acknowledged that civil society had only a minor role in my interview data. WHO experts interviewed for this study found it difficult to work with non-governmental actors at the national level for several reasons. First, in many countries, civil society action is not necessarily encouraged by national governments, and WHO might end up in an open conflict with governing authorities if they forcefully try to deepen the engagement with

civil society actors. Second, challenges are likely to emerge if WHO decides to work with some national representatives of civil society but at the same time excludes others. Many times the easier solution for WHO is not to work with civil society actors at all. Third, there has not been a clear framework for WHO's engagement with civil society. The WHO Framework of Engagement with Non-State Actors (FENSA) was adopted in 2016, and it is yet to be seen how it will change WHO's relationship with international and national actors representing civil society. The danger is that FENSA will indeed increase WHO's collaboration with non-State actors but do it in a way that has the main focus on well-resourced players in global health. In this scenario, smaller NGOs and citizen groups would not have an equal opportunity to get their voices heard and WHO's priorities might be shaped to represent the interests of the powerful global corporations and private foundations. The above development poses a challenge to WHO's own legitimacy and therefore should be taken seriously.

Lastly, my findings indicate that intersectoral action for health is truly challenging and should not be promoted as an easy solution or quick fix. However, it is equally clear that having an intersectoral approach is a core requirement in order to promote health in an effective and comprehensive way. The findings section of this dissertation provided a more nuanced perspective to intersectoral action for health than is usually given in the literature. Many of the barriers can be tackled by political determination and capacity-building within the health sector. Although, as stated earlier, it should be remembered that policy solutions are always contextual and policymakers need to apply them with varying emphasis in order to make them fit for purpose.

6.4.3 Final conclusions

This dissertation has revolved around the question of why advancing intersectoral action for health is difficult and what could be done better to facilitate it in the future. Based on the existing literature and this dissertation, it is evident that anyone interested in

promoting intersectoral policymaking should not ignore the crucial importance of governance structures, interests, and policy processes that shape the policy landscape at the local, regional, and international levels.

As my final conclusions, I highlight three separate priorities that could show the way forward. The first priority is to focus on finding ways to identify and seize mutual benefits and co-benefits between the health and non-health sector. In policymaking, everything cannot be pursued at the same time, and therefore a certain degree of prioritization is always required. Often it is common sense to focus on the initiatives that are the most feasible in the surrounding context and are likely to produce the most health gains. This is the least difficult strategy to utilize in initiating intersectoral action for health. However, it should be acknowledged that there are a number of barriers even when the partners are committed to collaboration. In the previous section, Box 4 outlined an extensive list of factors that are prerequisites for the effective implementation of intersectoral action for health. Another challenge is related to the co-benefits approach itself because having a strong focus on co-benefits for all sectors can lead to excessive conflict avoidance. Concretely, this can lead to turning away from politically contested areas where interests are likely to be in conflict. Consequently, the promotion of intersectoral action for health demands that health actors are both politically savvy and courageous at the same time.

The second priority is related to capacity-building within the health sector itself. The ability to negotiate conflicting interests is a skill that can be learned. Along with technical “hard skills”, health actors should equip themselves with softer skills that encompass areas such as communication, networking, and effective mediation strategies. In addition, health experts, civil servants, and politicians can build their capacity to better recognize and seize existing processes and other opportunities in order to promote health through activities that take place in non-health sectors. Specifically linking to existing processes can be an effective strategy to promote health goals. More specifically,

this could mean getting health-related targets or regulations included in international, national, or regional strategies that do not specifically consider only health. A list of relevant sectors is long and could include sectors such as agriculture, trade, transportation, environment, education, employment, social welfare, foreign policy, and so forth.

The third priority is related to the promotion of health equity. Reducing socioeconomic health inequalities through intersectoral action poses probably the greatest challenge to all governments. It requires addressing many of the social determinants of health that are also associated with the distribution of power, wealth, and other resources. Policy measures that aim to change the structural arrangements that influence resource distribution within a society are likely to meet opposition from a number of interest groups. In today's market-oriented society, health promoters should not ignore the power of commercial determinants of health and market-based interests that work against the goals of health promotion. Collaboration with some interest groups should be avoided altogether because it can greatly increase the risk of corruption and coercion. In other words, some interest groups could be seen to be "buying legitimacy" by working with health authorities, which can eventually be harmful to health on a larger scale.

Finally, it can be rather easy to formulate strategies and action plans, but the key challenge is related to putting those into action. It can be stated that the actual "proof" of a policy is in its implementation. As shown in this dissertation, all the statements from the global health promotion conferences have repeated the same message: There is a need to engage multiple sectors in health promotion through collaborative action. Furthermore, the WHO statements suggest that the existing evidence on effective health promotion practices has to be incorporated into a set of values of equity, freedom, and sustainability. The overarching goals are clear, but the actual implementation is a daunting task. There needs to be political will at the highest political level that is

accompanied by a long-term commitment to equity goals. Permanent intersectoral structures with clear accountability mechanisms are needed to implement policies and monitor the distribution of health from a health equity perspective. Lastly, persistence and sustained efforts should be the core strategies of all activities that aim to create social and political change. My hope is that this dissertation has succeeded in contributing to the understanding of the preconditions for intersectoral action in order to help health promoters thrive in their future work.

References

- Acheson, D. (1999). Conflict in Bosnia 1992-3. *British Medical Journal*, 319(7225), 1639-1642.
- Aggleton, P. (1990). *Health*. London: Routledge.
- AP. (2015). Emails: UN health agency resisted declaring Ebola emergency. The Associated Press. March, 20, 2015. Retrieved July 4, 2017, from <https://apnews.com/2489c78bff86463589b41f3faaea5ab2/emails-un-health-agency-resisted-declaring-ebola-emergency>
- APHA. (2012). Promoting Health Impact Assessment to achieve Health in All Policies. October 30, 2012. Policy statement 201210. Washington, DC: American Public Health Association (APHA). Retrieved October 26, 2016, 2016, from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/16/51/promoting-health-impact-assessment-to-achieve-health-in-all-policies>
- Ayres, L. (2008). Thematic coding and analysis. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 867-868). Thousand Oaks: Sage.
- Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International*, 20(2), 187-193.
- Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health*, 64(4), 284-291.
- Bartley, M. (2004). *Health inequality: An introduction to theories, concepts, and methods*. Cornwall, UK: Polity Press.
- Baum, F. (1995). Researching public health: Behind the qualitative-quantitative methodological debate. *Social Science & Medicine*, 40(4), 459-468.

- Baum, F. (2007a). Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. *Promotion and Education*, 14, 90-95.
- Baum, F. (2007b). Health for All now! Reviving the spirit of Alma Ata in the Twenty-first century: An introduction to the Alma Ata Declaration. *Social Medicine*, 2(1), 34-41.
- Baum, F., Lawless, A., Delany, T., Macdougall, C., Williams, C., Broderick, D., et al. (2014). Evaluation of Health in All Policies: concept, theory and application. *Health Promotion International*, 29(Suppl 1), 130-142.
- Bauman, A. E., King, L., & Nutbeam, D. (2014). Rethinking the evaluation and measurement of health in all policies. *Health Promotion International*, 29(suppl 1), i143-i151.
- Begun, J. W., & Malcolm, J. K. (2014). *Leading public health: A competency framework*. New York: Springer.
- Béland, D. (2005). Ideas and social policy: An institutional perspective. *Social Policy and Administration*, 39(1), 1-18.
- Béland, D. (2009). Ideas, institutions, and policy change. *Journal of European Public Policy*, 16(5), 701-718.
- Béland, D., & Cox, R. H. (2010a). *Ideas and politics in social science research*. New York: Oxford University Press.
- Béland, D., & Cox, R. H. (2010b). Introduction: Ideas and politics. In D. Béland & R. H. Cox (Eds.), *Ideas and politics in social science research* (pp. 3-20). New York: Oxford University Press.
- Berkeley, D., & Springett, J. (2006). From rhetoric to reality: Barriers faced by Health For All initiatives. *Social Science & Medicine*, 63(1), 179-188.
- Berman, S. (2006). *The primacy of politics: Social democracy and the making of Europe's twentieth century*. Cambridge: Cambridge University Press.
- Bernier, N. F., & Clavier, C. (2011). Public health policy research: making the case for a political science approach. *Health Promotion International*, 26(1), 109-116.

- Birn, A.-E. (2009). Making it politic(al): Closing the gap in a generation: Health equity through action on the social determinants of health. *Social Medicine*, 4(3), 166-182.
- Black, D. (1980). *Inequalities in health: Report of a research working group*. London: Department of Health and Social Security (DHSS).
- Blane, D. (1985). An assessment of the Black Report's explanations of health inequalities. *Sociology of Health & Illness*, 7(3), 423-445.
- Blas, E., Gilson, L., Kelly, M. P., Labonté, R., Lapitan, J., Muntaner, C., et al. (2008). Addressing social determinants of health inequities: what can the state and civil society do? *Lancet*, 372, 1684-1689.
- Blaxter, M. (1997). Whose fault is it? People's own conceptions of the reasons for health inequalities. *Social Science & Medicine*, 44(6), 747-756.
- Blaxter, M. (2010). *Health* (2nd ed.). Cambridge: Polity Press.
- Blumer, H. (1954). What is wrong with social theory? *American Sociological Review*, 18, 3-10.
- Bouchard, L., Albertini, M., Batista, R., & de Montigny, J. (2015). Research on health inequalities: A bibliometric analysis (1966–2014). *Social Science & Medicine*, 141, 100-108.
- Bowen, G. A. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*, 5(3), 12-23.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Braveman, P. (2006). Health disparities and health equity: Concepts and Measurement. *Annual Review of Public Health*, 27, 167-194.
- Braveman, P. (2010). Social conditions, health equity, and human rights. *Health and Human Rights*, 12(2), 31-48.

- Braveman, P. (2014a). What are health disparities and health equity? We need to be clear. *Public health reports*, 129(Supplement 2), 5-8.
- Braveman, P. (2014b). What is health equity: and how does a life-course approach take us further toward it? *Maternal and Child Health Journal*, 18(2), 366-372.
- Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, 32(1), 381-398.
- Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public health reports*, 129(Suppl 2), 19-31.
- Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57, 254-258.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Brown, C., Harrison, D., Burns, H., & Ziglio, E. (2014). *Governance for health equity: Taking forward the equity values and goals of Health 2020 in the WHO European Region*. Copenhagen: WHO Regional Office for Europe.
- Brunner, E., & Marmot, M. (2006). Social organization, stress, and health. In M. Marmot & R. Wilkinson (Eds.), *Social determinants of health* (2nd ed.). Oxford, UK: Oxford University Press.
- Bryant, T. (2010). Politics, public policy, and health inequalities. In D. Raphael, T. Bryant & M. H. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness and health care* (2nd ed., pp. 239-265). Toronto: Canadian Scholars' Press.
- Bryant, T. (2012). Applying the lessons from international experiences. In D. Raphael (Ed.), *Tackling health inequalities: Lessons from international experiences* (pp. 265-287). Toronto: Canadian Scholars' Press.
- Bryant, T., Raphael, D., Schrecker, T., & Labonte, R. (2012). Canada: A land of missed opportunities for addressing the social determinants of health. *Health Policy*, 101, 44-58.

- Bryman, A., Bell, E., & Teevan, J. (2012). *Social research methods* (3rd ed.). Toronto, ON: Oxford University Press Canada.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. *Public Administration Review*, 66, 44-55.
- Buse, K., & Hawkes, S. (2016). Sitting on the FENSA: WHO engagement with industry. *The Lancet*, 388(10043), 446-447.
- Buse, K., Mays, N., & Walt, G. (2012). *Making health policy* (2nd ed.). Berkshire: Open University Press.
- Campbell, J. L. (2002). Ideas, politics, and public policy. *Annual Review of Sociology*, 28, 21-38.
- Carey, G. (2016). Re-conceptualising public health interventions in government: A response to recent commentaries. *International Journal of Health Policy and Management*, 5(9), 569-570.
- Carey, G., & Crammond, B. (2015). What works in joined-up government? An evidence synthesis. *International Journal of Public Administration*, 38(13-14), 1020-1029.
- Carey, G., Crammond, B., & Keast, R. (2014). Creating change in government to address the social determinants of health: how can efforts be improved? *BMC Public Health*, 14(1), 1087.
- Carey, G., Malbon, E., Crammond, B., Pescud, M., & Baker, P. (2016). Can the sociology of social problems help us to understand and manage 'lifestyle drift'? *Health Promotion International*.
- Carstensen, M. B. (2010). The nature of ideas, and why political scientists should care: Analysing the Danish jobcentre reform from an ideational perspective. *Political Studies*, 58(5), 847-865.
- Catford, J. (1998). Tributes to Ron Draper. *Health Promotion International*, 13(1), 3-5.

- CCSDH. (2015). A review of frameworks on the determinants of health. Ottawa: Canadian Council on Social Determinants of Health. Retrieved September 26, 2016, from http://ccsdh.ca/images/uploads/Frameworks_Report_English.pdf
- CESCR. (2000). *General comment no. 14: The right to the highest attainable standard of health*. New York: UN Committee on Economic, Social and Cultural Rights (CESCR).
- CESCR. (2014). The website of the Committee on Economic, Social and Cultural Rights. New York: United Nations. Retrieved March 25, 2014, from <http://www2.ohchr.org/english/bodies/cescr/>
- Chang, W.-C. (2002). The meaning and goals of equity in health. *Journal of Epidemiology and Community Health*, 56, 488-491.
- Charmaz, K. (2003). Grounded theory: Objectivist and constructivistic methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies for qualitative inquiry* (2nd ed., pp. 249-291). Thousand Oaks: Sage.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA, USA: Sage.
- Chircop, A., Bassett, R., & Taylor, E. (2015). Evidence on how to practice intersectoral collaboration for health equity: a scoping review. *Critical Public Health*, 25(2), 178-191.
- Christensen, T., & Lægreid, P. (2007). The Whole-of-Government approach to public sector reform. *Public Administration Review*, 67(6), 1059-1066.
- CIHR, NSERC, & SSHRC. (2010). Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2). Ottawa, ON: Canadian Institutes of Health Research (CIHR), Natural Sciences and Engineering Research Council of Canada (NSERC), and Social Sciences and Humanities Research Council of Canada (SSHRC). Retrieved March 17, 2013, from <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/>

- Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2), 120-123.
- Clavier, C., & de Leeuw, E. (2013a). Framing public policy in health promotion: ubiquitous, yet elusive. In C. Clavier & E. de Leeuw (Eds.), *Health promotion and the policy process* (pp. 1-22). Oxford: Oxford University Press.
- Clavier, C., & de Leeuw, E. (2013b). *Health promotion and the policy process*. Oxford: Oxford University Press.
- Clift, C. (2013). *The role of the World Health Organization in the international system*. Working group on governance, paper 1. London: Chatham House.
- Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: the role of neo-liberalism. *Social Science & Medicine*, 51(1), 135-146.
- Colgrove, J. (2002). The McKeown thesis: A historical controversy and its enduring influence. *American Journal of Public Health*, 92(5), 725-729.
- Collier, R. B., & Collier, D. (1991). *Shaping the political arena: Critical junctures, the labor movement, and regime dynamics in Latin America*. Princeton: Princeton University Press.
- Collins, P. A. (2012). Do great local minds think alike? Comparing perceptions of the social determinants of health between non-profit and governmental actors in two Canadian cities. *Health Educ Res*, 27(3), 371-384.
- Corbin, J. H., Jones, J., & Barry, M. M. (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promotion International*, Article first published online: August 8, 2016.
- Council of Europe. (1950). European Convention on Human Rights. Strasbourg: European Court of Human Rights, Council of Europe. Retrieved October 24, 2016, from http://www.echr.coe.int/Documents/Convention_ENG.pdf
- Council of Europe. (1961). European Social Charter. Turin: Council of Europe. Retrieved 24 October, 2016, from <http://www.coe.int/en/web/turin-european-social-charter>

- CSS. (2016). Civil society statement on the World Health Organization's proposed Framework of Engagement with Non-State Actors (FENSA) 69th World Health Assembly, May 2016. Retrieved August 10, 2017, from <http://www.babymilkaction.org/wp-content/uploads/2016/05/Civil-Society-Statement-64.pdf>
- Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health*. Stockholm: Institute for Future Studies.
- de Leeuw, E. (2001). Global and local (glocal) health: The WHO healthy cities programme. *Global Change and Human Health*, 2(1), 34-45.
- de Leeuw, E. (2017). Engagement of sectors other than health in integrated health governance, policy, and action. *Annual Review of Public Health*, 38, 329-349.
- de Leeuw, E., & Breton, E. (2013). Policy change theories in health promotion research: a review. In C. Clavier & E. de Leeuw (Eds.), *Health promotion and the policy process* (pp. 23-42). Oxford: Oxford University Press.
- de Leeuw, E., & Clavier, C. (2011). Healthy public in all policies. *Health Promotion International*, 26(Suppl 2), ii237-ii244.
- de Leeuw, E., Clavier, C., & Breton, E. (2014). Health policy - why research it and how: health political science. *Health Research Policy and Systems*, 12(1), 55.
- de Leeuw, E., & Peters, D. (2014). Nine questions to guide development and implementation of Health in All Policies. *Health Promotion International*. Article first published online: June 10, 2014. Print: Dec 2015, 30(4), 987-97.
- Deber, R. (2014). Concepts for the policy analyst. In R. Deber & C. L. Mah (Eds.), *Case studies in Canadian health policy and management* (2nd ed., pp. 1-93). Toronto: University of Toronto Press.
- Dominguez-Redondo, E. (2010). Role of the UN in the promotion and protection of human rights. In A. R. Chowdhury & J. H. Bhuiyan (Eds.), *An introduction to international human rights law* (pp. 119-144). Leiden: Brill.

- Doyal, L. (2000). Gender equity in health: debates and dilemmas. *Social Science & Medicine*, 51(6), 931-939.
- Dubois, A., St-Pierre, L., & Veras, M. (2015). A scoping review of definitions and frameworks of intersectoral action. *Ciência & Saúde Coletiva*, 20, 2933-2942.
- Dunn, W. N. (2012). *Public policy analysis* (5th ed.). New Jersey: Pearson.
- Dye, T. (2008). *Understanding public policy* (12th ed.). New York: Longman Press.
- Eagleton, T. (1991). *Ideology: An introduction*. London: Verso.
- ECHP. (1999). *Health Impact Assessment: Main concepts and suggested approach*. Gothenburg consensus paper, December, 1999. Brussels: WHO European Centre for Health Policy (ECHP).
- Embrett, M. G., & Randall, G. E. (2014). Social determinants of health and health equity policy research: Exploring the use, misuse, and nonuse of policy analysis theory. *Social Science & Medicine*, 108, 147-155.
- Engels, F. (1845/1993). *The condition of the working class in England*. Oxford: Oxford University Press.
- Equity Action. (2012). Review tool: Strengthening Health in All Policies within your organisation. European Portal for Action on Health Inequalities. Retrieved August 11, 2017, from <http://www.health-inequalities.eu/wp-content/uploads/2016/05/HiAP-dissemination-tool-for-partners.pdf>
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press.
- Evans, R. G., & Stoddart, G. L. (1990). Producing health, consuming healthcare. *Social Science and Medicine*, 31(12), 1347–1363.
- Exworthy, M. (2008). Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning*, 23(5), 318-327.

- Fafard, P. (2012). *Ideas, policy, and the politics of public health*. Paper presented at the Annual Meeting of the Canadian Political Science Association. University of Alberta, June 12-15, 2012.
- Faid, M. (2012). *Tackling cross-sectoral challenges to advance health as part of foreign policy*. A report of the international research initiative "Foreign Policy as Part of Global Health Challenges". FNI report 2/2012. Lysake: Fridtjof Nansen Institute.
- Falvo, R., Regina Cubas, M., & Gulis, G. (2015). Health Impact Assessment: HIA. In S. Boccia, P. Villari & W. Ricciardi (Eds.), *A systematic review of key issues in public health* (pp. 263-276). Cham: Springer International Publishing.
- FCTC. (2003). The WHO Framework Convention on Tobacco Control (WHO FCTC). Geneva: World Health Organization. Retrieved November 12, 2016, from <http://www.who.int/fctc/about/en/>
- Firmin, M. W. (2008). Themes. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 868-869). Thousand Oaks: Sage.
- Flick, U. (2009). *An introduction to qualitative researching* (4th ed.). London, UK: Sage.
- Flowers, N. (Ed.). (1998). *Human rights here & now: Celebrating the Universal Declaration of Human Rights*. Minnesota: University of Minnesota, Human Rights Resources Centre (HRRC).
- Fox, A. M., & Meier, B. M. (2009). Health as freedom: addressing social determinants of global health inequities through the human right to development. *Bioethics*, 23(2), 112-122.
- Frankish, C. J., Green, L. W., Ratner, P. A., Chomik, T., & Larsen, C. (1996). *Health impact assessment as a tool for population health promotion and public policy*. Vancouver: Institute of Health Promotion Research, University of British Columbia.
- Freiler, A., Muntaner, C., Shankardass, K., Mah, C. L., Molnar, A., Renahy, E., et al. (2013). Glossary for the implementation of Health in All Policies (HiAP). *Journal of Epidemiology and Community Health*, 67(12), 1068-1072.

- Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*. Thousand Oaks, CA: Sage.
- Glaser, B. (1998). *Doing grounded theory. Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glesne, C. (2006). Finding your story: Data analysis. In C. Glesne (Ed.), *Becoming qualitative researchers* (3rd ed., pp. 147-172). New York, NY: Pearson Education.
- Gloppen, S. (2008). Litigation as a strategy to hold governments accountable for implementing the right to health. *Health and Human Rights*, 10(2), 21-36.
- Goldberg, D. (2009). In support of a broad model of public health: Disparities, social epidemiology and public health causation. *Public Health Ethics*, 2(1), 70-83.
- Grad, F. P. (2002). The Preamble of the Constitution of the World Health Organization. *Bulletin of the World Health Organization*, 80(12), 981-982.
- Graham, H. (2004a). Social determinants and their unequal distribution: Clarifying policy understandings. *Milbank Quarterly*, 82(1), 101-124.
- Graham, H. (2004b). Tackling inequalities in health in England: Remedying health disadvantages, narrowing health gaps or reducing health gradients? *Journal of Social Policy*, 33(1), 115-131.
- Graham, J., Amos, B., & Plumptre, T. (2003). *Principles for good governance in the 21st century*. Policy Brief No.15, August 2003. Ottawa: Institute On Governance.
- Greer, S. L., & Lillvis, D. F. (2014). Beyond leadership: Political strategies for coordination in health policies. *Health Policy*, 116(1), 12-17.
- Greer, S. L., Wismar, M., & Figueras, J. (2016). *Strengthening health system governance: Better policies, stronger performance*. European Observatory on Health Systems and Policies. Berkshire: Open University Press.
- Greer, S. L., Wismar, M., Figueras, J., & McKee, C. (2016). Governance: A framework. In S. L. Greer, M. Wismar & J. Figueras (Eds.), *Strengthening health system*

- governance: Better policies, stronger performance* (pp. 27-56). European Observatory on Health Systems and Policies. Berkshire: Open University Press.
- Groenewald, T. (2008). Memos and memoing. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 505-506). Thousand Oaks: Sage.
- Gruskin, S., & Tarantola, D. (2005). Health and human rights. In S. Gruskin, M. A. Grodin, G. J. Annas & S. P. Marks (Eds.), *Perspectives on health and human rights* (pp. 3-57). New York: Routledge.
- Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research*, 19(1), 38-42.
- Hall, P. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25(3), 275-296.
- Hancock, T. (1985). Beyond health care: from public health policy to healthy public policy. *Canadian Journal of Public Health*, 76 Suppl 1, 9-11.
- Hancock, T. (1990). Developing healthy public policies at the local level. In A. Evers, W. Farrant & A. Trojan (Eds.), *Healthy public policy at the local level* (pp. 7-11). Frankfurt am Main, Campus-Verlag / Boulder, Colorado: Westview Press.
- Hancock, T. (1993). The evolution, impact and significance of the healthy cities/healthy communities movement. *Journal of Public Health Policy*, 14(1), 5-18.
- Hancock, T. (2011). The Ottawa Charter at 25. *Canadian Journal of Public Health*, 102(6), 404-406.
- Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., et al. (2010). Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health*, 9(5).
- Harris, E., Wise, M., Hawe, P., Finlay, P., & Nutbeam, D. (1995). *Working together: Intersectoral action for health*. Canberra: Australian Government Publishing Service.

- Harris-Roxas, B., Viliani, F., Bond, A., Cave, B., Divall, M., Furu, P., et al. (2012). Health impact assessment: the state of the art. *Impact Assessment and Project Appraisal*, 30(1), 43-52.
- Harvey, W. S. (2011). Strategies for conducting elite interviews. *Qualitative Research*, 11(4), 431-441.
- Hertzman, C., & Power, C. (2003). Health and human development: Understandings from life-course research. *Developmental Neuropsychology*, 24(2&3), 719-744.
- Hill, M. (2013). *The public policy process* (6th ed.). Harlow: Pearson Education.
- Hill, S. (2015). Axes of health inequalities and intersectionality. In K. E. Smith, C. Bambra & S. E. Hill (Eds.), *Health inequalities: Critical perspectives*. Oxford: Oxford Scholarship Online.
- Hippocrates. (460-354 B.C.). On airs, waters, and places. Retrieved October 3, 2014, from <http://classics.mit.edu/Hippocrates/airwatpl.html>
- Hoffman, S. J., & Rottingen, J. A. (2014). Split WHO in two: strengthening political decision-making and securing independent scientific advice. *Public Health*, 128(2), 188-194.
- Holt, D. H., Frohlich, K. L., Tjornhoj-Thomsen, T., & Clavier, C. (2016). Intersectorality in Danish municipalities: corrupting the social determinants of health? *Health Promot International*, 32(5), 881-890.
- Hood, C. (1991). A public management for all seasons? *Public Administration*, 69(1), 3-19.
- Howard, R., & Gunther, S. (2012). *Health in All Policies: An EU literature review 2006 – 2011 and interview with key stakeholders*. Equity Action. European Union.
- Howlett, M., Ramesh, M., & Perl, A. (2009). *Studying public policy: Policy cycles and policy subsystems* (3rd ed.). Don Mills, ON: Oxford University Press.
- Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., et al. (2011). How should we define health? *British Medical Journal*, 343, d4163.
- Hunt, L. (2008). *Inventing Human Rights: A History*. New York: Norton.

- Hunt, P. (2007). *Neglected diseases: A human rights analysis Social, Economic and Behavioural (SEB) Research Special Topics No 6*. Geneva: World Health Organization (WHO).
- Hunt, P., Backman, G., de Mesquita, J. B., Finer, L., Khosla, R., Korljan, D., et al. (2015). The right to the highest attainable standard of health. In R. Detels, M. Gulliford, Q. A. Karim & C. C. Tan (Eds.), *Oxford textbook of global public health* (6th ed., Vol. 1, pp. 277-292). Oxford: Oxford University Press.
- Hyden, G., Court, J., & Mease, K. (2003). *Making sense of governance: The need for involving local stakeholders*. ODI Discussion Paper. London: Overseas Development Institute (ODI)
- IOG. (2014). *Defining governance*: Institute of Governance, Ottawa. Retrieved October 30, 2014, from <http://iog.ca/about-us/defining-governance/>
- IOM. (2000). *Promoting health: Intervention strategies from social and behavioral research*. Institute of Medicine (IOM). Washington, DC: National Academy Press.
- Irvine, L., Elliott, L., Wallace, H., & Crombie, I. K. (2006). A review of major influences on current public health policy in developed countries in the second half of the 20th century. *Journal of the Royal Society for the Promotion of Health*, 126(2), 73-78.
- Jakab, Z. (2014). *The European policy framework and strategy for health and well-being (Health 2020): From vision to implementation*. PhD Dissertation. Doctoral School of Health Sciences. Debrecen, Hungary: University of Debrecen.
- Jakovljević, B. (2008). International health services. In W. Kirch (Ed.), *Encyclopedia of public health* (Vol. Volume 1, pp. 803-807). New York: Springer.
- Jones, B. D. (2003). Bounded rationality and political science: Lessons from public administration and public policy. *Journal of Public Administration Research and Theory*, 13(4), 395-412.

- Jones, J., & Barry, M. M. (2016). Factors influencing trust and mistrust in health promotion partnerships. *Global Health Promotion*, Article first published online: July 27, 2016.
- Joyce, K., & Bambra, C. (2010). Health inequalities in developed nations. *Social Alternatives*, 29(2), 21-26.
- Julien, H. (2008). Content analysis. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 120-121). Thousand Oaks: Sage.
- Kangas, O. E., Niemelä, M., & Varjonen, S. (2013). When and why do ideas matter? The influence of framing on opinion formation and policy change. *European Political Science Review*, 6(1), 74-92.
- Kemm, J. (2001). Health Impact Assessment: a tool for Healthy Public Policy. *Health Promotion International*, 16(1), 79-85.
- Khayatzadeh-Mahani, A., Ruckert, A., & Labonté, R. (2017). Could the WHO's Framework on Engagement with Non-State Actors (FENSA) be a threat to tackling childhood obesity? *Global Public Health*, 1-4.
- Kickbusch, I. (2003). The contribution of the World Health Organization to a new public health and health promotion. *American Journal of Public Health*, 93(3), 383-388.
- Kickbusch, I. (2010a). Health in All Policies: the evolution of the concept of horizontal health governance. In I. Kickbusch & K. Buckett (Eds.), *Implementing Health in All Policies: Adelaide 2010* (pp. 11-23). Rundle Mall, SA: Department of Health, Government of South Australia.
- Kickbusch, I. (2010b). Health in all policies: Where to from here? *Health Promotion International*, 25(3), 261-264.
- Kickbusch, I., & Behrendt, T. (2013). *Implementing a Health 2020 vision: Governance for health in the 21st century. Making it happen*. Copenhagen: WHO Regional Office for Europe.

- Kickbusch, I., & Buckett, K. (2010). *Implementing Health in All Policies*. Adelaide: Government of South Australia.
- Kickbusch, I., Cassels, A., & Liu, A. (2016). *New directions in governing the global health domain - leadership challenges for WHO*. Global Health Programme working paper. No. 13. Geneva: The Graduate Institute, Global Health Programme.
- Kickbusch, I., Draper, R., & O'Neill, M. (1990). Healthy public policy: A strategy to implement the Health for All philosophy at various governmental levels. In A. Evers, W. Farrant & A. Trojan (Eds.), *Healthy public policy at the local level* (pp. 1-5). Frankfurt am Main, Campus-Verlag / Boulder, Colorado: Westview Press.
- Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. Copenhagen: WHO Regional Office for Europe.
- Kickbusch, I., Williams, C., & Lawless, A. (2014). Making the most of open windows: establishing health in all policies in South Australia. *International Journal of Health Services*, 44(1), 185-194.
- Kingdon, J. (1984). *Agendas, alternatives, and public policies*. Boston: Little, Brown and Company.
- Koh, H. K., & Jacobson, M. (2009). Fostering public health leadership. *Journal of Public Health*, 31(2), 199-201.
- Koh, H. K., & Nowinski, J. M. (2010). Health equity and public health leadership. *American Journal of Public Health*, 100(Suppl 1), S9-S11.
- Koivusalo, M. (2010). The state of Health in All policies (HiAP) in the European Union: potential and pitfalls. *Journal of Epidemiology and Community Health*, 64(6), 500-503.
- Krieger, N. (2001a). A glossary for social epidemiology. *Journal of Epidemiology and Community Health*, 55(10), 693-700.

- Krieger, N. (2001b). Historical roots of social epidemiology: socioeconomic gradients in health and contextual analysis. *International Journal of Epidemiology*, 30(4), 899-900.
- Labonte, R. (1993). *Health promotion and empowerment: Practice frameworks*. Toronto: Centre for Health Promotion and ParticipAction.
- Lalonde, M. (1974). *A new perspective on the Health of Canadians*. Ottawa: Minister of Supply and Services.
- Lasswell, H. D. (1958). *Politics: Who get what, when, how*. New York: Meridian Books.
- Lawless, A., Baum, F., Delany-Crowe, T., MacDougall, C., Williams, C., McDermott, D., et al. (2017). Developing a framework for a program theory-based approach to evaluating policy processes and outcomes: Health in All Policies in South Australia. *International Journal of Health Policy and Management*, 6(x), 1-12.
- Lawless, A. P., Williams, C., Hurley, C., Wildgoose, D., Sawford, A., & Kickbusch, I. (2012). Health in All Policies: Evaluating the South Australian approach to intersectoral action for health. *Canadian Journal of Public Health*, 103(Suppl. 1), S15-S19.
- Lee, K. (2008). *Global institutions: The World Health Organization (WHO)*. Abingdon: Routledge.
- Leger, L. S. (2007). Declarations, Charters and Statements – Their role in health promotion. *Health Promotion International*, 22(3), 179-181.
- Legowski, B., & McKay, L. (2000). *Health beyond health care: Twenty-five years of federal health policy development*. Ottawa: Canadian Policy Research Network Discussion Paper. No. H04.
- Leppo, K., & Melkas, T. (1988). Towards healthy public policy: experiences in Finland 1972-1987. *Health Promotion International*, 3(2), 195-203.
- Leppo, K., Ollila, E., Peña, S., Wismar, M., & Cook, S. (2013a). *Health in All Policies - Seizing opportunities, implementing policies*. Helsinki, Finland: Ministry of Social Affairs and Health.

- Leppo, K., Ollila, E., Peña, S., Wismar, M., & Cook, S. (2013b). Lessons for policy-makers. In K. Leppo, E. Ollila, S. Peña, M. Wismar & S. Cook (Eds.), *Health in All Policies: Seizing opportunities, implementing policies* (pp. 325-337). Helsinki, Finland: Ministry of Social Affairs and Health of Finland.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. London: Sage.
- Lindblom, C. E. (1959). The science of "muddling through". *Public Administration Review*, 19(2), 79-88.
- Lindblom, C. E. (1979). Still muddling, not yet through. *Public Administration Review*, 39(6), 517-526.
- Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80-94.
- Lombard, M., Snyder-Duch, J., & Bracken, C. C. (2010). Practical resources for assessing and reporting intercoder reliability in content analysis research projects. Retrieved November 1, 2016, from <http://matthewlombard.com/reliability/>
- Lucyk, K., & McLaren, L. (2017). Taking stock of the social determinants of health: A scoping review. *PloS ONE*, 12(5), e0177306.
- Lueddeke, G. (2015). *Global population health and well-being in the 21st Century: Toward new paradigms, policy, and practice* New York: Springer.
- Lynch, J. (2017). Reframing inequality? The health inequalities turn as a dangerous frame shift. *Journal of Public Health (Oxf)*, 1-8.
- Lynch, J. W., Davey Smith, G., Kaplan, G. A., & House, J. S. (2000). Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal*, 320(7243), 1220-1224.
- Mackenbach, J. P. (2012). The persistence of health inequalities in modern welfare states: the explanation of a paradox. *Social Science & Medicine*, 75(4), 761-769.

- Mackenbach, J. P., Stirbu, I., Roskam, A.-J. R., Schaap, M. M., Menvielle, G., Leinsalu, M., et al. (2008). Socioeconomic Inequalities in Health in 22 European Countries. *New England Journal of Medicine*, 358(23), 2468-2481.
- Mahler, H. (1988a). Keynote address. Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988. *Health Promotion International*, 3(2), 133-138.
- Mahler, H. (1988b). Present status of WHO's initiative, "Health For All by the Year 2000". *Annual Review of Public Health*, 9(1), 71-97.
- Mahmood, S., Morreale, S., & Barry, M. (2015). *Developing a checklist for intersectoral partnerships for health promotion*. Galway: Health Promotion Research Center, NUI Galway.
- Maietta, R. C. (2008). Computer-assisted data analysis. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 103-108). Thousand Oaks: Sage.
- Management Advisory Committee. (2004). Connecting government: Whole-of-Government responses to Australia's priority challenges. Canberra: Commonwealth of Australia. Retrieved August 22, 2017, from http://www.apsc.gov.au/__data/assets/pdf_file/0006/7575/connectinggovernment.pdf
- March, J. G., & Olsen, J. P. (2008). Elaborating the 'New Institutionalism'. In S. A. Binder & R. A. W. Rhodes (Eds.), *The Oxford Handbook of Political Institutions* (pp. 3-20). Oxford: Oxford University Press.
- Marmot, M. (2004). Social causes of social inequalities in health. In S. Anand, F. Peter & A. Sen (Eds.), *Public health, ethics, and equity* (pp. 37-61). Oxford: Oxford University Press.
- Marmot, M. (2006). Status syndrome: a challenge to medicine. *Journal of the American Medical Association (JAMA)*, 295, 1304-1307.

- Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. *Lancet*, 370, 1153-1163.
- Marmot, M., & Allen, J. (2013). Prioritizing health equity. In S. Cook, K. Leppo, E. Ollila, S. Peña & M. Wismar (Eds.), *Health in All Policies: Seizing opportunities, implementing policies* (pp. 63-80). Helsinki, Finland: Ministry of Social Affairs and Health of Finland.
- Marmot, M., Allen, J., Bell, R., & Goldblatt, P. (2012). Building of the global movement for health equity: from Santiago to Rio and beyond. *The Lancet*, 379(9811), 181-188.
- Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., et al. (2010). *Strategic review of health inequalities in England post 2010. Fair society, healthy lives—the Marmot review final report*. London: Department of Health.
- Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. *American Journal of Public Health*, 104(S4), S517-S519.
- Marmot, M., & Wilkinson, R. (2001). Psychosocial and material pathways in the relation between income and health: A response to Lynch et al. *British Medical Journal*, 322(7296), 1233-1236.
- Marmot, M., & Wilkinson, R. (Eds.). (2006). *Social determinants of health* (2nd ed.). Oxford, UK: Oxford University Press.
- Marmot, M. G., Stansfeld, S., Patel, C., North, F., Head, J., White, I., et al. (1991). Health inequalities among British civil servants: the Whitehall II study. *The Lancet*, 337(8754), 1387-1393.
- Marshall, M. N. (1996). The key informant technique. *Family Practice*, 13(1), 92-97.
- Mason, J. (2002). *Qualitative researching* (2nd ed.). London, UK: Sage.
- Mayring, P. (2000). Qualitative content analysis. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 1(2).
- McDaid, D. (2012). Joint budgeting: can it facilitate intersectoral action? In D. V. McQueen, M. Wismar, V. Lin, C. M. Jones & M. Davies (Eds.), *Intersectoral*

- governance for Health in All Policies: Structures, actions, and experiences* (pp. 111-127). Copenhagen, Denmark: World Health Organization, Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
- McDaid, D., & Park, A.-L. (2016). *Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors*. Health Evidence Network (HEN) synthesis report 48. Copenhagen: WHO Regional Office for Europe.
- McGibbon, E., & McPherson, C. (2013). Stress, oppression & women's mental health: A discussion of the health consequences of injustice. *Women's Health and Urban Life*, 12(2), 63-81.
- McIntyre, L., Shyleyko, R., Nicholson, C., Beanlands, H., & McLaren, L. (2013). Perceptions of the social determinants of health by two groups more and less affiliated with public health in Canada. *BMC Res Notes*, 6, 247.
- McKeown, T. (1979). *The role of medicine: Dream, mirage or nemesis*. Oxford: Basil Blackwell.
- McQueen, D. V., Wismar, M., Lin, V., & Jones, C. M. (2012). Introduction: Health in All Policies, the social determinants of health and governance. In D. V. McQueen, M. Wismar, V. Lin, C. M. Jones & M. Davies (Eds.), *Intersectoral governance for Health in All Policies: Structures, actions, and experiences* (pp. 3-21). Copenhagen, Denmark: World Health Organization, Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
- McQueen, D. V., Wismar, M., Lin, V., Jones, C. M., & Davies, M. (2012). *Intersectoral governance for Health in All Policies: Structures, actions, and experiences*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

- Mehta, J. (2011). The varied role of ideas in politics: From 'whether' to 'how'. In D. Béland & R. H. Cox (Eds.), *Ideas and politics in social science research* (pp. 23-46). New York: Oxford University Press.
- Melkas, T. (2013). Health in all policies as a priority in Finnish health policy: A case study on national health policy development. *Scandinavian Journal of Public Health*, 41(Suppl 11), 3-28.
- Merton, R. K. (1975). Thematic analysis in science: Notes on Holton's concept. *Science*, 188(4186), 335-338.
- Mikkonen, J. (2012). Finnish experiences. In D. Raphael (Ed.), *Tackling health inequalities: Lessons from international experiences* (pp. 155-184). Toronto: Canadian Scholars' Press.
- Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian Facts*. Toronto: York University, School of Health Policy and Management.
- Milio, N. (1981). *Promoting health through public policy*. Philadelphia: F.A. Davis Company.
- Milio, N. (1986). *Building healthy public policies: Focus for a new public health*. Background papers for an international conference on health promotion. November 17-21, 1986. Ottawa: World Health Organization, Health and Welfare Canada & Canadian Public Health Association.
- Mills, C. W. (1959). *Sociological imagination*. London, UK: Oxford University Press.
- MOHLTC. (2012). Health Equity Impact Assessment (HEIA) workbook. Toronto: Ontario Ministry of Health and Long-Term Care (MOHLTC). Retrieved October 24, 2016, from <http://www.health.gov.on.ca/en/pro/programs/heia/tool.aspx>
- Molnar, A., Renahy, E., O'Campo, P., Muntaner, C., Freiler, A., & Shankardass, K. (2016). Using win-win strategies to implement Health in All Policies: A cross-case analysis. *PloS ONE*, 11(2), e0147003.

- Moon, S., Sridhar, D., Pate, M. A., Jha, A. K., Clinton, C., Delaunay, S., et al. (2015). Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola. *The Lancet*, 386(10009), 2204-2221.
- Mpinga, E. K., Verloo, H., London, L., & Chastonay, P. (2011). Health and human rights in scientific literature: A systematic review over a decade. *Health and Human Rights*, 13(2), 102-129.
- Navarro, V. (2009). What we mean by social determinants of health. *International Journal of Health Services*, 39(3), 423-441.
- NCCHPP. (2016). *Policy approaches to reducing health inequalities*. March 2016. Briefing note. Montreal: National Collaborating Centre for Healthy Public Policy (NCCHPP).
- Ndumbe-Eyoh, S., & Moffatt, H. (2013). Intersectoral action for health equity: a rapid systematic review. *BMC Public Health*, 13(1056).
- Nickel, J. (2014). Human rights. Stanford: Stanford Encyclopedia of Philosophy, Metaphysics Research Lab, Stanford University. Retrieved June 28, 2017, from <http://plato.stanford.edu/entries/rights-human/>
- Nutbeam, D. (1998). Health Promotion Glossary. *Health Promotion International*, 13(4), 349-364.
- OECD. (2002). *Development co-operation report 2001: Efforts and policies of the members of the development assistance committee*. Paris: OECD Publishing.
- Ollila, E. (2011). Health in All Policies: From rhetoric to action. *Scandinavian Journal of Public Health*, 39(6 suppl), 11-18.
- Ollila, E., Baum, F., & Peña, S. (2013). Introduction to Health in All Policies and the analytical framework of the book. In K. Leppo, E. Ollila, S. Peña, M. Wismar & S. Cook (Eds.), *Health in All Policies: Seizing opportunities, implementing policies* (pp. 3-23). Helsinki, Finland: Ministry of Social Affairs and Health of Finland.

- Ollila, E., Lahtinen, E., Melkas, T., Wismar, M., Ståhl, T., & Leppo, K. (2006). Towards a healthier future. In T. Ståhl, M. Wismar, E. Ollila, E. Lahtinen & K. Leppo (Eds.), *Health in all policies: prospects and potentials* (pp. 269-279). Helsinki: Ministry of Social Affairs and Health.
- Östlin, P., Eckermann, E., Mishra, U. S., Nkowane, M., & Wallstam, E. (2006). Gender and health promotion: A multisectoral policy approach. *Health Promotion International*, 21(suppl 1), 25-35.
- Ottersen, O. P., Dasgupta, J., Blouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J., et al. (2014). The political origins of health inequity: prospects for change. *The Lancet*, 383(9917), 630-667.
- Palys, T. (2008). Purposive sampling. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1-2, pp. 697-698). Thousand Oaks: Sage.
- PHAC. (2007). *Crossing sectors: Experiences in intersectoral action, public policy and health*. Ottawa: Public Health Agency of Canada (PHAC).
- PHAC. (2009). *Mobilizing intersectoral action to promote health: The case of ActNowBC in British Columbia*. Ottawa: Public Health Agency of Canada and World Health Organization.
- PHAC & WHO. (2008). *Health equity through intersectoral action: an analysis of 18 country case studies*. Ottawa: Public Health Agency of Canada (PHAC) & World Health Organization (WHO), Health Canada Publications.
- Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *J Health Soc Behav*, 51 Suppl, S28-40.
- Pickett, K. E., & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science & Medicine*, 128c, 316-326.
- Pierson, P. (2004). *Politics in time*. Princeton: Princeton University Press.

- Pierson, P. (2007). The rise and reconfiguration of activist government. In P. Pierson & T. Skocpol (Eds.), *The transformation of American politics activist government and the rise of conservatism* (pp. 19-38). New Jersey: Princeton University Press.
- Pierson, P., & Skocpol, T. (2002). Historical institutionalism in contemporary political science. In I. Katznelson & H. V. Milner (Eds.), *Political Science: State of the Discipline*. (pp. 693-721). New York: W.W. Norton.
- Pinto, A. D., Molnar, A., Shankardass, K., O'Campo, P. J., & Bayoumi, A. M. (2015). Economic considerations and health in all policies initiatives: evidence from interviews with key informants in Sweden, Quebec and South Australia. *BMC Public Health*, 15, 171.
- Puska, P., & Ståhl, T. (2010). Health in All Policies. The Finnish initiative: background, principles, and current Issues. *Annual Review of Public Health*, 31(1), 315-328.
- Rached, D. H., & Ventura, D. d. F. L. (2017). World Health Organization and the search for accountability: A critical analysis of the new framework of engagement with non-state actors. *Cadernos de Saúde Pública*, 33.
- Raphael, D. (2008). Grasping at straws: a recent history of health promotion in Canada. *Critical Public Health*, 18, 483-495.
- Raphael, D. (2009a). Reducing social and health inequalities requires building social and political movements. *Humanity & Society*, 33(1-2), 145-165.
- Raphael, D. (2009b). Social determinants of health: An overview of key issues and themes. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives* (2nd ed., pp. 2-19). Toronto: Canadian Scholars' Press.
- Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health*, 21(2), 221-226.
- Raphael, D. (2012a). Canadian experiences. In D. Raphael (Ed.), *Tackling health inequalities: Lessons from international experiences* (pp. 123-153). Toronto: Canadian Scholars' Press.

- Raphael, D. (2012b). The importance of tackling health inequalities. In D. Raphael (Ed.), *Tackling health inequalities: Lessons from international experiences* (pp. 1-32). Toronto: Canadian Scholars' Press.
- Raphael, D. (2014). Beyond policy analysis: The raw politics behind opposition to healthy public policy. *Health Promotion International*, 30(2):380-96
- Raphael, D. (Ed.). (2009c). *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press.
- Raphael, D. (Ed.). (2012c). *Tackling health inequalities: Lessons from international experiences*. Toronto: Canadian Scholars' Press.
- Raphael, D. (Ed.). (2016). *Social determinants of health: Canadian perspectives* (3rd ed.). Toronto: Canadian Scholars' Press.
- Raphael, D., & Bryant, T. (2006a). Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. *Promotion and Education*, 13(4), 236-242.
- Raphael, D., & Bryant, T. (2006b). The state's role in promoting population health: Public health concerns in Canada, USA, UK, and Sweden. *Health Policy*, 78, 39-55.
- Reitz, J. G., & Banerjee, R. (2007). Racial inequality, social cohesion, and policy issues in Canada. In K. Banting, T. J. Courchene & F. L. Seidle (Eds.), *Belonging? Diversity, recognition and shared citizenship in Canada* (pp. 489-545). Montreal: Institute for Research on Public Policy.
- Riedel, E. (2009). The human right to health: Conceptual foundations. In A. Clapham & M. Robinson (Eds.), *Realizing the right to health: Swiss human rights book*, vol. 3 (pp. 21-39). Zurich: Rüffer & Rub.
- Rioux, M. H. (2010). Human rights approaches to health. In D. Raphael, T. Bryant & M. H. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness and health care* (2nd ed., pp. 93-120). Toronto: Canadian Scholars' Press.

- Rodriguez-Garcia, R., & Akhter, M. N. (2000). Human rights: the foundation of public health practice. *American Journal of Public Health*, 90(5), 693-694.
- Rose, G. (2008). *Strategy of preventive medicine*. Oxford: Oxford University Press.
- Rothstein, M. (2002). Rethinking the meaning of public health. *Journal of Law, Medicine and Ethics*, 30(2), 144-149.
- Rothstein, M. (2009). The limits of public health: A response. *Public Health Ethics*, 2(1), 84-88.
- Rowitz, L. (2013). *Public health leadership* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.
- Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in All Policies: A guide for state and local governments*. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute.
- Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, 15(1), 85-109.
- SA Health. (2010). *Papers from the Health in All Policies Adelaide 2010 international meeting*. Government of South Australia, Public Health Bulletin. Volume 7, Number 2, July 2010.
- Saari, J., & Kananen, J. (2009). Sosiaalipolitiikan ideat [Ideas in social policy]. In J. Kananen & J. Saari (Eds.), *Ajatuksen voima: Ideat hyvinvointivaltion uudistamisessa [The power of an idea: Ideas in welfare state renewal]*. Helsinki: Minerva.
- Sabatier, P. (1999). *Theories of the policy process* (2nd ed.). Boulder, CO: Westview Press.
- Saint-Arnaud, S., & Bernard, P. (2003). Convergence or Resilience? A Hierarchical Cluster Analysis of the Welfare Regimes in Advanced Countries. *Current Sociology*, 51(5), 499-527.
- Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Thousand Oaks: Sage.

- Sartorius, N. (2006). The meanings of health and its promotion. *Croatian medical journal*, 47(4), 662-664.
- Schmidt, V. A. (2008). Discursive institutionalism: The explanatory power of ideas and discourse. *Annual Review of Political Science*, 11, 303-326.
- Schmitz, H. P. (2016). The global health network on alcohol control: successes and limits of evidence-based advocacy. *Health Policy and Planning*, 31, i87–i97.
- Schrecker, T. (2014). Globalization, austerity and health equity politics: taming the inequality machine, and why it matters. *Critical Public Health*, 1-10.
- Shankardass, K., Solar, O., Murphy, K., Greaves, L., & O'Campo, P. (2012). A scoping review of intersectoral action for health equity involving governments. *International Journal of Public Health*, 57(1), 25-33.
- Silbey, S. (2006). Ideology. In B. S. Turner (Ed.), *The Cambridge dictionary of sociology* (pp. 278-279). Cambridge: Cambridge University Press.
- Silverman, D., & Marvasti, A. (2008). *Doing qualitative research: A comprehensive guide*. Thousand Oaks, CA: Sage.
- Siu, B. (2014). *Developing public policy: A practical guide*. Toronto: Canadian Scholars' Press.
- Smith, K. E. (2013). *Beyond evidence-based policy in public health: The interplay of ideas*. Basingstoke: Palgrave Macmillan.
- Smith, K. E., Bambra, C., & Hill, S. E. (2015). *Health Inequalities: Critical Perspectives*. Croydon: Oxford University Press.
- Smith, K. E., Bambra, C., Joyce, K. E., Perkins, N., Hunter, D. J., & Blenkinsopp, E. A. (2009). Partners in health? A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008. *31*(2), 210-221.
- Smith, K. E., Hill, S. E., & Bambra, C. (2015). Conclusion—where next for advocates, researchers, and policymakers trying to tackle health inequalities? In K. E. Smith,

- C. Bambra & S. E. Hill (Eds.), *Health inequalities: Critical perspectives*. Oxford: Oxford Scholarship Online.
- Smith, K. E., Stewart, E., Donnelly, P., & McKendrick, B. (2015). Influencing policy with research—public health advocacy and health inequalities. In K. E. Smith, C. Bambra & S. E. Hill (Eds.), *Health inequalities: Critical perspectives*. Oxford: Oxford Scholarship Online.
- Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2*. Geneva: World Health Organization.
- St. Pierre, L., & Gauvin, J. P. (2010). Intersectoral governance for Health in All Policies: an integrated framework (pp. 31-36). Government of South Australia, Public Health Bulletin (pp. 31-36).
- Ståhl, T. (2016). *Health in All Policies - From rhetoric to implementation and evaluation*. Presentation at the 8th Nordic Health Promotion Research Conference, June 20-22, 2016, Jyväskylä, Finland.
- Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E., & Leppo, K. (Eds.). (2006). *Health in All Policies: Prospects and potentials*. Helsinki: Ministry of Social Affairs and Health.
- Stoker, G. (1998). Governance as theory: five propositions. *International Social Science Journal*, 50(155), 17-28.
- Stone, D. (2011). *Policy paradox: The art of political decision making* (3rd ed.). New York: W. W. Norton & Company.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Taket, A. (2012). *Health equity, social justice and human rights*. New York: Routledge.
- Taylor, L. H., Latham, S. M., & Woolhouse, M. E. (2001). Risk factors for human disease emergence. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 356(1411), 983-989.

- TCD. (2010). Policy coherence and development: What is policy coherence? Dublin: Trinity College Dublin (TCD), The University of Dublin. Retrieved December 1, 2016, from <https://www.tcd.ie/iiis/policycoherence/concept/what-is.php>
- Thelen, K., & Steinmo, S. (1992). *Structuring politics: Historical institutionalism in comparative analysis*. Cambridge: Cambridge University Press.
- Tountas, Y. (2009). The historical origins of the basic concepts of health promotion and education: the role of ancient Greek philosophy and medicine. *Health Promotion International*, 24(2), 185-192.
- Townsend, P., Davidson, N., & Whitehead, M. (1986). *The Black report and the health divide*. Harmondsworth, UK: Penguin.
- Tremblay, M.-A. (1957). The key informant technique: A nonethnographic application. *American Anthropologist*, 59(4), 688-701.
- Tuohy, C. (1999). *Accidental Logics*. Oxford: Oxford University Press.
- UN General Assembly. (1948). *Universal Declaration of Human Rights*. Geneva: United Nations.
- UN General Assembly. (1965). International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), 21 December 1965, United Nations General Assembly resolution 2106 (XX). New York: United Nations. Retrieved October 24, 2016, from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>
- UN General Assembly. (1966a). International Covenant on Civil and Political Rights (ICCPR), 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171. Retrieved March 16, 2013, from <http://www.unhcr.org/refworld/docid/3ae6b3aa0.html>
- UN General Assembly. (1966b). International Covenant on Economic, Social and Cultural Rights (ICESCR), 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. Retrieved March 16, 2013, from <http://www.unhcr.org/refworld/docid/3ae6b36c0.html>

- UN General Assembly. (1979). Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), UN General Assembly, 18 December 1979. New York: United Nations. Retrieved October 24, 2016, from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>
- UN General Assembly. (1989). Convention on the Rights of the Child (CRC), UN General Assembly, 20 November 1989. New York: United Nations. Retrieved October 24, 2016, 2016, from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>
- UN General Assembly. (2011). *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*. UN General Assembly, Sixty-sixth session, 16 September 2011, A/66/L.1. New York: United Nations.
- UN General Assembly. (2015). Transforming our world: the 2030 Agenda for Sustainable Development. Resolution adopted by the General Assembly on 25 September 2015. A/RES/70/1. New York: Seventieth session of the United Nations General Assembly. Retrieved August 23, 2015, from <https://sustainabledevelopment.un.org/post2015/transformingourworld>
- UNDP. (2011). *Towards human resilience: Sustaining MDG progress in an age of economic uncertainty*. New York: United Nations Development Programme (UNDP), Bureau for Development Policy.
- UNESCAP. (2006). What is good governance? United Nations Economic and Social Commission for Asia and the Pacific. Retrieved March 15, 2015, from <http://www.unescap.org/sites/default/files/good-governance.pdf>
- United Nations. (1945). Charter of the United Nations, 24 October 1945, 1 UNTS XVI. Retrieved March 25, 2013, from <http://www.unhcr.org/refworld/docid/3ae6b3930.html>
- Vågerö, D. (1995). Health inequalities as policy issues - reflections on ethics, policy and public health. *Sociology of Health & Illness*, 17(1), 1-19.

- van der Wel, K. A., Dahl, E., & Bergsli, H. (2016). The Norwegian policy to reduce health inequalities: key challenges. *Nordisk välfärdsforskning / Nordic Welfare Research*, 1(01), 19-29.
- VanderStoep, S. W., & Johnston, D. D. (2009). *Research methods for everyday life: Blending qualitative and quantitative approaches*. San Francisco, CA: Jossey-Bass.
- von Schirnding, Y. E. R. (1997). *Intersectoral action for health: Addressing health and environment concerns in sustainable development*. Geneva: World Health Organization (WHO).
- von Schirnding, Y. E. R. (2015). Environmental health practice In R. Detels, M. Gulliford, Q. A. Karim & C. C. Tan (Eds.), *Oxford textbook of global public health* (6th ed., Vol. 1, pp. 1523-1541). Oxford: Oxford University Press.
- Walt, G. (1994). *Health policy: An introduction to process and power* London: Zed Books.
- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), 353-370.
- Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R., & Gilson, L. (2008). 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning*, 23(5), 308-317.
- Weiss, R. S. (1994). *Learning from strangers. The art and method of qualitative interview studies*. New York: The Free Press.
- Wernli, D., Jørgensen, P. S., Harbarth, S., Carroll, S. P., Laxminarayan, R., Levrat, N., et al. (2017). Antimicrobial resistance: The complex challenge of measurement to inform policy and the public. *PLoS Medicine*, 14(8), e1002378.
- White, K. (2001). *The early sociology of health and illness*. London: Routledge.
- Whitehead, M. (1990). *The concepts and principles of equity and health*. Copenhagen: World Health Organization, Regional Office for Europe.
- Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services*, 22, 429-445.

- Whitehead, M., & Dahlgren, G. (2006). *Concepts and principles for tackling social inequities in health: Levelling up Part 1*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe.
- Whitehead, M., Dahlgren, G., & Gilson, L. (2001). Developing the policy response to inequities in health: A global perspective. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 308-324). New York: Oxford University Press.
- Whitehead, M., Povall, S., & Loring, B. (2014). The equity action spectrum: taking a comprehensive approach. Copenhagen: WHO Regional Office for Europe.
- WHO. (1946). Constitution of the World Health Organization. Preamble to the Constitution of the WHO, as Adopted by the International Health Conference, New York, June 19–22, 1946; Signed on July 22, 1946 by the Representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and Entered into Force on April 7, 1948: World Health Organization.
- WHO. (1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978: World Health Organization.
- WHO. (1981). *Global strategy for Health for All by the year 2000*. Geneva: World Health Organization.
- WHO. (1984). *A discussion document on the concept and principles of health promotion*. The summary report of the Working Group, July 9-13, 1984. Copenhagen: WHO Regional Office for Europe.
- WHO. (1986a). *Intersectoral action for health: The role of intersectoral cooperation in national strategies for Health-for-All*. Geneva: World Health Organization (WHO).
- WHO. (1986b). Ottawa Charter for Health Promotion. First international conference on health promotion, Ottawa, Canada, 17-21 November 1986. World Health Organization.

- WHO. (1986c). *The role of intersectoral cooperation in national strategies for Health-for-All*. Geneva: World Health Organization (WHO).
- WHO. (1988). Adelaide Recommendations on Healthy Public Policy. Second international conference on health promotion, Adelaide, South Australia, 5-9 April 1988. World Health Organization.
- WHO. (1991). Sundsvall Statement on Supportive Environments for Health. Third international conference on health promotion, Sundsvall, Sweden, 9-15 June 1991. World Health Organization.
- WHO. (1997a). *Intersectoral action for health: A cornerstone for Health-for-All in the twenty-first century*. Report of the International Conference, 20-23 April 1997, Halifax, Nova Scotia, Canada. World Health Organization.
- WHO. (1997b). Jakarta Declaration on Leading Health Promotion into the 21st Century. Fourth international conference on health promotion, Jakarta, Indonesia, 21-25 July 1997. World Health Organization.
- WHO. (1998a). *Health21: An introduction to the health for all policy framework for the WHO European Region*. Copenhagen: WHO Regional Office for Europe.
- WHO. (1998b). *Health promotion glossary*. Geneva: World Health Organization.
- WHO. (1998c). *WHO's global school health initiative: Health promoting schools; a healthy setting for living, learning and working*. (WHO/HPR/HEP/98.4). Geneva: World Health Organization.
- WHO. (2000). Mexico Ministerial Statement for the Promotion of Health. Fifth global conference on health promotion, Mexico City, 5 June, 2000. World Health Organization.
- WHO. (2002). 25 questions and answers on health and human rights *Health & Human Rights Publication Series, No. 1*. Geneva: World Health Organization.

- WHO. (2005a). *The Bangkok Charter for Health Promotion in a Globalized World*. Sixth global conference on health promotion, Bangkok, Thailand, 7-11 August 2005. World Health Organization.
- WHO. (2005b). *The Health for All policy framework for the WHO European Region: 2005 update*. Copenhagen: WHO Regional Office for Europe.
- WHO. (2006). *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach?* Health Evidence Network (HEN) report. Copenhagen: WHO Regional Office for Europe.
- WHO. (2008a). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.
- WHO. (2008b). *International Health Regulations 2005* (2nd ed.). Geneva: World Health Organization
- WHO. (2009a). *Milestones in health promotion statements from global conferences*. Geneva: World Health Organization.
- WHO. (2009b). *Nairobi Call to Action*: Seventh global conference on health promotion, Nairobi, Kenya, 26-30 October 2009. World Health Organization.
- WHO. (2010a). *Global strategy to reduce the harmful use of alcohol*. Geneva: World Health Organization.
- WHO. (2010b). *Jo Eirik Asvall's Memorial Guide 1931–2010*. Copenhagen: WHO Regional Office for Europe.
- WHO. (2010c). *Sixty years of WHO in Europe*. Copenhagen: WHO Regional Office for Europe.
- WHO. (2011). *Rio Political Declaration on Social Determinants of Health*: Rio de Janeiro, Brazil, 21 October 2011. Geneva, World Health Organization.
- WHO. (2013a). *The economics of the social determinants of health and health inequalities: A resource book*. Geneva: World Health Organization.

- WHO. (2013b). *Health 2020. A European policy framework and strategy for the 21st century*. Copenhagen: WHO Regional Office for Europe.
- WHO. (2013c). Helsinki Statement on Health in All Policies. Eight global conference on health promotion, 10-14 June 2013, Helsinki, Finland. World Health Organization.
- WHO. (2014a). Basic documents. Forty-eighth edition, including amendments adopted up to December 31, 2014. Geneva: World Health Organization. Retrieved February 25, 2017, from <http://apps.who.int/gb/bd/PDF/bd48/basic-documents-48th-edition-en.pdf>
- WHO. (2014b). Health in All Policies: Framework for country action. Geneva: World Health Organization. Retrieved 1 April, 2016, from <http://www.who.int/healthpromotion/frameworkforcountryaction/en/>
- WHO. (2014c). *Healthy cities promoting health and equity – evidence for local policy and practice. Summary evaluation of Phase V of the WHO European Healthy Cities Network*. Copenhagen: WHO Regional Office for Europe.
- WHO. (2014d). *Twelfth general programme of work 2014–2019*. Geneva: World Health Organization.
- WHO. (2015a). Health in 2015: from MDGs to SDGs. Geneva: World Health Organization. Retrieved 14 July, 2016, from <http://www.who.int/gho/publications/mdgs-sdgs/en/>
- WHO. (2015b). Health in All Policies training manual Geneva: World Health Organization. Retrieved 1 April, 2016, from http://who.int/social_determinants/publications/health-policies-manual/en/
- WHO. (2015c). Health in All Policies training manual. Geneva: World Health Organization. Retrieved 1 April, 2016, from http://who.int/social_determinants/publications/health-policies-manual/en/
- WHO. (2015d). *Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice*. Regional Committee for Europe,

- 65th session, EUR/RC65/16. Vilnius, Lithuania, 14-17 September 2015.
Copenhagen: WHO Regional Office for Europe.
- WHO. (2016a). *Compendium of case studies. Partnerships for the health and well-being of our young and future generations. Working together for better health and well-being. High-level conference, 7–8 December 2016, Paris, France.* Copenhagen: WHO Regional Office for Europe. Retrieved January 15, 2017, from http://www.euro.who.int/__data/assets/pdf_file/0011/324947/Compendium-case-studies.pdf?ua=1
- WHO. (2016b). *Compendium of case studies. Partnerships for the health and well-being of our young and future generations. Working together for better health and well-being. High-level conference, 7–8 December 2016, Paris, France.* Copenhagen: WHO Regional Office for Europe.
- WHO. (2016c). Framework of engagement with non-State actors. WHA69.10. Sixty-ninth World Health Assembly (WHA69). Agenda item 11.3. May 28, 2016. Retrieved August 8, 2017, from http://www.who.int/about/collaborations/non-state-actors/A69_R10-FENSA-en.pdf
- WHO. (2016d). *Global consultation: monitoring system for action on the social determinants of health. Consultation paper.* Geneva: World Health Organization.
- WHO. (2016e). Shanghai Declaration on Health Promotion. Ninth global conference on health promotion, Shanghai, China, 21-24 November 2016. World Health Organization.
- WHO. (2016f). *The World Health Organization in the European Region.* Brochure. Copenhagen: WHO Regional Office for Europe.
- WHO. (2017a). Engagement with non-State actors. A70/52. Seventieth World Health Assembly (WHA70), Twenty-sixth Programme, Budget and Administration Committee meeting (PBAC26) and 141th Executive Board (EB141), May 2017.

- Retrieved August 8, 2017, from http://www.who.int/about/who_reform/documents/en/
- WHO. (2017b). Healthy settings. Geneva: World Health Organization. Retrieved May 7, 2017, from http://www.who.int/healthy_settings/en/
- WHO. (2017c). Leadership and management at WHO: evaluation of WHO reform, third stage. A70/50 Add.1. Seventieth World Health Assembly (WHA70), Twenty-sixth Programme, Budget and Administration Committee meeting (PBAC26) and 141th Executive Board (EB141), May 2017. Retrieved August 8, 2017, from http://www.who.int/about/who_reform/documents/en/
- WHO. (2017d). Overview of WHO reform implementation. A70/50. Seventieth World Health Assembly (WHA70), Twenty-sixth Programme, Budget and Administration Committee meeting (PBAC26) and 141th Executive Board (EB141), May 2017. Retrieved August 8, 2017, from http://www.who.int/about/who_reform/documents/en/
- WHO. (2017e). Proposed programme budget 2018–2019. Seventieth World Health Assembly (A70/7). Provisional agenda item 11.2. New York: World Health Organization.
- WHO. (2017f). Sector briefs: intersectoral action for better health and well-being. Copenhagen: WHO Regional Office for Europe. Retrieved August 11, 2017, from <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/implementation-package/1.-introducing-health-2020-to-different-stakeholders-across-sectors/sector-briefs-intersectoral-action-for-better-health-and-well-being>
- WHO. (2017g). United Nations system. Copenhagen: WHO Regional Office for Europe. Retrieved August 21, 2017, from <http://www.euro.who.int/en/about-us/partners/united-nations-system>

- Wilkinson, R., & Marmot, M. (2003). *Social Determinants of Health: The Solid Facts* (2nd ed.). Copenhagen: WHO Regional Office for Europe.
- Wilkinson, R. G., & Pickett, K. E. (2006). Income inequality and health: a review and explanation of the evidence. *Social Science and Medicine*, 62(7), 1768-1784.
- Wilkinson, R. G., & Pickett, K. E. (2009). *The spirit level: why more equal societies almost always do better*. London, UK: Allen Lane.
- Wilson, B. (2009). Social determinants of health from a rights-based approach. In A. Clapham & M. Robinson (Eds.), *Realizing the right to health: Swiss human rights book*, vol. 3 (pp. 60-79). Zurich: Rüffer & Rub.
- Yamin, A. E. (2008). Beyond compassion: The central role of accountability in applying a human rights framework to health. *Health and Human Rights*, 10(2), 1-20.

APPENDIX A. Review of human rights documents relevant to this study

Human rights are understood as fundamental, inalienable, and indivisible rights that every human being has from the moment he or she is born (UN General Assembly, 1948, 1966a, 1966b). Human rights can be divided into different categories, yet different rights are interdependent in the sense that violating one right often violates other rights as well (Flowers, 1998). The concept of human dignity is also closely linked to the human rights framework. To live a dignified life, there are some minimum conditions that need to be respected, protected, and fulfilled (Gruskin & Tarantola, 2005, p. 45; UN General Assembly, 1966b). In international human rights discourse, nation states are sovereign units but they also have the responsibility to protect and promote their citizens' human rights (Riedel, 2009).

In this Appendix, I review international human rights documents from a health perspective. This summary includes the most relevant documents for this dissertation: the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966),¹¹² and the International Covenant on Civil and Political Rights (ICCPR, 1966).¹¹³ These three documents comprise the International Bill of Human Rights (IBHR). In 2000, General Comment No. 14 on the Right to the Highest Attainable Standard of Health expanded ICESCR's Article 12 (CESCR, 2000). Other relevant UN conventions are the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC). In addition, I outline two European human rights

¹¹² The ICESCR was adopted by United Nations GA resolution 220 A (XXI) on December 16, 1966, and entered into force on January 3, 1976.

¹¹³ The ICCPR was adopted by United Nations GA resolution 220 A (XXI) on December 16, 1966, and entered into force on March 23, 1976.

documents: the European Convention on Human Rights (ECHR) and the European Social Charter (ESC).

In the following, I focus on existing UN conventions and declarations that I consider as key to understanding the human rights perspective to health that provides the normative base for health promotion. These documents are not academic publications; however, they are essential in understanding the value-based justifications for health-related actions that governments and public authorities can take. They are global documents that have been ratified by most of the countries of the world. For instance, the Universal Declaration of Human Rights (UDHR) is often considered to be the world's most translated document.

Universal Declaration of Human Rights (UDHR)

The most important human rights document is the Universal Declaration of Human Rights (UDHR) (UN General Assembly, 1948). The UDHR was drafted after the Second World War when the world desperately needed a new vision to avoid the calamity of war in the future. The United Nation's General Assembly adopted the declaration in Paris on December 10, 1948. The declaration was the first truly global expression of indivisible human rights, and it has influenced many national constitutions since its adoption. However, the UDHR is a declaration, not a legally binding treaty. Despite its non-binding nature, the declaration has come to be the most influential human rights document in history. The UDHR has thirty articles, and it has been described as "the cornerstone of the modern human rights movement" (Gruskin & Tarantola, 2005). Article 25 (1) of the UDHR states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of

unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The above quotation shows the progressive nature of the declaration. It considers “health and well-being” and acknowledges material living conditions, such as food and housing, as being essential prerequisites for health. The second paragraph of Article 25 states that mothers and children are “entitled to special care and assistance”, which is a recognition of the special needs for those in vulnerable life stages. The UDHR covers the different spheres of life to which human rights are relevant. These specific rights can be divided into at least six families. (See Chapter 2 in this dissertation and Nickel, 2014.)

International Covenant on Economic, Social and Cultural Rights (ICESCR)

The International Covenant on Economic, Social and Cultural Rights (ICESCR) focuses on equal and inalienable rights related to work, trade unions, social security, living conditions, health, education, culture, and enjoyment of the benefits of scientific progress (UN General Assembly, 1966b). The ICESCR states that each state party is “under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant.” Article 12 of the ICESCR addresses the right to health as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Article 12 of ICESCR is the only part of the covenant that explicitly mentions health. However, the other rights mentioned in the ICESCR can be seen as having major direct and indirect impacts on individual and population health. An individual's socioeconomic status – an important social determinant of health – includes income, occupation, and education, all of which are considered in the ICESCR. Interpreting the

ICESCR from a social determinants of health perspective makes obvious how its contents are highly relevant in terms of advancing individual and population health.

The covenant states that everyone should have an equal opportunity to attain the resources necessary for health, regardless of his or her socioeconomic status. As an example, Article 11 of the ICESCR considers living conditions:

The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.

The UN has limited means to enforce country-level compliance with the ICESCR. To monitor compliance, signatory states agree to submit reports on measures they have taken to realize the rights mentioned in the Covenant (Nickel, 2014). These reports are submitted to the Committee on Economic, Social and Cultural Rights (CESCR, 2014), which monitors the implementation of the covenant. Countries are required to submit a report within two years of signing the ICESCR. Thereafter regular reporting is required every five years.

General Comment No. 14: The Right to the Highest Attainable Standard of Health

Since 1988, the UN's Committee on Economic, Social and Cultural Rights (CESCR) has released "General Comments", which are interpretive statements based on existing treaties. In 2000, the CESCR issued General Comment No. 14 on the right to health, which expands ICESCR's Article 12 (CESCR, 2000).¹¹⁴ The Comment provides greater

¹¹⁴ In March 2013, the Committee on the Rights of the Child published its General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (The Convention on the Rights of the Child, Article 24, 1989).

clarity on how the right to health should be understood. Paragraph 9 of General Comment No. 14 (GC 14/2000) defines the right to health as “the enjoyment of a variety of facilities, goods and services and conditions necessary for the realization of the highest attainable standard of health.”

According to GC 14, the right to health can be pursued through complementary approaches such as the implementation of health policies and programs and the adoption of various legal instruments (paragraph 1). GC 14 considers the fulfillment of the right to health through the availability, accessibility, acceptability and quality of public health care (CESCR, 2000, paragraph 12). Availability refers to the existence of health care services as well as to the quality of the underlying determinants of health. In terms of accessibility, health services should be non-discriminatory and accessible for all, without any significant economic or physical barriers. The importance of non-discrimination is emphasized in terms of vulnerable populations such as children, mothers, older persons, persons with disabilities, and indigenous populations (CESCR, 2000, Article 12). Acceptability means that health facilities and services should respect medical ethics and be culturally appropriate. Finally, health facilities, goods, and services should be of high quality and based on medically and scientifically justified knowledge.

In addition to the provision of health care, General Comment No. 14 covers a range of socioeconomic factors and living conditions that contribute to the fulfillment of the right to health. These determinants include various rights such as access to potable water, housing, food, sanitation, and safe working and living conditions. Furthermore, GC 14 mentions the right to access health-related education and information.

Every state is required to take appropriate and concrete steps towards the full realization of the right to health (CESCR, 2000, paragraph 30). Paragraph 33 of GC 14 outlines the obligations to respect, protect, and fulfill the right to health. First, the obligation to respect requires that the signatory states do not interfere directly or indirectly with citizens’ right to health. Second, the obligation to protect requires that the

signatory states take active measures in order to prevent any third party from interfering with the realization of the right to health. Third, the obligation to fulfill requires that the signatory states should adopt “appropriate legislative, administrative, budgetary, judicial, promotional and other measures” towards the fulfillment of the right to health (CESCR, 2000, paragraph 33).

Due to unique national characteristics in terms of economic, social, and cultural conditions, the most appropriate measures to implement the right to health will be different in different countries. GC 14 instructs the signatory states to adopt national health strategies that outline national health targets, as well as to identify indicators to monitor the fulfillment of the right to health. After the national benchmarks are set, the UN’s Committee on Economic, Social and Cultural Rights must monitor changes in health indicators during each reporting period.

International Covenant on Civil and Political Rights (ICCPR)

The International Covenant on Civil and Political Rights (ICCPR)¹¹⁵ does not directly consider the right to health (UN General Assembly, 1966a). However, the covenant outlines obligations related to civil and political rights that can be understood as social determinants of health (Box 5). These include rights such as the right to life, security, and liberty, as well as freedoms such as the freedom of thought, freedom of expression, and freedom to participate in public affairs.

The monitoring body for the ICCPR is the Human Rights Committee (HRC), which reviews the regular reports submitted by the signatory parties. The Committee assesses the reports in terms of fulfillment of human rights obligations and it may provide recommendations for further improvement. States are expected to address these views

¹¹⁵ The ICCPR has two Optional Protocols. The First Optional Protocol gives individuals the right to complain to the Human Rights Committee about possible violations of the ICCPR. The Second Optional Protocol obliges signatory states to abolish the death penalty.

and recommendations and to implement them at the national level. However, there is no universal legal system that can force the signatory parties to implement the recommendations provided by the HRC.

Box 5. Rights and Freedoms covered in the ICCPR (adapted from the ICCPR, UN General Assembly, 1966a).	
Inherent right to life Freedom of discrimination Freedom of slavery/forced labour Right to liberty Right to security of person Treatment of prisoners Equality before the court Personal and family privacy	Freedom of thought Freedom of religion Freedom of expression Freedom of association Protection of family rights Protection of children’s rights Freedom to participate in public affairs Minority rights

Other relevant human rights documents

Several other international human rights conventions are relevant to health as they consider many of the social and economic conditions that shape the health of the population. In this regard, there are a number of UN conventions that have a focus on specialized groups such as visible minorities, women, children, and migrants. Many of these conventions make an explicit reference to the right to health (Hunt, 2007, p. 7). In the following, I will highlight three of these specialized UN conventions with relevant to health.

First, the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) obligates the signatory countries to “prohibit and to eliminate racial discrimination in all its forms” and to guarantee a number of rights to everyone, “without distinction as to race, colour, or national or ethnic origin” (UN General Assembly, 1965). Article 5 (e) (iv) of the ICERD refers explicitly to “the right to public

health, medical care, social security and social services” (UN General Assembly, 1965). In addition, many of the other economic, social, and cultural rights are mentioned in the ICERD, such as the right to just and favourable working conditions work and the right to equal pay for equal work (Article 5 (e) (i)).

Second, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is described as an international bill of rights for women and it consists of a preamble and 30 articles (UN General Assembly, 1979). The signatory parties are expected to prohibit discrimination against women and incorporate the principle of equality of men and women in their legal system. Article 12 of the CEDAW considers health and calls for access to health care services that take into account of women’s needs, such as “services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation” (CEDAW, 1979, Article 12:2). The State Parties are expected to submit a national report at least every four years to the UN Committee on the Elimination of Discrimination Against Women. The Committee is composed of 23 nominated experts who discuss the national reports with the government representatives and give recommendations for further action.

Third, the Convention on the Rights of the Child (CRC) is focused on the special needs of children and safe living environments for a good development (UN General Assembly, 1989). Article 24 of CRC is focused on health and explicitly recognizes the right of the child to the enjoyment of the highest attainable standard of health. In addition to safe physical and social environments, every child should have access to health care services for the treatment of illness and for rehabilitation. The State Parties are expected to take appropriate measures to decrease infant and child mortality, combat disease and malnutrition, ensure appropriate pre-natal and post-natal health care for mothers as well as educate parents in child health and nutrition, including the advantages of breastfeeding, hygiene, and environmental sanitation. The UN Committee on the Rights

of the Child, which has 18 independent experts, monitors the implementation of the CRC. The State Parties are obliged to submit an initial report two years after signing the CRC and periodic reports every five years.

European human rights documents

Although this study is focused on the UN conventions and the work of WHO, it should be noted that there is a body of European human rights treaties with implementation mechanisms. The most important treaty is the European Convention on Human Rights (ECHR), which was opened for signing in 1950 and came into force in 1953 (Council of Europe, 1950).¹¹⁶ The ECHR was the first instrument that bound countries to fulfill certain rights stated in the Universal Declaration of Human Rights. In terms of health, the most relevant sections in the ECHR are Article 2 ("right to life"), Article 3 ("prohibition of torture"), Article 8 ("right to respect for private and family life"), and Article 14 ("prohibition of discrimination").

The ECHR has since been amended multiple times and supplemented with sixteen protocols between 1952-2013. The ECHR is enforced by the European Court of Human Rights (ECtHR), which is a body of the Council of Europe. An individual, non-governmental organization, or a group of individuals feeling that a State party has violated their rights under the ECHR can take a case to the ECtHR, whose judgements are binding on the States with an obligation to execute them.

The European Social Charter is also a highly relevant human rights document in the European context (Council of Europe, 1961). With a special focus on health, Article 3 of the Charter considers the right to safe and healthy working conditions, and Article 11 addresses the right to protection of health by urging the Parties of the European Social Charter: (1) to remove as far as possible the causes of ill-health, (2) to provide advisory

¹¹⁶ The ECHR is formally known as the Convention for the Protection of Human Rights and Fundamental Freedoms.

and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health, and (3) to prevent as far as possible epidemic, endemic, and other diseases, as well as accidents. The European Committee of Social Rights (ECSR) monitors the compliance of the State Parties to the Charter through two complementary mechanisms: collective complaints by social partners or NGOs and national reports produced by the signatory states. The Committee is composed of 15 independent members, who are elected for a six-year term by the Council of Europe's Committee of Ministers.

APPENDIX B. Interview guide

The following thematic framework has been developed to guide the interview. More specific guiding questions will be tailored to each interview to address the most relevant themes of a specific programmatic area.

Approximately one hour is scheduled for each interview.

Introduction

- Introduction of interviewer
- Objective of the consultation and how the input will be used
- Name, professional title, and main responsibilities
 - Title of informant and division
 - Number of years in the position
 - Contact information
 - Main responsibilities
- Consent for research purposes

Background

In your programmatic area, we are interested to know about country experiences and good practices of intersectoral action for health. In particular we are looking for high-level mechanisms that were introduced to develop and/or implement policies, strategies, or plans in your area of expertise.

Key themes of the consultation

1. Intersectoral action for health: mechanisms, structures, and instruments
2. Opportunities and barriers to intersectoral action for health
3. Policy development and support for taking action
4. Case studies and good practices from the European region

The following questions are for the interviewer to facilitate and guide the interview.

Main questions	Additional questions	Clarifying questions
What are your programmatic areas?	Do you have priority countries?	Other priorities?
How do you understand the concept of intersectoral action for health?	What do these concepts mean to you in terms of your work? How do you see the differences between terms such as: • Whole-of-Government approach • Whole-of-Society approach • Healthy Public Policy • Health in All Policies (HiAP) • Social Determinants of Health approach	Explain how these approaches are related to your current work. How are they relevant? How are they currently integrated into the work, and could this be improved? If they are not relevant, please explain why.
Mechanism, structures, and instruments Describe mechanisms in place in your programmatic area for high-level intersectoral action/ collaboration to improve population health?	What are the key intersectoral mechanisms, initiatives, and structures currently in place in your programmatic area(s)?	Please provide examples at the country level. Can you tell me anything else?

Main questions	Additional questions	Clarifying questions
How are these mechanisms are governed?	What is the level of these mechanisms/ initiatives? Is the level national or sub-national? What is the level of government? What kind of mandate is there? Is there an involvement of the civil society/private sector/other international organizations? What is the time frame? Who is in charge or has the leadership role? How is the relationship between <i>governance structures</i> and <i>governance actions</i>?	E.g. interministerial, deputy ministerial, interparty level, other E.g. high-level formal committees, interministerial level with ministers or deputy ministers, or top-level officials E.g. formal with a constitutional /legal basis or informal/ad hoc (political) (See questions on non-state actors.) E.g. long-term, short-term for a specific task, ad hoc Are these roles clear?
What is the accountability framework of these mechanisms/ initiatives?	• What kind of concrete tools are used? • How is the monitoring and evaluation conducted? • What are the resources? Where does the funding comes from? • What is the level of transparency? • How are results communicated?	Tools such as Health Impact Assessments To politicians, experts, citizens ...

Main questions	Additional questions	Clarifying questions
Which factors have promoted the implementation of these specific intersectoral initiatives?	What are the key barriers and/or opportunities? OR What barriers can you identify for implementing intersectoral action and policies that acknowledge the importance of a Whole-of-Society/ Health in All Policies approach?	Please describe political, institutional, or bureaucratic barriers/opportunities? In your view, what kinds of capacities/tools/resources are needed for a successful implementation?
Policy development Describe ongoing or planned processes to increase intersectoral action for health in your programmatic area.	Describe some of the successes and failures in the implementation of intersectoral action for health in your programmatic area.	Can you mention any high-level strategic processes that would support intersectoral action for health?
What kind of support can facilitate intersectoral work in your area?	What is most needed to support your work in this area?	Enabling and disabling factors: • Mandate • Evidence base • Capacities of WHO • Capacities of the Member States
Case studies and examples What would you like to highlight as good practices and cases when we speak about intersectoral collaboration in the WHO context?	Who are the people or contacts who could provide more information? Are there publications and other documents available?	Which case studies could be highlighted in a report?

Main questions	Additional questions	Clarifying questions
Non-state actors (i.e. civil society, industry) and international organizations In relation to the intersectoral work outlined above, is your programme collaborating with any non-state actors?	Are any of the following actors involved? • NGOs • Industry/business/corporate sector • Media organizations • Other UN agencies • European Union • Other international organizations (e.g. OECD, ILO, IMF, World Bank)	In which countries, and how, is this collaboration carried out? How is the collaboration governed? What are the main challenges and opportunities?
In light of this discussion, how do you understand the concept of governance for health?	How do you understand the concepts of <i>good governance</i> and <i>smart governance</i>?	

To the end

Is there anything else you would like to say or comment on?	Are there any important topics we have not discussed yet?	Any other feedback?
--	--	----------------------------

APPENDIX C. List of key informants

Position	Programmatic area
Programme Manager	Alcohol and illicit drugs
Programme Manager	Alert and response operations
Programme Manager	Child and adolescent health and development
Programme Manager	Control of antimicrobial resistance
Programme Manager	Food safety
Programme Manager	Health information, monitoring and analysis
Programme Manager	Health services delivery
Programme Manager	Human resources for health
Programme Manager	Influenza and other respiratory pathogens
Programme Manager	Mental health
Programme Manager	Nutrition, physical activity and obesity
Programme Manager	Public health services
Programme Manager	Sexual and reproductive health
Programme Manager	Social determinants of health
Programme Manager	Tobacco
Programme Manager	Violence and injury prevention
Programme Manager	Vulnerable groups, gender and human rights
Unit Leader	eHealth
Unit Leader	eHealth: Information and evidence portal
Unit Leader	Evidence and information for policymaking
Unit Leader	Health information monitoring and analysis
Director	Healthy cities; Governance for health

Position	Programmatic area
Technical Officer	Environment and health
Technical Officer	Evidence-informed policy
Technical Officer	Prevention, control, and management of NCDs
Technical Officer	Vulnerable groups, gender and human rights
WHO Consultant	Health services delivery
Director, WHO Collaborating Centre	Social inclusion and health

APPENDIX D. List of case studies mentioned by the key informants

1. Better Health, Better Lives: Children and young people with intellectual disabilities and their families. European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families (26–27 November 2010)
2. Better Managing the Mobility of Health Professionals in the Republic of Moldova
3. Civil Registration and Vital Statistics (CRVS in general)
4. Decade of Roma Inclusion 2005-2015
5. Development of Palliative Care Services in the Republic of Serbia (2011-2014)
6. European Union Framework for National Roma Integration Strategies
7. European Action Plan on Antimicrobial Resistance
8. Eurostat, OECD and WHO Europe: Joint Data Collection
9. Evaluating Economic Potential and Impacts of Walking and Cycling
10. Final Report on the Implementation of the Tallinn Charter
11. Finnish Model of Strategic Health Workforce Planning
12. Gender Committees of the Health Counsellor in Serbia
13. Health Economic Assessment Tool (HEAT) (a web-based online tool)
14. Health Target Control System in Austria
15. Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025
16. International Classification of Functioning, Disability and Health, ICF (WHO)
17. International Classification of Diseases and Related Health Problems, ICD (WHO)
18. International Health Regulations, IHR (WHO, 1969 and 2005)
19. Investing in Children: The European Child Maltreatment Prevention Action Plan 2015–2020

20. Multi-country Meeting on Implementation of Healthy Lifestyle Education (16-18 February, 2015)
21. National Health Plan of Portugal 2012-2016
22. Multi-country Trainings to Reorient National Strategy Programs, Organized by WHO in Collaboration with UNICEF and UNFPA (Group #1: Serbia, Bulgaria, Macedonia, Montenegro and group #2: Albania, Slovakia, Romania, Ukraine, Kosovo)
23. National Reproductive Health Strategy in Moldova (2005-2015)
24. Non-communicable Disease Prevention and Control in Belarus
25. Promoting National Ownership on Reproductive Health Commodity Security (RHCS) Using Evidence Based Advocacy (6-7 June 2012, Brussels, Belgium)
26. Salt Reduction in the UK (experiences in general)
27. School Fruit Scheme (EU-wide voluntary scheme)
28. Serbia: Sustainable Waste Management Initiative for a Healthier Tomorrow (SWIFT): example of an intersectoral approach for improving the health of the Roma population
29. South-Eastern European Health Network (SEEHN)
30. Strasbourg Conclusions on Prisons and Health (2014)
31. Strategic Plan for Food Safety Including Foodborne Zoonoses 2013-2022
32. The Better Labs for Better Health Initiative
33. The Transport, Health and Environment Pan-European Programme (PEP, A joint program of WHO/EURO and UNECE)
34. United Nations Resolution on Road Safety
35. WHO Health and Migration initiative through the PHAME project
36. WHO European Advisory Committee on Health Research (EACHR)
37. WHO Evidence-informed Policy Network (EVIPNet)

38. WHO Framework Convention on Tobacco Control (FCTC)
39. WHO Global Action Plan on Antimicrobial Resistance
40. WHO Global Code of Practice on the International Recruitment of Health Personnel
41. WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010)
42. WHO Health Evidence Network (HEN)
43. WHO Health Information and Evidence Portal (website)
44. WHO Healthy Cities Network
45. WHO Manual for Developing National Action Plans on Transport, Health and Environment. A Step-by-Step Manual for Policymakers and Planners.
46. WHO Nutrient Profile Model