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Stretton Health Equity has prepared this evidence review on intersectoral models

* This work was commenced when the researchers worked at the Southgate Institute for Health, Society & Equity, Flinders University but completed at Stretton Health Equity, the University of Adelaide.

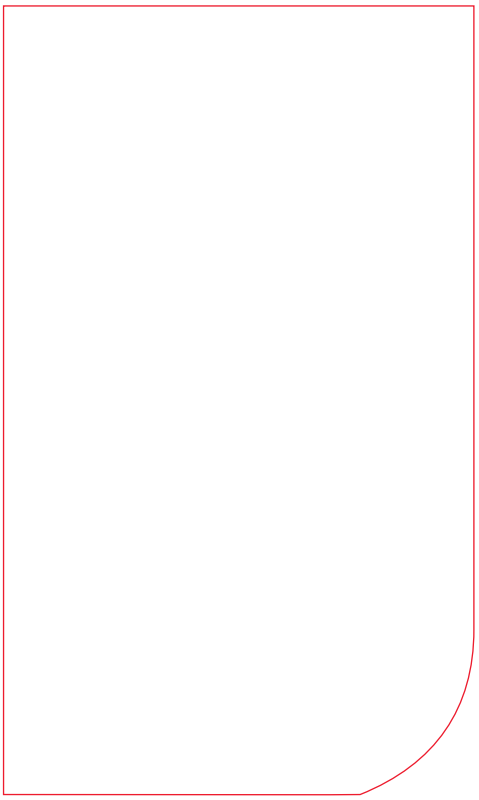
- The key barriers to intersectoral collaboration identified in the literature include:
  - Changing political priorities
  - Changing organisational structures
  - Funding cuts
  - Changing staff and loss of leaders/champions
  - When led by health, intersectoral collaboration can be viewed as health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

Models of intersectoral collaboration for healthy public policy

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

Section 1

Background to the concept



Section 2

Section 3

Key factors for and barriers to success in intersectoral collaboration

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

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

These factors are often interdependent in influencing outcomes of intersectoral collaboration.[34] A transparent, shared plan and agreed common goals contribute

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

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

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

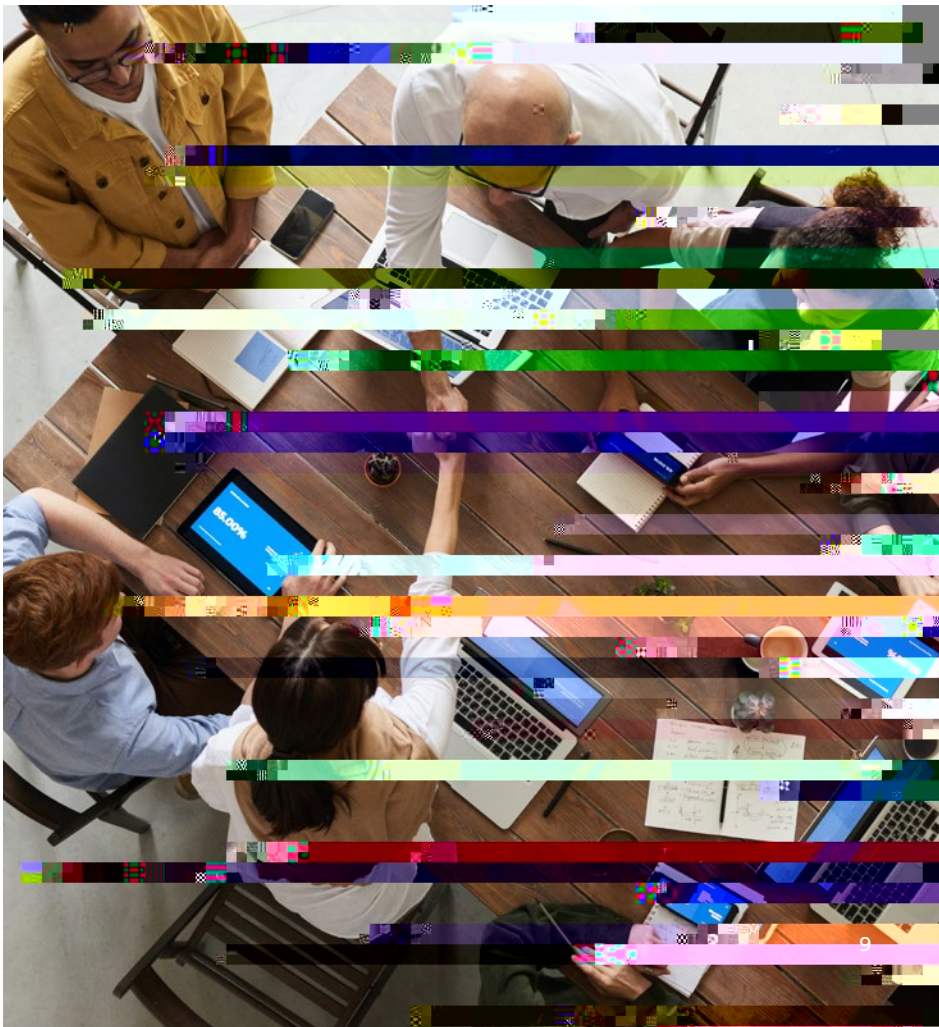
Changing political priorities and context
Initiatives involving intersectoral collaboration can be lengthy. If departmental or Government priorities shift during the project work or there are economic changes this can undermine commitment to intersectoral collaboration.

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

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

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

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



Section 4
Models of intersectoral collaboration

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

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

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

Healthy Cities

Healthy Cities is an approach used for intersectoral collaboration at local government level. The Healthy Cities Movement began in 1984 with the "Beyond Health Care" conference held in Toronto and an aim to grow awareness of the need to move away from a focus on individualised lifestyle focused health promotion and instead move towards healthy public policy initiatives.[33] The Healthy Cities approach has a commitment to intersectoral collaboration and community participation and focuses on health as a social concept rather than a medical one.[33] It embeds health in local political aealthwrnmeses wrs-1.35, u556 similar aid3 aeo i H4 Pco in s j 5g tio Tm(33)Tj8.5 0 511.5842 H1.7439

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

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

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

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

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

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

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

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

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

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

Early life

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

Chronic disease

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

The relationship between the social determinants of health and chronic disease is well established and relates to factors such as sex and gender identification, race and ethnicity, income and educational level, as well as systemic factors including the political and social conditions that support life chances in education, employment, housing, and social inclusion.[81] Addressing the social determinants to act on chronic disease has been identified as including: 1) intervening in the health care system to reduce the consequences of illness among those who are disadvantaged or vulnerable; 2) reducing the vulnerability of disadvantaged people to health-damaging factors; 3) decreasing exposure to health-damaging factors associated with loconcerns about99(onc[(asso4463T65656

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

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

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

It is important to note that while some models may receive more focus in published literature than others, there is no

Section 5

The role of community participation

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

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

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

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

Community participation can be divided between utilitarian and empowerment models. In the utilitarian model of community participation, an organisation u4 (6r0 -1.353 Td6n4.9555 132.0125 199s mechanisacht o)8 hdels. In t

Section 6

Building skills that support intersectoral collaboration for healthy public policy

There is an extensive literature on intersectoral collaboration, much of which identi□es facilitators and barriers to collaboration, including the organisational culture and capacities and the sta□ skills required to support e□ective collaboration between sectors. While the skills of individuals are important to make intersectoral collaboration work, e□ective intersectoral collaboration also requires the active support of organisations. Box 10 summarises the key organisational and individual skills identi□ed in the (e)-5 (c)-9.06494 (,t4 (,14 (e importairt e)4 (#pp)-4.9u in)22.1 (the 2.1 (the

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

The 'soft skills' needed for effective collaboration

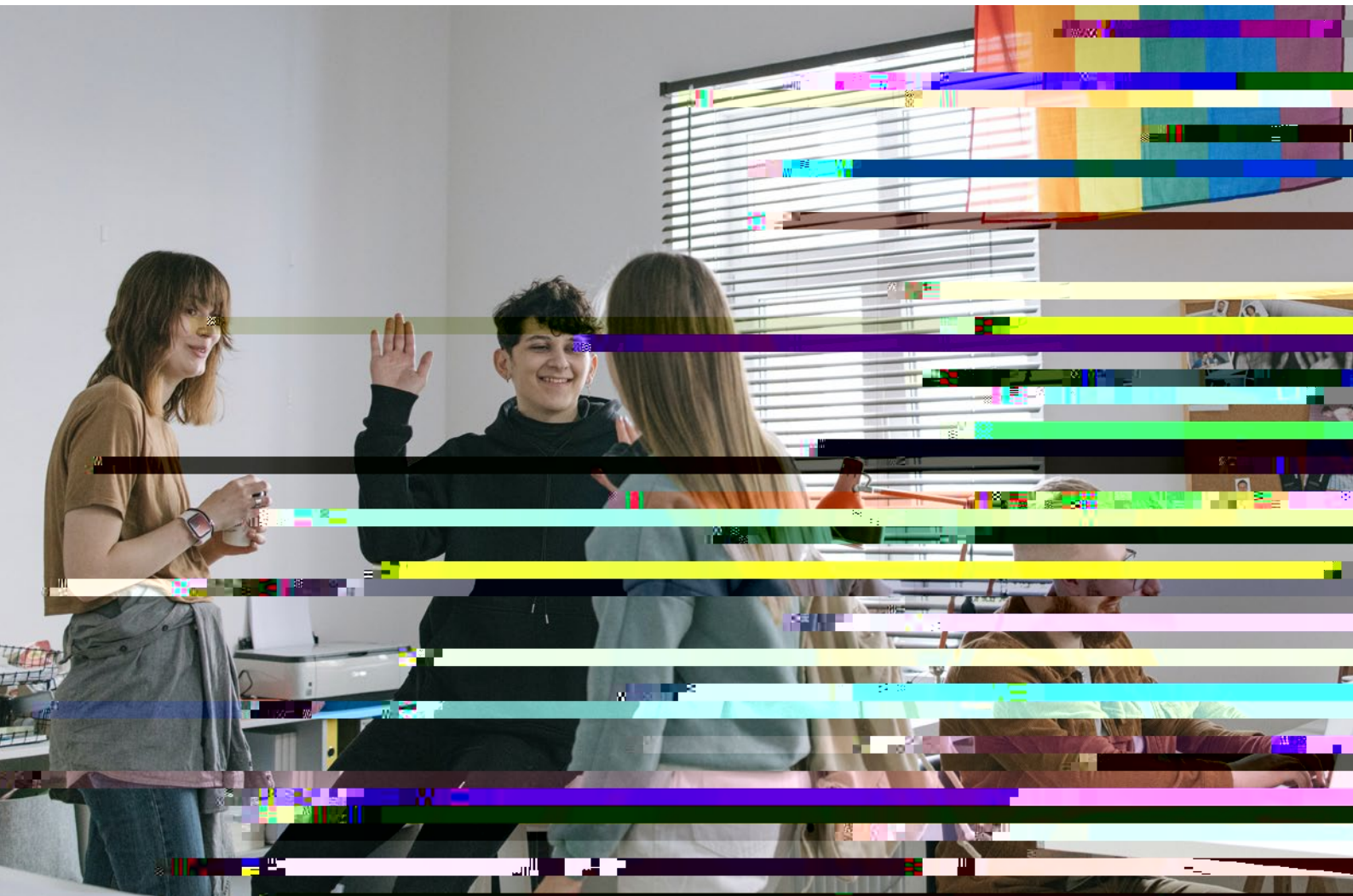
'Soft skills' include negotiation, collaboration, partnership and trust building skills,[23] supported by the following capabilities:

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

Attitudes

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

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



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

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

Communities of Practice

Communities of Practice (CoPs) can be used as a workforce development strategy to develop sta□ skills for intersectoral collaboration for health. CoPs have been implemented in many □elds to engage a group of people in intersectoral collaboration to address cstand health eo-23 ( )22 (t Td_1 1 Tf-0.01 Tc 10 0 0 e (ting)1ncern143.8612 557.3194 Tm(24203.9466 44/T1462 scn1n)5S0 g8157 Tm[(Communiti

Section 7

Conclusion

This evidence review has found that there is signi□cant intersectoral action for health in many di□erent forms occurring in many countries around the world.

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

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

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

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

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

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