



VOICES FROM OTHER FIELDS

An account of 40 consultations with non-health policy makers and politicians across Europe on tackling the socio-economic determinants of health inequalities

Working Document

30th January 2009

Preface

This report was written during the course of the second year of a three-year European project called “DETERMINE: An EU Consortium for Action on the Socio-economic Determinants of Health”. It presents the outcomes of one-to-one consultations conducted in 19 European countries with a total of 40 politicians and policy makers. These consultations were carried out by DETERMINE national partners, mostly based at national institutes of public health. They sought to investigate the respondents’ awareness of and experience with addressing the socio-economic determinants of health and health inequalities from a collaborative perspective. The discussion outlined in this report represents an overview of the main findings of these consultations; it does not intend to represent the individual views of the interviewers or respondents. The key findings and conclusions drawn in this report have been selected on the basis of how frequently the corresponding points were raised by the respondents, and with a view to how they could inform the subsequent activities of awareness raising and capacity building of this project. For consistency with other work carried out as part of DETERMINE, we refer throughout this report to the socio-economic determinants of health inequalities (SDHI).

The objective of this report is to document any useful information collected during these consultations for DETERMINE partners, as well as to use its main findings in order to guide the future work of the Consortium partners in the areas of awareness raising and capacity building on the socio-economic determinants of health. At this stage, it does not intend to be an authoritative representation of current engagement by non health policy makers with health equity in European countries. It is hoped that it will inform the next phase of activities of DETERMINE partners and that it contributes to current European action and debate on the socio-economic determinants of health inequalities.

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KEY FINDINGS

EXISTING CAPACITY and READINESS FOR INTERSECTORAL COOPERATION

- Virtually all respondents we consulted from across European countries engage in some forms of cooperation, whether at the local or national level, with other policy sectors
- Cooperation frequently happens on an ad hoc basis; there is a great need for cross-governmental institutional cooperation structures to be set up in most countries
- Existing cooperation between the health and other sectors is not necessarily initiated by the health sector or guided by health equity concerns
- Intersectoral action works best when measurable policy objectives and a win-win solution can be identified for all sectors involved
- Legislation and central guidelines that guide intersectoral collaboration help to ensure its effectiveness and sustainability. Cooperation may not be effective when not ‘compulsory’
- Establishing a personal rapport of trust helps to initiate collaboration
- These consultations have allowed us to identify some policy sectors that are more difficult to reach: examples include finance, justice, internal affairs, safety and security, foreign policy

UNDERSTANDING SOCIO-ECONOMIC DETERMINANTS OF HEALTH INEQUALITIES

‘Concrete’ determinants

- Health determinants are more readily understood when a direct link to human health can be established by means of their relation to the environment in which human beings live, work and move; cooperation on environmental and occupational health is more common than in other areas
- There is also great recognition of the role of social factors, education and employment as important determinants of health

Target groups

- Most respondents understand health inequalities as addressing vulnerable and marginalised groups, rather than adopting a systematic approach to tackling the health gradient across society; therefore, there needs to be greater awareness of health inequalities and their determinants
- Many respondents indicated that working on child and adolescent issues is crucial to addressing socio-economic inequalities, in particular by focussing on good education, and has the potential to yield concrete and measurable outcomes

CHALLENGES

Information

- Scientific data showing the correlation between health and socio-economic status already exist
- Although awareness of the importance of using evidence-based interventions has increased, methods are lacking to guide the implementation of such policies and interventions

Political guidelines and structures

- Civil servants and ministerial officials engage in intersectoral work more confidently when there is a legitimate basis such as central guidelines to work in the context of such partnerships
- Meeting fora and cross-governmental strategies and action plans are top priorities for facilitating collaborative action and decision making
- Collaboration on health inequalities needs to be guided and supported by measurable targets: health inequalities per se are too vague to gain political support and often seen as ‘abstract’

Role of the health sector

- Promote deeper understanding of other policy areas’ entry points to foster collaboration
- Other sectors need the support of the health sector in order to determine which specific determinants must be prioritised and to define concrete policy opportunities
- Internal fragmentation between health care and public health is seen to limit the potential for successful collaboration: the health sector should speak with ‘one voice’ and greater leadership
- The health sector must identify and effectively communicate to its partners the added value of a public health / health promotion strategy on the socio-economic determinants of health inequalities
- Public media must be more closely involved in order to foster debate and disseminate information

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1. Introduction

This report is the outcome of a series of consultations with local, regional and national policy makers throughout Europe. It appears in the context of the European project “DETERMINE: An EU Consortium for Action on the Socio-economic Determinants of Health”, a three year project supported by the European Commission and coordinated by EuroHealthNet on behalf of the Czech National Institute of Public Health. DETERMINE brings together a high level Consortium with representation from 26 European countries and is characterised by several work strands, including the analysis of policies and implementation of innovative pilot projects that focus on the socio-economic determinants of health inequalities. The objective of these consultations is to acquire greater understanding of whether, and how, policy sectors other than health take the issues of health inequalities into consideration when developing policies and programmes. This work takes place in the context of current European and global initiatives that aim at building greater awareness and building capacity to address the socio-economic determinants of health inequalities. Recommendations on how to take this forward are included at the end of this report.

The consultations focussed on exploring four distinct areas as set out below, which are also reflected in the structure of this report.

- a. Respondents’ existing experience and capacity in the area of intersectoral cooperation
- b. The respondents’ awareness of equity, health and health inequalities
- c. The respondents’ readiness to address the socio-economic determinants of health inequalities (SDHI)
- d. The respondents’ needs for information and support tools to support a sustainable cooperation to address the socio-economic determinants of health inequalities

This report is primarily intended to guide the intersectoral work of the DETERMINE Consortium partners. It is anticipated that the findings from these consultations will contribute to the efforts of partners in this Consortium to:

- Develop capacity building and awareness raising initiatives on the SDHI
- Develop and establish greater leadership by the health sector¹ when addressing the socio-economic determinants of health inequalities

This report aims to offer a starting point to analyse and identify ways in which different sectors can work more closely together to address the socio-economic determinants of health. In order to do this, it draws upon the respondents’ opinions of the necessary and proven success factors that, in their experience, facilitate intersectoral cooperation. The findings highlighted in this report are not intended to provide a comprehensive overview of how policy makers and politicians from across Europe engage with health issues in other policy sectors. They should rather be seen as ‘voices from the field’, an account of consultations with 40 policy makers and politicians.

Several important questions have emerged from these consultations:

- a. One reflection spurred by these findings concerns the extent to which it would be necessary or desirable to develop a universal ‘currency’ to denote the socio-economic determinants of health inequalities across sectors. Should non-health policy makers be encouraged to develop an understanding and a terminology associated with health,

¹ Throughout this report, we refer to ‘the health sector’ according to the definition of “*health systems*” contained in the Tallinn Charter, as we intend to refer to the ensemble of health care, public health and health promotion. According to the Tallinn Charter signed in Estonia in June 2008, a health system is “the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health”. (<http://www.euro.who.int/document/E91438.pdf>)

if their policies are already (directly or indirectly) addressing what we define as the socio-economic determinants of health inequalities?

- b. The answer to this question would further help the health sector define the ‘added value’ it can bring to initiatives that address the socio-economic determinants of health inequalities. It would also provide the health sector with the necessary tools and understanding to enable other policy fields to define their specific contribution to intersectoral strategies on health equity, in a sustainable manner.²

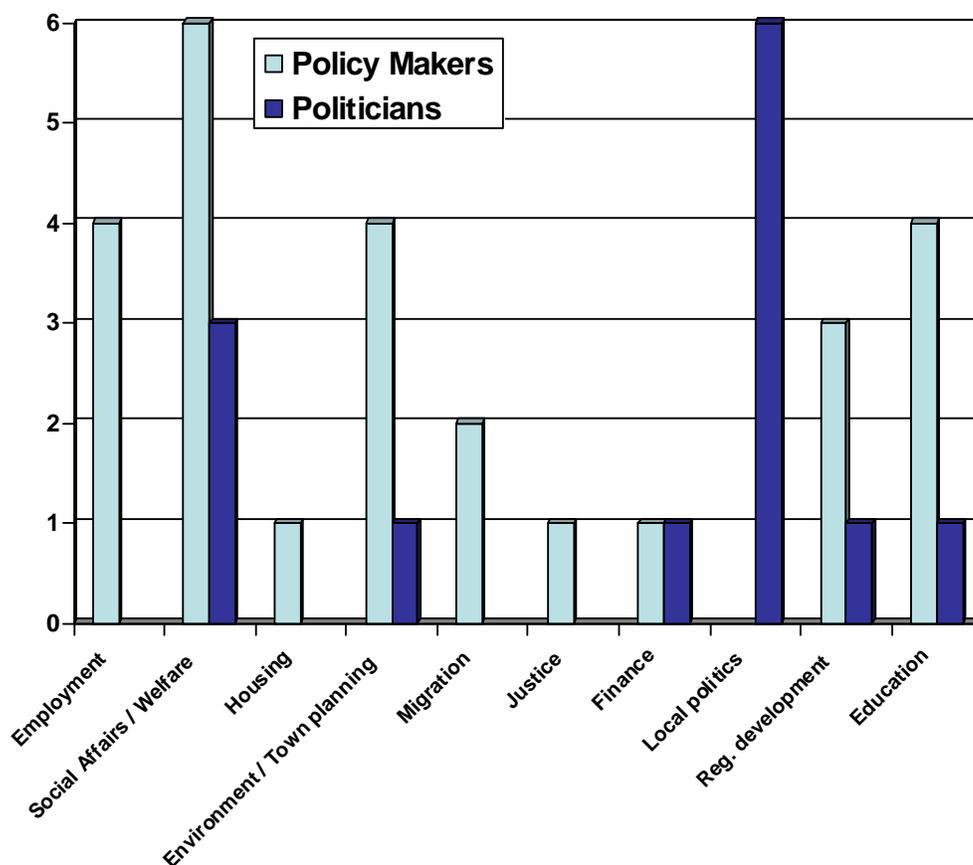
This report thus offers some reflections on the key insights and common experiences highlighted by respondents across Europe to facilitate and sustain collaboration on health equity, rather than attempting to generalise from these consultations.

² Another work stream of DETERMINE which consists of an extensive review of existing national strategies that implicitly or explicitly address health inequalities and the social determinants of health, both in and outside the health sector, has produced similar observations. See the Health in All Policies section of the Portal (<http://www.health-inequalities.eu/?uid=72f239a43602953a0a55020e7157a7a0&id=Seite2104>) for the final report.

2. Methodology

This report is based upon the results collected from 40 consultations³ in 17 European countries.⁴ The interviewers of these consultations were selected by current partners in the DETERMINE Consortium: most of the partners are national public health agencies, a few represent academic departments. Each interviewer was asked to recruit up to three policy makers or politicians from outside the health sector, and to select at least one respondent from one of the following policy areas: Treasury, Finance, Internal Affairs, Justice, Safety and Security, Internal Affairs, Foreign Policy. Consortium partners were also required to ensure a balanced representation at the local, regional and national levels, and to recruit at least one female respondent. 13 out of the 40 respondents are politicians (including local councillors), while the remaining 27 are policy makers and political advisors. Due to confidentiality agreements between the Consortium partners and the respondents, we have not identified individual respondents or their country of work, but have indicated their policy sector. Project partners were provided with a semi-structured questionnaire⁵ in order to conduct all consultations according to a common framework. They were not required to record or transcribe *verbatim* the consultations; their findings were instead summarised in the form of analysis templates that had been centrally prepared and distributed to all partners, which were then translated into English.

Graph 1: Represented policy sectors (Policy makers and politicians)



³ For the purposes of this report, Wales and Scotland are considered two different countries.

⁴ A total of 47 consultations were conducted by DETERMINE partners during this project. All of them will contribute to subsequent work on capacity building for addressing health inequalities, however only 40 of them were received in time for analysis as part of this report. In this report, Wales and Scotland are considered two different countries.

⁵ This questionnaire is included for reference in Appendix 3.

The respondents to these consultations represent a variety of policy areas and experiences in intersectoral collaboration, ranging from national governmental policies to municipal/local level policies. As can be expected, the feedback obtained from these consultations varies not only among countries, but also between sectors in the same country. Since the respondents were primarily selected and recruited by public health bodies, in the majority of cases they are fairly familiar with health policy or have already experienced working in collaboration with the health sector. Sectors in which cooperation on health issues is stronger, such as employment, education, welfare and social affairs, are therefore most often represented. One of the important objectives of the DETERMINE project is to also understand the perspective on socio-economic determinants of health inequalities from other very important but less traditional partners of the health sector, such as finance, justice and foreign affairs. In these consultations, only two respondents from the finance sector, two from immigration, and one from the ministry of justice were selected.

❖ ***Suggestion for further work – INVOLVE DIVERSE SECTORS***

We think it is important that future work on equity-driven collaboration between health and other sectors takes into account a diversity of potentially important partners, including the ministries of finance, justice and foreign affairs.

3. Respondents' existing experience of intersectoral cooperation

Although cooperation with other sectors is not usually routinely integrated into the policy work of the respondents we consulted, the majority of them have experienced cooperation with other policy sectors on single issues. Indeed, most examples of cooperation cited by respondents have taken the form of ad hoc intersectoral commissions.

As one respondent indicated, “Everyone works in his/her own box”. For systematic government-wide cooperation to take place there is a need for a legitimate basis either in legislation or clear departmental guidelines to facilitate partnership work. One respondent highlighted the need to generate changes in current attitudes to intersectoral collaboration, stating that at present cooperation involves as few partners as possible.

“It is hard to arrange in practice that policy makers map other possible partners... and involve them into cooperation”.

[Member of Parliament]

Existing cooperation between our respondents and health policy makers is seldom initiated by the health sector or guided by health equity objectives. Indeed, cooperation is often initiated by other sectors working on a range of issues.

A significant number of respondents have illustrated cooperation initiatives targeting children and adolescents as examples of a successful intersectoral agenda. In Germany, for example, intersectoral work is key to the implementation of the Federal Strategy for Children’s Health. Strategies with a focus on prevention and early problem detection can also offer strategic starting points that encourage cross-sectoral cooperation.

CASE STUDY: Anti-discrimination and integration guiding collaboration between migration and health in Germany

In Germany, a national working group on migration and public health was established in order to ensure intercultural access to regular health services by a) providing special health services to migrants tailored to diverse cultural needs and b) including migrants among healthcare professionals. The stated principle guiding this and other ministerial partnerships in the same country is that of ‘anti-discrimination’. Although health was a specific target of this collaboration, this was primarily driven by healthcare rather than public health motives.

In some other cases, social housing (especially for older people), fair and green transport programmes and ‘allergy-free’ environmental policy have provided the entry points for cooperation. Respondents working on these issues have indicated that such cooperation efforts can demonstrate a beneficial impact on health as an indirect effect of social interventions, without health gains being an explicit target at the outset.

Respondents also reported different experiences of successful intersectoral collaborations at different levels of government. In some countries, cooperation with the health sector was said to be more effective at the ministerial national level, but more challenging at the regional and municipal levels. This is due in part to the presence of more established structures for implementing partnerships at the level of national government. On the other hand, more immediate channels for interpersonal communications at the local and municipal level mean that cooperation across departments, including on health issues, happens more regularly at this level, but not always in an effective way. Some respondents stated that more sustainable collaborations can be established at the local level if communication is more closely and

regularly shared between government departments. A local politician stressed that “knowledge from national policy should inspire work at the municipal level”.

The feedback obtained from these consultations suggested indeed that integrated action on the ground is both more necessary, and more likely to show concrete results, as a consequence of more direct and frequent engagement between policy makers and their constituents. Indeed, one respondent stated that only at the local level is it possible to ‘tailor’ policies by devising solutions that respond to the needs of specific population sub-groups. In the experience of some respondents, local cooperation initiatives are also more open to the involvement of varied stakeholders, such as the local business community, civil society and nongovernmental organisations, while providing enough flexibility to involve the local community in the decision-making process.

❖ *Suggestion for further work*

It is worthwhile investigating in future work how and how often the health sector itself is responsible for initiating and establishing collaborations addressing health inequalities, at various levels of decision making. Greater knowledge is needed on successful and sustainable structures and ways for the health sector to drive and guide this cooperation.

4. Respondents' awareness of health equity and health inequalities

The perceived importance of tackling health inequalities

These consultations have sought to understand to what extent policy-makers from other sectors are aware of the concept of health inequalities and their root causes. Whilst a limited number of countries, primarily in north-western Europe, have developed political strategies that aim specifically at the reduction of health inequalities, health inequalities have not yet entered the current political debate across all of Europe⁶.

“Tackling health inequalities is not only the responsibility of the health sector but of the entire government. There should be more communication between sectors and planned activities for joint actions at the national level”.

[Policy maker from Ministry of Justice]

With a few exceptions therefore, the reduction of health inequalities does not seem to be a distinct political priority in many European countries. One respondent from a welfare department stated that the current Minister in charge of their department's policy clearly recognises the problems associated with health inequalities. Strong emphasis however was placed on the fact that awareness of health inequalities is lacking by key persons such as senior advisers in the minister's cabinet and even by executive managers in the public health department.

In order to investigate respondents' understanding of the principles of equity and equality, we asked them to what extent these inform their policy and decision-making. Most respondents stated that they do consider such principles in their work, and associated them with one or more of the following:

- Equal opportunities / equality (especially provision of equal access to services, gender equality, equal employment opportunities)
- Poverty reduction
- Social justice
- Integration, social inclusion and empowerment of
 - vulnerable/disadvantaged groups (the poor, unemployed, disabled, children)
 - marginalised and socially excluded groups (e.g. migrants and prisoners)

It is interesting to note that many respondents have focussed on specific target groups, such as 'vulnerable' or 'low socio-economic' groups, and have not shown a concern for the existence of a systematic correlation between individual health and socio-economic status across society, the so-called “gradient”. If tackling this systematic correlation is to be seen as an important part of any strategy to combat health inequalities, it will be perhaps the responsibility of the health sector to conduct awareness raising initiatives in other sectors in order to ensure greater recognition and more targeted responses to this societal phenomenon.

Health and health inequalities are sometimes seen as an abstract term when compared for instance with social equality, which often appears as one goal of national policies or cross-governmental strategies, as evidenced by another work stream of DETERMINE⁷. It has to be noted however that the goal of attaining equality for all, for instance in access to services and

⁶ A separate work stream of DETERMINE has conducted an extensive review of existing national strategies that implicitly or explicitly address health inequalities and the social determinants of health, both in and outside the health sector. The final report is available at www.health-inequalities.eu

⁷ See *supra* n.1.

opportunities, appears to be a more sensitive issue in some countries, as political ideology does have a bearing on whether action on the socio-economic determinants of health is considered a responsibility of the government or not.

Understanding the socio-economic determinants of health inequalities

The respondents we consulted do recognise that there exist direct links between social conditions and health problems, thereby supporting the assertion that reducing social inequalities is a necessary prerequisite for addressing health inequalities.

“The easiest way to address health inequalities is through the continuous efforts to improve social conditions, whereby health problems are simultaneously fought”.
[Policy maker from social welfare Ministry]

“The best health policy is a good social policy. You cannot reduce health inequalities without reducing social inequalities at all”
[Local politician]

The picture becomes more complicated however when we probe deeper into socio-economic determinants: indeed, only very few policy makers are familiar with the pathways between socio-economic determinants and health inequalities. Several respondents spontaneously recognised the difficulty of determining the causal links between social causes or factors and health problems; as a result of this difficulty, addressing the socio-economic determinants of health inequalities is seen as a “complex matter” by some.

Terminology

The process of conducting these consultations has shown that “socio-economic determinants of health inequalities” is a term strongly rooted in the English language and in the health promotion field, and therefore difficult to translate both across languages and across sectors. In order to involve diverse sectors in such collaborations on the socio-economic determinants of health inequalities, it is important to map and understand points of departure for different policy sectors, but perhaps conceptualising it differently than we currently do in the public health sector.

Respondents who are keen proponents of cross-governmental poverty reduction strategies see them as effective solutions to socio-economic inequalities and hence, by association, to health inequalities themselves. In one country with strong welfare policies in place it was noted that, although the impact of policies is measured on the reduction of poverty – rather than of inequalities – this offers a shared opportunity, since “poverty and health inequalities share the same determinants”.

“Social determinants are known but are not part of our [working] language among colleagues... For joint actions a joint language is needed for a common understanding.”
[National policy maker from Labour Ministry]

“Physical determinants”

Policy makers more readily acknowledge ways of impacting on the socio-economic determinants of health where these have a direct ‘physical’ relation to human health, for example in the case of the environmental and transport sectors, which often work according to local intervention plans, such as town planning. In the context of policies which aim at improving the physical environment in which human beings live, and in which therefore the

link to human health is easier to establish, socio-economic determinants are more easily introduced into the policy discourse.

“Local governments can influence the social determinants of health (e.g. by building ring roads or through local social policy), but not individual health behaviour. Local governments are not always aware of their competency in the field of social determinants of health. They are also not aware of the fact that different policy fields are interconnected.”
[Local politician]

We analyse in Chapter 6 below what are the support tools and information needs that policy makers deem necessary to the realisation of a successful and sustainable collaboration on health equity across sectors.

5. Opportunities and barriers to address the socio-economic determinants of health inequalities

Shared goals and opportunities

It is difficult to draw a uniform picture of policy makers' willingness and commitment to engage in cooperation with the health sector. Although our respondents confirmed that they were either a) already engaging in joint action with the health sector or b) not opposed in principle to such cooperation within their policy remit, they clearly stated that they cannot do so in a vacuum. As we saw in Chapter 3 on their existing experience of cooperation, respondents say they need clear guidance and precise structures to mainstream collaboration into their work. They need a framework to move away from single-issue cooperation to making cooperation itself an integral part of their policy making work.

To support this process, sustainable structures and shared objectives should be integrated into political and policy-making institutions, at all levels⁸. Cross-sectoral action on health equity would be made easier if it were made more systematic, for example through:

- the creation of 'rapporteur groups' consisting of policy makers from different fields of work
- external audits to collaborate with specialists from across sectors
- a fair distribution of resources to 'complementary' policy areas (e.g. employment, housing, education, health)

More importantly, policy makers need specific sectoral mandates to address socio-economic determinants; although many of the respondents deemed that personal interest and experience can provide a stimulus to generate integrated action, individual willingness alone is not sufficient. One politician recommended the adoption of horizontal objectives such as equity or health across different policy domains, for example in the context of sustainable development policies and working groups. In a few countries where whole-of-government approaches to policy-making operate, there is recognition that a holistic approach is needed in order to address health inequalities.

Some respondents felt that the creation of a specialised public health body would enhance such cross-sectoral policies. One policy-maker stressed that it is necessary to establish a body independent from the health sector, in order to guarantee the effectiveness of a collaborative approach; others supported the view that a specific body is needed to coordinate actions between sectors. A politician however disagreed with this view and pointed out that, where a specialised body exists to deal with public health issues, this can undermine the integration of public health issues into day-to-day activities by different policy areas.

“The creation of a specialised body can often be an alibi for not incorporating public health issues to a sufficient degree across every policy area... the issue must not be ‘hidden’ in the Public Health Council”.

[Local politician]

⁸ These and other needs identified by policy makers are further explained in Chapter 6: *Necessary factors to facilitate integrated policies on the socio-economic determinants of health inequalities.*

Obstacles to successful cooperation on health inequalities

None of the respondents we consulted declared themselves to be unwilling or opposed in principle to contribute to actions that address health inequalities. Willingness to act depends however on a good understanding not only of the tools and methods available to address them, but also on understanding the problem itself in the first place. As one respondent put it:

“The biggest obstacle is getting politicians to see the problems and to find the solutions. One has to break down the issues so that decision makers feel comfortable with the discussion and feel that they can play a role in solving the problem”.

[Local politician]

Part of the solution would thus appear to lie in ensuring greater awareness of health inequalities and their determinants by politicians and policy makers across all relevant sectors and at all levels of decision making.

In addition to this, the majority of respondents were obviously unaware of effective structures and tools that can be used to implement sustainable collaborations; the absence of these tools, or lack of knowledge thereof, represent indeed important obstacles to achieving durable integrated actions on health equity

Respondents also highlighted other important factors that can hinder successful cooperation on health equity. As can be expected, they frequently mentioned concerns about limited financial resources to share across sectors in an effort to reduce inequalities, and constraints of time and personnel resource allocation, which are dependent on each sector’s priorities. We highlight below some of the significant barriers to working in partnership with the health sector that were identified by respondents.

- Limited political mandate and/or guidelines of specific government committees or departments

In order to provide an incentive to the workforce of specific agencies or ministerial departments to work in cooperation with others, it is important that provisions for working in partnership and an indication of shared goals be included in their guidelines, regulations or mission statement of each department. This would create a legitimate and concrete basis for the establishment of cross-sectoral partnerships.

“Governments work very well in silos. Departments are associated with very highly specialised and therefore very unique workforces and can be reluctant to cross territories. It is not an irresolvable dilemma as long as it is determined where the crossovers are and a united ‘one stop shop’ service is presented to the public”.

[Policy maker from education and training sector]

- Dominance of healthcare and fragmentation of health sector into diverse actors/interests limits the potential for cohesive action and leadership

The main difficulty highlighted by our respondents is the power imbalance between the public health profession and healthcare services. A couple of respondents expressed concern at the superior power of the hospital sector, which leaves the public health field “in the shadow”. A joint effective strategy against health inequalities is also hampered by the split between, on the one hand, public health professionals advocating for a ‘social solution’ and, on the other hand, defenders of a medical/biological perspective on health who work with measurable illness-driven outcomes. It has been argued that, in order to facilitate work on health determinants, the health sector itself should adopt a more holistic perspective on health, mindful of social solutions to health and interrelated problems. The fragmentation inherent in

the health sector itself also limits the potential for effective leadership of health partnerships, as exemplified by the quotation below.

“There is a problem with [lack of] leadership. Who should be a leader in the case of cooperation on health: a politician, a doctor, a manager?”
[National politician/legislator]

- Different sectors have different problems, priorities and modus operandi

Several respondents mentioned the different mentality and modus operandi of health and other sectors as an obstacle towards effective cooperation. There seem to be three main challenges in this regard:

- i. differing agendas and priorities between sectors are an obstacle which is reflected in different opportunities for achieving goals
- ii. ministerial departments tend to be performance-driven structures, hence they may be exclusively focussed on their own objectives and have different measures of success than others
- iii. structural differences between different services or sectors lead to a failure to define common problems and strategies across sectors.

“A mutual win-win solution has to be defined to overcome obstacles. One obstacle is [the absence of] willingness to cooperate and the willingness to look beyond one’s table.”
[National policy maker from Labour Ministry]

Some respondents are of the opinion that the health sector – driven by a narrow healthcare approach – is too focussed on measurable outcomes compared to others; this approach makes it difficult to cooperate with sectors which may not be working towards quantifiable targets, such as ones that promote social inclusion strategies.

Other respondents believe it is difficult to mobilise strong political support and action around the issue of health inequalities, since measurable results cannot be achieved in the short term. One respondent stated that because a government’s success is usually measured on a 4-year term, “support goes out to policy fields with visible short-term success”. Some respondents felt that inequalities as a political strategy are too vague a concept and unlikely to succeed. Other areas where objectives and measurable results can be more clearly defined are often preferred, because (political) success is easier to demonstrate.

Of course different sectors have different approaches to collaborative work; their entry points and priorities will differ on an individual case basis. In the experience of some respondents, the failure to mainstream integration of vulnerable or marginalised social groups across several policy areas constituted the main obstacle to effective cooperation. A migration policy maker for example highlighted the failure to mainstream integration of migrants and other marginalised populations as a cross-sectoral issue.

The next Chapter will draw on some of the above mentioned obstacles and shared opportunities for cooperation to highlight some of the factors identified by respondents that can enhance the success of cross-sectoral partnerships on the socio-economic determinants of health.

6. Necessary factors to facilitate integrated policies on the socio-economic determinants of health inequalities

In order to enable DETERMINE partners to build capacity in this field, we asked respondents who participated in these consultations what they regard as the most important factors to ensuring a successful and sustainable collaboration that addresses the socio-economic determinants of health inequalities. We divided their responses and suggestions into ‘information requirements’ and ‘institutional support tools’. We illustrate them in the two tables below:

Table 1: Information requirements

- Research information
- International analysis and evidence
- Best practice examples
- Community Needs Analysis
- Media debate

Table 2: Institutional support tools

- Health Impact Assessment
- Clear Action Plans
- Collaborative Strategies
- Support from NGOs, public, media and public-private partnerships
- Health sector specific support

After exploring these factors, this Chapter will turn to a discussion of the proposed role for the health sector, as it emerged from these consultations, to facilitate these integrated actions.

Table 1: Information requirements

INFORMATION NEEDS	OBSERVATIONS
<p>Research information that defines the problem in a national context, including:</p> <ul style="list-style-type: none"> – Statistical longitudinal data on health inequalities – Improved health reporting, esp. <ol style="list-style-type: none"> a. reports on health status of vulnerable groups b. health data on immigrant women linked with information on culture, traditions and access to social, health and other public services – Data on welfare stratified acc. to socio-economic status – Objective reports produced by expert centres, e.g. in poverty – Statistics on disadvantages in gender issues 	<p>Much information already exists: up-to-date data must be better signposted and communicated to policy makers. In other words, there is a widely perceived need to improve the “accessibility of the information”: this includes better communication between experts and politicians, and expert analysis and application of data to policy options.⁹</p> <p>Awareness of the problem by political leaders and governmental party leaders was stated to be extremely important for action on health equity.</p> <p>Exchange of information and experience among sectors is as important as the research information itself.</p>
<p>Examples of best practices to tackle health inequalities</p>	<p>Examples of best practices mostly originate from community-level interventions that have targeted specific population groups in specific contexts, rather than a ‘one size fits all’ approach.</p>
<p>Community Needs Analysis</p>	<p>This requirement is particularly important for local politicians and policy makers, who have more direct engagement with local communities. One of them specified that community health plans are only useful if local inhabitants themselves are involved in their elaboration.</p>
<p>International analysis & evidence, to include:</p> <ul style="list-style-type: none"> – comparative data across regions and countries 	
<p>Media discussion and debate</p>	<p>It was stated that the media should discuss community health needs in order to stimulate public discussion.</p>

⁹ It was beyond the scope of this project to explore what are the desirable and most effective channels for communicating research information to policy makers. As the professional figure of the ‘knowledge broker’ is establishing itself, in some countries, to provide an effective mediation between the world of research and its applicability policy and practice, we feel this is an important area where the health sector has a specific contribution to make.

Table 2: Institutional support tools

INSTITUTIONAL SUPPORT TOOLS	OBSERVATIONS
Health Impact Assessment (HIA) (See Box 1 below)	Not many policy makers are familiar with HIA and very few implement it. Many respondents stated that <u>HIA should be legislated for and institutionalised as a policy process</u> , especially in collaborations between health and the social sector.
Clear action plans, e.g.: <ul style="list-style-type: none"> – cross-governmental strategies – Government White Reports 	In order for policy makers to integrate health equity as a policy objective to be implemented in collaboration with other sectors, they need to be guided by clear political directions and guidelines that highlight: <ul style="list-style-type: none"> – the mutual benefits of cooperation – a clear definition of the responsibility of each sector. Effective strategy reports and action plans would make for more effective implementation of shared policy goals, if they can be made relevant to each sector's agenda and it can be shown how individual sectors can specifically contribute to their implementation. Indeed most respondents shared the same opinion that legal <u>frameworks and agreements to institutionalise cooperation</u> , when effectively communicated across departments, have a great influence on empowering people to take action. <p>Awareness <u>Understanding and communicating</u> each other's priorities is of primary importance to ensuring successful coordination of intersectoral work.</p> <p>Monitoring Policy action plans can be most effective when they contain an in-built <u>monitoring</u> obligation, such as a yearly update and follow-up.</p>
Collaborative strategies, e.g.: <ul style="list-style-type: none"> – intersectoral committees – ad hoc commissions – meeting of state secretaries – joint communication platforms – topical working groups 	Intersectoral committees are the most effective and preferred method of intersectoral collaboration in our respondents' experience. They also seem to provide for greater prospect for sustainability when compared for example to 'ad hoc' structures. <p>There is a need for clear provisions for collaborative mechanisms and structures in sectoral or local legislative instruments, such as ad hoc parliamentary commissions: in the majority of cases, successful cooperation has been conducted in the form of '<u>ad hoc initiatives</u>', where concrete funding and measurable outcomes increase the possibility to reach effective and timely results.</p>

Case Study: Wales Policy Gateway

The Welsh Assembly Government has a Policy Gateway process which gathers senior decision makers from across various relevant departments and gives them the opportunity to study the documents of policy in-the-making and discuss its impacts on their specific policy area. This process forces departments to carry out impact assessments across several policy areas.

Box 1: Health Impact Assessment

Most respondents are familiar with environmental and social impact assessment, or other means of policy planning assessment, but not with health impact assessment (HIA). The majority of them however would be open to using HIA and would welcome its integration into their policy sector's planning processes, especially if their institution were legally required to do so. One education policy maker however emphasised that he would be open to HIA provided it would not introduce too many checks that would eventually prevent new policies from being implemented. It is unlikely therefore that health impact assessment would be proactively adopted and used by policy-makers in their work, with the exception perhaps of town planning, where one respondent stated it is a necessary tool. One finance policy maker also said it is important to consider its budgetary implications.

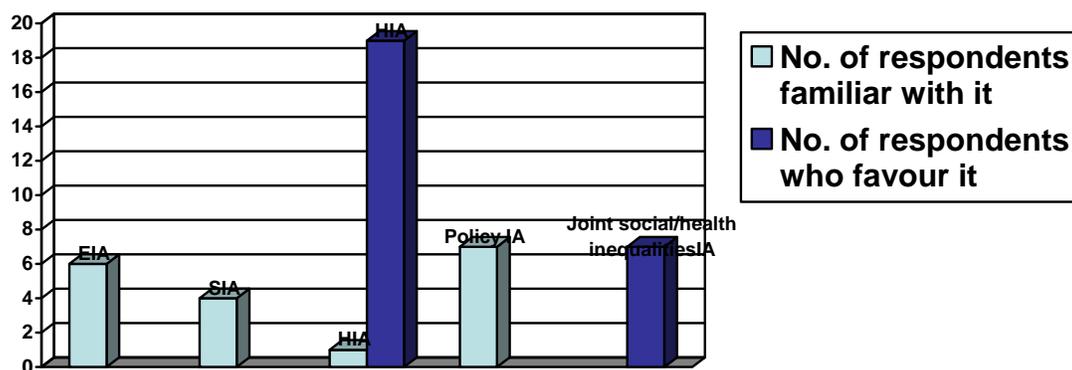
A significant number of respondents expressed support for the adoption of impact assessments "on social inequalities". These respondents would favour an integrated impact assessment in particular between the social and the health sectors, which would hence also be seen to address health inequalities.

"There is increasing awareness about social inequalities in health. Impact assessment focusing on this would be a good thing. It would be good to agree across government on what should be the prioritised fields".
[Policy maker from education and research Ministry]

"It would be interesting to look at the effects of improving socio-economic conditions on health status".
[Policy maker from social welfare Ministry]

The chart below (Figure 1) shows the proportion of respondents with actual experience of environmental (EIA), social (SIA) or other types of impact assessment in their policy making work, as well as their attitude to carrying out HIA in their policy remit.

Figure 1: Respondents' experience of and openness to (health) impact assessment



There are however some concerns regarding the implementation of HIA, especially about who would be responsible for funding it. Some commented on the difficulty of integrating impact assessments routinely across sectors, whilst one respondent stated that HIA is the prerogative of the health sector. Most respondents do however support its institutionalisation. One respondent expressed a stronger view than others, after commenting on a failed attempt to institutionalise HIA in his local government:

"HIA should be legislated for prior to project implementation and fund allocation. The State should oblige project leaders to conduct HIA from their own budget".
[Local politician]

Take away messages for the health sector: how to successfully coordinate integrated policies

Leadership by the health community

It is clear that the health sector itself has a central role to play when facilitating joint action on the socio-economic determinants of health inequalities. Political and personal leadership to advocate for and take forward action on the socio-economic determinants is pivotal. In order to unlock its leadership potential, the health sector needs to strengthen its role by providing concrete support to other sectors when they request its expertise in this area and to acknowledge the role that it can play in achieving the aims and objectives of other sectors.

Further gains would also be obtained from getting the healthcare community more closely involved in health equity initiatives: this could be pursued for instance through more persuasive lobbying of the healthcare community in order to establish effective leadership (for example by general practitioners and hospitals) when working with other sectors. The need to train personnel from other ministries on the socio-economic determinants was also highlighted by some respondents as an obvious task for the health sector to undertake.

“The role of the health sector is important in acting as a catalyst by raising health and health inequalities on the agenda”.
[Policy maker from environment Ministry]

The importance of early involvement

Overall, it would seem that in order to sustain successful partnerships, the health sector must take on a much more proactive role and actively invite other partners to the discussion table at an early stage, to help define both the problem and the strategy to be pursued. This should ideally occur at the early stages of policy planning, and not – as most often occurs – at the time of implementing the cooperation agreement. Early mapping and involvement of all parties by the health sector would increase the prospects of achieving the following:

- Identification of relevant partners for collaboration AND clear definition of
 - functions
 - responsibilities
 - objectives of each partner
- Problem formulation: the way in which policy makers identify and define a problem has the greatest effect on which and how many partners will be invited to the cooperation table
- Early dialogue and intervention are very important for agreeing on a shared set of values and objectives across sectors
- Fostering a common sense of commitment by all partners, through early communication of long term objectives and shared aims. Joint ownership of a policy or programme is very important for ensuring the equal commitment and participation of all parties
- Identification of win-win solutions by listening to and engaging with other sectors from an early stage

Shared funding

A shared budget is as important as the above mentioned factors for the success of a sustainable partnership. It helps to highlight concrete opportunities for action by individual sectors as well as to build shared ownership, commitment, and mutual responsibility. Some respondents also highlighted target-based funding as a useful tool for supporting the implementation of collaborative work on health inequalities. Some argued for example that intersectoral work focused on specific target groups such as children and women receives a specific budget in their work to achieve clearly identified targets and measurable objectives, which facilitates intersectoral work. As a local politician pointed out, “Money speeds up the process”.

“Policy decisions are usually determined by financial considerations... To make policy decisions ‘health-centred’ would need an alternative use of available resources”.

[Policy maker from justice Ministry]

❖ *Suggestion for further work: INVESTMENT DECISION-MAKING*

We believe it is crucial to assess to what extent politicians and policy makers are willing to commit to invest in funding equity-focused initiatives. Unfortunately it was beyond the scope of these consultations to investigate this issue. We think it is vital for the health sector to engage with representatives of the finance sector in order to understand how sufficient and sustainable investments can be made available and effectively utilised across departments in order to fund partnerships that address health equity.

In-depth perspectives from other sectors

Non-health policy makers and politicians who participated in these consultations have indicated that the health sector’s own vision and approach to health affects the extent to which it can provide guidance or effective leadership on the socio-economic determinants. Several respondents have claimed that where the role of the health sector is limited to influencing individual behaviour, this limits the potential for integrated action with other sectors on the determinants of health.

FEEDBACK FROM EMPLOYMENT POLICY MAKERS

The employment sector sets its own targets based on the belief that work life plays an important role for good health. Very often, there seems to be a case of lost synergy potential, due to the health sector’s perspective on absence from work as being necessary to treat illness, whereas the employment sector views occupation itself as a remedy to improve health. Perhaps there is a window of opportunity for the health sector itself to analyse more deeply the causes of the problems it seeks to address, and propose and devise joint solutions to joint problems in common with other departments. All consultations with representatives from the employment sector however almost exclusively emphasised occupational safety and health targets as an area for cooperation, which suggests that the employment sector too could investigate other ways to address health inequalities in cooperation with other sectors. Other issues they discussed were mental health at work and health promotion at the workplace.

FEEDBACK FROM EDUCATION POLICY MAKERS

Comments of a policy maker from the education sector have focussed on the health sector’s resolution to intervene in schools in matters related to physical activity and obesity, in which schools arguably have limited power to intervene, rather than stressing the important role of education as a determinant of health. Education policy makers proposed that this is indeed a target around which greater cooperation between these two sectors can and should be fostered.

The examples chosen illustrate the learning that health policy makers need to adopt a more holistic approach in order to understand the range of actions that are available, across sectors, to influence the socio-economic determinants of health inequalities. We have identified below a few areas highlighted by our respondents in which the health sector could maximise its contribution to integrated policies on the socio-economic determinants of health:

- Greater communication and dissemination of knowledge/information/tools
- Preparedness to adopt a really holistic perspective on health and move beyond medical and behavioural approaches
- Help with problem definition and identification of success criteria in order to offer win-win solutions for all partners involved
- Adopt a better listening approach to work being done in other sectors
- Willingness to learn from other sector's strategies, e.g. poverty reduction
- Emphasis on understanding and pinpointing the specific role of public health and health promotion in partnership work

The feedback and opinions collected from our respondents lead us to ask the question of what specific benefit a public health/health promotion response can bring to reducing health inequalities that can distinguish it from more established approaches such as poverty reduction and youth-centred strategies. It would be the task of the public health sector to formulate objectives and strategies that choose to either emphasise the unique individual contribution of the health sector or, alternatively, show its potential to contribute to a shared agenda in collaboration with other more established approaches.

7. Conclusions

- Health determinants are more readily understood by non-health policy makers where they have a physical association with the environment in which human beings live, notably within the environment and transport sectors. The education and employment sectors are also increasingly recognising the importance of their work for the determinants of health.
- There is still a heavy emphasis – by both health and non-health sectors - on lifestyle factors, and hence on influencing health behaviours, rather than addressing the structural determinants of health inequalities. “Socio-economic determinants of health inequalities” are a complex term to grasp, and must be translated not only across different languages, but also across different policy contexts, in order to be mutually understandable.
- Successful initiatives to address the socio-economic determinants of health inequalities depend in part on successful and sustainable intersectoral partnerships. In order to achieve this, the health sector should aim at building its own capacity primarily in the areas of:
 - Communication with other sectors and the media
 - Leadership on the determinants of health
 - Partnership work
- Public health and health promotion professionals should be encouraged to ‘listen’ to other sectors in order to understand their policy entry points and engage them in sustainable partnerships by identifying win-win solutions.
- Crucial practical recommendations for building effective and sustainable partnerships have included:
 - Identifying and involving all potential partners to the cooperation early on
 - Building shared ownership and commitment by defining shared aims and win-win solutions
 - Working according to a clear mandate and guidelines for cross-governmental policy collaboration
 - Building personal relationships based on trust
 - Identifying shared funding sources
 - Engaging the media to support such initiatives by encouraging debate about controversial and urgent issues related to health inequalities, using personal stories to bring message home to politicians and policy makers
 - Networking to bring together officials from different fields together and to apply pressure to bear at the top political level
- The health sector would benefit from enhancing the visibility of its role and defining the value of its particular contribution to intersectoral collaborations on the socio-economic determinants of health inequalities. One way to achieve this would be to distinguish the particular contribution of the disciplines of public health and health promotion from that of more established social interventions, such as those based upon rights-based or poverty reduction approaches.
- This consultation process was limited by the difficulty to access ministries and representatives of sectors further away from health such as justice, finance, internal and foreign affairs, etc. It is important that future work in this area attempts to understand and map these sectors’ entry points, also by building advocacy strategies that highlight their policy links with the determinants of health inequalities.

Appendix 1: The semi-structured questionnaire that guided these consultations

Policy-Maker Consultation Guide

A: EXPERIENCE OF AND EXISTING CAPACITY FOR INTERSECTORAL COOPERATION

1. What are your current roles and areas of work in your institution?
2. What objectives have been stipulated by your policy sector?
3. Have you ever worked in cooperation with other policy sectors?
 - 3.1 How was the cooperation initiated?
 - 3.2 What actions were taken?
 - 3.3 What structures or strategies were in place to guide this cooperation?
 - 3.4 What were the greatest challenges?
4. Does your institution have any capacity for intersectoral cooperation?

B: GENERAL AWARENESS OF EQUITY, HEALTH AND HEALTH INEQUALITIES

1. Does a concern for **equity or equality** (socio-economic and gender) come up as an issue in your policy-making work?
 - 1.1. Is equity a **priority** in your work?
 - 1.2. If so, how is it formulated in your policy?
2. Does a concern for **health** come up as an issue in your policy-making work?
 - 2.1 Do you feel any responsibility towards protecting and promoting citizens' health in your work?
3. Does the issue of **health inequalities** ever come up in your policy work? (Please refer to the definition of this term contained in the *glossary*, if necessary).
4. In your work do you give any consideration to address
 - 4.1. the impact of your sector's policies on population health?
 - 4.2. the differential impact of your sector's policies on the health of different population groups?

C: READINESS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH INEQUALITIES

1. Have you ever come across any debate concerning the “**social determinants of health inequalities**” (SDHI) or **Health in All Policies (HiAP)**? (Please refer to the definition of this term contained in the *glossary*, if necessary).
2. Would you be open to collaborating with the health sector and other sectors in order to achieve Health in All Policies?
3. What kind of actions could your sector take to address SDHI?
 - 3.1. Do you think there would be sufficient **political commitment** to it?
4. If the health or another sector invited you to work together in an effort to address health inequalities, what do you envisage could be the principal **obstacles** towards effective cooperation?
 - 4.1. *For example, probe into:*
 - Lack of knowledge about SDHI or effective interventions
 - Lack of appropriate tools and resources
 - Lack of leadership
 - Perceived vested interest for the status quo

D: NEEDS FOR INFORMATION AND TOOLS TO SUPPORT A SUSTAINABLE COLLABORATION

1. Information from different sources is an important aid to policy makers, and many different types are used to inform and influence policy-making and implementation. Which information would be most useful to your policy sector to support successful action in cooperation with the health sector and other sectors?
 - 1.1. *For example:*
 - Research information that defines the problem (development of health outcomes and SDHI for different population groups, evidence base, statistics, case studies)
 - Examples of best practices and successful solutions to tackle HI within your policy remit (policies/interventions in other sectors or countries that have a potential transfer value)
 - Community needs analysis
 - Political priorities and strategies
 - Analysis and evidence originating from international initiatives in this field
 2. Are you familiar with any **impact assessments** that have been conducted in your policy arena?
 - 2.1. Would you be open to an assessment of the impact of your sector's policies on health and health inequalities (**health impact assessment**)?
 3. If you were to integrate health equity objectives into your existing policies, what instruments and support would you find most useful?
 - Support from the government or the parliament
 - Clear action plans
 - Collaborative strategies
 - Support from non-governmental actors, public and media support, public-private partnerships, etc.
 - Other
 4. How could the health sector support your sector to address determinants of health inequalities?
 - 4.1. *Probe* into any tools, structures or mechanisms that could assist cooperation.

E: CONCLUSION

1. Many experts claim that cross-governmental cooperation is an important strategy to improve the health of citizens:
 - 1.1. what do you feel are the main **obstacles to cooperation** on health?
 - 1.2. what do you feel are the main **success factors** for a sustainable cooperation on health?
2. Can we conclude that, in principle
 - 2.1. There is general willingness to cooperate with other sectors to address health inequalities? → *verify*
 - 2.2. We identified possible actions to address Health Inequalities? → *specify*

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