http://ijhpm.com
Int J Health Policy Manag 2016, 5(6), 383–385

doi 10.15171/ijhpm.2016.28

IJHPM
International Journal of Health Policy and Management

Commentary

A Sophisticated Architecture Is Indeed Necessary for the Implementation of Health in All Policies but not Enough

Comment on "Understanding the Role of Public Administration in Implementing Action on the Social Determinants of Health and Health Inequities"

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Abstract
In this commentary, I argue that beyond a sophisticated supportive architecture to facilitate implementation of actions on the social determinants of health (SDOH) and health inequities, the Health in All Policies (HiAP) project faces two main barriers: lack of awareness within policy networks on the social determinants of population health, and a tendency of health actors to neglect investing in other sectors' complex problems.
Keywords: Health in All Policies (HiAP), Social Determinants of Heath (SDOH), Health Equity, Public Policy, Implementation
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Citation: Breton E. A sophisticated architecture is indeed necessary for the implementation of Health in All Policies but not enough: Comment on "Understanding the role of public administration in implementing action on the social determinants of health and health inequities." *Int J Health Policy Manag.* 2016;5(6):383–385. doi:10.15171/ijhpm.2016.28

Article History:
Received: 28 January 2016
Accepted: 28 February 2016
ePublished: 29 February 2016

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Carey and Friel[1] raise the topical issue of the implementation of intersectoral actions and policies addressing the upstream determinants of equity in health. Inter alia, they stress the importance for state and civil society actors to achieve the "sophisticated architecture" amenable to joining up efforts across state departments/agencies and organisations from the civil society. Although I cannot agree more with the need for this architecture, this idea needs to be further developed as the collaborative space created and the rules that govern it cannot be considered sufficient in making multisectoral partnership happen. I will illustrate my point drawing from the specific case of France which may conjure up similar experiences in other countries.

In France, the policy objective of joining up efforts in a Health in All Policies (HiAP) perspective within an intersectorial framework was officially translated into a policy instrument in 2010 with the creation of the regional commissions for the coordination of health-related public policies.[2] All 26 Regional Health Agencies (now 17 as a result of the latest reform) were mandated to chair these committees set up to improve coordination and collaborations across state departments and agencies.[3] Yet, most regional public health agencies have failed putting on the agenda discussions on population health strategies and actions. However, we do find instances of regional public health agency collaborating with another state agency (eg, employment) when funding community-based interventions (eg, public health funds the prevention component of the project while employment funds the job-creation one). At the central government level a similar steps towards HiAP strategy to reduce inequalities in health[4] was made with the establishment in June 2014, of an interministerial committee for health.[5] Again, benefits of this policy instrument are yet to come as 18 months since the inception of this committee (under the supervision of the minister of health) no meeting has been scheduled. Using Ollila's[6] terminology it appears that the health strategy to HiAP (ie, health objectives are at the core of the exercise) has yet to prove effective in France, while the win-win strategy (ie, cooperation by two agencies for their mutual benefits) has yielded results.

Besides the complexity of multi-partner collaborations, examination of the case of France and of the body of research on the social determinants of health (SDOH) and HiAP strategies suggest two substantial barriers public health professionals are likely to face in developing this "sophisticated architecture" allowing collaboration across multiple sectors. First is the enduring constricted view of the determinants of population health.[7–11] Scientific evidence (and anecdotal evidence from my discussions with members of the health policy elite here in France), points to the dominant view that population health is a function of the accessibility and quality of healthcare services. Such a reductionist perspective makes health professionals unlikely partners for actors in transportation, employment or housing (excepted for environmental exposures such as lead, moulds, asbestos and carbon monoxide). This clearly questions the capacity of public health actors in engaging conversations with other sectors within a policy network. Changing this perspective on population health will take time and will require among other things investments in educating the population about the SDOH.[12] It is more than time to update school health curricula to include along with dental hygiene, smoking and nutrition, lessons reflecting current knowledge on the social determinants of population health. This would hopefully

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expand the scope of the perspective on health of the next generation of decision-makers.

A second impediment to multi-sector collaborations is the view that the health sector often tries imposing its own priorities to other sectors. This "health imperialism," be it real or not, shows its head when health professionals complain about failed attempts at having other sector's representatives attending their meetings. The thing is, complex problems are not a specific feature of the health sector and of those working on improving equity in health by actions on the SDOH. A manager of the regional Paris road system confided once that, and this is no surprise, his complex problem was traffic jams and that from his position he could not expect any significant improvement on the road without having other sectors of the society (private and public employers, education, health, urban planning, etc.) contributing in addressing the broad spectrum of determinants of the problem. The need to improve collaborations across sectors is, therefore, shared by many and consequently amenable to what Ollila[6] refers to as cooperation strategies (making the health expertise available for the other sectors). What is required for multi-sector partnership are participants of these policy networks to accept investing time and energy attending each other sectors' meetings even though benefits of this investment may not stand out clearly at first. Yet this is the corner stone of a new governance to respond to complex "wicked" problems such as global warming and entrenched inequities in health.[13]

The development of the sophisticated architecture required for the operationalisation of the HiAP agenda does indeed face many challenges. There is, however, ground for optimism as we can find experiments being implemented to overcome the barriers. In Ontario, the Sudbury & District Health Unit initiated a social marketing strategy "to change the understanding and ultimate behaviour of decision-makers and the public to take or support action to improve the social determinants of health inequities." And one of the components of their strategy, the video "*Let's Start a Conversation About Health… and Not Talk About Health Care at All,*" was presented to the attendees of the 2011 World Conference on Social Determinants in Rio and adapted to other populations.[14] Ollila[6] also suggests raising awareness by releasing public health reports developed in collaboration with other ministries and publishing health data along key socio-economic indicators as a way to get the word out on the impact of policies from other sectors. But the impacts are never as tangible as when they can be put in terms of economic benefits and potential savings. Yet, for this to happen we need to further improve the level of resources/expertise and the models for economic evaluation of the impact.[15,16]

A HiAP strategy also requires the public health system to improve its capacity to anticipate the policy needs of other sectors in order to better shape solutions.[6] A number of theories of the policy change process points to the role belief systems/ideologies play in shaping the definition of problems and solutions and their implementation.[17] Anticipating potential clashes in values across government agencies and ministries is, therefore, a key determinant of a successful HiAP initiative. There is evidence that the capacity of public health to monitor the other sectors can be instrumental in successfully neutralising opposition to health policy from vested interest groups.[18]

Research can do much in defining best practice for HiAP intervention and in building capacities for intersectoral actions on the SDOH. However, researchers should give priority to documenting and analysing current natural experiments. "Boutique programmes"[19] initiated by research teams are unlikely to account for the whole set of resources (limited) and barriers (numerous) representatives of state and civil society are juggling with in real life situations when trying to join up for HiAP. However, capturing the effect of complex upstream intersectoral interventions still mostly elude current evaluation designs.[20]

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

EB is the single author of the paper.

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