

GOVERNANCE TOOLS AND FRAMEWORK FOR HEALTH IN ALL POLICIES

Written by: Louise St-Pierre, National Collaborating centre for Healthy Public Policy
Assisted by: Geneviève Hamel, National Collaborating Centre for Healthy Public Policy
Geneviève Lapointe, Institut national de santé publique du Québec
David McQueen, Centers for Disease Control and Prevention (CDC)
Matthias Wismar, European Observatory on Health Systems and Policies



Centre de collaboration nationale
sur les politiques publiques et la santé

National Collaborating Centre
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EXECUTIVE SUMMARY

Health in All Policies (HiAP) is a strategy to improve the health of the population. It addresses factors outside the health system that have important health effects. These factors relate to our common life: what we eat and drink, where we live, how we work and how we spend our leisure time may have positive or negative effects on our health. Many of these effects can be influenced by changes in policies, e.g. agricultural, transport, occupational and tax policies.

The growing political interest in HiAP in Europe and elsewhere is fuelled by concerns about the prospects for the health of the general population. Countries in Europe now have unprecedented levels of good health, but a continuation of this success cannot be taken for granted. Looming threats to health, such as the obesity crisis, pose serious challenges. Demographic changes require responses to maintain health in aging populations. In addition, increasing inequities require a government response. These concerns are not solely health issues. A substantial knowledge base provides evidence on the rising cost of ill-health and health inequalities; declining population health will have negative consequences for the economy and wealth of nations.

In order to implement HiAP, health systems need to endorse a broad vision of health and reach out to other systems. This implies sustained collaboration with all ministries and the inclusion of health as an important policy concern at all government levels.

This expert report provides important information on how several countries and regions have implemented HiAP. It includes case studies from, England (United Kingdom), Finland, New Zealand, Norway, Sweden and Quebec (Canada). The countries were selected because of their track record in implementing HiAP. They all employ a ‘whole-of-government’ approach, through which cross-departmental collaboration is established at the highest government level.

The country case studies demonstrate that many critical governance tools for the implementation of HiAP rest squarely in the hands of government. These governance tools may address organizational structures, processes, finance or regulation. They include cabinet committees, interdepartmental committees, steering committees, networks, dedicated organisations/units, planning and priority setting processes, policy formulation, health targets, joined-up evaluation, grant or financial support mechanisms, joint agreement on financing, laws, agreement protocols and accountability frameworks. A particular emphasis in the expert report was on health impact assessment (HIA). Health impact assessment supports the decision making process by informing decision makers on the health consequences of different policy options. All countries included in the case studies use to some extent the principles of HIA.

The country case studies also demonstrate that governance tools employed to implement HiAP aim at facilitating collaborative work and policy coherence. Health in All Policies establishes permanent links for dialogue on health in other sector policies and provides

opportunities to explore win-win situations to the mutual benefit of all the departments and sectors involved.

There are challenges in assessing the effectiveness of HiAP scientifically. There is no gold standard for the evaluation of governance strategies and tools; there are methodological problems that limit evaluation's scientific robustness of governance strategies and tools. In addition there is a lack of scientific literature with regard to governance tools and frameworks for HiAP, perhaps owing to the newness of the field of work. Despite these difficulties the case studies and the existing literature are pointing to several essential necessary elements for the successful implementation of HiAP:

- Strong leadership from the health system and strong leadership at the highest government level;
- A clear vision on health, with a well articulated policy that includes objectives and targets;
- A supra-departmental authority/organization in charge of HiAP;
- The establishment of new, permanent organisational structures supportive of HiAP or a substantial assignment of new responsibilities to an existing structure;
- Legal support of HiAP through revision of public health law;
- Legal support for endorsing specific activities;
- Simultaneous action at different institutional levels;
- Dedicated HIA units with sustainable funding.

The transferability of the results of this expert report has to be treated with caution. The way HiAP is implemented in the countries chosen and the choice of concrete governance tools is probably highly contextual. There is no one-size-fits-all solution due to the variations in political, social, economic and institutional contexts. However one does see the emergence of some conceptual commonalities that may well apply in general.

INTRODUCTION

The complex epidemiological, economic and social issues confronting health systems around the world make it necessary for governments to adjust their approaches in order to manage these challenges and ensure the health of their populations and the prosperity of their countries. In recent decades, knowledge development about what creates health and ill-health has made it clear that the only way to make real gains in population health is to broaden strategies beyond the health care system, to include conditions in which people live, work and play. Factors such as education, income, employment, housing and social cohesion make a fundamental contribution to a population's level of health. Health systems must therefore subscribe to this broader vision, and the governments that produce them must consider population health as an issue that concerns every sector and calls upon all actors of society. This realization is the basis for a concept that has recently been formulated as Health in All Policies (HiAP) (Stahl et al., 2006).

In this spirit, The Tallinn Charter on Health Systems for Health and Wealth has been adopted by the 53 Member States of the WHO European Region (2008b). By reminding us that an investment in health is also an investment in human development and prosperity, the Charter invites governments to grant a broader role to health ministers, who must take a leadership role in bringing population health to other sectors of society. It is clear that these health ministers shouldn't be seen as the only people responsible for population health. To this effect, the recent international WHO consensus expressed in the Bangkok Charter for Health Promotion (WHO, 2005) and the Commission on Social Determinants of Health (WHO, 2008a), recommend that governments establish processes favouring a "whole of government approach", which ensure more coherence among a government's missions insofar as they touch on population health and wellbeing. Other policy documents and declarations at Regional levels have also strongly promoted this view, including, for example, the WHO Health for all Update 2005, the European Council conclusions on HiAP, the Rome declaration and the recent Community strategy "Together for Health: a strategy approach for EU 2008-2013". The term "whole of government approach" refers here to what others call a pan-governmental approach (Keon & Pépin, 2008), that is, an approach that calls for both horizontal (cross-government) and vertical (across levels of government) management. Such an approach requires the establishment of various mechanisms allowing for coordination and collaboration between various government actors and stakeholders from civil society or the private sector.

In order to gain knowledge about the various intersectoral mechanisms, the Dutch Council for Public Health and Health Care (Raad voor de Volksgezondheid en Zorg) has requested the European Observatory on Health Systems and Policies to prepare a study that can provide an overview of how other countries organize their intersectoral policies. Specifically, the Dutch Council is interested in the governance tools and frameworks that facilitate the inclusion of Health in All Policies. This document therefore presents several international initiatives in Europe, Canada and Australia that can be seen as efforts to implement a "whole of government approach". The first section will present a brief overview of potential governance tools and summarize the results of literature that

examines their effectiveness. The second section will describe the analysis framework developed for describing the six case studies of countries that follow. The choice of illustrated cases in this report in no way presumes their superiority over the many other initiatives that could also have been given particular attention. These cases were chosen for their relevance to the Dutch context and the availability of the literature describing them. Finally, the last section proposes an exploratory discussion about the effectiveness of the tools these studies suggest.

I. GOVERNANCE TOOLS FOR COLLABORATIVE WORK

Taking an interest in governance tools also means taking an interest in the concept of governance. The literature on this topic varies, approaching the subject from different angles. Graham and colleague (2003) explain this variable by the different levels at which this concept is applied. He therefore suggests a distinction between:

- Global governance, which deals with relations between countries;
- National governance, which concerns government responsibilities and its relations with other actors in its country;
- Organizational governance;
- Community governance.

The object of our interest here is national governance. According to Stoker (1998) national governance could be described with five broad characteristics:

- It refers to a complex set of institutions and actors that are drawn from but also beyond government;
- It recognizes the blurring of boundaries and responsibilities for tackling social and economic issues;
- It identifies the power dependence involved in the relationships between institutions involved in collective action;
- It is about autonomous self-governing networks of actors;
- It recognizes the capacity to get things done which does not rest on the power of government to command or use its authority. It sees government as able to use new tools and techniques to steer and guide.

Thus, we can agree that the concept of governance refers to a general idea of **integration** (IPAA, 2002) for cohesive policies, and **partnership** or **collaborative** work is one of the central strategies for achieving this (Durose & Rummery, 2006).

Therefore, the governance tools we are looking at here are mainly those allowing the central government to promote collaborative work and policy coherence (and convergence) for a common goal. This goal is a shared responsibility for the health and wellbeing of the population. Various tools fostering coherence, collaboration and partnership can be identified in the literature on governance. We have classified them into four categories: those related to the **structures** (e.g. committees and organizations dedicated to collaboration); those related to the **processes** (e.g. joint planning and evaluation); those relating to the **financial** framework (e.g. mechanisms fostering intersectoral activities) and finally, those related to **mandates** (e.g. laws or regulations imposing accountability).

The following chart details the four categories, identifying the tools mentioned most frequently, and signalling the keys to success that were identified in the literature.

Governance tools that foster coherence, collaboration and partnership

Nature	Tools	Comments on effectiveness
Structures	Cabinet committee	The high level of political commitment which conveys this structure is one of the keys for success most often identified for interdepartmental work (Bourgault et al., 2008).
	Interdepartmental committee	This is the most frequent structure put in place to fostering intersectorial work. It promotes understanding of the different mandates but may produce additional bureaucratic burden (Barr et al., 2008). To counter this negative effect, certain countries opted for redefining the mandates of existing committees. It is often suggested to tend towards permanent committees for greater viability and profound change. However, according to (IPAA, 2002) governance by committee is not necessarily more effective than top-down governance.
	Steering committee	According to ANAO (2003), experience indicates that the likelihood of effective cross-agency implementation is greater when there is an overarching, high-level implementation plan that is coordinated by a nominated lead agency and has clearly defined critical cross-agency dependencies and responsibilities.
	Network	This structure offers a more flexible coordination mechanism, but whose existence is not assured. Joining a network is usually voluntary and there is a high level of confidence between members which favours mutual understanding, coordination and the development of a common goal (Rounce & Beaudry, 2002).
	Organisations/units	Represents an important investment of resources but ensures a real, stable and long-term commitment, which is necessary for creating the cultural change and practice which must be operative in the context of HiAP. Often, this structure assumes a role of skill development and sharing and support for the development of new practices.

Nature	Tools	Comments on effectiveness
Processes	<p>Planning and priorities setting process</p> <p>Joined-up evaluation</p>	<p>Sharing common goal is one of the important conditions of success of collaborative work (Ling, 2002). Within this task, leadership was shown critical to successful integration. Such arrangements must be initiated as soon as a transversal task is identified (Barr et al., 2008).</p> <p>Government level integration can be assisted through the option of integrated outcome (ANAO, 2003). This process was also found to promote recognition of the correlation between the missions of the different organizations participating with the health sector (Lundgren, 2008).</p>
Financial	<p>Grants or financial support mechanisms for partnership activities</p> <p>Joint agreement on financing</p>	<p>Certainty around funding commitment is seen as an essential ingredient of success (Rounce & Beaudry, 2002).</p> <p>Conveys a strong commitment among the partners.</p>
Mandates	<p>Laws and regulations</p> <p>Agreement protocols</p> <p>Accountability frameworks</p>	<p>Powerful levers that ensure profound changes (Gagnon et al., 2008). Depending on the context, can generate controversy.</p> <p>Important that the documents clearly identify: the objectives of the arrangement, the roles and responsibilities of each of the resources and the evaluation methods (Barr et al., 2008). Consideration should be given to formalising such arrangements through MOUs, agreements, contracts (ANAO, 2003).</p> <p>Where there is multifaceted implementation it is recommended to have a lead agency/person, otherwise things fall through the cracks (ANAO, 2003).</p>

The table represents a comprehensive, but by no means exhaustive list of governance tools. These are the tool most often cited in the literature and they are those which we have examined in the case studies.

II. HEALTH IMPACT ASSESSMENT AS A SPECIFIC GOVERNANCE TOOL FOR HIAP

Health impact assessment merits particular attention in this section dealing with governance tools, because it is considered one of the most structured approaches to putting health in all policies (HiAP) (Lock, 2000; Sim & Mackie, 2003). It is most often defined as “*a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population*” (WHO European Centre for Health Policy, 1999). The practice of HIA varies depending on the perspective adopted and the goals pursued. It is seen here as a process aiming to inform decision-makers about the potential impacts of a policy proposal on population health. It is therefore not seen uniquely as an evaluative methodology, but also as a way of increasing the knowledge and awareness of decision-makers outside the health field about links between their sector and the determinants of health.

The institutionalisation of this practice, or in other words its routine use within a government’s politico-administrative process, can be considered a governance tool, since it fosters interaction between public administration sectors and encourages “boundary works” (Bekker, 2007). It therefore favours horizontal management within a government and contributes to the transparency of the decision making process in allowing the participation of various set of actors (e.g. public health actors, civil society groups).

Several countries consider this practice a means of systematically integrating health into all public policies in order to improve population health, and some jurisdictions have made it mandatory (for examples, see box 1). It will be seen that most of the countries we have chosen to focus on in this study have, in one way or another, implemented the use of health impact assessment as an intersectoral strategy. Many other countries, such as Wales, Australia, Ireland, Holland and Thailand promote the use of HIA at various levels of government. The main factors for success identified to date are substantial support from the highest levels of government (administrative and legislative) and a common understanding of the HIA process and the concept of health (Gagnon et al., 2005; Quigley, 2005; Morgan, 2008). The adoption of a win-win perspective (i.e. HIA as a decision making support tool, not as a control tool) is also often mentioned, since it helps decision-makers gain a better grasp of public health knowledge (Bekker, 2007; Wismar et al., 2007b), promotes a reduction in the natural resistance caused by the silo mentality (Banken, 2001) and favours a better adaptation of the HIA process to the public policy development process (i.e. appropriate knowledge at the opportune moment). Recently, a large study on HIA effectiveness conducted with 19 European countries concluded that this practice influences the decision-making process and increases decision-makers’ awareness about important determinants of health (Wismar et al., 2007a). An independent British study also established a positive cost-benefit ratio for this practice (O’Reilly et al., 2006). However, when applied at the central level of government, the practice of HIA raises many issues and challenges. The most significant involve: the ability of the process to adapt to policy-making schedules, the availability of the knowledge and expertise required to support the HIA process, the legitimacy of public health actors passing

“judgement” about decisions made by other sectors, the potential administrative heaviness of the process, and the proper tools to use depending on the various levels of government and types of policy.

Box 1 *Geneva (Switzerland) and Québec (Canada): Similarities and Differences*

Two Francophone jurisdictions legislated the practice of HIA at the central government level. Geneva (in 2006) and the province of Québec (in 2001) took advantage of the revision of their public health laws to introduce the practice of HIA and make it sustainable. In both cases, HIA applies to legislative projects (laws and regulations) that could cause negative consequences on population health. However, they made different choices about who would be responsible for launching and running the HIA process. In Geneva, the State Council decides whether or not a project should be accompanied by an assessment of its potential impact on health, and if so, the HIA is run by the health sector. In Québec, this responsibility is entrusted to each of the government departments and agencies that must, according to the public health law, ensure that their legislative projects will have no significant negative effects on population health. The public health sector supports the HIA process at their request. In both cases, an inter-departmental mechanism was developed to favour exchanges and common understandings between the health sector and the other public administration sectors (Observatoire de l'Administration Publique, 2008)

III. ANALYSIS FRAMEWORK AND CASE STUDIES

Governance tools cannot be considered outside of the context of their application. Moreover, to produce an understanding of international experiences that is sufficiently complete to provide the Dutch government with useful information, it is also necessary to consider contextual elements that promote their effectiveness. These contextual elements can be brought to light by the literature focused on **stewardship** (Travis et al., 2002), and that focused on **intersectoral action**. These two concepts, along with that of **governance** provide us with the main elements needed to establish the analysis framework for describing the case studies presented in this document. These three concepts will be briefly described and their contribution to the analysis framework identified.

1. Stewardship

The concept of stewardship, particularly as used in relation to population health, puts the accent on the influence role that the Ministries of Health must play in order to lead other sectors of the public administration and the civil society towards taking their responsibilities for population health.

The concept of stewardship was put forward by the World Health Report 2000 as a central function for health ministers (WHO, 2000). It is “*about the role of Government in health and its relation to other stakeholders whose activities impact on health*” (WHO-Regional Committee for Europe, 2008: p.3) and it refers to three broad tasks:

- Providing vision and direction for health systems;
- Exerting influence;
- Collecting and using intelligence on health system performance in order to ensure accountability and transparency.

(http://www.euro.who.int/healthsystems/stewardship/20061004_1)

The function of stewardship is essentially to develop intersectoral work processes in all sectors of the government and with its partners to promote the implantation of health programs. A broad vision of health and society is necessary to provide clear lines for actors working both inside and outside health systems. Intersectoral collaboration in fact depends on the vision and leadership of the central government and the possibility of making each sector’s contribution visible (Boffin, 2002). Also, the health system must play an advocacy role to encourage other sectors to pursue public health goals. Exerting influence may be done by using so-called coercive measures, such as laws or regulations, or incentive measures, such as financial support. Finally, the ability to collect data and to report the results is essential for monitoring progress and informing the stakeholders about the progression of the health results of the intersectoral activities. This aspect is often neglected.

2. Governance

The concept of stewardship has similarities to that of governance (Travis et al., 2002; Boffin, 2002). Until now, the first was used in reference to health systems, while the notion of governance covers all government missions, including population health. This is what Armstrong (1997) is referring to when he mentions high order tasks. According to Flinders (2002), the notion of governance refers to the challenge to take on the direction and coordination of a complex ensemble of organizations through a control system built upon many links. Although the literature on governance tackles questions from different angles, as we mentioned earlier, it is still possible to find a constant that will serve as support for analysing the initiatives presented in this document. Thus, the key elements for good governance could be presented as follows:

- The inclusion of several actors from both inside and outside the government;
- The use of horizontal and vertical management;
- Accountability and control mechanisms;
- High-level political commitment;
- Financial and human resources support;
- Skills development;
- The existence of knowledge production systems.

As we can see governance has some overlap with the notion of stewardship. The elements that this model provides newly are 1) the inclusion of several actors in planning process, 2) the idea of horizontal and vertical management, 3) the necessity of an accountability mechanism, and 4) skills development.

3. Intersectoral action

We have seen that intersectoral action is the foundation for the practice of stewardship and governance. The literature on intersectoral action for health is therefore useful for identifying certain key elements linked to the success of these approaches. In a report submitted to the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (PHAC, 2007), the Public Health Agency of Canada identified some of these elements, and a few of them are linked to the recommendations that emerge from the literature on stewardship and governance. They are:

- Create an inspiring framework for health;
 - Ensure political support;
 - Engage key partners at the very beginning;
 - Focus on concrete objectives and visible results;
 - Ensure leadership and rewards;
 - Develop practical models, tools and mechanisms to support the implementation of intersectoral action;
 - Accountability frameworks;
 - Strengthening capacity.

This model reinforces key elements of stewardship and governance such as vision, leadership, commitment, and accountability. Moreover, it adds the importance of having clear objectives and concrete guiding tools.

The analysis framework

Those key elements from the literature about stewardship, governance and intersectoral action for health were used to build the following analysis framework. To the three “broad tasks” suggested by the stewardship model, we add two others: capacity building and evaluation/accountability. These are the Key Functions of a “whole of government approach” under which the mechanisms and measures related to these functions were grouped.

Analysis Framework for case studies of countries

<i>Key functions</i>	Providing broad vision of health	Exerting influence	Collecting and using intelligence	Support / Developing capacity building	Evaluation/ Accountability
<i>Mechanisms/ measures</i>	Vision for health and society	Consensus building	Intelligence gathering	Knowledge development and transfer	Formal control mechanisms and procedures
	Comprehensive national strategy for health (overarching goals)	Incentives for health and other sectors	Monitoring and evaluation of public health	Skills development	Public reports
	Commitment from high level (investment and resource allocation)	Coordination/ collaboration mechanisms	Dissemination of health status (reports)	Concrete tools	Targets evaluation
	Involvement from stakeholders and civil society groups	Laws, regulations and enforcement		Ongoing support from the high level	

Although even one of these mechanisms and measures can allow and foster intersectoral action, the “whole of government approaches” for health should include a combination of them, which act in synergy. There is no one recipe to fit every situation. The choice depends on historic, economic, cultural, and social contexts, as well as the preferences of the actors in place (Hunt, 2005). While keeping in mind that all of the combinations have their weaknesses (Bevir et al., 2003), the decision-maker’s challenge is to identify and put in place the best possible combination.

Structure of the presentation of case studies

The descriptions of the cases studied are structured according to the five key functions identified in the analysis framework. The mechanisms and measures used by health authorities or central government to promote collaborative work will be presented under the heading of *Exerting Influence*. It will be preceded by a brief description of the *General context*, and by a presentation of the information relative to the *Providing broad vision* section of the analysis framework. The measures associated with *intelligence* and *capacity building* will be grouped together in the *Support* section. Finally, when information about the *evaluation* activities or *accountability* is available, it is mentioned in the *Evaluation* section. Some of the examples illustrate cases of horizontal management, while others present examples combining horizontal and vertical management. In each of the descriptive sections, we have tried to highlight the various governance tools promoting collaboration and convergence.

Methodology and Limitations

This work is the result of a rapid review. The information was found mainly on the official Web sites of governments and national agencies and international health organizations. The scientific literature (scientific journals and publications) was consulted first to identify existing studies, literature reviews and comparative analyses. However, this type of literature rarely explores the theme of healthy public policies from the angle of governance tools and their effectiveness. Because of the limited amount of time available to produce this work, it was not possible to interview the key contacts for the countries and initiatives described which would no doubt have provided more detailed information on the use and implantation of the governance tools identified.

IV. CASE STUDIES OF COUNTRIES

Case study – England

General Context

England is the most heavily populated country in the United Kingdom, with 50 million inhabitants representing over 80% of the population. It is part of the United Kingdom's parliamentary system, but like the other nations that make up the United Kingdom, England is solely responsible for managing its health sector. The Department of Health is directed by the Secretary of State and three Ministers of State, including the Minister of Public Health since 1997. England is subdivided into nine administrative regions, each of which is divided into several administrative entities. The regional level includes a government structure made up of *Government Offices* representing eleven Whitehall Departments, including the Department of Health. The role of these regional structures is to foster the implantation of policies developed at the central level and to favour an integrated approach at the regional level. The local governments (counties and municipalities), have a degree of autonomy for the management of their responsibilities, and they are governed by elected boards. These local entities have no formal responsibilities with regards to health services however, but assume responsibilities related to the determinants of health, such as housing, transportation, quality of life and well-being. The healthcare system is managed separately from these structures, at the central level of government (the Department of Health Service and National Health Services) and the local level (Local NHS Agency). Public health teams are found in both the regional structures (Government Offices and NHS Strategic Health Authorities) and local health service structures (Primary Care Trusts).

Proving broad vision

England is recognized as much for its leadership in cross-government management (Ling, 2002; Durose & Rummery, 2006) as for its commitment to reducing health inequalities (WHO, 2008a). In 1997, the Labour government set up an investigative commission on health inequalities. The report appeared the following year (Acheson, 1998), confirming an accentuation of health inequality, insisting on the importance of taking measures to correct the underlying causes, and calling for government-wide actions (Barr et al., 2008). This widely-read report formulated three priorities: the practice of health impact studies for all policies that could have an effect on health; particular attention to families with children; the reduction of economic disparities. In 1999, in response to this report the government launched two important strategies: a new health strategy called *Saving Lives: Our Healthier Nation White Paper*, and a specific action plan called *Reducing Health Disparities: An Action Report*. These two strategies propose measures to promote cooperation between the government's different sectors and levels, based on the Acheson Report recommendations (Oliver & Nutbeam, 2003). In 2003, the government launched another important program to counter health inequalities, which was a real intersectoral strategy. *Tackling Health Inequalities: A Programme for Action* was ratified by twelve departments and a number of regional and local authorities (Keon & Pépin, 2008). This

programme proposes a very clear national target (to reduce the health gap by 10% on infant mortality and life expectancy by 2010), in addition to over 80 government commitments aiming to attack the underlying causes of the inequalities. The main focus of this programme is on the local action with local authorities having a role, and is linked to performance management across government. The Action Plan was based on the results of a broad consultation process and on the results of a 2002 Treasury spending review.

Exerting influence

The post-Acheson Report commitment to fighting inequalities in England was ratified by the highest authority in British government, the Cabinet and the Department of Finance, in conjunction with the Department of Health. New measures were put in place to promote collaboration and aligning efforts to meet the national objectives, and existing mechanisms were modified. For example, in the healthcare sector, *A plan for investment, a plan for reform* in 2000 included statutory objectives through which resources would be devoted to needs related to reducing inequalities (Hogstedt et al., 2008). In terms of structures, a Cabinet subcommittee under the responsibility of the Minister of Public Health is in charge of ensuring that the different departments contribute to the national inequality-reduction targets. A unit specific to inequalities, the *Health Inequality Unit*, part of the Department of Health, works to promote links between organizations, particularly at the regional and local levels (Keon & Pépin, 2008).

Two management mechanisms reinforce government coherence for attaining the national inequality-reduction objectives. The first are the cross-cutting spending reviews related to the national inequality-reduction objectives. The Treasury is in charge of these reviews, which deal with spending in the six departments (education, social protection, criminal justice, environment, transport, communities and local government) in relation to their Action Plan commitments (Wanless, 2002; 2004). Departments must take the results of these reviews into account in their strategic planning (Durose & Rummery, 2006). The second management mechanism is the agreement process between the central government and its departments and the local level for attaining the broad national objectives. The *Public Service Agreements* (PSAs) are linked with the spending reviews and gives the framework through which departments and local authorities and other local organisations agree on challenging targets with central government. It is seen as a “novel and ambitious tool for steering and coordinating public activity” (James O, 2004: p.398). The targets proposed in *Tackling Health Inequalities: A Programme for Action* were part of the PSAs for the departments concerned by this action plan and in the agreements between the Regional Government Offices and the local authorities. (<http://www.gos.gov.uk/localgov/lpsas/?a=42496>)

England is also known as a leader in Health Impact Assessment (HIA) for projects and policies developed outside the health sector. Its application to government policies has often been the object of recommendations in the official documents about the reduction of the social inequalities of health, recognizing that they take root in the social and economic conditions in which the populations live (Acheson, 1998; Secretary of State of Health, 1999; Wanless, 2004). In 2004, the government formally introduced HIA as a

mandatory practice for all new legislations by including health as a component in regulatory impact assessment (RIA) (Department of Health, 2004). In 2007, the Cabinet Office has revised RIA to impact assessment (IA) and HIA is now a specific impact test. This means that health and well-being are designed into national policy. The public health sector of the Department of Health supports this practice within the government through the production of guides and counsel. The Department of Health recently reiterated the government's desire to continue efforts to encourage this practice in the departments and to reinforce the inequality element within this process (Department of Health, 2008).

Support

In general, England has several ways of fostering the implantation of the ministerial objectives. In terms of reducing the social inequalities of health, it is worth mentioning the existence of nine Public Health Observatories, which provide each of the country's administrative regions with monitoring data on health and inequalities. This information is addressed to practitioners, policy makers and the wider community. The London Public Health Observatory has a specific mandate to develop knowledge and conduct follow-ups in relation to England's health inequalities. It produced *the local basket of indicators* which provides a list of measures that can be used to monitor changes in inequalities over time. Other documents were developed to help the local level attain the Action Plan objectives, for example: the *Local Area Agreements* developed by the Government Offices (<http://www.gos.gov.uk/national/>); the *Partnership for Action* strategy, developed by the Local Governments Association (<http://www.lga.gov.uk/lga/aio/21880>); and the *Health Inequalities Intervention Tool*, developed by the Association of Public Health Observatories and the Department of Health intended to health local authorities to plan their activities. The Department of Health also put together a team of experts on the subject, the *National Support Team for Health Inequalities*, whose role is to support practitioners in the health system.

Concerning the practice of HIA throughout the country, the Department of Health financed several organizations to develop the knowledge and skills needed for this practice. Thus, the Council for Science and Technology was mandated to create a health impact assessment guide as a strategy across government (Finch et al., 2006). The Public Health Observatories play an important role in supporting this practice. They collectively host a large reference Web site on the practice of Health Impact Assessment. Training is provided by the Association of Observatories and by the University of Liverpool. The latter houses an international consortium on the practice.

Evaluation

The objectives of the *Tackling Health Inequalities : A Programme for Action* are evaluated on a regular basis. In addition to the Treasury spending reviews, the government agreed to have a group of scientists (Scientific Reference Group on Health Inequalities chaired by Sir Michael Marmot) conduct an independent assessment on attaining the targets. In 2005, the first report (Department of Health, 2005) revealed little improvement in the reduction of inequalities, explained by the short period of time, but noted an improvement in the governments' collective efforts. The data was updated in

2006 (Department of Health, 2006), and followed by a second report by the Scientific Group. This last report, entitled *Tackling Health Inequalities: 2007 Status Report on the Programme for Action* revealed persistent health gaps but also showed signs of encouragement, especially with regards to mortality from cancers and cardiovascular diseases. The report also signalled that the policies in place since 1997 made a difference in reducing child poverty. Moreover, this report confirmed that the intersectoral convergence strategy worked, since almost all departmental commitments set out in the *Programme for Action* and due for delivery by the end of 2006 have been wholly or substantially achieved. However, the report showed that the *Programme for Action* was difficult to implement at the local level. The evaluation revealed the need to better target the local allowance, pointing out the absence of local leadership in certain areas (Barr et al., 2008). With these results, the government renewed its commitment and commissioned the Scientific Group to develop a new intersectoral strategy. In fact, the Secretary of State for Health, asked to Professor Sir Michael Marmot, Chair of the WHO Commission for Social Determinants, and his team to lead a *Post 2010 Strategic Review of Health Inequalities*. The new strategy will be intersectoral and lead by the Department of health (http://www.dh.gov.uk/en/Publichealth/Healthinequalities/DH_094770).

Governance tools

Structures	Committee Subcabinet; Dedicated Unit at the health Department
Process	Joined-up approach to developing national strategy
Financial	Cross cutting spending reviews
Mandate	Public Agreements Services HIA in mandatory Impact Assessment

Other characteristics

- Commitment from the high level: Treasury and Premier and Cabinet
- Cross-cutting governmental regional office
- Minister of Public Health
- Over arching policies on inequality ratified by 12 departments

Case study – Finland

General context

Finland is a country with a small population of a little over five million inhabitants. Like the other Nordic countries, Finland has a social system based on strong universality principles. The Ministry of Social Affairs and Health manages Finnish policy on social affairs and health, gender equality and occupational safety and health. The management of health policies is mainly divided between the national level and the municipal level, while the six provinces act as regional authorities serving the central State (Hogstedt et al., 2008). The State Provincial Offices act as joint regional authority for seven ministries. In the past 30 years, the health of Finland's population has greatly improved. Constant efforts were made at the highest level of government to improve practices for attaining public health objectives. The certainty that improving population health required intersectoral actions is one of the intrinsic characteristics of the Finnish model.

Providing broad vision

Finland was therefore the first country to adopt, in 1986, a health program aligned with the WHO "*Health for all by the year 2000*" declaration. Then, many modifications were made to finally arrive at the government's adoption in 2001 of the *Health 2015 public health program*. This policy is seen as a "cooperation programme that provides a broad framework for health promotion in various component areas of society. It reaches across different sectors of administration, since public health is largely determined by factors outside health care" (Ministry of Social Affairs and Health, 2001: p.4). Financing for this public health policy is ensured by a special budget. It was then specified through intersectoral action plans such as the *National action plan to reduce health inequalities*, produced in 2008 (Ministry of Social Affairs and Health, 2008).

The Finnish government considers policies made at the level of the European Union as determinant for the development of Finnish population health. The government is therefore particularly active with regards to links between the Finnish policies and programs and those put in place at the European level. In 2006, chaired by Finland, the European Union launched a HiAP initiative (international conference and direction document) demonstrating the need for collaboration among all of the sectors to achieve a real and sustainable improvement in population health (Ministry of Social Affairs and Health. See <http://www.stm.fi/Resource.phx/publishing/documents/8447/index.htm>)

Exerting influence

The Ministry of Social Affairs and Health is the main body responsible for the implementation and coordination of public health programs through different governance tools.

One of its most important coordination mechanisms is the Advisory Board of Public Health¹. This coordination mechanism was put in place in 1997 through a law, and its mandates and composition are governed by a decree (WHO Regional Office for Europe, 2002b). The Council of State determines the composition of this committee under the recommendations of the Ministry of Social Affairs and Health. There are about 17 members on this council from all sectors of government and non-government organizations, research institutes and municipalities. A permanent secretariat with 4 experts supports the committee's work (Stahl & Lahtinen, 2006).

The mandate of this entity is to monitor population health and the implantation of public health activities throughout the different sectors. It actively participates in developing public health programs. It has, among other things, coordinated the development of the *Health 2015 Public Health Program* and the *National action plan to reduce health inequalities*. Its role is also to promote intersectoral collaboration between government organizations, non-government organizations and the other partners involved.

The Advisory Board for Public health has three divisions, one of which specifically deals with intersectoral collaboration: the Division for National Intersectoral Cooperation. The task of this division is to support the integration of the objectives of the *Health 2015 Public Health programme* in sectors outside health. Eight of the twelve ministries that make up the government are represented in this division. The other ministries see this board as being very useful for sharing and exchanging information (Stahl & Lahtinen, 2006).

A second mechanism fostering intersectoral collaboration in health is the Intersectoral Policy programs which answer to the Prime Minister's office. The *Policy program for health promotion*, launched in 2007, is one of the three intersectoral programs making up this initiative that aim to foster, among other things, the implantation of sub-national health programs. In fact, one of the roles of the *Policy program for health promotion* is to structure the efforts of the municipalities in attaining health objectives (Finnish Government, 2007). One of the problems linked to the implantation of public health programs in Finland is the realisation of government health promotion orientations in concrete actions at the level of the municipalities, which enjoy a great deal of autonomy (Ministry of Social Affairs and Health, 2008).

A third mechanism favouring both horizontal management (at the local level) and vertical management is the *Public Health Act*. Its revision in 2006 allowed the addition of an amendment so that intersectoral action in health promotion on the local level is required by the Act (Hogstedt et al., 2008b).

Health impact assessment practice is also seen as an important intersectoral collaboration tool. Its use is largely encouraged in the various national health strategies and more specific action plans. For example, the *Policy programme for health promotion* adopted in 2007 specifies that "the ability to conduct assessments of impacts on people is

¹ More recently it seems to be referred to as the Multisectoral National Committee of Public Health or the National Committee of Public Health.

improved, and the scope of these assessments is expanded in legislation work in accordance with the instructions issued by the Minister of Justice.”(p.3). However, there is no legislation making health impact practice mandatory (WHO Regional Office for Europe, 2002).

Support

Many knowledge development strategies and skills were developed outside the margin of the *Health 2015 public health program* and action plans, *the National action plan to reduce inequalities in health* and the *Policy programme for health promotion*. The Ministry of Social Affairs and Health entrusted research institutes such as the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES)² and the Finnish Institute for Occupational Health the task of developing the tools needed for implanting and monitoring actions defined by the public health policies and programs. Those tools are:

- An Internet portal to provide reliable health information and online services meeting the needs of private individuals, experts and decision-makers.
- A few pilot projects such as TEROKA (joint and pilot project for reducing socio-economic disparities in health in Finland) and PARAS (Project to restructure municipalities and services)
- Curricula in diverse sectors (teacher training, social and health sectors, environmental architecture and building, sports, youth work, art and culture and, nutrition)
- A data bank on innovative practices
- The development of indicators that can be used at the municipal level to monitor resident health (Policy programme for health promotion, 2007)

Evaluation

Finland attaches great attention to evaluating its health policies and programs. For example, in 2002, it submitted itself to an external WHO evaluation of its health promotion system (WHO Regional Office for Europe, 2002). This led the government of Finland to optimise its health promotion policies.

Monitoring and evaluation mechanisms are usually included in each of the Finnish government’s strategies, policies and programs. Since the first public health report in 1996, all of the ministries are legally required to provide enough information for the preparation of a follow-up report (WHO Regional Office for Europe, 2002). Such a report must be presented to the government and discussed in Parliament every 4 years. In 2006, the Ministry of Social Affairs and Health used an intersectoral strategy, the “bilateral dialogues”, to gather the information necessary for the first evaluation report on the *Health 2015 public health programme* (Stahl & Lahtinen, 2006).

² These two research institutes were merged on January 1, 2009 to create the *National Institute for Health and Welfare (THL)*.

Governance tools

Structures	Multisectoral National Committee of Public Health With permanent secretariat and unity that foster intersectoral collaboration for health Intersectoral Policy Programs for health promotion under Prime Minister's Office
Process	Formal implication of height ministries in the implantation of Public Health Programme. Bilateral dialogues for evaluation task
Financial	
Mandate	Multisectoral committee established by law; Public Health Act that required intersectoral action at local level; ministries legally required to collaborate to the evaluation. All ministries are legally required to collaborate on the Public Health report

Other characteristics

- Cross-cutting governmental regional office
- Health impact assessment on legislation promoted but not mandatory

Case study – New Zealand

General Context

The organization of New Zealand's health and disability system changed with the adoption of the *New Zealand Public Health and Disability Act 2000*. This act established a new structure by creating 21 District Health Boards. In the current system, the Ministry of Health determines the orientations of programs and services at the national level, including those of public health, while the District Health Boards are responsible for managing and providing these programs and services in their districts based on the needs and priorities of their local communities. Since inequalities are a very serious problem in New Zealand, one of the objectives of the District Health Boards is to work to reduce the health inequalities between the different groups of the population, notably by improving the health of the Maori. The population of New Zealand was 4,186,900 at the time of the 2006 census. The Maori, who form the largest minority at 14.6% of the population, are one of the most socio-economically disadvantaged communities in New Zealand.

Providing broad vision

To support the *New Zealand Public Health and Disability Act 2000*, two strategic documents were written: the *New Zealand Disability Strategy* and the *New Zealand Health Strategy*. Launched by the Minister of Health in December 2000, the *New Zealand Health Strategy* defined a framework for governmental action in health, which specified the role and the place of District Health Boards. This strategy identifies a series of goals and objectives aiming to improve health and reduce the health inequalities of all New Zealanders, including the Maori and the Pacific peoples³. In this document, intersectoral action is presented as an essential lever for achieving this, both in the different sectors or agencies at the central level and with the local government and community groups. Using this strategy, the New Zealand government wished to develop healthy public policies and action plans in a more coordinated way. The first of the objectives is, in fact, the introduction of the health impact assessment of public policies and the inequalities of health.

This intersectoral approach for health is not new. The Government has used it first in 1989, then in 1993-1994 with the *A Strategic Direction to Improve and Protect Public Health* document. The revision of this platform by the Ministry of Health in 1996-1997 emphasized the reinforcement of public health action by concentrating future efforts on cross-cutting issues, such as a better consideration of the determinants of health and the construction of strategic alliances within and between the sectors (Signal & Durham, 2000). To meet the health goals, the platform recommended increasing intersectoral actions and increasing the links between the health sector and other sectors of

³ 10 goals and 61 objectives are presented in the strategy. Of these, the government chose to focus on 13 public health objectives, such as reducing smoking, improving nutrition, reducing obesity, increasing the level of physical activity, reducing the suicide rate, etc. (Ministry of Health, 2000: p. 13). This document thus places public health as a priority for the health sector.

government activity. In 2003, 36 central government agencies participated to the production of a series of statements of intent, a process in which they had to collaborate to identify common outcomes, the impacts of these outcomes on their respective responsibilities and ways to work together. This exercise contributed to advancing a common understanding of public health and its determinants within the government. For several agencies the expected results were related to the goals of public health (Gauld, 2004).

Exerting influence

In response to the *New Zealand Health Strategy*, the public health sector developed a framework for action entitled *Achieving Health for All People* using a consultation process. This document, published in 2003, also identified goals and objectives. The inter-related objectives are:

- Strengthen public health leadership at all levels and across all sectors
- Encourage effective public health through public health services and action across the health sector
- Build healthy communities and healthy environments
- Make better use of research and evaluation in developing public health policy and practice (Ministry of Health, 2003: p.6)

Linked to each of these objectives, the framework recommends actions and examples of possible outputs for various public health actors, but also those of other sectors influencing health. Taking the determinants of health into account and participation in intersectoral work is at the heart of these recommendations. For the government agencies in other sectors, these recommendations are not prescriptive but rather incentive. They are presented as actions to introduce into their planning and practices (Ministry of Health, 2003). *Achieving Health for All People* is a guide that defines the role of each of the actors and explains how or what to do to improve the health of the population. This intervention from New Zealand's Ministry of Health, which aims to increase the coordination of actions and intersectoral policies affecting health, can be associated with a stewardship approach favouring integrated governance.

Achieving Health for All People is viewed as an intersectoral framework. It presents a few case studies as models, such as the Health Promoting Schools Program, the Pacific Community Centre Promoting Healthy Eating and Exercise, and the Maori Community Development Used to Prevent Injuries. The *Strengthening Families Program*, which combines health, education and welfare, is another successful example of collaboration between different sectors (Wise & Signal, 2000). In recent years, four laws involving local authorities (governmental agencies) and concerning the health and wellbeing of the population were also adopted: the *Local Government Act 2002*, the *Land Transport Management Act 2003*, the *Building Act 2004* and the *Gambling Act 2003* (Public Health Advisory Committee, 2007).

To respect their legal obligations, the agencies responsible for these laws have a central tool at their disposal: health impact assessment (HIA). HIA is presented as a support tool for policy makers to promote the consideration of health aspects in their decision-making.

A guide was developed by the Public Health Advisory Committee⁴ in the mid-2000s. In New Zealand, HIA benefited from a high-level commitment. The government identified it as one of the objectives in its health strategy. In a publication released in February 2007, the Prime Minister also wrote that the government wanted government agencies to provide themselves with the means to formally evaluate the health impact of new policies and laws being developed (Public Health Advisory Committee, 2007). HIA is seen as a policy tool that procures a base or a platform for the “whole of government approach”. To go further in the formalisation or institutionalisation of this practice, the Public Health Advisory Committee addressed in 2007 a long list of recommendations to the Minister of Health., notably:

- Statutory recognition for policy-level HIA in the proposed Public Health Bill
- The Ministry of Health investigates the potential for Cabinet Office guidance as means of ensuring that central government agencies take the health impact of policies into consideration
- The Ministry of Health develops a formal procedure for responding to other agencies’ requests

In response to these recommendations, Cabinet agreed that the Ministry of Health would support the creation of a unit dedicated to HIA. The Health Impact Assessment Support Unit (HIASU) is mandated to develop and support the practice of HIA both within the Ministry of Health and with respect to policies developed by other government sectors. Leadership in the area of HIA thus shifted from the Public Health Advisory Committee to the Ministry of Health (Population Health Directorate). Since recently, the HIASU has been advised by an external group, the HIA Reference Group, composed of policy makers, experts, and representatives from various sectors, who advise the Support Unit.

Support

Starting from identified health goals, a significant proportion of the financing and health promotion activities are invested into different programs in relation to these priorities (Wise & Signal, 2000). The Government also put in place different ways to support intersectoral practices and foster the use of health impact assessments.

In 2001, the Ministry of Health financed the implementation of four *Intersectoral Community Action for Health Groups* in deprived areas to develop different ways to encourage communities and public health organizations to work together to improve the health of the Maori, the Pacific peoples and disadvantaged populations living in these areas. According to an evaluation undertaken in 2007, all the ICAH initiatives showed evidence of working towards reducing inequalities. The Ministry also finances research in this area such as the 2001 literature review entitled *Intersectoral Initiatives for Improving the Health of Local Communities*.

⁴ This Committee, established under the *New Zealand Public Health and Disability Act 2000*, is a sub-committee of the National Health Committee. Its role is to give independent advice to the Ministry of Health regarding public health issue.

The New Zealand Health Impact Assessment Support Unit, which answers to the Office of the Director of Public Health, part of the Ministry of Health, aims to promote this practice, to build partnerships and to offer expertise and information services to government agencies at the central, regional and local levels. For the local level, the Support Unit established the *Learning by Doing Fund* to support the District Health Boards with doing HIA. To facilitate the use of HIA and develop the skills and abilities of the policy makers, this unit also offers training activities.

Evaluation

Since the *New Zealand Health Strategy* in 2000, the Ministry of Health reports on an annual basis on the progress related to the implementation at central and local levels. The implantation of the *Achieving Health for All People* framework is monitored and measured in an evaluation process headed by the Public Health Directorate (Ministry of Health, 2003).

Governance tools

Structures	Public Health Advisory Committee New Zealand HIA Support Unit
Process	36 central agencies produce Statements of Intentions on health. Achieving For All Strategy (2003) developed in collaboration with others departments. Objectives of health presented to be included in Departments' planning
Financial	Learning by doing Fund to support HIA by local level Financing Intersectoral Initiatives at local level
Mandate	Laws that involves local authorities in public health issues

Others characteristics

- Health Impact assessment practice supported by high-level political commitment

Case study - Norway

General context

Norway's health system is structured into three government levels: the national government, the counties (19) and the municipalities (434). Public health guidelines are developed at the national level, but most of the services are delivered by the municipalities. Among the industrialized countries, Norway, with a population of 4.6 million inhabitants, is often considered one of the most advanced in terms of health status (Crombie et al., 2003; Keon & Pépin, 2008). However, compared to other European countries, in the past two decades Norway's indicators of good health have started to decline (Hole, 1999), especially when it comes to health inequalities. The Norwegian government therefore began a series of actions to correct this situation, such as the production of direction documents.

Providing broad vision

Norway's recognition of the importance of the social determinants of health and the need for intersectoral work dates back a number of years. In 1987 the Norwegian government produced a white paper entitled *Health Policy Towards the Year 2000* which mentioned the reduction of inequalities and recognized the merit of including health in all public policies (Hogstedt et al., 2008b). In 1993, the government published a white paper called *Challenges in Health Promotion and Preventive Efforts* in which intersectoral action was presented as an important stake (Keon & Pépin, 2008). In 2003, the white paper called *Prescription for a Healthier Norway* presented a ten-year plan, which, while promoting a balance between individual and social responsibilities, also looked at the social gradient of health. This white paper presented an action plan to reduce inequalities and create partnerships between the national government, the counties, the municipalities and other civil society organizations (Keon & Pépin, 2008; Hogstedt et al., 2008b). The action plan entitled *The Challenge of the Gradient* was developed by the Directorate for Health and Social Affairs⁵ and was filed in 2005. In this plan, the directorate agrees to develop the knowledge bases the government would need to establish a comprehensive strategy for reducing social inequalities. The *National Strategy to Reduce Social Inequalities in Health*, published in 2007, presents an integrated vision of the measures being used or that will be used to reduce the social inequalities of health. The factors that cause these inequalities are reviewed and the existing governmental policies or policies to be developed are presented⁶.

⁵ The directorate changed its name from The Norwegian Directorate for Health and Social Affairs to The Norwegian Directorate for Health on April 1, 2008.
http://www.helsedirektoratet.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english. This is in itself an interesting institutional arrangement: It is subordinate to the Ministry of Health and Care Services and the Ministry of Labour and Social Inclusion, and receives subsidies from the Ministry of Children and Equality and from the Ministry of Local Government and Regional Development (Helsedirektoratet. Norwegian Directorate of Health. PPT presentation, September 2008).

⁶ See: <http://www.regjeringen.no/en/dep/hod/documents/regpubl/stmeld/2006-2007/Report-No-20-2006-2007-to-the-Storting.html?id=466505&epslanguage=EN-GB>

Exerting influence

The governance theory underscores the importance of national direction documents presenting broad objectives as the basis for a “whole of government approach”. The *National Strategy to Reduce Social Inequalities in Health* meets this requirement. It presents the large stakes related to the fight against inequalities in the different sectors of government, and the policy measures already in place or to be established by each of these sectors. Among policy measures already in place, we can find some related to the redistribution wealth and fostering inclusion in employment goal (*Employment, Welfare and Inclusion and Action Plan to Combat Poverty - Report no. 9 to the Sorting, 2006-2007*), to the support of early childhood development goal (*Early Intervention for Lifelong Learning - Report no. 16 to the Sorting 2006-2007*) and to a healthy working environment with focus on inequalities, which was reinforced by the new *Working Environment Act 2006*. The strategy thus calls upon many sectors of government action, such as the world of work, education, finance, health and social services, along with many actors at both the national and local levels.

The strategy aims to procure guidelines for the government’s and ministries’ work on:

- Annual budget
- Management dialogues with subordinate agencies, regional health enterprises, etc.
- Legislation, regulations or other guidelines
- Interministerial collaboration, organisational measures and other available policy instruments” (Norwegian Directorate for health and Social Affairs, 2007: p.9)

Moreover, in this strategy, the government agrees to ensure that the distribution issue of policies is integrated into tools for the Norwegian Government Agency for Financial Management.

Two policy instruments are put forward to promote intersectoral action: health impact assessment and, at the municipal level, social and land use planning.

According to the strategy, health impact assessment (HIA) should be used nationally, regionally and locally to help generate knowledge on health impact more systematically for policy and strategy design. On the national level, work should be done to integrate HIA into existing official processes for analysing the economic and administrative impacts of proposed government policy measures (Official studies and reports). The Ministry of Health and Care Services agrees to develop tools to support the other ministries in integrating concerns about inequalities into their planning documents.

The strategy document was not explicit about using HIA at the local level. However, it recommended using legal levers that already exist in the municipal domain to introduce health and inequality concerns into the planning documents. According to the Strategy, “*the Planning and Building Act is the main tool available to local and county authorities in their social and land-use planning*” (Norwegian Ministry of Health and Care Services, 2007: p.86). The Ministry of Health and Care Services will work with the Norwegian

Association of Local and regional authorities to develop tools to facilitate the work of the municipalities that want to consider how their policies affect inequalities.

There is a government measure to encourage municipalities to work with the public health sector through grants supporting intersectoral activities fostering improved health for the population on their territory. The municipalities must fulfil two conditions in order to obtain these grants: they must contribute financially, and public health must be part of their planning system.

Support

The Directorate for Health plays a central role in supporting this new strategy. These tasks mainly consist of:

- Coordinating the development of new indicators and producing reports
- Providing an Internet portal for the municipalities and information about how to include inequality concerns in their planning
- Developing the skills of local public health actors
- Fostering collaboration between municipal authorities and local public health authorities
- Developing new knowledge that supports the practice of collaboration between the different ministries (HIA) and between the municipalities and the local health authorities

Evaluation

Annual policy reviews are expected from the Ministry of Health and Care Services. These reports, written in collaboration with the relevant ministries, will discuss the main measures and strategies at the national level and will be included in the budgetary proposals of the Ministry of Health.

Governance tools

Structures	Directorate of health with intersectoral responsibilities
Process	National Strategy on inequalities with intersectoral objectives HIA promotes as a decision tool Using Planning and Building Act as a lever for HPP at local level Join-up evaluation process of Health Policies
Financial	Grant for local authorities working in health
Mandate	

Case study – Sweden

General Context

Sweden, a country of almost 9 million inhabitants, is governed by a mixed parliamentary system. The three levels of government – central (Riksdag), regional (21 county councils) and local (290 municipalities) – are involved in the organization of health services. The Minister for Health and social Affairs is assisted by two other ministers, including a Minister for Elderly Care and Public Health. The county councils are responsible for curative care and certain public health responsibilities. The municipalities make decisions that have an effect on the determinants of health, including senior care, education, water quality and road maintenance. Although the central level is responsible for setting broad national guidelines, the regional and local levels have considerable autonomy in the application of these guidelines (Allin et al., 2004).

Providing broad vision

An internationally recognized model for population health and social policies, Sweden adopted a social perspective of health many years ago. The health services law adopted in 1984⁷ was inspired by the WHO declaration “Health for all by the Year 2000” which paid particular attention to vulnerable groups (Hogstedt et al., 2008). Several other direction documents encouraging the government to continue on this path were proposed over the next few years, and in 1997, it launched a parliamentary committee called the National Public Health Committee, responsible for proposing national public health objectives, with a focus on health inequalities. The committee’s report, delivered in the year 2000 and entitled *Health on equal terms* was the object of a vast community, political and scientific consultation. This led to the Government’s Public Health Objectives Bill, which proposes social health objectives. In April 2003 it was adopted almost unanimously by all of the political parties in power (Hogstedt et al., 2004).

The overarching aims of what is now known as the National Public Health Policy is “to create social conditions to ensure good health, on equal terms, for the entire population” (Backhans & Moberg, 2008: p. 294). The health targets were grouped together under eleven main objectives, reflecting the structural determinants of health, and linked to over 30 different public policy sectors. The broad objectives were formulated to better suit the way it currently runs public administration (Hogstedt et al., 2004), rather than in terms of risk factors, more familiar to the traditional public health sector.

In June 2008, the bill called *A renewed public health policy* (Government Bill 2007/08:110) was adopted. It maintains the 2003 objectives, but puts more emphasis on individual responsibilities and requires local-level involvement.

⁷ The Government Bill *on the Development of Health and Medical Care Services (...) in Sweden* (Govt. Bill 1984/85:181)

Exerting influence

The formulation of the national public health policy presents the main ingredients needed for leadership in a cross-government approach: a broad and social vision of health, strong political support, and involvement of the stakeholders. The objectives of this policy can only be met with the involvement of other sectors and intersectoral collaboration⁸.

However, the formal mechanisms promoting this intersectorality are unclear. In 2003, a national steering group for public health issues was established under the leadership of the Minister of Public Health to foster a coordinated vision of how to meet the objectives, but its role was not specified. Through an administrative directive, the central and regional government agencies were asked to specify how they would contribute to meeting the public health targets related to their sectors. The regional and local authorities were invited to improve their coordination and cooperation methods for their health promotion activities (Lundgren, 2008).

There do not seem to have been any coercive or incentive measures to promote the implantation of the policy in 2003⁹, other than support tools developed by the Swedish National Institute of Public Health.

The responsibility for coordination was a plan for monitoring the implantation of the policy and the attainment of the objectives, entrusted to the Swedish National Institute of Public Health (SNIPH). The institute had to develop new monitoring indicators appropriate to the policy's transversal objectives, which they did by soliciting the participation of over 40 central and regional agencies. According to the SNIPH, this process made it possible to bring out correlations between the missions and it fostered the partners' feeling of ownership for the health objectives (Lundgren, 2008).

Despite some progress in terms of a sense of ownership for the public health objectives at the regional and local levels, the 2005 assessment report noted weaknesses in horizontal and vertical coordination and recommended reinforcing coordination mechanisms. It was proposed that the county administrative boards be given clear public health coordination mandates at their level and that they be required to report on the progress of the public health policy's implantation at the central level (Agren & Lundgren, 2005a).

Support

The main source of support for the implantation of public health objectives comes from the Swedish National Institute of Public Health (SNIPH). To this effect, the Institute:

⁸ As examples of the eleven objective areas of the policy, we can cite: Participation and influence in society; Economic and social security; Secure and favourable conditions during childhood and adolescence; etc.

⁹ In 2003, no extra money was granted for the implantation of public policy objectives, since they were to be integrated into the current missions of different sectors. The renewed public health policy bill of 2008 came with money for municipalities, earmarked for very specific targets (http://www.fhi.se/default___1417.asp)x

- Developed and made available the indicators on the determinants of health and monitoring for the municipalities
- Proposed planning tools for reviewing and integrating public health at local municipal levels
- Held training seminars and other training activities in health sectors and other sectors
- Developed health impact assessment tools (HIA).

Evaluation

The public health policy adopted in 2003 requires an evaluation report to be presented every four years to the Swedish parliament, the highest level of decision-making. The first report was submitted in 2005. This report was addressed to a wide audience, including politicians, the health sector and their partners.

The implantation of objectives is difficult to evaluate in this case, considering the highly decentralized nature of the Swedish governance system and the many actors involved, to different degrees and at different levels. Moreover, the eleven objective areas are not precise and univocal targets. They are more like guidelines to follow, which could make the evaluation process more political than technical (Lager et al., 2007).

Governance tools

Structures	Directorate of health with intersectoral responsibilities New responsibilities to the public health institute
Process	Health Policy developed with broad consultation Objectives defined according to the governmental departments Shared performance indicators
Financial	Grant for local authority working in population health
Mandate	A renewed public health policy with local level requirement Administrative directives to the Departments Formal evaluation of the Strategy prepared for Parliament

Other characteristics

- Involvement of political parties
- Minister for Public Health

Case study– Québec (Canada)

General Context

Québec is one of Canada's ten provinces. By virtue of the Canadian federal system, responsibility for health is divided between the federal level and the 10 provinces and the three territories. Each province defines its own health policies. The province of Québec has a population of about 7.5 million, or a quarter of the Canadian population. It is considered one of the most progressive Canadian provinces in terms of social and public health infrastructure programs (Bernier, 2006). Public health policy programs are supported by laws and regulations that promote intersectoral work and action on the socio-economic determinants of health at the three levels of governance.

Providing broad vision

In 1992, the Québec government launched the Health and Welfare Policy (MSSS, 1992), which aimed to orient the activities of the Department of Health and Social Services towards the most efficient solutions by putting the accent on determinants of health. Improving living conditions and better harmonization among the various departments were cited as some of the means to use. This policy was not replaced after its coverage period (1992-2002), but the actions taken in its wake continue to influence health policy orientations. The province's current comprehensive public health program covers a period of ten years (2003-2012) and is based on the four essential functions of public health (health surveillance, protection, prevention and promotion) and on support functions, such as influencing public policies. This program, part of the Public Health Act, provides clear guidelines for regional and local public health offices. The first report from the Chief Medical Officer, named in 2002, was about the broad determinants of health and collective responsibility for them (MSSS, 2005).

Exerting influence

Québec has a powerful governance tool for influencing government practice so that health can be integrated into all policies. The new Public Health Act, adopted in 2001, includes a section explicitly devoted to the duty of government departments and agencies to collaborate with the Department of Health and Social Services to ensure that the measures enforced by different sectors have no harmful effects on population health. Section 54 of Québec Public Health Act in fact states that the health minister is (...) *by virtue of his or her office, advisor of the Government on any public health issue. The Minister shall give other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population. In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population* (<http://publicationsduQuébec.gouv.qc.ca/home.php#>).

The implantation of the section 54, which solicits all members of the provincial government, gave rise to an interdepartmental support committee. Almost all of the departments targeted by this section are represented on the committee. It is composed of member staffs responsible for linking the needs of their respective departments with the guidelines of the Department of Health and Social Services concerning the practice of health impact assessment (HIA), which the departments must carry out when developing new bills or regulations. The committee's meetings also provide a framework for knowledge exchange on how health relates to other government missions and the best HIA practices in their specific context.

The government's internal procedure for developing bills and regulations to be adopted by the cabinet was adjusted so that assessments and other collaboration efforts with the Department of Health would be taken into account at the highest level of government decision-making. Governance mechanisms already in place to facilitate the coherence of legislative decisions, namely interdepartmental committees linked to the Premier's cabinet, were therefore called into play.

Support

With the adoption of the Public Health Act and section 54, the Québec government implemented several measures to foster knowledge development and sharing in order to support intersectoral practice at the central level:

- The creation and maintenance of a Web site (public policy portal) for civil servants
- The financing of research programs (HIA processes and methods, and impacts of public policies on health)
- A contribution agreement with *Institut de santé publique du Québec* for the production of public health advices on a variety of healthy public policy themes in response to the needs of different departments;
- A training program for departmental policy makers and public health experts at the central level, and eventually at the regional and local levels.

Evaluation

The Department of Health and Social Services recently published its first assessment on the results of section 54's initial five years (MSSS, 2008). This report examines the status of the implementation of different measures, such as the practice of HIA by the other departments. It also examines progress, difficulties encountered and future orientations. The report was widely distributed to all of the departments and other partners implementing section 54. This section of the Act, which requires government departments and agencies to make prospective assessments of the potential effects of their bills and regulations, is not used from a coercive perspective, but rather as a lever to encourage and strengthen intersectoral action at the government decision-making level. It was mentioned that although economical ministries are still reluctant to be involved, some true progresses in inter ministerial relations was noted.

Governance tools

Structures	Dedicated Unit for HIA within the Ministry of Health Interdepartmental unit for HIA
Process	Cabinet committee with new responsibilities linked to HIA
Financial	Agreement with the National Institute of Public Health
Mandate	HIA embedded in Public Health Act

Other characteristics

- HIA as a duty of each Department
- Specific research group working on the implementation of HIA within Government Departments

Using Windows of Opportunity

The British Colombia (Canada) Case

One of the principles of governance is a government's ability to take advantage of windows of opportunity for mobilizing a number of the society's actors to work together towards a common goal. British Columbia (Canada), is a case in point. By capitalizing on the effervescence around the 2010 Winter Olympics, the Premier of this province of four million inhabitants launched an imposing partnership initiative to support the adoption of healthy lifestyle habits. The Premier invited all of the actors in the society to get involved in a joint effort "to make BC the healthiest jurisdiction to ever host the Winter Olympic and Paralympic Games" (British Columbia, 2006: p.5). This objective is one of five in the British Columbia government's Strategic Plan for the year 2006/2007-2007/2008 (www.gov.bc.ca). The *ActNow BC* initiative (<http://www.actnowbc.gov.bc.ca/>) proposes specific and measurable objectives in relation to five lifestyle habits (e.g. increasing physical activity by 20%) by 2010. The government program requires all of the province's ministries to specify in their strategic plans how they intend to meet the health objectives. A partnership support strategy under the responsibility of the Ministry of Tourism, Sport and the Arts, aims to group together a large number of provincial, regional and local organizations, both private and public, in order to meet these objectives. The strategy will be evaluated based on the processes, the outcomes, and the use of resources allocated for the strategy. This initiative encompasses many conditions that foster the integrated governance approach: a mobilizing objective and precise and measurable success indicators, a high-level political and administrative commitment, a responsabilized government authority (accountability), a coordination mechanism, and a comprehensive evaluation program.

The South Australia Case

For the past two years, the state of South Australia has been developing the health in all policies (HiAP) approach at the central level of government. This innovation was possible because the Department of Health took advantage of a broad consultation the state government conducted during the development of its latest Strategic Plan (2007-2014). The department put forward the relevance of including health as a transversal concern in the plan's objectives. This influence work was facilitated by the momentum created by Ilona Kickbusch, a leading international expert on healthy public policy, who was assigned in Adelaide during this period as a thinker in residence.

A strategic plan based on the interconnectivity of the State's objectives

This plan was seen as a "plan for everyone -for business, for the community, and for the government - not for the government alone", and the population was asked to help identify target principals for action and for their realisation. The 84 targets chosen were grouped into six broad objectives, all presented as inter-related. The plan states that growing prosperity, improving well-being, attaining sustainability, fostering creativity

and innovation, building communities and expanding opportunity cannot stand alone and require concerted effort.

South Australia's Strategic Plan is the ideal framework within which to progress the HiAP methodology because it offers examples of linkages between health and non-health sectors and complements the wider agenda to make use of interactions between the plan's target. (Tanya Smith, Deputy Chief Executive, Cabinet Office)

The implantation of this Strategic Plan is characterized by the following points:

- The creation of the Executive Committee of Cabinet, Chaired by the Premier, to provide central co-ordination and leadership to government departments in their efforts to meet the Strategic Plan targets
- The creation of a Community Engagement Board to maintain and support the commitment of groups in the society to meeting the Plan's objectives
- The creation of an independent group (the Plan's Audit Committee) in charge of producing a bi-annual progress report on the objectives
- The establishment of an Internet forum fostering ongoing communication with citizens and community groups about their involvement in meeting the Plan's objectives. (For example, see the programs "Alliance partners" and "Friends of the Plan" at <http://www.stateplan.sa.gov.au/>)

Health and the strategic plan

Starting in 2007, the Department of the Premier and Cabinet and the Department of Health developed a joint strategy for introducing the HiAP approach at the central level (Smith, 2008). A tool for analysing health impact, a health lens, was developed and applied to several targets of the Strategic Plan. The results of this exercise were used to raise awareness among senior State Government executives about the links between HiAP and the achievement of the Strategic Plan objectives. (Government of South Australia, 2007; Kickbusch, 2008).

Future developments will aim to consolidate the HiAP approach at the central level of government and to extend it to the local level, also involved in meeting the objectives of the Strategic Plan.

V. EXPLORATIVE DISCUSSION ON EFFECTIVENESS

The effectiveness of governance tools resides in the ability of such measures and mechanisms to promote a “whole of government approach” and to place health and the reduction of inequalities high on the government agenda (at the local and national levels). There is very little literature about the effectiveness of governance tools. One reason for this is the absence of appropriate assessment methods, and therefore of evaluative research on this subject (Barr et al., 2008). Another reason cited is the fact that the choice of governance tools and implementation strategies is highly contextual. There is never a one-size-fits-all solution in a world as complex as national governance, where considerations linked to individuals, past experiences, ambient political and social ideology and existing institutional arrangements always influence the ability of these tools to produce the desired effects. Nevertheless, it is possible to draw lessons from the case studies presented and from the existing literature.

Application of a HiAP strategy involves raising the awareness of all decision makers as to their role in influencing health determinants and ensuring the active involvement of these decision makers in efforts to reach health objectives. Two conditions are necessary for these goals to be met: firstly, strong leadership within the health sector to convince the highest level of government (the Cabinet) to make population health and the fight against inequalities a priority and, secondly, a formal commitment on the part of this high authority. Here, a clear vision and clear objectives defined by the central government, accompanied by incentives and coherent support measures, seem to be among the conditions for success. The case studies presented were chosen because their health programs involve a societal approach to health. In England the broad health strategy was underwritten by the Prime Minister himself, indicating a commitment at the highest level. In many countries, this commitment was given concrete expression through the establishment of a supra-departmental authority, a mechanism identified as a major vector for success in interdepartmental coordination (Bourgault et al., 2008).

According to a study produced by the Canadian senate, (Keon & Pépin, 2008), the support of finance departments is particularly important, not only so that funding will accompany the objectives, but also so that other departments will subscribe to health-related initiatives. Cross-cutting performance targets have proved helpful in this regard (Ling, 2002).

It seems that the combination of coercive measures (e.g. laws, accountability, etc.) and incentives measures (e.g. extra funding) is a winning one. It is easier to get other government departments involved when, for example, they view pursuing health targets as part of their own mission (Gagnon et al., 2008). The case of Sweden is interesting. Development of its health strategy was a collective effort, so all the partners involved recognize their own contribution to the set of targets, which promotes “ownership” of the national strategy.

Intersectoral work is recognized as difficult, especially when it takes place at the central government level. All the countries examined, as well as many others committed to tackling cross-sectoral problems (such as poverty, sustainable development and organized crime) have established permanent structures (dedicated units or national teams) or have

assigned additional responsibilities to existing structures to promote intersectoral coordination and collaboration. Such mechanisms also seem to be absolutely central to ensuring that the vision and commitment expressed at the central level are truly implemented. Johnson (2005) attributes failures of joined-up government “to lack of awareness for the need to create appropriate infrastructures to support this approach.” These authoritative structures often assume responsibilities related to the building of new capacities through the development of concrete tools, as well as training opportunities, and results monitoring – two other conditions for success.

Intersectoral action is effective when it takes place simultaneously on several levels and when work on these levels is integrated through policies or legislation (Barr et al., 2008). While central leadership is essential, acting on health determinants also requires significant involvement from local governments. In certain countries, decentralization seems to hamper efforts to implement such action. This has been the case in Finland (Keon & Pépin, 2008), Sweden (Agren & Lundgren, 2005) and England (Mulgan, 2002). Faced with these difficulties, Sweden introduced financial incentives and England sought the support of existing consensus-building organizations, such as the Local Government Association.

HIA

HIA is one of the most structured mechanisms for inserting health concerns into all policies. As we have seen, all the countries that subscribe to this idea (HiAP) use or promote this mechanism. HIA must, however, be understood and used more as a mechanism for supporting decision making than as a mechanism that allows the department of health to exercise control over other departments. It has been shown elsewhere (Bekker, 2007) that the most productive way of reaching the desired goal is to use HIA as part of a collective process guided by a spirit of collaboration.

Experiences with HIA have shown that incentive measures such as guidance documents and practical guides are not enough to lead reluctant sectors to subscribe to a HiAP strategy. Several studies in this field have shown that departments with an economic vocation (finance, revenue, employment, agriculture, etc.) show more resistance than departments with a social vocation (education, social solidarity, etc.) toward examining the health impacts of their policies ((Lavis et al., 2001; Observatoire de l'Administration Publique, 2008). Legal measures seem to provide a lever for overcoming this obstacle. However, as stressed by Gagnon and his collaborators, with reference to the case of Quebec, laws, in themselves, do not suffice, if they are not accompanied by a strategy for supporting intersectoral action (Gagnon et al., 2008). It was found elsewhere (Quigley, 2005) that a dedicated HIA support unit with sustainable funding is one key to success.

Conclusion

In conclusion of this section, we can say that each governance tool has its strengths and weaknesses regarding the capacity to allow a “whole of government approach” for population health. Because the effectiveness of each tool is dependent on the context in which they are used, it remains difficult to identify the “magic bullet”, i.e. the governance tool that would be effective in any context. The countries studied here were chosen because they were known for their broad and overarching public health policy that

provides vision and inspiration for the health sector as well as other sectors. The analysis also illustrated that every government manages the implementation of its broad health policy according to its own realities (historical, political, structural, and cultural contexts). In addition, the analysis suggests trends in the choice of governance tools which can provide useful insights on promising ways to follow. The most promising strategy seems to be combining coercive and incentive measures, but also providing strong and long-term support at each level of implementation of the strategy. Sub-cabinet committees for maintaining high commitment and cohesive policies, interdepartmental arrangements for coordination and mutual understanding, and dedicated unit for knowledge development and capacity building also emerge as promising **structural** tools. Countries that have experienced joined-up **process** for elaborating or evaluating their public health strategy found that it fosters a shared ownership for public health targets. **Financial** issues are certainly a central aspect for getting commitment from sectors other than health and to establish sub-national entities. The integration of determinants of health targets within existing financial and accountability mechanisms seems to have been successful. And finally, making intersectoral work and HIA **mandatory** gave powerful levers for public health decision makers and practitioners to break the traditional silo between them and others sectors. More than one country has taken advantage of the renewal of public health law to introduce measures that favor HiAP. Actually, using cleverly windows of opportunity to make change and introduce an innovation appears to be a winning strategy.

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