Intersectoral Action and Health Equity in Latin America: An Analytical Approach

Special Program on Sustainable Development and Health Equity (SDE)

Washington, D.C., 2015

Also published in:

Spanish (2015): *Intersectorialidad y equidad en salud en América Latina: una aproximación analítica*.
ISBN 978-92-75-31857-7

PAHO HQ Library Cataloguing-in-Publication Data

****

Pan American Health Organization.

Intersectoral Action and Health Equity in Latin America: An Analytical Approach.
Washington, DC : PAHO, 2015.

1. Equity in Health. 2. Intersectoral Action. 3. Public Policies. 4. Latin America. I. Title.

ISBN 978-92-75-11857-3 (NLM Classification: WA 525)

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This document is a product of a research study designed to formulate a regional framework for Health in All Policies (HiAP) and to identify case studies for the Region of the Americas. This analytical framework was used for the preparation of the case studies and the subsequent analysis.

The Pan American Health Organization would like to acknowledge that this document was developed with funds from the Rockefeller Foundation.

Contents

1. **Background** ... 1

2. **Premises and objective: intersectoral action and health equity** ... 3

3. **Scope of the intersectoral approach in Latin America** ... 5

4. **Institutional, economic, political, and social frameworks for intersectoral experiences** ... 8

5. **Hypotheses and rationales** ... 10

   5.1 The dominant conceptualization of health and its relationship to levels of intersectoral action ... 10

   5.2 Levels of intersectoral collaboration: the state of the art ... 12

   5.3 Models of intersectorality. What should be analyzed? ... 13

   5.4 Social participation and the intersectoral approach ... 15

   5.5 Intergovernmental coordination: the relationship between national and subnational levels ... 17

   5.6 Functionality of types of leadership ... 19

6. **Mechanisms for exerting influence on other sectors and making the strategy sustainable** ... 19

7. **The current agenda** ... 21

   7.1 New social protection policies ... 21

   7.2 Municipal initiatives for social development ... 21

References ... 23

1. Background

Intersectoral action is a recurrent theme in public health management. However, there is very little systematic documentation on how it is implemented, especially in the field of health. Nor does an explicit theory exist on how to construct a framework in the health sphere to determine what kinds of intersectoral actions are feasible under different scenarios, or the kind of intersectoral action needed to address the social determinants of health and reduce inequities in health (Solar et al., 2009).

This work proposes a preliminary conceptual framework to help identify and characterize experiences and studies on the intersectoral approach that have contributed to the objectives of health equity in Latin America in the past and present. We present elements of analysis to determine the context of the experiences and their specific features and scope, emphasizing the aspects that have characterized the origins and evolution of the intersectoral approach in the Region.

We also strive to identify elements that help explain under what conditions intersectoral action is successful. While the intersectoral approach in itself is not a central objective, we believe that it is necessary to emphasize that its success is associated, first of all, with reducing social and health inequities; secondly, with the health sector taking the needs and priorities of other sectors into account; and finally, with the inclusion of health as a goal or target in policies of other sectors.

Main differences between the intersectoral approaches to health in advanced industrialized countries and in Latin America

The intersectoral approach to health tends to be associated or equated today with the expression "Health in All Policies (HiAP)," a term coined at the end of the 1990s and developed in depth during Finland's second European Union presidency in 2006, when the main theme was health (Leppo and Ollila, 2013).

As the World Health Organization (WHO) defines it, "Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity" (WHO, 2013).

Despite that definition by WHO and the Adelaide Statement on Health in All Policies, of 2010 (WHO and Government of South Australia, 2010), there is no worldwide consensus on a definition that reflects the coexistence of various interpretations and practices.

A large majority of sources emphasize, although with differing nuances, that public policies should take into account not only their impact on health, but also their impact on the social determinants of health at the population level. In this regard, the European definitions tend to state that health needs and health equity should be taken into account by other sectors (McQueen, et al., 2012). Others, in contrast, not only highlight the key role of health but also consider health to be a necessary requirement that allows other sectors to meet their own objectives (WHO and Government of South Australia, 2010). In addition, some definitions of HiAP tend to focus on collaboration between governmental and nongovernmental sectors. Some even regard the HiAP strategy basically as a way of working and an opportunity to forge a positive public/private sector partnership in which the public sector seeks to have the private sector promote behavioral change (Gillies, 1998). Finally, there are those who see HiAP as one of the components to consider in necessary health reforms (Aspen Institute, 2013).

In the specialized literature as well, we find a diversity of terms that refer to coordinated efforts or integration of public policies, such as "whole-of-government," "joined-up government," and "multisectoral approaches." All these terms emphasize policy coordination of across sectors, although there are also differences between

them. For example, the "whole-of-government" approach emphasizes better coordination and integration, not only of government activities but also of the government's social objectives (United Nations, 2012).

The expression "*joined-up government*" originated in the United Kingdom during Tony Blair's Labour government as one of the linchpins for modernization of the civil service and improving the efficiency of public administration (Christensen and Lægreid, 2007). But there is no universally accepted definition of "joined-up"; this term is used to cover horizontal, comprehensive, or integrated government work. The Management Advisory Committee of Australia offered the following definition to the Australian public in 2004 (MAC, 2004: 4): "public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery. The objective of the government is aimed, usually, at improvement of results. Initiatives tend to be directed to a particular group of clients or geographical area." The concept of "multisectoral approach or action" is often understood as the response to health problems by ministries or agencies with different functions or in different sectors. This interpretation places less emphasis on the concepts of integration and alignment. The specialized literature suggests that multisectoral action (MSA) for health is a process that rarely occurs naturally and that tools are needed to help facilitate and sustain the process (Public Health Agency of Canada and WHO, 2008).

It should be pointed out that the drive for HiAP, "joined-up government," or "whole-of-government" comes mainly from countries whose governments have robust capacity for regulating markets and providers, coordinating the delivery of social services, and implementing redistributive policies by means of taxation or other mechanisms. Many Latin America and Caribbean governments, by contrast, have limited regulatory capacity, in particular with regard to the private sector. This, combined with limited redistribution mechanisms, makes the Region one of the most unequal in income distribution and suggests that the benefits of public-private partnerships cannot be transferred mechanically to the realities of Latin America and the Caribbean.

In fact, in the Region of the Americas, the term "HiAP" has been almost completely absent from public policy-making. This seems to be because the concept is linked to a European social-historical context and, within this, to promotion of the concept by Finland's European Union presidency in 2006.

In the Region of the Americas, "intersectorality" has been the preferred concept, based on the Declaration of Alma-Ata of 1978 and its call for "health for all," which had great influence in Latin America and the Caribbean. Added to this were the important contributions of the Ottawa Charter for Health Promotion in 1986 and, at the same time, developments and debates taking place in the Region of the Americas around Local Health Systems (SILOS). These were part of the health sector's response to the democratization processes unfolding in the Region. The emphasis was on the need to reorganize and reorient health systems on the basis of decentralization and local development, and to strengthen and renew the primary care strategy approved in Alma-Ata, stepping up the effort to achieve equity with solidarity and justice for the entire population. The intersectoral approach was among the central aspects of this agenda. The Declaration pointed out that primary care "involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors " (WHO, 1978).

Borroto and colleagues (cited by Castell, 2007) consider that the intersectoral approach has been one of the four cornerstones of primary care in many countries of the Region, although they point out that "[...] intersectoral participation ranges from carrying out isolated health actions up to systematic actions within the framework

of organized health action; this means that the sectors are not only organized in response to the emergence of a health-related problem, but also that their actions are organized to prevent the emergence of health problems involving their sector."

Intersectorality is not a new topic in the Region, but just as there are diverse interpretations of HiAP, this is also the case with the intersectoral approach. There seem to be not only technical but, above all, political reasons for the various interpretations and operationalizations of the intersectoral approach, arising from different dominant concepts of health, sociopolitical contexts, levels of development and well-being, and rationales for social policies in the Region, among other aspects.

Taking into account this general framework and understanding that a key aspect is the manner in which the intersectoral approach is interpreted and implemented in the Region, we present some relevant elements of analysis below.

2. Premises and objective: intersectoral action and health equity

Attainment of health requires the coordination of many different conditions and factors, since various social mechanisms coexist to generate health and disease processes. Most such conditions and mechanisms are known to be outside the direct scope of the health sector. It is clear that health problems are unlikely to be resolved exclusively by actions of the health sector or any other sector in isolation. This fact is particularly relevant when the objective is to reduce inequities in health, since this requires addressing the social determinants of health. Castell (2007) contends that "health appears as a social product and actions go beyond the borders of the so-called health sector." This is one of the central arguments for working "together" with other sectors, i.e., for intersectoral work (Solar et al., 2009).

In fact, intersectoral work is a technical and political requirement when the problem to be addressed is conceptualized in terms of its origin and in interventions beyond the health sector, associating it mainly with the social production and reproduction of health, disease, and quality of life. Similarly, when the agenda calls for addressing the causes of health inequities and their social determinants, the health sector cannot avoid taking account of other social and governmental sectors in designing, planning, and/or implementing policies, programs, or actions in this area.

This conceptualization, accordingly, differs from the notion of health as a process associated mainly with access to curative and preventive medical services, in which the relation of health with other sectors is not a priority objective or is seen as merely instrumental for sectoral health objectives (Solar et al., 2009). Thus, adopting the perspective of health equity as a central objective, one of the premises on which this work is based is as follows:

> Reducing health inequities requires joint action between the health sector and other governmental sectors that have influence on the social determinants of health.

Given this premise, our focus of interest is not just any intersectoral action, but those initiatives that can reduce or eliminate health inequalities, even if such initiatives may not come from the health sector, may not be led by the health sector, and may not involve participation by the health sector in every intervention constituting the intersectoral action.

Making equity the center of such a strategy makes it possible to analyze whether or not the intersectoral approach that has been developed has had an impact on the reduction of inequities. This points to several aspects that should be considered in the design and evaluation of an intersectoral approach (Solar, 2010).

A first aspect has to do with the coverage of an intersectoral program or policy, in terms of either *universalism* ("the entire population is the beneficiary of social benefits as a basic right") or *targeting* ("eligibility for social benefits implies some type of means testing to identify those who are 'truly deserving' of the benefits"). Social and liberal conceptions of the State tend to be located somewhere between the two positions described, although we often find hybrid forms. This seems to us to be crucial in analyzing the results of equity in the Region, since achievements in poverty reduction are not necessarily associated with the reduction of social inequities.

The approach that has dominated the development of public policies since 1980 (with some exceptions) is one that has presumed that the market is the fundamental mechanism for efficient allocation of resources to maximize social welfare. However, the policies associated with this approach have generated enormous inequalities in income and social conditions in the context of high rates of poverty and weakened public administration (Mkandawire, 2005; Skocpol, 1991).

A second aspect associated with the content and design of public policies refers to how the hierarchy of social determinants of health or the bases of social determination of health and disease are integrated into policy (Solar and Irwin, 2007). The question is whether actions are designed to achieve social and economic reforms that try to address structural social determinants, that is, to affect the mechanisms for generation of inequities, or whether they are limited to mitigating the consequences of these inequities.

In this regard, when one analyzes the content of an intersectoral strategy it is important to know what its main focus is.

For example, if the priority is to address impacts on health, such actions would be centered mainly on delivery of and access to health services, implying that the relationship with other sectors would be based primarily on optimizing these results and minimizing negative consequences (*downstream*).

On the other hand, if the priority is to address living and working conditions, psychosocial factors, and habits or lifestyles, the relationship with other sectors would focus on reducing exposure and vulnerability of the population (*midstream*). In this case it is also important to make a distinction between actions associated with lifestyle and psychosocial factors and those centered on material living and working conditions.

Finally, if the priority is to change the structural social determinants, the relationship with other sectors would address the mechanisms of redistribution of power. It would thus be relevant to analyze whether the actions include processes of reform or social transformation (*upstream*).

In this context, adopting equity in health as the central objective involves an additional premise:

> Intersectoral action can be effective in improving health in general but ineffective in reducing inequities, if its design does not include addressing structural causes.

A third related element is to analyze the goal of intersectoral actions. In this regard three broad approaches can be identified: (1) improving the health of groups with lower socioeconomic status or greater vulnerability, through targeted programs; (2) closing the health gaps between the poorer or more vulnerable social groups and better-off groups; (3) addressing the health gradient, that is, the association between socioeconomic status and health across the whole population. These three approaches differ significantly in their underlying values and programmatic implications. Each offers specific advantages and raises different problems (Graham and Kelly, 2004).

Programs designed to improve the health of populations with low socioeconomic status have the advantage of

targeting limited and clearly defined segments of the population. But this means benefiting subgroups that represent a relatively small percentage of the population, which often undermines the politics of solidarity (Deacon et al., 2005). Moreover, this approach does not imply a commitment to bring health levels in target groups closer to the national average, but only to improve them. Even if a program is successful among the disadvantaged, simultaneous advances in more advantaged groups can lead to greater inequities in health.

An approach targeting health gaps directly confronts the problem of relative outcomes. Such programs also direct their efforts toward more disadvantaged minority groups within the population, but compare them with groups in more advantaged situations; thus, they try to reduce the differences between groups at the two extremes. However, such a "health-gaps approach can underestimate the pervasive effect which socioeconomic inequality has on health, not only at the bottom but also across the socioeconomic hierarchy" (Graham, 2004). Finally, tackling the health gradient across the entire socioeconomic spectrum provides a much broader model for planning action on health inequities. In fact, with this approach the fight against health inequalities focuses on improving the health of all, including groups located in the middle of the social scale (Graham, 2004; Stronks, K., 2002; Solar, O.; Irwing, A.,2007).

3. Scope of the intersectoral approach in Latin America

Focusing on the Region of the Americas, we find that when the reduction of health inequities has been an objective, it has been part of very diverse kinds of public policies. A study by Cunill (2005) on experiences with intersectoral work on social policies in Latin America, particularly in Argentina, Bolivia, Brazil, Chile, and Mexico, suggests that health has played a marginal role in the development of intersectoral actions for equity but that there are various windows of opportunity to expand and deepen this strategy. One of the findings is that, in recent decades, the intersectoral approach has become central to various public policies on two different rationales:

a) Policy-based: expressed as an effort to modify the logic of public policies, and in particular of social policies, moving from a focus on solving specific needs to proactive action aimed at ensuring a decent quality of life as a right of citizenship.

b) Technically-based: expressed as an attempt to make governmental capacities and structures more flexible and ensure management aimed at collective problem-solving, or else an attempt to reduce governmental structures and rationalize expenditures.

Clearly, a policy-based approach offers greater opportunity for intersectoral actions aimed at equity.

The cited study shows that taking one approach or the other has led to different institutional combinations, depending on: (1) the phases of policy-making: the intersectoral approach may be taken in all policy formulation and implementation processes or only in some of them; (2) policy coverage: the intersectoral approach may be taken in all public policies, only in social policies, or only in specific social programs.

The analysis of these areas and their combinations helps define the environments in which the intersectoral approach has been developed and promoted in the Region in recent decades (see Table 1).

Table 1. Examples of the intersectoral approach in Latin America, by coverage and phase of public policies

Policy coverage / Policy management phases	All public policies (PP)	Only social policies (SP)
Formulation and implementation of policy (FI)	**FI-PP CASES** Suprasectoral governmental structures that act in micro-territories to address the full range of public policies in a given local area. (e.g., some subnational governments in Brazil).	**FI-SP CASES** Matrix structures for formulation and implementation of integrated social development projects. (e.g., some experiences with Healthy Municipalities and Agenda 21 in municipalities and states in Brazil and other countries). Systems made up of line ministries / a central coordinating authority / intersectoral entities at the national and subnational levels / local network implementation for development of national social programs involving several sectors. (e.g., conditional cash transfer programs such as Oportunidades in Mexico, Bolsa Família in Brazil, Chile Solidario in Chile, etc.; new social protection systems such as the Intersectoral Social Protection System in Chile).
Formulation of policy (F)	**F-PP CASES** Suprasectoral ministries that replace functional ministries. (e.g., Bolivia between 1993 and 1997). Committees or interministerial cabinet offices for cross-sectional issues or integrated development approaches. (e.g., National Council on Economic and Social Policy, CONPES, in Colombia; Chambers of State in Brazil; interministerial committees in Chile and Colombia, etc.).	**F-SP CASES** Social cabinet offices [with ministers] and National Social Policy Coordination Boards [with second-level ministerial officials]. (e.g., Uruguay [combines both]; Social CONPES in Colombia; Intersectoral Committee for Social Development in Mexico). New ministries of social development as regulatory entities for social policy. (e.g., Chile, Guatemala, Uruguay, etc.). Ministries for coordination of social development. (e.g., Ecuador). Central authorities or coordinating commissions for specific social programs. (e.g., interministerial committees on policies for children, youth, older adults, etc.).

Source: Adapted from Cunill (2005) and updated with data from Repetto (2010).

The table shows examples of efforts to redesign governmental structures so as to shift the focus from "sectors" to "problems," and from the provision of programs to the needs of the population.

For several years (1993-1997), Bolivia carried out an experiment at the national level in which the traditional functional division of the ministries were replaced with an intersectoral division, using a unified structure to achieve a more strategic implementation of all public policies (case F-PP). This implied creating a single ministry devoted to social issues, absorbing the ministry of health, among others. However, due to conflicting powers, this structure existed only for a short time, and the experiment did not prove the effectiveness of this type of design.

In any case, there are very few documented experiences where the intersectoral approach acts as the linchpin for a new way of planning, implementing, and monitoring the implementation of all public policies across the entire governmental structure (case FI-PP). All the findings in this regard have a clear spatial delimitation, whether at the state or municipal level (where legal regulations provide organizational autonomy to make significant modifications to the governmental structure) and almost all are from Brazil. These include the experiences of the Municipal Administration of Fortaleza (state of Ceará), the state of Maranhão, the Municipal Administration of Belo Horizonte (state of Minas Gerais), and the Municipal Administration of Tres Lagos (state of Mato Grosso do Sul). In general, such experiences at subnational level have consisted of the creation of suprasectoral regulatory bodies for territorial policy-making, as well as decentralized policy implementation. An example of this is in the municipality of Fortaleza in Brazil, where two kinds of changes occurred: a move toward integration, which resulted in the grouping of the traditional secretariats in suprasectoral regulatory organs (Secretariats for Social Development, Territorial Development, and Governmental Action); and a move toward decentralization, through the creation of regional secretariats in micro-territories. The objective in this type of experience has usually been a proactive effort to achieve a decent quality of life for the inhabitants of a given territory; in some cases, equity has also been an explicit objective. However, other experiences (for example, Maranhão) have been aimed mainly at greater efficiency (i.e., reduced expenditures) in governmental performance; in such cases the intersectoral approach has been simply technical and not based on a policy for social change, unlike the cases of Fortaleza and Belo Horizonte.

At the national level, the intersectoral approaches that encompass several types of public policies generally have mixed rationales, cover only the policy-making phase (case F-PP), and do not result in changes to the traditional ministerial structure. As the table illustrates, the usual practice is to group several ministers in a committee, cabinet office, or advisory body to deal with cross-sectional issues. Such an entity most commonly has an executive secretariat located in the most directly related line ministry, although in some cases there may be some degree of involvement (for example, monitoring) by the Ministry or Secretariat of the Presidency. In a broader sense, one of the experiences with the longest history is CONPES of Colombia, created by law in 1958 as the highest national planning authority, advising the government on all matters related to economic and social development (Repetto, 2010: 70). There is also a Social CONPES, which is involved in setting priorities for social policy (Repetto, 2010: 70).

It is in the field of social policy that efforts toward inter-sectoral designs are most visible, specifically in terms of policy formulation (F-PS cases). Although there is no consensus on the inclusion of "social cabinets"[1] in this phase, in general these began to be created in the 1990s as entities that would bring together different ministers within the social sector for priority-setting, allocation of resources, follow-up, evaluation, and coordination of social policy, and in this way would provide a "social authority" to counterbalance "economic authority." More

[1] A review of experiences with the functioning of social cabinets shows that not all function as policy-making entities; many instead have operated as coordination bodies that oversee the implementation of sectoral policies requiring the synergy and participation of several sectors, but without translating this into preparation of an integrated public policy of the various sectors.

recently such cabinets have been included in ministries of finance, although assessment of results has tended to show that these have not always been good experiences (see Repetto, 2005). Some more sophisticated structures of this type have arisen in Mexico and Uruguay, among other countries. In Mexico, the Social Development Law enacted in 2004 establishes an Intersectoral Committee for Social Development, which is intended to ensure comprehensiveness in the design and implementation of national social development policy and related plans (it proposes amounts for social spending in the provisional budget draft, among other actions). With regard to Uruguay, Repetto (2010) reports on two institutional mechanisms created in a coordinated process during the first leftist government: a Social Cabinet, made up of ministers, and a National Social Policy Coordination Council, involving second-level ministerial officials, to work toward developing a plan to reduce not only poverty but also inequality (the Equity Plan). Repetto affirms that this combination of mechanisms, together with the conditions in Uruguay (such as a culture inclined toward seeking agreements), made it possible to deal with both political and budgetary tensions and to marshal the technical knowledge needed to move from decision to implementation.

Another institutional design that transcends the use of collegial entities (although it includes them) has been adopted in Ecuador, where a Ministry of Social Development Coordination has been operating for some time. According to a 2007 decree, this ministry is in charge of coordinating policies and actions in the social sector adopted not only by the ministries directly linked to it, but also by others such as the ministries of finance, agriculture, livestock, aquaculture and fishing, urban development and housing, etc. In this case, it should be noted, there was a deliberate presidential decision to form ministerial structures that would focus on coordination, without diverting their energies toward program implementation (Repetto, 2010).

In addition, in recent years there has been a marked tendency to organize ministries of social development in an attempt to give greater political status to social policies. This has occurred, for example, in Chile, Guatemala, and Uruguay itself since 2010.

Such broad initiatives covering formulation and implementation of social policy (FI-SP cases) have generally been associated with the social agendas of subnational governments on the basis of territorial integration of either health promotion (healthy municipalities) or sustainable development (Agenda 21), promoted by the Pan American Health Organization (PAHO) and other international agencies. There are also experiences (especially in Brazilian municipalities and states) that seek to orient all social policies toward an overarching goal such as the quality of life and social development. When this occurs, the intersectoral approach tends to have a clear political basis (associated with projects of progressive governments) and is often implemented through matrix structures in integrated projects (for example, social inclusion, and economic development).

In any case, the most prevalent current approach is to incorporate the intersectoral approach into the formulation and implementation of national programs for poverty reduction through conditional or unconditional transfers and, more recently, social protection systems (FI-SP cases). Experiences led directly by municipalities are also noteworthy. Such cases, which currently provide windows of opportunity for intersectoral actions in the health sphere aimed at equity, will be discussed below.

4. Institutional, economic, political, and social frameworks for intersectoral experiences

Change does not occur in a vacuum. In fact, the emergence of new intersectoral policies and social protection systems in Latin America has been driven by an array of broad underlying causes, including the limited effects of previous attempts to address poverty and, consequently, the increasing risk of social and political instability (CEPAL, 2009). Furthermore, the trend is not uniform, but is influenced by different institutional contexts, the ideological positions of governments, and degrees of

influence exerted by international agencies such as the World Bank, the Inter-American Development Bank (IDB), and the International Monetary Fund (IMF). In some cases, drastic changes (e.g., changes in demographic structures) have also influenced the recent development of the intersectoral approach.

It should be kept in mind that both the objectives and the implementation of social policies are framed within broader political and ideological contexts. As Gunatilleke et al. (1984) have noted, "the political framework and the socioeconomic changes that have taken place are closely related."

Furthermore, the analysis must take into account the profound institutional transformations in the public sector in the majority of Latin American countries over the last three decades. These have involved powerful movements toward privatization and decentralization. They have also brought about radical changes in the rules of the game in the public sector, with the intent of extending market logic to the State (Cunill, 2012). Economic crises, dominant ideological contexts (neoliberalism, neoconservatism, libertarian currents, etc.), and dominant theoretical contexts (public choice, new institutional economics) have led to the configuration of a "new public sector" within the framework of the "second generation" of State reforms promoted by the World Bank and the Inter-American Development Bank, among others.

One of the most significant effects of the introduction of market mechanisms in the public sector is the changing shape of the sector itself. In fact, although there are differences among the countries of Latin America and the trend is not unidirectional, it is evident that the presence of the private sector in public activities has expanded significantly with State support, further strengthening a role previously established by the wave of privatizations. The difference now is that activities undertaken by the private sector receive essentially public financing (Cunill, 2012).

Data are not available on the exact proportion of social services provided in each country by public organizations, commercial entities, nonprofit organizations, and social organizations dedicated to the public interest. However, the fragmented available data suggest that the delivery of social services by commercial entities has grown especially rapidly. With few exceptions, Latin America has adopted more extreme market mechanisms for the provision of public services than in the countries where this approach first arose (Cunill, 2012). For example, immediately after the most profound transformations in this direction in the United Kingdom, the public sector, while losing its economic role, continued to play a strong social role (Ferlie et al., 1996: 3, cited by Cunill, 2012). It continues to finance and provide key goods and services in health, education, research and development, criminal justice, and social security.

Against this backdrop, citizens in Latin America have less confidence in the capacity of the State to solve their problems. For example, while in 2003, 57% of the inhabitants of the Region said that the State was the institution that had the most power, in 2005 this percentage declined to 49%. In contrast, the perception of the power of large companies increased from 40% in 2003 to 44% in 2005 (Corporación Latinobarómetro, 2005: 18, cited by Cunill, 2012).

In short, in most Latin American countries where processes of market-centered State reform have taken place, there have been profound changes in the relationships between the State, the market, and society. This has reduced the power of the State within the public sector and has also led to greater fragility in terms of citizenship itself (Cunill, 2012).

In this context, although social spending has increased, social rights have become restricted in much of Latin America. The coverage of education and health services has increased, but so have prices, even of services provided directly by the State. The most notable effect has been a profound *segmentation of services*, which has maintained and even widened social inequalities, and which puts a renewed focus on the State to address these inequalities (Cunill, 2012).

It is clear that the most important problems facing most of Latin America include poverty and inequality; the absence of universal access to basic public services of good quality; political patronage, patrimonialism, and corruption; and problems of territorial cohesion (Villoria, 2013).

Other significant problems include limited levels of professionalization in the public service (Longo, 2002); very fragmented governmental structures; and weak civil societies (although with a rising trend; see, for example, Delamaza, 2005). The overall context reflects limited efforts to implant a true welfare state, with the exception (despite limitations and criticisms) of the processes initiated in Argentina, Brazil, Ecuador, Uruguay, and Venezuela, among others.

In short, although there are windows of opportunity in the Region to move forward with implementation of intersectoral actions for health equity, there are also structural problems in practically all countries. It should be stressed that the opportunities cannot be considered without also taking into account the problems. In most cases, both the origins and results of current experiences can be explained only in this wider context.

It is essential, therefore, to consider every experience in its own context and to take into account international influences, particularly activities by the United Nations, WHO, and PAHO geared to the defense of human rights and respect for ethnic, cultural, gender, and other differences.

5. Hypotheses and rationales

Several hypotheses, outlined below, help explain how the intersectoral approach has been put into practice in Latin America. These hypotheses involve the relationship between the dominant conception of health and intersectoral approaches; the possible levels of intersectoral collaboration and its relationship to health or other problem areas; strategies for integration; linkage between the intersectoral approach and social participation; the relationship between national and subnational levels; and the role of different types of leadership in development of the intersectoral approach.

5.1 The dominant conceptualization of health and its relationship to levels of intersectoral action

The prevailing vision of health and the society as a whole exerts a great influence on the pattern of relationships established, both from the health sector toward other sectors and from other sectors toward health (Solar et al., 2009). This vision tends to model the conceptualization of intersectorality, for example: the role of social participation; whether to focus more on improving State efficiency than on reducing social inequities and addressing the social determinants of health; and the role of the private sector in the design and implementation of intersectoral actions.

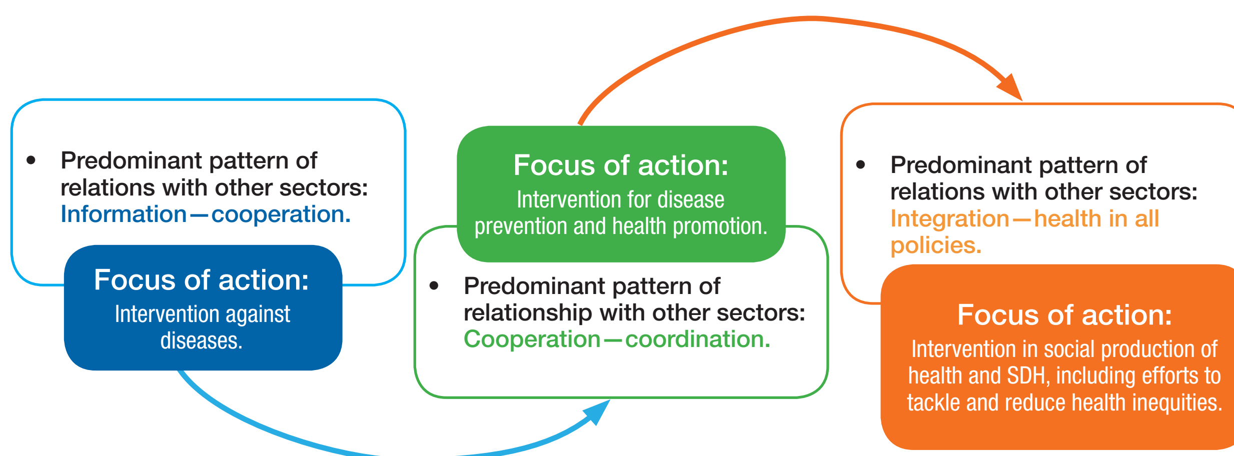
We can conclude, therefore, that the intensity of relations between the health sector and other sectors—i.e., the degree of intersectorality—is connected to the dominant conceptualization of health. The first of these visions of public health, which Gostin (2010) calls an expansive view, mainly involves addressing the structural or underlying social determinants and, at the same time, highlights the relationship between health and disease from the perspective of rights. The second, termed a limited view, is restricted to addressing intermediary or immediate social determinants and emphasizes interventions within the domain of the health sector itself.

This initial assessment allows us to identify whether or not the framework for intersectoral interventions includes the social determinants approach, and thus models the conceptual position or perspective for intersectoral work, leading to the following hypothesis:

Hypothesis 1: There is a certain correspondence between the level or intensity of intersectoral action and the dominant vision of public health in the health sector and other sectors

The findings of Solar et al. (2009), in principle, support this hypothesis, as Figure 1 shows.

Figure 1. Vision of health and society and its relationship to the focus of action and level of intensity of the intersectoral approach



Source: Adapted from Solar et al., page 9 (2009).

In the first box in Figure 1, the intersectoral approach is associated with a vision of health focused on interventions against diseases. This implies a relationship of subordination, with guidance from the health sector to other sectors. The predominant perspective is that of the health sector, with the implication that both relevant knowledge and responsibility lie with the health sector and, accordingly, that actions should be carried out primarily by the health sector. The logic is thus that the health sector designs and implements actions and work plans with the other sectors.

The second box shows a vision of health centered on eliminating or reducing risk factors, along with promoting measures to change lifestyles and habits. The strategies tend to be individual in nature, although they may be applicable to the entire population. In any case, the reduction of inequality is not explicitly included as a priority, and the dominant focus is on the general objectives of the health sector. This means that, most of the time, the relationship with other sectors is based on the sectoral objectives of health, which prevail over "broader" needs of the population. This occurs, for example, with policies to reduce tobacco consumption that are mainly centered on information campaigns. These call for changes in behavior (in this case, consumption) at an individual level of responsibility, often accompanied by population-level strategies such as a tobacco tax. But they do not include actions to create conditions to reduce tobacco use to a minimum or to change tobacco-related habits and needs.

In the last box, the vision of health is associated with a social model for the production of health and disease. This requires analyzing the causes of the distribution of health problems and the social determinants of health inequities. From this perspective, the heath sector, together with other sectors, should carry out deeper structural interventions. This, in turn, means that work in the respective sectors should be guided by the needs of the people rather than by sectoral objectives. It also implies that responses to these needs should be embodied in a new integrated policy or program that takes social determinants into account (Solar et al., 2009).

5.2 Levels of intersectoral collaboration: the state of the art

We have already noted that there are a wide range of potential experiences with intersectorality, according to different public policy approaches informed by different predominant visions of health. We can identify different levels of the intersectoral approach, based on information, cooperation, or coordination, up to full integration of policies and strategies. The key question is what level of intersectoral work contributes most to reducing social inequities, and health inequities in particular.

While the HiAP approach or "whole-of-government" approach in developed countries typically calls for coordination and convergence among different government sectors, the most critical issue requiring intersectoral work in Latin America suggest a need for integration. This is due to the high levels of inequality and social exclusion and, in general, the institutional, political, and social context in almost all countries of the Region, as previously noted.

Accordingly, in Latin America the challenge is somewhat different. The question is not only how to promote coordination, but how and under what conditions it is possible to integrate the sectors for social transformation, including but not limited to the relationship of the health sector with other sectors.

It is relevant, then, to determine whether specific mechanisms, structures, and processes have been recognized as useful in developing an intersectoral approach, which can be defined as the **integration** of sectors for a shared purpose, with an impact on health equity. It should be kept in mind that integration is only one possible type of intersectoral relationship.

In this regard, Solar et al. (2009), based on Meijers (2004), distinguish the levels or intensities of relations between the health sector and other governmental sectors as follows:

- Relations based on the exchange of **information**—a first step or level of the intersectoral approach. This is part of the process of constructing a common language for dialogue and mutual understanding of the logic that the different sectors follow in their work—especially for the health sector to be aware of the logic and priorities of other sectors, with a view to identifying aspects that are shared or important for working together.

- Relations based on **cooperation**, in which joint work between sectors is aimed at improving the efficiency of the actions of each sector. This type of relationship over time can scale up from incidental, casual, or reactive cooperation to actions focused on common problems and priorities, in which activities with other sectors are essential for achievements in health; such actions are often led by the public health sector. This kind of intersectoral action is generally focused on execution or implementation of programs or policies, and not on their formulation.

- Relations based on **coordination**, in which joint effort implies adjustments to the policies and programs of each sector for the sake of greater efficiency and effectiveness. Usually, this aims at establishing a more horizontal framework for intersectoral efforts, along with a more formal work structure and a source of shared financing. This is very important, since in order to create synergies (or at least in order to avoid anti-synergies) within the civil service, it is necessary to have a broader vision of common issues or problems. This is especially true when trying to develop a new approach, such as intersectoral action. It is not sufficient for the different sectors to establish joint planning and definition of responsibilities. It is also essential for this understanding to be reaffirmed in the plans and budgets of each sector.

- Relationships based on **integration**, which generally means developing a new policy or program jointly with other sectors. Thus, intersectoral action is defined not only by the implementation or application of joint policies, but also by joint formulation and financing on the basis of a common social objective.

This classification is similar to the typology prepared by Corbett and Noyes (2008), which distinguishes different intensities of inter-institutional relationships (*communication, cooperation, coordination, collaboration, convergence, and consolidation*), depending on the purposes of the policies or programs involved. Specifically, these authors note that the most transformative programs and agencies focus less on the delivery of specific benefits than on behavioral changes, requiring deeper changes in the sectors themselves and intense relationships between them.

This is also consistent with the heuristic models of Horwath and Morrison (2007) and Winkworth and White (2011), among others. The latter source, based on several typologies of collaboration, identifies three broad levels of collaboration between sectors: networking, coordination, and integration. It also emphasizes that the level of the intersectoral approach should be aligned with the specific purposes being pursued. Thus, for example, if the purpose is to address a high level of risk for children, the level of collaboration necessary within and between the systems must be adequate to protect those children. This leads to the following hypothesis:

Hypothesis 2: There is no single type of joint relationship or effort between sectors, but instead different levels or intensities of the intersectoral approach

In short, given the state of the art on the types of relationship between sectors, we can affirm that the levels of the intersectoral approach are associated with the complexity and depth of the pursued objectives.

Furthermore, considering the high costs of the intersectoral approach (in time, organization, financing, etc.), it would only make sense to seek integration among sectors when the problem is highly complex, when it is necessary to deal with high levels of vulnerability, and when profound changes are needed in the behavior of individuals and their families, as well as in their environment.

Therefore, the "best" strategy may be to aim for less ambitious levels of intersectoral collaboration when these conditions are not met. However, less ambitious approaches could still be part of an integration strategy, assuming that one level of collaboration can subsequently facilitate a higher level. The greater problem would emerge when, in practice, the collaboration strategy does not match the specific social changes pursued.

All the above leads to another hypothesis:

Hypothesis 3: The level or intensity of the intersectoral approach must be consonant with the related public policy goals and the context in which it is pursued

Although such consonance does not always occur, it is evident that for policies or programs aimed at comprehensive approaches to human development, integration is the most appropriate intersectoral relationship. The key question is how such integration can be achieved.

5.3 Models of intersectorality. What should be analyzed?[2]

We postulate that at least three variables affect the shape of the intersectoral approach, understood as integration of government sectors for the purpose of comprehensive change aimed at increasing equity. These variables are: the level of inclusivity in the policy-making cycle; the level of collaboration in the implementation of actions; and the level of change in preexisting organizational forms. These are examined below, showing their possible scope and how they function as both causes and results of the intersectoral approach.

a) Level of inclusivity in the cycle of policy design, budgeting, and evaluation

There is general agreement that when intersectoral action is proposed, it is first necessary to change how problems

[2] This point is based on Cunill (2014). The references to other authors can be found in that document.

are defined and solutions are planned. In broader terms, based on a comprehensive review of the specialized literature, Bryson et al. (2006: 47, cited in Cunill, 2014) propose that "the form and content of the initial collaboration agreement, as well as the processes used to formulate it, affect the outcomes of the collaborative work."

In this regard, the need for *joint planning* is stressed by the majority of specialists who address intersectoral approaches. It is also noted that adopting a rationale of integration also implies including it in the *budget*, since a breakdown of expenses by sector would not be in the spirit of an intersectoral approach.

Similar changes are needed in *performance evaluation* systems which, if focused solely on results by sector, or limited solely to measuring outputs rather than impacts, could lead to serious difficulties in implementing an intersectoral approach. Moreover, collaborative accountability requires a measurement system that documents joint results over time.

A *unified administration* system based on clearly identified shared objectives would be the expression of full integration translating into "inclusivity throughout the policy cycle." This, accordingly, would imply that planning, budget formulation, and monitoring and evaluation would all become intersectoral rather than sectoral in nature. Thus, when we refer to inclusivity, we are saying that this is both a result and a cause of the intersectoral approach.

b) Level of collaboration in policy implementation

In general, collaboration refers to bringing together people, forces, financial flows, or sectors to achieve a common goal. Here we emphasize joint work across sectors in the policy implementation phase.

There is greatest consensus around intersectoral action implying the existence of systems or mechanisms to facilitate *the sharing of information and financing*. Nevertheless, collaboration also requires a commitment to implement actions for a common objective or simply the *standardization of certain processes* to make implementation predictable and uniform.

The highest level of integration in the policy implementation phase involves *sharing resources, responsibilities, actions, and standardized information systems*. In this case, integration would be true collaboration.

c) Coverage of suprasectoral and intersectoral organizational structures

Intersectoral arrangements can constitute "*soft*" organization (for example, an interministerial committee) or they can involve *profound changes in organizational structures* and the work methodologies of every sector involved, giving rise to a new structure. These arrangements can even result in the creation of a different entity that merges previously distinct entities. In any case, the diverse literature on interagency collaboration underscores the need to establish, at minimum, "common arrangements for governance," that is, spaces or entities where the sectors involved in an intersectoral action can at least express their interests and try to reconcile their differences.

These points lead to the following new hypothesis:

Hypothesis 4: The ways that the intersectoral approach is organized, managed, and financed affect its intensity and results

Taking into account all of the above, true integration implies that government sectors engage in an inclusive process of decision-making and evaluation, collaborate in implementation, and share common governance structures. This in turn implies a shared design and planning process; common financing arrangements (joint budget, co-financing through delegation to a third party, agreements for transfer of resources from a central authority, or redirection of preexisting budget allocations, among other options); shared evaluation; and intersectoral governance structures.

5.4 Social participation and the intersectoral approach

It should also be pointed out that public participation, at least in the planning and evaluation phases, is critical for the success and sustainability of intersectoral collaboration (see Cunill, 2005 and 2009; Solar et al., 2009).

However, it is important to note that the dominant approach to health also influences forms of social participation, as illustrated in Figure 2 (Solar et al. 2009).

A vision of health that focuses on interventions against diseases also tends to focus on providing information to the population and civil society, constituting a model of social participation rather than social control of health.

A vision of health linked primarily to disease prevention and health promotion tends to be based on dissemination, information, and technical assistance aimed at changing the behavior and habits of the population.

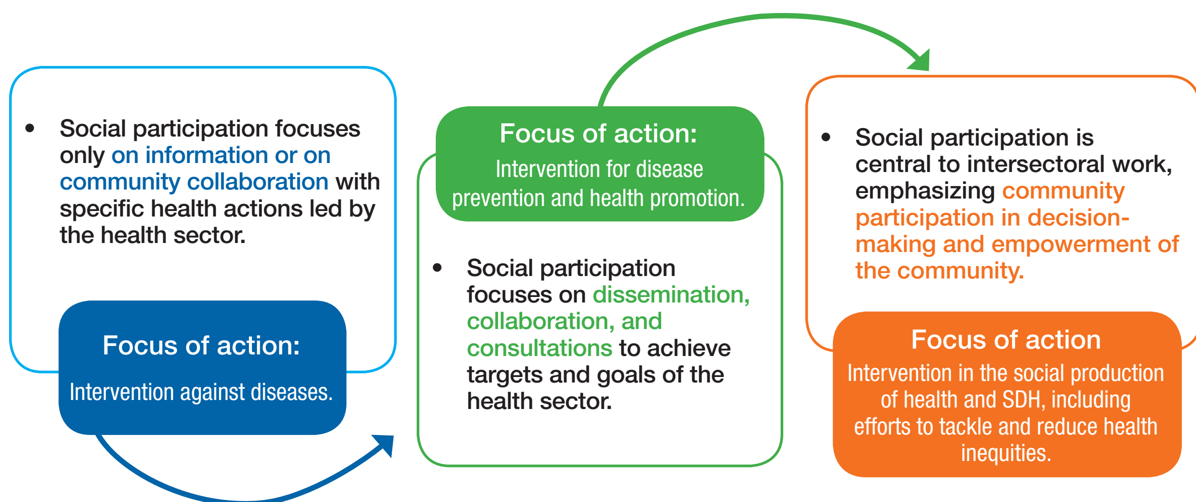
In contrast, when the focus is on social production of health, social participation becomes a strategic element, based on consultation and aimed at empowerment of citizens for social transformation.

These observations lead to the following hypothesis:

Hypothesis 5: There is synergy between social participation and the intersectoral approach, especially for efforts to advance equity in health

This hypothesis implies that in order to characterize an experience in intersectoral action for health equity, one should consider what kinds of social participation help to empower stakeholders, rather than simply integrating them into a system that may be exclusive in character. As noted by Villalba, p. 10 (2006), “the fundamental issue is not to measure to what extent a given strategy is participatory, but to analyze what conditions must be met by processes of popular participation to promote greater empowerment,

Figure 2. Vision of health and society and its relationship to forms of social participation



Source: Solar et al. (2009).

development, and well-being." The key is not only to determine how many opportunities exist to influence and control decision-making to a greater or lesser extent, but to seek ways in which the majority of the population can access the means to define the terms and nature of their participation (Kaufman and Dilla, 1997).

Villalba (2006) points out that one aspect to highlight in evaluating the scope of participation is to determine whether participation is regarded simply as a tool (one that may be more or less effective) or is considered to have a value intrinsic to the goals pursued. In the first case, participation is seen as a technique for improving project effectiveness. In the second, participation implies a process that increases people's capacity to improve their own lives and facilitates social change to benefit those marginalized (Cleaver, p. 598 1999).

In the first column of Table 2, Villalba (2006) summarizes four levels of participation according to the interests served, in terms both of ends and means. The second column summarizes the function of each type of participation. The third column lists the interests involved, from "top" to "bottom." The fourth column lists the interests in the opposite direction. The fifth shows how the participants are viewed in each type of participation.

Two clarifications need to be made regarding this classification. However, achieving social representativeness is in itself one of the most important challenges to participation, particularly in terms of the composition of bodies such as commissions, advisory groups, and committees, which by definition have limited membership. Socioeconomic inequalities tend to result in political inequalities, which means that the channels of citizen participation tend to

Table 2. Forms of participation, functions, and associated interests

Form	Function	Interests from top to bottom	Interests from bottom to top	Participants seen as
Nominal Functional	Exhibit Show	Legitimation	Inclusion	Objects
Instrumental	Means	Eficiency	Reduction in costs	Means
Representative	Representation Voice	Sustainability Information	Influence Accountability	Actors
Transformative	Means and end	Empowerment	Empowerment	Agents

Source: Villalba (2006), based on White (1996) and Cornwall and Gaventa (2001).

be dominated by organized interests, reproducing patterns of social exclusion. This is particularly the case when the designation of "representatives" is intentionally geared to serve dominant interests (see, for example, empirical findings in Cunill, 2010a). One of the most critical matters for citizen participation is to achieve the representation of unorganized sectors and minorities, and of the "person on the street." It is essential to confront this issue in order to minimize asymmetrical representation. Decisions on the type of representation are also key: functional, territorial, and mixed representation appear to have different effects on the democratization of decision-making processes.

A second element to consider is the concept of empowerment. A limited type of empowerment involves the capacity of people to be more self-reliant and depend less on State delivery of services, in line with the well-known rationale for promoting privatization. A more radical notion of empowerment, however, would focus on the mobilization of society from the bottom up, as a challenge to dominant interests within both State and market (Mohan and Stokke, 2000). In fact, Villalba (2006) points out that from the Marxist perspective, political power in a capitalist society cannot be separated from economic power, which means that the possibility of empowering marginalized social strata under capitalism is inherently limited.

5.5 Intergovernmental coordination: the relationship between national and subnational levels

Early on, within the framework of "health for all" policies, there was awareness that the relationships between the national level and subnational levels were among the most critical factors in the construction of a national health policy (WHO, 1990). One of the lessons derived from various experiences outside the Region is the importance of using diverse strategies and mechanisms to promote collaboration at different levels of government (Public Health Agency of Canada and WHO, 2010).

This topic, as our research has confirmed, is of central importance in Latin America, both because of the emergence of comprehensive social protection policies with implementation entrusted to subnational entities, and because of the significant roles given to municipalities in implementing intersectoral actions in health within the framework of local social development policies. All this takes place in a context in which the decentralization of health care has become the standard both in federal countries and in many countries with a unitary structure as well.

The specialized literature (see, for example, Cabrero and Zabaleta, 2009) stresses that decentralization promoted from above does not have the same effects as when it is promoted from below. In federal countries in the developed world, such as Germany, Australia, or Canada, this has been a bottom-up process (France, 2007). In Latin America, decentralization of the health sector has almost always been a top-down process, even in federal countries (Cabrero and Zabaleta, 2009; Galilea et al., 2011).

Research in several countries of Latin America, moreover, tends to show that, in general, there are gaps in institutional capacities and resources (Galilea et al., 2011) that limit the levels of autonomy formally granted to municipalities or intermediate entities, especially in primary health care management.

Within this framework, one of the most critical issues for implementation is where policy formulation and implementation should begin: from the bottom-up, from the top-down, or from both levels, interactively. Similarly, it is important to analyze whether there is vertical integration of different levels of government or, at least, intergovernmental coordination.[3]

The following hypothesis arises from these considerations:

Hypothesis 6: The relationships among levels of government (national and subnational) influence the development of intersectoral actions

[3] According to France (2007: 392) "'Coordinating' means ensuring that different governments contribute to harmonious joint action, acting in concert and oriented in the same direction [...]." "Coordination includes reducing the risk of conflict among the levels of government as each carries out its functions and exercises the responsibilities assigned to it by the constitution or ordinary legislation."

It is clear that absolute judgments on the merits of decentralization of health services are not appropriate, nor it can be presumed that collaborative coordination is always better than hierarchical coordination. As France (2007: 392) argues, "ideally the coordination should not be hierarchical, but cooperative or collaborative. However, for many issues the national government may be the most appropriate instrument for coordination of subnational government bodies or, at least, can play a leadership role in this regard." A key consideration is to clarify for which issues this is appropriate, especially with respect to health and its social determinants. In any case, models involving only one level (national or subnational) now are no longer considered adequate, as the creation of synergies between the two levels is indispensable.

It is therefore crucial to know not only to what extent intergovernmental relations do or do not facilitate intersectoral actions in health, but also what institutional arrangements exist to facilitate coordination between the various levels of government.

Some of the literature on this topic holds that the coherence and coordination of public policies is to a large extent determined by whether there is a planning system that links not only the sectors but also the national level and different subregional levels, in a process closely aligned with the national budget (see, for example, Martinez Nogueira, 2009). In Latin America some countries have a long tradition of planning (for example, Colombia and Costa Rica), while others dismantled their planning systems in the 1970s and 1980s. Currently, however, there is a slight trend toward resuming planning (e.g., in Uruguay).

There are also efforts to establish permanent channels of communication between the national government and the subnational levels, such as conferences and advisory services, to encourage intergovernmental consultation on general policy issues that can have an impact on the territories and at the same time facilitate the exchange of information. Such arrangements basically exist in federal systems such as those of Argentina and Brazil.

Thus, an empirical study conducted by Rey (2012) on the operation of three Federal Councils in Argentina (including the health council) showed that there are broad variations in the way agreements are reached on operational policy issues; that the national actor always wields influence; and that the institutional structure ("assignment of authority") in each policy sector establishes the framework within which the kind of "leadership" provided by the national actor and the "professional identity" of the actors determine the degree of articulation achieved. Taken together, the findings show that, in theoretical and methodological terms, in order to study the forms of coordination between jurisdictional levels and determine which approach is more effective, it is necessary to consider both: a) institutional determinants; and b) the specific features of the actors themselves, including their professional and partisan identities.

Finally, to obtain a more complete analytical picture of the level of intergovernmental coordination in terms of its relationship to the effectiveness of intersectoral action in health, we must consider the power that the central level can exercise through transfers to the subnational levels. Outside Latin America, there are "some federal countries that make extensive use of such transfers to promote national health standards on coverage, extent of protection, access, and geographic portability of health care, as well as to harmonize the policies of the subnational governments" (France, 2007: 400). Within Latin America, there are cases where the resources provided by the national level are key, but also others where national resources do not have this level of influence in promoting unity.

5.6 Functionality of types of leadership

As we have argued, it is not possible to ignore the role that institutions play in inhibiting or facilitating joint action. This is because collaborative goals, structures, and results can be radically affected by the institutional frameworks within each government sector, the configuration of the political system, the structure of the executive branch, and the political and territorial structure, to mention only a few factors (Cunill, 2014).

However, as noted above, the actors themselves tend to have different margins of maneuver, whether to collaborate with others or to resist such collaboration. Organizational autonomy tends to be seen (and used) as a resource for political influence. All the types of resources that each sector controls, including symbolic and social capital, are key to the political economy of intersectoral action (who wins and who loses, what their strategies are, how and where they use their influential resources, etc.) (Cunill, 2014). This is the framework in which one sector's leadership can have an impact on other sectors.

Thus it is important to discuss the role of the health sector in particular in shaping the intersectoral approach. Torgersen and Stigen (2007) note that health sector participation can take different forms. The health sector may take the role of "*leader*" on issues where it has knowledge about effective measures and also controls the means to implement them. It can also serve as "*negotiator*" where it is knowledgeable about effective measures but does not control either the arena or the means for implementing the measures. And it can play the role of "*partner*" when it knows about the adverse health impacts of policies in other sectors, but does not control the means for implementation nor have exact knowledge about how such measures should be framed. Examples include interventions in the job market and reduction of social inequalities in learning in schools.

These considerations lead to the following hypothesis:

Hypothesis 7: The development of an intersectoral approach aimed at reducing inequities in health does not necessarily require leadership from the health sector, but does require its participation as a partner

From this perspective, the most effective process for the development of intersectoral action in health does not necessarily imply leadership from the health sector. What is most important is to determine what type of leadership is most appropriate to each particular situation.

6. Mechanisms for exerting influence on other sectors and making the strategy sustainable

As already noted, the forms of organization, management, and financing of intersectoral actions affect their level of intensity and results. Processes for decision-making and for evaluation and monitoring, among others, play critical roles in shaping influence among the sectors and the sustainability of the experiences.

A wide range of mechanisms and tools can contribute to development of the intersectoral approach and to the sustainability of initiatives (St. Pierre, 2009). Examples include:

- Exchange of information among sectors on research, knowledge transfer, feedback from results of evaluation, communications, and other topics.
- Maintaining contacts for planning and priority-setting.
- Maintaining contacts on policy development and implementation.
- Reporting on progress and carrying out joint evaluations.
- Jointly obtaining approval of budgets or resources.

In all cases, it is important to take into account that the mechanisms for initiating and advancing intersectoral action tend to be different from those needed for sustainability of the process. These mechanisms therefore should be examined separately and in their specific contexts (WHO, 2010; Shankardass, Solar et al., 2012).

As noted above, mechanisms that can help make the intersectoral approach sustainable include structures to facilitate meetings and agreements among sectors of government, such as social cabinets, interdepartmental committees, or specific leadership committees. However, the existence of such a structure does not guarantee success of an initiative.

Another mechanism to facilitate the existence and sustainability of intersectoral action is budget integration. Budgetary mechanisms can be an important catalyst for intersectorality, whether through integrated budgets across various sectors, tax incentives for intersectoral collaboration, agreements between sectors on financing shared strategies, or in other ways.

Also important for sustainability are mechanisms for monitoring and evaluation of intersectoral interventions, which can become opportunities for coordination and dialogue among different sectors. Steps should be taken to examine and systematize cases of such evaluations in order to identify learning opportunities through monitoring of the intersectoral approach.

Finally, the sustainability of intersectoral work is also affected by stakeholder capacities, knowledge, and behavior, as well as their ability to work together and the cultures in their different sectors. It is therefore important to provide adequate training to all actors on public health issues, including training on the social determinants of health.

McQueen et al. (2012) point out that the intersectoral approach is effective to the extent that it contributes to integrating health into other policies. This means that its effectiveness should be assessed after the decision-making phase, when intersectoral action has had a chance to make a difference in the results or goals of a policy or strategy; that is, when the results of intersectoral actions have brought about changes in other policies (whether in their rationale, content, financing, implementation, or legal basis), with a positive influence on health or on the determinants of health.

In evaluating effectiveness, consideration should also be given to the extent to which the health sector has integrated the requirements of other sectors into its policies and whether the results have had a real impact on health equity.

The same is true in the opposite direction: a health impact assessment (HIA) is a tool to generate systematic evaluations and predict the health effects of policies outside the health sector, a process that requires consideration of health issues beyond the health sector (St. Pierre, 2009). This tool has also evolved to include the health equity impact assessment (HEIA) designed to determine the effects on health equity of policies or actions in other sectors. There are also variations on these tools for more nuanced analyses, including assessments of impact on environmental health and assessments of gender, sex, and diversity. In addition, there are other tools focused on social impact, emphasizing dimensions of well-being that go beyond health (for example, employment rather than disability-adjusted life years). However, there has been almost no use of these tools in the Region, with the exception of environmental impact assessments that have been limited and nonbinding in terms of implementation of their results and recommendations.

It should be kept in mind that no experience is static. Sometimes strong initial development can be cut short abruptly. Alternatively, an experience can be successfully scaled up. It is key, therefore, to examine the dynamics of implementation as well as the duration of the experiences

being analyzed. Changes in the government's ideological orientation can have decisive effects, as can a lack of legal bases for continuity.

7. The current agenda

7.1 New social protection policies

Currently in Latin America, the intersectoral approach is generally covered by legal frameworks and tends to be associated with national and subnational policies that embody an effort to take a multidimensional and rights-based approach to social issues . In fact, as Repetto (2010, 55) maintains, "at this historic moment one of the most interesting new developments in the field of social policy is that recently anti-poverty actions (scattered, fragmented, and often irrelevant) have begun to give way to broader approaches, related to what has come to be called social protection." This approach encompasses a set of critical but previously separated factors such as human capital, individual and collective risks, and linkage between economic and social factors. It emerges as an appropriate complement to different areas of social policy, such as health and education (Repetto, 2010, 55).

Actions by the health sector, at least those encompassed by this type of social policy presume that a broader understanding of social protection requires more than simple connections or groupings between government sectors and with other sectors. Repetto (2010) and Cunill (2010, 2014), among others, argue that the concept of *comprehensiveness* underlies the intersectoral approach.

This trend, putting intersectorality at the center of new social policies, offers a window of opportunity for the struggle against inequities in health. However, the trend is not uniform, nor is the understanding of social protection. In fact, two different visions of the scope of social protection currently coexist. One is the traditional vision, which although rights-based, targets only poverty and social vulnerability. The other emerging vision takes a more inclusive approach to human rights, associating them with universality and nondiscrimination. At the same time, two visions of comprehensiveness also coexist. One conceptualizes it as coordination of services to ensure that users have access to all available services. The other sees comprehensiveness as a new way of confronting the multidimensionality of social problems, emphasizing social transformation and, in broader terms, the relationships among political, social, economic, and cultural rights.

Each vision of social protection tends to be associated with a given vision of comprehensiveness. It is clear, accordingly, that each vision of intersectoral work has a different potential to advance equity in health. Nevertheless, this is a field still open for debate on the current agenda.

7.2 Municipal initiatives for social development

At the national level, in addition to the growing emphasis on intersectoral policies and social protection systems that also encompass the subnational levels, some Latin American countries have had experiences in intersectoral work driven by the objectives of the municipalities themselves, focusing on social development in a given territory.

This is a long-standing phenomenon found mainly in Brazil, as was noted earlier. Inojosa (1997) shows that the decentralization of the health services that began in 1987 at the state level did not originally give municipalities an important role. They did accumulate functions over time, but tended to reproduce the structures of the state secretariats which, in turn, reproduced the structures of the federal ministry, along with a parallel structure of deliberative health councils at the three levels of government.

From the organizational standpoint, several municipal health secretariats introduced the concept of health districts or "silos," directed at specific populations and risk groups, through coordinated actions for disease prevention, health promotion, and health care, as well as their linkage with the management of other policies implemented in the area (Inojosa, 1997).

In an evaluation of these initiatives up to 1997, ten years after the process began, Inojosa notes numerous positive evaluations in municipal governments that tried, with relative independence, to assume the management of the local health system. However, the author concludes, “It is precisely in those municipalities whose evaluations were positive where one can best see the limits of a project that aimed to spearhead a process of social development but that was confined to a single sector” (Inojosa, 1997: 4).

As we have noted, current initiatives in various countries go beyond the health sector, while still including it. These tend to be promoted by subnational governments, often with backing and even direct support from the central level. Analysis of this trend, although still in process, is of utmost importance in terms of possible windows of opportunity for intersectoral action for health equity, especially where such action converges with a broader effort to achieve social transformation.

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