Engagement of Sectors Other than Health in Integrated Health Governance, Policy, and Action

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Abstract

Health is created largely outside the health sector. Engagement in health governance, policy, and intervention development and implementation by sectors other than health is therefore important. Recent calls for building and implementing Health in All Policies, and continued arguments for intersectoral action, may strengthen the potential that other sectors have for health. This review clarifies the conceptual foundations for integral health governance, policy, and action, delineates the different sectors and their possible engagement, and provides an overview of a continuum of methods of engagement with other sectors to secure integration. This continuum ranges from institutional (re)design to value-based narratives. Depending on the lens applied, different elements can be identified within the continuum. This review is built on insights from political science, leadership studies, public health, empirical Health in All Policy research, knowledge and evidence nexus approaches, and community perspectives. Successful integration of health governance, policy, and action depends on integration of the elements on the continuum.

INTRODUCTION

This review is predicated on the following assumptions: (*a*) Health is created largely outside the health care (or disease) sector; (*b*) the health care (or disease) sector, however, often carries social ownership of all health issues, even when they are beyond its control; (*c*) the health sector itself is a reproduction of (power) divisions in the public and private sectors and, while calling for integration, is itself fragmented; and (*d*) calls for broad social engagement with integrated research, policy, action, and governance for health may not align well with assumptions *a*–*c*.

The purpose of this article is to provide an evidence-based overview of how broad social engagement in health policy, action, and governance can be initiated, developed, and sustained. Grounding the argument in the above four predicaments, we must assess the impact and influence of "outside health" sectors on health; how the traditional policy, governance, and action repertoire of the health sector has framed possible engagement of those outside health sectors; and what ideas and programs such as Health in All Policies and Healthy Cities bring to integration developments at the interface between health and nonhealth sectors.

WHO AND WHAT DETERMINES HEALTH?

The recognition that health is created by individuals in their social and physical environments can be traced back to the earliest records of human history (15). Depending on cultural, religious, social, and technological contexts, the designation and balance among sources of health have varied over time (78). With the advances of the Industrial Revolution in the nineteenth century, and the increasing technology-based specialization of the health field, the emphasis of the conceptualization and attributions of the sources of health shifted to what is now called a biomedical model of health (20, 93). This terminology implied that health was created or challenged by classes of pathogens and events, ordered into clear categories or strata, e.g., the ICD (International Classification of Diseases) or the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) (9). Since the 1970s, the pendulum has been swinging back to balance the technological view with more socioecological perspectives (69).

The Canadian Social Determinants of Health Framework Task Group produced an inventory of 36 frameworks that bring together integrated views of what causes health (13). The Task Group selected the seven most common models and discussed them in terms of the degree to which they explain and prioritize categories of determinants (the explanatory frameworks), show interactions and consequences of determinants (the interactive frameworks), and demonstrate actions to influence and shape determinants of health (action-oriented frameworks). Rarely is a framework exclusively one of these; the First Nations model (**Figure 1**) is one example of an approach that covers all three. This model helps to distinguish between sectoral determinants, governance arrangements (the pivotal autonomy and community-control aspects of Indigenous well-being), belief systems (an emphasis, common among First Nations around the world, on life course approaches in an ecological context, here referred to as "medicine wheel" and "lifespan"), and an outer ring of social connectedness and capital. The different levels of causation provide a useful distinction to start considering broader engagement for health.

Another Canadian effort at mapping the causes and factors of health inequity takes an evolutionary analytical approach of causal (cause–effect) and final (intervention–outcome) relations (**Figure 2**) (39). It attempts to explain the mediating and connecting relations in terms of psychoimmunological responses, in search of explanations for why groups at the high end of the socioeconomic gradient respond more healthfully to pathogenic threats than do those at the lower end. What seems to be missing is an interpretation of, or suggestions for, society- and community-based responses either within the domains or in relation to the connections between these

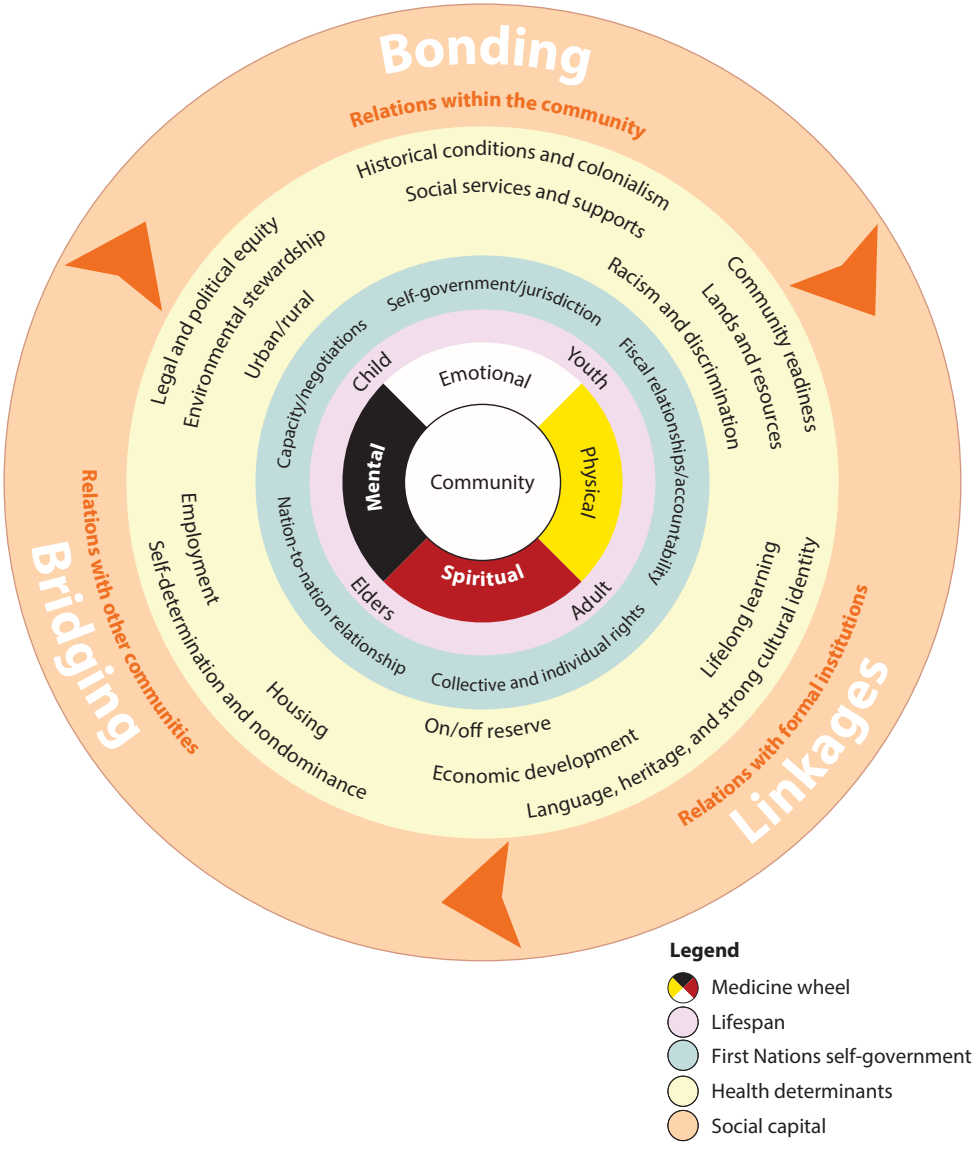

Figure 1

First Nations holistic policy and planning model (13).

domains. Although those social responses are present in most if not all the social determinants models investigated by the Task Group (13), they have not been classified unequivocally or mapped systematically across sectors and domains (26).

CONNECTING FOR HEALTH—ENGAGEMENT WITH OTHERS

The 1960s and 1970s saw the rebirth and growth of a broader conceptualization of health and its determinants (8). Critical were the environmental and women's health movements [e.g., the

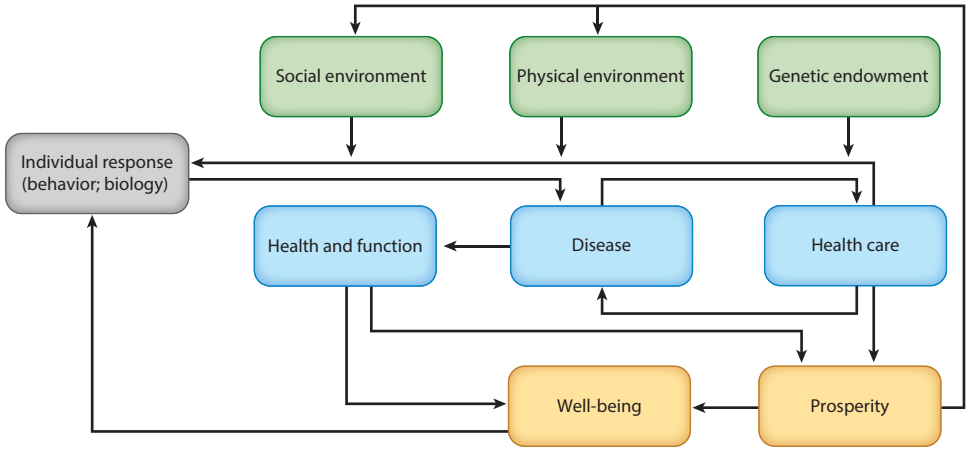

Figure 2

The causal-final relations model of *Why Are Some People Healthy and Others Not?* (39).

Boston Women's Health Book Collective (86)], which argued that those affected by system change and the decisions that drove such change should have a voice in determining their fate. The emancipatory perspective aligned well with the critical scholarly perspective on the "medical-industrial complex" (38). Critics of the biomedical professional gaze adopted a broad range of different stances, including the notion that the health care system is shaped through the medicalization of ordinary life events (17) to perpetuate a medicalized middle class (44), even extending the medicalization insidiousness into health rather than into medical treatment alone (18). The opposition to this systems dominance extended to perverse market mechanisms driving Big Pharma (1), the hermetic nature of health professions, and, in particular, the medical class (124) and how medical care in fact created, rather than cured, disease, a process known as iatrogenesis (64).

The emancipatory social health movements adopted these criticisms to revolt against the medical-industrial complex, either by separating themselves and taking fate into their own hands (86) or by trying to identify policies and mechanisms that would enable a health view rather than a disease view. The work by Antonovsky (2) on salutogenesis was important, although Kelly & Charlton (68) criticize the idea that salutogenesis provides a radically new gaze in the determinants of health discourse. Whether caused by iatro-, saluto-, or pathogenesis, there is a reductionist paradigm that links a cause to an individual health effect.

A political and systems-level solution to the dominance of a medicalized/medicalizing health care system was proposed by Milio (80) and Hancock (54). They simultaneously came up with the term "Healthy Public Policy" (HPP) in the mid-1980s (27). Milio authored the seminal book *Promoting Health Through Public Policy* (80), which had a major impact on the development of the Ottawa Charter for Health Promotion (123). Calling for a new public health, the Charter recognized that promoting health required enabling, mediating, and promoting a reorientation of health services, development of supportive environments for health, and community action, as well as personal skills. To support and reinforce these health promotion strategies, the Charter identified that HPPs were required, that is, policies at every level of government should take positive and/or adverse effects on health explicitly into account (113). The glossary (87) describes HPP as "characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy public policy is to create a supportive

environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing" (p. 359).

Fafard (41) believes that such a perspective on "a wide range of policies and program interventions that seek to make real change in the wide range of health determinants both at the national and international level" is "perplexing as it leads to a definition that encompasses most of what governments do (and beyond)" (p. 1). Marmor & Boyum (75) make the point even more succinctly: "It is naïve to assume that identifying a cause of ill health—like poverty—does much in itself to mobilize action against economic want" (p. 38).

Perhaps the Ottawa Charter, and Milio's identification of the full spectrum of government sectors potentially impacting on health, reflected an idealistic Zeitgeist that endeavored to deliberately shape a better future and believed in the power of rational approaches to evidence-based policy (12, 88). But the lasting legacy of the Ottawa Charter also shows that the visionary perspective has considerable appeal (21, 55). There is very little empirical evidence on the success or failure of HPP, with some positive (33) and other more mixed (41) assessments. At the local level, HPP seems generally successfully developed (29). Unfortunately, most scholarly authorship on HPP remains abstract and rhetorical (10) and devoid of foundation in policy studies and political science (11, 28, 41).

SECTORAL AND CROSS-SECTORAL—POLICY, ACTION, AND GOVERNANCE

Recognition of the fact that health determinants lie outside the sphere of the health sector has led to repeated calls for intersectoral action. The adoption of the Alma Ata Declaration of Primary Health Care (108) was pivotal but mention of intersectorality decreased after the adoption of the Ottawa Charter for Health Promotion (123). This also had to do with a regression from a more comprehensive (horizontal) view of primary health care (109) to efforts that frame the concept as being applicable to specific disease management programs (103) (see **Supplemental Figure 1**. Follow the **Supplemental Material link** from the Annual Reviews home page at **http://www.annualreviews.org**).

Supplemental Material

Intersectoral health, as advocated by the World Health Organization (WHO) and as argued over several decades now, is needed to improve the health of populations. A 1986 WHO report (112) provided insights about how other sectors contribute to health and development. The report was a coproduction between the WHO and six other peak UN bodies. It appears that no significant progress has been made because the Health in All Policy (HiAP) statement of the Eighth Global Conference on Health Promotion in 2013 (121) includes a similar array of partners, e.g., the OECD, the United Nations Development Program, the International Organization for Migration, etc., and offers similar recommendations. The 1986 report says,

> [E]fforts point to the potential resources that are available for health promotion through intersectoral action. But it cannot be said that they have as yet led to a comprehensive intersectoral approach that would enable the health sector to collaborate with other sectors to shape and influence their health-related components towards a positive outcome in health. (112, p. 13)

In the 30 years since this first significant effort to document and change other sectors' involvement in health, there has been a substantive growth in rhetoric that describes the problem. There have been calls from various disciplines and fields to establish—beyond the (multi)(inter)(cross)-sectoral jargon—joined-up government, whole-of-government, integrated governance (14), and

other comprehensive ideas to align distinct and separate views, disciplines, public sectors, and industry delineations toward health.

THE OWNERSHIP OF HEALTH

Integration, joining up, and providing coherence are all approaches to resolving one of the scourges of modern society and its bureaucracy: hyperspecialization, organizational silos, and lack of cross-silo engagement (82). Gusfield (53) has offered a sociological explanation of this phenomenon and its impact on policy development. He argues that, in the process of determining whether a public policy is deemed necessary, stakeholders assume or attribute ownership of social problems. Some social problems would be "easy" or within the legitimate domain of particular actors and their ownership is claimed and held, whereas for other classes of problems [in particular "wicked" or "fuzzy" ones—often seen in health, for instance, around the current obesity issue (25, 42)], stakeholders seek to disavow ownership. In those cases, the ownership may fall to an actor by default; it seems that complex issues in the area of livability and well-being thus become owned by "the" health sector.

If our aim is to present an inventory of methods of engagement with sectors other than health, then we need to provide (*a*) an overview of sectors that (may) have significant impact on individual and population health; (*b*) a finer-grained assessment of the health sector to enable identification of particular professions or fields that would engage; and (*c*) a particular scope and direction of engagement to distinguish between types and levels of change. Although Milio has demonstrated that virtually every walk of life, public policy, and civil society impacts on individual and population health (80), the sectors that have been identified persistently are education (114), housing and urban planning (115), transport and mobility (117), social protection and welfare support systems (116), and energy and sustainable development (119).

As has been argued for instance in the Ottawa Charter (37, 123) and in the Constitution of the WHO, there are clearly fundamental prerequisites to health (peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity) that interconnect and pervade a broader development agenda. However, the five sectors listed above have been thoroughly explored and mapped as having significant potential to impact on people's health in economically feasible and advantageous ways (118). Economic evaluations of intersectoral approaches to the social determinants of health generally fail to address distributional (equity) effects across the existing social gradients (77); economic arguments on health challenges seem to be a policy-critical "frame" (101) for successful engagement in horizontal public policy efforts. McIntyre & Mooney (77) show that inequity is inefficient and holds back national development, an argument sustained by Pickett & Wilkinson (90).

The question for the public health community is how to engage with these other sectors for mutual health and development benefit (37). A WHO report (118) suggests that there are three types of interventions at the interface of sectoral interests (**Figure 3**). Below we argue that such interventionist language may not be the most appropriate approach.

These types of interventions suggest the need to develop a more bespoke and differentiated view of what HiAPs are, can be, and should be. Some HiAPs are driven and owned by the health sector (type 1); others are perhaps initiated but co-owned with the health sector (type 2); and some are owned by other sectors with possible health sector input (type 3).

In all cases, we need a clearer view of the drivers and barriers of sectoral thinking, which would enable the developer of these types of interventions to blur boundaries and transcend siloed thinking. Concepts such as joined-up-government (40), whole-of-government, government coordination, horizontal and integrated government, and governance (echoing the intersectoral

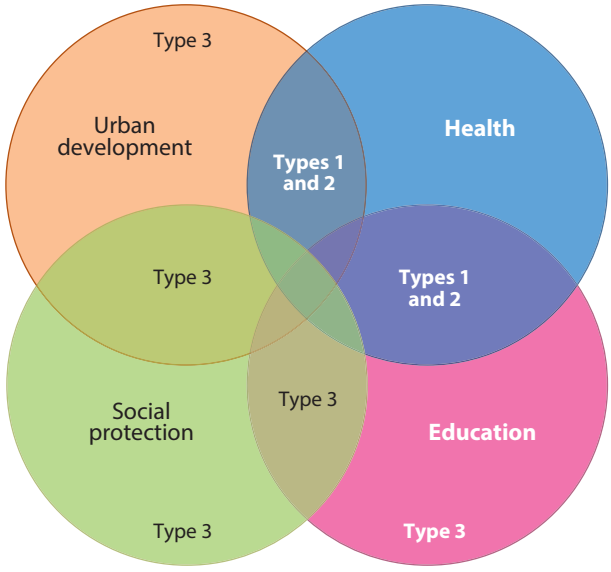

Figure 3

Types of interventions between and across sectoral realms (118, figure 1.2). Type 1, health sector lead; type 2, cross-sectoral with health; type 3, other sectors lead.

and HiAP rhetoric) have emerged from administrative and political science since the 1970s (63) and have been tried in the public sector since the 1980s (applying insights from governance and public administration science; cf. 89). Key notions to develop such comprehensive and coherent approaches, which Peters (89) calls the "holy grail" of public administration, relate to the idea of governance, "steering and co-ordinating a complex range of organizations via a control system constructed upon a multiplicity of linkages" (43, p. 51). The tools of governance include control, coordination, accountability, and power (43), but also "letting go" (40). Importantly, governance for integration must be driven by politics (32). It appears that political systems have failed to make integration a high priority, either because it is too complex and elusive or because it would challenge the very integrity of the political economy (105).

There is some consensus, as described by Peters (89) and by Hunt (63), that barriers to integration include, at minimum, issues around existing fragmentation; (lack of) accountability; organizational departmentalism; and interpersonal relationships, including with leadership. Even where statutory requirements for integration exist (84, 102)—often legislative—approaches do not necessarily facilitate or enforce material (sometimes called "substantive") policy development (beyond "symbolic" policy), that is, policy that dedicates resources accountably to resolving defined and attainable objectives (28).

In moving toward horizontal, integrated government, Peters (89) identifies four pathways: through systems of participation for all stakeholders; acknowledgment and institutionalization of networking; the establishment of coordination-targeted organizational behavioral values; and the extending of the epistemic community to include all relevant stakeholders in knowledge creation and utilization. Such rather abstract foci may not necessarily lead to success, particularly as the area of integrated health policy is considered "a moving target" (81, p. 365) or a "complex adaptive system" (91, p. 625): "a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents" (91, p. 625).

THE ASSUMED HOMOGENEITY OF THE HEALTH SECTOR

One element in this system is the health sector, which is internally already a complex, mildly adaptive, system. Apart from the semantics (health versus disease), it appears unhelpful to assume that the health system as a whole can unequivocally advocate for, engage in, develop, and/or sustain HiAP. National ministries of health, in their policy activities [on the basis of budget allocations (85)], far out-prioritize clinical care over comprehensive health promotion and HiAPs. This imbalance must have an impact on the status and relative policy engagement potential of organizational units/divisions inside the bureaucracy and the professionals that work there. Social (public and private) sectorality is reproduced within health bureaucracies, e.g., for education (human resource planning), industry (pharmaceuticals), and housing and infrastructure (hospitals and physical access). The prestige and status attributed to these sectors seems replicated within the health bureaucracy. Advocates for integrated population health efforts are on the periphery of the policy playing field and political radar.

Efforts to elevate public health, prevention, and health promotion in the government hierarchy are scarce, and where they happen they seem generally unsustainable. In Britain, a minister for public health was heralded as a triumph for the field (5), but she disappeared with the arrival of a new government. The much-praised Canadian Health Promotion Directorate, a direct consequence of the Lalonde Report (72), disbanded without much legacy (55).

One of the most compelling arguments for an integral approach to health development through HiAP—with clear consequences for the design of the health system and bureaucracy—has been made in the state of South Australia (SA) (48). In its original argument for HiAP, the South Australia government stated, "The SA health budget currently consumes close to 30% of the total state budget. In ten years this will be 50% and without change, health will consume the entire state government budget in less than 25 years (see [f]igure 1.2) . . . . This is clearly unsustainable and a new approach to improving the health and wellbeing of the population is needed" (p. 9). The resulting graph (**Figure 4**) presents a powerful policy frame ("health expense unsustainable—alternatives required"). The result of this argument was the establishment of a HiAP Unit that is directly connected to the State Executive (rather than to the ministry of health bureaucracy) and networked with a strong epistemic community (35); however, the sustainability of the approach was subject to political deliberation. Political leadership is important, and, apart from political

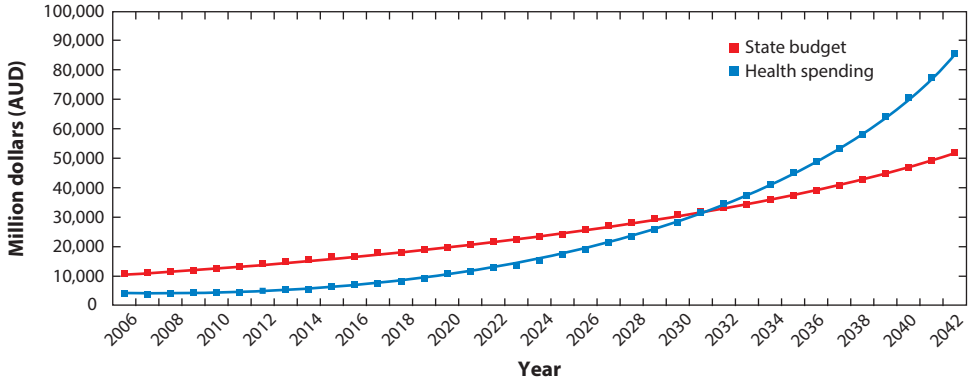

Figure 4

Total state budget compared with health sector expenditures, South Australia. From Department of the Premier and Cabinet, South Australia (36).

health literacy (106), political science offers conceptual and empirical views (52, 58) on its role. The role and analysis of political leadership are discussed below.

ENGAGEMENT: HEALTH IN ALL GOVERNANCE, POLICY AND ACTION

The literature on integrated public sector efforts for health is unequivocal in its conceptual development. Terms such as "intersectoral governance" (79), "intersectoral action" (76), "multisectoral action" (120), Healthy Public Policy, and Health in All Policies are used interchangeably. In fact, whereas HiAP as a concept was codified in the outcome document of the WHO and Government of Finland eighth Global Conference on Health Promotion (121) and its essential background documents (95), the relevant follow-up resolution of the World Health Assembly referred to HiAP only circuitously as "a framework to promote action across sectors of health and health equity" (111). This careful framing of the issue demonstrates how engagement toward integral approaches for health development is a politically challenging realm.

For the purpose of this review, a conceptual distinction between intersectoral/integrated governance, policy, and action is required, and we mirror how the European Healthy Cities Network has distinguished the terms (23). **Figure 5** maps these dimensions. Intersectoral governance is

> the sum of the many ways individuals and institutions, public and private, manage the connections of their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest. (23, pp. 177–78)

Health governance is an often intangible set of values and beliefs on "how we do things around here," and a decisive definition is called for but unavailable (3). Three types of governance have been identified (57) that play out at multiple levels between the social system and individual behavior.

Following De Leeuw et al. (28), intersectoral policy is "the expressed intent of government to allocate resources and capacities across relevant actors to resolve an expressly identified (health) issue within a certain timeframe" (p. 2). This intended problem resolution happens in regulatory, distributive, or redistributive fashion (73). In conceptualizing intersectoral action it seems useful to position "action" within the policy instrument literature grounded in the early 1960s by Lowi (73), culminating in a typology by Hood (59). Policy instruments "affect either the content or processes of policy implementation, that is, which alter the way goods and services are delivered to the public or the manner in which such implementation processes take place" (62, p. 414), but they play a role across policy design from problem definition to outcome evaluation. The intersectoral action toolbox consists of positive and negative sanctions, the availability of facilities, and communicative action. In summary, "governance" sets the overall rules for the game, "policy" is the substantive decision to address a problem, and "action" is the tool to make change happen (28). **Table 1** summarizes the three sets of three types.

Conceptual clarification is one thing, and the empirical study of integrated governance, policy, and action for health is another—if challenging—enterprise. A first attempt to produce a systematic overview of health governance at the interface between levels of government across 46 member states of the European Region of the WHO was produced in 1998 (50). A follow-up descriptive inventory of 99 European cities was published in 2015 (31). It becomes clear from this body of work that the sets of rules of the game, and how they relate between levels of government, are unique and specific for each particular setting, which presents challenges for systematic inquiry.

Problems	Solutions	Techniques	Governance		Implementation	Nexus models	Methods
Initiation	Political leadership	Executive commitment, staff support, epistemic community					Institutional systems change
	Bureaucratic change	Cross-departmental/ silo task groups					
	Indirect strategies	Health lens analysis, health impact analysis					
Coordination	Political leadership	Plans and targets establish roles and responsibilities, make commitments					
		Actions and statements of political leaders to signal support of HiAP	Institutional design	Constitutive	Policy coordination High-level leadership		
	Bureaucratic change	Appointments to place those in favor of HiAP in decision-making roles	Designing contextual relations		Creation of dedicated team (moderate)	Institutional redesign	
		Reorganization to orient bureaucracy toward HiAP	Developing professional norms		Capacity building (poor)	Blurring the boundaries	
		Updated requirements that expand procedures to include health	General rule setting	Directive	Scientific evidence Health Impact Assessment	Utilitarian evidence	
	Indirect strategies		Context maintenance		Integrating health in other agendas (moderate)	Conduits	
Durability	Political leadership	Plans and targets to hold partners accountable for their commitments	Situation-bound rule application		Financial incentives	Alternative evidence	
	Bureaucratic change	Reorganization to institutionalize change, make it more difficult to undo	Managing trajectories	Operational	Understanding community engagement	Narratives	
	Indirect strategies	Expanded availability to data to generate awareness of health inequalities	Managing relations		Dual outcomes (moderate) Take time to share language	Resonance	
		Interest group empowerment to hold government accountable for HiAP (e.g., by supporting an independent agency or NGO)	Managing contacts				
		Citizen involvement to challenge government decisions (e.g., creation of an ombudsman)					Narrative value-based connectedness

1 Problems, solutions, and techniques in HiAP development and maintenance (Greer & Lillvis 2014). Light-shaded area: Finnish experience (Leppo et al. 2013); dark-shaded area: South Australian experience (Dep. Health, Gov. S. Aust. 2011; Greer & Lillvis 2014).

2 Multilevel governance as a condition for policy development and implementation (Hill & Hupe 2006)

3 Empirical findings for the win-win implementation of HiAP (Molnar et al. 2016)

4 Conceptual approaches for action at the nexus between research, policy, and practice

Table 1 Typologies of governance (57), policy (73), and action (policy instruments). Adapted from Reference 59

Governance	Policy	Action
Constitutive	Regulatory	Sanctions
Directive	Distributive	Facilities
Operational	Redistributive	Communication

METHODS OF ENGAGEMENT

Accounts of methods to engage for integrated health governance, policy, and action are often cursory (based on a selection of particular case studies), abstract (based on theory and/or rhetoric), and missionary (providing instructions) in nature.

Two examples of training manuals and capacity building tools are relevant. The WHO developed and validated a manual for HiAP development (122). It states the following:

> Given government responsibility for health and the complexity of many contemporary health challenges, governments have several crucial roles to play in the HiAP approach including but not limited to: [c]ommissioning research; [e]ngaging stakeholders within and beyond government; [f]ormulating and implementing intersectoral policies; and [e]valuating their impact. (p. 69)

The manual further adopts the recommendations by the intersectoral governance proponents (79) that HiAP development would benefit from structures and strategies, including setting up cross-sector and legislature agencies, budget parameters, and rules that would facilitate broader stakeholder engagement.

To move toward the establishment and durability of such structures and approaches (110), the manual adopts Leppo's (71) typology of arguments for HiAP:

1. The health argument: Health is an intrinsic value and governments can and should support public-sector engagement in health development.
2. The health-to-other-sector argument: Health and equity improvements can help achieve government mandates across the public sector.
3. The health-societal-goal argument: Health and equity development contribute to wider societal gain across social spheres.
4. The economic argument: As identified above, health is good for wealth, and socioeconomic growth (77).

Many policies and developments have unintended health effects, though, and have no health argument whatsoever. One classic example is the Neolithic Demographic Transition (24) changing health, society, and culture. Worse, starting with the health argument may be counterproductive or politically inappropriate. Scottish respondents to a European survey on health equity (61) advise to "avoid the H word—'health'" (p. 35). In the same vein, Healthy Cities seem to thrive intersectorally when their starting point is environmental sustainability rather than health (24).

Figure 5

Four bodies of literature for cross-sectoral engagement aligned: 1, political leadership; 2, multilevel governance for policy development and implementation; 3, win-win strategies for Health in All Policy (HiAP) implementation; and 4, nexus models at the interface of research, policy, and practice. NGO, nongovernmental organization.

A realist perspective on engagement in policy development must, of course, also take into account which factors, actors, and arguments can be mobilized against a broad health pitch. Popular culture is inspiration for illustrations about the games that are being played, e.g., the TV series "Yes, Minister" (32) and "The West Wing" (6). These show that new, integral endeavors may encounter preemptive action, the peddling of half lies, distorted evidence, funding support for hitherto marginal policy actors, personal attacks on proponents of such action, etc.

Further HiAP guidance work was developed in the United States (99). Where the WHO emphasizes structural dimensions, the US approach advocates agency over structure (92). Starting a HiAP platform is a communicative issue, and a range of communication modalities is identified, including discussions, workshops, seminars, forums, social media, and invitations to submit evidence and views, among others (92).

Health in All Policies: A Guide for State and Local Governments (99) offers behavioral advice on norms, attitudes, and processes to integrate wider perspectives, e.g., practice humility, respect confidentiality, honor commitments, offer help, give credit, assume good intentions, discover shared values, identify win-wins and cobenefits, understand context, share information and ideas, be flexible, make introductions, recognize that language matters, remember that collaboration takes time, and get the most out of meetings.

Both guidebooks (99, 122) draw on experiential evidence documented from South Australia (4) and Finland (71). A key method of engagement that emerges from the Australian experience is that of the adoption and application of the "health lens analysis" (HLA) (48). Howard & Gunther (61) empirically assessed the utility of HLA and the communicative approach, and they found across Europe that this form of identification and engagement needs to be embedded in interministerial and interdepartmental committees, community consultations and citizens' juries, cross-sector action teams, partnership platforms, integrated budgets and accounting, cross-cutting information and evaluation systems, impact assessments (47), joined-up workforce development, and legislative frameworks. In the particular case of South Australia, the governance arrangements are such that the HLA fits with the high-level government state strategic plan and can focus on a wide range of sectoral domains (48). HLAs that are not entrenched at that high level may not achieve policy formulation, implementation, and outcomes.

Theoretical work on the identification and leveling of barriers that stand in the way of integral health work (52) purports that practical models of engagement should focus on making political leadership support integration sustainably, achieve bureaucratic change that enables coordination and lasting change, and espouse particular strategies that support political and bureaucratic commitments (**Figure 5**). These views connect seamlessly with the arguments made for multilevel governance as a precondition for effective policy implementation (57). Governance can be constructed or deconstructed at three levels—constitutive, setting the principles; directive, providing guidance; operational, promoting individual actions—for localized systems (whether national governments or health bureaucracy), their constituent organizations, and the people working in those organizations. Nine principal actions flow from this view (**Figures 5** and **6**), which shape a coherent and comprehensive methodology for engagement, methodology being the "logic of method" (22, p. 217). Such an approach would in fact address the calls that a range of tools is required to overcome the "pathology of departmentalism" (67, p. 16), from comprehensive systems redesign to interpersonal behavior change (57, 110).

Is there empirical support for the feasibility of such comprehensive methods of engagement? A review of operational aspects of HiAP in Sweden, Québec, and South Australia identified 12 win-win techniques and methods that were successfully put in practice to engage in integral health policy implementation (**Figure 5**). These were triangulated with the HiAP literature, and only four of these have poor or moderate support from other sources: the creation of dedicated

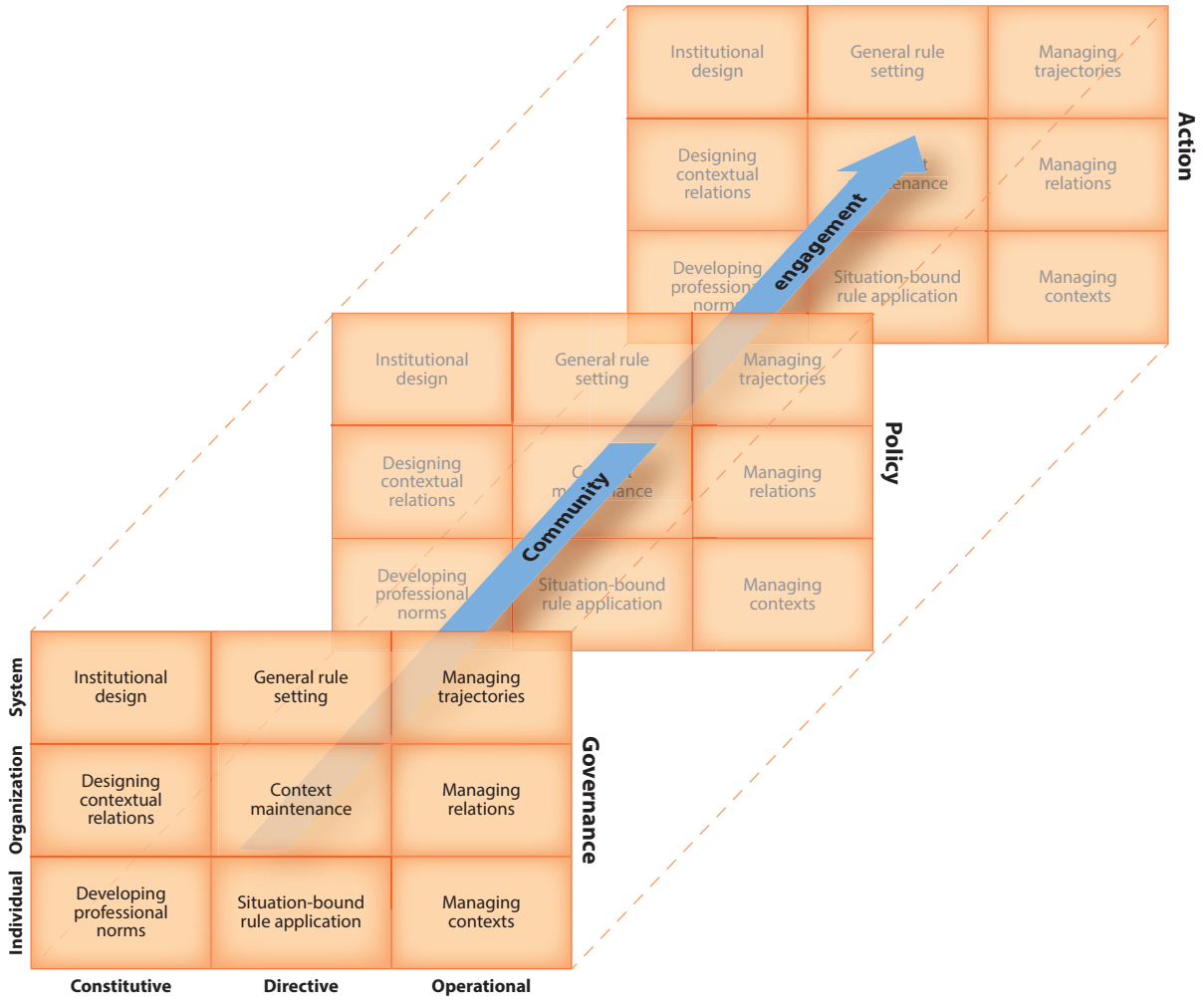

Figure 6

Methods of engagement across levels (system–organization–individual), action logics (constitutive–directive–operational), and governance–policy–action permutations (57).

teams for HiAP, capacity building for integration, integration of health in other-sector agendas, and the pursuit of dual outcomes across sectors. Further validation of the suitability of these methods of engagement needs to be undertaken. These actions map well onto the multilevel governance perspective (57) as well as the leadership–bureaucratic change–indirect strategy model (52), which confirms that a theoretical framework is emerging that can guide further research in this area.

One unresolved issue in the above discussion has been the role of knowledge and evidence in pitching the need for integration (88). Knowledge generation, dissemination, and utilization are critical methods in the creation of common parameters for governance, policy, and action across the public and private sectors, and, critically, civil society. A joint understanding of issues and possible resolutions in society would be a condition for effectively addressing complexity. For instance, theory and practice in this area have focused on organizational and second-order learning

(100), epistemic communities (56), and network governance and management (94). In the health sciences, the idea of knowledge translation has become a dominant paradigm (49), but admittedly the technocratic and linear approach that is firmly grounded in health services optimization may have done more damage than good in population health and health promotion (51).

An inventory across disciplines and sectors revealed about 36 empirically tested conceptual frameworks to act at the nexus between research, policy, and practice (30). These could be loosely categorized into seven classes of "nexus theories" (66). Nexus theories are reflections and abstractions of a realist view of knowledge creation, dissemination, and utilization. Knowledge translation could be viewed as a normative ideal type.

The first class of frameworks, institutional redesign, assumes that rules could be set and agreed on (implicitly as well as explicitly) about how knowledge is created, stored, and shared among stakeholders. The second category, utilitarian evidence, posits that knowledge is created and used for particular purposes and that utility-driven evidence is bespoke to research, policy, and practice arenas (34).

The idea of blurring the boundaries (a third group) is that barriers between research, policy, and practice are social constructs and that the actors in each of these are also, in fact, ordinary people who have needs, a social life, curiosity, aspirations, and daily challenges. A researcher would also inherently be able to appreciate and respect practice and, in some tasks and functions, be able to resemble the practitioner, and similarly across the other (professional) boundaries.

In the fourth group, conduits, also known as knowledge brokers, are individual or organizational agents or functions that explicitly and transparently straddle nexus boundaries. For that reason, they are also known as boundary spanners, social and political entrepreneurs, change agents, or advocates (104).

Fifthly, alternative evidence puts forward that it is possible to have an arsenal of evidence that can be rapidly shaped, substantiated, and sustained to insert into emerging social and policy discourses. Public intellectuals, talk radio hosts, and community leaders may act as repositories of alternative evidence.

Narratives (the sixth category) center around the finding that political leadership is predicated by street-level evidence explored by door-knocking and, e.g., the tabloid press. In this arena, work at the nexus requires the mobilization and crafting of coherent narratives.

And finally, a seventh class of nexus theories contains resonance models; they find that it is possible to align initially conflicting value systems in relation to contested (often moral, e.g., euthanasia or marriage equality) fields through careful reframing of concepts and words—often by cunning rhetorical perspicacity (74, 107). For instance, in countries that have legalized euthanasia, initial conflict between individual freedom and the will of God resolved around a common resonance of dignity.

WORKING WITH COMMUNITIES

Across the literature that we have used in the above argument, community is consistently identified as key to integral health governance, policy, and action. In the discourse on the social determinants of health, arguments to involve community have been pervasive. In an influential analysis for the WHO Social Determinants of Health Commission, investigators found the full engagement of the community to be essential (7).

Community ownership and control yield better outcomes; sometimes ownership has physical dimensions, e.g., for Indigenous peoples' connection to country (70). Community-based participatory research produces more sustainable health efforts and outcomes (65). Others have reviewed how partnering between the community and various government and nongovernment

actors effectively contributes to health improvements (65). However, these reviews only peripherally touch on community action for policy development. Evidence has emerged [particularly sponsored by the World Bank for mostly non-OECD countries (46)] that certain forms of community decision making are effective in the governance and policy spaces: deliberative and participatory decision making allocates resources more efficiently for greater (health) equity (60).

Participatory decision making has acquired some fame through international examples around participatory budgeting. Participatory budgeting is a process of democratic deliberation and decision making in which ordinary people decide how to allocate part of a municipal or public budget. Participatory budgeting allows citizens to identify, discuss, and prioritize public-spending projects and gives the public the power to make real decisions about how money is spent. Evaluations have shown that participatory budgeting, after a period of trial-and-error engagement to establish sufficient commitment and trust, results in more equitable public spending, greater government transparency and accountability, increased levels of public participation (especially by marginalized or poor residents), and democratic and citizenship learning (45).

The literature is, however, rife with cautions to see community participation as the miracle solution to addressing complexity in a highly interconnected and interdependent world. Calls to empower communities have been analyzed (19), and these run the risk of becoming a panacea for appropriate accountability and decision making. Even still, full community participation and empowerment, particularly in influencing policy and systems change for health, remain the bedrock of health promotion (97). One investigation sought to review systematically the impact of community engagement on health (83). The authors found only 13 studies with methods rigorous enough to be included (but found strong suggestions that community engagement works).

Interestingly, the notion that communities determine their destiny by influencing policy and civil and public institutions is not captured in this heuristic. Why? The work by Commers (16) may shed some light on this question. It maps the understanding of the Dutch population, media, and politicians of social determinants of health and finds that unprompted queries such as "what is health?" and "what determines your health?" produce responses that neatly fit with the biomedical paradigm. The Dutch community prioritizes proximal determinants of health (pathogens and lifestyles) over more distal determinants (such as corporate interests, politics, and systems parameters). Commers also finds that, if prompted appropriately (for instance, by asking "who determines your health?"), the same community quite adequately frames virtually all social determinants of health as important.

Australian researchers have proposed some factors that exacerbate such findings (96). They investigated lay understandings of the causes of health inequity. The authors concluded that "the findings in this study are evocative of a kind of collective inertia within the public health field. The lack of congruence between explanations and public policy responses suggests that public health arguments directed at addressing the social determinants of health have not become absorbed into bodies of lay knowledge" (p. 9). Clearly very few communities, or members of communities, understand social determinants well enough to start advocating for them at a systems level, be it through participatory budgeting, through influence on policy processes, or through activism aimed at reshaping public administration.

One of the few research efforts to consider what it would take to mobilize communities politically toward a more substantive social determinants policy effort has been undertaken by the Robert Wood Johnson Foundation (98). Researchers systematically investigated frames and metaphors for health in the United States and found that there is a meaningful divide between language and rhetoric deployed by public health professionals and scholars and what the US public (across the Democratic–Republican spectrum) feels. The social determinants message needs to resonate

at a deep metaphorical level. Such an approach is consistent with framing theory (101) and the messages on language use in policy discourse by Stone (107).

CONCLUSION

Health is created largely outside the health sector. Other sectors are called on to contribute to health through governance, policy, and action. Arguments have been formulated under a range of monikers to develop these contributions across public and private sectors and with full involvement of civil society. Such developments, as public health scholarship argues, may need to be initiated predominantly by the health sector and its public-sector leadership. However, the health sector itself may not have a unified policy and governance presence in this engagement—social sectorality is replicated within the public policy bureaucracy.

The moral high ground that many if not most health professionals and scholars occupy may also stand in the way of a realistic appraisal of the complex and competitive nature of integration efforts. There is significant naiveté when it comes to the politics and power games and the role that the health sector can or should play. Within the mainstream of public health scholarship, there has been little attention to the existing science of governance, policy, and implementation instrumentation (the toolbox of government); consequently, a terminology in the health field has emerged and sustained that does not meaningfully distinguish between essential concepts. Joined-up governance is not the same as integral policy, which also is not the same as intersectoral action. Governance is not policy nor is it action.

To argue evocatively for cross-sectoral engagement would require a clear conceptual heuristic. We have argued that this could be grounded in a multilevel governance perspective in which systems, organizations, and individuals take on constitutive, directive, and operational gazes, which then shape-shift and permeate across governance, policy, and action logics (**Figure 6**). Different levels of governance, policy, and action need to be complementary—integration for health means that value-based messages are critical for high-level systems design and political leadership, as much as they are important for individual behavior (**Figures 5** and **6**). At its core, at each of the resulting 27 activity modalities, the realization of the effort is determined by full deliberative and participatory engagement of communities. Direct control by communities over decisions that affect resource generation and allocation is essential but recognized as an evolutionary stage in a much broader social development.

Ultimately, the cunning deployment of language through appropriate communication channels is essential to engaging communities and professionals. We need to remain aware that systems and organizations are made up of people who use language and rhetoric to claim, reaffirm, or deny carriage of health and solutions to its issues.

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LITERATURE CITED

1. Angell M. 2005. *The Truth about the Drug Companies: How They Deceive Us and What to Do About It*. New York: Random House
2. Antonovsky A. 1996. The salutogenic model as a theory to guide health promotion. *Health Promot. Int.* 11:11–18

3. Barbazza E, Tello JE. 2014. A review of health governance: definitions, dimensions and tools to govern. *Health Policy* 116:1–11
4. Baum F, Lawless A, Williams C. 2013. Health in All Policies from international ideas to local implementation: policies, systems and organizations. In *Health Promotion and the Policy Process*, ed. C Clavier, E De Leeuw, pp. 188–217. Oxford, UK: Oxford Univ. Press
5. Beaglehole R, Bonita R. 1998. Public health at the crossroads: which way forward? *Lancet* 351:590–92
6. Beavers SL. 2002. *The West Wing* as a pedagogical tool. *Polit. Sci. Polit.* 35:213–16
7. Blas E, Gilson L, Kelly MP, Labonté R, Lapitan J, et al. 2008. Addressing social determinants of health inequities: What can the state and civil society do? *Lancet* 372:1684–89
8. Blum H. 1981. *Planning for Health: Generics for the Eighties*. New York: Hum. Sci. Press
9. Bowker GC, Star SL. 2000. *Sorting Things Out: Classification and Its Consequences*. Cambridge, MA: MIT Press
10. Bowman S, Unwin N, Critchley J, Capewell S, Husseini A, et al. 2012. Use of evidence to support healthy public policy: a policy effectiveness-feasibility loop. *Bull. World Health Organ.* 90:847–53
11. Breton E, De Leeuw E. 2011. Theories of the policy process in health promotion research: a review. *Health Promot. Int.* 26:82–90
12. Burger MJ, Van der Knaap B, Wall RS. 2014. Polycentricity and the multiplexity of urban networks. *Eur. Plann. Stud.* 22:816–40
13. Can. Counc. Soc. Determ. Health. 2015. *A Review of Frameworks on the Determinants of Health*. Ottawa: Can. Counc. Soc. Determ. Health
14. Christensen T, Lægreid P. 2007. The whole-of-government approach to public sector reform. *Public Adm. Rev.* 67:1059–66
15. Cohen MN. 1989. *Health and the Rise of Civilization*. New Haven, CT: Yale Univ. Press
16. Commers M. 2002. *Determinants of Health: Theory, Understanding, Portrayal, Policy*. New York: Springer Sci. Bus. Media
17. Conrad P, Schneider JW. 2010. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple Univ. Press
18. Crawford R. 1980. Healthism and the medicalization of everyday life. *Int. J. Health Serv.* 10:365–88
19. Crawshaw P, Bunton R, Gillen K. 2003. Health action zones and the problem of community. *Health Soc. Care Community* 11:36–44
20. Davies SC, Winpenny E, Ball S, Fowler T, Rubin J, Nolte E. 2014. For debate: a new wave in public health improvement. *Lancet* 384:1889–95
21. De Leeuw E. 2011. The Ottawa Charter for Health Promotion 25 years on. *Health Promot. Int.* 26:ii157–272
22. De Leeuw E. 2012. Do healthy cities work? A logic of method for assessing impact and outcome of healthy cities. *J. Urban Health: Bull. N. Y. Acad. Med.* 89:217–31
23. De Leeuw E. 2015. Intersectoral action, policy and governance in European Healthy Cities. *Public Health Panor.* 1:175–82
24. De Leeuw E. 2017. Cities and health. In *Healthy Cities—The Theory, Policy, and Practice of Value-Based Urban Health Planning*, ed. E de Leeuw, J Simos. New York: Springer
25. De Leeuw E. 2016. From research to policy and practice in public health. In *Public Health*, ed. P Liamputtong, pp. 213–33. Cambridge, UK: Cambridge Univ. Press
26. De Leeuw E. 2016. *The nature of the silent arrow*. March 14, Glocal Health Consult., Victoria, Aust. **http://glocalhealthconsultants.com/the-nature-of-the-silent-arrow/**
27. De Leeuw E, Clavier C. 2011. Healthy public in all policies. *Health Promot. Int.* 26:ii237–44
28. De Leeuw E, Clavier C, Breton E. 2014. Health policy—why research it and how: health political science. *Health Res. Policy Syst.* 12:1–11
29. De Leeuw E, Green G, Spanswick L, Palmer N. 2015. Policymaking in European healthy cities. *Health Promot. Int.* 30:i18–31
30. De Leeuw E, McNess A, Crisp B, Stagnitti K. 2008. Theoretical reflections on the nexus between research, policy and practice. *Crit. Public Health* 18:5–20
31. De Leeuw E, Palmer N, Spanswick L. 2015. *City Fact Sheets: WHO European Healthy Cities Network*. Copenhagen: World Health Organ. Reg. Off. Eur.

32. De Leeuw E, Peters D. 2015. Nine questions to guide development and implementation of Health in All Policies. *Health Promot. Int.* 30:987–97
33. De Leeuw E, Polman L. 1995. Health policy making: the Dutch experience. *Soc. Sci. Med.* 40:331–38
34. De Leeuw E, Skovgaard T. 2005. Utility-driven evidence for healthy cities: problems with evidence generation and application. *Soc. Sci. Med.* 61:1331–41
35. Delany T, Lawless A, Baum F, Popay J, Jones L, et al. 2016. Health in All Policies in South Australia: What has supported early implementation? *Health Promot. Int.* 31:888–98
36. Dep. Health, Gov. S. Aust. 2011. *The South Australian Approach to Health in All Policies: Background and Practical Guide version 2.* Rundle Mall, S. Aust.: Health in All Policies Unit, Dep. Health, Gov. S. Aust. **https://sahealth.sa.gov.au/wps/wcm/connect/cb6fa18043aece9fb510fded1a914d95/HiAPBackgroundPracticalGuide-v2.pdf?MOD=AJPERES&CACHEID=cb6fa18043aece9fb510fded1a914d95**
37. Eckermann L. 2016. Health promotion principles as a catalyst for translating the SDGs into more transformative action. *Health Promot. Int.* 31:253–57
38. Ehrenreich B, Ehrenreich J. 1970. *The American Health Empire.* New York: Random House
39. Evans RG, Barer ML, Marmor TR. 1994. *Why Are Some People Healthy and Others Not?: The Determinants of Health of Populations*. New York: Aldine de Gruyter
40. Exworthy M, Hunter DJ. 2011. The challenge of joined-up government in tackling health inequalities. *Int. J. Public Adm.* 34:201–12
41. Fafard P. 2008. *Evidence and Healthy Public Policy: Insights from Health and Political Sciences*. Ottawa: Can. Policy Res. Netw.
42. Finegood DT. 2011. The complex systems science of obesity. In *The Oxford Handbook of the Social Science of Obesity*, ed. J Cawley, pp. 208–36. Oxford, UK: Oxford Univ. Press
43. Flinders M. 2002. Governance in Whitehall. *Public Adm.* 80:51–75
44. Foucault M. 1983. *Naissance de la clinique. Une archéologie du regard médical.* Paris: Press. Univ. France
45. Fung A. 2015. Putting the public back into governance: the challenges of citizen participation and its future. *Public Adm. Rev.* 75:513–22
46. Goldfrank B. 2012. The World Bank and the globalization of participatory budgeting. *J. Public Deliberation* 8: Art. 7
47. Gottlieb LM, Fielding JE, Braveman PA. 2012. Health impact assessment: necessary but not sufficient for healthy public policy. *Public Health Rep.* 127:156–62
48. Gov. S. Aust. 2016. *Health Lens Analysis Projects.* Adelaide: Gov. S. Aust. **http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/health+lens+analysis+projects**
49. Graham ID, Logan J, Harrison MB, Straus SE, Tetroe J, et al. 2006. Lost in knowledge translation: time for a map? *J. Contin. Educ. Health Prof.* 26:13–24
50. Green G. 1998. *Health and Governance in European Cities: A Compendium of Trends and Responsibilities for Public Health in 46 Member States of the WHO European Region*. London: Eur. Hosp. Manag. J. Ltd.
51. Greenhalgh T, Wieringa S. 2011. Is it time to drop the 'knowledge translation' metaphor? A critical literature review. *J. R. Soc. Med.* 104:501–9
52. Greer SL, Lillvis DF. 2014. Beyond leadership: political strategies for coordination in health policies. *Health Policy* 116:12–17
53. Gusfield JR. 1989. Constructing the ownership of social problems: fun and profit in the welfare state. *Soc. Probl.* 36:431–41
54. Hancock T. 1985. Beyond health care: from public health policy to healthy public policy. *Can. J. Public Health* 76(Suppl. 1):9–11
55. Hancock T. 2011. Health promotion in Canada: 25 years of unfulfilled promise. *Health Promot. Int.* 26(Suppl. 2):ii263–67
56. Heritage Z, Green G. 2013. European national healthy city networks: the impact of an elite epistemic community. *J. Urban Health: Bull. N. Y. Acad. Med.* 90(Suppl. 1):154–66
57. Hill M, Hupe P. 2006. Analysing policy processes as multiple governance: accountability in social policy. *Policy Polit.* 34:557–73

58. Hofstad H. 2016. The ambition of Health in All Policies in Norway: the role of political leadership and bureaucratic change. *Health Policy* 120:567–75
59. Hood C. 1983. *The Tools of Government*. London: MacMillan
60. Horton K, Friel S, de Leeuw E, McKeone C, Bolam B. 2015. Fair foundations for health equity. *Health Promot. Int.* 30(Suppl. 2):ii2–7
61. Howard R, Gunther S. 2012. *Health in All Policies: An EU Literature Review and Interview with Key Stakeholders*. Brussels: Equity Action
62. Howlett M. 2000. Managing the "hollow state": procedural policy instruments and modern governance. *Can. Public Adm.* 43:412–31
63. Hunt S. 2005. *Whole-of-Government: Does Working Together Work*? Canberra: Aust. Natl. Univ.
64. Illich I. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon
65. Jagosh J, Bush PL, Salsberg J, Macaulay AC, Greenhalgh T, et al. 2015. A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health* 15:725
66. Jansen MW, De Leeuw E, Hoeijmakers M, De Vries NK. 2012. Working at the nexus between public health policy, practice and research. Dynamics of knowledge sharing in The Netherlands. *Health Res. Policy Syst.* 10:33
67. Kavanagh D, Richards D. 2001. Departmentalism and joined-up government. *Parliam. Aff.* 54:1–18
68. Kelly M, Charlton B. 1995. The modern and the postmodern in health promotion. In *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, ed. R Bunton, S Nettleton, R Burrows, pp. 78–90. London: Routledge
69. Kickbusch I. 2007. Health governance: the Health Society. See Ref. 78, pp. 144–61
70. Kingsley JY, Townsend M, Phillips R, Aldous D. 2009. "If the land is healthy. . .it makes the people healthy": the relationship between caring for country and health for the Yorta Yorta Nation, Boonwurrung and Bangerang Tribes. *Health Place* 15:291–99
71. Leppo K, Ollila E, Peña S, Wismar M, Cook S. 2013. *Health in All Policies. Seizing Opportunities, Implementing Policies.* Helsinki: Ministr. Soc. Aff. Health
72. Lalonde M. 1974. *A New Perspective on the Health of Canadians. A Working Document.* Ottawa: Gov. Can.
73. Lowi TJ. 1964. American business, public policy, case-studies, and political theory. *World Polit.* 16:677–715
74. Malone RE. 1999. Policy as product. Morality and metaphor in health policy discourse. *Hastings Cent. Rep.* 29:16–22
75. Marmor TR, Boyum D. 1999. Medical care and public policy: the benefits and burdens of asking fundamental questions. *Health Policy* 49:27–43
76. Marmot M, Allen JJ. 2014. Social determinants of health equity. *Am. J. Public Health* 104(Suppl. 4):S517–19
77. McIntyre D, Mooney G. 2007. *The Economics of Health Equity*. Cambridge, UK: Cambridge Univ. Press
78. McQueen D, Kickbusch I, Potvin L, Pelikan J, Balbo L, Abel T. 2007. *Health and Modernity: The Role of Theory in Health Promotion*. New York: Springer Sci. Bus. Media
79. McQueen D, Wismar M, Lin V, Jones CM, Davies M. 2012. *Intersectoral Governance for Health in All Policies: Structures, Actions and Experiences*. Copenhagen: World Health Organ. Reg. Off. Eur.
80. Milio N. 1981. *Promoting Health Through Public Policy*. Philadelphia: Davis
81. Milio N. 2001. Evaluation of health promotion policies: tracking a moving target. *WHO Reg. Publ. Eur. Ser.* (92):365–85
82. Millgram E. 2015. *The Great Endarkenment: Philosophy for an Age of Hyperspecialization*. Oxford, UK: Oxford Univ. Press
83. Milton B, Attree P, French B, Povall S, Whitehead M, Popay J. 2012. The impact of community engagement on health and social outcomes: a systematic review. *Community Dev. J.* 47:316–34
84. Molnar A, Renahy E, O'Campo P, Muntaner C, Freiler A, Shankardass K. 2016. Using win-win strategies to implement Health in All Policies: a cross-case analysis. *PLOS ONE* 11:e0147003
85. Mossialos E, Wenzl M, Osborn R, Sarnak D. 2016. *2015 International Profiles of Health Care Systems*. Washington, DC: Commonw. Fund

86. Norsigian J, Diskin V, Doress-Worters P, Pincus J, Sanford W, Swenson N. 1999. *The Boston Women's Health Book Collective* and "Our Bodies, Ourselves": a brief history and reflection. *J. Am. Med. Womens Assoc*. 54:35–38
87. Nutbeam D. 1998. Health promotion glossary. *Health Promot. Int.* 13:349–64
88. Oliver K, Lorenc T, Innvær S. 2014. New directions in evidence-based policy research: a critical analysis of the literature. *Health Res. Policy Syst.* 12:34
89. Peters BG. 1998. Managing horizontal government: the politics of co-ordination. *Public Adm*. 76:295–311
90. Pickett KE, Wilkinson RG. 2015. Income inequality and health: a causal review. *Soc. Sci. Med.* 128:316–26
91. Plsek PE, Greenhalgh T. 2001. Complexity science: the challenge of complexity in health care. *BMJ* 323:625–28
92. Polsky C, Stagg K, Gakh M, Bozlak CT. 2015. The Health in All Policies (HiAP) approach and the law: preliminary lessons from California and Chicago. *J. Law Med. Ethics* 43:52–55
93. Porter R. 1999. *The Greatest Benefit to Mankind: A Medical History of Humanity*. New York: Norton
94. Provan KG, Kenis P. 2008. Modes of network governance: structure, management, and effectiveness. *J. Public Adm. Res. Theory* 18:229–52
95. Puska P, Ståhl T. 2010. Health in All Policies—the Finnish initiative: background, principles, and current issues. *Annu. Rev. Public Health* 31:315–28
96. Putland C, Baum FE, Ziersch AM. 2011. From causes to solutions—insights from lay knowledge about health inequalities. *BMC Public Health* 11:67
97. Rissel C. 1994. Empowerment: the holy grail of health promotion? *Health Promot. Int.* 9:39–47
98. Robert Wood Johnson Found., Carger E, Westen D. 2010. *A New Way to Talk about the Social Determinants of Health*. Princeton, NJ: Robert Wood Johnson Found.
99. Rudolph L, Caplan J, Ben-Moshe K, Dillon L. 2013. *Health in All Policies: A Guide for State and Local Governments*. Washington, DC: Am. Public Health Assoc.
100. Schön DA. 1973. *Beyond the Stable State: Public and Private Learning in a Changing Society*. London: Harmondsworth Penguin
101. Schön DA, Rein M. 1994. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books
102. Shankardass K, Solar O, Murphy K, Greaves L, O'Campo P. 2012. A scoping review of intersectoral action for health equity involving governments. *Int. J. Public Health* 57:25–33
103. Shigayeva A, Atun R, McKee M, Coker R. 2010. Health systems, communicable diseases and integration. *Health Policy Plann*. 25:i4–20
104. Skok JE. 1995. Policy issue networks and the public policy cycle: a structural-functional framework for public administration. *Public Adm. Rev.* 55:325–32
105. Smith K, Schrecker T. 2014. *Understanding health inequity and related policy responses: What insights can political and social theories offer?* Presented at World Congr. Polit. Sci., 23rd, July 19–24, Montreal
106. Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, et al. 2012. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health* 12:80
107. Stone D. 2002. *Policy Paradox: The Art of Political Decision Making*. New York: Norton
108. UNICEF, WHO (World Health Organ.). 1978. *Primary Health Care: Report of the International Conference on Primary Health Care, September 6–12, Alma Ata, USSR*. Geneva: WHO
109. Van der Geest S, Speckmann JD, Streefland PH. 1990. Primary health care in a multi-level perspective: towards a research agenda. *Soc. Sci. Med.* 30:1025–34
110. Warner M, Gould N. 2009. Integrating Health in All Policies at the local level: using network governance to create 'virtual reorganization by design.' In *Policy Innovation for Health*, ed. I Kickbusch, pp. 125–63. New York: Springer
111. WHA (World Health Assemb.). 2014. *Resolution WHA67.12: Contributing to social and economic development: sustainable action across sectors to improve health and health equity*. Plenary Meet., May 24, World Health Organ., Geneva
112. WHO (World Health Organ.). 1986. *Intersectoral Action for Health: The Role of Intersectoral Cooperation in National Strategies for Health For All*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/41545/1/9241560967_eng.pdf**

113. WHO (World Health Organ.). 1988. *Adelaide recommendations on healthy public policy*. WHO, Adelaide/Geneva. **http://www.who.int/healthpromotion/conferences/previous/adelaide/en/**
114. WHO (World Health Organ.). 2011. *Education: Shared Interests in Well-Being and Development*. Geneva: WHO
115. WHO (World Health Organ.). 2011. *Housing: Shared Interests in Health and Development*. Geneva: WHO
116. WHO (World Health Organ.). 2011. *Social Protection: Shared Interests in Vulnerability Reduction and Development*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/44876/1/9789241503655_eng.pdf**
117. WHO (World Health Organ.). 2011. *Transport (Road Transport): Shared Interests in Sustainable Outcomes*. Geneva: WHO
118. WHO (World Health Organ.). 2013. *The Economics of the Social Determinants of Health and Health Inequalities: A Resource Book*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf**
119. WHO (World Health Organ.). 2013. *Energy: Shared Interests in Sustainable Development and Energy Services*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/91591/1/9789241506199_eng.pdf**
120. WHO (World Health Organ.). 2013. *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1**
121. WHO (World Health Organ.). 2014. *Health in All Policies: Helsinki statement. Framework for country action*. WHO, Geneva. **http://www.who.int/healthpromotion/frameworkforcountryaction/en/**
122. WHO (World Health Organ.). 2015. *Health in All Policies Training Manual*. Geneva: WHO. **http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf?ua=1**
123. WHO (World Health Organ.), Health Welf. Can., Can. Public Health Assoc. 1986. *The Ottawa charter for health promotion. The move towards a new public health*. Adopted at Int. Conf. Health Promot., 1st, Nov. 17–21, Ottawa. **http://www.who.int/healthpromotion/conferences/previous/ottawa/en/**
124. Willis E. 1983. *Medical Dominance: The Division of Labour in Australian Health Care*. Scoresby, Aust.: George Allen & Unwin