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Published in:
Health Promotion International

DOI:
10.1093/heapro/daw020

Publication date:
2017

Document version
Accepted manuscript

Citation for published version (APA):

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Title: Intersectoriality in Danish municipalities: Corrupting the social determinants of health?

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Funding: This work was supported by Trygfonden (the Tryg foundation).

Journal section: The submission is intended for Original articles

Word count total: 7143
Title: 10
Summary: 245
Main body of text: 5502
References: 1332
Acknowledgements: 53

Acknowledgements:
We would like to thank the participants in the 10 municipalities for open-heartedly sharing their experiences. Furthermore, the faculty and students of the doctoral programme in Health Promotion at Université de Montréal where the first author was a visiting student in spring 2015 were inspirational in developing the argument of the paper.
INTERSECTORIALITY IN DANISH MUNICIPALITIES: CORRUPTING THE SOCIAL DETERMINANTS OF HEALTH?

Summary
Action on the social determinants of health (SDH) through intersectoral policymaking is often suggested to promote health and health equity. This paper argues that the process of intersectoral policymaking influences how the SDH are construed and acted upon in municipal policymaking. We discuss how the intersectoral policy process legitimates certain practices in the setting of Danish municipal health promotion and the potential impact this can have for long-term, sustainable healthy public policy.

Based on ethnographic fieldwork we show how the intention of intersectoriality produces a strong concern for integrating health into non-health sectors to ensure productive collaboration. To encourage this integration, health is often framed as a means to achieve the objectives of non-health sectors. In doing so, the intersectoral policy process tends to favor smaller-scale interventions that aim to introduce healthier practices into various settings, e.g. creating healthy school environments for increased physical activity and healthy eating. While other more overarching interventions on the health impacts of broader welfare policies (e.g. education policy) tend to be neglected. The interventions hereby neglect to address more fundamental SDH.

Based on these findings, we argue that intersectoral policymaking to address the SDH may translate into a limited approach to action on so-called “intermediary determinants” of health, and as such may end up corrupting the broader SDH. Further, we discuss how this corruption affects the intended role of non-health sectors in tackling the SDH, as it may impede the overall success and long-term sustainability of intersectoral efforts.

Introduction
It is generally accepted that the settings of everyday life and the conditions in which people “learn, work, play and love”, as it is phrased in the Ottawa Charter, have important impacts on health (WHO, 1986). The concept of social determinants of health (SDH) captures this, as it draws attention to the social factors that impact on health, such as social and economic circumstances, and inequalities in their distribution. Attention to the SDH was propelled forward by the WHO’s Commission on Social Determinants of Health (CSDH) where it was cogently argued that behavior change is not the answer to reducing inequalities in health. Their final report “Closing the gap in a generation” (2008) advocated for creating better health and reducing health inequality through action on the SDH (CSDH, 2008; Koh et al., 2010). This is necessary as socio-economic differences in health persist in spite of overall better health and wealth, and have even widened in recent decades (CSDH, 2008; Graham, 2009; Mackenback et al., 2008; Mackenback, 2012).

The concept of SDH has a dual meaning. It is used to refer to both the social causes of health and the social factors determining the distribution of these causes (Solar and Irwin, 2010; Graham, 2004, 2009). In particular the term “broader determinants” is used flexibly, referring to the conditions of everyday lives as well as the broader societal structures that help shape these conditions (Graham, 2009). Following the work of CSDH, we further classify these broader determinants into two categories: 1) so-called “intermediary determinants” of health, such as health behavior and material circumstances like housing and neighborhood quality, and 2) structural determinants of health inequality or so-called “causes of causes” such as socio-economic position and public (social and macroeconomic) policies (Solar and Irwin, 2010). It has been demonstrated that action on SDH is often directed at intermediary determinants (Graham, 2009; Collins and Hayes, 2010; Shankardass et al., 2012). In order to affect how health is distributed in the population it is necessary to act on the causes of causes as well (Solar and Irwin, 2010; Chaufan et al., 2014). Chircop et al. (2015) note that the way the relationship between SDH and health equity is conceptualized is not neutral, but depends on the discourses they are presented in (Chircop et al., 2015). Therefore, how we delineate SDH legitimates certain actions while making others improbable (Blackman et al., 2012). As such, we need to focus on the ways in which SDH is being constructed as an object of intervention.

Concerns for SDH have been accompanied by calls for intersectoral action (Exworthy, 2008; CSDH, 2008; Chircop et al., 2015; McQueen et al., 2012). This rests on the notion that health is created outside of the healthcare sector (de Leeuw and Clavier, 2011; Leppo et al., 2013; Kickbusch et al., 2014). Health considerations in policies and programs of all key sectors are therefore necessary to tackle the SDH, and intersectoral policymaking is generally presented as the means to do so (Shankardass et al., 2012; Freiler et al., 2013; McQueen et al., 2012). Since the Ottawa Charter called for healthy public policies (WHO, 1986), various approaches have tried to put health on the agenda and achieve policy level integration across sectors. These approaches vary in scope and content from ad-hoc partnerships to more systematic governance approaches like Health in All Policies. They share the aspiration of a policy practice that take health into account by “including, integrating or internalizing health” (McQueen et al., 2012) in policies and programs that shape or influence the SDH (McQueen et al., 2012; Freiler et al., 2013; Ståhl et al., 2006; Leppo et al., 2013). In this paper we use the term intersectoral policymaking to define government-centered action that reflects this aim. By policymaking we understand the government processes of planning, prioritizing, implementing and evaluating public policies at all levels of government.
Despite the many attempts to do intersectoral policymaking in recent decades implementation has been difficult (Baum et al., 2014; Exworthy, 2008; Exworthy and Hunter, 2011; Carey and Crammond, 2015; Shankardass et al., 2014; Ollila, 2011). On the one hand, policy studies have showed that the policy process is not linear (Clavier and de Leeuw, 2013; deLeon, 1999) and implementation of policy decisions necessarily changes the policy in question (Pressman and Wildawsky, 1984; Peters, 2014). Beyond that, we are only beginning to comprehend the reasons for successful implementation or failures of intersectoral policymaking for health, and scholars call for a better understanding of the intersectoral policy process (de Leeuw and Peters, 2014; Shankardass et al., 2014; Freiler et al., 2013; Carey and Crammond, 2015; Chircop et al., 2015). In this paper we explore the intersectoral policy process and the role it plays in constructing SDH as an object of intervention using the case of Danish municipalities.

The Danish case – intersectoral policymaking by local governments

The Danish welfare state is universalistic (Esping-Andersen, 1990) and relies on decentralization (Bogason, 2013). Local government is responsible for the majority of welfare services. Historically, municipalities are responsible for local services such as schools, daycare, traffic, physical planning and social services, while the main healthcare services are part of the regional jurisdiction (Bogason, 2013). A reform in 2007 made municipalities responsible by law for population health promotion and prevention (Hanak et al., 2007; Waldorff, 2013; Larsen et al., 2014). The reform was developed with intersectoral action in mind, and municipalities were expected to utilize the opportunities of integrating health perspectives into the work of non-health sectors. The guide to the Danish Health Act states “prevention and health promotion are multisectoral tasks. Municipalities have good opportunities to adopt a holistic approach to the task of prevention and think health efforts together with activities in other sectors, such as the social sector and environment, health, transportation, employment and education” (Hanak et al., 2007). In Denmark, the term “sundhed på tværs”, which directly translated means “health across”, is a dominant discourse (Sando et al., 2010). It is a generic expression that reflects a concern for acting on the SDH across sectors. Many municipalities have established governance structures such as interdepartmental committees and/or introduced health on the municipal agenda in existing meeting structures to ensure joined-up-government. Some have founded units with an intersectoral mandate and/or council committees to ensure coordination between policies (Hansen and Jørgensen, 2008). As such, Danish municipalities make a unique case for studying intersectoral policymaking. De Leeuw and Clavier (2011) argue that, “the policymaking processes at the local level have always, better than the national level, allowed for creating the conditions for healthy public in all policy engagement.” (de Leeuw and Clavier, 2011). In Denmark this is true, insofar as efforts are put into the intersectoral collaboration and many municipalities have made health a strategic objective in overall strategies.

The aim of this paper is to better understand how the SDH is accommodated for or rejected in intersectoral policymaking for health and in particular to explore the significance of intersectoriality in this process using Danish municipalities as a case example. To do this, we examine how the way intersectoriality is practiced affects the way SDH is being constructed as an object of intervention and discuss how this influences the potential for long-term, sustainable healthy public policy.

We argue that attempts to do intersectoral policymaking can end up corrupting the SDH insofar as the process of intersectoral policymaking favors interventions focused on intermediary determinants of health. By corruption we refer to “the process by which a word or expression is changed from its original state to one regarded as erroneous or debased” as defined by Oxford Dictionaries (Oxford Dictionaries, 2015). In this study we use this concept of corruption to capture the displacement and reduction of SDH. The study shows how an emphasis on integrating health into core operations translates as framing health as a means to achieve the objectives of non-health sectors, hence not dealing with the causes of causes and its potential to reduce health inequality. We discuss how the role of non-health sectors changes dramatically depending on the approach to tackle the SDH, which in turn can influence the sustainability and long-term support for and success of intersectoral policymaking.

Methods and data materials

This paper reports on fieldwork carried out in Danish municipalities in 2013-2014 where the first author was studying the phenomenon of “Sundhed på tværs” with an emphasis on intersectoral policy processes. The fieldwork was exploratory in design and guided by the empirical problem that ideas about intersectoral policymaking were highly popular although hard to implement. To explore this apparent paradox, the initial observations were grounded in theory of organizational neo-institutionalism (Meyer and Rowan, 1977; Sahlin and Wedlin, 2008; Ruvik, 2007). This implies a critical perspective focusing on socially constructed institutional reform-ideas and the translation of these ideas into local practice. Some of the data called for further insights from intersectoral policymaking for health, which has also guided this paper.

As part of the fieldwork, the first author visited 10 municipalities. The municipalities were chosen to ensure variation according to 6 criteria: socio-economic situation, size of population, rural/urban location, geographical region, political organization of public health responsibilities, and administrate organization of public health efforts. The first author carried out 49 semi-structured interviews and a number of informal interviews with municipal civil servants from both health and non-health sectors (see supplementary material for further details). Interview participants were selected to represent perspectives and experiences on intersectoral policymaking from both health- and non-health sectors. Beyond public health departments, participants represented social services, employment services, elderly care, schools, child and youth services, leisure activity services and sports, as well as top-level management. The interviews were conducted during visits at local venues. An interview guide was developed as a general template, and then individually designed for each interview to adjust for local conditions. The interviews were all structured to learn more about what intersectoral policymaking and intersectoral action for health meant
to the participants, and how it was organized, implemented and performed. The interviews gave information on processes of intersectoral policymaking as well as access to follow one such process. The first author undertook participant observation over the course of eight months, following meetings and informal situations and conversations.

Data consists of interview summaries and transcripts, audio recordings of meetings and field notes. To organize the extensive material, thematic codes were developed empirically in an iterative process based on readings of field notes, interview summaries and transcripts (Gibbs, 2007). This was aided by ‘messy maps’ (Clarke, 2005) which the first author produced throughout the fieldwork to help structure impressions and analytical themes by mapping observations. Guided by the neo-institutional interest in the social construction of institutions, the coding focused on how concepts such as health, SDH, intersectoriality among others, were articulated and framed in discourse. This relies on the notion that institutionalization occurs through language, as “actors interact and come to accept shared definitions of reality” (Phillips et al, 2004). Due to the exploratory design we remained open to empirical themes that emerged in the coding process. A cross-sectional coding of the interview data was carried out using Nvivo (Mason, 2002). The field notes and audio recordings have been organized more pragmatically and serve to provide context and information on the social interaction in the intersectoral processes. Selected examples from the audio recordings of specific meetings have additionally been transcribed and included in the analysis of specific themes. Quotes are translated from Danish by the first author and edited for readability. Beyond the insights from intersectoral policymaking, we relied on the social epidemiological concept of SDH and the conceptual literature discussing it to structure the final analysis.

Results
To structure the argument, we first analyze the intentions to act on SDH. We then illustrate how the challenge of intersectoriality causes the municipalities to frame health as a means, hereby introducing smaller-scale interventions. Finally, we show how a distinction between health and social issues causes the municipalities to act on intermediary determinants, with significant implications for the role non-health sectors play in promoting health.

Intention to act on SDH
SDH is central when analyzing the Danish case of intersectoral policymaking. The concept was often not used explicitly by municipal actors, but was expressed in other ways, often by references to living conditions or the broad scope of services related to health. One example is how almost all services and functions of the municipality were conceptualized as relevant to health:

“There are not a lot of all the things a municipality already do that is not related to health. If you consider the broad concept of health, you can even consider the garbage collector as such.”

Another example is the prominence in all municipalities of so-called “structural health promotion and prevention” that referred to efforts like urban planning to increase physical activity, and local public policies such as meal policies in daycare centers, among many others. Most municipal civil servants regardless of sectors expressed awareness about a broad and social conceptualization of health, and they emphasized the importance of setting-based interventions (Green et al., 2000) to make “the healthier choice the easier choice”. Further, inequality in health and its social causes and consequences was high on the agenda in most municipalities:

“It is also about equality in health, when someone has more difficult conditions than others [...] Because those who seek early retirement, those who are last, those who are most marginalized, they are the ones with the greatest cocktail of lifestyle problems as well as poor educational backgrounds.”

Consequently, the social and physical environments were seen as central to health in line with the concept of SDH, and upstream interventions (McKinlay, 1974) were considered necessary and desirable municipal action by all municipalities. As in the scholarly literature, concerns for SDH were central to the reasoning that intersectoriality is important to promote health:

“[…] the social determinants of health inequalities, if you look at them, many of them do not relate to classic health efforts. So that's why we say, we have to go out and affect health everywhere we know that health is affected by something. That is, it is the very early childhood, i.e. daycare centers and kindergartens, etc. It is also in schools […]”

The quote illustrates how participating municipalities all considered intersectoral policymaking crucial to impact on health outcomes beyond traditional health services.

The challenge of intersectoriality necessitates integration
All public health departments voiced concerns about the challenges of implementation. They experienced difficulties with motivating and engaging other sectors. Establishing so-called “ownership” and “commitment”, while avoiding “resistance” among non-health sectors, were central concerns, when the public health departments tried to engage other departments in intersectoral policymaking. To overcome this challenge, the public health departments were very attentive to ensure that health promotion and prevention did not constitute an “extra task”. Contrary, such efforts should ideally be integrated into non-health sectors as part of their so-called “core operations” to avoid “resistance”. This notion of integration was taken as a central prerequisite for the intersectoral policymaking to succeed in all participating
municipalities. A few top- and midlevel managers focused on integration of health outcomes into existing management documents such as monitoring and evaluation reports. However, the most common notion of integration was to frame health as a means to achieve the objectives of other sectors:

“*When we talk about intersectoriality, health is not an isolated entity. [...] Intersectoriality means that health is part of other core services. So it becomes a means and a tool to achieve something else.”*

By integrating health into non-health services, it was commonly anticipated that efforts would not only promote health. It would also improve the quality and delivery of these other services. This experience or anticipation, that in order to be successful with intersectoral policymaking health needs to be a means to achieve other objectives, was shared by health and non-health sectors alike. It implied that health departments would need to present health as a “tool” that contributes with “added value” for non-health sectors, in order to legitimately engage them in intersectoral policymaking.

An illustrative example was how interventions targeting aspects related to physical health were endorsed based on the social effects of these interventions, effects that coincided with the objectives of other sectors.

“*It has a lot to do with well-being; that you get the right diet and you are physically active. And it has something to do with self-esteem. If you feel a little sad, we know it helps if you are physically active. So we wanted to see whether it could have an effect on the wellbeing and learning among students*”

The quote refers to a setting-based intervention to improve the availability of healthy food in the school cafeteria and introduce extra physical activity during school hours. This was hoped to improve wellbeing and self-esteem among students and, in effect enhance students’ learning, which is the overall objective of the school sector. This line of reasoning was common; introducing physical activity interventions to increase physical and mental wellbeing in employment and child services (two important areas of responsibility for Danish municipalities) was often mentioned as a means to achieve sector goals of improving employment and ensure better concentration and learning capabilities among students. As such, with this anticipation of health as a means, expectations of smaller-scale health interventions seemed to follow:

“*[…] if you can introduce a smoking policy into an effort to reduce absence in workplaces, or if you can talk food policy into an agenda about wellbeing in daycare, then we’re talking about something completely different. […] KRAM is just not the goal in itself. KRAM is the means to achieve some other things.*”

While the framing of health as a means was a general trend, we observed that some public health officers and top-level managers articulated health explicitly as a means to cut costs. For instance, many of the municipalities were planning, or actively implementing, short interviews in various settings to detect big alcohol consumption among citizens. One public health manager expressed it as “realizing the profits of prevention”. He was preparing a business case on how the municipality could cut its budget to save 40 million Danish kroner on better alcohol prevention. Beyond the preventive potential to detect problematic alcohol consumption earlier, these interventions were hereby endorsed as innovative ways to manage austerity measures by acting on problems before they grow big. They were endorsed as means to save expenses in child and youth services, social services and employment services among others, making it possible to cut costs in their budgets.

**Legitimate health interventions**

The intersectoral policy processes we observed were ongoing negotiations and operationalization of what constituted the main health problems, and in response what the proper health promotion efforts should be. In these processes, it was continuously redefined what sets health apart as an intervention different from existing core operations of various welfare sectors. We observed that the emphasis on health as a means narrowed the scope of interventions to be mostly focused on changing health behaviors.

“But [the suggested health interventions] fall very much in line with the outcome measures in our Child and Youth Policy, which are also a reduction in obesity, fewer smokers, increased participation in afterschool activities and better wellbeing. And then we have the other outcome measures, where health might be a means to reach them. These are a decrease in the number of placements [children placed outside the home], a decrease in the number of youth cases in the family social service center and more children profiting from education”

The municipalities made distinctions between what was considered to be health interventions and other social issues. The social issues were considered to be related, but were not constructed as the object of intervention in the intersectoral policy process for health. As such, these other social issues were not legitimately part of the intersectoral policymaking for health. This restricted the municipalities’ ability to articulate the health effects of broader welfare policies in the context of intersectoral policymaking for health.

1 KRAM is an acronym that is routinely used in public health referring to the risk factors based on individual behaviors; diet, smoking, alcohol, and physical activity. The word ‘kram’ also signifies a hug.
This challenge is well illustrated by a discussion from an intersectoral working-group on how to define priorities in order to intervene on social inequality in health in the child and youth departments (including schools, daycare, social services and a number of specialized services):

“Actually, the fact is that there is a 10 year difference between the Danes who are wealthy and have a good education and the Danes who do not have as much money to spend. [...] We actually see a 10 year difference in life expectancy. The majority of this difference is due to alcohol and smoking, which actually causes 60-70% of the social inequality in health. So if we can do something about these two factors, then we can also do something about the social inequality in health.”

Inequality in health is here presented by a public health officer in terms of accumulation of risk factors and shorter life expectancy among different groups, and the proper intervention is to prevent alcohol and tobacco consumption among young people. In opposition to this, a manager of a youth counselling unit in the same working-group suggested that action to ensure higher levels of education was more important:

“[...] we need to fight alcohol, we need to fight tobacco. I think it is the other way around. That this will be a side-effect when we ensure they get an education. [...] I don’t perceive it as if I need to do something specific. I think that by raising the level of education in our municipality we will indirectly, hopefully, also see a reaction on many other factors. So it might not be called health, but it is certainly included implicitly.”

She suggested that the main intervention should focus on ensuring higher completion rates in secondary education. Education is key to social position, and as such education policies are important in tackling the causes of causes of SDH (Solar and Irwin, 2010; Graham, 2004). It contrasts the emphasis on intermediary determinants such as smoking and alcohol suggested by the public health officer above. In this situation, they decided to focus on smoking prevention in schools. The efforts to ensure more students completing a secondary education were not considered further. They agreed it was already dealt with in a parallel policy processes. A process where the public health office was not involved.

The example above illustrates a general observation throughout the fieldwork, that whenever discussions touched upon existing core operations of non-health sectors, e.g. the educational environment in schools or completion rates in secondary education, participants were quick to re-direct the discussion (back to health interventions), with phrases such as “we already work on that” referring to different policies or parallel policy processes, or as above “I don’t need to do something specific other than what I already do”, suggesting that the core operations could not legitimately be addressed intersectorially in relation to health. Only interventions explicitly introducing smaller-scale health interventions were accepted as legitimate interventions.

The significance of this disposition, to introduce smaller-scale health interventions while not targeting the core operations of non-health sectors, can be illustrated by singling out the positions as the difference between “exemplary school” and “healthy school”. This example is constructed on the basis of the overall fieldwork, where healthy school was commonly addressed, while exemplary school only rarely.

“What cuts across is how to use health to improve core operations of other departments: When the educator realizes ‘well this food and meal scheme actually makes sense because my kids thrive. This health and exercise, well the citizens are really happy [...] and hey, the kids started concentrating in school because we have made a playground where they always stay’ [...]”

The framing of health as a means favored what we here term healthy schools; the emphasis is the school environment as healthy in itself, e.g. by providing healthy food options, ensuring physical activity as part of daily activities etc. Policies are concerned with creating healthy settings to impact intermediary determinants. Contrary, policies that favor an exemplary school approach would be conceptualized as health promoting by ensuring better education and higher numbers of graduates. In effect, this would have an effect on social position (Graham, 2004) and corresponds with a SDH perspective that emphasizes action on causes of causes, such as education policies. The first approach targets the social and physical environments of everyday life, and as such only the social causes of health, not their distribution. The second approach is concerned with the underlying distributive mechanisms of social inequality.

Discussion and conclusion
To sum up, the practice of intersectoral policymaking for health in the Danish municipalities is mainly concerned with introducing smaller-scale health interventions into various settings where non-health sectors are running operations. The ambition of making “the healthier choice the easier choice” is the motto that directs attention to setting-based interventions such as developing urban spaces that motivate and increase access to physical activity. However, they remain focused on intermediary determinants in the sense that these interventions are primarily focused on changing health related behaviors. Not much attention is paid to the health impacts of broader welfare policies. Hereby the structural determinants, that is, the causes of causes of social inequality in health, tend to be neglected. We argue that this can be conceptualized as a corruption of the SDH as it captures a displacement and reduction of the SDH concept. This corruption is most evident when health as a means is articulated as a means to cut costs in non-health sector budgets, but it is not isolated to these cases. The overall observation from the fieldwork has been that the more emphasis municipalities had on intersectoral policymaking for health, the more
emphasis they tended to put on smaller-scale setting-based interventions intended to change intermediary determinants such as health behavior. We argue that the framing of health as a means, which is strategically employed to make intersectoral policymaking more feasible, reinforces this trend, since the pursuit of intersectoriality encourages this focus on smaller-scale health interventions. As such, we show that the intersectoral policy process is not neutral, but ends up favoring certain types of actions while neglecting others. Furthermore, it raises the question whether success in intersectoral policymaking is potentially counterproductive to overall progress on the SDH.

**Absence of “causes of causes” determinants**

Emphasis on intermediary determinants is not isolated to the Danish case (Graham, 2009; Pons-Vigués et al., 2014; Collins and Hayes, 2010). Shankardass et al. (2012) found that intersectoral action mainly targeted downstream and midstream determinants of health. Fewer than a quarter of the articles (22%) described government-centered initiatives addressing upstream determinants in their review of intersectoral action for health equity (Shankardass et al., 2012). Even when policies are intended to act on a broad concept of determinants, Graham (2009) has showed that it is not uncommon to see a “slippage” that gives way to a more narrow focus on risk factors (Graham, 2009). As such, the challenge of insufficiently addressing the causes of causes through intersectoral policymaking has broader implications beyond Danish municipalities.

Emphasizing the causes of causes involves a limitation when studying the municipal level. Structural SDH such as fiscal policy and many redistributive mechanisms are defined by national governments. As such, decentralization has its limits, and national governments also need to implement intersectoral policymaking for health, such as the Health in All Policies approach (Leppo et al., 2013) to complement the work done at local levels. However, as Collins and Hayes (2010) along with Pons-Vigués et al. (2014) argue, local governments have competencies in a number of sectors that can help to reduce e.g. socio-economic inequalities.

**The importance of framing**

As shown, the challenge of implementing intersectoral policymaking for health may reinforce the tendency to neglect the causes of causes. To ensure legitimacy, the framing of health as a means and as something distinct from other social issues, narrows the scope of potential policies and interventions. On the contrary, targeting the causes of causes can often be done without explicitly considering health, and does not necessarily require that non-health sectors work to promote health per se. We note, that neglecting the causes of causes in the intersectoral policymaking for health does not mean that the broader welfare policies are necessarily neglected all together, only that they are not framed as health related and as such not legitimately part of the intersectoral policymaking for health. The framing of problems (and solutions) is thus central to which policies and interventions are included in the intersectoral policy process for health, and consequently how sectors may contribute to promote health. As such, framing is essential to efforts of engaging sectors in intersectoral policymaking. This importance of framing is supported by Freudenberg (2008), who argues that some sectors are more motivated to join efforts on matters such as promoting economic development or reducing social inequalities, prior to health. He emphasizes that deciding on how problems are framed has critical implications for who will join and who can provide leadership (Freudenberg, 2008). This has significant implications for the planning and implementation of intersectoral policies, and as such the success of (future) intersectoral policymaking for health.

Exworthy and Hunter (2011) question the ability of health to catch on as a central policy goal in other sectors. Greer and Lillvis (2014) suggest that one of the problems of intersectoral policymaking is that various sectors must pay the costs of providing healthy policies, while the ultimate benefit is to health (Greer and Lillvis, 2014). We argue that this problem may primarily manifest itself insofar as the focus is on intermediary determinants. On the contrary, a win-win strategy (Ollila, 2011) with an emphasis on broader structural SDH may suit the objectives of non-health sectors better, as the role and responsibilities of non-health sectors are more legible, as are their interests, when intersectoral policymaking focuses on the causes of causes, e.g. ensuring higher levels of education. A framing that includes the causes of causes would potentially combine the interests of health and non-health sectors without corrupting the SDH, thus making it more appropriate for non-health sectors to engage in intersectoral policymaking.

**Changing the role of non-health sectors**

As illustrated with the example of exemplary school and healthy school, the role of non-health sectors varies greatly depending on whether the intersectoral policy process focuses on healthy public policy to improve the causes of causes, or on intersectoral health policies concerned with establishing healthy settings. The distinction between doing exemplary school and healthy school is significant as it changes the main contribution to health, as either providing (free) access to high quality education and ensuring the learning gains of all students, as opposed to functioning as an arena for setting-based interventions to promote healthy behaviors. One is the core objectives of the school sector, what teachers are trained to do and what schools are evaluated on. The other is an external concern essentially benefiting the health sector. Based on this insight we argue that not only is the broader, structural SDH important to promote health and its equal distribution, but it is also more likely to ensure long-term commitment and support for intersectoral policymaking among non-health sectors. The argument is not that one approach excludes the other entirely, as both are surely important. But we suggest that an overemphasis on setting-based interventions (Green et al. 2000) may counteract the ability to address the causes of causes through intersectoral policymaking due to the narrowing scope of “health” interventions. As such, we agree with the critique raised by Carey and Crammond (2014) who problematize the imperative of health at the center of the intersectoral policy process. Drawing on insights from Freudenberg (2008), Carey and Crammond (2015), and Christensen and Legreid (2007) we argue that it should not be considered a problem (but be recognized as a normal state of affairs), when non-health sectors do not have health as their central priority. Governmental silos, although a challenge, exist for good reason (Carey and Crammond, 2015; Christensen and Legreid, 2007). Instead we suggest that recommendations on how to do intersectoral policymaking must adapt to the fact that health is not a key priority of non-health sectors. On the contrary, health is unlikely to effectively
motivate decision-makers of non-health sectors who will pursue solutions to their own problems, rather than an ostensible problem like health (Carey et al., 2014). In a welfare state context the health sector may start with a more humble approach, by emphasizing the (potential) contribution of non-health sectors’ core operations to health. We caution that it is necessary to frame problems broadly in line with the wider structural SDH and strike a balance between health outcomes and social or economic objectives. Careful attention is important to evaluate when health would be better off supporting policies that strengthen other sectors, and when to seek health as an explicit goal of the intersectoral process. This may help to ensure more sustainable healthy public policies.

Acknowledgements

References


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