

Intersectorial health-related policies: the use of a legal and theoretical framework to propose a typology to a case study in a Brazilian municipality

Políticas Intersetoriais Relacionadas à Saúde: uso de marcos legais e teóricos para a proposição de uma tipologia aplicada a um estudo de caso em um município brasileiro

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Abstract *This article analyzes intersectorial health-related policies (IHRP) based on a case study performed in 2008-2009 that mapped the social policies of the city of Piracicaba, State of Sao Paulo, Brazil. The research strategy comprised quantitative and qualitative methodologies and converging information sources. Legal and theoretical conceptual frameworks were applied to the Piracicaba study results and served as the basis for proposing a typology of IHRP. Three types of IHRP were identified: health policies where the health sector is coordinator but needs non-health sectors to succeed; policies with a sector other than health as coordinator, but which needs health sector collaboration to succeed; and thirdly, genuine intersectorial policies, not led by any one sector but by a specifically-appointed intersectorial coordinator. The authors contend that political commitment of local authorities alone may not be enough to promote efficient intersectorial social policies. Comprehension of different types of IHRP and their interface mechanisms may contribute to greater efficiency and coverage of social policies that affect health equity and its social determinants positively. In the final analysis,, this will lead to more equitable health outcomes.*

Key words *Intersectorial action, Health equity, Public policies, Social determinants of health, Brazil*

Resumo *Este artigo analisa as Políticas Intersetoriais Relacionadas à Saúde (PIRS), com base em um estudo de caso realizado em 2008 e 2009 que mapeou as políticas sociais do município de Piracicaba, São Paulo, Brasil. A estratégia de pesquisa compreendeu metodologias qualitativa e quantitativa. Marcos legais e teóricos foram aplicados aos resultados do estudo de Piracicaba, servindo de base para a proposição de três tipos de PIRS: políticas de saúde coordenadas pelo setor saúde e que necessitam de outros para serem bem sucedidas; políticas coordenadas por outro setor, diferente do da saúde, mas que necessitam da participação deste para serem efetivas; e as políticas intersectoriais genuínas, que não são lideradas por um único setor mas sim por um órgão intersectorial criado especificamente para sua coordenação. Os autores sustentam que somente a vontade política do gestor pode não ser suficiente para a promoção de políticas intersectoriais eficientes, e que a compreensão dos tipos de PIRS, e seus diferentes mecanismos de articulação, podem contribuir para o aprimoramento e a cobertura das políticas sociais que afetam positivamente a equidade em saúde e os determinantes sociais. No final, isto irá conduzir a resultados com maior equidade em saúde.*

Palavras-chave *Intersetorialidade, Equidade em saúde, Políticas públicas, Determinantes sociais da saúde, Brasil*

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Introduction

Over the past two decades, Brazil has been experiencing an increase in the number and coverage of national and local social policies aimed at improving Brazilian social indicators. Although the national social and economic situation has been improving steadily, Brazil still has to overcome one of its most striking problems: inequity^{1,2}.

The 1988 Brazilian Constitution states that the objectives of the Republic are to eradicate poverty and marginalization and to reduce social and regional inequities. To achieve these goals, the Constitution recognizes health, education, food security, social assistance, social security, housing, healthy environment, leisure, security and work as social rights for all citizens³.

The main strategy of the Brazilian government to support social rights, and to take action against inequity, has been the promotion of social and economic public policies³. These policies have been formulated, executed and coordinated by sectoral ministries, secretariats and other organizations of the public administration in all federative levels, particularly in the states and municipalities. The administrative organization based in sectors has been a common feature of modern federative nations, but it may, *per se*, jeopardize the sharing of governance power, consensus building and funding of intersectoral policies. Additionally, in Brazil, political issues may contribute to this unfavorable scenario because different political parties usually occupy different administrative levels and different institutions within a level. As a result, institutional fragmentation in social protection policies has led to poor outcomes in tackling complex problems, such as health inequity¹. From the health sector point of view, social rights should not be understood as rights to be fulfilled separately, but instead, as determining factors of the health-disease process.

In a recent publication, Spiegel et al.⁴ highlighted that, to fight health inequity, it is imperative that public policies address social determinants of health intersectorally. The authors noted that regular engagement of different sectors in dealing collaboratively with health determinants at the municipal level in Cuba contributed to a reduction in health inequity and to provision of high standards of health. In a similar vein, Franco-Giraldo and Álvarez-Dardet⁵ had emphasized the perspective of public health policies based on human rights. This kind of approach might shed light on the relationship between public policies and the practice of human rights, beyond the

right to health. It is the fulfillment of human rights considered as a whole that allow a better protection of the right to health itself and the promotion of social equity.

The importance of intersectoral policies for health equity was reiterated in the Rio Declaration on Social Determinants of Health, signed by all World Health Organization (WHO) members in 2011⁶. The principles affirmed by the Declaration of Alma Alta⁷ were then reinforced, i.e., integrated practices aiming at health promotion, health protection and health recovery and rehabilitation should consider the interrelations between the bio psycho social determinants of the health-disease process.

Putting public policies with integrated purpose into practice poses substantial challenges. Several studies have discussed different experiences of intersectoral practices⁸⁻¹³, but knowledge about the mechanisms that may facilitate interrelations across sectors is scarce.

Based on a two-phase study, this paper aims to analyze and to discuss intersectoral health-related policies (IHRP) by applying legal and theoretical conceptual frameworks to a case study on public social policies in Piracicaba, southeastern region of Brazil. By doing so, the authors tried to advance the understanding of the managerial and political needs to pursue intersectoral practices.

Methods

The first phase of the study comprised analysis of part of the results of a two-year research project (2008-2009) that investigated social policies in the municipality of Piracicaba, Sao Paulo State, Brazil. The second phase focused on identifying the legal and theoretical conceptual frameworks used to characterize IHRP. Finally, we use the lessons learnt from the case of Piracicaba and recognition of the conceptual frameworks to propose three main types of IHRP as a contributing strategy to improve the planning and implementation of social policies by governments.

The case of Piracicaba

Piracicaba, a middle-sized city (estimated population 365.440 in 2008), was selected due to the high level of interest expressed by local administrators in collaborating on research in the field of intersectorality. The main objective of the case study was to explore the role of health

workers, at the primary health care level, in disseminating information on social policies to the local communities. For the purpose of this study, social policies were defined as planned actions of particular interventions directed to specific populations that present health-related demands.

The methodological strategy consisted of a "case study" using quantitative and qualitative approaches and converging information sources¹⁴. Ethical approval was given by the Ethics Committee of the Medical School of São Paulo, University of São Paulo. Secondary data consisted of public documents which allowed us to map the social policies in place in Piracicaba during the years 2008 and 2009. A list of social policies was generated. Policy makers and public managers completed written, semi-structured interviews. These interviews included questions on the target population, coverage, budget and duration to characterize the policies. Social policies run by the non-public sector such as non-governmental organizations and religious institutions, were not considered in our analysis due to the lack of systematic information about their performance.

Based on the identified local social policies in place in Piracicaba, we proposed the development of an information tool to help health workers to inform primary health care users on the available social policies relevant to their needs. The guide was made available in printed and electronic versions and was adopted by the primary health care team in their work routine and helped them be aware of the local social policies.

Results and discussion

Eight out of the 11 municipal secretariats offered social policies to Piracicaba's inhabitants. A total of 37 social policies were included in our guide and they were drawn from Health (13 policies), Social Assistance (15), Education (2), Culture (1), Housing (1), Employment (1), Sports (3) and Environment (1). Agriculture, Planning and Industry and Commerce did not promote social policies during the study period. Although several policies were identified, their delivery was unbalanced; the Health and Social Assistance secretariats were by far the main social policy promoters.

The thorough review of the information collected through interviews with policy managers allowed us to classify the 37 social policies according to their target population. Results are shown in Table 1.

Table 1. Number of social policies according to their target population. Piracicaba, Brazil, 2008-2009.

Social policies by target population	N
Assistance to children and adolescents	12
Assistance to disabled people	11
Assistance to vulnerable families	9
Assistance to the elderly	5
Total	37

No rational decision-making process to initiate, plan and implement a social policy was evident. A selective approach to social policies was observed: while some populations, such as drug abusers, had no social policies directed to their needs, some specific groups, such as disabled people and children, were targeted by several policies. It should be noted that by classifying social policies based on their target populations, overlap between categories may have occurred.

Another important finding was that the only intersectoral practice reported was a formal exchange of information on health-related policies between the Health and Social Assistance secretariats. However, these efforts did not result in joint planning of intersectoral policies.

These results were surprising because despite the political will of the local government to approach complex problems with intersectoral policies, most public policies in Piracicaba were fragmented in their origination and implementation. Individual sectoral goals were predominant, without coordination or integration between secretariats. There was thus a need for the government to improve its practices. These findings motivated the current study, which tried to move understanding of IHRP forward. Analyzing the advances in the legal and theoretical landmarks and characterizing different types of IHRP may be considered important steps to building efficient intersectoral practices.

Legal and theoretical conceptual frameworks to understand IHRP

The most relevant international legal documents that comprise conceptual frameworks on IHRP are: WHO's Constitution, which established health as a human right and government responsibility¹⁵; the International Covenant on Economic, Social and Cultural Rights¹⁶; the International Conference on Primary Health Care⁷; and the First International Conference on Health

Promotion¹⁷. These documents provide a solid legal ground for IHRP as they underline the notion that public policies should take the social determinants on health into account. They also suggest that global health is one of the most important social goals, emphasizing that to achieve it, there is a need for action from several other social and economic sectors in addition to the health sector, i.e., it requires intersectoral action. Recently, the Commission on Social Determinants of Health¹⁸ and the Rio Political Declaration on Social Determinants of Health⁶ reinforced the principles brought about by the primary documents. They stated that global health improvement depends not only on equitable and effective health systems, but also on actions involving sectors other than health.

The main legal landmarks on IHRP were accompanied by a relevant theoretical publication reporting on how governments put intersectoral experiences for health into practice. The theoretical conceptual framework for IHRP is based on the concepts of Intersectoral Action for Health (IAH)^{4,19,20} and of Health in All Policies (HiAP)^{12,18}.

IAH is defined as any action in which the health sector and other sectors collaborate to pursue health goals. It includes actions which are coordinated by other sectors and are considered as potential effort to fulfill the right to health²¹. In other words, IAH can be understood as intersectoral public policies that take into account health matters in their development.

A scoping review of IAH for health equity involving governments was carried out by Shankardass et al.¹⁹. The authors analyzed 128 articles and acknowledged four patterns of relationships for intersectoral policies, within health and non-health government sectors. They were information sharing, cooperation, coordination and integration. These patterns provided a better understanding of the main mechanisms used by governments to develop and implement intersectoral policies on the social determinants of health⁸.

Puska and Stahl¹² used another approach, based on a scientific background in public health sciences and epidemiology, to explore the concept of Health in All Policies (HiAP). They suggested that HiAP are public policies which are coordinated by non-health sectors but have an impact on the social determinants of health.

Whereas IAH have health as the main target, HiAP offer a broad understanding on IHRP by identifying, in the health and other sectors, ways

to achieve health goals by tackling the social determinants of health equity. By applying these different intersectoral approaches to the concept of patterns of relationships for intersectoral policies, intersectoral possibilities of action aimed at developing more efficient health results can be identified.

Identifying types of intersectoral health-related policies

There is a need for governments to develop public policies which address social determinants of health and health equity. By analyzing the case study of Piracicaba in the light of the conceptual frameworks, we recognized three general types of IHRP.

The most common type of IHRP are health policies run by the health sector. In such cases, the health sector is the protagonist and coordinator, but needs to co-operate with non-health sectors to succeed¹⁰. Several studies cited examples of this type of intersectoral health policy, especially in relation to issues such as mental health²², dengue control^{23,24}; health promotion²⁵; primary health care¹³, cardiovascular health²⁶, cancer disparities²⁷ and childhood obesity²⁸.

The second most common IHRP are those with a sector other than health as the protagonist. Although not directly concerned with health, these policies have to consider health issues because they may affect health outcomes or be affected by them²⁹. The concept of HiAP can be directly applied to this type of IHRP. Examples include nutrition^{28,30}, agriculture³¹, environment³² and educational policies¹¹.

The third type of IHRP, which we call literal intersectoral policy, refers to public policies that do not have any specific sector as the protagonist. In other words, the planning and implantation of this kind of policy must be shared – literally, joining different sectors. Due to their complex nature, this type of policy is uncommon and not easily acknowledged. However, at least three examples can be cited: public disasters³³, violence³⁴ and drug control³⁵.

Identifying these types of IHRP is important in that it can lead to better understanding of the practical aspects of planning political and managerial structure of local, regional or national governments in dealing with intersectoral policies. For each of them, the different patterns of relationships described in 2012 by Shankardass et al.¹⁹ must be considered (Chart 1).

Chart 1. Types of IHRP and patterns of relationships.

Patterns of relationships/ Type of IHRP	Intersectoral Health Policies	Health in All Policies	Literal Intersectoral Policies
Coordination	Health sector is protagonist	Non-health sector(s) is protagonist	Shared coordination
Cooperation	Non-health sector(s) cooperates with health under its leadership	Health sector cooperates with non-health sector(s) under others' leadership	Formal cooperation between sectors is established at creation
Integration	Health sector leads political process to integrate with non-health sectors goals, administrative tools, actions and their financing	Non-health sector(s) leads political process to integrate health issues into their policies	Integration is part of political creation process among health and non-health sectors. Policies are born intersectorally
Information sharing	Health sector leads process of exchanging information with other sectors about its policies	Non-health sector(s) exchanges information with health sector about policies	Information sharing is part of political creation process among health and non-health sectors

From theory to practice: pathways to implement intersectoral health-related policies

As legal and theoretical frameworks show, intersectoral policies are important to improve the health of populations and promote health equity in Brazil and elsewhere. By identifying three types of IHRP and relating each type to one or more patterns of relationship, it may be easier to acknowledge the practical steps of the organization of intersectoral policies, helping governments to develop IHRP more efficiently.

Although we were able to identify several legal and theoretical frameworks which support the need to develop IHRP, in the case study of Piracicaba there was an important gap between those frameworks and government practices. This gap may have been caused, at least partially, by the difficulty in understanding the pathways that might be followed by governments to implement IHRP successfully.

The starting point of any IHRP includes the clear definition of public policy objectives and the identification of the sectors that need to be involved. By doing this, policy makers can comprehend the relationship between the health goals and the specific policy to be implemented. Moreover, identifying which type of IHRP best fits the policy objectives will facilitate structuring

of government organizations to put policy into practice.

As Chart 1 shows, if the main goals to be achieved are directly related to health, it must be established that the health sector will coordinate the IHRP, as well as defining the patterns of relationships that are going to be used to articulate the health sector with the other sectors involved. The same kind of process should be used when a non-health sector (e.g. housing) has clear responsibility for the IHRP. In this case, the non-health sector will be the coordinator of the policy and the above-mentioned patterns of relationship will apply. On other hand, if the objectives of the health related policy to be implemented point to the need for a literal IHRP, it might be necessary to create a special intersectoral structure to coordinate, evaluate and execute this specific intersectoral policy.

By applying these methods of analysis to the Piracicaba case, two types of IHRP were identified as being practiced by the local government. Thirteen policies could be classified as the first type (policies coordinated by the health sector). Twenty-four policies could be classified as the second type (coordinated by non-health sectors). The third type of IHRP, the literal intersectoral policies, was not seen in Piracicaba.

The only pattern of relationships for intersectoral action reported was an exchange of infor-

mation between the Health and Social Assistance secretariats, the most active sectors in Piracicaba. Although they did not formulate or execute policies together, they shared formal information on their priorities for action. This practice could be interpreted as a first step to integrating these two sectors. As far as the second type of IHRP is concerned, non-health sectors did not initiate any moves towards intersectoral action.

It is noteworthy that there was an imbalance in the distribution of social policies in Piracicaba. While some groups, such as disabled people and children, were targeted by several policies, other groups, such as drug abusers, were not covered by any social policy. This finding demonstrates that poor intersectoral practice is preventing the local government from building a more comprehensive plan to deal successfully with their public health issues.

It is, however, not surprising that no literal intersectoral policies (third type) were found. The political challenges and administrative technologies involved in this type of intersectoral policy require an administrative structure and a work culture that is not usually seen. Intersectoral practice demands an institutionalized administrative structure specifically created to facilitate intersectoral relationships. The political will to tackle complex problems in Piracicaba was not enough to guarantee intersectoral action.

Final considerations

Although governments and scientists recognized the need for IHRP to achieve health equity for future decades, our findings illustrate that putting IHRP in place is not an easy task. Piracicaba and most middle-sized cities face complex problems but local governments usually deal with such problems on a sectoral basis. By functioning in a fragmented way, different sectors may be unaware that they are targeting their actions towards the same populations as other sectors.

One way to promote IHRP is to create institutional tools to formalize intersectoral strategy

as a political and administrative reality. To influence health determinants it is necessary, then, to put together health sector and non-health sectors with the same goals, sometimes even under the same public authority, or under a shared coordination practice. Public policies are only able to promote positive results in health development if policy makers are capable of organizing different sectors' skills and of orienting them towards the same goals. To improve the efficiency of IHRP we must consider the need to create specific intersectoral institutions or mechanisms within the government structure. This will allow different sectors to work together to define goals, plan actions and define financing, as well as to evaluate the results.

By analyzing the local level practices on IHRP and by combining them with the legal and theoretical frameworks, we could identify three general types of IHRP. For each type, different patterns of intersectoral relationships and different coordination structures may be needed, helping to clarify the planning and managerial strategies required to improve intersectoral actions for health and also the role that health sector must play in different types of IHRP. When the demand is for an intersectoral health policy, the health sector must be the protagonist and create the conditions for intersectoral relationships. When it is the health in all policies type of IHRP, governments may need to establish institutional mechanisms to implement coordination, cooperation, integration and information sharing among all the sectors involved. Finally, when the demand is for a literal intersectoral policy, governments may consider an intersectoral administrative structure capable of bringing together different sectors in order to formulate and coordinate the policy, sharing responsibility evenly.

Comprehension of different general types of IHRP and the necessary pathways to develop successful intersectoral public policies may contribute to better efficiency and coverage of social policies that affect health equity and its social determinants positively. Eventually, this will lead to more equitable health outcomes.

Collaborators

BH Tess and FMA Aith participated in the general conception, research and final writing.

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