Workshop Proceedings November 3-5, 2008 – Vancouver, CANADA

INTERSECTORAL ACTION TO IMPROVE HEALTH:

Applying evidence, achieving impact

WHAT HAS BEEN LEARNED? WHAT IS NEEDED? WHAT IS NEXT?

BACKGROUND

In February 2008 a workshop of Canadian and Cuban health researchers on "Intersectoriality in the Social Production of Health: Sharing perspectives and experiences to orient a Cuba-Canada research program" was held in Havana, Cuba. This session was successful in stimulating discussion on conceptualizations in each country with regard to health determinants, their intersectoral management and the role of primary care practitioners in this area and pointed to priorities for follow-up.

The workshop revealed that perceptions of key challenges were different in each national setting. For instance, in Canada, health research and policy areas themselves were seen as compartmentalized in distinct areas, such as "public health", "population health", "health promotion", "community health" and "primary care"; while Cuba tends to embrace a broader definition of public health that encompassed these areas, albeit with different areas of specialty still recognized. For Canada, a predominant challenge appears to be achieving integration in both setting agendas and implementation; while for Cuba the challenge is especially seen as maintaining community participation and ensuring effectiveness in execution of policies. Draft proceedings of the workshop are attached.

The Havana workshop especially provided a timely opportunity to take stock of research findings from pilot studies that had been conducted in Cuba by members of the Canada-Cuba team, and to refine the research protocol for a new study on the intersectoral management of health determinants. Notably, it also permitted a consideration of another globally recognized "success story" in achieving excellent health outcomes in a context of relatively low income by looking at the Indian State of Kerala. Interest was expressed in thus pursuing the possibility of bringing together researchers from Kerala and Cuba to explore a broader perspective of the "social production of health." A funding proposal that had been submitted to the Canadian Institutes of Health Research was subsequently approved, but the Havana workshop represented the first opportunity to provide face-to-face discussion of this opportunity – and especially exploration of recent trends in response to policy changes

It was agreed at the Havana workshop that drafting of papers on specific topics should be pursued to explore specific relevant issues with consideration of Cuban and Canadian experience; that the final protocol for the "intersectoral management of determinants" study be refined and pursued; that a "template" case study examination be prepared and that a workshop for the fall of 2008 be conducted to follow up on all identified areas and to allow an exploration of a collaboration to include consideration of the Keralan experience, perhaps leading to a new research proposal.

OBJECTIVES OF VANCOUVER WORKSHOP:

1. *Reassessing "social production of health"*. Can the concept of a "social production of health" be usefully reframed from how it was discussed in Social Science & Medicine in 2005, to address issues raised through the Commission on Social Determinants of Health?
2. *Intersectoral management and health outcomes*. Can we develop methodologies for evaluating intersectoral processes for managing health determinants and their contribution to achieving improved health outcomes?
3. *Intersectoral management and primary care revisited* – Observations re Canada, Cuba, Kerala
4. *Canada-Cuba-Kerala collaboration*. What would this collaboration look like? What are the common research questions for a research program?

REVISITING THEMES FOR FURTHER EXPLORATION

As the management of health determinants necessarily involves forces that go well beyond those that are more narrowly involved with the provision of healthcare services, the specific challenges discussed in Havana serve as specific areas for further examination:

a) Perspectives on Health Determinants
   - *How is health conceptualized and how is it addressed through public policy?*
   - *What are the implications for agencies involved and not involved with health care?*

b) Intersectoral Management
   - *How is Intersectoral Management conducted to consciously ensure that conditions in support of population health are created – systematically, case by case or rarely?*
   - *How do we more explicitly factor in and analyze concepts such as "political will" and "community participation"?*

c) Use of evidence
   - *How is health information produced and used to support intersectoral management - systematically, case by case or rarely? Are the techniques adequate?*
   - *Are there opportunities for greater effectiveness, efficiency, communication, translation?*

d) Role of primary care and other health care providers
   - *How are health care professionals involved in the management of health determinants?*
   - *Exclusively, intermittently, or rarely?*

EXPECTED OUTCOMES

- Print and electronic publications of papers prepared for the workshop with specific timelines and writing teams (Preparation of a special journal issue or a monograph).

- A work plan for further areas of collaboration, including possible new proposals e.g. based on the concept of "Revisiting 'Good Health at Low Cost'".
- Detailed work plan for the "Intersectoral Collaboration in Securing Health Outcomes" project involving three Cuban Provinces.
- Consideration of desirability of a follow-up conference in Cuba, and the necessary conditions that would make this feasible and other future conferences/events
- Clarification of opportunities for mentoring trainees and students

DAY 1: TAKING STOCK OF DEVELOPMENTS AND OPPORTUNITIES

What are the key questions to explore?

The day started off with the query: What are the questions to examine with regard to social production of health, intersectoral management of health determinants and methodological challenges? These questions are more comprehensively raised in the background papers

Evans' paper visually positions Cuba as the "black swan" which proves that not all swans are white – that is, Cuba shows that good health can be achieved with limited financial resources. In fact wealth is neither necessary nor sufficient to achieve good health, according to Evans. Rather, a primary care physician "trained in both the medical and non-medical aspects of health" who is held "accountable for the health of their populations and provide them with channels through which to influence the relevant non-medical determinants" may seem to be the operational key to the social production of health. Succinctly put, good population health can be achieved with "conscious political will and people trained to carry it out".

Spiegel's paper is based on many years of observing the Cuban healthcare system and conducting collaborative research in Cuba. He reflects that while most countries have failed in the implementation of the principles of Alma Ata established 30 years ago, "the evolution of Cuba's health policy has closely echoed" those principles. Spiegel elaborates in more details on "how concepts such as 'intersectorality' and 'community capacity' have been central to [effective] implementation" of health policies. The paper also addresses "factors such as 'social capital' and 'political will' … not as rhetorical concepts, but as constructs that can systematically be observed in examining how health determinants can be addressed in any society, not just in the context of the fascinating 'Cuban natural experiment'." Case study reports from research in Cuba are given to illustrate how the social production of health is carried out in Cuba.

What do we know about Intersectoral management of health determinants?

Heather Fraser of the Public Health Agency of Canada (PHAC), focused on the intersectoral action (ISA) to improve health by reflecting on the WHO Commission on Social Determinants of Health (CSDH) and how ISA is positioned, and providing learning from the Canadian Case Study. The key messages of the CSDH final report include:

- Health and social inequalities are costing lives
- Health inequalities can and have been reduced through policy action

- Investment in early child development represents the greatest chance of health inequalities reduction and best return on investment
- Strengthening the system of social protection will improve health at little cost to the economy

The report recognizes that a key strategy to achieve coherent health policy and for addressing the social determinants of health and health equity is the Intersectoral Action for health. Further, among other recommendations, the CSDH recommends that:

- Parliament and equivalent bodies adopt health equity as a marker of societal progress and a measure of govt. performance
- National govt. establish a govt. mechanism that is accountable to parliament, chaired at the highest political level possible

Fraser reported that in an effort to increase knowledge on use of intersectoral action to reduce health inequities, and identify next steps and supports, PHAC has published an analysis of 18 Country Case Studies in May 2008. A few challenging learning lessons have risen from those case studies such as better understanding of the role of health sector, evaluating and attributing outcomes, and sustaining interest over time and through political change. Within the Canadian context, lack of models, tools and accountability frameworks were mentioned as other challenges.

What we have learned since the Havana workshop?

The Havana workshop held in February reviewed the progress of the joined Canadian-Cuban pilot project on intersectoriality and made a recommendation to conduct a case study in order to better understand the link between intersectoral action and health outcomes. The case study focused on early child development since this is one of the major programs in Cuba. Barbara Martinez, a colleague from the Centro Provincial de Higiene, Epidemiologia y Microbiologia of Villa Clara, Cuba, gave a detailed report of that case study.

The study covered two health areas (Area de Salud) and interviewed a wide range of decision-makers within and outside the health sector. One of the health areas (Chiqui Gomez) had an infant mortality rate 3 times higher than the other (José R. León) during the period 2001-07.

In terms of health determinants in the two areas the role of political will and action was found to be similar, whereas others such as physical, social and economic environment, family and social influence, individual characteristics and health services were found to differ in the two areas.

Some of the relevant sectors that are involved in the healthy child development program were: Agriculture (food production), Ministry of Interior, Institute of Sports, Culture, the Federation of Cuban Women, School Children Organization (Organización de Pioneros), Federation of Intermediate Students (high school students), Federation of University Students, Red Cross, Ministry of Education and Ministry of Health.

This case study revealed that the intersectoral structure, functionality, action and flow of information were found to be similar in the two areas. Nevertheless, when other indicators are

taken into account, disparities may appear in connection with infant mortality rate; for example, Chiqui Gomez health area showed a higher teen pregnancy rate and poorer personal health practices and poorer health services which resulted in lower performance of health programs.

In a typical Cuban fashion, results from this case study immediately prompted a quick response and Martinez announced that a new home to provide services for young mothers has already been created in the Chiqui Gomez health area at the time of this report.

Adolfo Alvarez PRESENTATION

Pastor Castell is the leading professional on intersectoriality in Cuba. His presentation was based on the content of his book on "Intersectoriality in the Social Practice" (Castell, P. (2007). *La intersectorialidad en la práctica social*. Editorial Ciencias Médicas, La Habana, Cuba). His main message was that intersectoriality has to transition from empiricism to a more technological approach at the managerial level developing and taking into account knowledge, concepts, methods and instruments. At other levels, intersectoriality requires national and local policies. The action needs to be not only intersectoral but "integral" (intersectoriality versus integrality). Finally, based on the Cuban experience, the "integrating" element must be the public health sector with its ultimate objective to improve population health. In his book Castell emphasizes the need for training of professionals in intersectoral approach.

What should we know about the Kerala experience ?

Moving from Cuba to another area of interest for its achievements in health outcomes in spite of financial constraints, D. Narayana presented a different view for the case of the Indian State of Kerala. He presented some indicators of incidence of vector-borne diseases in high growth Indian States including Kerala. Taking Dengue, Chikungunya and Malaria as such indicators Narayana asks: Why are the high growth states not able to reduce incidence? Where is the failure?

More specifically in Kerala other indicators suggest health related problems: inadequate sewage system, only 24% of the population uses piped water (most use well water), highly contaminated water, and poor garbage disposal. Kerala is the first state where all the districts have been affected by dengue for three consecutive years.

Finally, Narayana wondered whether public health in Kerala, which does not have any intersectoral action, is in decline given the following current challenges: poor presence of public health care personnel and services and uneven geographical coverage, continued spread of the private sector in healthcare, poor regulations, decreased response capacity to new emerging diseases, and reemerging diseases.

C. U. Thresia, also from Kerala, presented a point of view more in accordance to the common knowledge of Kerala. She reported health indicators that are better when compared within India or with other Asian countries. These are: infant mortality rate, children under 5 mortality, maternal mortality and life expectancy. Some historical factors can be credited for the good health outcomes such as social reform movements, a communist government with progressive policies (public sector allocation of 10-15% to health and 20-25% to education), land reforms

(distribution to the landless) and public action. Other enabling factors that were mentioned by Thresia are: higher levels of Literacy (>90%) especially female literacy (87%), better distribution and utilization of health care services (97% institutional delivery), and relatively fair distribution of income and other resources.

Admittedly, the situation is changing in Kerala. Some health indicators have deteriorated recently (higher infant mortality rate from 11 to 15 per 1000). But this has occurred at the same time of declining public allocation to the health sector, increasing market orientation of health sector and growing unregulated private sector. More social challenges have also appeared such as increasing unemployment, health inequality and increased violence against women. Kerala ranks highest in suicide rate among Indian states (26.8%); while average in India is 10.5%.

DAY 2: WHAT VALUE CAN WE ADD THROUGH COLLABORATION? HOW COULD WE DO THIS?

What is the value of a transnational approach? How can it be conducted?

Katia Mohindra re-examined the report "Good health at low cost" (Rockfeller Foundation Conference in 1985) in considering the value of the transnational approach in global health research. That report examined four societies with high achievements in health despite relatively poor economies: Kerala, Sri Lanka, Costa Rica and China. Cuba was not included in that study which raises the question: "Why has the debate on solving the most urgent challenges in public health in poor countries ignored the experience of success?" (Cooper et al. 2006).

The CSDH (2005) was quoted saying: "A generation later, the issues raised in Good Health at Low Cost [GHLC] remain relevant, and it is well worth looking in greater depth at some of the strategies pursued by GHLC countries which contributed to their status as good practice models." To this effect Mohindra reported that for "Good Health at Low Cost in the 21st century" preliminary workshop with academics from US have been conducted to explore follow-up of GHLC cases and new cases; also included may be case studies, perhaps of paired entities for comparisons (e.g., good performers compared to bad performers). This does not appear to be in the public domain.

Mohindra ended her presentation with an invitation for the workshop participants to engage in discussing the following questions:

- What issues are of interest to your society – and could benefit from a comparative approach?
- What interests you from other societies – Cuba, Kerala, Canada?
- What from your society do you think needs to be disseminated globally?

This was followed by group discussions.

How are primary care services linked to managing health determinants?

Veronic Ouellette presentation

Next presentations of the day focused on examples of how evidence can be used to support effective decision-making and one specific example of methodology that can be used to produce evidence about the intersectoral management of health determinants.

How can we use evidence to support effective decision-making?

Andrew Kmetic from the Provincial Health Services Authority (PHSA) addressed evidence and decision-making in the context of British Columbia (BC). In BC there is a core function of Health Assessment and Disease Surveillance (of which Health Authorities are members) at multiple levels and across sectors of the health authority, ranging from community engagement and front-line detection and response, to interpretation of regional aggregated data, and planning and decision-making by senior management.

Another example of intersectoral action was given by the work of the Population and Public Health Evidence and Data Expert Group which is jointly chaired by the Ministry of Healthy Living and Sport and PHSA; it includes the Ministry of Education, Ministry of Agriculture and looks at indicator definitions and data sources.

Yet another example is the BC Healthy Built Environment Alliance whose purpose is to foster inter-sectoral networks and to provide a venue to coordinate knowledge exchange and key activities around health and the built environment in BC. One of the objectives is to provide a forum for the sharing of knowledge, evidence and data between the members in support of the development of programs and policies that will improve population health, and better practices related to the built environment. Some of the outputs are: Health & the Built Environment – knowledge synthesis, indicators development and health impact assessment development.

Ultimately, at a practical level, questions still remain on how to make data/knowledge appealing/applicable using an intersectoral approach.

The last presentation of the day was given by Deepthi Jayatilaka, a graduate student whose interest is in food security and is also working at PHSA. Her presentation addressed a resource guide that was developed by PHSA on how local governments can engage partners to promote food secure communities around the issue of obesity and healthy eating. The benefits to local governments are: improve the local economy, improve the environment and improve health and community.

One program is in place called “Community Food Action Initiative” that was created in 2005 as a systems approach to supporting healthy eating. The relevance of promoting healthy eating is that from a health perspective, what is important is affordability, availability, accessibility of food – none of which fall within health’s mandate.

Evaluating Intersectoral management - methodological challenges

Nino Pagliccia presented some results from the Canada-Cuba collaborative study in two Cuban municipalities. Information from focus groups of decision-makers representing up to 15 sectors (health and non-health) about links they had with other sectors on 11 health determinants was processed using network analysis. The analysis provides measurements (among others) of

intensity of intersectoral actions for the intersectoral space that is represented by the municipal Health Councils as a whole. Health Councils were created in Cuba in 1995 and are subcommittees of the Popular Councils (government level) with a mandate to address health determinants, facilitate the intersectoral collaboration and solve health problems in the community.

Some of the findings presented were:

- Striking similarities in patterns of measurements across health determinants despite the variation between the two Cuban municipalities in the measurements used.
- Similarity in patterns of network density in the two municipalities that suggest common intersectoral policies albeit with different outcomes.
- Variation in the intersectoral management of some health determinants; for instance, Education, Healthy Lifestyles and Healthy Child Development have a relatively good network density with many central sectors suggesting that an active flow of information and resources in the network is possible.
- Shared collective responsibility that may confirm the claim of a decentralized health structure in Cuba.

The study concludes that network analysis seems to be a suitable tool to evaluate intersectoral action and produce evidence.

What do we mean by political will? How do we analyze this and why?

One issue that has been suggested as key in the intersectoral management of health determinants is the government determination and commitment or "political will". What do we mean by political will? How do we measure it and why?
Adolfo Alvarez reported on the Cuban expression of political will and its relevance in achieving good health outcomes. He graphically motivated the interest of participants on why we need political will by showing cases of extreme poverty in the world, extreme concentration of wealth in developed countries while Africa, the poorest continent, has extremely high incidence of HIV. Given this scenario, the need to develop coherent policies on primary healthcare should be one of the objectives of political will. Reforms in primary healthcare should have priority from the current commercialized focus to one that strives for health equity, universal access to people-oriented care and healthy communities. Reforms are called for in universal coverage, service delivery, leadership and public policy. This has been the transformative process that Cuba has undergone in the last 50 years.

To stress the power of political will in health, Alvarez also referred to a current case in Venezuela where the implementation of the government sponsored "Misión barrio adentro" is producing dramatic improvements in health care by focusing where the need is highest – the "barrio" (slums).

Alvarez is aware that he has not answered all the questions about political will: What is it? How to implement it? How to measure its impact? Which methods and instruments to use? But he does offer a possible definition that is applicable to the Cuban case: "[Political will] Is the real and total commitment of the state and government (at every level) to act according to the public

discourse and make a reality of public policies in health, well being, quality of life and human behavior. It must have as a mandate the integration of the political action and socioeconomic needs."

Bob Evans presentation

DAY 3: NEXT STEPS – OPEN SPACES FOR SMALL GROUP WORK

APPENDIX A: PARTICIPANTS

INVITED PARTICIPANTS

Canada:

1. Robert Evans, UBC CHSPR
2. Ryan Hoskins UBC Family Medicine Resident
3. Katia Mohindra
4. Louise Nasmith
5. Nino Pagliccia
6. Jerry Spiegel
7. Annalee Yassi
8. Veronic Ouellette
9. Deepthi Jayatilaka
10. Kendra Foster
11. Ben Brisbois
12. Azar Mehrabadi
13. John Millar (regrets – not able to attend)

Cuba

1. Adolfo Alvarez Perez, Vice-Director, INHEM (Research, Training, Scientific Information)
2. Pastor Castell Director of ENSAP (Escuela Nacional de Salud Publica)
3. Barbara Martinez Director of CPHEM (Centro Provincial de Higiene, Epidemiología y Microbiología) of Villa Clara

Kerala

1. D. Narayana, Professor, Centre for Development Studies
2. C.U. Thresia, Senior Research Fellow, Achutha Menon Centre for Health Science Studies

APPENDIX B: WORKSHOP AGENDA

Day 1: Monday, Nov 3*: Taking stock of developments and opportunities*
WHAT HAS BEEN LEARNED? ; WHAT IS NEEDED? ; WHAT IS NEXT?
(Liu Institute Multi-Purpose Room)

8:00 Coffee / Refreshments

8:30 – 9:00 ***1a) INTRODUCTIONS: Purpose of workshop & individual introductions***

Responsible: All participants to introduce themselves – Jerry Spiegel / Adolfo Alvarez introduce session
Material: Background & Objectives section of agenda; Proceedings from Havana

9:00– 10:15 ***1b) What are the key questions to explore?***

Responsible: - Jerry Spiegel: perspective on significance of Cuba experience;
- Adolfo Alvarez: significance of framework introduced in Havana workshop
What are the questions to examine with regard to social production of health, intersectoral management of health determinants and methodological challenges?
- General Plenary Discussion on key questions
Material: Draft papers (Jerry Spiegel: Beyond health services; Bob Evans: Thomas McKeown)

10:15 – 10:40 BREAK

10:40- 12:00 ***1c) What do we know about Intersectoral management of health determinants?***

Responsible: Heather Fraser, Public Health Agency of Canada (PHAC): The Crossing Sectors project and the Commission on Social Determinants of Health – What has been learned? What is next?
Discussant: Pastor Castell
Material: Crossing Sectors and Case Studies documents prepared by PHAC

12:00 –13:00 LUNCH BREAK (on-site)

13:00 – 14:30 ***1d) What we have learned since the Havana workshop?***

Responsible: Cuba team
Presenters Barbara Martinez - Reporting on the Villa Clara case study
Adolfo Alvarez - discussion of significance re how determinants are managed
Pastor Castell - discussion of significance re intersectoral capacities
Plenary Discussion

14:30 – 15:00 BREAK

15:00 – 16:30 ***1e) What should we know about the Kerala experience ?***

Responsible:
Presenters: Narayana / Thresia (20 minutes each)
Discussant: Katia Mohindra (10 minutes)
Questions and discussion (40 minutes)

16:30 – 17:00 ***1f) Wrap-up***

Comments on the day

18:30 DINNER

Day 2: Tuesday, Nov 4 – What value can we add through collaboration? How could we do this?
WHAT HAS BEEN LEARNED? ; WHAT IS NEEDED? ; WHAT IS NEXT?
(Liu Institute Multi-Purpose Room)

8:30 – 8:45 ***2a) Organization of the day***

Orientation to examining research activities and outputs that we can produce/ take stock of day 1
--Introductions with reference to general questions and perspective on their national context;
--Discussion introduced from other national perspectives; General exploration of opportunities to follow
Responsible: Jerry Spiegel / Adolfo Alvarez

8:45 – 10:10 ***2b) What is the value of a transnational approach? How can it be conducted?***

Presenter: Katia Mohindra (consideration of a "Revisiting Good Health at Low Cost" approach) -25 min
-Small group discussion of opportunities / key questions / approaches (30 min)
-Plenary (30min)

10:10 – 10:30 BREAK

10:30 – 11:30 ***2c) Evaluating Intersectoral management - methodological challenges***

Presenter Nino Pagliccia – Network analysis as a tool to assess intersectoral management (25 min)
Discussants (5-10 min each): Pastor Castell; Thresia (5-10 minutes each)
Discussion :
Material: Network analysis draft;

11:30– 12:30 ***2e) What do we mean by political will? How do we analyze this and why?***

Presenter (25 minutes): Adolfo Alvarez
Discussants (5-10 min each): Narayana, Jerry
Discussion:

12:30 – 13:30 LUNCH BREAK (on site buffet)

13:30 – 14:30 ***2d) How are primary care services linked to managing health determinants?***

Presenters: Louise/Veronic/Ryan
Discussants (5-10 min. each): Barbara; Thresia?
Discussion:

14:30 – 15:30 ***2e) How can we use evidence to support effective decision-making?***

Presenters : Andrew?
Discussants : Pastor; Katia
Discussion:

15:30 – 15:45 BREAK
15:45 – 16:30 ***2f) Reflections on the global significance of looking at Cuba, Kerala and Canada***

Presenter: Bob Evans
Discussants (10 min each):
Questions: 25 minutes

16:30 – 17:00 2g) Next steps

Comments on the day
Plan for Wednesday, Nov. 5

Evening : Get-together for pizza, salad etc and watch US Election results

Day 3: Wednesday, Nov 5 ***Next steps – Open spaces for small group work***
(Global Health Research Program Rooms – 4th Floor, 2206 East Mall)

8:30 – 8:45 ***Introduction: Organization of the day***

Introduction to plan for taking stock and planning next steps for research program Presenter: Jerry Spiegel

12:30 – 13:30 LUNCH BREAK (on site buffet)

Future Directions– Where we go from here

New ideas based on exchanges - Plans for dissemination / publications - Plans for a follow-up in Havana (2009) - Plans for further work in the area - Basis for a proposal Facilitators: TBA

15:00– 17:00 PLANS FOR NEXT STEPS

(REFERENCES)

Robert Evans: Thomas McKeown, meet Fidel Castro: Physicians, Population Health and the Cuban Paradox. Healthcare Policy Vol. 3 No. 4, 2008.
Jerry Spiegel: Beyond health services: Channeling capacity to manage health determinants.
Other materials