Health in all policies (HiAP): A realist multiple explanatory case study examining the implementation of HiAP

by

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ABSTRACT

Health in All Policies (HiAP) is a health promotion strategy that aims to improve population health and equity through a whole-of-government approach to the development and implementation of public policy. This dissertation tests the hypotheses about factors that shape implementation of health in all policies in multiple jurisdictions. The study: (1) through a narrative review, reviewed public health perspectives on HiAP, focusing on the role of politics in implementation, (2) using a single explanatory case study, advanced theory about buy-in for HiAP in California, and (3) through a multiple explanatory case study, advanced theory about the influence of non-state actors in HiAP implementation in a number of jurisdictions, namely, California, Norway, Ecuador, Thailand, and Scotland.

Data for the narrative review were obtained from the peer-review literature and data for the explanatory case studies relied on primary data collected during 2012 to 2015 and

secondary data extracted from the HARMONICS (HiAP Analysis using Realist Methods On International Case Studies) study at the St. Michael's Hospital Centre for Urban Health Solutions. The narrative review provided broad perspectives on political considerations in the HiAP literature, while the realist explanatory case study methodology advanced theories of the mechanisms involved in the implementation of HiAP in multiple jurisdictions. These methodologies were complemented by the systems framework which serves as a heuristic tool to aid policy makers and HiAP researchers better understand how government sectors implement HiAP initiatives, and how non-governmental actors shape implementation.

Primary findings are multifaceted. First, the narrative review revealed a paucity of political considerations in the public health literature on HiAP implementation. Second the findings revealed strong evidence on the factors that contributed to buy-in in California. We found buy in for HiAP occurs when: 1) there is a history of prior experience, 2) governments employ knowledge translation, 3) governments employ sectoral language, 4) governments use dual outcomes, 5) governments use expert advisors and, 6) governments employ consensus building. Third, the findings of the cross-case analysis of non-state actors influence on HiAP implementation found weak support for the influence of supranational institutions, medium support for private sector, low support for civil society.

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TABLE OF CONTENTS

CHAPTER SIX: Non-state actors influence in HiAP implementation: a realist explanatory multiple case study of HiAP implementation in Norway, Finland, Scotland, Thailand, Ecuador and California

CHAPTER SEVEN: CONCLUSION AND SUMMARY OF FINDINGS

LIST OF TABLES

CHAPTER 2

CHAPTER 3

CHAPTER 5

CHAPTER 6

LIST OF FIGURES

CHAPTER 3

Appendix A

CHAPTER 6

APPENDICES

CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

Health promotion is a process that enables people to increase control over their health and as such, improve it (Porta, 2008). Because “health, disease, and well-being are complex states that develop and change over the entire life course…[n]o single intervention, or set of interventions, is likely to address the wide range of factors that influence health, disability, and longevity” (IOM, 2000, p.5). Health promotion strategies therefore should involve and include: building healthy public policy, the creation of supportive environments, strengthening community action to improve health, developing personal and social skills by providing information and education for health, enhancing individuals’ life skills, and reorienting health services in ways that move away from clinical and curative services towards health promotion (Ottawa Charter for Health Promotion, 1986). Health promotion should also involve political interventions designed to facilitate behavioural and environmental changes that contribute to health (Green, 1979). Equally important is the need for behavioural and social science research to improve population health (IOM, 2000).

1.2 PROBLEM STATEMENT

Biomedical research alone cannot adequately identify complex challenges to improving public health in the 21st century (IOM, 2000). The Institute of Medicine Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health (IOM) argues that “[b]ehavioral and social science research has provided many new advancements in the effort to improve population health, and offers promise for the development of new interventions with even greater utility and efficiency in the years to

come" (IOM, 2000, p. 33). Applying behavioural and social science research to improve health they note requires that researchers "transcend perspectives that have, to this point, resulted in public health problems being defined in relatively narrow terms. Efforts to design and implement multi-pronged interventions will require the cooperation of public health officials, funding agencies, researchers, and community members. Evaluation efforts must transcend traditional models of randomized control trials and incorporate both quantitative and qualitative methodologies" (IOM, 2000, p. 34). Moreover, social and behavioral research and interventions should be based on an ecological model (IOM, 2000). In short, "IOM recommends that governments engage in HiAP when considering 'major legislation, regulations, and other policies that could potentially have a major impact on public health," (Gakh, 2015, p. 2).

Ecological models assert that factors outside of individuals influence their health behaviours (Sallis, Owen & Fisher, 2008). As a result, these models propose that multi-level interventions are often the most effective in achieving health behaviour change as policy and environmental changes affect "virtually entire populations in contrast to interventions that reach only individuals" (p. 479). Ecological models, recognize the interplay of influences at the different environmental levels on health behaviour; so that, interaction across the different levels, the individual, community, organization, policy, and system, influence health behaviour (Sallis, Owen, & Fisher, 2008). Additionally, these models maintain that influences at the various ecological levels interact with one another (Sallis, Owen, & Fisher, 2008). In other words, the ecological models suggest "that intervention efforts should address not only "downstream" individual-level phenomena (e.g., physiologic pathways to disease,

individual and lifestyle factors) and “mainstream” factors (e.g., population-based interventions), but also “upstream,” societal-level phenomena (e.g., public policies)” (IOM, 2000, p. 3). Population and societal level influences of health “however, have not received the same degree of scientific attention as individual-level phenomena, due in part to their inherent challenges. One challenge posed by population or societal-level research is that, it is methodologically complex and requires different methods than individual-level research. As a result, some population-level research has been less conclusive because it is at an earlier stage of scientific development and sophistication. In addition, population-level interventions may raise social, political, and ethical questions regarding attempts to change social conditions, as changes may produce unintended effects. Further, individuals subject to change efforts rarely have an opportunity to offer consent to the intervention” (IOM, 2000, p. 3).

In recent years, a health promotion strategy, *Health in All Policies* (HiAP), has been touted as a means through which to improve population health (Kickbusch & Buckett, 2010; Baum & Laris, 2010; Cotter, Metcalfe & Ritchie, 2011; Stahl et al., 2006). HiAP emerged in 2006 during the Finnish presidency of the European Union (EU; Kickbusch, 2010; Kranzler et al., 2013; Melkas, 2013; Puska, 2007) and builds on *Health for All* and early health promotion strategies promoted in: The Alma Ata Declaration (1978), the Ottawa Charter (1986), the 1997 Jakarta Declaration and the 2008 WHO Commission on the Social Determinants of Health (Kranzler, Davidovich, Flieschman, Grotto, Moran & Weinstein, 2013; Kickbusch & Buckett, 2010). While *Health for all* emphasized equity and social justice as its major goals and fostered a “resurgence of interest in public health internationally, particularly by re-focusing

attention on social and economic determinants of health and their unequal impact on the health of populations" (Lincoln & Nutbeam, 2006, p. 18), the Commission on the Social Determinants of Health called for action on health and health equity at the highest level of government in order to ensure that health was considered across all policy sectors (CSDH, 2008). Unlike healthy public policies which strove to ensure that non-health sectors adopt "specific health-promoting measures", HiAP is initiated in a context of joint policy making which enables all sectors to address issues that are relevant to them (Kranzler et al., 2013, p. 2). This is particularly important given that the levers for addressing complex health issues tend to fall outside of the health sector. In essence, HiAP aims to improve health equity through action on the social determinants of health (National Collaborating Centre for the Determinants of Health, 2012; Baum, Ollila & Peña, 2013) by essentially promoting policy-level action and collaboration in various sectors on the determinants of health. In this sense, it is touted as a means to address complex population health issues.

While HiAP is anchored in the formal governmental sector and involves an all-encompassing government-led approach to addressing the determinants of health (Shankardass, Solar, Murphy, Freiler, Bobbili & Bayoumi, 2011), it does not fully examine the political and ideological structures that shape policies and their implementation.[1] In other words, the HiAP strategy facilitates conceiving problems that are deeply embedded in politics and ideologies as a failure of governance rather than in relation to the underlying contextual factors such as political traditions (the existence of strong or weak redistributive policies) and ideologies that influence policy making (F.

[1]This is also true of the HiAP literature.

Armada, personal communication, August 14, 2013). Indeed, F. Armada (personal communication, August 14, 2013) argues that by understanding the various contextual political factors that shape HiAP and inhibit or promote intersectoral collaboration, governments can more effectively address these factors and in so doing improve population health.

In light of these facts some researchers such as Potvin (2012) have argued that empirical knowledge about intersectoral action to address the social determinants of health is scarce. Few researchers she asserts, have identified successful intersectoral initiatives that address sectors other than, perhaps, in education (Potvin, 2012). This assertion is problematic given the need for social and behavioural research required to reduce complex public health problems (see Institute of Medicine (US) Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health, Smedley & Syme, 2000; Smedley, Syme & Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health, 2001). Potvin's argument is echoed by Shankardass et al. (2012) whose scoping review of 128 articles on cases of ISA across 43 countries found that the description of the "complex, multi-actor processes in the published documents was generally superficial and sometimes entirely absent" (p. 32). Like Potvin (2012) they called for improvements in documentation in future publications and for richer sources of information on ISA such as interviews in order to facilitate a "more comprehensive understanding from the perspective of multiple sectors involved" (p. 32). On the otherhand the WHO Commission on the Social Determinants of Health (2008) has argued that there has been mounting evidence for "integrated action on societal-level factors" (p. 110) to

address the social determinants of health. This dissertation will not address the contestable evidence but rather aims to address some of the gaps identified from the literature review, the Institute of Medicine (IOM) Committee's recommendations, and Potvin's (2012) and Shankardass et al.'s (2012) call for more research on intersectoral approaches to health and as such aims to understand HiAP implementation in various jurisdictions, namely: California, Norway, Finland, Scotland, Ecuador, and Thailand with the goal of understanding why and how HiAP implementation

1.3 THEORETICAL LOCATION

This dissertation primarily applies the political economy of health approach as espoused by Birn, Pillay and Holtz (2009) (also see Doyal, 1979; Packard, 1989; Navarro, 2004). As a macro level theory that recognizes the influence of structural factors on health (Minkler, Wallace & McDonald, 1994; Birn, Pillay & Holtz, 2009), the political economy approach will guide my dissertation.

1.3.1 Political economy of health framework

The central argument in the SDH framework is that unequal social conditions lead to poor health outcomes for some sections of the population (Birn et al., 2009; Raphael, 2009). The literature here also highlights that inequities in health are unnecessary and avoidable, particularly as has been couched in the influential Report of the World Health Organization's Commission on the Social Determinants of Health (2008).

The SDH framework regained prominence in the 1970s in an attempt by social epidemiologists to displace the biomedical model's explanations of illness, disease and health (Krieger, 2011). Contemporary thinkers emphasizing the links between health and social environments include: Michael Marmot, Richard Wilkinson, Vicente Navarro,

Anne-Emanuelle Birn, Carles Muntaner, Nancy Krieger and Dennis Raphael, to name a few. The political economy of health framework (Birn et al., 2009), with its foundations in Marxist political economy (PE), is one SDH framework which may be located in the critical social scientific paradigm (Denzin & Lincoln, 2011). For Marxist PE, material production is fundamental to human activities. The forces and relations of production constitute the economic base of society while the societal superstructures are shaped by the economic base (Crinson, 2007).

Writing within this framework, Birn and colleagues distinguish between "social" and "structural" determinants arguing that the former are "the social characteristics within which living takes place" and the latter "are the political, economic, social, and cultural structures that shape health and health pattern" (p.310) or the " 'causes of the causes' of health and disease" (p.312). For them, the societal determinants of health framework illustrates "how political economy of health pathways operate" (p.311), often simultaneously. It provides a framework for an understanding of the ways in which ill health and health are "produced and reproduced at the societal level" (Birn et al., 2009, p. 311). This framework further highlights the multiple levels through which determinants of health affect health and disease ranging from household, community, social policy and governmental regulation, or social, political, economic, and historical context (see Birn et al., 2009, p.311).

Immediate determinants of health, they note, operate at the household and community levels and shape "exposure, susceptibility, and resistance to death and illness" (p.311). An example includes unhealthy behaviours that are shaped by "neighbourhood conditions, cultural and social factors, and the available means to

relieve stress and resolve conflict" (p.311). The other levels affect health and disease directly or indirectly. Intermediate determinants "manifest themselves largely in terms of social policy and government regulation… [and] include societal poverty levels, education, nature of employment, environmental conditions, and human rights" (p.311). The last level that they identify is the "underlying social, political, economic, and historical context" (311). Key determinants here include "class and social structure, distribution of wealth and power, and international trade regimes" (p.311). As such, this framework can be used to examine HiAP, in terms of how class, power, ideology, and politics influence or shape HiAP policy implementation and whether evaluations of HiAP effectiveness take social structures into consideration. While Birn and colleagues' as well as other political economy of health frameworks are useful for critiquing HiAP, and understanding how determinants shape health and disease since it comprehensively addresses the multiple scales and factors that produce ill-health, it does not provide a much needed framework to evaluate HiAP implementation or effectiveness. In addition, employing Marxist PE to inform contemporary policymaking can be difficult given that it is value laden and often recommends radical policy changes such as a total restructuring of social and economic systems to promote health equity. While paradigmatic political change is a normative process radical changes can be challenging due to competing interests of policy paradigms (in this case Marxist PE and neo-liberalism) as they have competing "beliefs about the role of government … which structures the way problems and solutions are identified and evaluated" (Crammond & Carey, 2017, p.368). As a result, I turn to critical realism, specifically realist evaluation, for this purpose (Denzin & Lincoln, 2011; Pawson & Tilley, 2004).

I will also draw on the societal determinants of health literature to argue for the need to address the political and structural determinants of health (Feldacker, Emch & Ennett, 2010; Doyal & Pennell, 1979; Doyal 1995; Sallis, Owen & Fisher, 2008; Birn, Pillay & Holtz, 2009). The societal determinants of health framework will complement the political economy framework as it "illustrates how political economy of health pathways operate --- how health and ill health are produced and reproduced at the societal level" (Birn, Pillay & Holtz, 2009, p. 311). The societal determinants of health framework is also important as it shows the simultaneous and multiple levels at which determinants of health operate, such as from the "household and community levels," "social policy and governmental regulation," or "social, political, economic, and historical context" (Birn, Pillay & Holtz, 2009, p. 311). I will also use the Commission on Social Determinants of Health (CSDH) conceptual framework which highlights the multiple levels at which determinants operate and conceptualizes the structural, intermediate, and social determinants of health and their impact on equity in health and well-being (Solar & Irwin, 2010). In other words, the CSDH conceptual framework reveals how:

> … social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people's place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions (Solar & Irwin, 2010, p. 5).

This dissertation also tests and advances theories of HiAP implementation in a number of contexts. This was achieved in a number of ways. First, I used theory, specifically, the political economy, and social determinants of health to inform my analysis and interpretation of the findings of the dissertation. Second, I tested theories (hypotheses)

in this dissertation and modified the theories of HiAP implementation based on the evidence from the dissertation. In other words, the findings of the dissertation led to modified theories of HiAP implementation and advanced knowledge on the factors shaping implementation. This is consistent with explanatory case study methodology which emphasizes theory testing and refinement after a review of the evidence (Yin, 2014; Ridder, 2016; Ridder, 2017). Furthermore, the use of theory plays "a critical role in helping … to generalize [analytical generalization] the lessons learned from … [the] case study" (Yin, 2014, p. 40).

1.4 RESEARCH OUTLINE

My dissertation follows the integrated dissertation format and is organized as follows.

In Chapter two, I will discuss the research methods that have been used in the past to investigate HiAP, as well as the theoretical frameworks guiding HiAP as a strategy for health promotion. The aim is to critically appraise the HiAP literature focusing on the strengths and weaknesses of the body of research, as well as the theoretical and methodological limitations (Adapted from Randolph, 2009).

Chapter three provides a discussion of the HARMONICS multiple realist explanatory case study methodology, its inception, and provides a detailed discussion of the methods employed in the studies. The aim in this chapter will be to provide the background of the study as well as to lay the foundation of the methods underpinning the narrative review, the single and multiple explanatory case studies.

Chapter four is a narrative review of the public health literature focusing on how the politics on HiAP implementation is viewed from the public health perspective. I focus on political context which is a major factor influencing policy implementation. I

synthesize the findings from the review, as well as discuss gaps in analysis from this discourse. I conclude with a discussion of emergent hypotheses to guide future research. I should note that the narrative review is intended to be distinct from the literature review. While the narrative review assesed the state of politics in the public health literature, my original intent when I started my research for Chapter 4 was to conduct a comparative analysis of the public health and political science literature to understand how they discuss politics of HiAP implementation. In this vein, I classified articles as "public health" if they were published in a public health journal, and/or if one or more of the authors identified as public health specialists. Articles were classified as "political science" if they were published in a political science journal, and/or if one or more of the authors identified as political scientists. In addition, articles were classified as political science because political science journals cater to specific disciplines (e.g., political science, policy sciences, public policy) and as a result capture certain norms and standards that could influence writing about HiAP implementation. An examination of the articles however revealed that those published in political science journals were in fact written by public health practioners and not political scientists. In addition, because I had a singular 'political science' article, a comparative analysis was not feasible which led to the focus on a narrative review of the public health literature.

I conceived the idea of the chapter along with insight from Dr. Ketan Shankardass and Dr. Carles Muntaner. I collected the data and conducted the analysis as well as wrote the paper. Drs. Shankardass and Muntaner were consulted for their expertise on the subject matter and on the direction of the paper. They also

provided guidance on the scientific and stylistic revisions to the paper.

In Chapter five, I investigate implementation in California. Deriving from the information presented in Chapter 3, this chapter employs a realist multiple explanatory case study methodology to analyze the contextual factors that facilitated buy-in for HiAP in California. The analysis also employs the systems framework to provide an explanation of HiAP implementation within the government system.

Dr. Patricia O'Campo and I conceived the idea of the chapter. I collected the data and performed that the main role of analyzing and writing the paper. I along with the team at CUHS drafted the methods. Drs. O'Campo and Shankardass provided scientific and stylistic/grammatical revisions to the paper.

In Chapter six, I conduct a cross-case analysis to analyze how non-state actors (non-governmental actors) influence HiAP implementation across a number of jurisdictions (California, Norway, Finland, Thailand, Scotland, and Ecuador). Similarly, to Chapter 4, the analysis employs the systems framework.

P.J Vasdev (a member of the Centre for Urban Health Solutions (CUHS) at St. Michael's Hospital at the time of data analysis,) and I coded the transcripts and interviews. I analyzed the data with instruction/assistance of Dr. Ketan Shankardass, and I wrote the paper. I conceived the idea of the paper. I collected the data and performed that the main role of analyzing and wrote the paper. I along with the team at CUHS drafted the methods. Drs. O'Campo, Shankardass and Muntaner provided scientific and stylistic/grammatical revisions to the paper.

Finally, in Chapter seven, I provide a summary of the major findings of the research; discuss the disseration's contribution to knowledge, as well its limitations and strengths; the implications of the findings; and offer future directions for research.

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CHAPTER TWO: REVIEW OF THE LITERATURE

2.1 INTRODUCTION

Health in all policies (HiAP) is a health promotion strategy that aims to improve population health and equity through a whole-of-government approach that recognizes the health impacts of policies (Baum, Ollila & Peña, 2013; Kickbusch & Buckett, 2010; Kickbusch, 2008). It employs a rights-based approach to policy development and implementation (Baum, Ollila & Peña, 2013; Kickbusch & Buckett, 2010; Kickbusch, 2008; Helsinki Statement on Health in all Policies, 2013).

HiAP is not a replacement for health promotion but is a part of health promotion initiatives that advocate an intersectoral or multisectoral approach to policy making (Baum et al., 2013; Cook, Zhang & Yi, 2013). Addressing health through macro or structural approaches differs from interventions that focus on the individual level primarily because they recognize that health is "significantly determined by the different social, economic, and environmental circumstances of individuals and populations" (Morgan & Cragg, 2013, p. 105). As Kickbusch (2008) notes, "[p]ublic policies in all sectors influence the determinants of health and are a major vehicle for actions to reduce social and economic inequities, for example by ensuring equitable access to goods and services as well as health care" (p.1).

Activities that have aimed to improve population health by improving the health impacts of policies across various sectors are not new. They can be traced to European nineteenth century and early twentieth century Latin American public health movements (Cook et al., 2013; WHO, 2008; Allende, 2006). More recent antecedents of HiAP that aimed to ensure comprehensive health policy-making include the: Alma Ata Declaration (1978); Ottawa Charter (1986); and Adelaide Conference on Healthy Public Policy

(1988) (Baum et al., 2013). The Alma Ata Declaration (1978) emphasized the need for an intersectoral approach to comprehensive primary health care that would involve non-health sectors alongside the health sector. While the Ottawa Charter (1986) affirmed the need for supportive social environments to promote health, it placed health equity at its center. The Adelaide Conference on Healthy Public Policy (1988) reaffirmed the need for supportive environments and an equity focus to improve population health.

The 1980s health promotion movement gave rise to the concepts of intersectoral action for health (ISA) and healthy public policy (HPP) which like Alma Ata, were characterized by continuing concern for cohesive action on public policy in order to improve health equity and population health thereby "going beyond health sector activities" through various intersectoral strategies (Baum et al., 2013, p.32; Sihto, Ollila & Koivusalo, 2006). These were developed following the failure of the international health community to implement Alma Ata's comprehensive primary health care and a recognition that the 1970s health promotion movements' emphasis on lifestyle and behavioural change failed to improve health in the absence of structural changes (Baum et al., 2013). Like HiAP, the major aims of ISA and HPP involved improving population health and health equity by "going beyond health sector activities" (Baum et al., 2013, p.32).

HiAP's origins can be traced back to the 1970s when the Finnish government promoted the HiAP principle in policy development and implementation. In 2006, the HiAP principle was formally introduced to international health policy during the Finnish presidency of the European Union (EU; Kickbusch, 2010; Kranzler et al., 2013; Melkas, 2013; Puska, 2007). Following this, the term, "Health in all Policies", became widely

adopted in international health policy, replacing its predecessors, ISA and HPP (Melkas, 2013). The whole-of-government approach characteristic of HiAP is in part a consequence of globalization where measures to promote economic competitiveness limit national and local health policy making (Sihto et al., 2006). In other words, increasingly, decisions that affect health occur in forums outside the health sector, outside national borders at international levels (Ollila, Baum & Peña, 2013). Much like the previous intersectoral interventions to reduce health inequalities where health was conceptualized as a development goal (Muntaner, Chung & Sridharan 2009), health is still conceptualized as a "development goal" under HiAP.

Importantly, HiAP makes explicit the need for an equity focus to "the development, implementation and evaluation of policies and services" (WHO & Government of South Australia, 2010:2). Whitehead and Dahlgren (2006, pp.4-5) argue that equity in health is based on the idea that all individuals can attain their full health potential and should not be prevented from achieving this potential due to their social position or other socially determined circumstance. They argue that efforts to promote social equity in health are "aimed at creating opportunities and removing barriers to achieving the health potential of all people" and involve "fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill" (p.5). These efforts, they assert, would result in a "gradual reduction of all systematic differences in health between different socioeconomic groups" (5). Whether or not this actually occurs in all stages of policy making and whether it is uniformly adopted by governments that have pledged to employ a HiAP approach across sectors remains to be seen. Moreover, the theoretical basis of HiAP's

equity focus, the ways in which HiAP has been operationalized to address health equity, and ultimately whether HiAP initiatives have led to better population health outcomes remain under examined.

In this chapter, I review the HiAP literature in order to understand whether and how HiAP, as a health promoting strategy, has contributed to improving population health, paying attention to its claims to advancing health equity. I first discuss the theoretical approach guiding my literature review. Next, I outline the theoretical and methodological approaches that have been employed to study HiAP and its effectiveness. Here, I also selectively review the intersectoral action for health (ISA) literature due to the paucity of empirical work on HiAP. I conclude the review with a summary of my findings and their implications. I hope to make clear that while the literature has succeeded in promoting HiAP as a means for achieving health equity, it does not effectively address core issues that are instrumental for determining HiAP effectiveness. In the second half of this chapter, I delve further into the theoretical underpinnings of HiAP. Given the lack of theoretical analysis in the HiAP literature, I borrow from the fields of public administration, political science, and sociology to discuss possible theoretical influences on HiAP. Then I present two alternative approaches that may fruitfully be used to critically examine and evaluate HiAP, discussing their shortcomings as I proceed. Based on my review, I conclude by raising a few questions and some suggestions for future research.

THEORETICAL FRAMEWORK

I approach this review from a social determinants of health (SDH) framework (Solar & Irwin, 2007). SDH frameworks have their basis in diverse theories including

psychosocial, political economy of health, and eco-social approaches (Solar & Irwin, 2010). In contrast to the biomedical model, which emphasizes biological and behavioural factors as determinants of ill-health, an SDH framework requires taking into account the multiple scales and factors that interact to produce ill-health (Dahlgren & Whitehead, 2006; Birn, Pillay & Holtz, 2009). It emphasizes the influence of societal conditions, and disparities and their effects on population health, highlighting the need to address these conditions to promote population health (Solar & Irwin, 2007; Wilkinson, 2006). From this perspective, I review the HiAP literature in order to understand to what extent the social determinants of health are addressed in the implementation of HiAP policy, specifically focusing on efforts to reduce inequities in health. I return to SDH frameworks again in the second half of my paper.

REVIEW METHODOLOGY

A search was conducted in PubMed, Web of Science, and Scopus using the following terms: “health in all policies” or, “intersectoral action for health” or “multi-sectorial policies for health” from 2000/01/01 to 2013/12/31 to allow for an adequate lag period as HiAP is a relatively new concept. Because of the paucity of research on HiAP in this time frame however, I also searched Google Scholar, Google, and SUMMON using the search terms from the PubMed search. The review that follows is based on this body of work.

Table 1. Databases searched and articles examined and retained for analysis

Databases Searched 2000 to 2013	Number of articles retrieved	Relevant articles examined	Articles analyzed after exclusion criteria[2]
PubMed Searched Article title, Abstract	10	10 articles were examined.	10
Web of Science 2007[3] to 2013 Searched Article title	53	23 articles were examined. I excluded meeting abstract, editorials, corrections, book chapters, reviews, letter and non-English articles.	14
Scopus Searched Article title, Abstract, Keywords	88	44 articles were examined. I excluded editorials, reviews, surveys, book chapters, conference papers etc.	12

2.2 REVIEW OF THEORETICAL APPROACHES TO HIAP

Theory allows us to situate the problem formulation and understand the various sides and views advanced by different schools of thought (Laflamme, 2008). In what follows, I examine the theoretical underpinnings of HiAP in order to consider the theoretical frameworks used to explain health inequities and to understand how health equity is theorized in this literature.

A number of frameworks have shaped health promotion initiatives, and many of these models primarily emphasize individual change as a means of improving health and well-being (Davies & Macdowell, 2006). While some argue that theories of healthy public policy development and implementation include the ecology framework for policy development, intersectoral action for health (ISA), healthy public policy (HPP) or health

[2] The following were excluded: books, book chapters, articles published in a language other than English. Following this step, I read the abstracts to examine if they mentioned Health in all Policies (HiAP). If HiAP was not mentioned in the abstract the article was discarded.
[3] Web of Science did not go as far as 2000, with the earliest date being 2007.

impact assessment (HIA) (Nutbeam et al, 2010), the theoretical underpinnings of these frameworks are either not explicitly discussed or are overlooked altogether.

This is also true of the HiAP literature where discussions of the theoretical underpinnings of HiAP are at most superficial (see, as examples, Ollila et al 2013; McQueen et al. 2012). Although the HiAP literature emphasizes the importance of the social determinants of health, this literature fails to theorize the latter. For example, while Ollila and colleagues (2013) argue that HiAP is rooted in early European theories namely those posited by Virchow, Villerme, Neumann and Engels, and McQueen and colleagues (2012) contend that the theories of Durkheim, Virchow, and Engels were influential. Durkheim was one of the first to draw a link between social factors and health in his study of suicide (Cockerham, 2007) while Villerme, Engels and Virchow "documented health inequities and advocated action in a range of sectors to improve the lot of the poor" (Baum et al., 2013, p.27). Yet these contemporary authors did little to explain how HiAP drew on such theories. A possible reason for the neglect of philosophical debates underlying HiAP may be the emphasis placed on middle-range theories such as HPP or ISA. The philosophical basis of these frameworks is rarely shared in the literature, a trend consistent with empirical work on health inequities (Wainwright & Forbes, 2000). Following my review, I return to the question of theory in HiAP, but before I do this, I discuss methodological approaches to HiAP. This methodological review highlights recent methods used to examine and evaluate HiAP, as well as reviews the literature on HiAP effectiveness. Because the majority of the studies retained from the databases searched do not address HiAP effectiveness, I review case studies (secondary studies) that are presented in the HiAP literature.

2.3 METHODOLOGICAL APPROACHES TO STUDY HIAP

In this section I provide a brief overview of the methodological approaches used to study HiAP in the body of work under review. The summary of the studies is presented in Table 2.

Table2[4]: Theoretical and methodological orientations of HiAP studies in PubMed, Web of Science, and Scopus (2000-2013)

Authors, year	Hendricks et al (2013)	Avey et al (2013)	Hendricks et al (2012)	Lawless et al (2012)	Steenbakkers et al (2012)	Storm, Harting, Stronks & Schuit (2013)	Rheland er et al (2012)	Ritsatakis (2012)	Barton & Grant (2013)	Ritchie & Nolan (2013)	Gase, Pennotti and Smith (2013)	Kranzler et al (2013)	Kahlmeier et al (2010)	Mannheimer, Lehto & Ostlin (2007)	Mannheimer et al (2007)
Theoretical framework	Behavior change wheel framework	HiAP framework including the Farley Model of Social Determinants of STD Inequities and Place Attachment Theory	Behavior change wheel framework	Implicit	Implicit	General maturity model	None stated/Implicit	Implicit	Implicit	Ecological and social determinants of health frameworks	Implicit	Implicit	Implicit	Kingdon's theory	Kingdon's theory
Methodological framework	Case-study	Mixed methodology	Implicit	Action research	Participatory action research	Implicit	Stakeholder analysis	Survey (Implicit-questionnaire); case-study	Implicit	Action research	Implicit	Implicit	Systematic review	Qualitative content analysis	Implicit
Research objectives	To examine facilitators and barriers to intersectoral collaboration for public health in general, and for preventing childhood obesity.	To use a HiAP framework to address "what data, policy, and community efficacy opportunities exist for improving sexual health and reducing sexually transmitted diseases (STDs) in an area experiencing change and	To "propose operational criteria for evaluating the range and magnitude of integrated public health policy" (p. 175).	To "… examine both processes and short-term impacts in terms of changes in the knowledge, skills and attitudes of participants and the incorporation of health considerations in resulting policies" (S16).	To ""see if municipalities are able to make progress in inter-sectoral collaboration at the strategic, tactical and operational level and in the assessment of HiAP proposals" (p. 289).	To explore the opportunities of maturity model for classification stages of HiAP, and necessary conditions in each stage.	To investigate institutional and promotional strategies and constraints, as well as roles and responsibilities of stakeholders who are involved in rural hygiene and sanitation promotion (RHSP) in a multi-ethic population in Northern	To find out if (p. S94): (1) equity in health is on the political agenda in cities … how it is conceived; (2) … information is available for raising awareness, defining health inequalities to be tackled, and monitorin	To "evaluate the progress made by European cities in relation to Healthy Urban Planning (HUP) during Phase IV of the World Health Organization's Healthy Cities programme (2003–2008)" (Abstract).	Taking action to work on issues of health disparities and equity in Rhode Island.	To identify a framework that shows HiAP was implemented in the United States.	To: (1) identify where Israel's National Program echoes and falls short of HiAP and; (2) "assess ways in which the National Program could be utilized as a case-study in HiAP and public health intersectoriality" (p. 12).	To " •develop a review of approaches to including health effects in economic analyses of interventions related to cycling and walking … • critically discuss the identified indicators, health effects, relative risks, and applied methodological approache	To "analyse the agenda setting, formulation, initiation and implementation of the intersectoral public health policy and one tool of HiAP, health impact assessment (HIA), at the national and local level (exemplif	To investigate: (1) the "barriers and enablers in the political and administrative working process of introducing HIA from the perspective of civil servants, politicians and other actors" (p.); (2) why there was a window of opportunity for HIA; what were perceived as the general

4

The table is not meant to be exhaustive but is based on my reading of the implicit and explicit discussion of the categories as identified in the literature.

		redevelopment" (Abstract).					Vietnamese province.	g progress; (3) … the past focus on access to health care and care for certain vulnerable groups has shifted to deal with the wider spectrum of inequalities; and (4) … the main areas and types of interventions.					s … • formulate suggestions for options for further developing a harmonized methodology for including valuations of interventions … [and] data sources and methods to be used [for analyses] … • the achievement of scientific consensus on these options"(p. S121).	ied by Stockholm County) in Sweden" (*Summary*).	problem that required a solution and; (3) the barriers that were identified in delaying the full implementation of IAH(intersectoral action for health)(p.526).
Sample collection/selection	Not specified	Strategic non-representative sampling strategy for Photovoice participants	Not specified	Not specified	Not specified	Heterogeneous sampling: Twenty-four municipalities selected using criteria such as: such as "size, geographical distribution, and the explicit to reduce health inequalities as described in their municipal health policy documents" (pp. 185-186)	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified
Data collection	In-depth semi-structured interviews	(1) Literature review and consultation with experts;	(1) Literature review	Group and individual interviews (semi-	(1) Questionnaire; (2) logbook registries; (3) in-depth	(1) Document analysis; (2) digital questionnaire; (3)	Semi-structured interviews	Questionnaire using open-ended questions	Questionnaire	Not specified	(1) Review of the published and gray literature; (2)	Not specified	Not specified	Literature review	Semi-structured interviews

		(2) assessment of data that represents the social determinants of STDs and mapping data;(3) key informant interviews; (4) community based participatory Photovoice and; (5) sharing data with stakeholder groups		structured format)	interviews	individual interviews					analysis of case examples in order to identify a draft framework that included tactics and broad strategies for implementing HiAP; (3) "vetting the draft framework through individual and group consultation" (p. 530)				
Analysis	Analysis performed using NVivo and behaviour change framework. categories of analysis not specified	Not specified	Following a review of the literature: (1) identifying gaps in operationalizations (2) searching for conceptual approaches narrative review (3) proposing operational criteria.	Not specified	ANOVA analyzes for questionnaire; score between 0 and 1 for log-book data; interview notes linked to conceptual framework.	Data that were quantitative and qualitative (SPSS) were summarized and then "ranked conform different capability levels. The 14 characteristics associated with the six maturity levels were scored as positive (+), doubtful (±), or negative (−)" (sic, p. 186).	Content analysis	Not specified	Not specified	Segregation data analysis (the addition of segregation indices to existing indicators of socio-economic status in order to expand the "solution sets often used to explain health disparities" p. 32).	Content analysis; thematic analysis	WHO analytical framework for intersectoral governance	Not specified	Content analysis; Kingdon's opportunities for policy change	Systematically; Kingdon's framework: (1) problem, (2) policy, (3) politics.
Results	Six factors, divided over the three resources: motivation,	Avey and colleagues "…identified the following HiAP-relevant determin	Integrated policies should include "an appropriate mix of interventions that optimizes	(1) "…[i]ncreased understanding by policy-makers of the impact	"Six of the nine coached municipalities showed concrete outcomes in	HiAP growth processes classified by several characteristics:	Barriers to the implementation of RHSP included: "weak inter-sectorial	While cities continue to focus on "focus considerable support on	Cities have a good understanding of HUP and acitivty in HUP	Rhode Island residential segregation indices shows that "hypersegregation	Identified 7 strategies for implementing HiAP (pp.532-534): (1) Developin	"…elements of the National Program, such as joint planning, integration in the	"The review identified critical issues to address and approaches	Actors perceived problems differently, namely, their agenda	Factors that delayed HIA included traditional health care focus and deterioratin

	capability, and opportunity are barriers to intersectoral collaboration.	ants of STD inequities in the literature: education, employment, male incarceration, drug and alcohol marketing, and social capital. Quantitative data confirmed challenges in education, employment, and male incarceration in the area. Interviews identified policy opportunities such as educational funding ratios, Community Hire Agreements, code and law enforcement, addiction and mental health resources, lighting for safety, and a nonemergency public safety number. Photovoice participants identified community assets	the functioning of the behavioural system" and policies should be implemented by "relevant policy sectors from different policy domains" Abstract).	of their work on health outcomes; changes in policy direction; (2) development and dissemination of policy-relevant research; (3) greater understanding and stronger partnerships between health and other government departments; (4) and a positive disposition toward employing health lens analyses in future work" (Abstract).	terms of HiAP proposals. The results show that more support and involvement at each system level stimulates" (Abstract).	"…recognition of the importance of HiAP (Stage I; four municipalities), HiAP described in policy documents and collaboration with sectors present (Stage II; seven municipalities), concrete collaboration agreements and structural consultations forms (Stage III; four municipalities), and a broad, shared vision on HiAP (Stage IV; two municipalities). Examples of necessary conditions were sufficient support and resources" (Abstract).	collaborations; constraints faced by frontline promoters; almost exclusive information-based and passive promotion methods applied; and context unadjusted promotion strategies across ethnic groups, including a limited focus on socio-economic differences, language barriers and gender roles in the target groups" (Abstract). Highland communities were the least targeted and most in need of intensive and effective RHSP.	vulnerable groups, rather than the full social gradient, most are now making the necessary shift towards more upstream policies to tackle determinants of health such as poverty, unemployment, education, housing, and the environment, without neglecting access to care" (Abstract).	has increased. Cities that are "achieving effective strategic integration of health and planning have increased" Abstract).	exists across three dimensions for African Americans in Rhode Island … [and there are] aspects of isolation and clustering for racial/ethnic populations in Providence" (p. 33).	g and structuring cross-sector relationships; (2) v Incorporating health into decision-making processes; (3) Enhancing work force capacity; (4) Coordinating funding and investments; (5) Integrating research, evaluation, and data systems; (6) Synchronizing communications and messaging; (7) Implementing accountability structures.	policy agendas and settings of other ministries and budget sharing, to a more limited extent, adhere to the principles of HiAP" (p.12). Israel can increase its HiAP potential by strengthening "these and other directions, including utilizing the inter-ministerial steering committee to lead the National Program, leveraging the Health Ministry's widespread presence in and out of government, and focusing on knowledge translation and dissemination according to the policy needs and knowledge bases of other sectors" (p.12).	warranting further development toward a more unified methodology" (p.S121).	and interests.	g health of the population, a lack of multisectoral language cooperation and function; whereas factors that accelerated HIA included membership of international organizations, strong political commitment and a belief that intersectoral action would have a positive benefit for health.

		to protect including family-owned businesses, green spaces, gathering places, public transportation resources, historical sites, and architectural elements. Stakeholder feedback provided numerous opportunities for next steps" (Abstract).													
Conclusions	Investments in intersectoral collaboration can increase the effectiveness and sustainability of existing health promotion efforts targeting childhood obesity.	They conclude that the "unique combination of methods proved to be an excellent way to operationalize HiAP, yielding meaningful data to document challenges, highlight assets, and explore policy opportunities while simultaneously engaging stakeholders in dialogue regarding next steps" (p. 41).	The Behavior Change Wheel provides a useful framework for developing the operational criteria needed to assess the state of integrated public health policies in practice.	HLA is a promising to move HiAP agenda from policy rhetoric to policy action and to achieve public policy that is supportive of positive health outcomes.	The effects of coaching program are limited and uncertain, but they had small positive effect on HiAP interventions that targeted obesity.	It is possible to use a maturity model to classify the stages of HiAP in municipalities.	The Vietnamese government should prioritize increasing capacity and collaboration among stakeholders; should focus on frontline workers to facilitate behaviour change communication; and support participatory and community level initiatives to address socio-economic and	While the author states that "there is compelling evidence that health inequalities are not reducing" (p. S101) she notes that her evaluation of phases III and IV of the implementation "demonstrate improvements in monitoring inequalities in health and a greater understanding of	Barton and Grant conclude that while there is an improvement in the understanding of the significance of planning for health, there is need for fundamental changes to ensure the integration of health and planning, and a commitment to a Health in all Policies	Creation of legislation aims to improve health disparities by focusing on the social determinants of health. Law RIGL 23-64, asks for the use of a social determinants of health framework, to use a cross-sector approach to evaluate health disparities and to report progress on benchmarks for measurement and	Review offers a "starting point for categorizing and describing the emerging practices used to work across sectors and address the determinants of health" and stress that their delineation of different types of strategies and tactics to achieve Health in All Policies provides public health officials	Expecting health practitioners to depart from traditional roles may come at a cost in terms of their personal and professional effectiveness and well-being, thereby, necessitating a need to strike a balance.	"[T]here is a need for a more methodologically consistent approach to the quantification of health benefits from cycling and walking" (S123).	"Swedish development correlated with the international progress and promotion of intersectoral health policy and HIA; (ii) the process of policy change was more expert-based at the national level and more politician-based at the local level; and (iii) the interest of HIA mainly	While politicians were committed to HIA, civil servants required more support in order to "adjust to 'western standards'" (p.530)

							cultural determinants of multi-ethnic groups.	the need to tackle the socioeconomic determinants. She further notes that political commitment is not, however, always translated into processes which, over time, will improve health outcomes and reduce health inequalities" (p. S101).	approach which will help to "ensure effective leadership from the top … to rethink established policy" (p. S140).	accountability. It is a start to continue to develop a clearer look at the social determinants of health and develop greater capacity to do prospective Health Impact Assessments with the goal to advance a Health in All Policies approach" (p.36).	with a range of options to incorporate HiAP into their work.			took place from the mid-1990s and at least up to the approval of the national policy in 2003" (Abstract).	

Methodologies that were used to examine HiAP were diverse and included: case-study; mixed-methodology; action research; survey; systematic review; content analysis; and implicit stakeholder analysis. Of the methodologies, case-study, mixed methodology, content analysis, systematic review, and action research can be used for examining HiAP's equity focus. Mixed-methods evaluations can strengthen evaluations of interventions like HiAP when "different evaluation questions require different methods, or when a single evaluation question requires more than one method to answer all components", and when different methods are used to answer the same elements of a single question, increasing confidence in the validity and reliability of the evaluation results (USAID, 2012, pp. 1-2). Similalry, case studies can be used as (1) a meta-evaluation, (2) to explain causal links, (3) describe interventions, (4) illustrate topics within an evaluation, and (5) to explore situations when an intervention does not have

clear single set of outcomes (Yin, 1994, p.15); while systematic reviews can appraise and synthesize evidence on HiAP (see Munn et al., 2018). Action research on the other hand is committed to "social, economic, and political development [that is] responsive to the needs and opinions of ordinary people" (Kemmis & McTaggart, 2008, p.273). Meanwhile stakeholder analysis gathers and analyzes "qualitative information to determine whose interests should be taken into account when developing and/or implementing a policy or program" (Schmeer, n.d. p.4).

While showing positive results of HiAP or HiAP-like interventions, methodologically speaking, the studies have a number of issues. One, some of the authors fail to discuss their respective theoretical and methodological orientations. This is consistent with much positivist research and research on social inequalities in health (Dunn, 2011; Wainwright & Forbes, 2000; Muntaner, 1999; O'Campo, 2003). Two, the studies' discussion of sampling, methods of data collection, and analyses are poor as few of authors provided detailed or adequate discussions in these sections. Three, with the exception of Ritchie and Nolan's (2013) study, the literature does not adequately address the political context in which policy making occurs.

While the studies' methodological choices are suited to the examination of the issues under investigation, they are not well suited to evaluating whether HiAP improves health outcomes. Evaluation of HiAP's effectiveness is necessary to ascertain whether it does in fact lead to improved health equity and health outcomes (for example Aday and colleagues' analytical framework, referenced in Ritchie and Nolan, 2013), as well as improves determinants of health. Not surprisingly, none of the studies (2011-2013) examined or evaluated HiAP effectiveness (the impact of the HiAP initiative on the

health of populations) but focused instead on other issues connected with implementation. These include for example: evaluating the implementation of HiAP; measuring the degree to which HiAP is implemented, in various sectors; and how it can be applied to various health issues and in various geographical regions. Again, the exception is Ritchie and Nolan's (2013) study which is more comprehensive engagement with addressing inequities in health. Here the action framework nature of their study led them to work with legislators to address health inequities, leading to the creation of legislation that addresses the social determinants of health. While they discuss evaluation (biennially), they do not evaluate the impact of the policy presented.

In short, the HiAP methodological literature reviewed does not address HiAP effectiveness, whether it improves the determinants of health, or the political context in which HiAP implementation occurs (with a few exceptions, e.g., Ritchie & Nolan, 2013). Before I discuss two alternative approaches that may be used to address these gaps in the HiAP literature, I explore the effectiveness of HiAP, as outlined in the reviewed body.

2.4 DOES HIAP EFFECTIVELY ADDRESS INEQUALITIES IN HEALTH?

In this section I review the HiAP literature to find if studies have evaluated whether HiAP promotes health equity and population health (HiAP effectiveness). I mainly review case studies presented in the HiAP literature of HiAP or HiAP-like strategies due to the paucity of evaluative studies on HiAP effectiveness.

2.4.1 *HiAP in developing countries*

The context of implementation is a major determinant of the successful implementation of HiAP initiatives. In developing countries examples of HiAP-like initiatives have

occurred in the agricultural and social sector. 'HiAP-like' is used to denote intersectoral action for health (ISA) initiatives that have been implemented before HiAP was incepted , and or are being implemented during HiAP but have not been classified as HiAP for a number of reasons (see Shankardass et al. 2012 for example for a discussion of how some researchers classify HiAP). Here the results have been mostly positive. Gillepsie, Egal and Park (2013) for example, discuss Malawi's integrated approach to nutrition, and Afghanistan's *National Public Nutrition Policy and Strategy 2010-2-13* that aim to incorporate an intersectoral approach to agricultural policies in these countries. They report that intersectoral action in Malawi has led to four SWAPs that have integrated nutrition security into their respective frameworks. Additionally, in Afghanistan, intersectoral action has led to the formulation of a national priority program by the Ministry of Agriculture, Irrigation and Livestock, and assistance from the World Food Programme and the Food and Agriculture Organization of the United Nations (FAO) to help the government to create a comprehensive food and nutrition security (FNS) policy. Similarly, Ram (2013) presents a HiAP type intervention, the Millennium Villages Project (MVP), which strove to work and empower impoverished communities in rural Africa to achieve the Millennium Development Goals. Evaluations of the MVP have demonstrated a number of health, economic and other outcomes for individuals in these communities. On the other hand, Thailand's attempt at *traffic-light labelling* for snack food (an alternative to existing labelling that is difficult to understand) and strategic plan on overweight and obesity was replaced by messages promoting physical consumption and dietary restrictions following concerns by the World Trade

Organization (WTO) on their impact on trade (Koivusalo, Labonte, Wibulpolprasert & Kanchanachitra, 2013).

It is noteworthy that while developing countries provide examples of "successful" HiAPs, they are implemented under different conditions that were a consequence of structural adjustment programs that were part of IMF or World Bank initiatives (see Thompson, Kentikelenis & Stubbs, 2017; Kentikelenis et al., 2016; Babb, 2009). In this case, the context of implementation is significantly different from that of developed countries where HiAP is implemented voluntarily by governments, something that is not readily addressed in the HiAP literature. In other words, the majority of studies fail to address the different contexts in which HiAPs' are implemented and in so doing depoliticize the significant influence of neoliberal policies on the development and implementation of HiAP in developing country contexts.

2.4.2 *HiAP in transitional and developed countries*

Examples of HiAP-like initiatives in developed countries have occurred in or involved early childhood development (ECD)[5], transportation, labour, education sectors, and sectors working to reduce tobacco use and heart health promotion. Here the results have been mixed. Mercer, Hertzman, Molina and Vaghri (2013) discuss the importance of early childhood development (ECD) as a part of HiAP, in order to promote social development and well-being focusing on a number of issues including the importance of policies for achieving ECD and the need for equity-based policies from birth. Examples of ECD programs that they examine include the Chilean child protection policy *Chile Crece Contigo* and the *Child and family friendly policies in Sweden.* Their discussion of

[55] Also see Bilodeau, Laurin, Giguere & Potvin (2017).

Chile Crece Contigo examines the context of initiation and implementation of the policy, the policy details (services provided) by the policy but does not evaluate the impact of the policy for improving child health. Mercer and colleagues' discussion of the ECD program in Sweden is more evaluative in nature and reveals that the HiAP initiative is associated with better health outcomes. They note that following an investment of 1.7% of GDP for ECD, Sweden experienced a drop in infant mortality of 2.3 per 1000 live births by 2008 and the lowest low-birth weight rates among OECD countries.

Mauer-Stender (2012), examines the Serbian tobacco control strategy. She notes that Serbia ratified the WHO Framework Convention on Tobacco Control in 2006 and its strategy includes the Tobacco Control Strategy and the Action Plan for Tobacco Control and is monitored by the Council for Tobacco Control, a multisectoral body which includes representatives from the ministries of "Trade and Services, Environment, Mining and Spatial Planning, Agriculture, Forestry and Water Management, Justice, Labour and Social Affairs, Culture, Internal Affairs, Education, Finance and Youth and Sport" (26). Following this initiative, the prevalence of smoking among adults decreased in Serbia (Mauer-Stender, 2012). Likewise, Bettcher and da Costa e Silva (2013) examine policy tools (including the Framework Convention for Tobacco Control) to curb tobacco use and argue that one key component for tobacco control is multisectorality as "[v]irtually all countries that have implemented successful tobacco control programmes … have involved multiple partners and sectors" (p.211). Their discussion of Brazil's tobacco control strategy shows that Brazil's strategies succeeded in decreasing tobacco use and mitigating the negative impacts of tobacco.

Gulis (2012) reports on the effect of a Slovak government decree to establish an intersectoral committee in road traffic safety to "improve road traffic safety in Slovakia and decrease the number of road traffic accidents, casualties and fatalities by serving as an advisory committee for the government" (p.87). The work of the committee led by the Ministry of Transport, Post and Telecommunications of Slovakia and with membership from the Ministries of Internal Affairs, Finance, Defence, Justice, Education and Science, Environment, Health and Construction and Regional Development led to a "dramatic decrease in road traffic accidents and fatalities related to road traffic accidents observed in Slovakia during 2008 and 2009" (p.88). In discussing heart health promotion, Jousilahti (2006) also examines heart health in Europe and evaluates, among other things, the role of the non-health sector for addressing heart health given that policies in non-health sectors (for example agricultural policies, tobacco policies often influence dietary and lifestyle behaviours (which are linked to heart disease). As a part of this, he presents a case study of an intersectoral heart disease prevention initiative in North Karelia, Finland that reduced mortality from coronary heart disease (CHD) among working-age men to "one-fifth [in 2004] as compared to the situation 30 years earlier" (p.52).

Other examples that discuss "effective" HiAPs or HiAP-like interventions include: vocational rehabilitation in Sweden (Axelsson, 2012); Finland's career preparedness program (Jenkins & Minoletti, 2013); Health-Promoting Schools in Zhenjiang China (Jenkin & Minoletti, 2013); Ukraine's tax increases on tobacco products (Mauer-Stender, 2012) to name a few. These studies show the effectiveness of different types

of HiAPs in various contexts and in so doing maintain that HiAP can be adopted across varying contexts.

Others present HiAP or HiAP-like interventions with mixed results (Breda & Bollars, 2012; Lin, 2012). For example, Breda and Bollars' (2012, pp.190-191) find that an evaluation of the European Unionwide scheme that provides fruit and vegetables to school aged children rates the intervention "very negatively" (p.191) and finds that it "still has very limited impact" (p.191).

In short, the HiAP literature mainly provides an optimistic account of the positive effects of HiAP and HiAP-like interventions in various settings. The methodology of the evaluations however is not clear, and the evaluations of the effectiveness of HiAP seldom address how it improves equity.

2.5 SUMMARY OF REVIEW FINDINGS

The review highlighted a number of issues in the HiAP literature. One, the literature is not clear on whether HiAP has been successful in achieving its objective to advance equity. Moreover, discussions of population health and health equity are missing if they are addressed at all. Establishing this link is necessary given the intricate link between health equity and population health. In discussing principles for policy action to improve health, Whitehead and Dalhgren (2006, p.16) note that there is a tendency of some to promote these goals as presenting a trade-off between "improved health for the population as a whole and even faster improvement in health among the worse off in society – that is, between overall gains in population health and reducing social inequities in health." They argue that population health policies need to have the dual

goals of promoting population health as a whole, as well as reducing health inequities. Yet these issues are rarely addressed in the HiAP literature.

The effectiveness of HiAP cannot be discussed without empirical/evaluative research which examines the extent to which HiAP has achieved its stated outcomes of improving population health through promoting health equity (see Nutbeam, 1998). In a majority of these cases it is not clear if the HiAPs were evaluated or how they were evaluated, which makes it difficult to assess whether the improvements in health outcomes were a consequence of their implementation. Some authors argue that it is difficult to evaluate the overall impact of the policies due to the newness of collaborative partnerships (Gulis referenced in Brand & Michelsen, 2012, p.175); and because "major changes often take a long time and require sequential efforts" (Olilla et al., 2013, p.14). These issues can also be due to a lack of consensus on a definition on equity in health which creates problems with policy and measurement (see Braveman, 2006).

Two, this literature also does not discuss the distribution of the effects of HiAP. Whitehead (2007) reinforces the importance of looking at the "distribution of the effects of policies, rather than relying on overall figures … [as it] is essential to monitor where the human costs and benefits of policies fall across the population" (p. 477). Interventions should therefore be assessed for differential impact by socioeconomic status, and should include gender and ethnicity specific analyses (Whitehead, 2007) as "both the magnitude and causes of observed social inequalities in health may be very different for men and for women, and for different ethnic groups" (p.476; also see Blas et al, 2008).

Three, the studies often fail to discuss the political context of policymaking and the impact of politics on population health outcomes. Such studies are essential to identifying the pathways through which politics operates in various contexts of implementation.

Four, the methodological review found that the HiAP literature did not adequately address the methodological underpinnings of HiAP inquiry.

Fifth, context is often unclear in the public health literature, and has been poorly discussed in the public health literature (see for example, Edwards & Di Ruggiero, 2011). This is problematic because research "has shown that health inequities are often shaped by long-standing sctrucural influences that unevenly distribute power and resources and benefit some social groups over others" (Edwards & Di Ruggiero, 2011, p.48).

The paucity of empirical/evaluative studies is problematic given that monitoring and evaluation are governance actions to ensure progress on the SDH (McQueen, Wismar, Lin & Jones, 2012). In short, these findings draw attention to the methodological issues stemming from among other things; a time lag between implementation and observed health inequalities, poor data collection, and a lack of reporting on health inequalities which further complicate evaluation of the relationship between policy and health (Bleich et al., 2012). Having said that, this review does have one limitation, which is that, the HiAP literature is increasingly evolving so that pertinent or instrumental literature in the field can easily become outdated within a short period of time.[6]

[6] This review examined HiAP literature from the inception of HiAP in 2006 to 2014 which was the year in which I completed my qualifying examination.

2.6 THEORETICAL UNDERPINNINGS AND ALTERNATIVE FRAMEWORKS FOR HiAP ANALYSIS

In the previous section, I argued that the HiAP literature fails to address theory and that much of this work draws on middle range theoretical frameworks which generally rely on a positivist framework (Dunn, 2011). Given the lack of theoretical analysis on HiAP's equity focus in the health literature, and flowing from Potvin and colleagues' (2005) and Porter's (1999) assertions that public health is influenced by theories of public administration, government (political science), and sociology, I explored potential theoretical influences on HiAP in these disciplines. Consequently, in this section, I will borrow from these literatures to discuss possible theoretical underpinnings of HIAP. Specifically, I draw on theories of horizontal governance, Rawl's theory of social justice, Frederickson's theory of social equity, and Phelan and Link's fundamental causes theory.

2.6.1 *Theories of horizontal governance*

An emphasis on engaging all sectors of government in promoting health equity suggests the influence of theories of horizontal governance on HiAP. Horizontal governance is a policy innovation that aims to correct the challenges of hierarchical models of government by engaging diverse sectors in order to achieve governance and policy goals (Ferguson, 2000; Rhodes, 1997; Bourgault & Lapierre, 2000; Phillips, 2004; Termeer, 2009). It is less formalized (Termeer, 2009) and is characterized by partnership, cooperation, collaborative and interactive governance, network management, and deliberative policy making, among governments, firms, non-profit organizations and citizens (Termeer, 2009; Diamond & Liddle, 2005; Feldman & Khademian, 2007). Termeer (2009, p. S214) writes that these strategies are directed at

achieving greater horizontal interactions between government, citizens, firms and social organizations to decrease the “perceived gap between government and society”, strengthen policy proposals and their realization. Echoing Termeer (2009), Ferguson (2000) notes that common features of horizontal governance include the prioritization of partnership over completion and individual recognition and coordinated governance to name a few. In a similar vein, Phillips (2004) notes that this form of governance involves partnership and interdependence as well as involves working through networks instead of hierarchies, the use of cooperation between state and non-state actors and “takes advantage of the proliferation of policy tools” (p.383). The literature here however presents a purely technical discussion of governance and as such does not address issues such as how governance can promote or improve equity.

There are a number of limitations of horizontal governance as a means to improve governance (Ferguson, 2000; also see Fitzpatrick, 2000; Bardach, 1996; Phillips, 2004; Ansell & Gash, 2007; Papadopoulos, 2012). Issues involve: lack of accountability, turf protection, power distribution, and competition for resources (Ferguson, 2000, p. 3). Speaking of horizontal governance in Canada, Phillips (2004) writes, “… it would be a myth to assume that horizontal governance is being practiced as conceived [particularly given that] there remain some significant contradictions and tensions between old and the new embedded in current modes of governing…” (p.400). These criticisms are warranted given that horizontal governance is ‘embedded’ in a neoliberal ideology that advocates a ‘roll-back’ of the state (see Peck & Tickell, 2002). Needless to say, governance structures which are built on collaboration and cooperation can help to facilitate and encourage shared and joint action on complex

challenges including addressing health inequities compared to the traditional hierarchical forms of governance which would have placed the responsibility of improving health squarely on the “shoulders” of the health sector.

2.6.2 *Rawls’ and Frederickson’s theories of governance*

Unlike theories of governance that fail to incorporate an explicit concern for equity, Rawls and Frederickson arguments pinpoint the need for equity as a foundation of governance. In his theory of social justice, Rawls (1971; 2005; 2003; 2009; Frederickson, 2005; Robinson, 2014) argues that all individuals have the same claims to basic liberties. According to Rawls (2005; 1971), “basic liberties must be assessed as a whole” (p. 201). He also notes that social and economic inequalities should be managed in order for them to provide the greatest benefit to individuals that are the least advantaged (Rawls, 2005; 1971; 2003; Frederickson, 2005; Robinson, 2014). More explicitly in discussing his two principles of justice, Rawls (2005, p. 1971) writes that,

> … each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others [and] social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be everyone’s advantage, and (b) attached to positions and offices open to all (p.60).

Elsewhere Rawls states,

> … [t]he social system is to be designed so that the resulting distribution is just however things turn out [and]… to achieve this end it is necessary to set the social and economic process within the suitable surroundings of suitable political and legal institutions (p.275).

In this sense Rawls’ theory of social justice makes explicit the need for incorporating justice in policy decisions, and can be used to assess the impact of government policy,

particularly in relation to gauge whether policies are consistent or not with the principles he applied (Robinson, 2014).

Frederickson's theory of social equity also addresses issues of equity as they relate to governance in the realm of public administration. Frederickson (1971; 1980, 1982; 1985; 1990; 1994; 2005 referenced in Glaser, Hildreth, McGuire & Bannon, 2011-12; 2010) writing from a perspective that "public administration is a form of politics" (2005) and that "public administration tends to practice social equity" (2005), discusses governance more generally and proposes the need for public administration to include a social equity agenda in theory and practice so that public administrators should focus on social equity on equal footing with other measures of performance (referenced in Glaser, Hildreth, McGuire & Bannon, 2011-12; Frederickson, 2010). Frederickson (2005; 1990) theory of social equity places social equity as the "third pillar" for public administration and places it on the same level as economy and efficiency which are existing values of public administration (p.209). Frederickson's (1990) compound theory of social equity also recognizes that multiple equalities require consideration when evaluating policy impacts on a community (Glaser, Hildreth, McGuire & Bannon, 2011-12).

Both Rawls and Frederickson make space for incorporating an equity agenda in policy making. Arguably, given HiAP's failure to address structural inequalities in a comprehensive way, it is possible that HiAP has its philosophical basis in a liberal framework such as those posited by Rawls and Frederickson, which place equity and justice at their center but largely overlook the structural causes of inequality.

2.6.3 *Fundamental causes theory*

Sociological theories like the fundamental causes theory provide an additional theoretical basis for HiAP. The theory highlights the need to contextualize disease, the important link between social conditions and disease, and identifies key mechanisms through which social inequality leads to disease. Based on Liberson's concept of basic causes and developed by Link and Phelan (1995; Phelan et al., 2004; Link, Phelan & Tehranifar, 2010), the theory seeks to explain "why the gap between high and low [socio-economic status] SES has been so persistent across time" (Link & Phelan, 2002, p.731). Link and Phelan (1995) argue that SES is a fundamental cause of disease and "fundamental causes are linked to multiple disease outcomes through multiple risk-factor mechanisms" (88). Likewise, Link et al, (2010, pp. S29-S30) posit, socio-economic status is related to "multiple disease outcomes through multiple pathways" (p.S29) because individuals and groups make use of resources to avoid risks as well as to "adopt protective strategies" (p.S29). Flexible resources such as money, power, and social connections can be employed irrespective of the risk or protective factors involved. Individual level resources "cause of causes" or "risk of risks" shape individual health behaviour by "influencing whether people know about, have access to, can afford, and receive social support for their efforts to engage in health-enhancing or health-protective behaviors," while contextual level resources shape access to "contexts that vary dramatically in associated risk profiles and protective factors" (p. S30). To address social conditions, Link and Phelan (1995) argue that health policy makers should address inequality in resources that fundamental causes entail and recognize

that policies that are relevant to addressing the fundamental causes of disease fall outside the health sector.

Sociological theories like the fundamental causes theory when combined with theories of governance provide a framework through which HiAP can be understood. Unfortunately, the theory's neglect of the social structures, such as class, ethnicity and gender for example, the intersection of these factors, and how they limit access to resources that promote health is problematic. HiAP's foundation in these theories may explain why HiAP does not address the structural determinants of health. In this regard, the political economy of health framework, discussed in the next section, may help us address the political, economic and structural determinants of health (Birn et al., 2009).

2.7 CONCLUSION

In this chapter, I reviewed the HiAP literature in order to understand whether and how HiAP, as a framework for policy implementation, has contributed to improving population health, focusing on its claim to advancing health equity. In reviewing the theoretical and methodological approaches to study HiAP and its effectiveness, I found that the HiAP literature is theoretically and methodologically weak, apolitical, and lacks an evaluative component. I argued that a political economy analysis of HiAP could highlight the structural factors that shape health equity and population health, elements often neglected in conventional HiAP research. Although the political economy framework may provide a comprehensive understanding of the structural roots of health inequities, given its theoretical nature it is unlikely to 'speak to' or 'convince' policy makers who are often preoccupied with evidence-based empirical research. In this context, realist evaluation provides perhaps the most effective means to studying HiAP

and its effectiveness.[7] In the final section of my dissertation, I explored the potential of case study as a method for evaluating HiAP and its effectiveness critically given its utility for answering "how" and "why" questions in real-life contexts.

2.8 PROBLEM STATEMENT

My review of the HiAP literature highlights the need for:

1) Theoretical analyses of HiAP implementation.

2) Empirical studies that evaluate HiAP, particularly in relation to how and whether HiAP improves population health and equity in health.

4) Research that seeks to better understand the political context of policymaking and the impact of politics on population health outcomes in relation to HiAP.

Flowing from this review, my dissertation will examine more broadly, the role that politics plays in the implementation of HiAP across multiple jurisdictions. The research questions investigated in this dissertation are: 1) How does the public health literature discuss the role of politics in the implementation of HiAP? 2) What are the factors that facilitated buy-in for HiAP in California? and 3) How do non-state actors influence the implementation of HiAP in Norway, Finland, Scotland, Finland, Ecuador and California? The narrative review chapter advanced understanding of how the public health literature conceptualizes politics in HiAP implementation; while the buy-in for HiAP in California chapter highlights that concerted effort by governments along with prior experience in instersectoral action are instrumental for HiAP implementation across sectors. Lastly, the non-state actors in HiAP implementation chapter provides much required insight into the influential and contextual influences of non-state actors in HiAP implementation.

[7] There are those however, who consider Marxist political economy within critical realism, or more broadly Marxism with critical realism (see for example Alvesson & Sköldberg, 2009).

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CHAPTER THREE: METHODS

3.1 INTRODUCTION

This chapter is organized into three parts. First, I discuss the HiAP Analysis using Realist Methods On International Case Studies – HARMONICS) projects and the systems framework guiding the dissertation. Second, I discuss the narrative review method for public health perspectives on HiAP. Third, I discuss the single case and multiple case study methods and hypotheses guiding the investigation.

This dissertation employs the explanatory case study methodology to test hypotheses and advance theory about HiAP implementation across various settings. More specifically, this dissertation examines: 1) How and to what extent the public health literature discusses the role of politics in the implementation on HiAP; 2) Tests hypotheses and advances theory on buy-in for HiAP implementation in California; 3) Tests hypotheses and advances theory on the influence of non-state actors in the implementation of HiAP in Norway, Finland, Scotland, Finland, Ecuador and California. The case study approach draws from the case study method and as such focuses on explanations, which are important for answering these research questions.

3.2 HARMONICS PROJECT AND THE SYSTEM FRAMEWORK

This research builds on the work of Drs. Ketan Shankardass, Patricia O'Campo and colleagues, the HARMONICS project which is a study of HiAP implementation at the St. Michael's Hospital Centre for Urban Health Solutions. The HARMONICS project uses a realist explanatory case study approach to advance theory about implementation of complex policies such as HiAP. This project has examined 8 cases of HiAP implementation in various jurisdictions worldwide. These cases were selected from 43 countries implementing HiAP (Shankardass et al., 2012). Cases

were selected based on three criteria proposed by Stake (2006, p.23): is the case relevant to the quintain[8]? Do the cases provide diversity across contexts? Do cases provide good opportunities to learn about complexity and contexts?

Table 1. Characteristics of HiAP cases included in the multiple case study

Case	HiAP mandate	Number of informants	Informant Sector	Articles Included
Scotland	Equally Well (2008-2015)	15	Health (9) Non-Health (6)	52
Norway	National Strategy to Reduce Social Inequalities in Health (2007-2015)	13	Health (9) Non-Health (4)	28
Finland	Health 2015 (2001-2015)	10	Health (6) Non-Health (11)	23
California	HiAP Task Force (2010-2015)	9	Health (4) Non-Health (5)	25
Ecuador	Buen Vivir (2009-2015)	17	Health (8) Non-Health (9)	25
Thailand	National Health Act (2007-2015)	13	Health (10) Non-Health (3)	45

Table 2. Selected research produced in the HARMONICS Project

Methodologies	**Shankardass K, Renahy E, Muntaner C, O'Campo P. Strengthening the implementation of Health in All Policies: a methodology for realist explanatory case studies. Health Policy Plan.** 2015;30(4):462–73.
Single case studies	*** An explanatory case study of the implementation of health in all policies in California.
Multiple case studies	Molnar A, Renahy E, O'Campo P, Muntaner C, Freiler A, Shankardass K. Using win-win strategies to implement Health in All Policies: a cross-case analysis. PLoS One. 2016;11(2): e0147003. Pinto AD, Molnar A, Shankardass K, O'Campo PJ, Bayoumi AM. Economic considerations and health in all policies initiatives: evidence from interviews with key

[8] A quintain according to Stake (2006) is "an object or phenomenon or condition to be studied" (p. 6); in multi case studies the quintain is the umbrella for the cases that are studied.

	informants in Sweden, Quebec and South Australia. BMC Public Health. 2015;15:171. *** Non-state actors influence in HiAP implementation: A realist explanatory multiple case study of HiAP implementation in Norway, Finland, Scotland, Thailand, Ecuador and California
Glossaries	Oneka, G, Shahidi, FV, Muntaner, C, Bayoumi, A, Finn-Mahabir, D, Freiler, A, O'Campo, P, Shankardass, K. A glossary of terms for understanding political aspects in the implementation of Health in all Policies (HiAP). J Epidemiol Com Health. 2017;71(8):835-838. Freiler A, Muntaner C, Shankardass K, Mah C, Molnar A, Renahy E, O'Campo P. Glossary for the Implementation of Health in All Policies (HiAP). J Epidemiol Commun Health. 2013;67:1068–1072.
Systems framework	Shankardass K, Muntaner C, Kokkinen L, Shahidi FV, Freiler A, Oneka G, M Bayoumi A, O'Campo P. The implementation of Health in All Policies initiatives: a systems framework for government action. Health Res Policy Syst. 2018 Mar 15;16(1):26.
Commentaries	Kokkinen L, Muntaner C, O'Campo P, Freiler A, Oneka G, Shankardass K. Implementation of Health 2015 public health program in Finland: a welfare state in transition. Health Promotion Int. 2017; 10.1093/heapro/dax081
Review	Shankardass K, Solar O, Murphy K, Freiler A, Bobbili S, Bayoumi A, O'Campo P. Health in All Policies: Results of a Realist-Informed Scoping Review of the Literature. In: Getting Started with Health in All Policies: A Report to the Ontario Ministry of Health and Long-Term Care. Toronto: Centre for Research on Inner City Health; 2011. http://www.stmichaelshospital.com/ crich/wp-content/uploads/Health-in-All-Policies-A-Snapshot-for-Ontario_ FINAL.pdf. Shankardass K, Solar O, Murphy K, Greaves L, O'Campo P. A scoping review of intersectoral action for health equity involving governments. Int J Public Health. 2012;57(1):25–33.

The initial findings from this study, reported to the Ministry of Health and Long-Term Care in Ontario, focused on the state of the science on implementation of intersectoral action for health (ISA), as well as Health in all Policies (HiAP) globally. The aim of the report was to understand the lessons of intersectoral action for health (ISA), as well as Health in all Policies

(HiAP) in other jurisdictions. The scoping review developed "an explanatory conceptual model of the initiation and implementation of 'Health in all Policies' … based on a synthesis of existing literature describing intersectoral and whole-of-government approaches to policy making … and health equity" (Shankardass et al., 2011, p. 15). Furthermore, the report identified examples of HiAP, or whole-of-government type approaches across 16 countries jurisdictions, namely: "Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales" (p. 3). The report also highlighted that HiAP "involved a high degree of interaction and interdependence across sectors, and limited individual sectors' autonomy... [and] was not supported through simple information-sharing... [In fact, mechanisms] for supporting 'Health in All Policies' included formal intersectoral committees … joint budgets, and evaluation and monitoring tools" (p.3). Subsequent to this report, Shankardass and colleagues developed a multiple explanatory case study methodology to examine mechanisms of HiAP implementation across various jurisdictions. This methodology was developed over the course of multiple sessions by a multidisciplinary team of researchers comprising experts from various disciplines, namely: social epidemiology, geography, political science, nursing, public health, and medicine. Shankardass and colleagues also developed a systems framework as a heuristic tool to aid policy makers and HiAP researchers better understand how various government sectors shape HiAP implementation, and as a supplement to the existing methodology. More specifically, the systems framework conceptualizes HiAP implementation as occurring within a government system[9] which includes (involves) three elements: 1) the executive, 2) the intersectoral subsystem, and 3) the intrasectoral subsystem. This framework is comprised of 14 components

[9] We did not focus on the legislative branch because we were interested in how political elites are able to influence implementation and bypass the legislative branch of government. We had detailed discussions

within the three subsystems of government while recognizing non-state influences (see Figure 1). The systems framework recognizes the implementation of HiAP as a process that involves interactions between the components (executive, intersectoral subsystem and intrasectoral subsystem) that affect buy-in and capacity for HiAP. Additionally, the systems framework recognizes that non-state influences (for example, non-governmental actors, civil society, and supranational organizations to name a few) can interact with the systems components.

Studies of HiAP by Shankardass and colleagues that employed the multiple explanatory realist case study methodology have examined several factors relevant to HiAP implementation. These studies have examined or included for example: 1) a methodology for realist explanatory case studies (Shankardass et al., 2014); 2) win-win factors that are essential for implementation (Molnar et al., 2016); 3) economic considerations in health in all policies initiatives (Pinto et al., 2015); 4) political factors influencing implementation (Kokkinen et al., 2017); 5) implementation of HiAP in a Welfare State (Kokkinen et al., 2019), as well as; 6) two glossaries. The first glossary addressed the "techniques, structures and strategies required to bring sectors together for health equity… [by expanding on] the dimension of policy implementation introduced … by Smith and Katikireddi [2013, as well as highlighting] issues specific to intersectoral action … [and the] theoretical premises that have been [previously] empirically refined (Freiler et al., 2013, p. 1068); while the second, discussed the "theoretical concepts from political, policy and public health sciences to articulate a framework for studying how political mechanisms influence HiAP implementation, as well as the techniques, structures and strategies operating in HiAP" (Oneka et al., 2017, p. 835). My dissertation builds on these studies by examining a case on HiAP implementation with respect to the role of politics in the implementation of HiAP, buy-in for

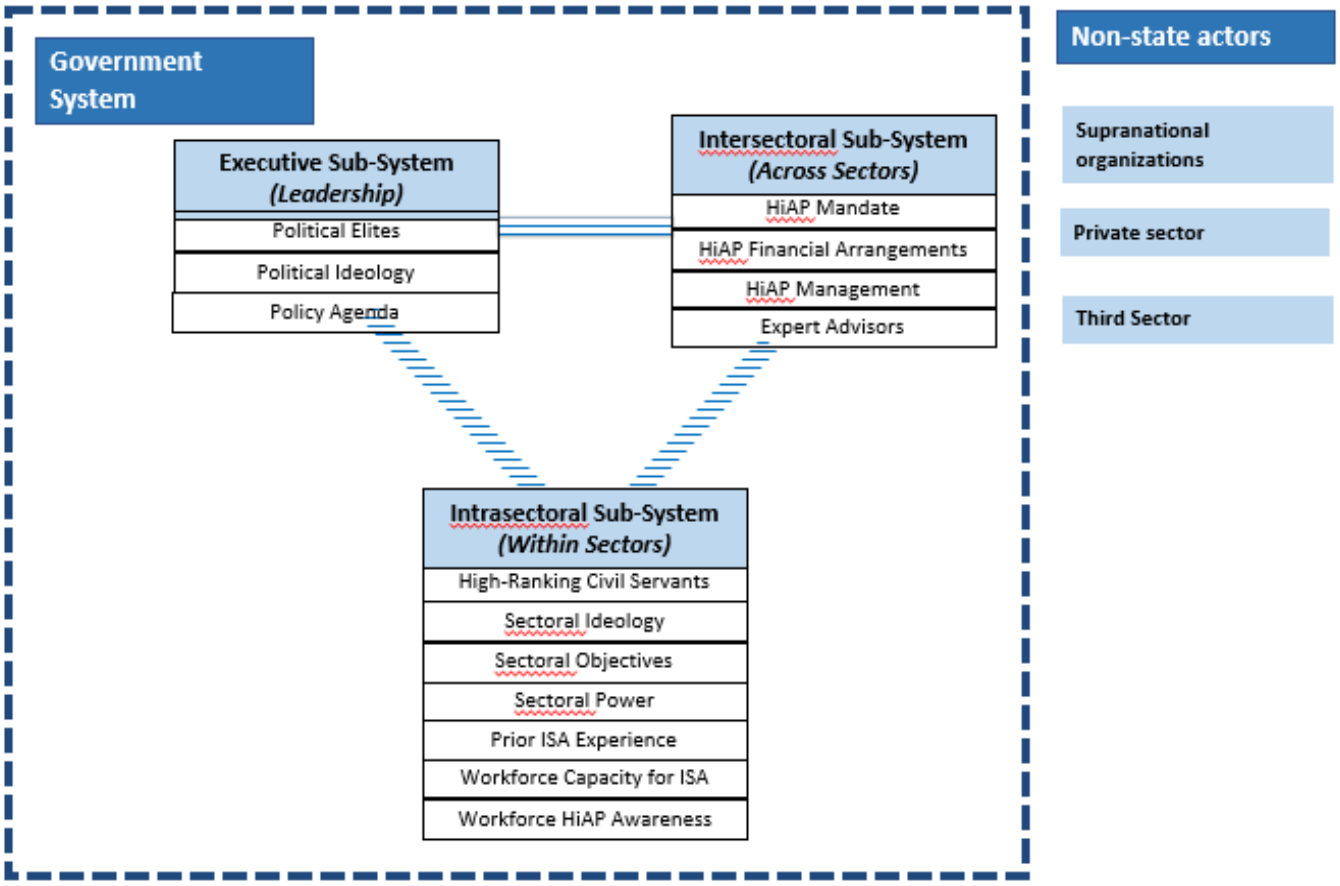
within the group and decided that we would focus on the executive and how the executive along with other parts of government mentioned here influence implementation.

implementation, and the influence of non-state actors in HiAP implementation across multiple jurisdictions.

My involvement in the HARMONICS study has been multifold. I have learned about realist philosophy of science through this project. I also learned methods of single and multiple case studies. Specifically, I collected data for a single case and contributed it to the quintain. Quintain are, “cases that are linked and bound by their common characteristics, which are what the researcher is most interested in exploring and understanding” (Goddard, 2010, p.3). I also participated in coding data for testing hypotheses and also generated hypotheses about non-state actors to be tested in a multiple case study led by myself.

Ethics approval for the project was obtained through the Research Ethics Board at St. Michael's Hospital, Toronto, Canada.

Figure 1. HARMONICS Systems Framework of HiAP Implementation: Components of the government and non-state systems involved in HiAP implementation



3.3 *Critical realism[10] and realist evaluation*

In this section, I explore the potential of critical realism to study HiAP and HiAP effectiveness. Specifically, I argue that realist evaluation provides an ideal methodology in this respect (Pawson & Tilley, 1997; Pawson & Tilley, 2004; Pawson, 2013; Wainwright & Forbes, 2000; also see Fletcher, 2016).

Critical realism combines a realist ontology with a relativist epistemology (McEvoy & Richards, 2003). Wainwright and Forbes (2000, p.274) argue that it is well suited to examine

[10]I have used framework to describe critical realism, however, but it is also conceptualized as a philosophy of science. Fletcher (2016) for example notes that "[a]s a philosophy of science … CR functions as a general methodological framework for research but is not associated with any particular set of methods" (p. 182).

health inequalities because it “provides the opportunity to develop comprehensive, cumulative and theoretical deep explanations for health inequalities within the dynamics of the real world.” They contrast such an approach to positivist research which produces “surface structures rather than explanations from deep structures.” According to Wainwright and Forbes, even interpretive research provides only a “superficial ‘explanation’ of individual action” (p.274). Both approaches, they note, “result in contextual stripping at the micro (positivists neglect agency) and also at the macro (interpretivists neglect structure) levels” (p.270). Critical realists on the other hand seek “to produce deep explanations and not only understanding” (p.270). Gibbs (2005, p.144) argues that critical realism “differs from positivism by its emphasis on mechanisms and contexts as influential, and its application of qualitative data collection techniques like focus groups or interviews.” For Clark (2008), critical realism is well suited to answer questions that aim to explain outcomes. He argues that while research, primarily quantitative, describes outcomes and researchers use trial interventions or programs to examine which approaches work best to improve outcomes for various populations, there is very little work that explains the patterns that are identified or that provide an understanding of the underlying phenomenon which leads to difficulties in explaining why “trends exist or why programs perform as they do” (p.168). Like Wainwright and Forbes, he notes that critical realism is suited for exploring research questions that aim to understand complexity so that rather controlling or simplifying complexity, it advocates that complexity must be “embraced and explored” (p.168).

A research methodology that is rooted in critical realism is realist evaluation and that can be employed to evaluate HiAP, and HiAP effectiveness is realist evaluation. Realist evaluation is not a research technique but a “logic of inquiry” (Pawson & Tilley, 2004) which is grounded in realism or the realist philosophy of science. It is positioned as a “model of scientific explanation

that avoids the traditional epistemological poles of positivism and relativism" (Pawson & Tilley, 1997, p. 405). A key strength of realist evaluation involves its analysis of the context, mechanisms, and outcomes when evaluating social interventions (see Pawson & Tilley, 2004; Connelly, 2007). It is "well suited to investigating complexity, either for evaluations of complex interventions … or of complex causal pathways" Marchal et al. (2012, p.201). For Poland, Frohlich and Cargo (2008, pp. 307-308), the questions that are posed in critical realist evaluation differ from the questions that conventional evaluation researches. While realist evaluation addresses the "question of context", in "much conventional evaluation research, the central aiming question that drives the study is either 'which interventions work best?' (the best practice option), or 'what are the vital ingredients of success?' (generalizable recipe for success). The question of context is largely ignored, except to specify what needs to be factored in or factored out of the model." In other words, conventional evaluation may be suitable for evaluations of simple interventions (e.g. interventions that promote behaviour change) but are not suitable for evaluating complex health interventions (see Dunn et al., 2013). This is noted by Pawson and Tilley (2004, p.2) who assert that "[r]ealist evaluations asks not, 'What works?' or, 'Does this program work?' but asks instead, 'What works for whom in what circumstances and in what respects, and how?'" Dunn et al (2013) argue that unlike conventional evaluation research which neglects the "heterogeneity of effect", realist evaluation addresses the fact that "programs have different effects for different people" (p.185).

Another strength of realist evaluation lies in that it is an approach combining quantitative and qualitative methods[11] in order to investigate both program processes and impacts (Pawson & Tilley, 2004: 23; Cohen & Crabtree, 2006; Wainwright & Forbes, 2000). This flows from the critical realist paradigm's focus which places "overriding importance on understanding reality" and considers methodological decisions as secondary (Clark, 2008, p.168). In this regard, Pawson and Tilley argue that the "balance of methods to be used is selected in accordance with the realist hypothesis being tested, and with the available data" (Pawson & Tilley, 2004, p.10). There are some like Davis (2005) however, who question the utility of realist evaluation to influence public policy and Connelly (2007) who finds that the methods are fragmented. Notwithstanding, realist evaluation provides an alternative methodology for addressing complex social interventions like HiAP. Interestingly despite its merits, it has not been widely used in the evaluation of HiAP, if at all, (the only realist-informed research obtained from the literature search was undertaken by Shankardass et al., (2011).

[11] The use of mixed methods, however, is not unique to realist evaluation as other forms of evaluation research can employ mixed methods (see Miller & Fredericks, 2006; Mertens, 2018; Burch & Heinrich, 2016). In discussing the use of mixed-methods for educational evaluation, Miller and Fredericks (2006, p. 578) for example note that mixed-methods'

… general strength lie in their possibility to complement traditional (mostly empirical) methods by insightful qualitative interpretations. Combined methods are potentially capable of expanding evaluation research findings in such a way that rational policymaking can be enhanced. A further advantage of incorporating MM into evaluation research is that both broad and specific parameters have been developed as to what types of MM are available and to what areas they might properly apply.
Mertens (2018) expands on this stating that,

… [m]ixed methods are particularly appropriate for addressing … wicked problems and others that are couched in complex contexts because they allow evaluators to have a common language to discuss methodology with colleagues, to address the needs of diverse stakeholders who can be accommodated by using a variety of methods, and to provide information about the nature of problems and solutions in a more nuanced way (*Complexity in evaluation contexts an d the role of mixed methods, Para 3).*

3.3 *Case study method to evaluate HiAP implementation*

One research method that can be applied to the study of HiAP effectiveness within the realist evaluation methodology is the case study (see Marchal, Dedzo & Kegels, 2010). In fact, the review findings show that two studies used case-studies to evaluate barriers to intersectoral collaboration (see Table 2). None of the studies however used the case study method or methodology to examine HiAP effectiveness.

Case studies according to Yin (2009) are excellent for an examination of how and why questions, and elsewhere defines a case study as "[a]n empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (2003, p. 13). They can address situations where there are "more variables of interest than data points …[rely]on multiple sources of evidence … [and benefit] from the prior development of theoretical propositions to guide data collection and analysis" (Yin, 1994, p.13). Yin (1994, p.15) argues that case studies have a "distinctive place in evaluation research" and identifies five applications of case study research relevant to evaluation: one to explain causal links, two, to describe an intervention, three, to illustrate topics within an evaluation, four, to explore situations when an intervention "has no clear, single set of outcomes", and, five, as a meta-evaluation.

The strength of the case study methodology lies in its ability to employ a variety of evidence including observation, interviews, artifacts and documents (Yin, 2009). Writing about case studies, Simons (2009) pinpoints theory-led or generated case studies, noting that an evaluation case study needs to determine the value of the program or project that is a part of the case. Evaluative research on HiAP is important as it can help to assess the effectiveness and impact of HiAP in light of its objectives (adapted from Guest, Ricciardi, Kawachi & Lang, 2013).

Given HiAP's equity focus and the need to evaluate whether it leads to better health outcomes, studies on HiAP that employ realist evaluation or case study methodology, provide strong theoretical information, which move beyond the typical positivist concerns with establishing associations between variables, thereby leading to social action to address health equity (Dunn, 2011).

Case study research however can be problematic. Common issues with case studies include researcher subjectivity, the manner in which inferences are drawn particularly from single cases, and the "validity and usefulness of the findings to inform policy" (Simons, 2009, p.24). However, Yin (2009) asserts the so-called lack of generalizability and rigour are not in any way unique to the case study method. Moreover, these issues can be easily resolved through triangulation, which is a means of improving research validity and reliability (Golafshani, 2003).

3.3 NARRATIVE REVIEW OF PUBLIC HEALTH LITERATURE ON POLITICS IN THE IMPLEMENTATION OF HIAP

3.3.1 METHODS

3.3.2 LITERATURE REVIEW SEARCH STRATEGY

Three electronic databases were searched in March 2016 for HiAP literature: 1. PubMed, 2. Worldwide Political Science Abstracts, and 3. ProQuest Interdisciplinary Database. These databases were selected because of their ability to search a wide number of citations in the biomedical, political science and interdisciplinary fields. I and a group of two to three researchers used a combination of generic terms along with terms that were related to the names of other forms of intersectoral collaboration to literature that were relevant to HiAP (see for example Shankardass et al., 2015). We searched the PubMed and Worldwide Political Science Abstracts using search terms: implementation [All Fields] AND ("health in all policies" [All Fields] OR "intersectoral action for health" [All Fields] OR "health public policy" [All Fields]). On the other hand, we searched the ProQuest Interdisciplinary Database using the search terms: implementation [anywhere] AND ("health in all policies" [anywhere] OR "intersectoral

action for health" [anywhere] OR "health public policy" [anywhere]) because of the difference in the database fields of ProQuest.

3.3.3 SELECTION CRITERIA

We included articles that discussed the role of politics in the implementation of HiAP. Studies that met the following criteria were included in the review:[12] 1) Published in the English language; 2) Published since the inception of Health in all Policies (HiAP), July 2006 to May 2016[13]; 3) Studies from public health;[14] 4) Described or focused on Health in all Policies (HiAP); and 5) Were empirical studies, editorials, discussion papers, and commentaries. The following types of studies were excluded from the review: 1) Published in non-English language; 2) Described or focused on Intersectoral Action for Health (ISA) absent of HiAP; 3) Studies from other fields (not public health); 4) Studies with limited (scant) discussion of politics; 5) Dissertations /theses; 6) Duplicates; and 7) Conference proceedings. For the purpose of the review, we conceptualized studies as having limited or scant discussion of politics when politics or political considerations was not a major topic within the paper.

3.3.4 ANALYTICAL APPROACH

The papers were reviewed and analyzed thematically following Milat, Bauman and Redman (2015) to examine how the public health literature discussed the role of politics in the implementation of HiAP. Papers were analyzed based on the following criteria: 1) the role of high-level leadership and changes in leadership during implementation, (2) power, (3), the relevance of ideology, 4) and the role of values in HiAP implementation. We used relevance

[12]Adapted from Inclusion and Exclusion Criteria for Papers - BioMed Central (Retrieved April 18, 2016 from https://www.biomedcentral.com/content/.../1471-2288-13-10-s2.doc)

[13] This is based on the Finnish Presidency of the European Union (EU), the period when the main health theme was Health in all Policies (HiAP) (see Stahl et al., 2006).

[14] These were articles that were published in public health journals, or studies where authors from the public health discipline.

sampling in order to select “all [the] textual units that contribute[d] to answering [the] given research questions” (Krippendorff, 2004, p. 119; also see Oneka, 2014). The coding instrument for the analysis included a list of key themes (the role of political power, influence of political elites, and political values and traditions affecting HiAP implementation). While the coding sheet enabled a sorting of the manifest themes,[15] we had to use some discretion when coding (classifying) the information as some of the themes were not readily visible.

3.4 SINGLE EXPLANATORY CASE STUDY ON THE INFLUENCE OF BUY IN FOR HIAP IMPLEMENTATION IN CALIFORNIA[16]

3.4.1 METHODS

Our study employed the realist single explanatory case study methodology to test hypotheses about what facilitated buy-in for HiAP implementation in California. We hypothesize that buy-in in non-health sectors would be facilitated by: (1) increasing the awareness of how non-health sectors contribute to public health outcomes; (2) the use of a directive approach which provides clear instructions, in addition to government leadership and accountability on HiAP; (3) the use of a win-win approach which emphasizes dual outcomes to engage non-health sectors as well the use of public health arguments to engage other sectors; and (4) prior experience with ISA as it provides non-health sectors with an understanding of mission and culture of the health sector, and a shared language between health and non-health sectors.

We used a realist single explanatory case study methodology and systems theory to understand HiAP implementation within the government system (while recognizing the influence of non-state actors). The explanatory case study methodology explains and tests hypotheses

[15] Manifest themes are tangible and observable and do not require a deeper reading of a text, whereas latent themes require a deeper reading and understanding of the text, and are often not readily apparent or hidden (see Content Analysis Understanding Text and Image in Numbers, p. 216).
[16] Adapted from Molnar et al. (2016) and Pinto et al. (2015).

about mechanisms and causal linkages involved in HiAP which then support “inferences about ‘how’ and ‘why’ certain phenomena occur” (see Shankardass et al., 2014, p. 9; Fischer & Zivaiani, 2004; Yin, 1994). The purposeful and structured approach of explanatory case studies can enhance research quality and rigour (Fischer & Zivaiani, 2004). Systems theory is useful for understanding HiAP implementation as it “can harness an understanding of social elements that [are] often unpredictable and uncontrollable” (Battle-Fisher, 2017, p. 7; also see Norman, 2009). It is premised on systems thinking which according to Battle-Fisher (2017), is “an approach to understand how a whole of interrelated parts change dramatically over time” (p. 5). Systems, she notes, “are built upon interaction … [E]xternal environmental factors can affect how a system operates … [so that with] feedback, there is a continuous flux in social influences from the external environment that requires the recalibration of the system” (p.5).

The internal validity of the study is strengthened by “interrogation of specific [Context-Mechanism-Outcome, configurations (CMOs)] … by triangulating evidence across data sources and multiple team members” (Shankardass et al., 2014, p.9). The CMO configurations are concepts from realist evaluation (Linsley, Howard & Owen, 2015) and were developed to describe how

> … an intervention is expected to work for which (group of) actors and how … Contexts represent conditions needed for an intervention to trigger (or not) mechanisms, the causal processes that produce particular outcomes… Articulated together, they become a CMO configuration, which begins to describe which contextual elements and what mechanisms led to different outcomes. As new insights emerge from data collection and analysis, hypothesized relationships between CMOs are iteratively altered to reflect realities on the ground (Adams, Sedalia, McNab & Sarker, 2015, p. 268).

Our study uses three types of triangulation: (1) multiple sources of evidence (grey and peer-reviewed literature, interviews with key informants, as well as reviews of case-related documents), (2) diverse methodological approaches, which include the explanatory case study

as well as realist evaluation; (3) and a team-based approach to constructing and summarizing CMOs configurations that employs multiple raters in order to interpret evidence (see Shankardass et al., 2014).

3.4.2 CASE SELECTION

A scoping review was conducted by Shankardass et al (2011) on intersectoral action for health (ISA). The review identified various jurisdictions that implemented ISA or HiAP. Following the scoping review, cases were selected. Cases selected were based on the period of initiation, the richness of the data and the similarities and differences between them (Molnar et al., 2016). The grey and academic literature on theories of buy-in for intersectoral action, and the role of non-governmental actors in implementation were then consulted for theories of buy-in for intersectoral action, and the role of non-governmental actors in implementation. The grey and academic literature were also consulted for articles that were relevant for testing the hypotheses on buy-in and the role of non-governmental actors, as well as for potential key informants of HiAP in each jurisdiction. California was selected as a case for analysis from the findings of the scoping review.[17] California was selected for a number of reasons: 1) it was the first case of HiAP in the United States, 2) it was implemented by a Republican government, and therefore an unsual case of HiAP implementation given that HiAP has generally been adopted by governments with more left-leaning political ideologies, and 3) funding for HiAP was through the private sector. Once the case was selected, a case summary was created from the literature to develop an understanding of HiAP implementation in California. Following the construction of

[17] For the multiple case study, Scotland, Norway, Finland, Ecuador, and Thailand were selected following the scoping review by Shankardass et al., 2011. Once selected a case summary was created for each of these cases of HiAP, key informants recruited, and hypotheses/propositions tested.

the case summary we developed hypotheses (propositions) that attempted to explain the implementation of HiAP.

3.4.3 PARTICIPANT RECRUITMENT

We identified initial potential key informants from the literature as well as snowball sampling following a consultation with a key stakeholder which was identified by a member of our advisory committee. To eliminate bias that was introduced by the stakeholder's values, we recruited informants that were as diverse as possible (see Morgan, 2008, pp. 815-816). In all, participants were recruited using purposive and snowball sampling. Because the focus of the case studies was theoretical and not statistical generalization, we used purposeful sampling and not randominzed sampling (see Morgan, 2015). Interviews were conducted with key stakeholders across a variety of sectors (which included public health and non-health sectors) in order to gain a comprehensive understanding of the issues surrounding buy-in for HiAP implementation in California. Potential informants were sent emails inviting them to participate in the study. The email described the project, including the types of information we were seeking, and invited the individual to participate in a telephone interview. Participants who did not respond to emails were contacted by telephone. Informants that expressed interest in the study were further screened for eligibility based on their responses on their self-rated familiarity with HiAP implementation. Informants were asked to rate their familiarity with HiAP implementation on a Likert scale (1-5) ranging from very unfamiliar (1) to very familiar (5). This screening process was utilized in order to assess potential participants' level of knowledge with the case as we were only interested in interviewing those with high levels of familiarity of HiAP implementation in California. These individuals had an established role in the implementation and initiation of HiAP in California, individuals from the California Health in all Policies Task

Force, and individuals who were well acquainted with the HiAP initiative in California. Following the self-rated survey, we conducted semi-structured interviews with 9 key informants (4 from the health sector, and 5 from the non-health sector) who scored a rating of 3 to 5, across various sectors and jurisdictions in California. While we initially aimed to have 10 to 15 informants, we only recruited 9 informants due to the non-availability of some potential participants for the study. Hypotheses were generated from reviews of the grey and scholarly literature and from consultations with HARMONICS advisory group members who were policy makers involved in ISA/HiAP (see Molnar et al.,2016). These hypotheses were further refined following my discussions with the co-investigator and my doctoral supervisor (Dr. Patricia O'Campo), and the lead investigator (Dr. Ketan Shankardass).

Table 3. Hypotheses tested for buy-in for HiAP implementation in California

Buy-in for HiAP implementation is facilitated when:
1) Non-health sectors are made aware of their specific contributions of their sector to public health outcomes and how they can coordinate their policies to improve outcomes.
2) Governments employ a directive approach (i.e., legislation, executive order) as it compels non-heath sectors to participate in HiAP.
3) Governments use dual outcomes ("win-win") in order to engage non-health sectors in HiAP implementation.
4) There is prior experience with ISA, the health sectors' understanding the mission and culture of non-health sectors, and the development of a shared language between health and non-health sectors.

3.4.4 DATA COLLECTION

I conducted interviews using a semi-structured telephone interview process. Informants were asked questions that aimed to understand the factors that facilitated buy-in for HiAP in California across a number of factors that were linked to the study hypotheses (see Molnar et al., 2016). Interviewers asked questions as directed in the interview guide, and were also encouraged to

probe interviewees' responses for mechanism (how and why) related to each hypothesis. Following the interview process, participants were asked to nominate the names of individuals who could serve as key informants for the study.

3.4.5 DATA ANALYSIS

Following the method applied by Shankardass et al. (2014), we coded interview data flagging passages that were relevant to articulate context-mechanism-outcome configurations. Specifically, we articulated context-mechanism-outcome- configurations about how non-state actors influence the implementation of HiAP (also see Pawson & Tilley, 1997). Interviews were later coded by myself and at least two members of the research team to identify passages relevant to study hypotheses. These passages were flagged, followed by researchers creating context-mechanism-outcome (CMO) configurations to articulate the hidden processes that appeared to explain outcomes and note any contextual factors that influenced these mechanisms. Following initial coding, the researchers worked through the interview data discussing all coded mechanism in order to reach consensus on how and why each mechanism triggered related outcomes, as well as the interview passages were relevant to the mechanism of interest. Each CMO configuration was assessed for the richness of the evidence based on the level of detail available to create the CMO (thick or thin). All CMO configurations supporting specific hypotheses were then qualitatively summarized by themes, and the strength of support for each hypothesis was assessed (strong, adequate, limited, thin), as described in Table 3.

In order to ensure rigour during the coding and CMO creation each team member coded the same interview after which we discussed discrepancies in the group. Rigour was also established through the use of a multidisciplinary team which comprised individuals from a wide range of disciplines (medicine, health policy, social epidemiology, health economics, public

health, nursing, and geography) (see Pinto et al, 2015). The researchers coded additional interviews until they reached a common understanding and established inter-rater reliability. Finally, team members used triangulation of the evidence in order to assess whether the mechanisms for each hypothesis were supported by interview and literature sources (academic, grey-literature and information gleaned from relevant websites). In fact, a major strength of the case study methodology involves its use of "multiple sources and techniques in the data gathering process … [all of which] provides an important way of ensuring the validity of case study research" (Shoaib & Mujtaba, 2016, p. 87; also see Carter et al., 2014, Denzin, 1978). In other words, triangulation was employed as it ensures the validity of case study research (Shoaib & Mujtaba, 2016), and in this case, the dissertation. The triangulation in this study was not limited to data collection methods, but data sources, theory, and investigators (see Shoaib & Mujtaba, 2016; also see Denzin, 1978).

The data were then interrogated by examining the interviews for evidence. This process was repeated as many "times as needed" in order to refine the theory for each case. Following the interrogation of the data, I, and 3 or 4 researchers (KS, AF, FVS, PV) examined the grey and scholarly literature that were relevant to each case for evidence that confirmed or contradicted the mechanisms that were articulated in the interview data. The researchers then used a worksheet that catalogued the evidence from the literature. The literary evidence provided a description of mechanisms identified, as well as themes that were "addressed by the confirmatory or contradictory evidence" (Shankardass et al., 2015, p. 468). Following our analyses, a single case study report was prepared.

3.5 MULTIPLE EXPLANATORY CASE STUDIES ON THE INFLUENCE OF NON-STATE INFLUENCES IN HIAP IMPLEMENTATION IN NORWAY, FINLAND, SCOTLAND, THAILAND, ECUADOR AND CALIFORNIA

3.5.1 METHODS

3.5.2 CASE SELECTION

Cases were selected for analysis based on the results of the scoping review conducted by Shankardass et al., (2011).[18] Cases were selected if they met the following criteria: (1) HiAP was implemented in the past three to ten years (2) they were described in detailed in peer-reviewed and grey literature, (3) variability across cases (cases were selected based on similar and distinctive characteristics), and (4) the presence of diverse mandates and governance structures (O'Campo et al., 2018; Shankardass et al., 2011). In total 6 cases of HiAP from various jurisdictions were selected namely: Norway, Finland, Scotland, Thailand, Ecuador, and California (see Table 4).

[18] For the multiple case study, Scotland, Norway, Finland, Ecuador, and Thailand were selected following the scoping review by Shankardass et al., 2011. Once selected a case summary was created for each of these cases of HiAP, key informants recruited, and hypotheses/propositions tested.

Table 4. Triangulation: Quality rating table (single and cross-case analysis)

Strength of evidence (single case analysis)	Ratings of evidence for data sources
Strong	Thick evidence from three or more sources of data
Adequate	Thick evidence from two sources of data
Limited	Thick evidence from a single source of data
Thin	Thin evidence
No evidence	No evidence
Strength of Evidence (Cross case analysis)	**Degree of support for hypotheses**
High	Triangulation across 60% or more of cases
Medium	Triangulation across 40% of cases
Low	Triangulation is less than 40%
Thin	Thin evidence
No evidence	No evidence

Adapted from O'Campo et al., (2018[a, b]); Shankardass et al., (Manuscript in Preparation)

3.5.3 PARTICIPANT RECRUITMENT

Key informants for the study were identified from a review of the literature and through snowball sampling. Informants were individuals who were knowledgeable of HiAP implementation in each jurisdiction. Informants were contacted through an email and follow up phone call which screened their eligibility for the study using a Likert scale that assessed their knowledge of HiAP implementation in each jurisdiction. The Likert scale assessed participants' familiarity on a scale ranging from very unfamiliar to very familiar (see Molnar et al., 2016). Individuals who met the criteria for participation and who agreed to participate in the study went through a telephone interview conducted through a semi-structured interview process. Informants were asked questions that aimed to understand the factors that contributed to HiAP implementation (see Molnar et al., 2016). On average we recruited 10-15 informants in each jurisdiction for the

study. Interviews were transcribed and coded for the CMO configurations that assessed the effects of politics on implementation. In all, 77 informants were selected from health and non-health sectors (see Table. 7).

3.5.4 ANALYSIS

Following the method applied by Shankardass et al. (2014), we coded interview data flagging passages that were relevant to articulate context-mechanism-outcome configurations. Specifically, we articulated context-mechanism-outcome- configurations about how non-state actors influence the implementation of HiAP (also see Pawson & Tilley, 1997). Interviews were coded by at least two members of the research team to identify passages relevant to study hypotheses. These passages were flagged, followed by researchers creating context-mechanism-outcome (CMO) configurations to articulate the hidden processes that appeared to explain outcomes and note any contextual factors that influenced these mechanisms. Following initial coding, the researchers worked through the interview data discussing all coded mechanism in order to reach consensus on how and why each mechanism triggered related outcomes, as well as the interview passages were relevant to the mechanism of interest. Each CMO configuration was assessed for the richness of the evidence based on the level of detail available to create the CMO (thick or thin).

3.5.5 CROSS-CASE SYNTHESIS OF EVIDENCE FOR HYPOTHESES AND RIVAL EXPLANATIONS

We applied a “replication logic” for interpreting the findings across cases (*(Very) brief refresher on the case study method*: Sage publications) (Table 2). Cases were designated as literal or theoretical replications based on a number of factors namely: 1) regional grouping of state (whether a nation state is classified as low to middle income or high income, 2) strength of commitment to HiAP (e.g., type of mandate, accountability mechanisms, new structures), and 3)

welfare state institutions (i.e., strong, weak) for the hypotheses regarding how and why non-governmental actors are influential in HiAP implementation. Literal replications are cases that are similar leading to similar predicted results while in theoretical replications, cases are selected based on the assuumption of contradictory results (Bengtsson, 1999; Yin, 2014).

To complete the cross-case analysis, one researcher and a coordinator on the team that was trained to perform realist coding, coded the interview transcripts for information that that were relevant to answering each hypothesis. The use of multiple researchers was to "control or correct the subjective bias from the individual" (Denzin & Lincoln, 2017, *Methodological concept of triangulation, Para 1*) note, or stated differently, to enhance the credibility of the findings by "decreasing bias in gathering, reporting and/or analysing study data" (Hales, 2010, p.15), and subsequently, the internal validity of the study (see Shoaib & Mujtaba, 2016; also see Johansson, 2003; Denzin, 1978: Creswell & Miller, 2000). Our reference case was Finland as it had a strong history of influence of non-governmental actors compared to the other cases. Each case was then compared to the reference (Finland) in order to ascertain whether they were literal replications or theoretical replications. Literal replications were Norway, whereas theoretical replications were Scotland, Thailand, California, and Ecuador. Establishing a case as a literal or contrast replication is important because literal replications indicate that "the cases selected are similar and the predicted results are similar too [whereas the] theoretical replication means that the cases are selected based on the assumption that they will produce contradictory results" (Bengtsson, 1999, p.3). Theoretical replications according to Yin (2014) predict "contrasting results but for anticipatable reasons" (p.57). Following the method applied by Shankardass et al. (2014), we articulated context-mechanism-outcome- configurations about how non-state actors influence the implementation of HiAP (also see Pawson & Tilley, 1997).

We then created a thematic summary of how the CMO configurations from each of the jurisdictions confirmed or refuted the hypotheses. The cases were summarized with information on the: "context of the country, details of the HiAP initiatives, key players, and positions of key informants, summaries of [the thick] context-mechanism-outcome configurations (CMO) (all of which provided) … case specific support for hypotheses" (O'Campo et al., 2018). System components were then identified with emphasis on the parts of the system that were relevant to each hypothesis. The evidence was applied to the systems framework in order to assess the degree to which the systems predictions were represented by the evidence (Shankardass et al., *Methods,* In Press).

Following the analysis of the interviews, we analyzed the literature in the same manner (Molnar et al., 2016). The use of multiple data sources is consistent with the case study's converging lines of inquiry (Yin, 2009, referenced in Shoaib & Mujtaba, 2016) and ensures the validity of case study research (see Shoaib & Mujtaba, 2016; Johansson, 2003). Once coded, we developed context-mechanism-outcome configurations (CMOs) for each context (case) to identify if the CMOs supported our hypotheses.

After conducting the steps for the single case study and analyzing the data, we synthesized the findings from across single cases in order to draw cross-case conclusions to highlight similarities and differences across cases. CMOs for each case were collected and entered into a spreadsheet. This allowed us to track within and cross case evidence for each hypothesis. We then synthesized the quality and strength of the evidence across cases with evidence classified as thin or thick. This was completed for evidence that supported or refuted our hypotheses regarding the role of non-state actors in the implementation of HiAP. We then summarized the thick evidence for each hypothesis and drew cross-case conclusions regarding

the evidence across the cases. Thick evidence in case study research "is an essential part of the process of determining what the particular issues, dynamics, and patterns are that make the case distinctive" (Dawson, 2010, p. 944).[19] we also assessed the components of our system which we predicted would be relevant for a given hypothesis and applied our findings of all cases to the systems framework in order to ascertain whether our predictions were correct (see O'Campo et al., 2018; Shankardass et al., Manuscript in Preparation). Our assessment of the components of our system was because HiAP implementation requires policy coordination across multiple levels of government, as well as non-state actors (non-governmental actors) all of which can affect health equity (Shankardass et al., 2018).

Table 5. Quintain level hypotheses for non-state actors' influence in HiAP implementation

While HiAP implementation is facilitated by governments, with processes within the government system:
1) Supranational organizations influence implementation as they can force governments to shift policy to reflect the former's goals (compelling changes in governance) by bypassing legislation at the governmental level.
2) Private sector influence implementation (HiAP policy and program decision making) through collaboration with governments' resulting in HiAP that focuses less on promoting equity and well-being because they are concerned with profit.
3) Third sector positively influence implementation (namely, community-based organizations that are focused on improving social determinants) by implementing policies in place of governments, and in so doing implementing policies that are commensurate with the health equity values of HiAP.

Table 6. HiAP cases included in the multiple case study

Case	HiAP mandate **(Period of analysis)**	Informant Sector and number of interviews	Peer-review and grey literature articles Included
Scotland	Equally Well (2008-2015)	Health (9) Non-Health (6)	52
Norway	National Strategy to Reduce Social	Health (9) Non-Health (4)	28

[19] A detailed discussion of thick evidence is provided by the work of anthropologist Clifford Geertz (1973), as well as Norman Denzin (2001), and Jane Dawson (2010).

	Inequalities in Health (2007-2015)		
Finland	Health 2015 (2001-2015)	Health (6) Non-Health (11)	23
California	HiAP Task Force (2010-2015)	Health (4) Non-Health (5)	25
Ecuador	Buen Vivir (2009-2015)	Health (8) Non-Health (9)	25
Thailand	National Health Act (2007-2015)	Health (10) Non-Health (3)	45

Source: *Shankardass et al, 2017*

Table 7. Literal or contrast status of cases based upon ratings on key contextual variables

Case	Contextual factors informing replication or contrast ratings			Replication Status
	Regional grouping of Case	**Strength of commitment to HiAP[20]**	**Welfare State Institutions[21]**	
Finland	High income countries	Weak	Strong	Reference
Norway	High income countries	Weak	Strong	Literal Replication
Scotland	High income countries	Weak	Weak	Contrast
Thailand	Low- and middle-income countries	Strong	Weak	Contrast
California	High income countries	Strong	Weak	Contrast
Ecuador	Low- and middle-income countries	Strong	Weak	Contrast

[20] This rating was determined during analysis meetings by the HiAP Research Unit. The Strength of Commitment was classified as strong or weak. We established that a country's strength of commitment was strong when there was a strong mandate as evidenced by legislation or the creation of institutions to facilitate HiAP implementation. On the other hand, the strength of commitment was weak when government commitment to HiAP was implemented through a strategy primarily because unlike legislation, strategies are not enforceable by law.

[21] This rating was determined during analysis meetings by the HiAP Research Unit. Welfare State Institutions were classified as either strong or weak based on a number of factors, mainly, whether the country had a welfare state, and the type of welfare state institution: 1) liberal democracy, 2) social democratic, and an informal security regime. These classifications were obtained from the literature (see Sharkh & Gough 2010; Ferragina E & Seeleib-Kaiser 2011).

3.5.6 APPENDIX A

WORKED EXAMPLE OF CROSS-CASE ANALYSIS

HYPOTHESIS	Third sector positively influence implementation (namely, community-based organizations that are focused on improving social determinants) by implementing policies in place of governments, and in so doing implementing policies that are commensurate with the health equity values of HiAP (*see OPHA/ALPHA, 2010).
Regional grouping of State	LMICs are more likely to have greater role of third sector due to more deference and high rates of activism by the third sector compared to HICs.
Welfare State Agenda	Nation-states with a strong welfare agenda will have a greater role for the Third Sector in HiAP implementation compared to those with little or weak Welfare state agenda.
Welfare State Institutions	Nation-states with strong welfare institutions will have a greater role for the Third Sector in HiAP implementation compared to those with little or weak Welfare institutions.

Hypothesis 23 c

The third sector positively influence implementation (namely, community-based organizations that are focused on improving social determinants) by implementing policies in place of governments, and in so doing implementing policies that are commensurate with the health equity values of HiAP (*see OPHA/ALPHA, 2010).

To begin the cross-case analysis, we considered the indicators that would enable us to apply the replication logic for each hypothesis across each case. These criteria were decided on by the domain leads[22] and I, and approved collectively by I and members of the HiAP team. Cases were then classified within the indicator (e.g., binary, ternary, etc.). For example, Regional Grouping of State has a range of LMIC and HIC, whereas Welfare State Agenda has a range of Strong or Weak. In establishing these decisions, we ensured that the cases were well

[22] Domain leads were members of the HiAP team who were in charge of talling the context-mechanism-outcomes (CMOs) for each area that was investigated, rewriting the CMOs as narratives, and plotting the evidence on the systems framework. For example, hypotheses related to 1) buy-in, 2) prior experience, and 3) political elites were assigned a domain lead.

distributed. We then determine if the cases are literal replications or contrast replications based on the following categories:

1. Regional grouping of State
2. Welfare State Agenda
3. Welfare State Institutions

Establish rationale guiding replication logic, that is, the conditions under which the hypothesis is valid, i.e., where the third sector positively influences HiAP implementation. For example, we expected that hypothesis 23c would hold true in cases where the Regional Grouping of State is LMIC, Welfare State Agenda is Weak, and Welfare State Institutions are Weak. Because Thailand met the ideal expectations for this rationale, Thailand was considered a literal replication for this particular hypothesis. We then determined which variations of our indicators were considered as Literal or Contrast, and in doing so, weighed some indicators more heavily than others. Our Literal Replication 2 was: Regional Grouping of State is HIC, Welfare State Agenda is Weak, and Welfare State Institutions are Weak. Our Literal Replication 3 was: Regional Grouping of State is HIC, Welfare State Agenda is Strong, and Welfare State Institutions are Weak, Literal Replication 4 was: Regional Grouping of State is LMIC, Welfare State Agenda is Strong, and Welfare State Institutions are Weak. Cases that met the above criteria were placed in Literal 2, Literal 3, Literal 4 in the excel table. The remaining combinations were categorized as contrasts and were placed in the appropriate columns.

Step 1: Establish literal replication logic

Literal 1	Regional grouping of State	LMIC	**Contrast 1**	Regional grouping of State	HIC
	Welfare State Agenda	Weak	**Contrast 2**	Welfare State Agenda	Strong
	Welfare State Institutions	Weak		Welfare State Institutions	Strong
Literal 2	Regional grouping of State	HIC		Regional grouping of State	HIC
	Welfare State Agenda	Weak		Welfare State Agenda	Weak
	Welfare State Institutions	Weak		Welfare State Institutions	Strong
Literal 3	Regional grouping of State	HIC			
	Welfare State Agenda	Strong			
	Welfare State Institutions	Weak			
Literal 4	Regional grouping of State	LMIC	**Contrast 3**	Regional grouping of State	HIC
	Welfare State Agenda	Strong		Welfare State Agenda	Weak
	Welfare State Institutions	Weak		Welfare State Agenda	Weak
Rationale Welfare state will drive the degree to which the private sector can shape or influence implementation. A strong welfare state will decrease the degree to which private actors are involved in implementation.					

Step 2: Establish multiple indicators

	23c-1		23c-2		23c-3		23c-4		23c-5		23c-6	
Indicator	**Contrast**	**Literal**	**Contrast**	**Literal**	**Contrast**	**Literal**	**Contrast**	**Literal**	**Contrast**	**Literal**	**Contrast**	**Literal**
Regional grouping of State	HIC	LMIC	HIC	LMIC	HIC	HIC		HIC		HIC		LMIC
Welfare State Agenda	Strong	Weak	Weak	Strong	Weak	Weak		Strong		Weak		Strong
Welfare State Institutions	Strong	Weak	Weak	Weak	Strong	Weak		Weak		Weak		Weak
Cases	Finland					California				Scotland		Thailand
	Norway											Ecuador

In step 2, we plotted all possible literal and contrasting evidence on an excel spreadsheet and plotted each case on the sheet as literal or contrast based on the findings (how they scored on) multiple indicator ratings. Cases that met the above criteria were then placed in the multiple indicators table. The remaining indicator combinations were labeled as Contrast and cases were sorted into the appropriate columns (see table above).

Step 3: Replication logic results based on Step 2

Category	Relevant Hypotheses	California	Ecuador	Finland	Norway	Scotland	Thailand
Regional grouping of State	23c	HIC	LMIC	HIC	HIC	HIC	LMIC
Welfare State Agenda		Weak	Strong	Strong	Strong	Weak	Strong
Welfare State Institutions* Welfare state is a stong indivator of whether the third sector conceptualized as the community organizations are involved in implmentation.		Weak	Weak	Strong	Strong	Weak	Weak
RESULTS FROM STEP 2		Literal	Literal	Contrast	Contrast	Literal	Literal

Each case was assessed based on scholarly and grey literature to determine 1) their regional grouping, 2) their welfare state agenda, and 3) their welfare state institutions (see rubric). Next, cases were categorized based on literal replication logic as literal replications or contrast replications.

Step 4: Cross case evidence

Case	Replication	For	Against
California	L	Limited	No evidence
Ecuador	L	No evidence	No evidence
Finland	C	No evidence	No evidence
Norway	C	No evidence	No evidence
Scotland	L	Limited	No evidence
Thailand	L	Strong	No evidence

Establish cross-case evidence.

Step 5: Assess within and across case evidence

In order to assess within case evidence, we rated each CMO according to the richness (thick or thin CMO) and kept track of the thick and thin CMOs. We then rated within case triangulation as: 1) Strong, 2) Adequate, 3) Limited, 4) Thin evidence only, or 5) No evidence. In the across cases ratings, we summarized the strength of evidence focusing on the degree of support for the hypotheses within either the literal or contrast replication for a given hypothesis across cases.

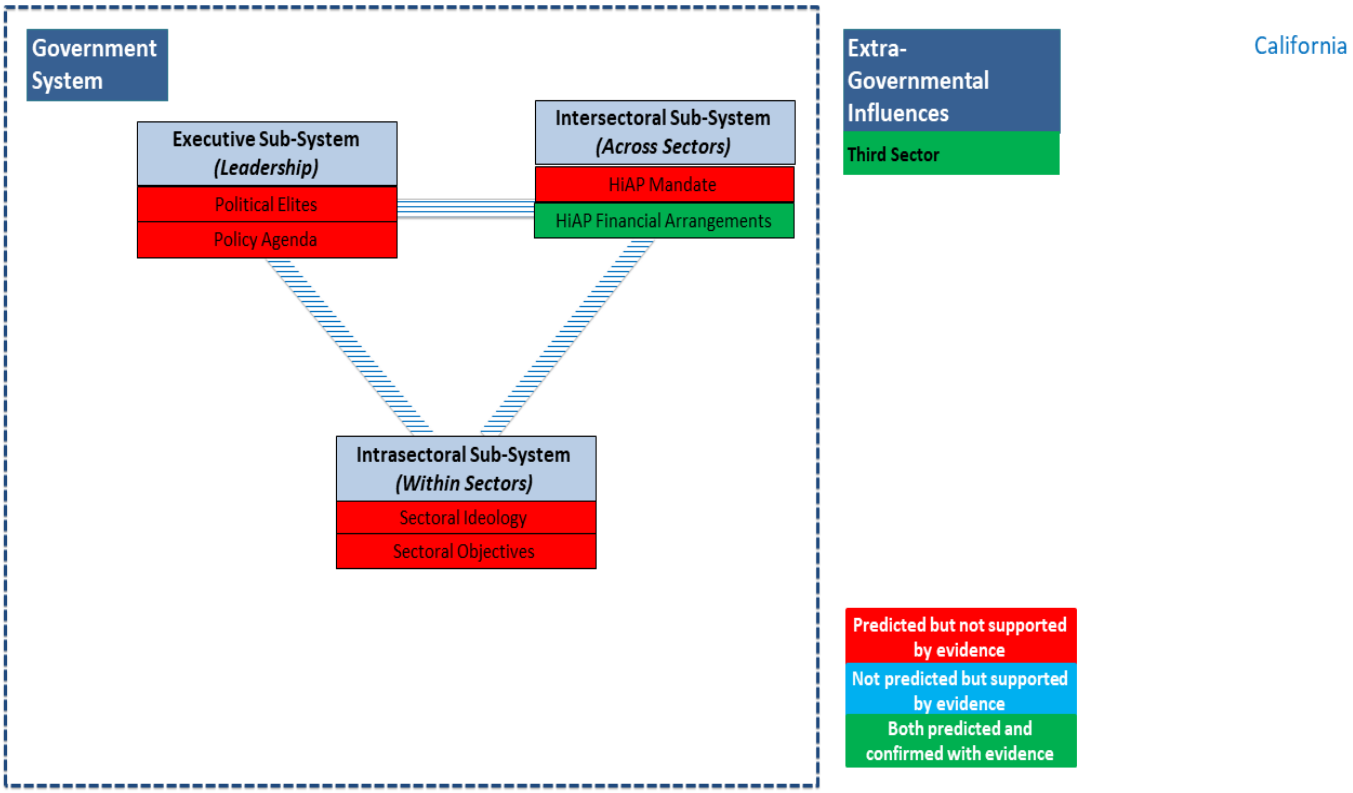
23c

	For		**Against**	
Case	**within**	**across**	**within**	**Across**
California	**Limited**		No evidence	
Ecuador	**No evidence**		No evidence	
Finland	**No evidence**	**Low**	No evidence	**Low**
Norway	**No evidence**		No evidence	
Scotland	**Limited**		No evidence	
Thailand	**Strong**		No evidence	

Step 6: Systems theory tracker

Plot the cross-case findings on the systems tracker highlighting the systems components that are relevant to each hypothesis. In order to identify systems components that were relevant to each hypothesis, we noted elements of the system that could be influential for implementation based on grey and academic literature. Systems components that were predicted and confirmed by evidence were denoted as: blue, were not predicted but supported by evidence, green, predicted and supported by evidence, red, predicted but not supported by evidence.

Figure 1. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in California



Supranational organizations/Intergovernmental sector influences on HiAP

Figure 2. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in Norway

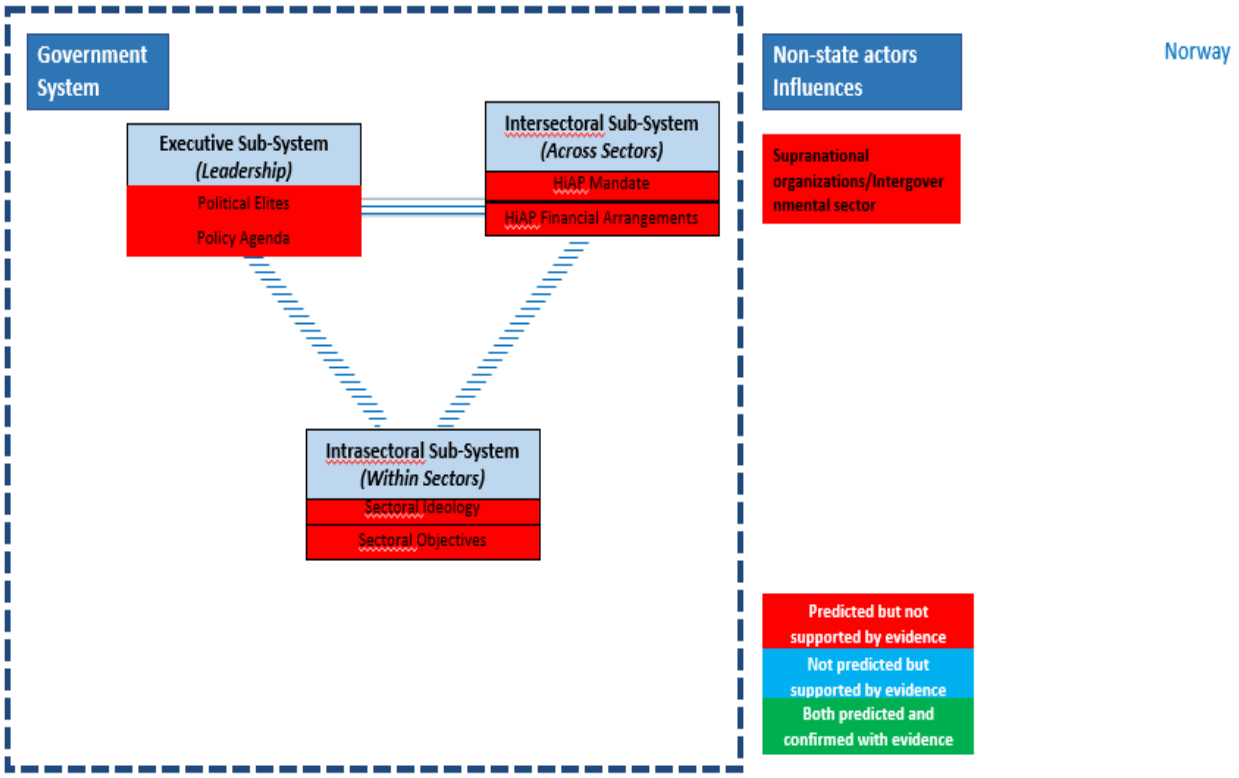


Figure 3. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in California

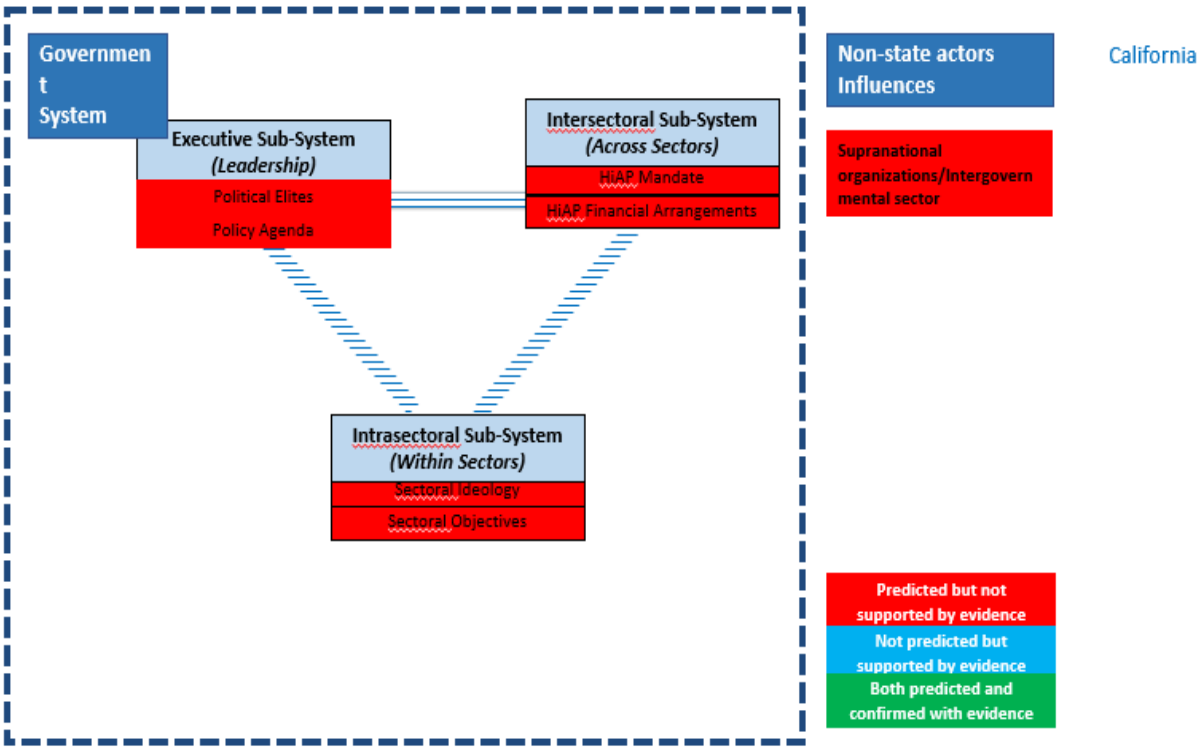


Figure 4. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in Ecuador

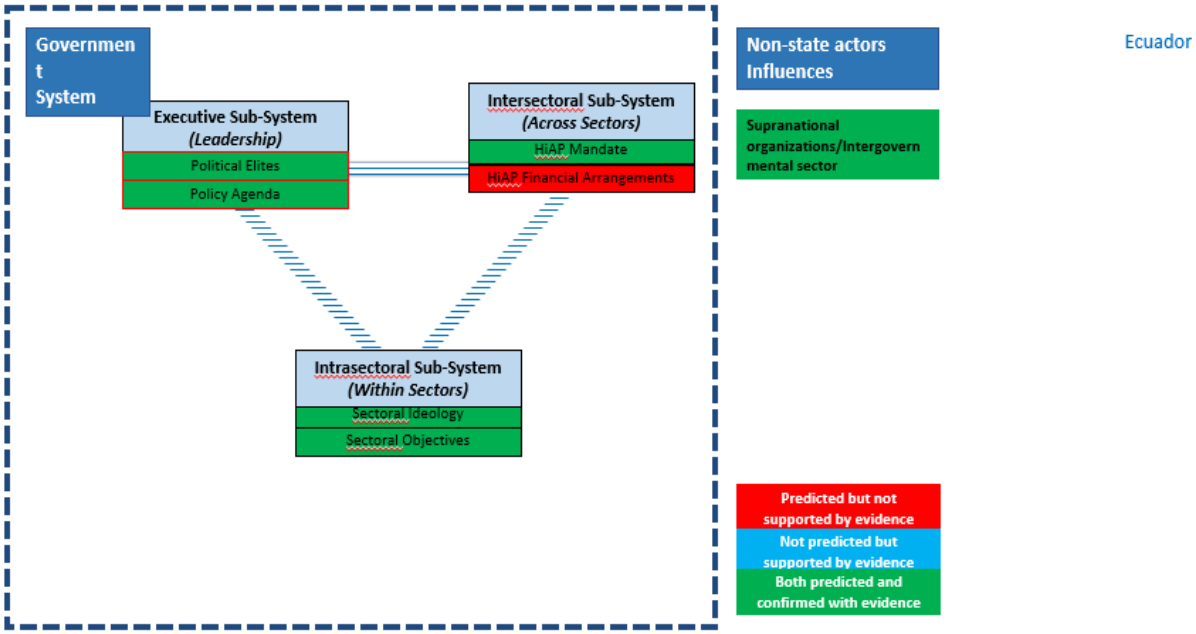


Figure 5. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in Thailand

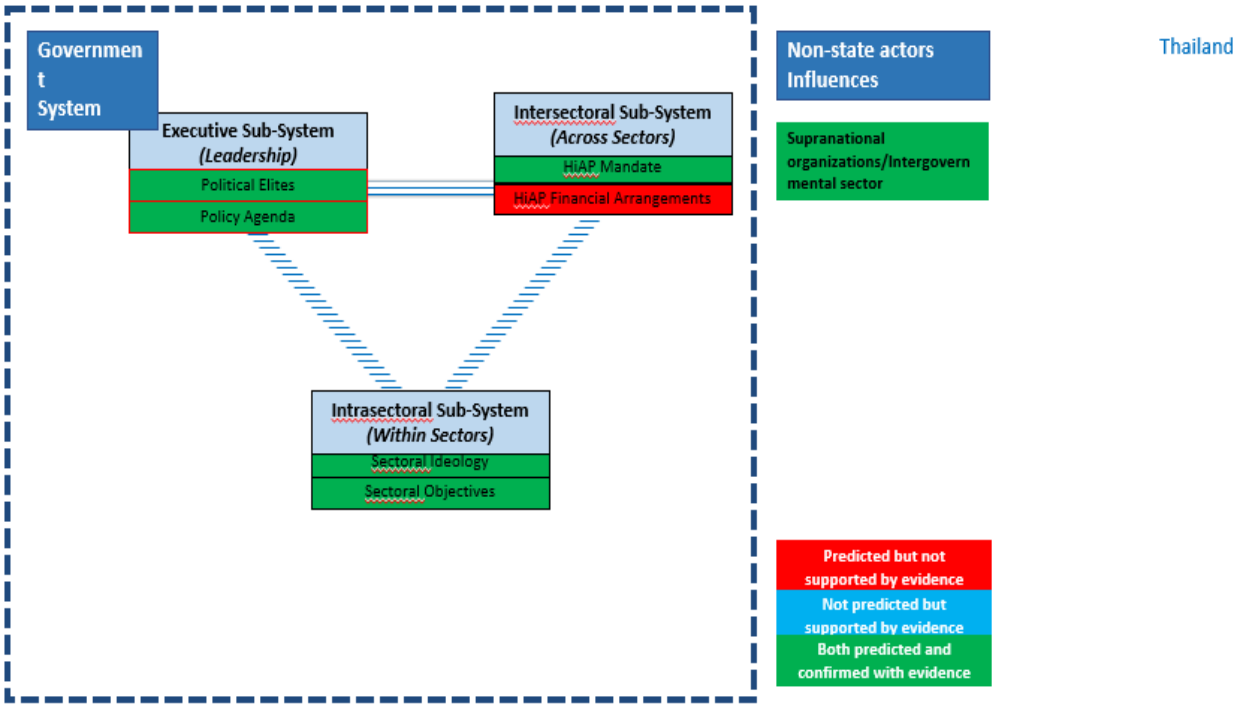


Figure 6. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in Scotland

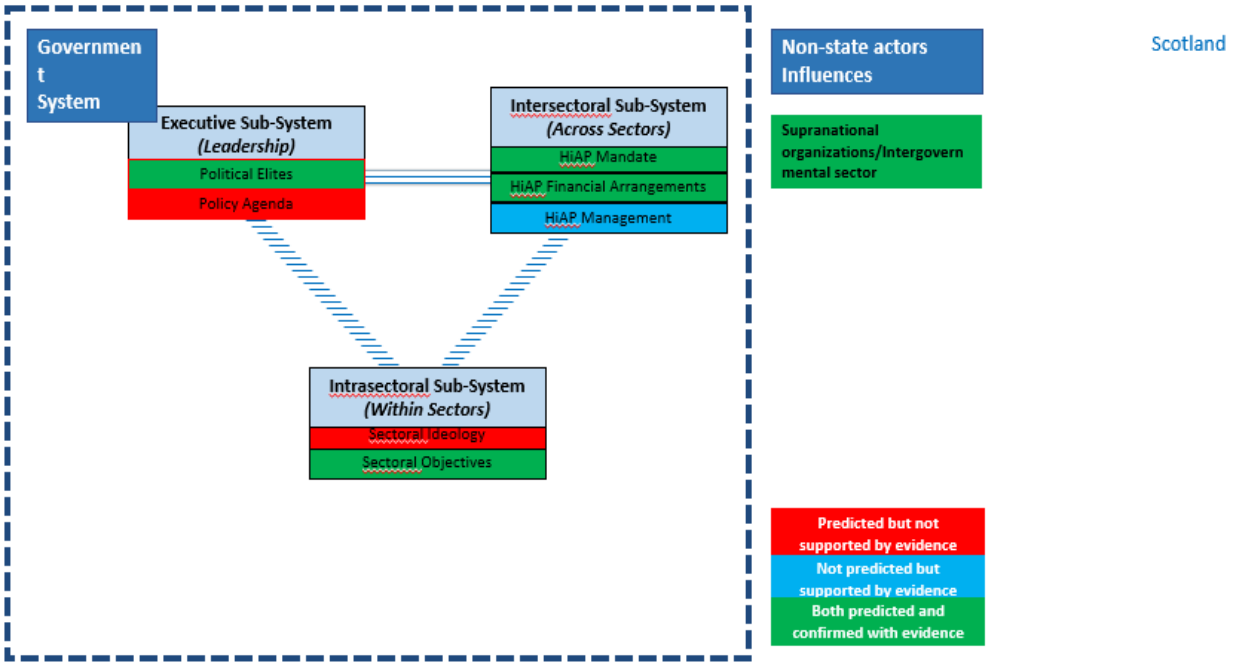
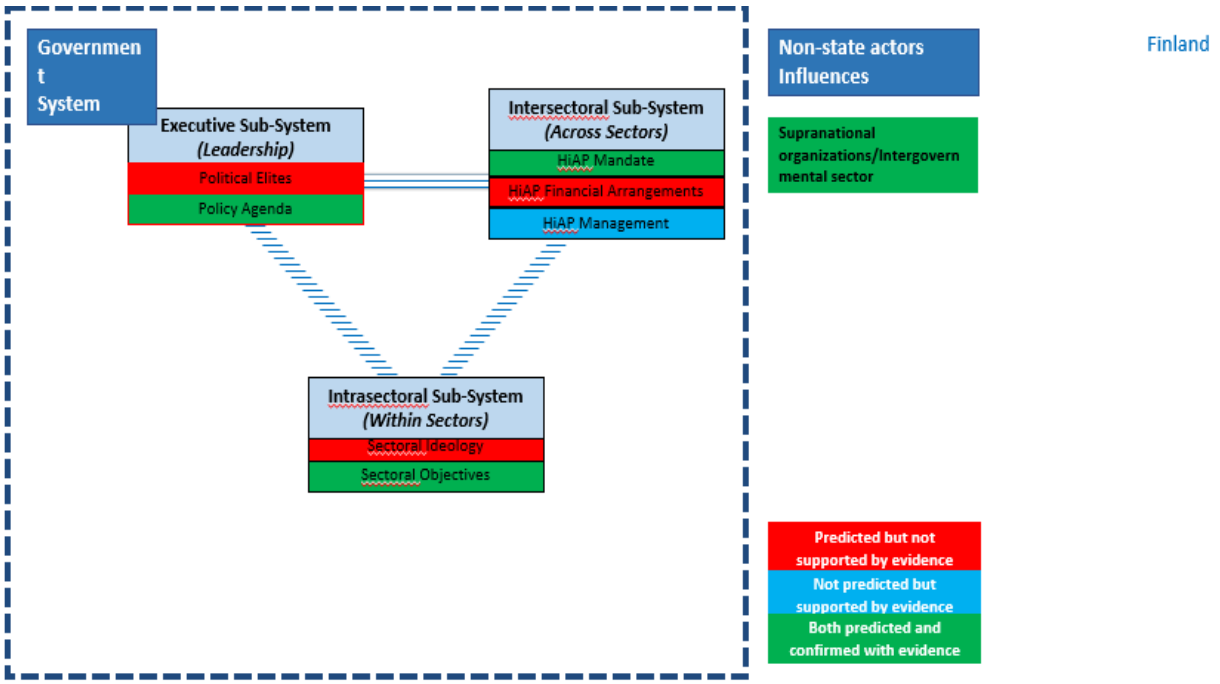


Figure 7. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning supranational organizations/Intergovernmental sector influences on HiAP in Finland



Private sector influences on HiAP

Figure 8. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in Norway

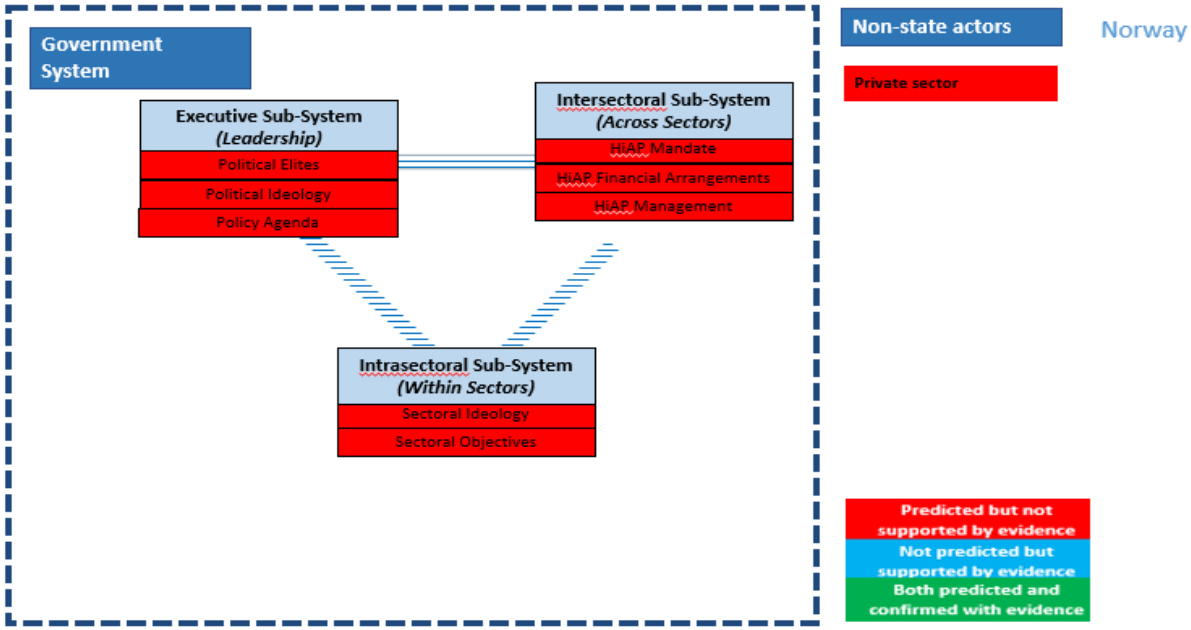


Figure 9. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in California

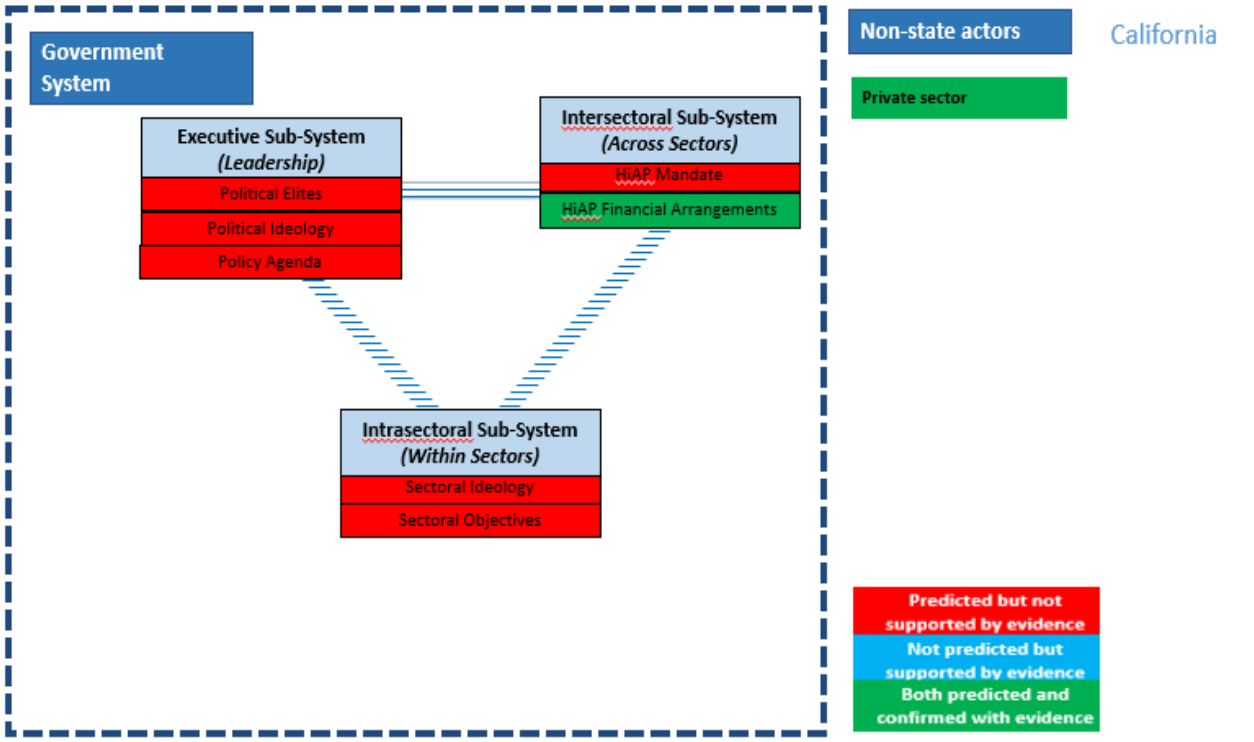


Figure 10. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in Ecuador

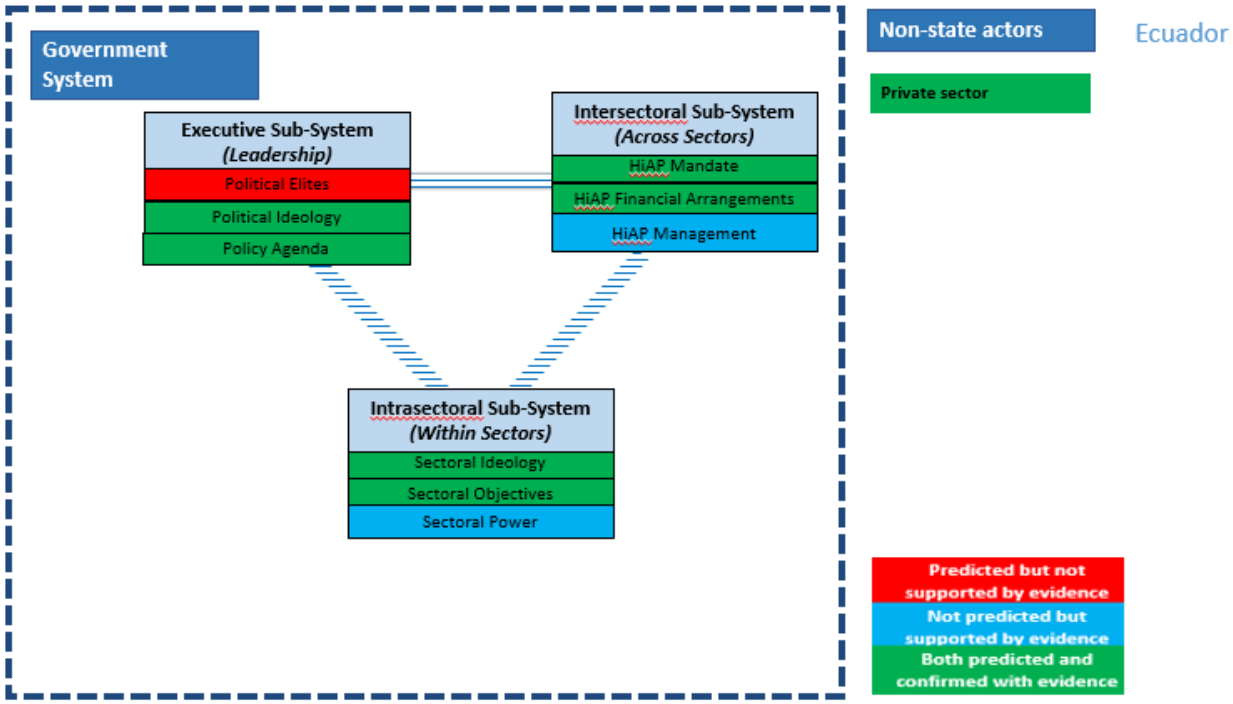


Figure 11. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in Thailand

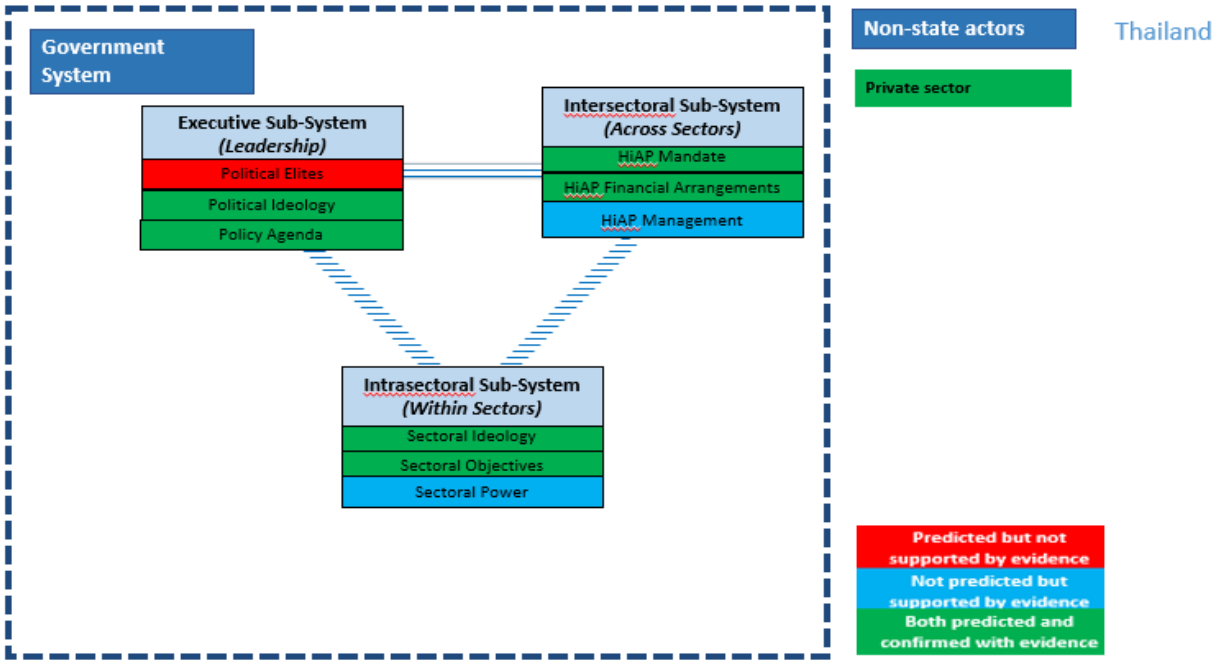


Figure 12. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in Scotland

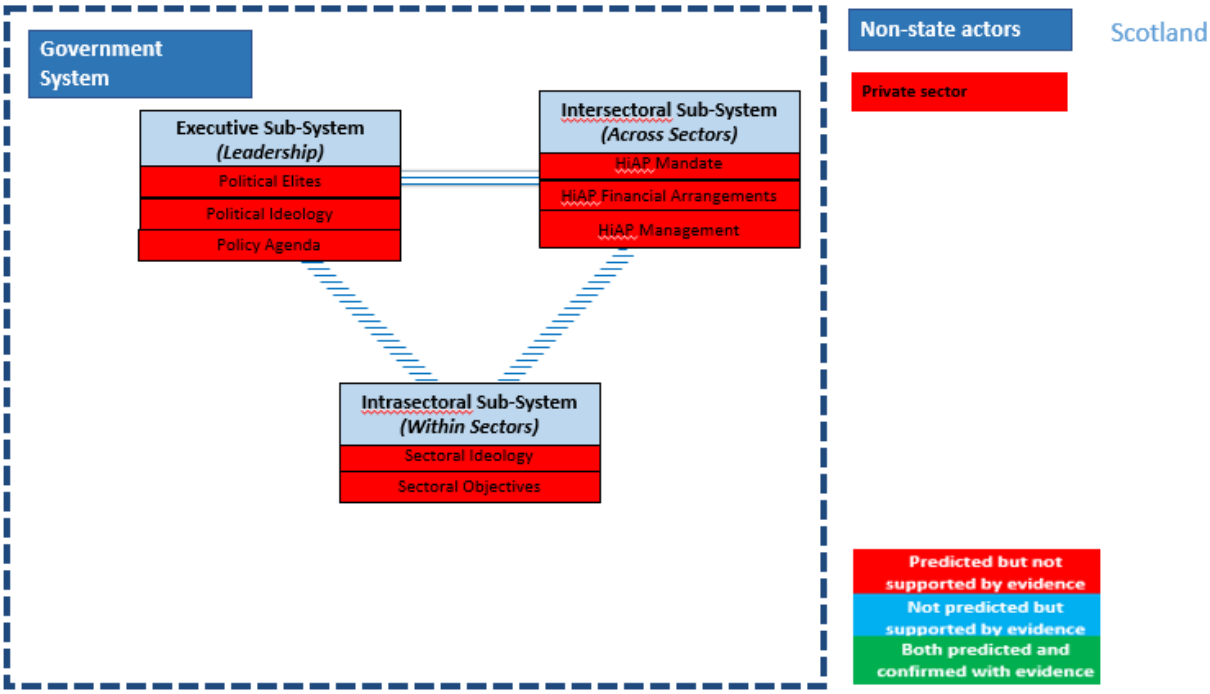
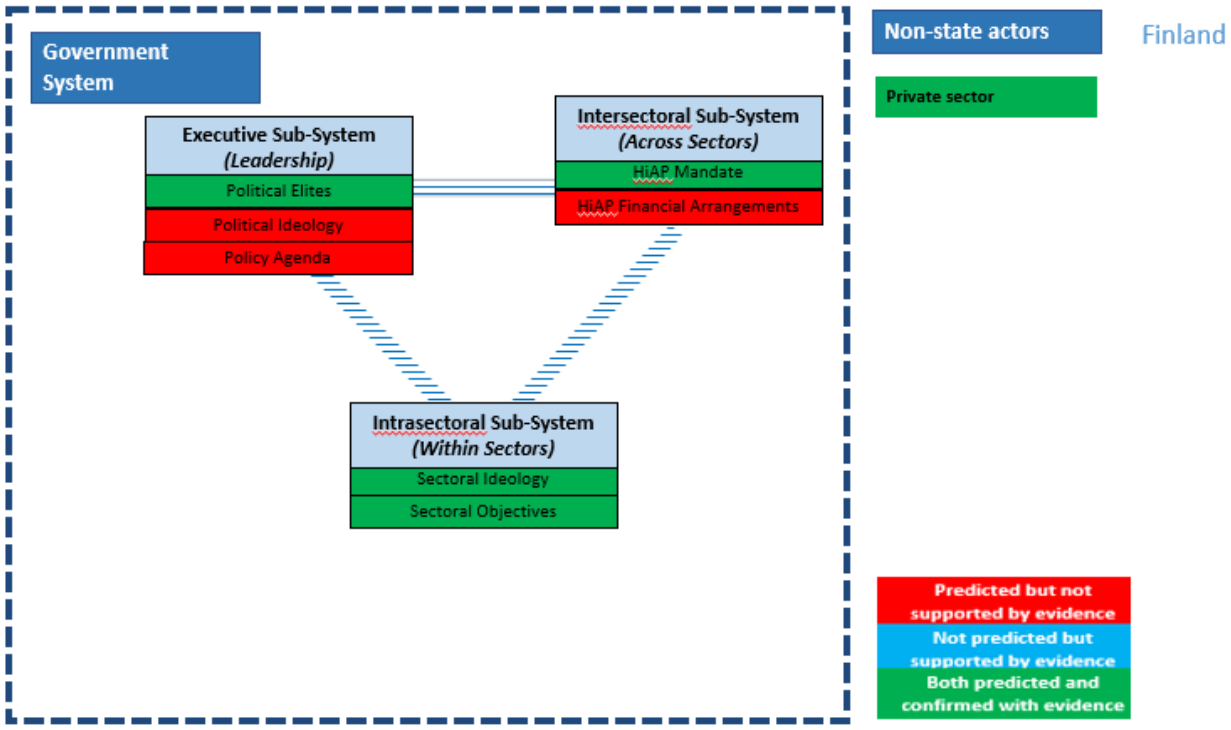


Figure 13. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning private sector influences on HiAP in Finland



Third sector influences on HiAP

Figure 14. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in Norway

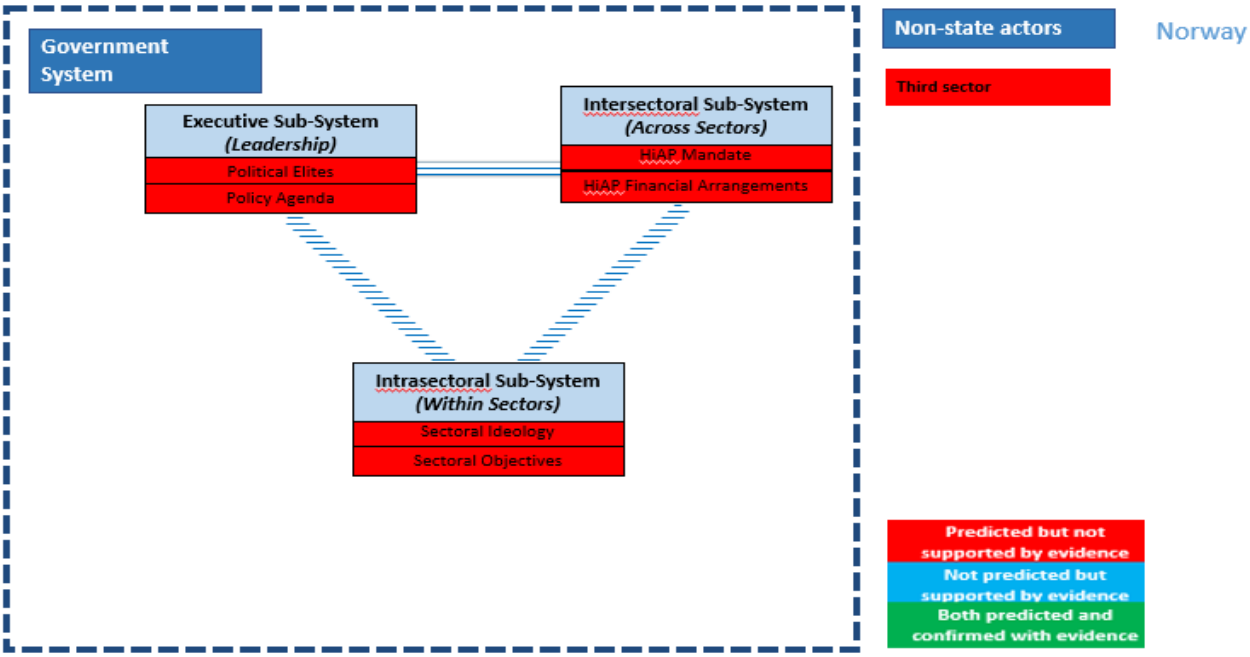


Figure 15. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in California

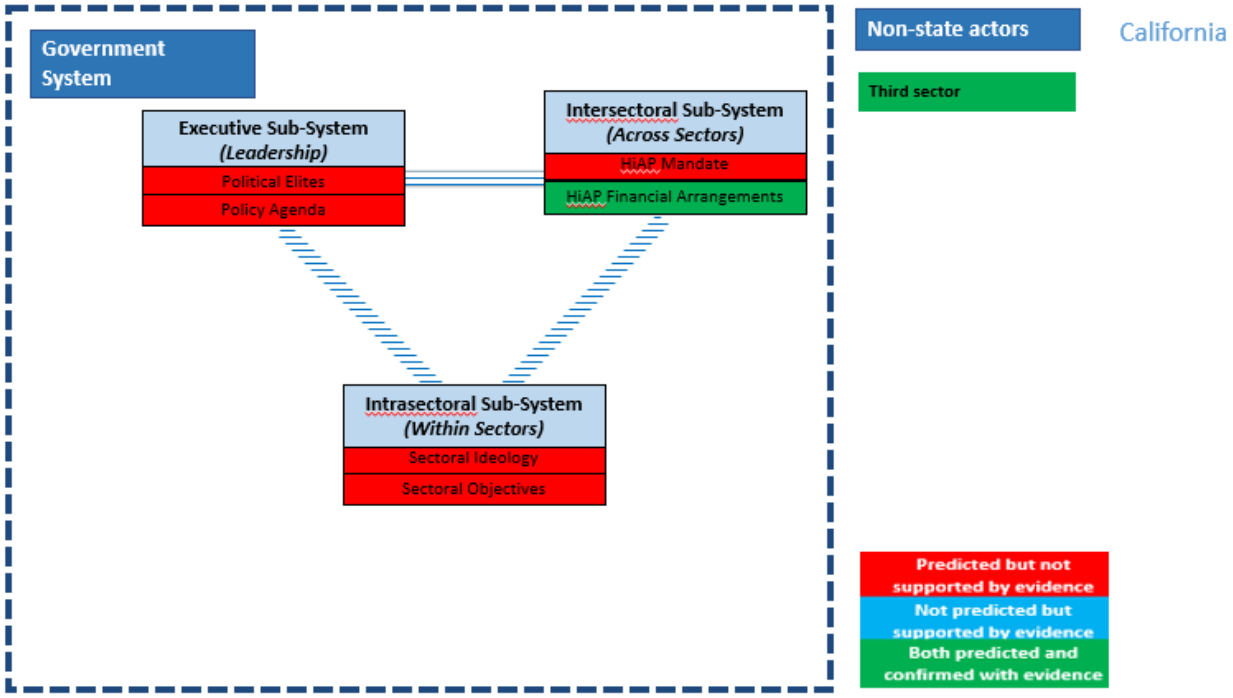


Figure 16. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in Ecuador

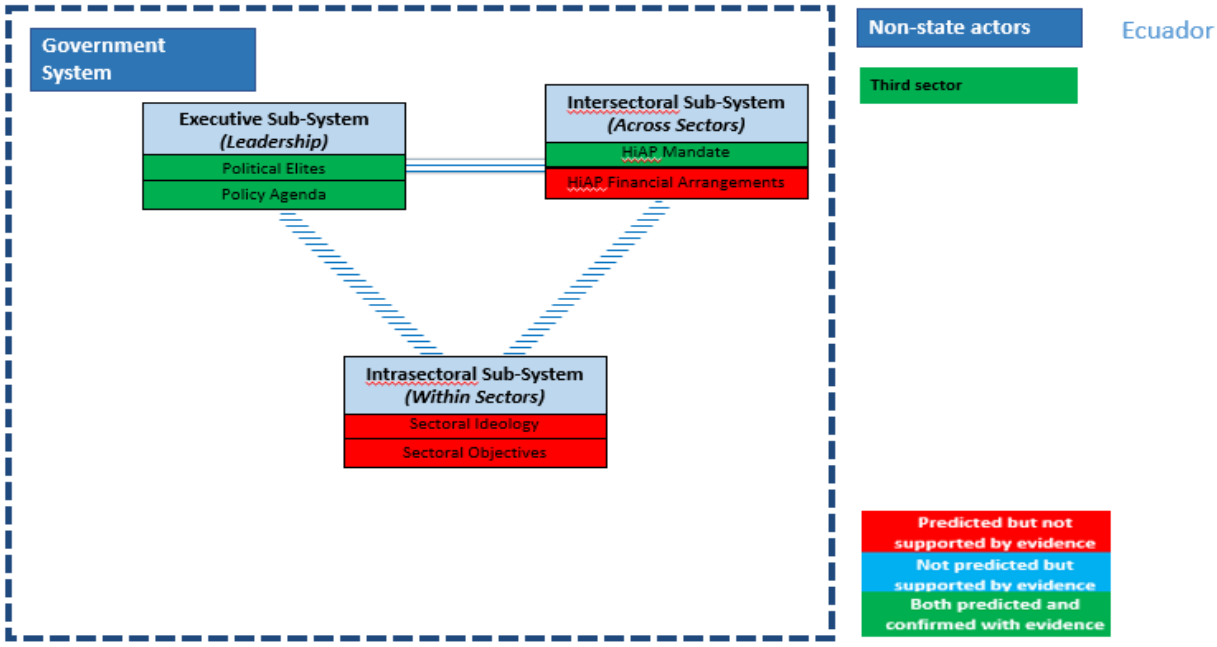


Figure 17. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in Thailand

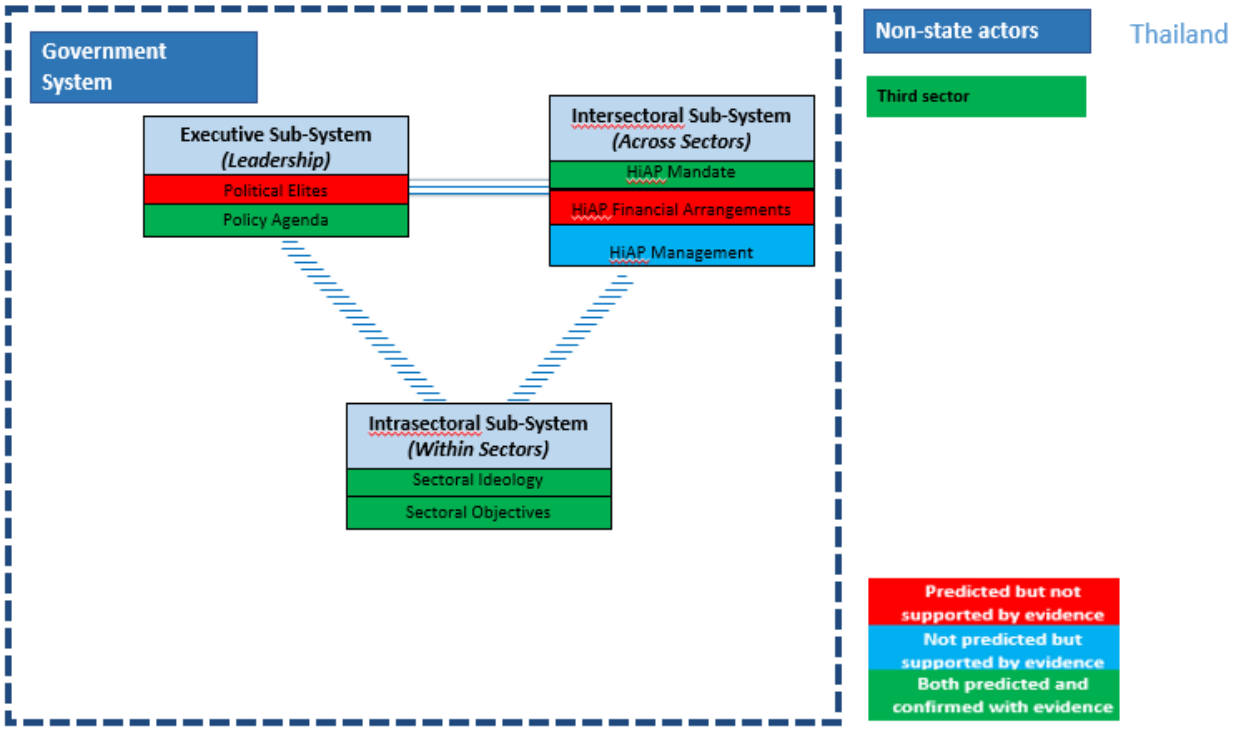


Figure 18. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in Scotland

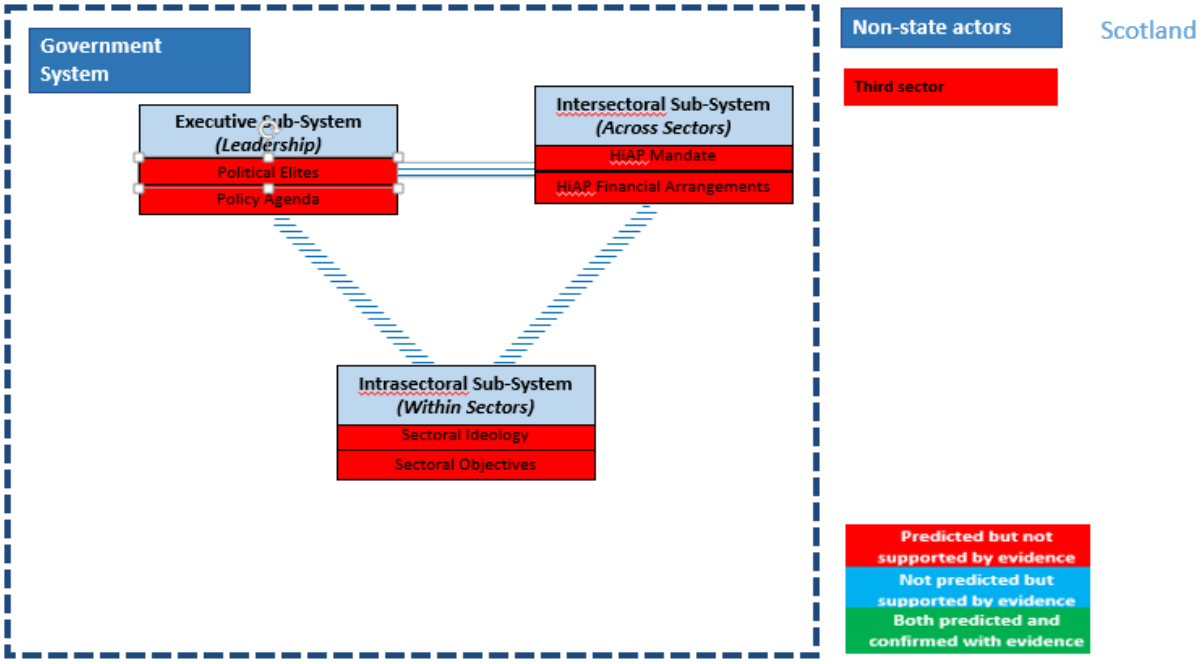
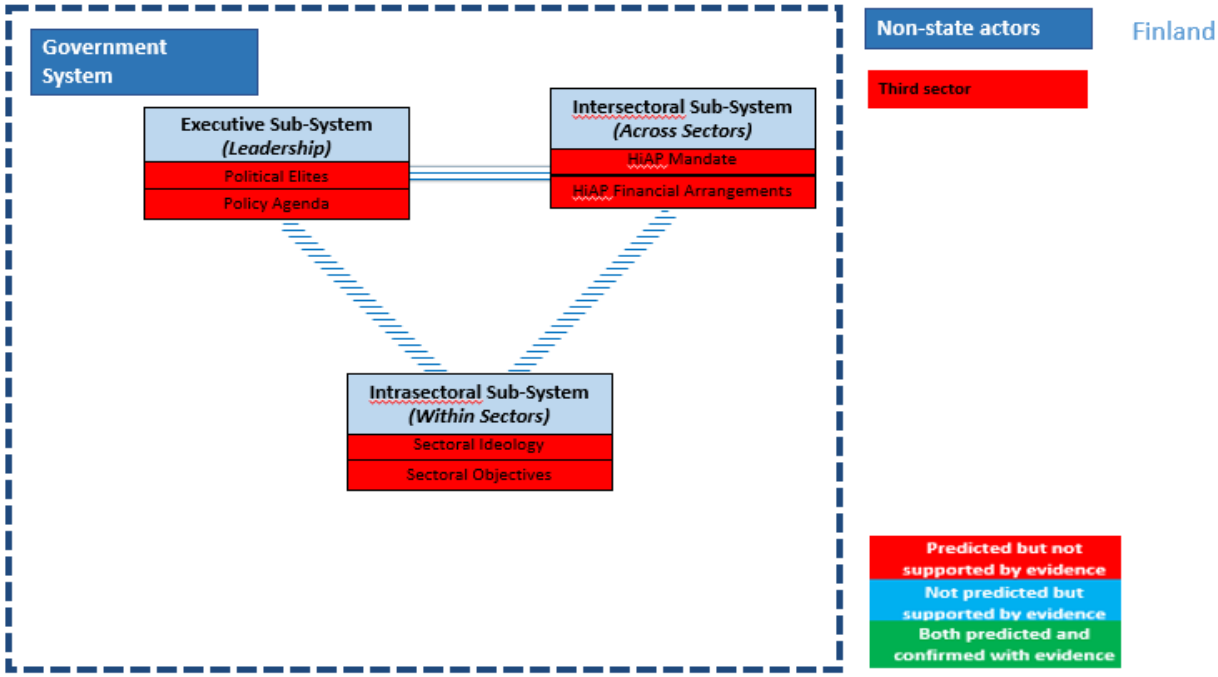


Figure 19. Cross case findings depicted on a systems framework visual identifying confirmed and unconfirmed predictions about hypotheses concerning third sector influences on HiAP in Finland



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CHAPTER FOUR. PUBLIC HEALTH PERSPECTIVES OF POLITICS IN THE IMPLEMENTATION OF HEALTH IN ALL POLICIES (HIAP): A NARRATIVE REVIEW

4.1 INTRODUCTION

In recent years intersectoral action has been touted as a key way to address a range of difficult health issues (Leppo et al. 2013). A key form of intersectoral collaboration for health is the health in all policies (HiAP) approach. HiAP represents a whole of government approach to address population level health inequalities (Shankardass et al., 2012). A HiAP approach improves population health by making explicit governments' goals to address equity. This approach ensures that policy considerations that fall outside the purview of the health and health care policy sectors "take account of the potential to contribute to population health" (Cotter, Metcalfe & Ritchie, 2011, p. 4). HiAP is founded on "health-related rights and obligations ... and improves accountability of policymakers for health impacts at all levels of policy-making" (WHO & Ministry of Social Affairs and Health, 2013, p.6).

A HiAP framework formalizes the use of "structures, mechanisms, and actions that are managed mainly outside of the health care sector to improve population health and reduce health inequalities across social groups" (Shankardass et al. 2012, p. 4; also see World Health Organization and Ministry of Social Affairs and Health, May 8, 2013). It recognizes that the health-care sector is not the principal sector that affects population health (CSDH, 2008), but that health is often affected by non-health/health care sectors (Cotter, Metcalfe & Ritchie, 2011; Stahl et al., 2006; World Health Organization and Ministry of Social Affairs and Health, May 8, 2013). Despite the involvement of governmental sectors in the implementation of HiAP, the HiAP literature does not adequately address the issue of politics, nor does the political science literature adequately address HiAP (Oneka, 2014). This is despite a recognition by several prominent theorists on the importance of political factors affecting health (Navarro & Shi, 2000;

Muntaner, et al. 2002; Navarro & Muntaner, 2004; Navarro, et al. 2006; Muntaner, et al. 2011; Bambra, 2009). These arguments have historically been voiced by Durkheim, Virchow and Engels (McQueen, et al. 2012).

Durkheim for example, was one of the first to draw a link between social factors and health in his study of suicide (Cockerham, 2007) while Villerme, Engels and Virchow "documented health inequities and advocated action in a range of sectors to improve the lot of the poor" (Baum, et al. 2013, p. 27). More recently, Navarro has repeatedly argued for and highlighted the important influence of politics on health and the need to address political traditions related to health outcomes (see Navarro, 2008; 2004; Navarro & Muntaner, 2014; also see Muntaner et al 2011; Bambra 2009). Likewise, in a study that examines the impact of political traditions on health in advanced OECD countries, Navarro and Shi (2001) argue that political forces represent interests of classes, asserting that countries with labour movements and social demographic parties tend to be committed to redistributive policing and have better health indicators, whereas countries with weaker labor movements and social democratic parties but stronger capitalist classes have weaker commitment to redistributive policies and experience worse health indicators. These arguments suggest that "health is politics," as a society's patterns of health and illness are affected by its values, cultures and institutions (Rachlis 1999, Health is politics, Para 1; also see Rachlis, 2004).

4.1.2 STUDY PURPOSE

We conducted a narrative review of the public health literature to determine the extent to which this body of literature focuses on political factors that shape HiAP implementation. Narrative reviews (NRs) have been employed in the medical sciences to assess the 'state of the science', to identify and summarize previously published research in order to avoid duplications, and to

identify new study areas which have not been previously published (Ferrari, 2015). In essence, they are important for presenting a broad perspective on a topic and describing the "history or development of a problem or its management" (Green, Johnson & Adams, 2006, p. 103). While subjectivity of study selection is a major weakness of NRs, a "historical NR is irreplaceable to track the development of a scientific principle or clinical concept; as … the narrative thread could be lost in the restrictive rules of a SR" (Ferrari, 2015, p. 231). To limit these issues, and to improve the quality of our NR, we systematically searched the literature and established clear inclusion and exclusion criteria for the literature, focused on a specific set of studies, established relevant criteria for selection (Ferrari, 2015). Our research question was, how does the public health literature discuss the role of politics in the implementation on HiAP? The primary objective of this review is to identify the strengths and gaps in the way that the literature discusses politics in relation to the implementation of HiAP. The secondary objective of the review is to propose emergent hypotheses that can guide future research in the public health discipline about the implementation of HIAP.

4.2 METHODS

4.2.1 LITERATURE REVIEW SEARCH STRATEGY

Three electronic databases were searched in March 2016 for HiAP literature: 1. PubMed, 2. Worldwide Political Science Abstracts, and 3. ProQuest Interdisciplinary Database. These databases were selected because of their ability to search a wide number of citations in the biomedical, political science – single discipline and interdisciplinary fields. A group of two to three researchers used a combination of generic terms along with terms that were related to the names of other forms of intersectoral collaboration to literature that were relevant to HiAP (see for example Shankardass et al., 2015). We searched the PubMed and Worldwide Political

Science Abstracts using search terms: implementation [All Fields] AND ("health in all policies" [All Fields] OR "intersectoral action for health" [All Fields] OR "health public policy" [All Fields]). On the other hand, we searched the ProQuest Interdisciplinary Database using the search terms: implementation [anywhere] AND ("health in all policies" [anywhere] OR "intersectoral action for health" [anywhere] OR "health public policy" [anywhere]) because of the difference in the database fields of ProQuest.

4.2.2 SELECTION CRITERIA

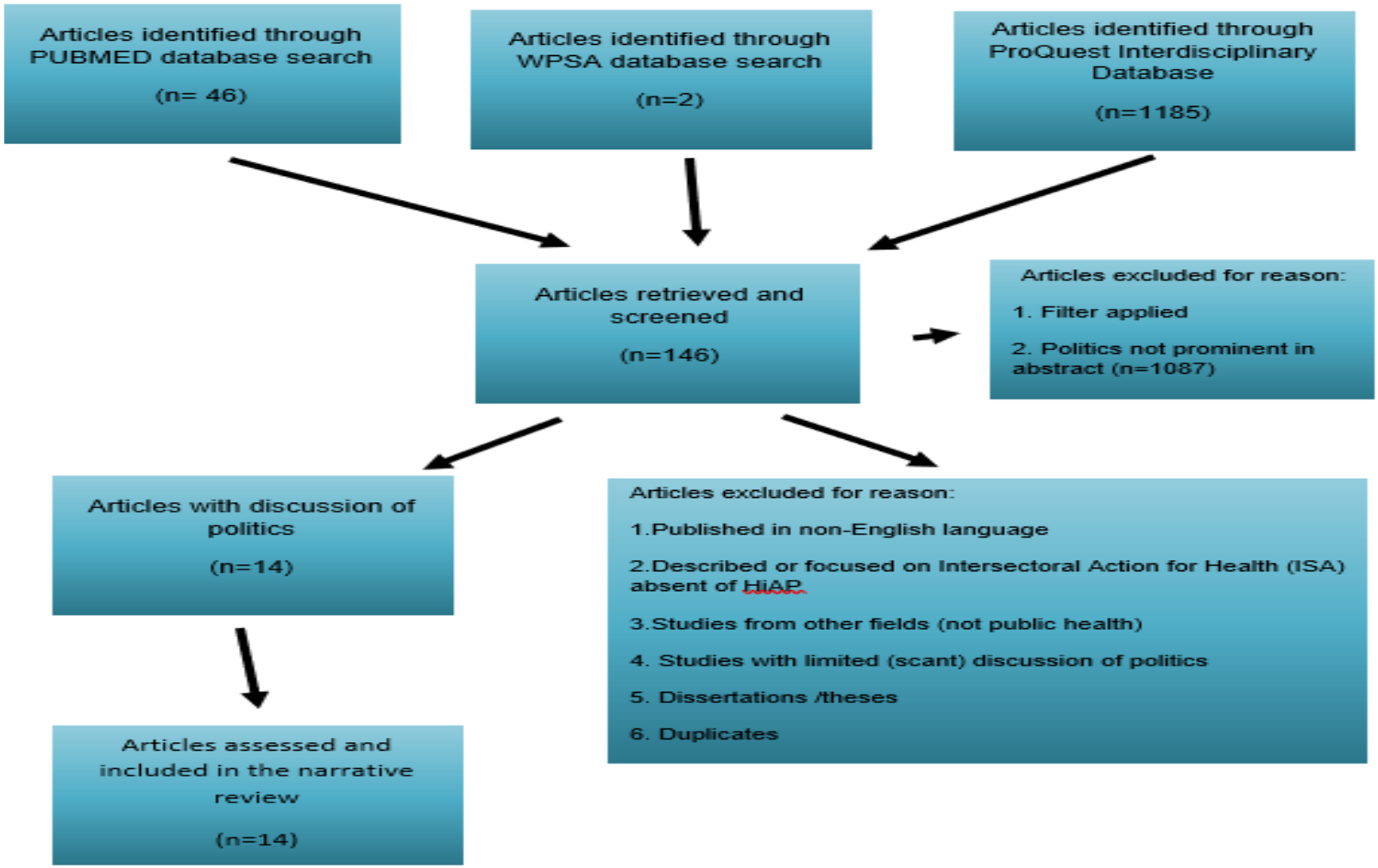
We included articles that discussed the role of politics in the implementation of HiAP. Studies that met the following criteria were included in the review:[23] 1) Published in the English language; 2) Published since the inception of Health in all Policies (HiAP), July 2006 to May 2016[24]; 3) Studies from public health;[25] 4) Described or focused on Health in all Policies (HiAP); and 5) Were empirical studies, editorials, discussion papers, and commentaries. The following types of studies were excluded from the review: 1) Published in non-English language; 2) Described or focused on Intersectoral Action for Health (ISA) absent of HiAP; 3) Studies from other fields (not public health); 4) Studies with limited (scant) discussion of politics; 5) Dissertations /theses; 6) Duplicates; and 7) Conference proceedings. For the purpose of the review, we conceptualized studies as having limited or scant discussion of politics when politics or political considerations was not a major topic within the paper.

[23]Adapted from Inclusion and Exclusion Criteria for Papers - BioMed Central (Retrieved April 18, 2016 from https://www.biomedcentral.com/content/.../1471-2288-13-10-s2.doc)

[24] This is based on the Finnish Presidency of the European Union (EU), the period when the main health theme was Health in all Policies (HiAP) (see Stahl et al., 2006).

[25] These were articles that were published in public health journals, or studies where authors from the public health discipline.

FIGURE 1. FLOW CHART FOR SELECTION OF ARTICLES DISCUSSING THE POLITICS OF IMPLEMENTATION



4.2.3 RESULTS

The search yielded 46 (PubMed), two (Worldwide Political Science Abstracts) and 1185 (ProQuest Interdisciplinary Database) articles. Because of the large number of articles found in the ProQuest Interdisciplinary Database, we applied the following filters: (“implementation” AND “health in all policies” OR “intersectoral action for health” OR “health public policy”) AND (subt.exact(“public policy” OR “public administration” OR “political science” OR “politics” OR “leadership” OR “policy making” OR “decision making” OR “health policy”) AND la.exact(“ENG”) NOT stype.exact (“Scholarly Journals”), leaving 98 articles. The lead author screened titles and abstracts for articles that fulfilled the inclusion criteria. Articles that fulfilled the inclusion criteria were further screened which consisted of reading the abstracts looking for themes related to politics, a detailed discussion of politics, and other criteria. Duplicates and articles that were not in the English language were also excluded from the review. Of the articles that were reviewed, 14 met the inclusion criteria and full papers were retrieved for the review.

4.2.4 ANALYTICAL APPROACH

The papers were reviewed and analyzed thematically following Milat, Bauman and Redman (2015) to examine how the public health literature discussed the role of politics in the implementation of HiAP. Papers were analyzed based on the following criteria: 1) the role of high-level leadership and changes in leadership during implementation, (2) power, (3), the relevance of ideology, 4) and the role of values in HiAP implementation. We used relevance sampling in order to select “all [the] textual units that contribute[d] to answering [the] given research questions” (Krippendorff, 2004, p. 119; also see Oneka, 2014). The coding instrument for the analysis included a list of key themes (the role of political power, influence of political elites, and political values and traditions affecting HiAP implementation). While the coding sheet

enabled a sorting of the manifest themes,[26] we had to use some discretion when coding (classifying) the information as some of the themes were not readily visible.

4.3 RESULTS

This review investigated how the public health literature discussed the role of politics in the implementation on HiAP. 14 articles were examined from multiple databases (PubMed, Worldwide Political Science Abstracts, and ProQuest Interdisciplinary Database). Previous research by Oneka et al., (2017) identified several important political constructs for the implementation of HiAP: (1) political elites, (2) institutional power, (3) ideology, (4) political agenda, (5) political support, (6) policy elites, (7) jurisdiction, (8) resource allocation, and (9) political culture. The majority of these themes however were not found in the HiAP literature examined. Instead the HiAP literature focused on (1) high level leadership, (2) Ideological influences, and (3) power and values.

4.3.1 THE IMPORTANCE OF HIGH-LEVEL LEADERSHIP IN THE IMPLEMENTATION OF HIAP

We conceptualize high level leadership as leadership from political elites (elected officials who occupy privileged positions within the government and as such have significant influence over the policy process) and policy elites (actors with significant knowledge of policy, and as such, have significant influence over policy making) (see Knill, 2012; Parry, 1969; Putnam, 1976). High level leadership is instrumental for HiAP implementation because political elites can help to facilitate political change towards HiAP (De Leeuw & Peters, 2014). Wismar, et al. (2013) emphasize the need to understand the politics and implementation of HiAP by focusing on the

[26] Manifest themes are tangible and observable and do not require a deeper reading of a text, whereas latent themes require a deeper reading and understanding of the text, and are often not readily apparent or hidden (Semantic Scholar, n.d, p. 216).

politics of adoption and implementation of Israel's National Programme to Promote Active, Healthy Lifestyles. They argue that tackling challenging health policy issues requires that "we … get the politics and implementation of health policy right … [in order to] better understand what it takes to raise the standing of health issues on the political agenda, induce policy change and ensure sustainable implementation" (p. 1).[27] Raising the issue of intersectoral governance high on the agenda in Israel, they argue, has several implications for the policy:

> One is that more analysis of politics and governance is required in order to build strategies to strengthen accountability for health across government departments and society. The second is that we need to better understand how diverse actors such as government officials, private industry and citizens may internalize health as an important objective, as we all have internalized the importance of evidence, efficiency, integrity, anti-discrimination and many other values (Wismar, et al. 2013, p. 2).

High-level leadership is particularly important for coordinated and concerted implementation across jurisdictions. The World Health Organization and the Government of South Australia (2010, p. 2) find that the Adelaide Statement on Health in all Policies emphasizes the importance of high-level leadership for HiAP to include, for example, "head of government, cabinet and/or parliament, as well as the administrative leadership." The report also emphasizes the need for health departments to understand the political agendas of other sectors as part of building the "process" for HiAP. This argument is echoed by Gase, Pennotti and Smith (2013) who "trace" the origins of HiAP in the United States to formal legislative processes, namely, the National Prevention Council and the California Health in All Policies Task Force. They note that "[g]overning structures are more successful when they have clearly defined roles and responsibilities, high levels of political support, stable funding sources, and a

[27] While intersectoral structures are vital for preparing, adopting and implementing HiAP, "interdepartmental committees can only resolve administrative bureaucratic issues, and if they do not work then it is probably an expression of a lack of political support" (Wismar, et al. 2013, p. 2).

backbone organization to coordinate participating agencies" (Gase, Pennotti & Smith, 2013, p. 531). Likewise, Melkas (2013) shows how Finland's success with HiAP has been largely due to a "whole of government" focus which has included among other factors the strengthening of the "status of the Prime Minister's Office" in order to implement horizontal policy as well as the creation of national legislation, the Finnish Public Health Act that required municipalities "in far more precise terms to promote health" (Melkas 2013, p. 9). And in South Australia Delaney et al. (2015) find that a mandate for action from a central government agency is one key factor for the implementation and commitment to HiAP in South Australia. This is because leadership can help to promote sectoral engagement as well as direct sustainable resources towards policy implementation (Khayatzadeh-Mahani et al., 2015).

The influence of high-level leadership however wanes in more decentralized forms of government. In the Netherlands for example, Steenbakers et al. (2012) find that despite the political prioritization of a coaching program to encourage an integrated health policy regarding obesity (coaching) in municipalities, political priority for HiAP decreased in coached municipalities over time. In fact, they found that "coaching did not contribute to improvements in the determinants of inter-sectoral collaboration at the strategic and tactical level" (p. 293). On the contrary, the determinants in coached municipalities got worse, especially with respect to political priority and managerial support. They note that this is in part due to a lack of a national strategy in which intersectoral collaboration is established law leading to the "infancy" of local level HiAP. Similarly Storm et al. (2011) show that although HiAP is recommended in several Dutch policy documents, the Netherlands lacks a formal, "whole of government approach" to HiAP at the national level in order to address health inequalities. This issue they assert is compounded by the lack of power of the Dutch Ministry of Health for coordinating and

supporting the HiAP strategy as Dutch ministries are autonomous in their governance (have independent governance), leading to a limited influence by the Dutch Ministry of Health on health-related issues. Likewise, Greer and Lillvis (2014) argue that while political leadership is instrumental in HiAP implementation, "the problem with political leadership is that it depends on politicians. [But the] direct actions of politicians be they speeches, plans, or targets, have …limitations" (p.14). They further note:

… From a coordination perspective, the problem is that individual political leaders have difficulty controlling large government bureaucracies. From timing perspective, political leadership faces the problem that politics changes. The politician might move on, the government might lose office, or events might change government agendas and priorities. Bureaucrats will respond to their new leader which means they will often give up on initiatives that do not interest the new minister" (p.15).

Similarly, Ollila (2011) posits that while politicians are influential, the time lag between policy implementation and health outcomes can make it harder to get commitment from governments. This she suggests is because politicians are dependent on electoral periods, making investments in health friendly policies whose effects are seen following electoral periods, less attractive compared to investments "with more rapid clear results" (p. 16). While high-level leadership is instrumental for implementing HiAP, the lack of legislation as well as jurisdictional autonomy (lack of power) can inhibit the process. In other words, the notion of an influential leader who can shift policy is too simple and often mischaracterizes the problems and solutions that policy makers employ. Moreover, reliance on "political leadership alone is problematic because it cannot always produce coordination and is highly unlikely to be durable in a modern political system" (p. 16).

4.3.2 IDEOLOGICAL INFLUENCES SHAPING HIAP IMPLEMENTATION

Ideology is a "set of beliefs about the proper order of society and how it can be achieved" (Erikson & Tedin, 2003, p. 64). Political actors employ ideological constructs to create

blueprints for policy action (Gaus and Kukathas, 2004). Ideological values are also instrumental for HiAP implementation. For example, Bacigalupe, et al. (2010) emphasize the importance of neoliberal ideology and its 'colonization' of public health. They argue that the tenets of neoliberalism which are based on the ideas that emphasize escape from the controls of nature and the unlimited use of resources for production. These ideals, in particular, the "neo-liberal market-oriented individualist ideology" has been introduced into public health (p. 505). In doing so, they argue that there is a need to focus on the political commitment to HiAP that is required to ensure that the effects of social and macroeconomic policies on health are taken into consideration. In addition, they call for leaders (politicians) to "think" about the long-term consequences of their policies and to ensure a comprehensive strategy and approach to promoting health. Frieler et al. (2013, p. 1070) note that values associated with a mandate, such as values that are commensurate with the promotion of a health equity or social sustainability agenda, can limit or promote the intersectoral collaboration required for the initiation and implementation of a HiAP strategy. Further, they describe how a lack of agreement on values requires a win-win approach, and that working through such ideological conflict may be easier in jurisdictions where there is prior experience with intersectoral engagement, since sectors might have already learning how to facilitate agenda setting processes, perhaps even around values that are part of the local HiAP strategy (e.g., health equity, health promotion).

4.3.3 POWER AND VALUES SHAPING HIAP IMPLEMENTATION

Mannheimer, Lehto & Ostlin (2007) assert that HiAP can only be properly accomplished via the coordinating efforts of high forms of government-boasting high levels of power. This power they note (granted by the public itself, for example, federal government) enables the support and/or management of interventions among individual sectors. In order to properly and permanently

institute all-encompassing policy concepts (like HiAP) there must be a universally accepted value of importance in society. For example, because Swedish society holds public health as a universally important issue, HiAP schemes have been applied properly and remain a permanent policy fixture. In this sense government ideology are instrumental for ensuring the introduction and implementation of HiAP. Mannheimer et al. (2007) further argue that in order to properly and permanently institute all-encompassing policy concepts (like HiAP) there must be a universally accepted value of importance in society. Societal values act as heavy influencers of prioritized policy-making. The public health sector's goal should be to improve health literacy amongst the public in order to encourage moral obligations that translate upwards to policy-makers in positions of power.

Ollila (2011) for example argues that in order to successfully introduce HiAP, the health and political sectors must share a common understanding of the determinants of health and underpinning HiAP. These values need to be transparent between both public health and political academic perspectives in order to avoid varying societal agendas. Similarly, Baum et al. (2013) note that the social determinants of health is not a "powerful" issue for policymakers, compared to economic development, which may hinder buy-in for implementation of HiAP. Because political buy-in is required for initiation of HiAP, there may well be support for implementation early on; while the sustainability of the initiative may require broader (e.g., bipartisan) support to emerge. In order to implement HiAP in partnership with non-traditional partners using the win-win, or cooperation strategy, topics where there are conflicts in values between partners should be avoided.

Greer and Lillvis (2014) note that HiAP as a potential ISA program is threatened by specific coordination and durability issues regarding policy. They note that top policy-makers

(i.e. higher tiers of governments) hold the most significant degree of power (given their bureaucratic influence) to alleviate said coordination and durability issues. Human value of sustained health equity is a driving force for HiAP initiative! However, bureaucratic obstacles (ex. non-shifting bureaucracy “missions”) and natural political changes can inhibit the ISA necessary of HiAP initiation.

Successful HiAP implementation often occurs when political will is present. Mannheimer et al., (2007) note that HiAP implementation in Sweden occurred because of clear political will along with successful working methods between politicians and civil servants. They further assert that even though public health is important, it often does not reach the highest national policy level which limits the extent of political support that HiAP receives.

4.4 DISCUSSION

The findings of this review reveal that the public health literature emphasized the role of political leadership, ideology, and power and values as key factors influencing HiAP implementation. Having said that, the number of articles addressing the influence of politics in HiAP implementation is negligible. This is consistent with previous studies examining the role of politics in the public health literature (for example see Oliver, 2006). Furthermore, in the overwhelming number of articles reviewed, there is a lack of attention given to political processes such as, theories of policy implementation, policy cycles, as well as a lack of understanding of policy processes and tools, a finding which is consistent with Breton and De Leeuw (2011) review of the public health literature. This gap can be attributed to a number of factors, the first two of which are most pertinent and have been widely alluded to in critiques of the public health field. First is, the apolitical nature of the HiAP literature, and the field of public health more broadly (Brown, 2010; Navarro, 2009; de Leeuw & Breton, 2013; Birn, Pillay &

Holtz, 2009; Oneka, 2014). Second, this finding is consistent with the public health field's lack of use of theories of political science. This perhaps points to the fact that "the body of knowledge developed by political scientists (has) made little inroads in the field of public health" (Breton & de Leeuw, 2010, p. 6). In fact, the overwhelming majority of the literature did not refer to or discuss frameworks or theories from the field of political science that are relevant to health policy development (see Breton and de Leeuw, 2013). The one exception is Kingdon's Multiple Streams Theory, which was used to explain the process of HiAP policy making. Third, and related to the second point, is the often narrow conceptualization of policy in the public health field as formal rules (e.g., legislation, regulation, laws); where Breton and de Leeuw (2010, p. 6) note that this "runs against a whole array of contemporary theoretical constructs," such as for example, the Advocacy Coalition Framework, Punctuated Equilibrium Theory, Narrative Policy Framework, and Diffusion of Innovations models, all of which highlight the complexities of the policy process, the influence of actors, institutions and narratives, and how they interact to produce policies (see Cairney & Heikkila, 2014). Fourth, the review findings point to the fact that public health professionals and the public health field tend to be concerned with establishing and working with evidence-based practice, given the public health field's mandate to ensure: protection, prevention, promotion, prognosis and provision (Brown, 2010). In a similar vein the neglect of politics in health is a consequence of a "complex interaction of issues" so that health is conceptualized as health care (Bambra, Fox & Scott, 2005, p. 189). This medicalization of health they argue, has transferred the responsibility of health to

> medical and health professions and the multinational pharmaceutical companies … [which have] taken the power and responsibility for health for themselves … [and] thus been able to determine what health is and therefore, how political it is (or, more usually, is not). [In fact, t]heir historic power over the definition and management of health has contributed substantially to its depoliticization: health is something that doctors are responsible for, they are the providers, and we are the recipients. [In essence] the

> reduction of 'health policy' to 'the content of health policies' diverts attention from, and renders invisible the political nature of the policy process.

These narrow conceptualizations and focus of public health are largely faulty because as Brown (2010) has succinctly noted, "health policies ("public" health or other) do not arise spontaneously from scientific evidence and arguments" (p.171). Given these important facts, there should be a push from public health researchers to move away from the de-political nature of research that has been the hallmark of HiAP research. Neglecting the role of politics in shaping HiAP, which is based on a value-based stance of ensuring equity in health, is problematic as health is a political issue (Oliver, 2006; Bambra, Fox & Scott-Samuel, 2005) and because it fails to uncover the important role that values, in this case, politics can play in the implementation of this collaborative strategy. In other words, explaining HiAP implementation as apolitical shifts the "locus of responsibility" (see Oliver, 2006), fails to account to acknowledge the influence of "political will," and can lead to inaction or inadequate action by governments in effectively implementing HiAP. As Oliver (2006, p. 199) succinctly notes, "[t]he responsiveness of government to a problem depends not only on the perceived level of risk but also on who is held responsible for the problem." Moreover, this failure to recognize the influence of politics neglects the effects of incremental policy making, variations that can occur across jurisdictions in terms of the "political, financial, and technical support for [central government] policies" and as such can impair effective policy implementation (Oliver, 2006, p. 207).

Recent attempts to address the social determinants of health such as HiAP have focused on the use of horizontal governance across sectors (and in some cases the tertiary sector[28]) to ensure awareness of the health impacts of policies on population health and the need for an

[28] The tertiary sector, or the third sector is a term that is used to "describe the range of organisations that are neither public nor privateprivate sector. It includes voluntary and community organisations …, social enterprises, mutual and co-operatives" (Natonal Audit Office, n.d, *What are third sector organisations?*)

equity focused approach to policy making. Political economists have long argued that health is in many ways shaped by political factors and thus requires recognition of the influence of politics as well as concerted efforts to address the underlying political determinants of health. Critiques of the social determinants of health particularly from political economists argue that the discourse about the social determinants of health has paid little attention to the underlying political-economic systems and their varied structures (Krieger, 2011; see Navarro & Muntaner, 2004; Navarro, 2009; Birn, et al. 2009; Birn, 2009; Raphael & Bryant, 2002). Navarro's critique of SDH often notes that the SDH literature is void of arguments that discuss the influence of political determinants and how political power (determined by race, class, gender and national power) is reproduced and the forces through which it is reproduced is problematic as researchers tend to study policies without analyzing the context that determines the policies (Navarro, 2009). Despite this, social and behavioural researchers striving to "promote intersectoral action and improve population health are left with one foot firmly grounded in science and the other hesitantly positioned in politics" (Rachlis, 1999: Conclusion). Because HiAP has emerged as an innovation in policy-making and as such is providing governments with a 'novel' means through which to address the complex challenges of policy making for health, public health and political analyses, governments need to better address political considerations that are relevant to implementation of HiAP. In so doing, they can begin by creating a comprehensive research agenda that addresses issues of implementation, as well as create a comprehensive approach to strengthen policy-making. This can begin with research by public health researchers on the politics of HiAP implementation. The following proposed hypotheses (which stem from the review) can guide future research on the role of politics in HiAP implementation:

(1) Power and autonomy of governments can inhibit or facilitate implementation of HiAP

(2) Ideological congruence across governments (jurisdictions) can help to ensure implementation of HiAP, and

(3) Governments with strong health equity values are more likely to create formal HiAP implementation compared to governments with weaker health equity values.

4.5 CONCLUSION

Our narrative review focused on public health perspectives on the role of politics in the implementation of HiAP. Our findings are consistent with a similar review by Oliver (2006, referenced in Brown, 2010, p. 156) on the politics of public health policy, which found a limited number of studies in the field of the politics of public health.

While there is some discussion of the importance of politics in shaping implementation, the paucity of studies in these fields is problematic as a lack of such studies limit an effective understanding of the various contextual political factors that shape HiAP and inhibit or promote intersectoral collaboration. This paper is a call to public health researchers conducting HiAP research to focus on politics of HiAP instead of studying it as an apolitical strategy. Understanding these multiple perspectives should be at the forefront of public health and political science researchers given the former's focus on promoting health and equity, and the latter's focus on understanding political processes, as well as the value that these contributions add to the policy decision-making (and implementation) process.

4.6 STRENGHTS OF STUDY

Our study employed the narrative review as we sought to "describe and discuss the state of the science of" ("*Systematic literature review X narrative review*," 2007) the politics of implementation from a public health viewpoint. Narrative reviews are important for discussing

theoretical points of view (Jahan et al., 2016) and as such can be thought provoking (Green, Johnson & Adams, 2005). In addition, we sought to inquire about the history and development of public health scholarship on the politics in HiAP implementation (see Green, Johnson & Adams, 2005; Milat, Bauman & Redman, 2015). This review also made use of methods which included information on our process for selecting information, inclusion and exclusion criteria, and an analytical approach in order to avoid some of the pitfalls involved in conducting narrative reviews (see for example Green, Johnson & Adams, 2005).

Future studies could also employ a different methodology, such as systematic or meta-narrative review in order to integrate the public health and political science literature on the politics of implementation (see Noar, 2003), as well as to evaluate the findings of studies on the politics of implementation of HiAP.

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CHAPTER FIVE: AN EXPLANATORY CASE STUDY OF THE IMPLEMENTATION OF HEALTH IN ALL POLICIES IN CALIFORNIA

5.1 INTRODUCTION

Health in all policies (HiAP) is a health governance idea where a strategy of intersectoral action is used to improve health equity. HiAP has been increasingly adopted and implemented in a number of large urban centres across the United States, such as: Seattle/King County, Los Angeles, San Francisco, Washington, DC, Richmond, Nashville, and Chicago (Wernham & Teutsch, 2014; Polsky, 2015). In the US, HiAP initiatives have employed "a mix of analytic methods, engagement and leadership strategies, and legal and policy tools to address the root causes of illness by supporting activities in non-health sectors" (Wernham & Teutsch, 2015, p. S59). Financial arrangements for HiAP in the US tend to be unique compared to other jurisdictions as it often includes a mix of government and private foundation funding (Wernham & Teutsch, 2015; Rudolph et al., 2013) (as opposed to a more government-driven model).

The spread of HiAP across US cities can be largely attributed to California's 2010 executive order to create a task force for HiAP, which was conceived of during Governor Schwarzenegger's tenure (Wernham & Teutsch, 2014). The governor's interest in addressing fitness and childhood obesity, coupled with his commitment to addressing climate change and environmental sustainability provided the California Department of Public Health (CDPH) with a policy window through which to improve population health and equity (Rudolph et al., 2013). The executive order built on legislation that was implemented in 2007, which called for improved coordination of land use and planning, and legislation that created the Strategic Growth Council (SGC), which was charged with supporting state agencies in coordinating work on climate change and sustainability (Rudolph et al., 2013; Wernham & Teutsch, 2014). While mandates are necessary for creating buy-in, there are instances where government mandates fail to

achieve desired outcomes due to the "complex, multifaceted and multileveled" nature of the factors that shape implementation, and the fact that "public policies invariably … [resemble] "wicked problems"[29] that are resistant to change, have multiple possible causes, and … potential solutions that vary in place and time according to local context (Hudson, Hunter & Peckham, 2019, pp. 1-2).

5.1.2 THE CHALLENGE OF MAINTAINING BUY-IN HEALTH IN ALL POLICIES DURING IMPLEMENTATION

Although much has been written about the value of using HiAP as a health equity strategy, and some description of the difference governance approaches used, there are few studies that have examined the implementation of HiAP for mechanisms that explain positive and negative outcomes (for example see Molnar et al, 2016; Delany et al., 2015; Delany et al., 2014; Pinto et al., 2015; Frieler et al, 2013), including no empirical studies examining implementation in non-welfare state countries or local jurisdictions. Some studies have emphasized how the implementation of HiAP requires ways of developing sustainable intersectoral collaboration by engagement diverse partners from various sectors (Olilla, 2011). Branching out to different sectors "can open the door for new opportunities that were not previously available"* In other words, active involvement across different stakeholders increases buy-in of partners, improves the longevity of the partnership, as well as the chances of developing long-term sustainable solutions.* Frieler et al's (2013) glossary on HiAP implementation suggest that "agenda setting [which is part of implementation] may entail agreement on values associated with the mandate … achieved by raising awareness, or finding other ways to motivate buy-in to mandate, such as

[29] I am following the precedent of many public health scholars who have argued that HiAP is a strategy that to address wicked problems. Wicked in this sense being, "highly resistant to change" (Kickbusch & Buckett, 2010, pp. 3-7). Also see Kickbusch (2010).

a win-win approach" (p. 1070). Yet, few studies focus specifically on the process of getting buy-in for HiAP from non-health sectors. One notable study however by Molnar et al. (2016) tested three governance strategies for achieving buy-in for HiAP implementation from the government and nongovernmental actors in Quebec, Sweden, and South Australia using the explanatory multiple case study method. These include: raising awareness, the use of a directive approach, and a win-win approach. Their study found little evidence of rasing awareness to achieve buy in, no evidence for the use of a directive approach, but strong support for win-win strategies namely, the development of a shared language, the use of dual outcomes, the integration of health into other policy agendas, the use of scientific evidence to showcase HiAP effectiveness and the use of health impact assessment to ensure the feasibility of policy coordination for public health outcomes across sectors.

The process of collaboration inherent to the implementation of HiAP can be challenging for a number of reasons, which can include varying mandates, issues of power, funding constraints, and ideological norms of governmental sectors. Taylor et al. (2004)[30] imply that sometimes partnerships can cause challenges that threaten the ability of a sector to achieve its mandate, or conflict with the identity (read: perceived responsibilities) of one or more of the partners. These authors suggest that balancing power can be achieved through the process of equalization; that is, analyzing the balance of power by mapping out roles and dynamics, ensuring equal representation, democratic decision making, providing excellent facilitation, training and support. Similarly, Dotterweich (2006) claims that issues of power can be resolved through the re-establishment of "vision and goals of the partnership, …the roles and

[30] Taylor et al. (2004) in Centre for Research and Education in Human Services & Social Planning Council of Cambridge and North Dumfries. (2004). Building sustainable non-profits.

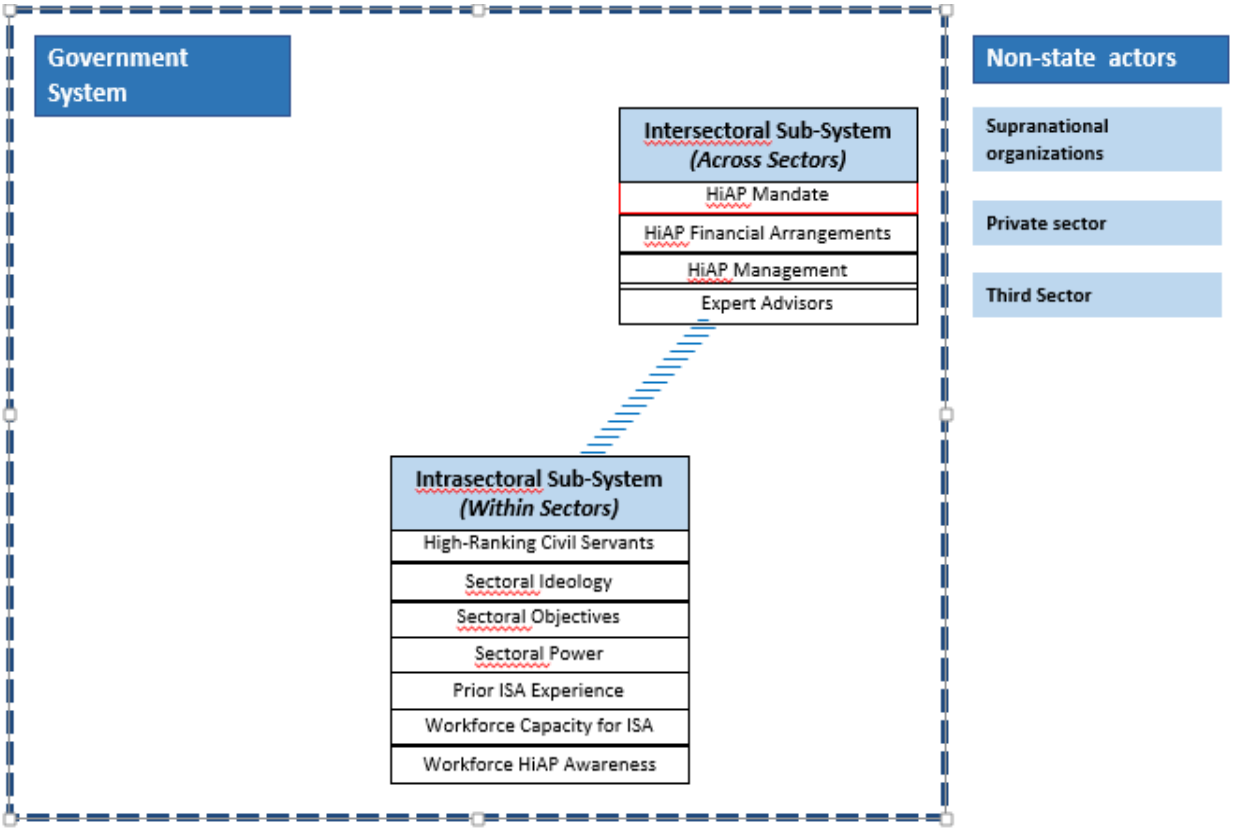
contributions of the partners, …and developing strategies and policies for communication and decision making (p. S53)." A similar view is held by Waldell and Brown (1997) who claim that "when parties are perceived to be unequal in power, taking the steps to [e]nsure that they have some degree of influence with each other may be essential" (p.23). They suggest that it is not necessary to make partners equal, but that it is important to "create circumstances that enable participants to recognize each other's own resources, to speak and listen freely, and to challenge decisions that contradict their interests" (Waldell & Brown, 1997, p.23). In other words, as Frank and Smith (2000) assert, it is important to recognize when forming partnerships that "power is present yet rarely equal (p.15)." Successful partnerships they claim value and openly acknowledge the different types of power that each player brings, so that acknowledging the power differentials enables "the partnership is then able to deal with any issues or conflicts that arise from the use of power (p.15)." Dotterweich, (2006) also identifies another key issue that arises particularly when partnership occurs around a lead agency (such as a public health organization). These include discomfort and a lack of trust that ensue from the control that the lead agency exercises. Maintaining trust within partnerships thereby becomes essential to reducing opportunistic behaviour that arises within these partnerships as well as for addressing other issues.

The issue of mandated funding and the sharing or retention of that funding in the process of implementing HiAP is another key challenge as the "processes are complicated and not always clear. For example, sometimes funding agencies place restrictions on how the funds will be used or want specific outcomes tied to the funding" (Danaher, 2011, p. 13); outcomes that may conflict with the mandate or perceived responsibility of a sector. The challenges of intersectoral collaboration can be exacerbated when sectors have little prior experience of

collaborating thereby decreasing buy-in for HiAP. In a recent study examining state-level strategies to promote health beyond the health care system, Beers et al (2018) noted how the HiAP Task Force, which formally connects 22 California ~~state~~ government departments and agencies, provided legitimacy to intersectoral activities and opportunities while improving the accountability of partners for health impacts. Over time, state agencies or departments that had previously worked together developed trust that supported collaboration. The HiAP Task Force staff were also noted as being helpful in several ways that might indicate greater buy-in, including by serving as conveners and facilitators for collaboration, and engaging local and community stakeholders, and disseminating the HiAP approach to local and state agencies.

In short, while California's 2010 executive order create a task force for HiAP, and provided legitimacy to intersectoral activities, little is known about the factors that facilitated buy-in for HiAP. This study examined the factors that facilitated buy-in for HiAP in California as sectors were being engaged at the outset of adoption until interviews were conducted in 2014. Buy-in for HiAP occurs when sectors agree to adopt health equity considerations in their policies. Buy-in, or acceptability for HIAP is one of the significant factors that help to propel the adoption of HiAP by stakeholders in non-health sectors, and often occurs when "stakeholders consider the acceptability of both the need for and appropriateness of the policy solution (e.g., is the problem important, is the solution logical and one that we can live with), as well as of the legitimacy/accountability and capability of the system within which the policy will be implemented (ie, decision makers, the decision-making process and the actors involved in implementation)" (Freiler et al., 2013, p. 1070).

Figure 1. HARMONICS Systems Framework of HiAP Implementation: Components of the government system involved in HiAP implementation in California



A case study of HiAP implementation in California is significant because California was the first state in the United States to implement HiAP (Rudolph et al., 2013; Wernham et al., 2015). Furthermore, the topic of buy-in in California is noteworthy because (1) California has primarily relied on private funding for HiAP with very limited commitment of government resources (Rudolph et al., 2013).

We used a realist single explanatory case study methodology and systems theory to understand HiAP implementation within the government system (while recognizing the influence of non-state actors). The explanatory case study methodology tests hypotheses about mechanisms and causal linkages involved in HiAP which then support "inferences about 'how' and 'why' certain phenomena occur" (see Shankardass et al., 2014, p. 9; Fischer & Zivaiani, 2004; Yin,

1994). The purposeful and structured approach of explanatory case studies can enhance research quality and rigour (Fischer & Zivaiani, 2004). Systems theory is useful for understanding HiAP implementation as it "can harness an understanding of social elements that [are] often unpredictable and uncontrollable" (Battle-Fisher, 2017, p. 7; also see Norman, 2009). It is premised on systems thinking which according to Battle-Fisher (2017), is "an approach to understand how a whole of interrelated parts change dramatically over time" (p. 5). Systems, she notes, "are built upon interaction … [E]xternal environmental factors can affect how a system operates … [so that with] feedback, there is a continuous flux in social influences from the external environment that requires the recalibration of the system" (p.5).

5.2 METHODS

Our study employed the realist single explanatory case study methodology to test hypotheses about what facilitated buy-in for HiAP implementation in California. We hypothesize that buy-in in non-health sectors would be facilitated by: (1) increasing the awareness of how non-health sectors contribute to public health outcomes; (2) the use of a directive approach which provides clear instructions, in addition to government and state leadership and accountability on HiAP; (3) the use of a win-win approach which emphasizes dual outcomes to engage non-health sectors as well the use of public health arguments to engage other sectors; and (4) prior experience with ISA as it provides non-health sectors with an understanding of the mission and culture of the health sector, and a shared language between health and non-health sectors.

The internal validity of the study is strengthened by "interrogation of specific CMOs by triangulating evidence across data sources and multiple team members" (Shankardass et al., 2014, p.9). Our study uses three types of triangulation: (1) multiple sources of evidence (grey and peer-reviewed literature, interviews with key informants, as well as reviews of case-related

documents), (2) diverse methodological approaches, which include the explanatory case study as well as realist evaluation; (3) and a team-based approach to constructing and summarizing Context-Mechanism-Outcome (CMOs) configurations that employs multiple raters in order to interpret evidence (see Shankardass et al., 2014).

5.2.1 CASE SELECTION

A scoping review was conducted by Shankardass et al (2011) on intersectoral action for health (ISA). The review identified various jurisdictions that implemented ISA or HiAP. Following the scoping review, cases were selected. Cases selected were based on the period of initiation, the richness of the data and the similarities and differences between them (Molnar et al., 2016). The grey and academic literature on theories of buy-in for intersectoral action, and the role of non-governmental actors in implementation were then consulted for theories of buy-in for intersectoral action, and the role of non-governmental actors in implementation. The grey and academic literature were also consulted for articles that were relevant for testing the hypotheses on buy-in and the role of non-governmental actors, as well as for potential key informants of HiAP in each jurisdiction. California was selected as a case for analysis from the findings of the scoping review.[31] Once the case was selected, a case summary was created from the literature to develop an understanding of HiAP implementation in California. Following the construction of the case summary we developed hypotheses (propositions) that attempted to explain the implementation of HiAP.

[31] For the multiple case study, Scotland, Norway, Finland, Ecuador, and Thailand were selected following the scoping review by Shankardass et al., 2011. Once selected a case summary was created for each of these cases of HiAP, key informants recruited, and hypotheses/propositions tested.

5.2.2 PARTICIPANT RECRUITMENT

We identified initial potential key informants from the literature as well as snowball sampling following a consultation with a key stakeholder which was identified by a member of our advisory committee. In all, participants were recruited using purposive and snowball sampling. Interviews were conducted with key stakeholders across a variety of sectors (which included public health and non-health sectors) in order to gain a comprehensive understanding of the issues surrounding buy-in for HiAP implementation in California. Potential informants were sent emails inviting them to participate in the study. The email described the project, including the types of information we were seeking, and invited the individual to participate in a telephone interview. Participants who did not respond to emails were contacted by telephone. Informants that expressed interest in the study were further screened for eligibility based on their responses on their self-rated familiarity with HiAP implementation. Informants were asked to rate their familiarity with HiAP implementation on a Likert scale (1-5) ranging from very unfamiliar (1) to very familiar (5). This screening process was utilized in order to assess potential participants' level of knowledge with the case as we were only interested in interviewing those with high levels of familiarity of HiAP implementation in California. These individuals had an established role in the implementation and initiation of HiAP in California, individuals from the California Health in all Policies Task Force, and individuals who were well acquainted with the HiAP initiative in California. Following the self-rated survey, we conducted semi-structured interviews with 9 key informants (4 from the health sector, and 5 from the non-health sector) who scored a rating of 3 to 5, across various sectors and jurisdictions in California. While we initially aimed to have 10 to 15 informants, we only recruited 9 informants due to the non-availability of some potential participants for the study.

5.2.3 DATA COLLECTION

We conducted interviews using a semi-structured telephone interview process. Informants were asked questions that aimed to understand the factors that facilitated buy-in for HiAP in California across a number of factors that were linked to the study hypotheses (see Molnar et al., 2016). Interviewers asked questions as directed in the interview guide, and were also encouraged to probe interviewees' responses for mechanism (how and why) related to each hypothesis. Following the interview process, participants were asked to nominate the names of individuals who could serve as key informants for the study.

Table 1. Hypotheses tested for buy-in for HiAP implementation in California

Buy-in for HiAP implementation is facilitated when:
1) Non-health sectors are made of their specific contributions of their sector to public health outcomes and how they can coordinate their policies to improve outcomes.
2) Governments' employ a directive approach (i.e., legislation, executive order) as it compels non-heath sectors to participate in HiAP.
3) Governments' use dual outcomes in order to engage non-health sectors in HiAP implementation.
4) There is prior experience with ISA, the health sectors' understanding the mission and culture of non-health sectors, and the development of a shared language between health and non-health sectors.

5.2.4 DATA ANALYSIS

Interviews were coded by at least two members of the research team to identify passages relevant to study hypotheses. These passages were flagged, followed by researchers creating context-mechanism-outcome (CMO) configurations to articulate the hidden processes that appeared to explain outcomes and note any contextual factors that influenced these mechanisms. These CMOs were specific to the hypotheses being tested, in our case, around buy-in for HiAP. Following initial coding, the researchers worked through the interview data

discussing all coded mechanism in order to reach consensus on how and why each mechanism triggered related outcomes, as well as the interview passages were relevant to each of the hypotheses being tested. To promote quality in our analyses, each CMO configuration was assessed for the richness of the evidence based on the level of detail available to create the CMO (thick or thin). All CMO configurations supporting or refuting specific hypotheses were then qualitatively summarized by themes, and the strength of support for each hypothesis was assessed (strong, adequate, limited, thin), as described in Table 2. Strong evidence had thick CMO configurations from at least three or sources of data, for example, interviews, grey, and or academic literature. The use of multiple data sources, data triangulation, and the collaboration of the multiple sources of data are essential for corroborating the study's findings (Yin, 2014). In essence, the convergence of evidence from two or more data sources enhances the validity of the study (Shoaib & Mujtaba, 2016; Carter et al., 2014; Yazan, 2015). We categorized the evidence as thick when there was a rich description of the contextual factors, mechanism and, a clear link to outcome (Freiler, *Methods Protocol for HARMONICS*). On the otherhand, we categorized the evidence as thin when, it lacked critical details about contextual factors, mechanisms, and descriptions about why activities were undertaken. Additionally, thin evidence contained only a description of the HiAP strategy, and unclear outcomes (Freiler, *Methods Protocol for HARMONICS*). Following our analyses, a single case study report was prepared.

Table 2. Within case ratings of CMO thickness and adequacy of triangulation and across case rating of strength of evidence for propositions

Strength of evidence (single case analysis)	Ratings of evidence for data sources
Strong	Thick evidence from three or more sources of data
Adequate	Thick evidence from two sources of data
Limited	Thick evidence from a single source of data
Thin	Thin evidence
No evidence	No evidence
Strength of Evidence (Cross case analysis)	**Degree of support for hypotheses**
High	Triangulation across 60% or more of cases
Medium	Triangulation across 40% of cases
Low	Triangulation is less than 40%
Thin	Thin evidence
No evidence	No evidence

O'Campo et al., (2018[a, b])

5.3 RESULTS

We conducted 9 interviews, 4 with informants in the health sector, and 5 with informants in the non-health sector. Our results confirm our hypotheses about what facilitated buy-in for HiAP in California. We found that buy-in was facilitated by: (1) raising awareness for non-health sectors of the merits of intersectoral engagement; (2) the use of a directive approach which provides clear instructions on HiAP; (3) employing a win-win approach that focused on HiAP activities that benefit the achievement of sectoral objectives of health and non-health sectors; (4) and prior experience as it enables non-health sectors to perceive issues in 'intersectoral terms.' Our findings are consistent with previous research which found that buy-in for intersectoral collaboration was achieved when a number of conditions or factors were achieved. Molnar et al.

(2016) for example found that HiAP implementation was successful when a win-win approach was emphasized in intersectoral collaboration. Similarly, Khayatzadeh-Mahani, Ruckert and Labonté (2018) argue that co-framing health issues as systemic issues in order to align with goals of non-health sectors can encourage non-health sectors to develop and implement integrated preventive policies, as well as help to ensure more effective outcomes.

5.3.1. RAISING AWARENESS

We found limited evidence of the influence of rasing awareness for buy-in for HiAP. One informant noted, "… it's a great, concept to, kind of, organize around across sectors. And I think everybody sees, sees their, issues reflected in, in, the, the goals of a healthier, a healthier community." The hypothesis was revised as follows. Buy-in for HiAP implementation is facilitated when non-health sectors are made aware of the specific contributions of their sector to public health outcomes, in particular, when these issues are reflected in HiAP values.

5.3.2. DIRECTIVE APPROACH

The use of the directive approach facilitated intersectoral engagement for HiAP as noted by one informant,

> … I mean the executive order that created Health in All Policies in the State of California by Arnold Schwarzenegger in 2010 is the largest one ... The one that has had the greatest impact. I use that in my slides, and that creates buy-in for a lot of policy-makers already, because it's something that I'm not just asking your city or county level. This is something in, you know, four years ago was adopted at the state level. So, they really like hearing that."

This was noted by another informant who added that,

> … the initial motivation is, was, the executive order, initially. But then that's just part of the picture because I think it's easy for all of the sectors involved to say that while health is not our first mission for most of the sectors health is within the, the scope of what all of our sectors would want to be involved in. And, and all of our sectors have some degree of responsibility and influence on health and because we recognize that, that it…not so much a motivation as something obvious.

One informant stated that … political will helped to facilitate greater sectoral collaboration "[b] ecause you need the political will in order to do this work. You need to – you can't really do what you need to do unless you've got the political will to make it happen."

The hypothesis was revised as follows. Buy-in for HiAP implementation is facilitated when governments' use a directive approach which creates political will that helps to facilitate greater sectoral collaboration to support HiAP buy-in.

5.3.3. DUAL OUTCOMES ("WIN-WIN")

Buy-in for HiAP was also facilitated by a focus on HiAP activities that benefit both sectors (health and non-health sectors) as noted by one informant.

> … Yeah, well, I would say in California (…) the initial driver was (…) a concern about climate change, and so the health issues that were initially the subject of attention on the Task Force were the things that had really obvious co-benefits for climate change. So, issues like active transportation or a more local food supply were really prioritized, because it was very clear that if you did things that made people healthier, you would also be doing things that reduced carbon emissions. So, other areas that are public health areas (…) mental health, vaccination (…) bullying in schools, all those things, were not the initial focus (…) But as the Task Force has become more established, as it's become codified as a part of the Department of Public Health that has a read equity mission we're starting to examine a lot more of the issues that don't have an obvious nexus to global warming while continuing to work on the ones that do. So, for example, when I talked about different criminal justice reform initiatives, crime prevention through environmental design was something that has a global warming nexus, at least in an attenuated way, because if you make, you know, urban, living feel then people get more engaged locally, they don't feel like they have to go in their protected cars to do everything. Whereas criminal justice reform related to, say, mental health or substance abuse, you know, that doesn't have a lot to do with global warming, and that's an area we're starting to wade into now.

The hypothesis was revised as follows. Buy-in for HiAP implementation is facilitated when governments use dual outcomes ("win-win") and employ a focus on HiAP activities that benefit the achievement of sectoral objectives of health and non-health sectors to support HiAP buy-in.

5.3.4. PRIOR EXPERIENCE

We found strong evidence that suggests prior experience facilitates motivation to participate in HiAP as it can encourage awareness of health equity as well as, promotes intersectoral

relationships particularly among low-level civil servants (i.e. facilitated intersectoral conversation about health equity and awareness of its importance) and creates a level of familiarity of tools and processes involved in ISA at the intrasectoral system HiAP. Prior experience was instrumental in achieving sectoral buy-in as it enabled non-health sectors to perceive issues in 'intersectoral terms' (i.e., they have a better understanding of the nature of problems because of prior experience). One informant commented that buy-in was easier because of prior experience of sectoral engagement.

> … it's definitely been easier because the connectivity was already there. And also, when it comes to…because the HEAL campaign was already mentioned some of these decision-makers had already had on their radar Healthy Eating Active Living. That's not a very far stretch to start saying, let's think about health in other capacities. So, it definitely made it easier to bring up the term health.

More generally, prior experience enabled sectors to recognize the cross-cutting nature of common issues as noted by this informant,

"Inevitably the issues that we're dealing with are more cross-cutting. I mean, you recognize that you can't (…) address the (…) barriers or the constraints in any functional area independent of working across those of the other, other functional areas."

Prior experience also facilitated buy-in as it led to familiarity among sectors in working collaboratively, as stated by an informant,

> … I think it was a learning process for all of us to go from, you know, collaborating less to collaborating more. I think we've all learned a great deal about how to do it well. Particularly if Public Health … were the leads, that I think we've … all learned. And I think, you know, it's been, it's been a really, a positive experience for pretty much everyone at the table.
> [Prior experience] definitely helped. The … common experience was very helpful in … implementing – in developing our strategies and moving forward.

The hypothesis was revised as follows. Buy-in for HiAP implementation is facilitated when a history of prior experience enables non-health sectors to perceive issues in 'intersectoral terms' to support HiAP buy-in.

We also found additional evidence that were relevant for buy-in for HiAP in California.

5.3.5 CONSENSUS BUILDING

We found adequate evidence that consensus building was also instrumental in getting sectors to buy-in to HiAP. This was noted by an informant who suggested that talking between sectors led to greater buy-in for HiAP

> … What I see in California is not so much the use of tools, per se, as something…to me it's more informal bringing people together. That's really at the heart of it. And through (…) the Task Force and through conversations with the Task Force, we identify an issue that, that might benefit from having multiple sectors work on that issue together. And (…) it might spin off into an action plan, as in some cases it has. Some things where we really want to focus on a series of, of tasks that we want to achieve.
> But I see at the Task Force, where, where ideas bubble up and it spawns a new a new intersectoral interest area. But then others follow up on it. So, it's really been more about people talking. And people talking across sectors. And as they do so, they identify new areas to focus on. So, it hasn't really been a use of tools as much as, as much as getting to know people in other sectors. And building relationships across sectors.

The hypothesis was formulated as follows. As one strategy to promote buy-in, governments employ consensus building which is instrumental in getting sectors to buy-in to HiAP as it enables building relationships across sectors.

5.3.6 SECTORAL LANGUAGE

Adequate evidence showed that buy-in was also achieved by the use of employing sectoral language (different language) to highlight gains for non-health sectors of working intersectorally. As one informant stated when trying to get lower levels of government to engage in HiAP, "… Even though it's just a guidance. So, you know, [they are] working with us to really craft that language to be really, to be clear." The hypothesis was formulated as follows. As one strategy

to promote buy-in, governments employ sectoral language (different language) to more effectively highlight gains for non-health sectors of working intersectorally.

5.3.7 EVIDENCE OF LESS BUY-IN FOR HIAP

On the other hand, our study also found that less buy-in from non-health sectors occurred because of (1): the use of the directive approach which made sectors feel threatened, (2) conflict by sectors over addressing issues of justice, (3) a lack of awareness of the role of non-health sectors in promoting health equity, (4) jurisdictional conflict/issues (for example, the fear of public health taking over), and (5) conflict over policy solutions. Less buy-in also occurred due to (6) a lack of funding which led to resistance by non-health sectors as well as due to (7) the perceived lack of capacity (sometimes the expertise was there, but not the human resources/staffing levels) for HiAP and (8) a lack of awareness about why more ISA was valuable.

When discussing the role of lack of awareness and jurisdictional conflict, and how they could have contributed to less buy-in by non-health sectors, an informant commented that non-health sectors,

"… didn't have, they didn't have – they didn't see how it would benefit them and so they didn't understand why they should put, put their resources toward that."
We didn't have anybody say they, they wouldn't participate… there's been people who have been less active, but all of our departments have participated. To the extent that they can. I mean, sometimes there's departments that, that are a little bit harder to engage because the work is – it's, it's a little bit less relevant to them.

Similarly, in addressing less buy-in for HiAP from non-health sectors another informant noted,

"... I don't know of any real resistance. I think, I mean there's always territorial you know, concerns and in government (…) maybe some resistance to fully participating as opposed to, sort of, peripherally participating (…) I think there's probably - in the transportation sector, sometimes around active transportation – because (…) there's just such a strong bias and, constituency for, for roads and automobiles (…) there are, you know, major lobbyists, in controlling a lot of American government, probably internationally, but I think there's a lot of cultural institutional resistance. Again (…) trying to accommodate biking and walking as

legitimate forms of transportation. So that's kind of (…) generally (…) what we're up against (…) I mean, I'm dealing with that, kind of, every day with the transportation department.

In a similar vein, while discussing the negative impact of policy conflicts, an informant notes,

> … Well, well, let me just qualify that … I'm not aware of any direct resistance, you know, officially but there has been some resistance within some of our individual efforts. So, in the housing siting work group, for example, there has been resistance by one of the departments to some particular recommendations or proposals or activity… [It was] not – the lack of expertise or resources were not the issue ... I think the control, the control or authority – sharing authority on the subject matter, I think that's the issue.

The lack of government funding for HiAP, perceived lack of capacity by some sectors, as well as non-health sectors lack of awareness about why ISA was valuable were additional contributory factors for lack of buy-in. When addressing non-health sectors concerns over lack of resources (human resources, funding) for HiAP implementation one informant noted,

… Many of us were concerned (…) there's also the, the concern about it being a part of the Department of Public Health. Because I don't think they're seen as the strongest, most resourced, State agency. They're kind of always scraping by and they're very heavily dependent on government funding. So, they don't have a lot of discretionary funds and that kind of thing. And so, you know, there was at one point … a conversation or concern that the, the half course would go to, would come out from under the Strategic Growth Council. That the Strategic Growth Council was going to go away (…) because that's an agency level council, and it would just be the Department of Public Health. That would be bringing it on ... And there was definitely concern about that of whether or not the, the department would have enough (…) gravitas resources, and influence to continue the work of the Task Force.

Several factors provide an explanation for these findings: including California's prior experience with ISA, the executive order and leadership for HiAP.

5.4 DISCUSSION

5.4.1 CALIFORNIA'S PRIOR EXPERIENCE WITH ISA

The strong evidence for buy-in for HiAP in California can be attributed to the state's prior history or experience with ISA. Prior experience or history of sectoral collaboration in ISA can encourage sectors to buy-in for new forms of collaboration (Frieler et al., 2013; Molnar et al., 2016]. Prior experience facilitates buy-in as it allows "organizations to become familiar with their partners' organizational philosophy and style of operation than they would have had they not

had the benefit of prior contact and agreeing to work together was a less uncomfortable step than it might otherwise have been" (Maloney & Maguire, n.d, p.4). For example, prior experience may be relevant where activities involved adherence to similarly intersectoral values (e.g., in working toward social sustainability) or required similar intersectoral solutions (e.g., in using environmental impact assessment). Prior experience may also facilitate implementation because of a sector's familiarity with the structural aspects of HiAP (Frieler et al, 2013, p. 1071). In addition, prior experience is instrumental as it helps to create trust among sectors. Building trust across sectors or partners has always been challenging as well as time-consuming but once achieved can provide a strong foundation for partnership (Waldell & Brown, 1997; Danaher, 2011). In short, as Molnar et al. (2016) suggest, the integration of health into the agenda of non-health sectors requires in part prior experience along with the utilization of existing intersectoral structures, processes, and agendas as they establish a level of familiarity **"**with social concepts and 'automaticity' in terms of intersectoral work" (Molnar et al., 2016, p. 10).

5.4.2 EXECUTIVE ORDER S-04-10

HiAP implementation is not an apolitical process. Rather we will argue that implementation is a political process (Lock & McKee, 2005; Muntaner et al., 2015; Shankardass et al., 2014; Oneka et al., 2017; Oneka, 2014; Frieler et al., 2013). Legislation is often used by governments to formalize institutional arrangements such as with the establishment of the European Union's Health Commission and Regulations to govern the application of HIAs to "policy proposals initiated within and outside the health sector" (Lock & McKee, 2005, p. 357 quoted in PHAC, 2007). The use of political instruments to compel sectoral engagement or buy-in is no different in California. In other words, while California's history of ISA or prior experience helped to

facilitate HiAP implementation, the use of other "political" instruments or devices (see Harold, 2001) can in some ways explain the buy-in for HiAP in California. In this regard, Governor Schwarzenegger issuance of the Executive Order S-04-10 which established the Health in All Policies Task Force (Rudolph et al., 2013) can help to explain the strong evidence for buy-in in the state. In instances where obtaining legislative agreement for government policy is difficult, a leader (chief executive such as president or governor for example) can also employ an executive order to compel participation in the absence of, or apart from legislation as it usually does not require inputs or approval from the legislation (Cohen, 2012; Markel, 2008). In fact, when legislative production declines, the use of executive order increases (Cohen, 2012). Unlike legislation that requires combined agreement by various sections/parties in government, an executive order is much easier to accomplish than legislation (Cohen, 2012). Additionally, the strength of the executive order lies in the fact that it is enforceable. As such, the use of the executive order by Governor Schwarzenegger compelled sectors to adopt HiAP in California outside of other factors like prior experience. What's more, because an executive order cannot be easily overturned (Cohen, 2012) the governor's use of Executive Order S-04-10 will help to ensure the continued/sustainability of HiAP. In addition to the executive order, "[l]egal mandates [like the Strategic Growth Council (SGC) Mandate] can motivate partners to participate, inspire political will, and promote a foundation for building relationships" (Wyss, Dolan & Goff, n.d., p.12).

5.4.3 LEADERSHIP OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH/PUBLIC HEALTH SECTOR (EFFECTIVE GOVERNANCE STRUCTURE AND LEADERSHIP ROLES)

Governance and leadership go hand in hand. Clear governance structure or principles mediated through a clear definition of roles, responsibilities, and accountabilities provide the foundation for successful collaboration (Dawes, 2003; Gant, 2003; Centre for Technology in

Government, 2004; Centre for Research and Education in Human Services & Social Planning Council of Cambridge and North Dumfries, 2004; Blickstead, Lester & Shapcott; 2009). The lack of a clear governance structure and formal rules and relationships can lead to inefficiencies primarily because "the roles and responsibilities of partners can become ambiguous" (Gant, 2003). Governance is also related to trust as it influences the degree of trust that emerges within partnerships. This, Blickstead, Lester and Shapcott (2009) posit is because "definitions of roles agreed to by participants" define relationships and set expectations, thereby forming the "the foundation for trust to grow" (pg. 16). Moreover, clear roles and responsibilities can mitigate issues of trust, and enable trust to develop through interactions over time. Good governance cannot occur without effective communication and coordination. According to the Centre for Technology in Government (2004), "high levels of information sharing, good communication, and problem solving help a collaboration project succeed. (This requires that) "employees of all partners …work in a highly coordinated fashion… (and that) the partnering organization provide the motive, opportunity and structure for this to happen" (pg. 2). Skage (1996) argues that although shared responsibility and equality are essential components for a good partnership, having a strong lead partner to coordinate and steer the partnerships is vital particularly in the early stages of the project. She suggests that this can be achieved through a designated coordinator as partnerships take place between people and not agencies.

The leadership of the California Department of Public Health, leadership that was created through the Executive Order, coupled with the department's knowledge and focus on advancing population health through encouraging intersectoral collaboration was instrumental for encouraging non-health sectors to achieve buy-in for HiAP. This is because multisectoral partnerships such as HiAP are a collaborative process. Leadership is essential to collaboration

and is “closely tied to strong working relationships and a transparent process for working together” (Danaher, 2011, p. 12). Furthermore, leadership is important for facilitating buy-in as it can advance “shared purposes and sustaining the collaboration, adequate, sustainable and flexible resources” (Danaher, 2011, p.3). Moreover, buy-in is also facilitated by motivation of the leadership of each sector to form “mutual relationships and interactions rather than remaining autonomous” (El Ansari & Phillips, 2001, p. 124). In essence, “[t]he collaborative process can help ‘[p]artners across sectors shape responsibility in decision making and implementation … the California Task Force …[provided] a comprehensive process [that] helped agencies create goals, solutions, and policy implementation plans” (Wyss, Dolan & Goff, n.d., p.15). “The California Department of Public Health proposed HiAP as a process for improving health statewide and increasing government efficiency” (Wyss, Dolan & Goff, n.d., p.15). As such, the absence of strong leadership by the Department of Public Health might have limited the degree to which non-health sectors engaged in HiAP implementation (despite the executive order) as they might not have been aware of practices that promoted health and well-being.

Buy-in for HiAP in California can also be explained by political elites who gave leadership to HiAP implementation. The leadership of Governors’ Brown and Schwarzenegger in particular were instrumental for the implementation for HiAP (Executive Order, S-04-10; Rudolph et al., 2013). The leadership of political elites or champions in government (Danaher, 2011, p. 12) is instrumental for sectoral engagement. This is because champions in government help to ensure that the issues remain a priority (as seen by the establishment of the executive order). Moreover, leadership, in particular high-level leadership can “enhance capacity to redirect ‘discussion of issues and enhance policy coordination” (Peters, 1998, p.30; Rudolph et al., 2013).

5.5 CONCLUSIONS

This is an empirically based case study about HiAP implementation using a rigorous methodology, the HARMONICS multiple explanatory realist case study methodology. In addition, our study used a systems approach which provides an understanding of the interrelationships and synergies between the government sub-systems and their components that are involved in HiAP implementation (Shankardass et al., 2018).

The study found that most prominent factors in driving buy-in California included: (1) prior experience which enabled non-health sectors to perceive issues in 'intersectoral terms'; (2) knowledge translation which showed non-health sectors the merits of intersectoral engagement for achieving their own goals, (3) employing sectoral language (different language) to more effectively highlight gains for non-health sectors of working intersectorally, as well as employing a focus on HiAP activities that benefit the achievement of sectoral objectives of health and non-health sectors, (4) the use of dual outcomes, and (5) the use of expert advisors to identify collaborations which provided non-health sectors with a sense that they were addressing their own goals. In addition, (6) consensus building was instrumental in getting sectors to buy-in to HiAP because it enabled building relationships across sectors. The study also found that the least prominent factors in driving buy-in for HiAP in California were: the use of the directive approach, conflict by sectors over addressing issues of justice, non-health sectors' lack of awareness over issues of health equity, jurisdictional issues, conflict over policy solutions, a lack of funding for HiAP activities, non-health sectors perceived lack of capacity, and a lack of awareness about why more ISA was valuable.

Systems components which were involved in generating buy-in included the: Intersectoral Sub-System and the Intrasectoral-Sub-system. More specifically, buy-in for HiAP in California

occurred within the Intersectoral Sub-System, and from the Intersectoral Sub-System to the Intrasectoral Sub-System.

This study is an empirically based case study about HiAP implementation using a rigorous methodology, realist explanatory case study approach, to understand factors facilitating buy-in for HiAP implementation in California. The study employed a systems framework which conceptualized HiAP implementation as occurring within a government system involving three elements (the executive, the intersectoral subsystem, and the intrasectoral subsystem). The systems components which were involved in generating buy-in for HiAP in California comprised the Intersectoral Sub-System and the Intrasectoral Sub-System.

Our study is significant for a number of reasons. Few empirical studies have examined the nature of HiAP as well as of HiAP implementation in non-European jurisdictions. Our study is the first empirical study of HiAP implementation in non-welfare state countries and one of a few of HiAP in a local jurisdiction (versus national). As such, the study provides evidence that HiAP implementation can occur in non-welfare state jurisdictions. The California case study also provides evidence of how HiAP implementation can be sustained after a change in government (republican to democratic) due to the issuance of an executive order particularly in a setting where partisan politics typically affects the continuity of existing legislation ("Americans' opinions about health policy are polarized on political partisan lines, with recent survey evidence demonstrating that Republicans and Democrats seemingly disagree on nearly every aspect of health care and approaches to reform" Gollust, Lantz & Ubel, 2009, p. 2165). In addition, this study highlighted a number of factors that helped to contribute to buy-in for HiAP implementation, among which is, is the importance of politics. Furthermore, using the HARMONICS explanatory case study method contributes to a better understanding of 'how' and

'why' buy-in for HiAP occurred in California as well as to an understanding of the (government) systems component involved in achieving buy-in.

Our study however has one key limitation, namely that, the majority of informants were from the public health sector which might have limited the information that we would have achieved from informants from non-health sectors. Having said that, our use of triangulation of data sources support the findings of the study.

Future studies on HiAP implementation could investigate how political elites facilitated the sustainability of HiAP in various jurisdictions and how legislation or formal governance tools can influence or hinder HiAP implementation across various settings.

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CHAPTER SIX: NON-STATE ACTORS INFLUENCE IN HIAP IMPLEMENTATION: A REALIST EXPLANATORY MULTIPLE CASE STUDY OF HIAP IMPLEMENTATION IN NORWAY, FINLAND, SCOTLAND, THAILAND, ECUADOR AND CALIFORNIA

6.1 INTRODUCTION

Intersectoral action initiatives such as Health in all Policies (HiAP) improve population health and equity by making explicit concerns about health and equity "particularly in non-health sectors" (St Pierre, 2008, p. 1). In recent years much attention has been directed to comprehensively address population health equity (Rio Political Declaration on Social Determinants of Health, 2011; Ottawa Charter on Health Promotion, 1986; Social Determinants of Health, 2008). In essence, health promotion policy requires a combination of "diverse but complementary approaches including legislation, fiscal measures, taxation, and organizational change. It is coordinated action that leads to health, income, and social policies that foster greater equity" (WHO, 1986, *Para 1*). Unlike the preceding initiatives, HiAP uniquely calls for governments to transcend this established 'silo' system of policy interventions. This shift from siloed policy interventions also includes a recognition of the effects of non-governmental actors (from here on referred to as non-state actors) in HiAP implementation given the shift from government to governance that occurred in the latter part of the 20th Century (McQueen et al., 2012; Frahm & Martin, 2009; Carino, n.d).[32] Interestingly however, the HiAP literature does not pay attention to the role of non-state actors in the implementation process. Prior to shift to governance policy implementation was the purview of the nation-state, or governments'[33] which resulted in greater autonomy of governments' in the policy making process (for a detailed discussion see Bellamy & Palumbo, 2010). As Carino (n.d) noted, [i]n traditional parlance,

[32] While HiAP implementation is the purview of governments', implementation does not occur within a closed system. This is not unique to HiAP as policy implementation is influenced by multiple actors who operate outside of the government system (see Kokinnen et al., 2017; Shankardass et al., *In Press**).
[33] The state according to Carino (n.d) is the "wielder of power, the principal actor in government" (p. 5).

government rules and controls, but in a state of governance, it orchestrates and manages" (p.6). Governance in essence is: … the process whereby elements in society wield power and authority, and influence and enact policies and decisions *concerning public life, economic and social development* (Carino, n.d, p.7). Key features of governance include: "institutions and actors within and beyond government; self-governing network of actors; …[and] and a shift occurs from authoritative direction by government … to negotiation among stakeholders" (McQueen, Wismar, Lin & Jones, 2012, pp. 9-10). Public policy in essence is a layered and path dependent[34] process characterized by "competing interests within and outside government" (p. 10). So, while the "state is considered the most powerful actor in policy making … an analysis focused entirely on the state is no longer sufficient … because the role of the state has changed and the private sector now features more prominently in health policy making – either independently or in association with the state" (Buse et al., 2002, p. 61). Despite this, the HiAP literature (and public health literature more generally) have rarely addressed these factors with a few exceptions (see review below). There is a need within public health to recognize the role of power and politics which are the hallmarks of governance due to the competing interests of various actors (Bevir, 2019, Para, *Governance beyond the state*). Key actors in governance include the state/public sector, civil society, and the business sector (UNDP). Examples of non-state actors in policy implementation include and are not limited to: civil society, the private sector, the third sector, supranational organizations, and international institutions (see Shankardass et al., 2018*; Birn, Pillay & Holtz, 2017; Carino, n.d; For a detailed discussion of non-state actors see Higgott, Underhill & Bieler, 2000; Tantivess & Walt, 2008; Evans &

[34] Path dependency according to Pierson(2004) is the idea that shows "how certain laws, rules, and institutions can create heavy disincentives for change because so much is already invested in the existing ways of doing things" (quoted in Stuteville & Jumara, 2010, p. 5).

Sapeha, 2015; Torajada, 2016). These non-state actors often shape the direction of policy within nations, and in some cases usurp the power of governments. This phenomenon is particularly prominent in the international arena where there has been a proliferation of non-state actors in international actions, complicating lines of authority, and creating a context in which states increasingly share power with non-state actors (see Youde, 2018, pp. 87-88; also see Matthews, 1997). Furthermore, "non-state actors defy the separation of powers sovereignty demands … and undermine the social contract essential to any form of governance" (Simmons, McGraw & Lauchengoo, 2011, *Reinvigorating sovereignty,* Para 4).

6.2 NON-STATE ACTORS, POLICY IMPACTS, AND HEALTH

The aim of this paper is to test hypotheses about how non-state actors influence the implementation of HiAP in Norway, Finland, Scotland, Finland, Ecuador and California. We hypothesize that there will be a distinction between the Low-to-Middle-Income Countries (LMICs) and High-Income-Countries (HICs) in the influence of non-state actors in HiAP implementation due to the greater influence of non-governmental actors in the implementation of policies in LMICs and protectionist policies of HICs. Protectionist policies are created to reduce or block imports (Lumen Learning, n.d). Protectionist policies take three main forms namely: "tariffs, import quotas, and nontariff barriers" (Lumen Learning, n.d., *Protectionism: An indirect subsidy from consumers to producers, Para 1).* Unlike LMICs, HICs have been able to enact protectionist policies to shield domestic producers and workers from foreign competition. LMICs also have restrictions imposed on their governments' due to the influence of structural adjustment programs (SAPs), sector, and so on (for a reading of these restrictions and influences from non-state actors in LMICs please see Birn, Pillay & Holtz, 2009; 2017). As a

condition to receiving loans, countries must “agree to adopt IMF structural adjustment programs” which require among a number of things that countries adopt policies that promote:

> … Reductions in government spending; Monetary tightening (high interest rates and/or reduced access to credit); Elimination of government subsidies for food and other items of popular consumption; Privatization of enterprises previously owned or operated by the government; and Reductions in barriers to trade, as well as to foreign investment and ownership (Naiman & Watkins, 1999, *What is Structural Adjustment and ESAF*).

Similarly, Birn, Pillay and Holtz (2017) note that conditionalities accompanied the loans which included: “deep cuts in government spending (in benefits and in health, sanitation, water, housing, and other social sectors), removal of trade tariffs and of agricultural and other basic goods subsidies, labour market reforms, lifting of restrictions on foreign investment in domestic industries… financial-sector liberalization, currency devaluation, and privatization of state enterprises (Birn, Pillay & Holtz, 2017, p. 386; also see Villanger, Pausewang & Jerve, 2003). All these loans imposed from the outside along with foreign investments, trade liberalization, trade agreements, and TNCs have resulted in the limited scope for LMICs over their domestic policy making and to negative health and social consequences in an overwhelming majority of these countries (see Birn, Pillay & Holtz, 2009; 2017; Labonte, Blouin & Forman, 2009; Koivusalo, Schrecker & Labonte, 2009; Phillips, 2017; Rahman, 2007; also see Uhlin, 1988; Payne & Philips, 2014). Because HICs were not affected by the SAPs and/or adversely affected by these regimes because of their trade protectionist policies and their position in international financial institutions, supranational organizations, and the global economy, they have more autonomy over their domestic policy making (Birn, Pillay & Holtz, 2009; 2017; also see Conybeare, 1984). Exemplifying one such disparity between HICs and LMICs is the General Agreement on Trade in Services (GATS) which encourages “liberalization of a wide spectrum of

services" (Birn, Pillay & Holtz, 2017).[35] While HICs have been able to exclude some services from GATS, LMICs have been unable to do so since they made prior commitments which make it difficult to revert without compensating investors (Birn, Pillay & Holtz, 2017; also see Koivusalo, 2014). Exacerbating this is the fact that LMICs do not often have the resources to challenge disputes within these institutions and agreements (Birn, Pillay & Holtz, 2017).[36] Furthermore in addition to undermining sovereign decision-making, the WTO stipulations had led to instances where corporate interests enjoy "insider access to negotiations … which are kept secret … while the public interest is routinely ignored" (Birn, Pillay & Holtz, 2017, p. 391). In essence, it is important to understand these forces because by shaping policy, non-state actors subsequently often usurp nation-states domestic policy decision making. These practices can fundamentally co-opt the health equity values of HiAP strategies towards policies that reflect the ideological and policy prescriptions of these non-state actors.[37] As a result, recognizing the pathways through which non-state actors are able to shape HiAP implementation is instrumental if HiAP strategy is to improve population health and well-being. Our research (how and why non-state actors shape HiAP implementation) can inform policy makers in terms of the best recourse for ensuring HiAP policies are not co-opted. In addition, this paper will showcase how and why interests of non-state actors can facilitate or hinder HiAP implementation.

[35] This is despite the provisions provided in GATS which allows countries to decide which sectors they will liberalize (see Birn, Pillay & Holtz, 2017).

[36] According to Birn, Pillay and Holtz (2017), the WTO is undemocratic because poor countries cannot afford to defend themselves in cases of trade disputes brought against them to the WTO.

[37] A majority of these non-state actors propose policy solutions that call for a reduced role of governments' in policies that commensurate with the social determinants of health (see Birn, Pillay & Holtz, 2009; 2017).

6.3 NON-GOVERNMENTAL ACTORS AND POLICY IMPLEMENTATION[38]

The academic literature suggests that there is a "pluralisation of policy making," where the neoliberal priority allocated to markets and the traditional Weberian hierarchies of public administration have given way to networks" (Evans & Sapeha, 2015, p.2; also see Dickinson, 2016; Philips & Smith, 2011; Newman, 2004). In other words, there has been a transformation of the "state in terms of the ways in which it governs society, away from a strongly centralised executive and a controlling unified state to a fragmented and decentralised entity" (Dickinson, 2016, p.45). This proliferation of actors has significant implications for how governments implement public policies. While non-governmental policy actors do have a significant role in the policy implementation process, their role is mainly focused on implementation and service delivery (Evans & Sapeha, 2015), and there are some actors with significant influence over policy implementation (see Birn, Pillay & Holtz, 2009; 2017). Furthermore, the influence of these non-governmental policy actors is variable and differs and is contingent on a number of factors such as their: (1) position within the global economy, (2) power, (3) ideology, and (4) the political culture in which these actors are embedded (Tortajada, 2016; Bach, Niklasson & Painter, 2012; Birn, Pillay & Holtz, 2014; 2017). A political culture that favours market influence on policy implementation for example, is associated with a greater role of non-governmental actors in the implementation process versus a political culture that values traditional governance structures (see for example Kokkinen et al., 2017). Similarly, a "political culture that values group welfare

[38] I realize that non-state actors in policy implementation are numerous and diverse in terms of their role on policy implementation. In this section I focus primarily on transnational corporations (TNCs) due to time and spatial limitations. I also focus on one type of non-state actor as the aim of the paper is not about which actors' shapes implementation, but rather that, implementation which was once the primary purview of governments' is now influenced by other non-state actors. I also focus on transnational corporations as the HiAP literature is scarce on the role of other non-state actors where HiAP implementation is concerned.

… over individual interests … is more likely to adopt HiAP policies that address the social determinants of health" Oneka et al., 2017, p. 837).

This shift along with globalization has weakened the power of national government (Gemmill & Bamidele-Izu, 2002; Birn, Pillay & Holtz, 2017) so that while governments might value health equity values of HiAP, the weakened role of governments limit the extent to which policies reflect them. This is because few countries are immune to global influences (Buse, Mays & Walt, 2005). Health policies are subject to, for example, international trade rules, transnational corporations, and the influence of donors (Buse, Mays & Walt, 2005). Examples include: the Canadian government's challenge of the French ban on the importation of Canadian asbestos on health grounds, policy conditions that are set by "donor organizations on ministries of health in return for access to loans" in low to middle income countries, as well as policy responses to pressure from global social movements (Buse, Mays & Walt, 2005). Because HiAP implementation is a complex process shaped by multiple factors and actors, it is essential to achieve an understanding of the mechanisms (how and why) through which non-governmental actors influence its implementation.

The influence of non-governmental actors over policy has been discussed extensively in the public health and political science literatures (see for example, Birn, Pillay & Holtz, 2009; Birn, Pillay & Holtz, 2017; Labonte, Mohindra & Schrecker, 2011; Labonte, Schrecker, Packer & Runnels, 2009; Schrecker & Bambra, 2015; Doyal, 1995; Buse, Mays & Walt, 2005; Mahmood & Muntaner, 2013; Baum & Saunders,2011; also see Gollata & Newig, 2017; Ansell, Sørensen, & Torfing, 2017; Brinkerhoff, 1999). For example, Birn, Pillay and Holtz (2017) argue that the greatest health challenge of our era is the neoliberal phase of global capitalism. In this

neoliberal space, there are a myriad of non-governmental actors that shape and influence domestic and international policy.

The implementation of HiAP involves policy coordination across multiple levels of governments “as well as with other systems outside of government that affect health equity” (Shankardass et al., 2018, p. 4). These actors, hereon referred to as non-state actors include systems outside of government that can influence HiAP implementation, including, supranational organizations (WHO, EU), community organizations and individuals that have partnered in the implementation of HiAP by participating in planning, or executing intersectoral action, or as subjects of some attendant regulatory action (Shankardass et al., 2018). Non-state actors are also “likely to be more indirect influences, such as policy entrepreneurs who advocate or lobby for influence over the implementation process, and cross-national policy and agenda-setting frameworks… [and] at the global and local levels … [include] research programmes and knowledge hubs producing information to support implementation” (Shankardass et al., 2018, p. 5).

One key pathway through which neoliberalism impacts health is through the impact of transnational corporations (TNCs) (Birn, Pillay & Holtz, 2017; Baum et al., 2016). They argue that TNCs bolstered by neoliberal globalization, national elites and government allies, have “ratcheted down environmental regulations, consumer protections, labor standards, and occupational safety and health, aggravating precarious and dangerous work conditions across the world, social and economic inequality, and civil strife” (pg. 614) --- all of which negatively impact health. It is precisely for these reasons that the role of governments in protecting and promoting population health and equity becomes paramount. The influence of TNCs to affect such change is due to “global governance structures [that] are either lacking or too weak to

effectively ensure that global trade and economic policies are implemented in a way that protects health and encourages health equity" (Baum & Saunders, 2011, *What is changed*). Baum and Margaret (2015) recognize the role of non-state actors in HiAP (transnational corporations) and argue that while HiAP has been a key strategy through which government agencies promote health, there is a need to ask what this focus implies for the national and supranational policy level particularly with respect to transnational corporations.

While these analyses recognize the influence of non-state actors on HiAP implementation, they fail to examine other supranational organizations, and the other ways in which supranational organizations affect health, in particular, through their impact on policy implementation. Moreover, they fail to recognize that appeal mechanisms such as those that occur through the World Trade Organization (WTO) can hinder the extent to which TNCs are held accountable for the impact of, and their influence over domestic policy making. Likewise, although Birn, Pillay and Holtz's (2017) argument exemplifies instances where governments voluntarily encourage influence of non-governmental actors over the implementation process, in more cases than not however, non-governmental actors shape policy implementation due to the 'open nature' of the government systems which allows influence from non-state actors. In other words, because HiAP is a key strategy for government agencies to promote population health and equity, and given the rise of non-state influences in policy implementation, it is important to investigate how and if they influence government implementation of HiAP either positively or negatively. Understanding the mechanisms through which these non-state actors shape policy implementation is instrumental if governments are to effectively act to promote policies that are commensurate with the health equity values of HiAP, as well as to mitigate the negative impacts of non-state actors.

The purpose of the study is to test hypotheses about how non-state actors influence the implementation of HiAP in Norway, Finland, Scotland, Finland, Ecuador and California.

Table 1. Hypotheses tested through multiple explanatory cross case study analyses

While HiAP implementation is facilitated by governments, with processes within the government system:
1) Supranational organizations influence implementation as they can force governments to shift policy to reflect the former's goals (compelling changes in governance) by bypassing legislation at the governmental level.
2) Private sector influence implementation (HiAP policy and program decision making) through collaboration with governments' resulting in policies that reflect the aims and agendas of these entities.
3) Third sector influence implementation (HiAP policy and program decision making) through collaboration with governments' resulting in policies that reflect the aims and agendas of these entities

The critical realist philosophical paradigm undergirds the study as it seeks to "provide clear, concise, and empirically supported statements about causation, specifically how and why a phenomenon occurred" (Wynn & William, 2012, p. 789). Additionally, the study employs the multiple explanatory case study methodology to test our hypotheses of the role of non-state actors in HiAP implementation, thus yielding "richer, more in-depth … knowledge" (Harder, 2010, Para Critical Summary) of the how these actors influence implementation. Furthermore, "how" and "why" questions (theories) "are more suitable for designing and doing explanatory case studies" (Yin, 2012, 45).

6.4 METHODS

We tested the influence of non-state actors in facilitating or hindering the implementation of HiAP in a number of jurisdictions. We hypothesize that non-state actors exert some influence over HiAP implementation due to the effects of globalization, the power of supranational

organizations, and the shift from government to governance. Our study used the multiple explanatory case study methodology as it enables an investigation of mechanisms, how and why questions (Yin, 2014). To this end, we tested hypotheses using our systems framework to uncover mechanisms that were related to how non-governmental actors are influential in HiAP implementation in Norway, Finland, Scotland, Thailand, Ecuador, and California.

Hypotheses testing occurred in a number of steps: (1) data were collected and analyzed for each case, (2) data were analyzed across cases in order to draw inferences about cross-case hypotheses, (3); this was followed up by a write up and dissemination of findings about cross-case hypotheses (O'Campo et al., Forthcoming). Our multiple case study analysis aims to "find similarities across cases, and to further explain the broader mechanisms around which" non-governmental actors shape the implementation of HiAP (SOPHIE Newsletter: Explanatory Case Study).

6.4.1 CASE SELECTION

Cases were selected for analysis based on the results of the scoping review conducted by Shankardass et al., (2011).[39] Cases were selected if they met the following criteria: (1) HiAP was implemented in the past three to ten years (2) they were described in detailed in peer-reviewed and grey literature, (3) variability across cases (cases were selected based on similar and distinctive characteristics), and (4) the presence of diverse mandates and governance structures (O'Campo et al., 2018; Shankardass et al., 2011). In total 6 cases of HiAP from various jurisdictions were selected namely: Norway, Finland, Scotland, Thailand, Ecuador, and California.

[39] For the multiple case study, Scotland, Norway, Finland, Ecuador, and Thailand were selected following the scoping review by Shankardass et al., 2011. Once selected a case summary was created for each of these cases of HiAP, key informants recruited, and hypotheses/propositions tested.

6.4.2 PARTICIPANT RECRUITMENT

Key informants for the study were identified from a review of the literature and through snowball sampling. Informants were individuals who were knowledgeable of HiAP implementation in each jurisdiction. Informants were contacted through an email and follow up phone call which screened their eligibility for the study using a Likert scale that assessed their knowledge of HiAP implementation in each jurisdiction. The Likert scale assessed participants familiarity on a scale ranging from very unfamiliar to very familiar (see Molnar et al., 2016). Individuals who met the criteria for participation and that agreed to participate in the study went through a telephone interview conducted through a semi-structured interview process. Informants were asked questions that aimed to understand the factors that contributed to HiAP implementation (see Molnar et al., 2016). On average we recruited 10-15 informants in each jurisdiction for the study. Interviews were transcribed and coded for the CMO configurations that assessed the effects of politics on implementation. In all, 77 informants were selected from health and non-health sectors (see Table. 7).

6.4.3 ANALYSIS

Following the method applied by Shankardass et al. (2014), we coded interview data flagging passages that were relevant to articulate context-mechanism-outcome configurations. Specifically, we articulated context-mechanism-outcome- configurations about how non-state actors influence the implementation of HiAP (also see Pawson & Tilley, 1997). Interviews were coded by at least two members of the research team to identify passages relevant to study hypotheses. These passages were flagged, followed by researchers creating context-mechanism-outcome (CMO) configurations to articulate the hidden processes that appeared to explain outcomes and note any contextual factors that influenced these mechanisms. Following

initial coding, the researchers worked through the interview data discussing all coded mechanism in order to reach consensus on how and why each mechanism triggered related outcomes, as well as the interview passages were relevant to the mechanism of interest. Each CMO configuration was assessed for the richness of the evidence based on the level of detail available to create the CMO (thick or thin).

6.4.4 CROSS-CASE SYNTHESIS OF EVIDENCE FOR HYPOTHESES AND RIVAL EXPLANATIONS

We applied a "replication logic" for interpreting the findings across cases (Yin, 2012) (see Table 2). Cases were designated as literal or theoretical replications[40] based on a number of factors namely: 1) regional grouping of state (whether a nation state is classified as low to middle income or high income, 2) strength of commitment to HiAP (e.g., type of mandate, accountability mechanisms, new structures), and 3) welfare state institutions (i.e., strong, weak) for the hypotheses regarding how and why non-governmental actors are influential in HiAP implementation.

To complete the cross-case analysis, one researcher and a coordinator on the team that was trained to perform realist coding, coded the interview transcripts for information that that were relevant to answering each hypothesis. The use of two researchers (investigator triangulation) was to in order to "control or correct the subjective bias from the individual" (Denzin & Lincoln, 2017, *Methodological concept of triangulation, Para 1*) note, or stated differently, to enhance the credibility of the findings by "decreasing bias in gathering, reporting and/or analysing study data" (Hales, 2010, p.15), and subsequently, the internal validity of the

[40] Literal replications according to Yin (2009, p.54) are cases that are selected that predict similar results whereas theoretical replications are cases that are selected that predict contrasting results for reasons that can be anticipated.

study (see Shoaib & Mujtaba, 2016; also see Johansson, 2003; Denzin, 1978: Creswell & Miller, 2000). Our reference case was Finland as it had a strong history of influence of non-governmental actors compared to the other cases. Each case was then compared to the reference (Finland) in order to ascertain whether they were literal replications or theoretical replications. Literal replications were Norway, whereas theoretical replications were Scotland, Thailand, California, and Ecuador. Establishing a case as a literal or contrast replication is important because, literal replications indicate that "the cases selected are similar and the predicted results are similar too [whereas the] theoretical replication means that the cases are selected based on the assumption that they will produce contradictory results" (Bengtsson, 1999, p.3). Theoretical replications according to Yin (2014) predict "contrasting results but for anticipatable reasons" (p.57). Following the method applied by Shankardass et al. (2014), we articulated context-mechanism-outcome- configurations about how non-state actors influence the implementation of HiAP (also see Pawson & Tilley, 1997). We then created a thematic summary of how the CMO configurations from each of the jurisdictions confirmed or refuted the hypotheses. The cases were summarized with information on the: "context of the country, details of the HiAP initiatives, key players, and positions of key informants, summaries of [the thick] context-mechanism-outcome configurations (CMO) (all of which provided) … case specific support for hypotheses" (O'Campo et al., 2018). System components were then identified with emphasis on the parts of the system that were relevant to each hypothesis. The evidence was applied to the systems framework in order to assess the degree to which the systems predictions were represented by the evidence (Shankardass et al., *Methods,* In Press).

Following the analysis of the interviews, we analyzed the literature in the same manner (Molnar et al., 2016). The use of multiple data sources is consistent with the case study's

converging lines of inquiry (Yin, 2009, referenced in Shoaib & Mujtaba, 2016) and ensures the validity of case study research (see Shoaib & Mujtaba, 2016; Johansson, 2003). Once coded, we developed context-mechanism-outcome configurations (CMOs) for each context (case) to identify if the CMOs supported our hypotheses. The CMO configurations are concepts from realist evaluation (Linsley, Howard & Owen, 2015) and were developed to describe how

> … an intervention is expected to work for which (group of) actors and how … Contexts represent conditions needed for an intervention to trigger (or not) mechanisms, the causal processes that produce particular outcomes… Articulated together, they become a CMO configuration, which begins to describe which contextual elements and what mechanisms led to different outcomes. As new insights emerge from data collection and analysis, hypothesized relationships between CMOs are iteratively altered to reflect realities on the ground (Adams, Sedalia, McNab & Sarker, 2015, p. 268).

After conducting the steps for the single case study and analyzing the data, we synthesized the findings from across single cases in order to draw cross-case conclusions to highlight similarities and differences across cases. CMOs for each case were collected and entered into a spreadsheet. This allowed us to track within and cross case evidence for each hypothesis. We then synthesized the quality and strength of the evidence across cases with evidence classified as thin or thick. This was completed for evidence that supported or refuted our hypotheses regarding the role of non-state actors in the implementation of HiAP. We then summarized the thick evidence for each hypothesis and drew cross-case conclusions regarding the evidence across the cases. Thick evidence in case study research "is an essential part of the process of determining what the particular issues, dynamics, and patterns are that make the

case distinctive" (Dawson, 2010, p. 944).[41] we also assessed the components of our system which we predicted would be relevant for a given hypothesis and applied our findings of all cases to the systems framework in order to ascertain whether our predictions were correct (see O'Campo et al., 2018; Shankardass et al., Manuscript in Preparation). Our assessment of the components of our system was because HiAP implementation requires policy coordination across multiple levels of government, as well as non-state actors (non-governmental actors) all of which can affect health equity in (Shankardass et al., 2018).

Table 2. Factors used to inform replication logic rationale for non-state influences hypothesis

		RATINGS	**HYPOTHESES**		
			Supranational organizations influence implementation as they can force governments to shift policy to reflect the former's goals (compelling changes in governance) by bypassing legislation at the governmental level.	*Private sector influence implementation (HiAP policy and program decision making) through collaboration with governments' resulting in policies that reflect the aims and agendas of these entities.*	*Third sector influence implementation (HiAP policy and program decision making) through collaboration with governments' resulting in policies that reflect the aims and agendas of these entities*
	REGIONAL GROUPING OF STATE	A more generalized grouping of countries includes: 1. Low and middle-income countries (LMIC) 2. High-income countries (HIC)	Low and middle-income countries (LMICs) and high-income countries (HICs) have varying levels of control over their domestic policy making due to various	LMICs will be less likely to include the private sector in their policy implementation stages due to the nature of governments whereas HICs will have a greater role for	Low and middle-income countries (LMICs) are more likely to have a greater role of the third sector due to more deference and high rates of activism by the

[41] A detailed discussion of thick evidence is provided by the work of anthropologist Clifford Geertz (1973), as well as Norman Denzin (2001), and Jane Dawson (2010).

RATIONALE			factors. LMICs have less control over their domestic policy making due to restrictions imposed from actors outside of their governments, e.g., WTO, IMF, WB etcetera. Policies in the former are also driven by interests of international donors.	the private sector because they historically have a record of collaborating with the private sector in policy implementation. which can limit the role of the governments. HICs are more autonomous compared to the former.	third sector compared to high-income countries (HICs).
	STRENGTH OF COMMITMENT	Strength of commitment includes: 1.Type of mandate 2.Accountability mechanisms 3. New structures Sources of funding	Where HiAP is mandated by the law, it becomes difficult for supranational institutions to shift governments' prioritization and implementation of HiAP.	Greater commitment by governments can limit the power or the extent to which private sector are influential in HiAP implementation.	N/A
	WELFARE STATE INSTITUTIONS	Welfare state institutions are: 1. Strong 2. Weak	Welfare states generally implement social and economic policies that promote population health and well-being. Nation states that emphasize redistributive social policies are more likely to limit the extent to which their domestic policies are influenced by non-state actors, particularly	Having a strong welfare state institution can serve to reduce the extent to which private influence HiAP implementation, especially, when these institutions promote values that are not commensurate with the health equity values of HiAP.	Nation-states with a strong Welfare institution will have a greater role for the Third Sector in HiAP implementation compared to those with little or weak Welfare institutions.

			when these influences promote values that are not commensurate with the health equity values of HiAP. In some cases non-state actors can co-opt or shift domestic policy decisions that promote equity in health to policies that are not commensurate with health equity values of HiAP.		
	WELFARE STATE AGENDA	Welfare state agendas are: 1. Strong 2. Weak	N/A	N/A	Nation-states with a strong Welfare agenda will have a greater role for the Third Sector in HiAP implementation compared to those with little or weak Welfare state agenda.
	ROLE OF NON-GOVERNMENTAL ACTORS	The role of non-governmental actors is: 1. Strong 2. Weak	N/A	The role of non-governmental actors in the implementation process is strong or weak based on a number of factors, such as the type of governmental system, and legislation that either promotes or prohibits the role of these entities in the implementation	N/A

				process. When there is no or limited role of these actors, their effects are weak or negligible in the policy process.	

Table 3. Triangulation: Quality rating table (single and cross-case analysis)

Strength of evidence (single case analysis)	Ratings of evidence for data sources
Strong	Thick evidence from three or more sources of data
Adequate	Thick evidence from two sources of data
Limited	Thick evidence from a single source of data
Thin	Thin evidence
No evidence	No evidence
Strength of Evidence (Cross case analysis)	**Degree of support for hypotheses**
High	Triangulation across 60% or more of cases
Medium	Triangulation across 40% of cases
Low	Triangulation is less than 40%
Thin	Thin evidence
No evidence	No evidence

Adapted from O'Campo et al., (2018[a, b]); Shankardass et al., (Manuscript in Preparation)

Table 4. Literal or contrast status of cases based upon ratings on key contextual variables

Case	Contextual factors informing replication or contrast ratings			Replication Status
	Regional Grouping of Case	Strength of commitment[42]	Welfare State Institutions[43]	
Finland	HIC	Weak	Strong	Reference
Norway	HIC	Weak	Strong	Literal Replication
Scotland	HIC	Weak	Weak	Contrast
Thailand	LMIC	Strong	Weak	Contrast
California	HIC	Strong	Weak	Contrast
Ecuador	LMIC	Strong	Weak	Contrast

Adapted from O'Campo et al., (2018[a])

[42] This rating was determined during analysis meetings by the HiAP Research Unit. The Strength of Commitment was classified as strong or weak. We established that a country's strength of commitment was strong when there was a strong mandate as evidenced by legislation or the creation of institutions to facilitate HiAP implementation. On the other hand, the strength of commitment was weak when government commitment to HiAP was implemented through a strategy primarily because unlike legislation, strategies are not enforceable by law.

[43] This rating was determined during analysis meetings by the HiAP Research Unit. Welfare State Institutions were classified as either strong or weak based on a number of factors, mainly, whether the country had a welfare state, and the type of welfare state institution: 1) liberal democracy, 2) social democratic, and an informal security regime. These classifications were obtained from the literature (see Sharkh & Gough 2010; Ferragina E & Seeleib-Kaiser 2011).

Figure 1. HARMONICS Systems Framework of HiAP Implementation: Components of the government and non-state actors involved in HiAP implementation

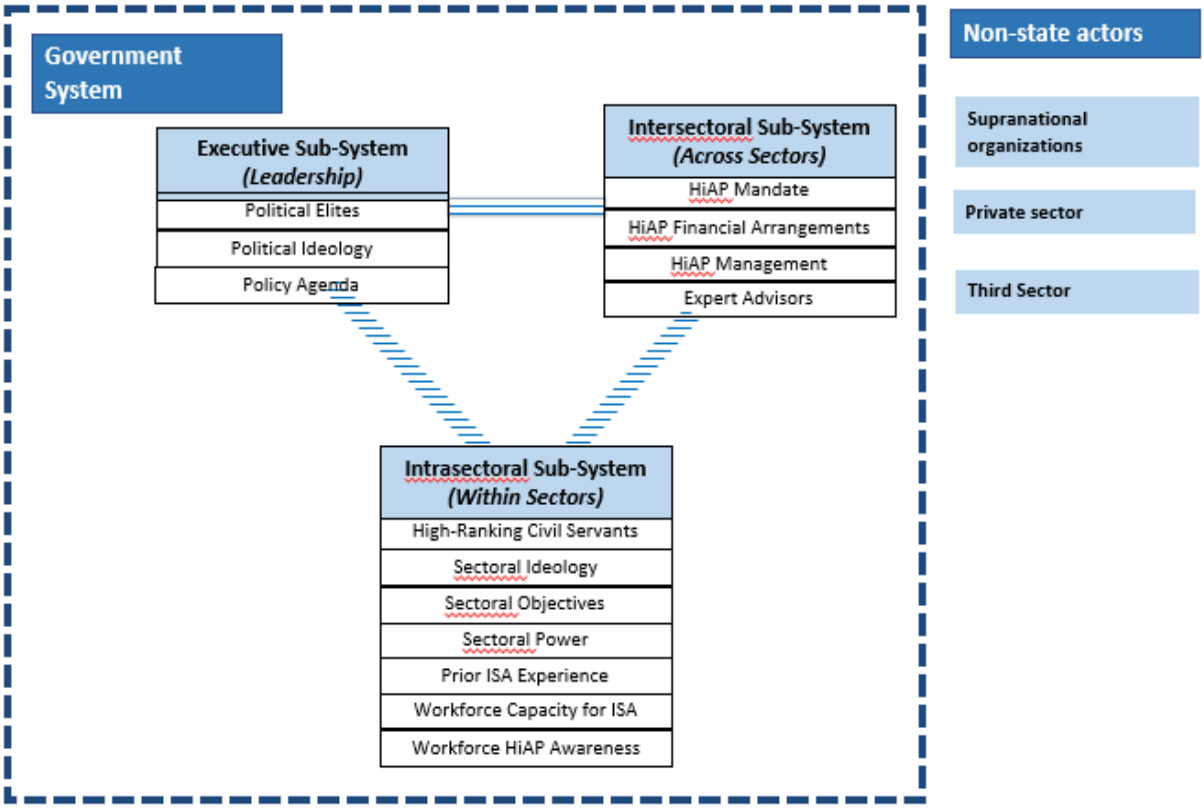
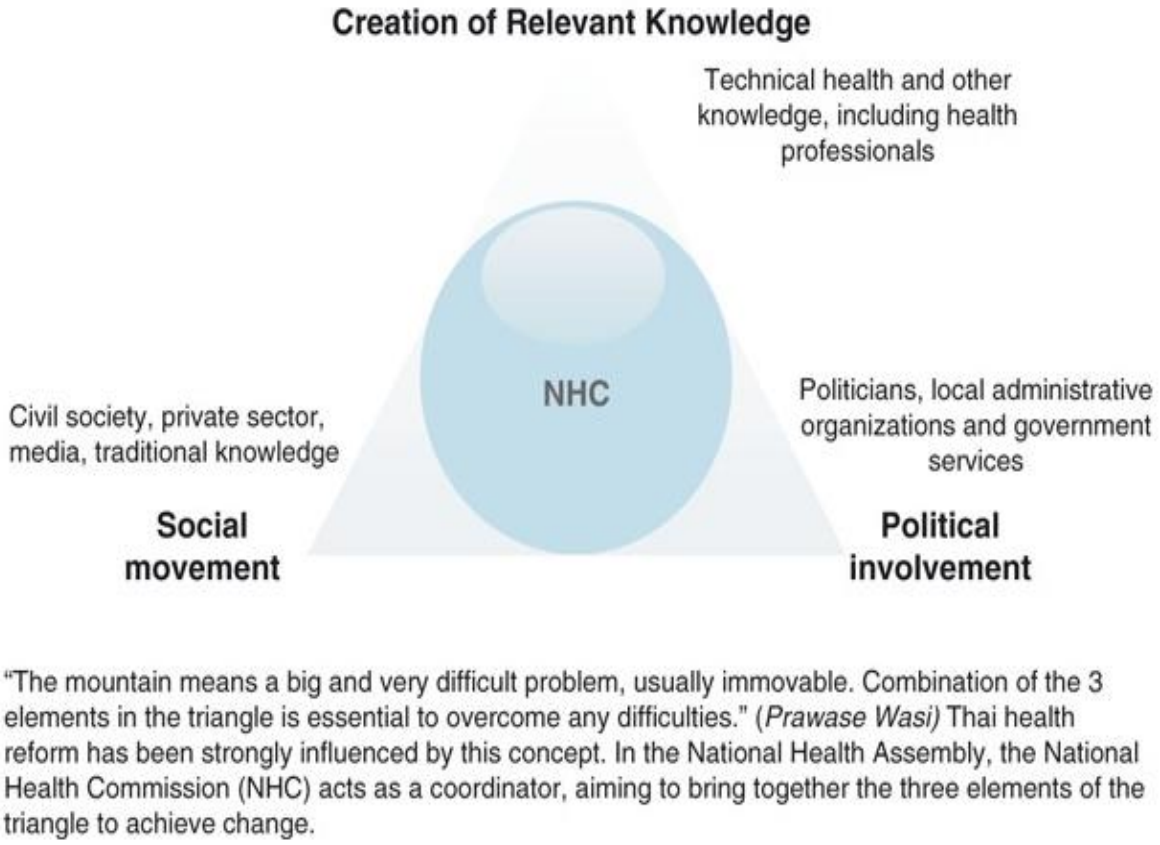


Figure 2.



"The mountain means a big and very difficult problem, usually immovable. Combination of the 3 elements in the triangle is essential to overcome any difficulties." (*Prawase Wasi)* Thai health reform has been strongly influenced by this concept. In the National Health Assembly, the National Health Commission (NHC) acts as a coordinator, aiming to bring together the three elements of the triangle to achieve change.

Source: Rasanathan, Posayanonda, Birmingham & Tangcharoensathien (2012)

6.5 FINDINGS

We interviewed 68 key informants for the multiple case study, 46 from the Health-Sector, and 22 from the Non-Health Sector.

We thought that influence of supranational institutions would be strong in LMICs and weak in HICs. More specifically we thought that the influence of supranational organizations would be strong in Ecuador and Thailand, because of the influence of supranational institutions such as the World Bank (WB), and the International Monetary Fund (IMF), and strong in Norway and Finland because of membership in the Eurozone and the European Union. We also thought that the influence of supranational institutions would be weak in California. Our cross-case analysis however found weak support for the influence of supranational institutions in the implementation of HiAP. More specifically, we found no evidence for the hypothesis in California, Finland, and Norway. The evidence in Finland and Norway was contrary to our hypotheses that there would be strong evidence because of their membership in the European Union and the Eurozone. In addition, we found limited evidence for the hypothesis in Ecuador, Scotland, and Thailand despite our predictions that the influence of supranational institutions would be greater in the two LMICs (Ecuador and Thailand).

With the exception of California, we thought that the influence of the private sector in HiAP implementation would be strong in LMICs and weak in HICs. Our cross-case analysis however reveals medium support for private sector involvement in HiAP implementation. We found no evidence in Norway and Scotland. There however was adequate evidence of the influence of the private sector in Thailand, limited evidence in Ecuador, while Finland and California showed strong evidence of private sector involvement in HiAP implementation.

Table 5. Characteristics of HiAP cases included in the multiple case study

Case	HiAP mandate	Informant Sector	Articles included
Scotland	Equally Well (2008-2015)	Health (9) Non-Health (6)	52
Norway	National Strategy to Reduce Social Inequalities in Health (2007-2015)	Health (9) Non-Health (4)	28
Finland	Health 2015 (2001-2015)	Health (6) Non-Health (11)	23
California	HiAP Task Force (2010-2015)	Health (4) Non-Health (5)	25
Ecuador	Buen Vivir (2009-2015)	Health (8) Non-Health (9)	25
Thailand	National Health Act (2007-2015)	Health (10) Non-Health (3)	45

We thought that civil society would be influential in HiAP implementation in LMICs compared to HICs because of the lack of welfare state policies and social security nets in the former. Our cross-case analysis found low support for civil society involvement in HiAP implementation. Not surprisingly, the results confirm our hypothesis that civil society activity would be greater in one LMIC, Thailand. Thailand had strong evidence for civil society influence over HiAP implementation whereas California and Scotland had limited evidence for the influence of civil society actors. We found no evidence for civil society influence in Ecuador, Finland, and Norway. Systems components which were impacted by non-state influences included the: Executive Sub-System, Intersectoral Sub-System, the Intrasectoral-Sub-system, and the Extra-governmental influences.

6.6 DISCUSSION

6.6.1 SUPRANATIONAL INSTITUTIONS INFLUENCE ON HIAP IMPLEMENTATION

We thought that the influence of supranational organizations would be greater in Ecuador and Thailand because of the influence of supranational institutions such as the IMF and WB. We also thought that the influence of supranational institutions would be considerably stronger in Finland and Norway because of the EU, and the Eurozone membership. Our findings however revealed no evidence of supranational institutions in California, Finland, and Norway, and limited evidence in Ecuador and Scotland. These findings can be attributed to various forms of governance and citizen engagement. In Norway for example, two referendums on Norway's decision to join the European Union were rejected by the Norwegian population.[44] Unlike Norway however, Finland is a member of the EU which makes the finding of no influence from supranational institutions in HiAP implementation in Finland interesting. This evidence can be attributed to the fact that Finland's domestic policies might already be commensurate, or aligned with the policies of the EU, which limits the influence of the latter on the countries domestic policies (see Kokkinen et al., 2015). In fact, according to Jungar (2002), Finland had a more positive view of the EU compared to other Nordic countries such as Sweden. Additionally, Finland had been represented "as a 'model pupil' that has socialized the norms and rules of the EU and is more prone to compromise --- even core interests" (Jungar, 2002, p. 397).

On the other hand, the limited evidence of supranational institutions in Ecuador is a consequence of the erosion of democracy under the Correa government. As de la Torre and Lemos (2016) note, "Correa's project was built on the notions of national sovereignty, the critique to US imperialism, and attempts to create alternative supranational Latin American

[44] Why isn't Norway in the EU? https://www.euronews.com/2013/03/29/norway-and-the-eu.

institutions without US influence" (p. 233). Consequently, the Correa regime employed a number of strategies to confront domestic [and international] actors that could resist his projects" (de la Torre & Lemos, 2016, p. 236). These events are interesting, especially in light of the fact that LMICs tend to be targets of non-state pressures to alter their domestic institutions (see for example, Krasner, 2001).[45]

6.6.2 PRIVATE SECTOR INFLUENCE ON HIAP IMPLEMENTATION

The medium evidence for influence of the private sector in implementation confirm the increased role that the private sector has in HiAP implementation (Bovaird, 2004). The strong evidence for private sector involvement in HiAP implementation in Finland can be attributed to a number of factors, chief of which is the increasingly influential role of lobbyists in Finnish policy-making due to Finland's entry into the European Union (EU). In 2015, Finland adopted Health 2015 as a long-term strategy to address health equity using ISA, with the Ministry of Social Affairs and Health develop guidelines which would direct other sectors to consider the use of Health Impact Assessments in their evaluation of key policy decisions (Shankardass et al., 2018). The increased role of Finnish lobbyists however, in policy implementation which coincided with the country's entry into the EU, the non-mandatory nature of the strategy (it is not mandatory for sectors to perform a HIA), coupled with the neo-liberal political ideology of the Finnish government, have co-opted the objectives of Health 2015, and subsequently health equity considerations of the strategy (Shankardass et al., 2018). In this political space, "wealthier interests (e.g. private industry) have stronger lobbies, such as direct financial support for election campaigns for politicians, more persistent communications in the media, and greater

[45] It should be noted however, that powerful countries such as the United States are not immune to these pressures (see for example, Kransner, 2001).

access to political elites and other key decision-makers" (Kokkinen et al., 2017, p. 7). This has been accompanied by an ideology of deregulation that has emerged in the discourse on the implementation of Health 2015 (Kokkinen et al., 2017).

For instance while health impact assessment revealed a negative outcome for lowering alcohol taxes in the country, the private sector lobby organizations lobbied Finnish government to lower alcohol taxes, which had a negative impact on Health 2015 "because the ruling party had a political ideology that favoured economic growth over health equity [and as a result] … opted to not heed the findings of the Health Impact Assessment on the effects of lowered alcohol taxes (Shankardass et al., 2018, p. 17; also see Kokkinen et al., 2017).

Strong evidence of private sector in HiAP implementation in California on the other hand can be attributed to no dedicated funding for HiAP (Rudolph et al., 2013), as well as the fact that in an overwhelming majority of cases, private foundation funding initiatives support HiAP-related approaches in the United States (Wernham & Teutsch, 2015). Private sector stakeholders are another important partner in HiAP, as their investments shape many health determinants, including economic and employment opportunities, traffic and pollution exposure, and the availability of amenities important to health. Moreover, HiAP funding in California is provided by the private sector (the California Endowment) due to the California government's decision to not to provided dedicated funding for HiAP in the State (see Association of State and Territorial Health Officials, 2018).

Although we expected a strong role of the private sector in HiAP implementation in Thailand, our analysis surprisingly found only adequate evidence of the influence of private sector. The weaker than expected results for Thailand, however, can be attributed to strong legislation for HiAP that has provisions for civil society to protest any non-health equity-oriented

policies which can limit the influence of the private sector. In fact, Thai civil society "coexists with strong constitutional guarantees of direct political participation, freedom of assembly, requirements for governments consultation, and local determination of community rights" (Asian Development Bank, n.d, *Development of civil society to current state*, Para 4).

6.6.3 CIVIL SOCIETY INFLUENCE ON HIAP IMPLEMENTATION

The high rate of civil society participation in Thailand is a consequence of the system of government which has legislative space for civil society, in addition to the provisions for civil society involvement in the Thai political system (Asian Development Bank, n.d.). In fact, Thai "civil society is … varied and diverse, and coexists with strong constitutional guarantees of direct political participation, freedom of assembly, requirements for government consultation, and local determination of community rights" (Asian Development Bank, n.d, p.2). Under the NHA, individuals or groups have the right to request for and to participate in Health Impact Assessment (HiA) (Posayanonda, n.d). An additional factor for civil society in implementation is the Thai Health Promotion Fund in 2002, which has "resulted in increased public resources to strengthen the role of civil society and the community in intersectoral action, health promotion and healthy public policy in Thailand. The Fund has actively sponsored civil society groups to build capacity for health promotion activities" (Rasanathan et al., 2012, p. 88). The limited role of civil society in HiAP implementation in other jurisdictions on the other hand, might be a consequence of the reduced involvement of civil society in those jurisdictions. In other words, while civil society have traditionally been actively involved in policy implementation in a myriad of ways, their influence is limited or in some cases non-existent in some of the jurisdictions that we examined (Parvin, 2018; Putnam, 2001; also see Whiteley, 2012; Hay, 2007).

In Ecuador, for example, no evidence of civil society in Ecuador is a consequence of the political climate that discouraged civil society participation in policy (and politics) (Freedom House, 2018). While "Ecuador has a high level of CSO membership, the level of civic engagement and citizen participation is low. Notably, since the Constitutional Court declared … the obligatory affiliation to Chambers of Commerce and professional associations on May 14, 2008 [unconstitutional], the number of members of these types of CSOs has diminished" (International Center for Not-for-Profit Law (ICNL), 2018, Para 2) (also see UN News, 2016).

Low evidence for civil society in Ecuador is also a consequence of the weak civil associations and poorly institutionalized political parties ---- and a lower tendency of the population for collective action (Basabe-Serrano, 2018). In fact, while the return to democracy in Ecuador came with the birth of a new cohort of political parties after years of dictatorship, citizen organization did not follow (Basabe-Serrano, 2018). Additionally, although there were some civil society groups during Ecuador's period of dictatorship government, Ecuadorian civil society did not flourish after the dictatorship. Instead, "[in] some cases, social organizations weakened, and the parties that represented their interests were affected in the electoral field. Some even disappeared" (Basabe-Serrano, 2018, p. 155). These events occurred primarily because Correa employed strategies based on militancy and incorporation in order to weaken and co-opt social movements in Ecuador and limit freedom of the press (de la Torre & Lemos, 2016). For example, the government created legislation (Executive Degree 16 enacted in June 2013) that required civil society organizations to register with the state (de la Torre & Lemos, 2016). This legislation also provided the Ecuadorian government with the authority "to sanction organizations for deviating from the objectives for which they were constituted, for engaging in politics, and for interfering in public policies in a way that contravenes internal and external

security or disturbs public peace" (de la Torre & Lemos, 2016, pp. 229-230).

Similarly, while Britain and a majority of EU member countries, and the United States have witnessed "a significant growth in the number and significance of NGOs and lobby organisations since the 1960s at the same time as they have also seen the number and memberships of traditional broad-based and grassroots organisations such as political parties and trade unions decline" (Parvin, 2018, p. 35). This shift is primarily attributed to social and economic inequality, decline in traditional forms of association and civil life, changing patterns of social capital, as well as a retreat of democratic politics from citizens to elite communities leading to a disconnect between citizens and the democratic system (Parvin, 2018).

Thailand's results confirm the hypothesis that civil society activity would be greater in LMICs, in particular, LICs. Thailand civil society influence in HiAP implementation can be explained by the stipulation in the Thai legislation that provides space for Thai civil society in policy implementation. The higher rates of civil society influence in HiAP implementation in LMICs compared to HICs could also be attributed to the lack of welfare state policies in the former (see for example Birn, Pillay & Holtz, 2009). This result is expected, even though some of the HICs (California and Scotland) have weaker welfare institutions because deference for political decisions tends to be lower in HICs compared to LMICs (see for example Nexitte, 1996).

6.7 CONCLUSION

Once the purview of the nation state, policy implementation is increasingly shaped by non-state actors. HiAP implementation is a complex process (Clavier, 2016) that involves multiple actors within the governmental system as well as from non-state actors. While public administrations are at the core of the implementation as they are responsible for carrying out policy decisions,

they do not “act alone as they are part of a policy process that encompasses a whole range of political, public, private, and community actors” (Clavier, 2016, p. 609). It is important to understand the context of policy implementation namely: types of government, political culture, including deference to authority, the role of non-state (non-governmental) actors to understand the varying contextual factors that facilitate or hinder the implementation of HiAP.

These shifts have major implications for HiAP implementation so that while governments may favour values commensurate with HiAP principles, non-state actors can hinder implementation.

Table 6. Modified hypotheses for testing through multiple explanatory cross case study analyses

While HiAP implementation is facilitated by governments, with processes within the government system:
1) Supranational organizations influence implementation as they can force governments to shift policy to reflect the former’s goals (compelling changes in governance) by bypassing legislation at the governmental level when governments’ have membership in supranational organizations, and their policies are commensurate with those of supranational institutions.
2) Private sector influence implementation through collaboration with governments when the governments’ political ideologies are aligned with the private sector’s agenda, and where there is no dedicated government funding for HiAP.
3) Third sector influence implementation (HiAP policy and program decision making) through collaborations with governments in jurisdictions where third sector involvement in governments are prioritized through legislative provisions in the political system, and in jurisdictions where there are strong civil society organizations.

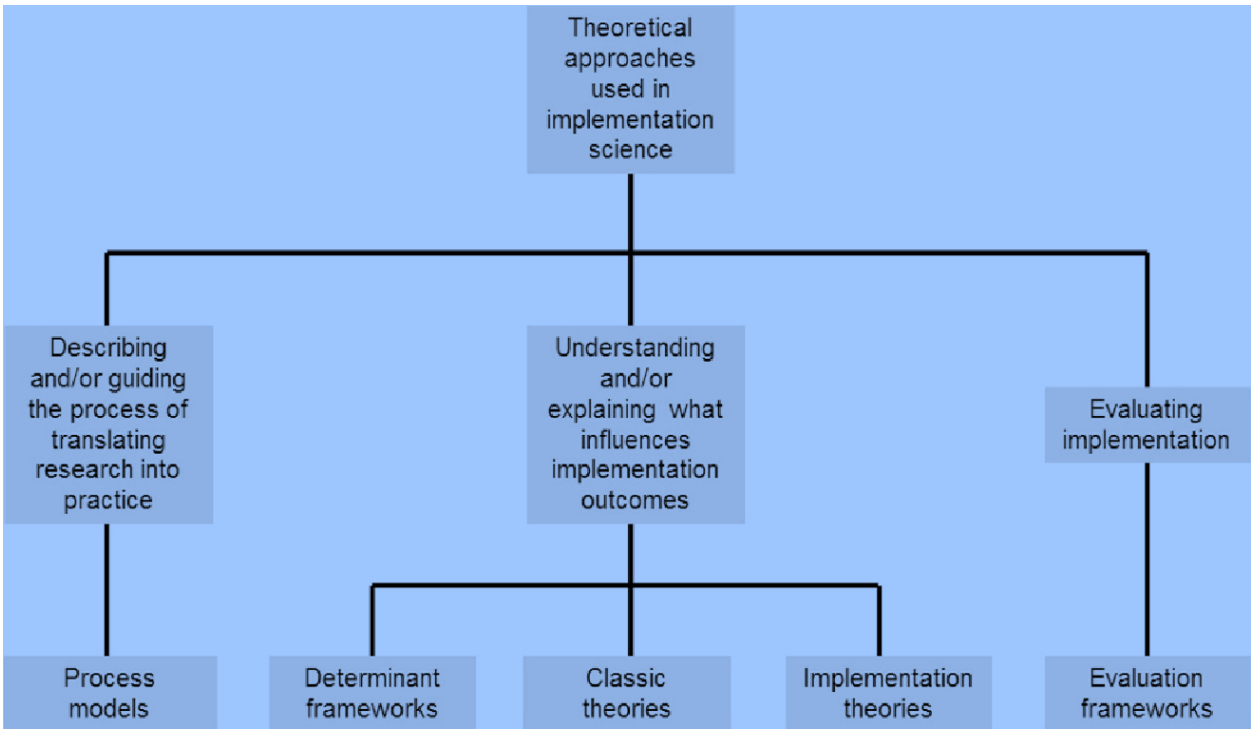
This study examined how and why non-state actors shape HiAP implementation in Norway, Finland, Scotland, Thailand, Ecuador, and California. Our study found that non-state actors are somewhat influential in how governments implement HiAP: we found weak support

for the influence of supranational institutions, medium support for private sector involvement, and low support for civil society involvement. Understanding how these non-state actors shape implementation of health equity strategies such as HiAP, is necessary to curtail their negative impacts on population health.

6.7.1 STRENGTHS AND LIMITATIONS OF THE STUDY

This study is one of the few studies to employ a theory driven realist multiple explanatory cross-case methodology to investigate the influence of supranational institutions in HiAP implementation across multiple jurisdictions. Moreover, the study tested theory of HiAP implementation. This is an essential component in the development of implementation theory on the influence of non-state actors on HiAP. Implementation theories according to Nilsen (2015), are theories developed by implementation researchers from "scratch or by adapting existing theories and concepts [in order] to provide understanding and/or explanation of aspects of implementation" (p. 3). This is significant as there are some advantages to applying formal theory over common sense, as hypotheses based on an established theory are "a more educated guess than one based on common sense" (Nilsen, 2015, p. 9). In addition, "theories give individual facts a meaningful context and contribute towards building an integrated body of knowledge, whereas common sense is more likely to produce isolated facts" (Nilsen, 2015, p. 9). Last but not least, theory generation is consistent with the study's focus on influencing how policy makers implement policies.

Figure 3. Three aims of the use of theoretical approaches in implementation science and the five categories of theories, models and frameworks



Source: *Nilsen (2015)*

The study has a number of limitations. First, the findings are limited to HiAP implementation in social democratic, high-income countries (HICs), and low-to-middle-income countries (LMICs) which limits the study's generalizability to HiAP implementation outside of these contexts. Second, the data for the study were not obtained from questions that were in the interview guide, but rather from purposive coding that sought to uncover the influence of non-state actors in HiAP implementation.

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CHAPTER SEVEN: CONCLUSION AND SUMMARY OF FINDINGS

7.1 INTRODUCTION

The goal of this dissertation was to investigate the factors that shape implementation of health in all policies (HiAP) across multiple jurisdictions. This dissertation focused on advancing theory through realism with an explicit focus on politics. In testing hypotheses, I found that a number of factors were instrumental in shaping HiAP implementation, namely: the use of an executive order, policies and ideologies of non-state actors, and politics. This last chapter will summarize the findings of the three papers by providing a concise recapitulation of the findings. In addition, this chapter will discuss the limitations of the study, implications of findings, future directions, and contributions to knowledge.

7.2 SUMMARY OF FINDINGS

The Narrative Review of the public health literature on the implementation of HiAP revealed a tremendous gap in the literature of a recognition of influence of politics in policy implementation. In Chapter 4, the findings from the single case study identified that buy-in for HiAP was facilitated by : sectoral language (different language) to more effectively highlight gains for non-health sectors of working intersectorally; knowledge translation which showed non-health sectors the merits of intersectoral engagement for achieving their own goals; the use of expert advisors to identify collaborations which provides non-health sectors with a sense that they are addressing their own goals; and consensus building which enabled building relationships across sectors. The single case study also found that buy-in for HiAP in California was limited by: the use of the directive approach, conflict by sectors over addressing issues of justice, non-health sectors' lack of awareness over issues of health equity, jurisdictional issues, conflict over policy solutions, a lack of funding for HiAP activities, non-health sectors' perceived lack of capacity,

and a lack of awareness about why more ISA was valuable. This finding is supported by Delaney et al. (2014) who note that, "[t]he acceptability of the HiAP approach within the (South Australian) SA Government is also bolstered by the mandate provided to it by the central Government agency. HIA operates without such support in (New South Wales) NSW, and without being positioned as an integrated part of the policy process. As such, HIA is usually introduced later in the decision-making process than HiAP. Relationship building occurs as a benefit or impact of the HIA process, although the main intent is to assess and predict the health and equity impacts of a proposal. This more technical intent of influencing a proposal and advocating for health and equity differs from the more tactical intent of the HiAP approach (p. 6)." These findings reflect the intricacies of engaging in intersectoral collaborations such as HiAP and highlight the important role that politics plays in HiAP implementation.

In the multiple case study of non-state actors, support for the following hypotheses were found: the private sector influenced implementation when governments' political ideologies were aligned with the former's agenda, and where there was no dedicated government funding for HiAP; and the third sector influenced implementation in jurisdictions where third sector involvement in governments were prioritized through legislative provisions in the political system, and in jurisdictions where there were strong civil society organizations.

The multiple case study found that while HiAP implementation is the purview of governments', non-state actors also shape implementation, but in various ways across different jurisdictions. The study found limited evidence on the influence of supranational organizations in HiAP implementation in Ecuador, Scotland, and Thailand. The study also found that the influence of the private sector was strong in Finland and California, limited in Ecuador and surprisingly not so in LMICs (Low to Middle Income Countries). In addition, the study found that the influence of

civil society was strong in Thailand, limited in Scotland and California, but weak elsewhere. In all, the findings did not confirm that the LMICs have low influence over HiAP implementation compared to High Income Countries [HICs], but instead found a variation across various jurisdictions and types of government.

7.3 CONTRIBUTION TO KNOWLEDGE

In addition to providing some directions for future research, my dissertation has made four contributions to the literature on HiAP implementation.

Firstly, using the realist explanatory case study methodology, this dissertation tested hypotheses about what shapes HiAP implementation in a number of jurisdictions. The paper revealed a glaring gap in the HiAP and public health literatures on the political factors that influence implementation. Because HiAP aims to improve population health and equity, understanding the complex processes that shape implementation can help policy makers in the process of implementation.

Secondly, in California, the findings from the study reveal that implementation of HiAP is influenced by a number of processes such as California's prior experience with ISA, the use of an executive order, and the leadership of the California Department of Health. More specifically, the study found that the inclusion of HiAP implementation in California was facilitated by: (1) prior experience which enabled non-health sectors to perceive issues in 'intersectoral terms'; (2) knowledge translation which showed non-health sectors the merits of intersectoral engagement for achieving their own goals; (3) employing sectoral language (different language) to more effectively highlight gains for non-health sectors of working intersectorally, as well as employing a focus on HiAP activities that benefit the achievement of sectoral objectives of health and non-health sectors; (4) the use of dual outcomes; (5) the use of expert advisors to identify

collaborations which provided non-health sectors with a sense that they were addressing their own goals; and (6) consensus building which helped to build relationships across sectors. In addition, the systems framework revealed the components of the government systems that were instrumental for facilitating HiAP implementation in California. This systems framework can be employed by policy makers to help understand HiAP implementation within government systems. My findings should enhance policy knowledge on HiAP implementation in California and can inform California policy makers to more effectively implement sustainable HiAP policies across the State. These factors alone however do not occur in isolation but are also shaped by the influence of non-state actors, that is, non-governmental actors whose influence can influence the degree to which governments implement policies that are commensurate with the health equity values of HiAP.

Thirdly, my investigation of the role of non-state actors in HiAP implementation across multiple jurisdictions highlights how non-governmental actors can influence the extent to which governments are able to implement policies that are commensurate with the health equity values of HiAP. The findings from this paper contribute to an understanding of HiAP within government systems, as well as the non-state influences on HiAP implementation. These findings have major implications for implementation so that while governments may favour policies that are aligned with the values of HiAP, non-state actors can hinder or co-opt the implementation of these values.

Fourthly, this dissertation contributes to the methodological rigour of existing studies on HiAP. The study employed a theory driven realist multiple explanatory cross-case methodology to investigate the multi-faceted factors that shape implementation of HiAP across multiple jurisdictions. In fact, the study's use of the realist explanatory methodology contributed to theory

of HiAP implementation in various settings. Furthermore, the context-mechanism-outcome configuration (CMO) which is a feature of the realist methodology can be employed in other jurisdictions to understand the contextual factors underpinning HiAP implementation across space and time. This is significant as theory is important for policy evaluation, "diagnosing policy problems and making decisions. Policymakers have to rely on theory because they are trying to shape the future, which means that they are making decisions they hope will lead to some desired outcome" (Mearsheimer & Walt, 2013, p.436).

Fifth, this dissertation highlights and addresses the political factors that shape HiAP implementation a fact, that is glaringly missing from the majority of the HiAP literature, and public health more broadly. Moreover, the narrative review of public health perspectives on HiAP (implementation) is one of a few in the public health field. In this sense, this dissertation makes significant contributions to understanding the political factors that influence implementation within the public health discipline, and more broadly.

Sixth, this dissertation contributes to understanding of context in the HiAP literature and the public health literature more broadly. This contribution is significant because of the paucity of contextually based research in public health (Edwards & Di Ruggiero, 2011).

Last, this dissertation contributes to body of theories of implementation in the public health discipline. This particular contribution is significant for a number of reasons, chief of which, is the discipline's failure to adequately investigate or conceptualize theories of policy implementation. In this sense, this dissertation examines as DeLeeuw, Clavier and Breton (2014) note that, "public policy through the lens of political science rather than through the lens of intervention … that policy is not an intervention, but drives intervention development and implementation … [and] that understanding policy processes and their pertinent theories is

pivotal for the potential to influence policy change". In this sense, the dissertation recognizes "that the health promotion, and education research toolbox should more explicitly embrace health political science insights" (p. 2).

7.4 LIMITATIONS OF THE DISSERTATION

It should be borne in mind that the study has a number of limitations:

The findings of the single and multiple case studies are limited to HiAP implementation in social democratic with the exception of California (the United States), High Income Countries (HICs), and middle-income countries (MICs). This limits the generalizability of the study's findings to other contexts such as low to middle income countries (LMICs) or low-Income Countries (LICs) which have a longstanding history of ISA, but under different auspices. LMICs examples of HiAPs or intersectoral activities for health offer excellent cases of the effectiveness of HiAPs; they are implemented under different conditions such as a part of IMF, or World Bank initiatives. In this case, the context of implementation is significantly different from that of developed countries where HiAP is implemented voluntarily by governments, which is something that is not readily addressed in the HiAP literature. In other words, the overwhelming number of studies fail to address the differential contexts in which HiAPs are implemented and in so doing depoliticize and neglect the role of neoliberal policies and their influence on the implementation of HiAP in these instances. The choice of these countries however was due to challenges of data collection in LMICs/LICs.

Another shortcoming of the study was that it focused on HiAP implementation within the government sector and as a result the overwhelming number of informants were political elites from within government or government agencies. Engaging primarily with informants within these jurisdictions may have skewed the study results towards the opinions of political actors,

thereby limiting insight from non-governmental actors that might have been influential in the implementation process. The original hypotheses were not focused on non-state actors; therefore, the evidence was limited to that collected for the other hypotheses. Instead this information was obtained from informant responses to the questions from the interview guide. As a result, there is a possibility of bias in coding the interviews. In addition, the findings of the implications of non-governmental actors on HiAP implementation might not be as comprehensive due to this method of data collection. Having said that, the focus of HiAP implementation on the government system, provided a better understanding of how governments implement HiAP within and across their jurisdictions.

7.5 STRENGHTS OF DISSERTATION

This dissertation has a number of strengths. One, the narrative review of the public health literature provided a systematic review of the evidence on how the public health discipline views the role of politics in the implementation of HiAP. Second, the single and multiple explanatory case studies employ a rigorous approach to the explanatory case study methodology. Additionally, the case studies use strong realist methods, multiple sources of data, and had a good response rate for interviews. Third, the dissertation advanced theory on HiAP implementation across multiple jurisdictions.

7.6 IMPLICATIONS OF FINDINGS

In all, my study offers evidence for the influence of political factors in the implementation of HiAP. HiAP implementation is not an apolitical process but rather, is influenced by a number of factors such as ideologies, values, and actors acting from within and outside of the government system (Oneka et al., 2017; Shankardass et al., 2018; Kokinnen et al., 2017; also see Frieler et al., 2013). The findings run counter to the widely expressed view in the HiAP literature that

HiAP is an apolitical process. On the other hand, the study confirms previous research that the policy process, in this respect, implementation, does not occur solely within the government system but is affected by non-state actors (non-governmental) influences or feedback from outside of the government system (see for example, Tantivess & Walt, 2008; Brown & Hartman, 2013; Sissenich, 2007; Rachlitz, 2017). The implications of these findings are that for governments to implement HiAP initiatives that reflect health equity values, policy makers need to capitalize on existing cooperation among sectors where these occur, and where absent, encourage a culture of cooperation that comes from prior intersectoral collaboration, an event that facilitates buy-in from non-health sectors. Additionally, governments should strive to reduce the negative influences of non-state actors within the government system. To this end, policy makers adopting HiAP can use the systems framework to increase the extent to which their policies mirror HiAP values. By recognizing the pathways through which interventions flow into the system, as well as the intricacies of the policy implementation process, policy makers can act to create more sustainable HiAP initiatives that reflect the health equity values of HiAP.

7.7 FUTURE RESEARCH

Future research on HiAP implementation should focus in particular on implementation in various contexts to enable a comparative analysis, as well as to provide additional insight into the factors that shape the implementation of HiAP in these jurisdictions. One avenue for further study would be the research into the specific ways in which HiAP differs in LMICs compared to HICs, or from social democratic nations vis-à-vis other nations. Future research can also examine how power and autonomy of governments can inhibit or facilitate implementation of HiAP, as well as how ideological congruence across governments (jurisdictions) can help to ensure implementation of HiAP. Furthermore, another avenue of research would be an

examination of whether governments with strong health equity values are more equipped to create formal HiAP implementation compared to governments with weaker health equity values.

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