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EDITORIAL

Intersectoral action for health: more research is needed!

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A plethora of explanatory models of health and health disparities that give prominence to social determinants have been published during the past two decades. From the Dalhgren-Whitehead ecolo-social model of health (Dahlgren and Whitehead 1991) to the WHO Commission's pathway model of the social determinants of health inequalities (WHO 2008), all these models explicitly recognize that health is produced in everyday life using resources and services, the availability and accessibility of which are determined by actors situated mostly outside of the health sector. As a consequence, numerous policy documents have pleaded for the health sector to take leadership in reaching out other sectors of activity in order to improve the conditions and resources that shape population health (WHO 1986). Intersectoral action is thus broadly defined as the alignment of intervention strategy and resources between actors from two or more sectors within the public sphere in order to achieve complementary objectives that are relevant and valued by all parties. Healthy school projects are often cited as success stories of intersectoral action. Such projects entail the coordination and pooling of resources from both the health and education sectors, two distinct spheres of government activity that most often compete for the same scarce resources. There is abundant literature demonstrating that to be successful, such projects require much more integration between public health and the education sector than just having a public health nurse servicing local schools.

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Despite the appealing rhetoric of intersectoral action, very few among health promotion professionals and researchers would be able to describe successful initiatives that involve sectors other than education. There would be even fewer people being able to list the conditions of success of such initiatives. The reason for this is quite simple: such projects are not that frequent and only a very small proportion of them have been studied. Although some case reports have been compiled for the WHO Commission on the Social Determinants of Health (WHO and Public Health Agency of Canada 2008), there is still a dearth of in-depth analysis of how they come about and the process by which they overcome the formidable obstacles that the normal functioning of public administration represent for intersectoral coordination and intervention.

In this issue of IJPH, we publish three original studies that were submitted following an international call for paper on intersectoral action. Altogether these papers provide examples of intersectoral action at the municipal, provincial and international levels. Spiegel et al. (this issue) examine the complex interplay of municipal sectors involved in municipal government in Cuba, showing that specific practices and structures are required for their proper functioning. For their part, Dewa et al. (this issue) interviewed program developers involved in a partnership between the mental health and the justice sectors in the Canadian province of Ontario. They showed the greater demands put on both systems by such partnerships and how greater flexibility is required from both systems in order for such partnerships to function. Finally, the scoping review published by Shankardass et al. (this issue) confirms our diagnosis on the scarcity of empirical knowledge about the practices and structures involved in intersectoral action. Although they found a fair number of articles published and from the grey literature describing intersectoral

projects in 43 countries, these articles provide very superficial analyses of the conditions in which these projects were developed and implemented. Taken together, these papers constitute a compelling argument that much more research is needed if we were to base our plea for intersectoral on scientific evidence.

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