

[David McDaid](#) and [A-La Park](#)

Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors

Report

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HEALTH EVIDENCE NETWORK SYNTHESIS REPORT 48

Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors

David McDaid | A-La Park



**World Health
Organization**
REGIONAL OFFICE FOR **Europe**

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Health Evidence Network synthesis report **48**

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David McDaid | A-La Park

Abstract

Intersectoral collaboration between health and the social welfare, education or labour sectors can help to influence social determinants of health. Funding of such collaborations can be problematic as these sectors may be subject to very different regulatory structures, incentives and goals. This review found 51 documents on the use of different financial mechanisms to facilitate intersectoral collaboration for health promotion, involving at least two of these sectors. A systematic search of the evidence identified approaches used, including discretionary earmarked funding, recurring delegated financing allocated to independent bodies and mechanisms for joint budgeting between two or more sectors. Many of these examples are implemented at a regional or local, rather than national, level and their success is influenced by factors including organizational structures, management, culture and trust. Potential facilitators include regulatory and legislative frameworks providing incentives, clear accountability for actions and the identification of specific benefits to all participating sectors.

Keywords

BUDGETING, FINANCING, HEALTH PROMOTION, INTERSECTORAL COLLABORATION

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ABBREVIATIONS

CINAHL	Cumulative Index to Nursing and Allied Health Literature
ERIC	Education Resources Information Center
NGO	nongovernmental organization
NHS	National Health Service (United Kingdom)
PHF	Population Health Fund



GLOSSARY

Actor: a participant in an action or process.

Budget silo: financial resources that can only be used within a specific sector or programme.

Delegated financing: the allocation of funds from one or more sources to an independent statutory organization such as a health promotion agency or foundation; this implies a transfer of power and discretion to prioritize programmes away from government.

Earmarked funding: the practice by one or more tiers of government of setting aside specific funds from new or existing revenue streams for a specific purpose.

Fiscal incentive: the use of taxation and financial subsidies to influence organizational and/or individual behaviour.

In-kind resource: non-monetary contribution to total resources, such as information and expertise, physical space or the provision of equipment.

Joint budgeting (also known as resource pooling or pooled budgets): a practice in which two or more sectors share their resources to address a specific health promotion issue; this may be a mandatory or voluntary process and can take different forms from the alignment of budgets to a fully integrated budget between two or more sectors.

Stakeholder: a person or group with an interest, involvement or investment in an activity (e.g. health promotion).

Vertical policy-making: integrated policy-making between different tiers of government responsible for one specific sector.

CONTRIBUTORS

Authors

David McDaid

Associate Professorial Research Fellow, Personal Social Services Research Unit, LSE Health and Social Care, London School of Economics and Political Science, London, United Kingdom

A-La Park

Assistant Professorial Research Fellow, Personal Social Services Research Unit, LSE Health and Social Care, London School of Economics and Political Science, London, United Kingdom

External peer reviewers

Stephan Van den Broucke

Professor of Health Psychology and Prevention, Université catholique de Louvain, Faculté de Psychologie et des Sciences de l'Éducation, Psychological Sciences Research Institute, Louvain-la-Neuve, Belgium

Bernd Rechel

European Observatory on Health Systems and Policies, London School of Hygiene & Tropical Medicine, London, United Kingdom

WHO Regional Office for Europe

Division of Policy and Governance for Health and Well-being

Monika Kosinska, Governance for Health programme

Christine Elizabeth Brown, Social Determinants for Health and Development programme

Division of Health Systems and Public Health

Elke Jakubowski, Director's Office

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SUMMARY

The issue

The social determinants of health include all aspects of daily living conditions and are influenced by resource distribution at global, national and local levels. To address these determinants, health promotion initiatives often require intersectoral collaboration between health and other sectors. As different sectors are subject to discrete regulatory structures and have distinct goals, funding intersectoral collaborations can be problematic. Separate funding streams, organizational budget silos, a lack of flexibility in funding arrangements and restrictions on the use of funds can significantly impede investment in intersectoral health promotion activities. Well designed financing mechanisms may overcome some of these barriers to intersectoral collaboration.

The synthesis question

The objective of this report is to conduct a scoping review of available academic and grey literature to inform policy-makers in the WHO European Region on the following question. What financing mechanisms have been used to facilitate intersectoral collaboration between the health sector and at least one of the education, social welfare and labour sectors?


Types of evidence

The evidence was obtained from a qualitative analysis of themes identified in published examples and evaluations of the use of financial mechanisms to facilitate intersectoral collaboration for health promotion activities that involved at least two of the health, social welfare, education or labour sectors. This review considered a total of 51 full-text articles published worldwide in English up to 31 March 2016. Only English literature was included due to limited resources.

Results

There is limited explicit discussion of the use of financing mechanisms to encourage intersectoral collaboration for health promotion in the literature.

Three principal approaches to financing for intersectoral collaboration are described: discretionary but earmarked funding, which usually remains under the control of a ministry in charge of health; recurring delegated financing allocated to an



independent body; and joint budgeting between two or more sectors. Positive examples of all three financing mechanisms can be identified. Their effectiveness in supporting intersectoral collaboration depends on factors such as organizational structures, management, culture and trust. Imbalance in the financial and resource contributions from different sectors can hinder implementation of an intersectoral activity. A sense of ownership for each sector was important for the successful collaborations identified. To date, there has been little assessment of the equity implications of different financing mechanisms.

Policy considerations

To support policy-makers in strengthening or introducing specific policies to support intersectoral collaboration between health and other sectors, the following financing mechanisms are suggested.

- Earmarked funding, delegated financing and joint budgeting schemes can ensure that resources are available for intersectoral activities.
- When looking at the architecture for intersectoral working, legislation and regulations that allow budget sharing between agencies and ensure accountability for funds received may provide a framework for financing intersectoral collaboration.
- Identifying outcomes of interest to all potential intersectoral partners within a partnership, in addition to the economic costs and payoffs, can facilitate partnerships. Financial compensation may be helpful for partner sectors that do not receive direct funding.
- Making ongoing financing of intersectoral activities conditional on routine effective monitoring and evaluation of whether defined outputs and outcomes have been achieved (i.e. phased funding) could lead to replication and/or scaling up.
- Voluntary joint budgeting with appropriate regulatory safeguards may be more sustainable through developing mutual trust, rather than imposing mandatory requirements to pool budgets.
- Most existing experiences are at the local rather than national level. Pioneer areas can share experiences with others to help to improve subsequent replication of approaches.
- Fiscal incentives and access to technical advice and support may be effective in stimulating intersectoral activity, particularly with private sector workplaces.





1. INTRODUCTION

1.1. Background

WHO recognizes that the social determinants of health, including lifestyles, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental conditions, are influenced by resource distribution at the global, national and local levels (1). These multifaceted determinants of health need to be addressed across all relevant sectors (2). They cannot easily be tackled by direct action by a ministry in charge of health or be attributed to a single policy or sectoral activity outside of the health sector (3). For the purposes of this review, intersectoral health promotion is considered “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions” (4).

Different concepts and terms have been used to describe the intersectoral approach to health promotion, such as intersectoral action for health, healthy public policy, whole-of-government approach and health in all policies. Health 2020, the WHO European Region’s health policy framework, places considerable emphasis on the importance of intersectoral actions by stating that the “health sector must engage in working with other sectors in ways that are mutually supportive and constructive, in engagements that are ‘win-win’ for overall societal public health goals, in addition to delivering individual health care services” (5). The United Nations also stressed the importance of a “whole of government and whole of society effort”, as well as the “need to put forward a multisectoral [i.e. intersectoral] approach for health at all government levels” in its 2011 Political Declaration at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (6).

The importance of intersectoral actions and shared responsibility for health has long been recognized by those working in the area of health promotion (7). An intersectoral approach to health promotion may include programmes that aim to improve access to and quality of education, or the environments in which people live and work (8,9). Intersectoral collaboration may also be necessary for achieving local community participation, making it more likely that programme goals and methods are adapted to local conditions, and that programme outcomes are effective and sustainable (10).

1.1.1. Challenges in implementing intersectoral actions

Implementing intersectoral actions to promote health can be highly problematic. Non-health sectors may be reluctant to implement health promotion initiatives if they believe these will hamper their chances of achieving their primary (non-health) policy goals (11). Imbalances between incentives and rewards are commonly found in joint health promotion initiatives between different tiers and departments of government (11). These challenges must also be addressed to facilitate intersectoral collaboration between the health sector and nongovernmental organizations (NGOs), such as private sector employers or private housing providers.

Overcoming these challenges to achieve effective intersectoral collaboration depends on various factors, including the regulatory and governance environment and institutional infrastructures, as well as the extent to which a culture of partnership working and political commitment exists at national and local levels. It may also depend on the way in which these actions are financed.

1.1.2. Financing intersectoral activities

The 2010 Adelaide Statement on Health in all Policies spoke of the need for “incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions” for health (12). Different scenarios for funding and delivery of intersectoral activities can be derived by combining the possible funding options (i.e. health sector only, other sector only, health plus one or more other sectors) with the possible delivery options (i.e. health sector only, other sector only, health plus one or more other sectors). When just one sector is responsible for funding an activity, then at least one other sector must be involved in delivery, perhaps alongside the sector providing funding. Alternatively, if multiple sectors provide funding, at least one of them must also be involved in delivery.

In different sectors, funding streams may have tight restrictions on their use and be subject to different financial incentives and cost-containment concerns. A predominance of vertical policy-making structures and funding silos may reduce the prospects for intersectoral work (13). This challenge is compounded when one sector is disproportionately financially responsible for the delivery of a health-promoting action but does not perceive that it will enjoy many of the benefits of the action (11). For example, education budget holders may be reluctant to fund activities such as school-based anti-obesity or mental health promotion programmes unless there are accompanying improvements in education-related



outcomes. This will be particularly relevant if health promotion programmes imply a greater workload for teachers (14–17). A non-health sector may be more reluctant to invest outside its core activities in times of constrained economic circumstances when there is heightened pressure to demonstrate efficiency and added value.

Well designed approaches to financing may help to overcome barriers and disincentives to intersectoral collaboration. Therefore, the principal review question is to identify what financing mechanisms have been used to facilitate intersectoral collaboration between the health sector and at least one of the education, social welfare and labour sectors. Secondary aims were to identify whether (i) the financing mechanisms led to a reduction in health inequities; (ii) there was any explicit attempts to ensure a wide and fair inclusion of contributing actors to the collection and distribution of funds; and (ii) there was evidence that this initial convening of actors and/or funds made a difference to the outcomes and impacts of intersectoral measures.

1.2. Methodology

1.2.1. Sources for the review

Nine bibliographic databases were searched: Business Source Complete, Child Development & Adolescent Studies, Cumulative Index to Nursing and Allied Health Literature (CINAHL), EconLit, Education Resources Information Center (ERIC), the International Bibliography of the Social Sciences, Medline, PsycINFO and Social Care Institute of Excellence. This was supplemented by a structured Google search and a search of English language materials from relevant universities and government departments. In addition, citations of relevant papers identified in the review were examined.

1.2.2. Data extraction

Annex 1 shows the strategies used for database searching. The review methodology was based on the PRISMA statement (18) and covered the period from 1 January 2006 to 31 March 2016. There were no language restrictions, although only English language databases were searched due to resource and time constraints. In order to maximize the chances of finding relevant material and capturing learning, there were no geographical restrictions. Evidence could have come from countries with low, middle or high incomes. Eligible studies had to describe and/or evaluate the use of financial mechanisms to facilitate collaboration for health promotion between health and one or more of the social welfare, labour and education sectors. Actions

taken directly by ministries of finance to facilitate collaboration between health and these sectors were also eligible for inclusion.

The initial search found 1146 publications of which 104 were considered relevant on the basis of abstracts and titles. Full reading of the text reduced this number to 51 publications. Most of these papers are descriptive, with limited mention of financing issues and no formal evaluation of effectiveness. It was, therefore, not possible to perform a formal quality assessment of retrieved data. Several reports briefly discussed financing mechanisms as one element in the evaluation of intersectoral programmes for health promotion in Canada (19–22), Denmark (23,24), Finland (25–28), the Netherlands (29–31) and the United Kingdom (32). Annex 2 provides more detailed information on the studies discussed in this review (33–53).



2. RESULTS

2.1. Overview of funding mechanisms

The review identified three major mechanisms that have been used to fund intersectoral health promotion activities:

- **dedicated earmarked funding** provided and controlled by one ministry or agency (usually the ministry in charge of health or that for finance);
- **delegated financing** for independent or semi-independent statutory health promotion bodies; and
- **joint budgeting** across different sectors.

Limited information was also available for other funding mechanisms such as fiscal incentives and in-kind resources. Each of these areas is considered in turn, including case studies to illustrate their use, and what is known about their success or failure is summarized.

None of the reports assessed the distributional impacts of different financing mechanism or the impact of different financing mechanisms on health inequalities.

2.2. Dedicated earmarked funding

Earmarked funding often refers to the practice by one or more tiers of government of setting aside specific funds from new or existing revenue streams for a specific purpose. It is widely used for financing health systems: some form of earmarking of revenue streams has been identified in at least 85 countries worldwide (54). While earmarking the collection of revenue can take many different forms, most notably through earmarked payroll taxes to fund public health insurance systems (54), here the focus is on earmarking expenditure for intersectoral health promotion activities.

Examples of the use of earmarked funding for intersectoral health promotion were identified in Canada (19–22), Denmark (23,24), Finland (25–28), Germany (36,37), Republic of Korea (43,44) and Sweden (45). These earmarked funds appear mainly to be under the control of the ministry in charge of health at national level; if at local level, funds are usually under the control of regional or municipal administrations.


Greater flexibility in funds earmarked for intersectoral actions can help to maximize the opportunities for action, as in the case in Finland with the National Development Programme for Social Welfare and Health Care (Kaste programme) (25,26), which since 2012 has put a strong emphasis on intersectoral activities to promote physical, mental and social well-being, as well as reducing inequalities in well-being and health. Earmarking national funding for this programme has provided opportunities to strengthen the ability of the national government to facilitate and influence regional and local-level projects, although interviews with the managers of 25 projects indicated that the funding duration was often too short, making it difficult to achieve objectives within funding timescales (27,28). This had a negative impact on the motivation of these project managers.

The Kaste programme is also one of several earmarked fund schemes identified that provide the opportunity for relevant actors to apply for funds for delivering intersectoral health promotion activities (Case study 1) (25,26).

Case study 1. The Kaste programme and intersectoral work in Finland

The Kaste programme was established in 2008 (25,26) and includes the provision of discretionary funding for local-level intersectoral work involving at least two different sectors in local municipalities, for example the education sector and workplaces. Municipalities and joint municipal boards for social welfare and health care can apply for discretionary government transfers to create and implement projects. Overall, €17.5 million per annum is allocated to the programme. Additional funding may be brought into projects by the municipalities and other actors.

Since 2007, local municipalities in Denmark have had responsibility for most health promotion and public health issues (23). Most municipalities have developed their own intersectoral policies for health. Earmarked funding was used as a way to help in implementing such intersectoral health policies in Varde, a town of 50 000 people in Denmark (Case study 2) (23). Initially, a lack of dedicated funding for intersectoral activities was a cause of “frustration” because different municipal departments found it difficult to find the funds or time from their own resources. To counter this, the Fund for Health was established by the municipality. As with the Kaste programme in Finland, different local stakeholders could bid for funding for intersectoral projects, and the Fund for Health was successful in becoming a catalyst for action. The award of funding was conditional on the involvement of two or more sectors. It provided “tangible motivation for the different sectors to collaborate and find intersectoral solutions” (23). For example, funds were awarded



to the health, children and youth, and planning sectors to create a collaborative SPACE (schoolyard, playspot, active transport, fitness club activities and environment) project to develop attractive and inviting physical surroundings to encourage more physical activity in young people (24). Swedish county councils have also provided earmarked project funding to help to facilitate health promotion at municipality level, although in a more modest fashion by providing expertise to municipalities and through the appointment of local health planning officers (45).

Case study 2. “Fund for Health” in Varde, Denmark

The development and implementation of an intersectoral health policy by the town council in Varde, Denmark, has been evaluated (23). All sectors of the municipality, including those responsible for schools and social welfare, were involved in policy development, but implementation proved difficult, partly because of a lack of dedicated funding. Subsequently, the Fund for Health was set up, with an initial earmarked budget of 1 million Danish kroner, and made available by the council to support intersectoral health projects. Different departments in the council could then bid for funding conditional on their projects being conducted by at least two sectors (which did not need to include the health sector). Interviews with stakeholders indicated that, as well as creating health networks to share information and knowledge, the fund helped to stimulate intersectoral activity and overcome budgetary silos. It is considered a model for wider adoption in other municipalities.

Another example of earmarked funding for health promotion was the Population Health Fund (PHF) of the Public Health Agency of Canada (19). Operating between 1997 and 2008, approximately Can\$ 12.1 million per annum was divided equally between national and regional projects. Most projects were the result of a competitive bidding process in which applications had to demonstrate that intersectoral work would be undertaken, for example linking academic, community, educational and voluntary sector organizations within and outside the health sector. Each regional project ran for an average of 26 months and received Can\$ 150 000, while national projects ran for 36 months on average and received Can\$ 312 000. An evaluation of the programme in 2008 found that more than a quarter of successful applications were able to provide/raise additional funding, while 54% provided additional in-kind resources (20). For example, in a four-year project to improve nutrition in children and their parents through collaboration among child care centres and schools, food retailers, the agricultural sector, NGOs and local government, a PHF grant of Can\$ 428 000 was supplemented by in-kind contributions equivalent to Can\$ 13 100 from partners. Volunteers were involved in at least a third of all projects.

Evaluation found that the PHF facilitated intersectoral actions, with some projects sustained beyond the lifetime of the grant through the successful acquisition of funding from other sources. However, many smaller one-off projects had insufficient time to generate evidence of what activities had worked, had limited project funding for evaluation and did not share the lessons learnt. The PHF was replaced by an Innovation Strategy in 2009 (Case study 3). Again, there was competitive bidding for earmarked funding for intersectoral work but the programme structure was changed to adopt a phased longer-term funding approach, focused on projects of larger scale, to respond to the criticism raised during evaluation of insufficient time for some (particularly small) projects to have an impact. Recent evaluation concluded that the new funding model for intersectoral partnership working has had more success in developing sustainable population health interventions. This is because the funding model has ensured that funds are concentrated on the most promising projects; it has also been helped by the substantial additional leveraged and in-kind funding that has been generated (21).

Case study 3. Funding through the Innovation Strategy in Canada

The Innovation Strategy Fund focuses on initiatives to promote mental health and tackle obesity and is managed by the Centre for Health Promotion within the Public Health Agency of Canada. Approximately Can\$ 9.7 million per year was awarded to successful project applicants between 2009 and 2014. There is a phased approach to funding:

phase 1: 12–18 months of funding for early development and implementation


phase 2: up to 48 months of funding for full implementation and evaluation

phase 3: further funding for the scaling up of successful projects.

This approach is designed to target funds to sustainable projects more likely to have a positive impact on health. Twenty-one projects have received continued funding for a second phase of development (21), including Can\$ 13 million for nine projects for promoting healthier body weights (22).

Partnerships developed through the Innovation Strategy have enabled projects to raise approximately Can\$ 5.7 million in additional funds and obtain approximately Can\$ 5.6 million of in-kind support.

In other examples, funds from various taxes are earmarked for intersectoral health promotion activities. The city of Wonju in the Republic of Korea, with a population of more than 300 000, was one of the first cities to join the WHO Alliance for Healthy Cities of the Western Pacific Region in 2004 (43). It established a Healthy City project



to develop a range of intersectoral actions for health, including programmes in workplaces and schools. Legislation ensured that the project would be funded by revenues from a local tobacco consumption tax (Case study 4). The programme has been associated with positive health outcomes but its sustainability relies heavily on the strong political will and continued support of the city mayor. It is now one of 81 Healthy Cities across the country (55).

Case study 4. Using a local tobacco tax to fund intersectoral health promotion in Wonju, Republic of Korea

In 2004, the mayor of Wonju announced a plan for a Healthy City project (43). Legislation was passed to fund the initiative through a local tax on tobacco consumption. The project initially had an annual budget in 2006 of US\$15 million, with programmes including creating smoke-free zones, life-stage and setting-specific (e.g. schools, workplaces, hospitals) health promotion strategies, greening the city and improving housing conditions.

The mayor championed this legislation, which was passed by first establishing a steering committee that recommended 40 intersectoral priority programmes for health and then working with academics to identify the best financing mechanism and campaigning for political support from the municipal government and city council.

In another example using taxation revenue for earmarked funding, the Navajo Nation Council (controlling the largest reservation in the United States of America, covering 27 000 square-miles in Arizona, New Mexico and Utah) enacted a tax on sugary drinks and junk food in April 2015 (50). The funds were “earmarked for health and wellness programmes on the reservation, like gardening and nutrition education”.

Other schemes with approaches similar to earmarked funding were also identified. Although not strictly earmarked, revenues raised from the introduction in Mexico in 2014 of a specific excise tax of one peso per litre on sugary drinks (excluding alcohol) were intended by legislators in part to help to fund a programme to provide clean drinking-water fountains in schools (38). Introduction of this programme was under way by late 2015 (39). In another example, the Act to Strengthen Health Promotion and Prevention became law in Germany in July 2015. One aim of this new law is to ensure that the different social health insurance funds and long-term care insurance companies invest at least €300 million per annum in health promotion activities

in kindergartens and day care facilities, schools, local government, workplaces and nursing homes (36). The different states (länder) and municipalities will also contribute resources and collaborate with insurers to develop a common strategy and goals. For example, activities in nursing homes can include balance training for fall prevention, healthy eating and actions to support mental well-being (37). It is too early to judge what impact this law will have.

2.3. Delegated financing

Delegated financing is a second approach to financing intersectoral health promotion activity; it involves allocating funding to an independent statutory organization such as a health promotion agency or foundation (35,56). Funds can be delegated to the independent agency from multiple sources, not just health budgets. Delegated financing also implies a transfer of power and discretion to prioritize programmes away from the government. Being independent of government, organizations operating through this financing mechanism may be more sustainable through being less vulnerable to government budgetary and electoral cycles (57).

Health promotion foundations were first set up in Australia, beginning in the state of Victoria, with another long-standing foundation in Western Australia (58). Similar organizations can be found in other countries with high, middle and low incomes, including Austria, Malaysia, Mongolia, New Zealand, Republic of Korea, Singapore, Switzerland, Thailand, Tonga, the United Kingdom and the United States (35,51,59,60). They can decide which projects and activities to fund and whether or not projects have to be intersectoral in scope. Many of their projects will cross sectoral boundaries as health promotion agencies funded independently of government do not have to contend with the same organizational and financial silos; however, they still need to secure the support of those sectors that will need to implement action.

The review found that delegated financing may be secured through various means (shown in Table 1). Some health promotion foundations fund their activities by receiving a share of specific tax revenues, for example ThaiHealth is funded by a 2% surcharge on excise taxes on alcohol and tobacco (46,47). In the Republic of Korea, a substantial share of all taxes on tobacco is used to fund an independent foundation (61). Heavy reliance on so-called sin taxes can, however, sometimes have unintended consequences: in the Republic of Korea, local areas with a greater level of funding for health promotion projects from tobacco taxes tended to have fewer staff and resources allocated to antismoking programmes (44). Around a third of funding for the Health Promotion Agency in New Zealand comes from a

levy on alcohol and it receives part of the funds from a levy on problem gambling. However, it is reliant for most of its funding on an annual share of the Ministry of Health budget (59).

Table 1. Examples of delegated financing for selected health promotion organizations

Country	Organization (website) ^a	Delegated financing source(s)
Australia	VicHealth (http://www.vichealth.vic.gov.au)	Core funding from Victoria Department of Health and Human Services
Australia	Healthway (https://www.healthway.wa.gov.au/)	Core funding from Government of Western Australia
Austria	Fonds Gesundes Österreich [Healthy Austria Fund] (http://www.fgoe.org)	Receives €7.2 million from value-added tax receipts
New Zealand	Health Promotion Agency (http://www.hpa.org.nz/)	Approximately one third of budget from alcohol levy; remainder from annual health budget and a share of problem gambling levy
Republic of Korea	Korea Health Promotion Foundation (http://eng.khealth.or.kr/)	Share of all taxes related to the tobacco industry
Switzerland	Promotion Santé Suisse [Health Promotion Switzerland] (https://promotionsante.ch/)	Levy on health insurance contributions
Thailand	ThaiHealth (http://en.thaihealth.or.th/)	Surcharge of 2% on alcohol and tobacco excise tax
United Kingdom	Big Lottery Fund (https://www.biglotteryfund.org.uk/)	Share of 40% of National Lottery revenues
United States	Oklahoma Tobacco Settlement Trust (https://www.ok.gov/tset/)	Share of proceeds from federal state law suit against tobacco companies

^a May receive additional funding from other sources, e.g. government contracts to deliver specific services. All websites were accessed 1 June 2016.

In Australia, health promotion agencies were originally financed through a share of tobacco taxation and focused on replacing tobacco sponsorship at sporting and cultural events with positive health-promoting actions (33,62). For example, VicHealth in the state of Victoria was created in 1987 and funded through a tobacco levy. However, after a successful legal challenge from the tobacco industry, its annual funding allocation is now determined by the Victorian Ministry of Finance (63). It must spend at least 30% of its budget on health promotion (in 2014–2015, actual spending was 39%). Similarly, Healthway in Western Australia is funded directly by the state government (64). In two similar European examples, a specific monetary sum from value added tax (€7.2 million) is delegated to health promotion in Austria (35), while a levy on top of mandatory health insurance contributions in Switzerland raised 18 million Swiss francs to fund the Swiss health promotion agency Promotion Santé Suisse in 2015 (65).

In the United Kingdom, 28% of national lottery ticket sale revenue goes to a number of so-called good causes (66). The good causes were determined by Parliament and include the Big Lottery Fund, which receives 40% of this share of revenue for health and well-being promotion, environment, education and other charitable causes (60). Since it was set up in June 2004, it has awarded over £6 billion to projects across the United Kingdom. Between 80% and 90% of grants are made to voluntary and community sector organizations, and grants vary in size from a few hundred pounds to several million. Most, but not all, of the health-related schemes are intersectoral in nature.

In Oklahoma in the United States, the population voted to set up the Tobacco Settlement Endowment Trust in 2000 as an independent statutory organization to receive and manage a share set down in legislation of the state's allocation from the 1998 legal settlement between four tobacco companies and 46 states (51). This settlement is worth at least US\$ 206 billion over 25 years to all 46 participating states. The Trust can allocate earnings from the endowment to local organizations and community groups for health promotion projects. Initially, the focus was tobacco cessation, but over time the remit expanded to other areas of health promotion, including addressing obesity (51). Projects include different intersectoral activities, and those given grants are encouraged to also seek additional funding from other sources.

Small-scale delegated financing initiatives are also beginning to be used to support intersectoral health programmes within Native American territories in the United States (67).



2.3.1. Challenges related to delegated financing

Some issues related to the success and sustainability of delegated funding programmes were identified.

The extent to which delegated financing can facilitate good intersectoral actions for health can depend on the level of flexibility in funding use. This can be seen, for example, in an evaluation of the Streets Ahead school-based programme, which was funded by VicHealth to create supportive environments for children's physical activity when travelling to and from school (Case study 5) (34). More flexibility to compensate schools financially for teacher time spent on the programme, as well as more efforts to demonstrate direct benefits to schools, would have been desirable.

Case study 5. Funding and scope for intersectoral action in the Streets Ahead programme, Victoria, Australia

In the Streets Ahead programme, VicHealth provided direct funding to local councils for creating supportive environments for children to be more physically active, with a specific focus on travel to and from school (34). Programme activities took place in six localities that faced high levels of social disadvantage and health inequalities.

Project evaluation indicated that working with local councils helped in connecting with other relevant sectors, including road safety and planning. Effective partnerships with teaching staff and different council departments were essential for providing a wide range of opportunities for children to develop the necessary skills to gain confidence and enjoy walking, cycling or playing sport in their local neighbourhood.

A disadvantage of the projects being council based was that this made some aspects of intersectoral work with and within schools difficult. It was important to have the support of schools, but this was hindered by a lack of specific funding to compensate schools for the time pressures faced. Some disadvantaged schools did not see the issue as part of their core business. However, when the Streets Ahead project was shown to address needs relevant to schools, results were very positive. For example, Streets Ahead targeted disengaged students in some schools with workshops teaching bicycle maintenance. When the school saw that these students re-engaged with school as a result, support for the programme surged.

A second issue relates to the sustainability of organizations reliant on delegated financing. One example is the failure of a health promotion foundation mechanism in Hungary; the Health 21 Hungarian Foundation was unable to obtain governmental support for any taxes or levies for support during the early 2000s when budgetary resources were tight (35). Even though it was possible for Hungarians to allocate 1% of their taxes to a foundation of their choice, this foundation did not convince enough members of the public to do so because they did not perceive health promotion as important.


In Germany, efforts on two occasions to set up a health promotion foundation with an annual budget of €250 million did not receive sufficient support in Parliament; at that time, parliamentarians did not want to see accident, pension and long-term insurance funds used to support the health system (35). In addition, there was no involvement of private health insurers or of the unemployment insurance system, which led to a perception that they would be free riders. However, as noted in the discussion of earmarked funding above, legislation was passed in Germany in 2015 requiring the various insurance funds to invest directly in health promotion activities (36).

Even successful health foundations can experience uncertainties over the level of funding received. The revenues of most are likely to depend on changes in consumption patterns of alcohol and cigarettes (as in the Republic of Korea (46) and Thailand (43)) or changes in the demand for lottery tickets (as in the United Kingdom), or they would require legislative change to increase funding (as in Austria). In Australia and New Zealand, budgets may also fluctuate depending on political priorities.

One way of addressing these challenges is to encourage co-financing of projects. In both Austria and Switzerland, foundations only provide part of the costs for any project – up to 39% and 17%, respectively, with the remaining funding provided from other sources, including government and the insurance sector (35). Schang and colleagues noted that “although co-financing would always entail opportunity costs, it appears that health promotion foundations can, even with their own rather small revenues, multiply available funds for health promotion through intersectoral co-financing action” (35).

2.4. Joint budgeting

Joint budgeting (also known as resource pooling) is a third approach to funding intersectoral collaboration in which two or more sectors share their resources to



address a specific health promotion issue (68–71). This method may overcome narrow sectoral interests by widening the area of responsibility and increasing the interest of stakeholders, and it may promote flexible funding. An important point is that joint budgeting can be either mandatory or voluntary. Under this mechanism, financial resources can be shared in a number of ways, including budget alignment (68). For example, shared budgets between the health sector and a local municipality can be arranged to meet agreed health promotion aims. In another approach, different departments contribute a set amount of resources to a joint fund, often time limited, to be spent on agreed projects or delivery of specific services. There may also be an agreement to jointly fund a post for an individual who will be responsible for providing services and/or attaining objectives relevant to both departments. Budgets across organizations might also become fully integrated, with resources and the workforce fully coming together; however, most initiatives stop short of fully pooling resources.

Joint budgeting arrangements in other areas of health and public policy sometimes have been accompanied by legislation, regulatory instruments and detailed legal agreements between sectors (68). Some have, for example, included specifying a host/lead partner for the budget and clarifying the functions, agreed aims and outcomes and levels of financial contributions by different sectors, as well as relevant accountability issues. Such agreements may also deal with the ownership of common premises and equipment, as well as how any surpluses or liabilities are dealt with.

The United Kingdom has devolved health services, with different formats in England, Scotland Wales and Northern Ireland. Although joint budgeting has been used to link health and social care services for older people in the United Kingdom (72), this review found few examples of joint budgeting being used for intersectoral health promotion. One English example documents how joint local health and council budgets were used to improve children's services, including health promotion (32). A legislative framework allowing resources to be shared and a phased approach to implementation was key to the success of this approach (Case study 6). Partnerships with integrated budgets between health and local authorities for providing children's services in England have also been perceived by participating stakeholders as ultimately helping to promote efficiency and improve care pathways for children in need (74).

In England, moves towards greater levels of local devolution are also increasing opportunities for pooling resources across sectors to improve health and well-being. One example is the development of a project to improve the health and work prospects


Case study 6. Joint budgets for children's services in Swindon, England, United Kingdom

In Swindon, joint health and local council funds were used to provide children's services, including measures to reduce teenage pregnancies, the number of children in care and the rate of young people not in education or employment (32). The key catalyst and enabler for creating joint budgets was a provision in the 2006 National Health Service (NHS) Act in the United Kingdom, applicable in England and Wales only, known as a section 75 agreement (73). This made it legally possible for local government and NHS organizations to share budgets and/staff to deliver health-related services.

The council and NHS made three separate legal agreements. The first allowed the bodies to align and eventually pool their budgets, with the council putting in £20 million and the NHS £8 million. The council's strategy director said that the approach "forces you to agree common priorities and outcomes across the two agencies, so everyone is very clearly signed up to those". Two further agreements allowed the organizations to combine staff, with 200 NHS employees seconded to four "integrated locality teams". Each team had staff from many disciplines, including education welfare, speech and language therapy, and youth work.

of the long-term unemployed in Manchester: the Working Well programme has a budget of £100 million in pooled funding from the 10 local authorities in Greater Manchester, supplemented by support from central government and the European Social Fund (48). The programme will support older workers with chronic health problems and unemployed people with mental health problems to obtain employment.

In New Zealand, legislation in response to recommendations from a major report on the workings of the public sector also allowed for better integration and flexibility in cross-sectoral funding between government departments to encourage "clustering projects", bringing together relevant government agencies to pool budgets and resources for public health projects (40). For example, the Healthy Eating-Healthy Action Initiatives Fund allowed for partnership arrangements and some dedicated budgets and commitments for matched funding between local district health boards, agencies for nutrition action and NGOs, the fitness and food industry, and Sport and Recreation New Zealand (41). There was some evidence that changes could be achieved (42).



Several papers looked at factors that influenced the sustainability of the whole-school approach to health in the Netherlands, where local government, health and education sectors can all contribute financial and/or in-kind resources to these projects (29–31). The differing roles of the various partners, with the municipal authorities being passive providers of finance rather than having more active involvement, may have hindered the implementation of these school-based programmes (Case study 7).

Case study 7. Shared budgeting for school health promotion in the Netherlands

“Schoolbeat” is a model of health promotion in the Netherlands that focuses on establishing and monitoring sustained intersectoral collaborations for comprehensive school-based health promotion (29–31). Municipalities are legally obliged to develop and finance local public health policy; consequently, the principal source of funding was the local municipality, although schools and other partners contributed, sometimes with in-kind resources rather than funding.

The main aim of the programme was to reduce risky health behaviours in young people, but schools were not under any legal obligation to implement health promotion programmes.

An evaluation of programme implementation in the Maastricht region involving surveys with stakeholders found that attitudes within sectors towards providing ongoing funding were important. Even after several years of collaboration, there was little change in attitudes towards financing in the education sector, with schools remaining reluctant to contribute financial resources to the partnership. This may have been caused by an imbalance in collaboration. Passive partners such as the municipalities were then the least supportive of collaboration, suggesting that being involved only as a provider of finance is insufficient to stimulate development of the collaborative support needed for supportive policies and (financial) agreements between municipalities and other partners.

2.4.1. Challenges in joint budgeting

While the review found few examples evaluating the outcomes of joint budgeting initiatives for health promotion, there is some evidence on process measures, such as the level of agreement and cooperation achieved (68). Previous research on health and social care services suggests that pooling funds may help to reduce administration

and transaction costs, thus generating economies of scale through shared staff, resources and purchasing power while facilitating more rapid decision-making (75). Joint budgets can also improve understanding across sectors and promote flexibility in how funds are used (76). Swedish experience also suggests that pooling arrangements at a local or regional level, where institutional structures are closer to stakeholders who have a better understanding of local problems, may be most effective (77). Based on this positive experience in Sweden, it has been suggested that joint budgeting between local employers and the local health sector could also be used to stimulate workplace health promotion in the United Kingdom (78).

One challenge is the long-term sustainability of partnerships arising from joint budgets. In some schemes where time-limited grants from central government were included in the budget, partners had to make up the shortfall in the budget after the end of grant funding for work to continue (68).

It is also important to distinguish between joint budgeting schemes that are mandatory (usually imposed by central government) and voluntary schemes that also require support from different stakeholders. Both approaches have strengths and weaknesses. In the short term, mandatory budget pooling and a de facto requirement for different sectors to collaborate may facilitate intersectoral actions and provide opportunities for mutual learning across sectors. However, the imposition of mandatory schemes may lead to resistance to collaboration from different sectors, which may threaten the long-term sustainability of schemes. Evidence from partnerships between health and social welfare services in the United Kingdom suggests that there may also be a reluctance to collaborate beyond what is stated in specific contracts and detailed legal partnership agreements; good accountability mechanisms, as well as clear legal and financial frameworks, need to be in place (79). If mutual learning or trust does not develop between sectors, then mandatory partnerships may be difficult to sustain if any mandatory joint funding or central government grant funding ceases. In contrast, although voluntary partnerships may take longer to develop, they may be more sustainable.

2.5. Other financing mechanisms

While the review only found three types of financing mechanism that had actually been used to deliver intersectoral collaboration for health promotion, two other mechanisms that might be used in future initiatives were identified: fiscal incentives and in-kind resources.



2.5.1. Fiscal incentives

Fiscal incentives, usually involving taxation or financial subsidies, may also be used to stimulate intersectoral activity. This funding mechanism may be particularly relevant for promoting better health in the workplace, for example by allowing some corporate tax liability to be offset against the costs of investing in workplace health promotion schemes in some countries (52,78). In effect, the ministry of finance would be contributing towards the cost of such a scheme, while companies may be incentivized to develop closer links with health promotion agencies and occupational health services.

The recent Affordable Care Act in the United States provides employers with tax incentives and grants to encourage the provision of workplace wellness programmes (52). Tax incentives have also been recommended by the Work Foundation in the United Kingdom, which noted that many employer-sponsored health interventions were currently taxed as benefits in kind. It also argued that matched funding, in which a government grant is equally matched by employer investment in health and well-being interventions, could also be used (76). This approach may be particularly useful for stimulating health promotion activity in small and medium-sized enterprises that might otherwise find it difficult to implement any type of health promotion activity. It may become more relevant in Europe if more welfare systems transfer more of the responsibility for paying salaries and long-term sickness benefits to employers. In the Netherlands, it is no coincidence that increased interest and efforts in workplace health promotion occurred after labour market reforms obliging employers to pay up to 70% of the salaries of employees who go on long-term sick leave for up to two years (80).

2.5.2. In-kind resources

Intersectoral activity also benefits from sharing in-kind resources, rather than funding, between sectors. This might, for example, involve agreements on the secondment of staff between sectors, sharing of equipment or expertise, as well as the provision of space to host a joint project or activity (11,68). The accountability requirements associated with in-kind resources are often less stringent than those for investments of financial resources, while still offering some flexibility to adapt to the changing needs of intersectoral work in the different stages of policy development, implementation and evaluation (68). Some of the intersectoral examples highlighted here include some sharing of resources as well as funds; this can be seen in Canadian (21), English (49) and Finnish (28) examples.

3. DISCUSSION

3.1. Strengths and limitations of the review

This review sought to identify which financial mechanisms have been used to facilitate intersectoral collaboration to implement health promotion activities. It identified three principal funding approaches: earmarked funding, delegated financing and joint budgeting between two or more sectors. It also identified case studies suggesting that these mechanisms can help to facilitate intersectoral actions, although also noting the dependence on other factors such as legal and organizational structures, differences in culture and objectives between sectors, and the level of mutual trust and respect between participants.

The review found that nearly all intersectoral actions facilitated by these three financing mechanisms take place at local or regional level, often with a key role for local government. Local governments are usually well positioned to lead intersectoral processes by influencing several sectors that can be fundamental to health, such as land use, transportation, environmental protection, leisure services, education and community development. A number of the evaluations and examples of best practice identified in the review are linked to the international Healthy Cities network, which recognizes the power of local government (23,43).

It is clear that, although no geographical restrictions were placed upon the review, the literature is sparse. Few publications have explicitly looked at the effectiveness of intersectoral financing mechanisms to facilitate health promotion, even though there is an evidence base on financing intersectoral activities, especially between health and social care services in the United Kingdom and in the Nordic countries for the provision of health care supports (81–84). This greater interest in actions for health care may be because of a perceived greater imperative to improve coordination between these sectors, for example to reduce delayed discharges for frail older people from hospital because of a lack of suitable accommodation or to improve coordination of support for vulnerable children. Intersectoral financing has also been discussed for promoting better collaboration among public employment agencies, social welfare services and health services to help individuals with chronic health problems or disabilities to return to work (77).

The limited literature on intersectoral financing for health promotion may also reflect the lower level of policy attention these issues have received. There was little



mention of financing mechanisms in relevant policy publications, discussions and guidance on intersectoral action (85,86); instead, the focus was on other dimensions of intersectoral partnership working. Moreover, there was little discussion on intersectoral funding mechanisms in the extensive literature on joint actions for health promotion with the education and labour sectors. The main focus of papers identified in this review was not on evaluation of financing mechanisms; this aspect was generally discussed only in a brief subsection of the paper. When present, evaluations of the impact of financing mechanisms tended to be qualitative (23,28). The review also identified case studies from governmental and academic reports. Again, financing issues were not prominent in these reports.

3.2. Policy options and implications


The review did not uncover any specific evaluations of the equity implications of different financing mechanisms. This is not surprising as there appears to be relatively little literature generally on many of the equity implications of intersectoral interventions (87). In some instances, health promotion actions had to be consistent with local legislation around equity and inclusion. For example, ThaiHealth states that it provides dedicated funding for “hard to reach groups” (46). It is easy to imagine scenarios with equity implications, for example if an external sector partner was expected to implement an intersectoral health-promoting intervention without having received sufficient funds to do so. It may also be the case that an external sector partner can no longer provide a core service because it has to use its budget for the intersectoral activity, or the service provider might not be able to provide the health promotion service.

Another possible issue for joint funding is that funding from a non-health sector organization may influence the type of health-promoting action undertaken. This could mean that scarce resources from the health sector budget are not used optimally to meet the health needs of the population. Careful needs assessment is, therefore, required regardless of the type of financing mechanism used.

The review did identify a number of factors to consider when developing policy options for a financing approach to stimulate intersectoral activity. When describing these factors, it is important to stress that there will be many other issues that influence the success or failure of intersectoral activities and that approaches to their financing cannot easily be considered in isolation. For example, even where there is experience from within Europe, decision-makers in WHO European Region countries may need to be mindful of variations in the degree of centralization

within health systems, as this may influence the architecture and type of legislative frameworks within which intersectoral activities take place. They may also need to consider what effect differences in the balance between reliance on general government revenues and health insurance for health system funding may have on the feasibility of implementing intersectoral financing. Notwithstanding these caveats about context and transferability of different approaches, some factors to consider are now briefly highlighted.

- **Financial and regulatory mechanisms may need to be combined.** The review of practice in Canada, for example, identified the importance of combining financial and regulatory mechanisms to ensure that funding earmarked for an intersectoral activity was actually used for that purpose (19).
- **Collaboration and accountability are vital.** The case study on sustainability of health promotion in Dutch schools highlighted the importance of both collaborative support from partners and good project management (29,31). The level of support from funders was partly influenced by whether they also had a role in delivery of the project. Different system contexts also influenced the level of collaboration. In the Netherlands, schools simply anticipated the continued receipt of block grants to conduct activities rather than having to demonstrate the value of the project to health promotion funders who were used to operating in a competitive environment. The Australian case study indicated that any imbalance in resources and funding between partners, for example to compensate schools for undertaking additional activities beyond the curriculum, could hinder implementation of the school physical activity scheme (34). Compensatory financial mechanisms might be considered so that any cost offsets for all sectors are distributed between different budget holders (88). In this way, all sectors share in both the risks and the potential rewards of investment.
- **Duration of funding needs to be realistic.** Another issue for policy-makers to consider will be the funding duration. The review indicates that funding is usually project based and with time limits. If there is a mismatch between funding duration and the ambition of intersectoral projects, this can be demoralizing for teams delivering projects. It can also mean that too much time and effort is spent on looking for ways of sustaining financing before service providers have had time to determine whether or not they are effective. This review identifies that one way to overcome some of these issues is to provide phased funding, as seen in Canada (21). If intersectoral projects demonstrate initial progress in a pilot phase, they receive additional funding to allow for longer-term evaluation;



further funding to scale up and/or replicate intersectoral activities may then also be available.

- **Appropriate legal and regulatory frameworks can provide safeguards.** For earmarked funds, such frameworks support accountability for organizations that manage delegated funds and allow sufficient flexibility on how funds can be pooled across sectors. In the case of shared funds, a single rather than separate accountability structure for each partner sector can also help to promote transparency and flexibility in how funds are used. In Canada (19–22), Denmark (23,24), Finland (25–28) and the United Kingdom (32,49), for example, legislation and regulations have provided more flexibility in how funding can be used, how different stakeholders can work together and the ways in which partnerships with NGOs may develop. In the United Kingdom, the regulatory environment provided the flexibility both to pool funds and to allow a workforce from two different sectors to be assigned to an integrated team (32). A further feature of local devolution of control for public budgets in England, with the opportunity to pool budgets across sectors, has been the creation of a strong mayoral system for oversight and coordination of intersectoral partnership work (89). Reforms in Finland were also explicitly intended to help to facilitate more intersectoral activity, including regional coordination support to help with implementation (27). Having a dedicated, fully financed Health in All Policies Unit within the Department of Health in the state of South Australia has been crucial for the successful establishment of intersectoral activities (90).
- **Quantifying costs and benefits for partners can stimulate intersectoral initiatives.** Clearly outlining the economic costs and benefits of enhanced intersectoral working may also help to build support for any combined initiative from the health and other sectors (11,68). Partners need to perceive collaboration to be in their own interests by adding value to what they can achieve in isolation. Too often, stakeholders from the health sector do not look at the consequences of health promotion for their partners. In the case of a school health promotion activity, this would involve estimating the costs to teachers and other staff, for both training and delivering the activity, as well as any positive impacts on educational outcomes such as academic performance or classroom disruption.
- **Intersectoral collaboration requires trust to be built between partners regardless of the financing mechanism.** This can take time between partners with very different backgrounds and perspectives, even when all partners contribute financially to the budget. Building trust is particularly important when different sectors voluntarily come together to collaborate and share resources. This necessarily relies more heavily on trust and open discussion; in turn, mutual learning and innovation is

enhanced by the development of trusting relationships. Voluntary collaboration and sharing of resources and risk may consequently be more sustainable in the long term than any mandated collaboration between sectors (91). Trust can be helped by locating staff in the same premises, having team-bonding exercises and involving representatives of all sectors in decision-making processes (84). Employing facilitators at the start of a partnership can also help to foster trust and resolve with disagreements.

Given these factors, the following policy considerations are identified.

- Earmarked, delegated financing or joint budgeting can ensure that resources are available for intersectoral activities.
- Financial mechanisms to promote intersectoral activity might be best used alongside appropriate enabling legislation and regulation to support intersectoral partnership working by allowing the sharing of budgets between agencies and ensuring accountability for funds received.
- Identifying outcomes of interest to all potential intersectoral partnerships, as well as the economic costs and payoffs, can help to facilitate partnerships; for example, compensation mechanisms may be helpful when one sector does not financially benefit.
- Ongoing financing of intersectoral activities could be made conditional on effective monitoring and achievement of defined outputs and outcomes. This could include phased funding that could eventually lead to replication and/or scaling up.
- Voluntary pooling of budgets with appropriate regulatory safeguards is more likely to be sustained through development of mutual trust than through mandatory requirements to pool budgets.
- Most experiences are at local rather than national level. Pioneer areas can share experiences with others to help to improve subsequent replication of approaches.
- Fiscal incentives and access to technical advice and support might be used to stimulate intersectoral activity, including with private sector workplaces.



4. CONCLUSIONS

While there is limited literature on the effectiveness of different financing mechanisms to facilitate intersectoral health promotion activities, the main financing mechanisms that have been used have been identified. It is noteworthy that most of the examples of financing mechanisms related to actions at the local level, and that the role of local authorities is central to most of the intersectoral activities identified. It would be helpful to share existing expertise and knowledge from different local and national contexts, for example through the Healthy Cities movement or through national public health agencies.

Whatever the financing mechanism used, it is important to consider options within a wider policy and regulatory context for intersectoral and partnership working. While voluntary budget sharing between sectors could be more sustainable, earmarked and delegated funds can stimulate activity. For all funding mechanisms, careful assessment is needed to determine whether funds are well spent and for sustaining and replicating those intersectoral activities that are shown to work. Access to resources may be included in a competitive application process, which could help to improve the quality and feasibility of intersectoral projects. It is also important that future evaluations of intersectoral activities are clear about the impact of the funding mechanisms on which they are reliant.

Finally, the experiences and outcomes of different successful and unsuccessful approaches to pooling resources should be disseminated widely to strengthen the evidence base for determining which of the different budgeting mechanisms have been associated with improved health and other outcomes, as well as cost efficiencies.

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ANNEX 1. SEARCH STRATEGY

Databases and websites

The search covered the databases of Business Source Complete, Child Development & Adolescent Studies, CINAHL, EconLit, ERIC, the International Bibliography of the Social Sciences, Medline, PsycINFO and Social Care Institute of Excellence. A structured Google search and a search of English language materials from relevant universities and government departments provided supplementary material as did references cited in the sourced papers.

Search protocol

The review examined English language databases to cover the period from 1 January 2006 to 31 March 2016 with no language restrictions, geographical restrictions or restrictions based on the income level of a country. Eligible studies had to describe and/or evaluate the use of financial mechanisms to facilitate collaboration for health promotion between health and one or more of the social welfare, labour and education sectors. References were screened independently on the basis of titles and abstracts by both authors, with disagreements on inclusion and exclusion resolved through discussion. Full texts were then obtained and a final decision on inclusion or exclusion taken.

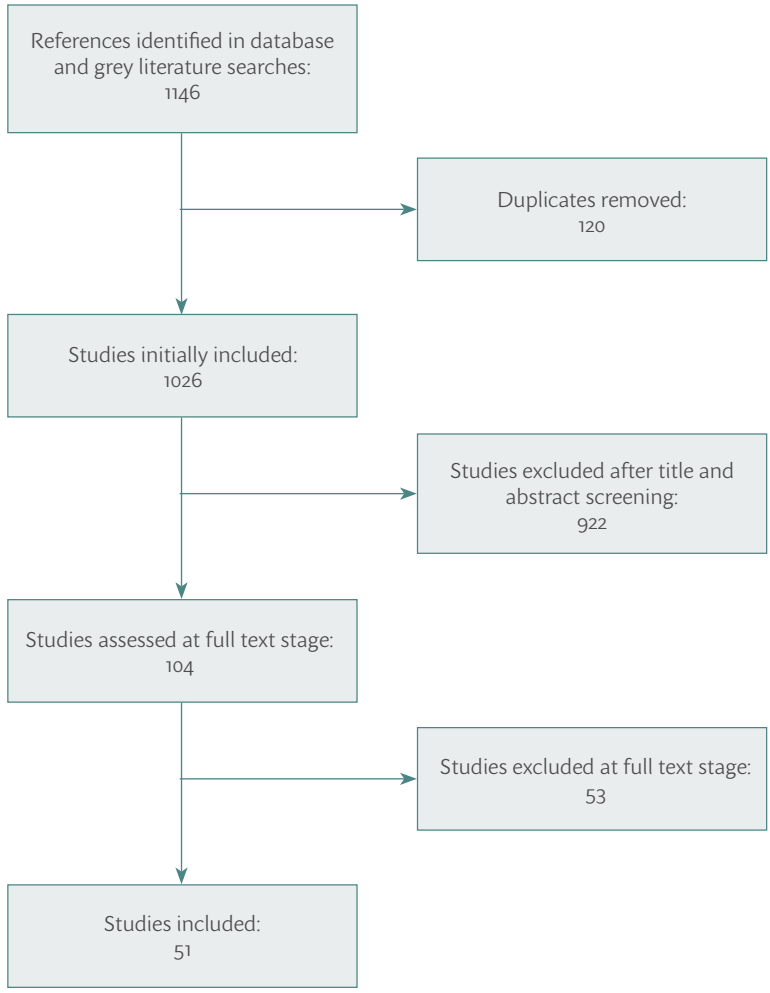
Initially, 1146 relevant publications were identified, of which 104 were considered relevant on the basis of abstracts and titles; this was reduced to 51 after reading the full text (Fig. A1).

Search terms

A common strategy was used for Medline, CINAHL, PsycINFO, ERIC, Business Source Complete, Child Development & Adolescent Studies and EconLit as follows:

1. Pooled N5 budget*.ti,ab
2. Shared budget*.ti,ab
3. Total budget\$
4. Joint budget\$
5. Integrated budget\$
6. Intersectoral adj3 budget*


Fig. A1. Selection of studies



7. Inter-sectoral adj3 budget*
8. Intersectoral adj3 financ*
9. Inter-sectoral adj3 financ*
10. Intersectoral adj3 fund*
11. Inter-sectoral adj3 fund*
12. Cross sectoral adj3 budget*
13. Cross-sectoral adj3 budget*
14. Cross sectoral adj3 financ*
15. Cross-sectoral adj3 financ*
16. Cross sectoral adj3 fund*
17. Cross-sectoral adj3 fund*
18. Health promotion fund*
19. Health promotion finance*
20. Public health
21. Health in all policies
22. Health promotion
23. Healthy cities
24. Intersectoral health
25. Inter-sectoral health
26. Education
27. School*
28. Employment*
29. Workplace*
30. Social welfare
31. 1–19/OR
32. 20–25/OR
33. 26–30/OR
34. 31–33/AND
35. Limit 1 January 2006 to 31 March 2016

The strategy for the Social Care Online database was as follows:

1. Pooled budget
2. Shared budget
3. Joint budget
4. Integrated budget
5. Intersectoral budget
6. Intersectoral financ
7. Inter-sectoral financ

- 
8. Intersectoral fund
 9. Cross sectoral budget
 10. Cross sectoral financ
 11. Cross sectoral fund
 12. Health promotion fund
 13. Health promotion financ
 14. 1-13/OR
 15. Limit 1 January 2006 to 31 March 2016

The strategy for the International Bibliography of the Social Sciences was as follows:

1. Pooled budget*
2. Shared budget*
3. Joint budget*
4. Integrated budget*
5. Intersectoral budget*
6. Intersectoral finance*
7. Inter-sectoral finance*
8. Intersectoral fund*
9. Cross sectoral budget*
10. Cross sectoral finance*
11. Cross sectoral fund*
12. Health promotion fund*
13. Health promotion finance*
14. 1-13/OR
15. Limit 1 January 2006 to 31 March 2016

A limited Google search combined the terms for health promotion, intersectorality, financing and funding: ((“health promotion” OR “public health”) AND (“intersectoral” OR “cross sectoral”), AND (“financing” OR “funding”)). All grey literature identified in this search and included in this report is taken from international agencies and organization, governmental documents, conference reports and/or academic working papers.

All references that met the inclusion criteria were stored in an EndNote database.

ANNEX 2. EXAMPLES OF THE USE OF FINANCING MECHANISMS TO FACILITATE INTERSECTORAL ACTIVITIES

Table A1 shows examples of the use of financing mechanisms to facilitate intersectoral activities.

Table A1. Examples of use of financing mechanisms to facilitate intersectoral activities

Country, programme: sectors	Intersectoral financing mechanism	Brief description
Australia, VicHealth: various sectors including schools, workplaces, police, arts and culture, transport (33,34)	Specified share of annual health budget allocated to VicHealth; change for legal reasons from original system, which was a surcharge on tobacco tax	Funds allocated to time-limited health promotion and primary prevention activities
Austria, Austrian Health Promotion Foundation: workplaces, schools and kindergartens, local government (35)	Legally defined specific monetary share of sales tax revenue (€7.2 million per annum)	Funds allocated to time-limited health promotion and primary prevention; funds one third to two thirds of project costs
Canada, PHF/Innovation Strategy Fund: health and various sectors in different localities including schools, food retailers, culture and leisure sectors, city governments, the media (19–22)	Earmarked nationwide grant funding from Public Health Agency of Canada; competitive process to obtain time-limited funding that is conditional on development of intersectoral health-promoting activities	Goal of programme is to "increase community capacity for action on or across the determinants of health by funding projects to develop community-based models for applying the population health approach, increase the knowledge base about population health, and increase partnerships and intersectoral collaboration in Canada" Competitive process to obtain additional funding for continuing and expanding schemes, subject to results of evaluation



Study design and key findings

Implementation issues

Documentary analysis and interviews
Evaluation reports for specific projects
Delegated financing helps to leverage further co-financing for projects

Reliant on Victoria Ministry of Health to determine annual funding allocation

Documentary analysis and interviews
Model of co-financing in Austria has successfully leveraged much higher levels of funding from other partners

No specific issues raised

Several evaluations including audit of activities, documentary analysis and interviews
Programme generally well implemented, leading to intersectoral partnerships
More than 25% of projects secured additional funds; half provide in-kind support; one third have volunteers input; some projects sustained beyond grant

Innovation Strategy introduced in 2009; phased levels of funding; projects must reach specific development goals within a period of 12–18 months to obtain additional funding

If second phase is successful, then further funding is made available for projects with the greatest potential impact; this also means that money is then focused on projects that are more likely to have an impact

Table A1 (contd)

Country, programme: sectors	Intersectoral financing mechanism	Brief description
Denmark, Fund for Health in city of Varde: various sectors under control of municipality including health, schools and social welfare (23,24)	Conditional earmarked “Fund for Health” for intersectoral health promotion activity at municipality level	Municipality awards grants to intervention proposals annually through competitive process; all administrative units in the municipality may apply for funding conditional on their projects being conducted by at least two sectors
Finland, Kaste programme: health, local municipal administrative government (25–28)	Specific earmarked funding from central government for intersectoral health promotion; allows additional funding to be added by partners	€17.5 million per annum available for programme that focuses on promoting physical, mental and social well-being; programmes should also have a focus on reducing inequalities in well-being and health Municipalities and joint municipal boards for social welfare and health care can apply for discretionary government transfers for creating and implementing projects
Germany, Act to Strengthen Health Promotion and Prevention: health, nurseries and schools, local government, workplaces, nursing homes (36,37)	Legislative requirement in 2015 to set aside specific level of insurance funds for health promotion and prevention activities; länder and municipalities also contribute funding	Social health insurance funds and long-term care insurance funds mandated to invest at least €300 million per annum in health-promoting activities in different sectors
Germany, planned health promotion foundation (35)	Plans for an health promotion foundation to be funded by health, accident, pension and employment insurance funds	Not implemented



Study design and key findings	Implementation issues
<p>Case studies involving documentary analyses and interviews</p> <p>Introduction of health fund helped to overcome silo barriers between departments caused by a lack of dedicated funding for intersectoral activities; fund provided “tangible motivation” for sectors to collaborate</p>	<p>Political will insufficient to encourage intersectoral activity; need to address disincentives between sectors to share resources</p> <p>Non-health sectors had been concerned about insufficient time and resource to implement health promotion activities</p>
<p>Survey of participating organizations and interviews with various participants</p> <p>Associated with improved outcomes (e.g. for health and well-being in schools and in workplace health) but no impact on health inequalities</p>	<p>Power struggles between organizations and differences in attitudes towards intersectoral collaboration</p> <p>Short time frame, making it difficult to achieve all objectives; this could demoralize project managers</p>
<p>No evaluation as yet; legislation recently passed</p>	<p>Too early to assess the impact; legal constitutional barriers blocking earlier initiatives were overcome</p>
<p>Documentary analysis and interviews</p> <p>Not implemented</p>	<p>Legal and constitutional barriers to mandating insurers to allocate funding to planned fund</p>

Table A1 (contd)

Country, programme: sectors	Intersectoral financing mechanism	Brief description
Hungary, Health 21 Hungarian Foundation: health and other sectors (35)	Economic conditions prevented a dedicated tax or insurance surcharge; option for citizens to choose to allocate 1% of their tax to Health 21 not popular	Previously had been funded through grant; unable to secure long-term funding
Mexico, Tax on sugary drinks: finance, health and education (38,39)	Legislation to introduce a specific excise tax of 1 peso per litre on sugary drinks in 2014	Although not strictly earmarked, some of the revenue raised from the tax is intended to help to fund clean drinking-water fountains in schools
Netherlands, Schoolbeat: health, schools, social welfare, youth services, municipalities (29–31)	Joint budgeting, primarily with contribution from local municipalities but with all partners making financial or in-kind contribution	Development and voluntary implementation of plans to promote health and reduce risky behaviours in schools
New Zealand, Healthy Eating–Healthy Action: health, schools, workplaces, housing sector and others (40–42)	Dedicated budget; includes Innovations Fund to increase physical activity and reduce obesity; competitive process that can allocate funds to collaborative activities	Aimed to facilitate collaboration between local health organizations, communities and other sectors; applicant organizations were required to match funding and to include an evaluation component
Republic of Korea, Healthy City Wonju: health, education, housing, transport, other departments of city/municipal government (43,44)	Earmarked tax revenues from tobacco sales	US\$15 million allocated to fund 40 public health programmes intended to promote health across the lifespan and in different settings, including schools, workplaces and hospitals, in the city of Wonju



Study design and key findings	Implementation issues
<p>Documentary analysis and interviews</p> <p>Foundation not sustained due to poor economic conditions; no appetite for surcharges</p>	<p>Economic conditions can be a barrier to the use of dedicated taxes for health promotion activities</p>
<p>Trend analysis indicates that the tax is effective in reducing sugary drink consumption, with a greater impact on lower socioeconomic groups</p> <p>No evaluation of effectiveness of tax as a mechanism for financing intersectoral activities, but roll out of programme to supply clean drinking-water begun in 2015</p>	<p>Too early to assess</p>
<p>Interviews with stakeholders involved in Dutch Healthy Schools Approach</p> <p>Mechanism can help to promote coordination and cooperation between partners</p>	<p>“Encouraging and accommodating attitude” from funders with long-term commitment helps to facilitate intersectoral collaboration</p>
<p>Evaluation contract was terminated early after change of government in 2008 and no formal assessment of outcomes, but a sense that was positive about strategy and early outcomes; later small-scale evaluation indicated approach could promote better outcomes</p>	<p>Short-term funding barrier to sustainability of initiatives; intergovernment collaboration initially difficult</p>
<p>Before and after analysis of financial sustainability</p> <p>No focus on outcomes, but earmarked tax revenue from tobacco sales (even though rate of smoking decreased) was able to sustain the financing of health programmes over 5 years</p>	<p>Importance of political support for legislation allowing the earmarking of funding; needed a strong commitment from the city mayor to build partnerships across sectors</p>

Table A1 (contd)

Country, programme: sectors	Intersectoral financing mechanism	Brief description
Sweden, local municipal health promotion: county councils and local municipal government, local trade and industry, public authorities (45)	Specific earmarked funding from county councils that can support intersectoral health promotion at municipal level	County councils can provide targeted project funding to help to facilitate health promotion at municipality level by providing expertise to municipalities and through the appointment of local health planning officers
Switzerland, Promotion Santé Suisse: health and various sectors (35)	Legislation defining annual surcharge on health insurance premiums to be allocated to health promotion services	Promotion Santé Suisse co-finances intersectoral projects; majority of funding coming from partners
Thailand, Health Promotion Foundation (ThaiHealth): health and various sectors (46,47)	Delegated financing 2% additional tax on alcohol and tobacco funds for ThaiHealth	ThaiHealth develops strategic partnerships with various government departments, private and nongovernmental sectors and communities to promote health
United Kingdom, Swindon Council: health, children's services (32)	Legislation allowing voluntary pooling of budgets between council's child (£20 million budget) and health (£8 million budget) services	Three separate legal agreements; one to allow council and health services to align and eventually pool their budgets on services for children and young people
United Kingdom, Working Well in Manchester: health, workplaces, social welfare, local government (48,49)	Legislation allowing voluntary pooling of budgets between different municipal governments in Manchester for intersectoral and interarea collaboration; also includes funding from other sources including the European Union and central government	When fully rolled out, the programme will cover 50 000 individuals and have a £100 million budget; it will include projects to help long-term unemployed with health problems return to work; service providers paid on a payment by results basis



Study design and key findings	Implementation issues
Case studies involving documentary analyses and interviews; no specific analysis of outcomes of intersectoral actions	Not discussed substantively although a lack of resources in some case studies noted as a barrier to action
Documentary analysis and interviews	Revenues have been sustained because grown as population has increased due to inward migration
Detailed 5- and 10-year reviews of ThaiHealth have been conducted; they have not focused on how the financing mechanisms works	Noted even in a situation of sustained financing need to work to develop local government/other partner capacity for more health partnership working
Joint budget has been effective in development of common priorities and outcomes across agencies	Strong governance mechanism helped to ensure voluntary partnership agreements would be implemented as agreed
Too early for impact assessment but interim evaluation of small-scale pilot work using focus groups and interviews has taken place and indicates client expectations improved and scheme is associated with effective partnership working	Too early for assessment of barriers or facilitators; expected that strong role for future elected mayor of Greater Manchester will help to aid collaboration across sectors

Table A1 (contd)

Country, programme: sectors	Intersectoral financing mechanism	Brief description
United States, sales tax on sugary drinks and junk food and reduction in tax on fruit and vegetables in the Navajo Nation: health, wellness, gardening (50)	Legislation in 2015 to introduce additional sales tax on specific products with funds earmarked to health promotion activities	Two sales tax on sugary drinks and snacks, sweets and baked and fried goods of “minimal-to-no nutritional value”
United States, Oklahoma Tobacco Settlement Endowment Trust: health, community organizations, NGOs (51)	State’s share of revenue from 1998 settlement of legal action against four tobacco companies; compensation paid over 25 years to 46 states; 75% of these funds is allocated to the Oklahoma Trust for health promotion activities, including intersectoral activities	The Trust invests in primary prevention across sectors to reduce tobacco use and obesity; partners who apply to deliver activities are also encouraged to bring matched funding
United States, Department of Health and Human Services Prevention and Public Health Fund: states, community organizations, health sector, early years child care sector (52,53)	Federal funding allocated to a prevention and public health fund; competitive grant opportunities; funds also delegated to other federal health-related agencies	Competitive opportunities to bid for grants from the fund, including some areas that are intersectoral in nature, such as suicide prevention and supporting physical activity and nutrition support for young children



Study design and key findings

Implementation issues

Too early for formal evaluation

Too early to assess the impact

No formal evaluation

No formal assessment

No formal evaluation

No formal evaluation

World Health Organization

Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00

Fax: +45 45 33 70 01

Email: euwhocontact@who.int

Website: www.euro.who.int

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