Local health contracts as instruments of cross-sectoral collaboration: the French CLoterreS study

E. Breton[1-2], Y. Le Bodo[1], D. Diallo[1], C. Harpet[2–3], H. Hudebine[4], F. Jabot[1 -2], W. Sherlaw[1-2]

1 - Department of Human and Social Sciences, EHESP School of Public Health, Rennes, France; **2** - Arènes Research Unit, UMR CNRS 6051, Rennes, France;
3 -Department of Environmental and Occupational Health, EHESP School of Public Health, Rennes, France; **4** - LABERS Research Unit, Université de Bretagne Occidentale (UBO), Brest, France

WPHC Conference Oct. 2020

Highlights

- In **France**, since 2009, **Local Health Contracts (LHCs)** *(Contrats Locaux de Santé)* involve Regional Health Agencies, local governments and stakeholders to intervene in 4 areas: health promotion, prevention, health care and social care.
- The **CLoterreS study*** assesses the extent to which the LHC fosters **health-promoting actions** through cross-sectoral collaboration.
- Although access to health care often appears to be a primary driver for local authorities to engage in a LHC, our results indicate that LHCs' actions **mostly address living conditions**, **health promotion** or **primary prevention**.
- When looking at actions planned on some key factors (e.g. physical activity, diet), **some innovative actions** at the intersection of urban planning, transportation, recreational or food environments illustrate the **potential for further cross-sectoral collaboration**

Background

- Although recognized as essential, the **role of local governments** in **promoting health** remains under investigated. Yet their mandate impacts directly upon health determinants and health equity, such as early childhood services, housing, transport, leisure, etc.
- In France, the **LHC** is a public, **multi-stakeholder policy instrument** generally including a portrait of the population's health and a **series of multi-year action forms** focused either on health promotion, prevention, health care or social care.

Objective

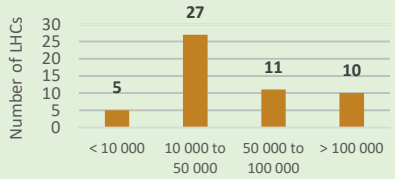
- The CLoterreS study* assesses the **extent to which the LHC fosters health-promoting actions** through **cross-sectoral collaboration**

Methods

- We analyzed the **action plans** of a national stratified random sample of **53 LHCs** from the 165 signed between 2015 and March 2018. We used a **validated multidimensional coding tool** essentially based on the WHO's Essential Public Health Operations[1].
- We distinguished between actions targeting **individuals** or their **environment** using the tool for the **assessment** of the **integration** of the **ecological approach** in public health programs[2] regarding **4 key factors** (smoking, alcohol, physical activity and diet)
- We also conducted 49 **semi-structured interviews** with staff from all Regional health agencies (RHAs) and local stakeholders.

Results

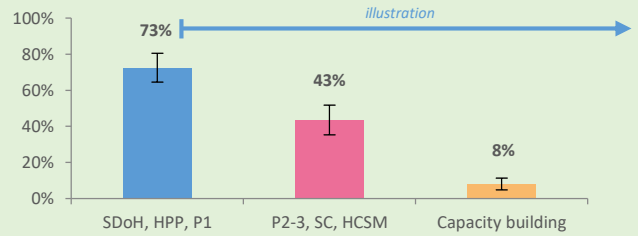
Number of inhabitants* on the territory covered by a LHC (n=53)



* 2016 census or, where applicable, as indicated in the LHC

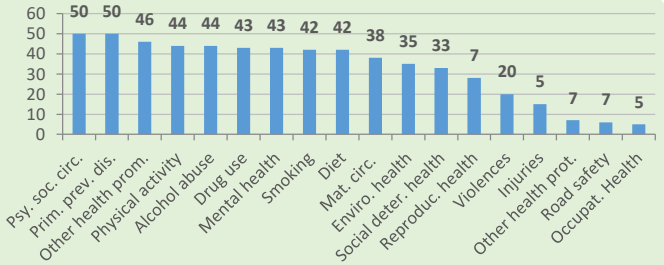
Most LHCs are implemented in a community < 50 000 inhabitants. Overall, 45% of LHCs have been signed by a town, 38% by a syndicate of municipalities, and 13% by a mixed association (mostly rural area).

Average proportion of action forms / LHC per main category of themes



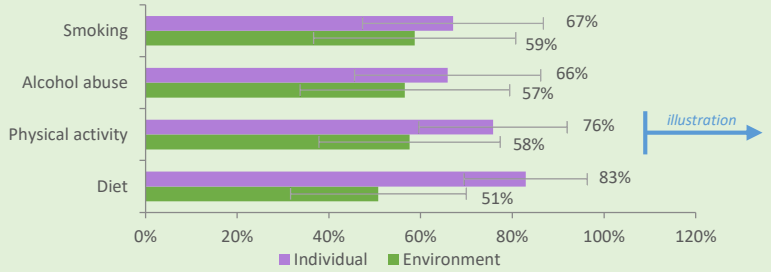
The proportion of action forms addressing the social determinants of health (SDoH), health promotion and protection (HPP) or primary prevention (P1) was around 75%. The proportion addressing secondary/tertiary prevention (P2-3), social care (SC) or health care services and management (HCSM) was around 45%. The proportion devoted to capacity building actions for the whole LHC is low.

Number of LHCs addressing SDoH-HPP-P1 themes in at least 1 action (n=51)



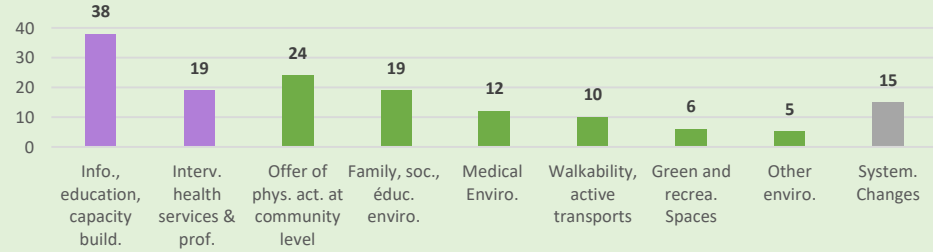
Among SDoH-HPP-P1, psychosocial life circumstances (e.g. access to rights) and primary prevention of diseases (e.g. advice by health professionals) were addressed in almost all LHCs. Alcohol, smoking, diet and physical activity are factors frequently targeted, which is also the case of mental health and, to a lesser extent, material life circumstances and environmental health (e.g. housing condition, air quality).

When smoking, alcohol, physical activity or diet is addressed, average proportion of action forms / LHC targeting individuals and/or their environment



Looking closely at actions targeting key factors such as smoking, alcohol, physical activity or diet, those tend to focus more often on the individuals (knowledge, attitudes, skills of the ultimate beneficiaries) rather than the interpersonal, organizational, community and political environments to which the individuals are exposed.

For example, regarding physical activity, number of LHCs including various types of individual / environmental actions (n=51)



- For example, for physical activity, most LHCs directly target individuals through awareness events, discovery or capacity building workshops (n=38) or the intervention of health professionals (e.g. adapted physical activities) (n=19).
- However, a few innovative measures requiring the collaboration of other sectors such as leisure and sports (n=24), land use planning and transportation (n=10) or parks and green spaces (n=6) make it possible to act on living environments.

Discussion

- Beyond the social and health domains, there are relatively few instances of cross-sectoral solutions brought by LHCs. Among possible barriers is that improvement of access to health care is often monopolizing efforts of local elected officials. However, political will and past experience in establishing "win-win" relationships with other sectors can be helpful, as well as the fact that RHAs generally make LHCs an instrument to coordinate health promotion efforts instead of ad hoc funding of isolated actions. Long-term advocacy efforts of civil servants within and beyond RHAs and municipal services can also be a vehicle to bring other sectors and stakeholders on-board.
- Reinforcing cross-sectoral collaboration in health promotion implies further capacity building through a combination of leadership, resource mobilization, training and coordination of sectors for which health is not a core priority.

* This research has benefited from the support of the IReSP's funding partners in the context of the 2016 General Call for Projects - Prevention (BRETON-AAP16-PREV-16)

With financial support from

Key conceptual References :

1. WHO Regional Office for Europe. (2015). Self-assessment tool for the evaluation of essential public health operations in the WHO European Region.
2. Breton E, Richard L, Lehoux P, Labrie L, Léonard C. Analyser le degré d'intégration de l'approche écologique dans les programmations de santé publique: le cas des programmations de réduction du tabagisme de deux Directions de la santé publique québécoise. Can J Program Eval - 2004;19(1):97-123.

www.cloterres.fr **Principal investigator** eric.breton@ehesp.fr **Contact** yann.lebodo@ehesp.fr