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## Health enhancing physical activity in all policies? Comparison of national public actors between France and Belgium

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# Health enhancing physical activity in all policies? Comparison of national public actors between France and Belgium

## Abstract

Despite evidence on the benefits of health enhancing physical activity (HEPA), only few countries have developed “health in all policies” and specifically integrated HEPA policies. Paucity of studies have questioned the role of public national actors in PA policies enactment and delivery, the barriers and levers for adopting cross-sectoral HEPA. The present work seeks at comparing France and Belgium in regard to their competencies of ministries promoting HEPA, the presence of leadership and coordination in HEPA policies implementation, their key public legal entities working on HEPA. Expert interviews and document analysis were realized to complete the HEPA policy audit tool in each country. Results have shown that HEPA cross-sectoral policies are at their early stage. A broad diversity of sectors was implicated in HEPA policies: sport, health, transport, environment, and education, but often with weak activity. No leadership or coordination exist to implement HEPA policies, although different public legal entities could work on this aim. Ministries relationships were principally coming from formal co-interventions mandated by national public plans in France, where in Belgium relationships were punctual. Lobbying within each sector and in key public legal entities to promote HEPA is needed, and the development of official national coordination is essential.

Keywords: physical activity, policy, actors, health in all policies

## INTRODUCTION

The health benefits of physical activity have now been widely demonstrated, as well as the important role PA could play in the prevention of non-communicable disease and mortality (1, 2). Despite these evidences, only 45% and 36% of the French and Belgian population do reach the WHO recommendations to preserve their health (3). Moreover, numerous works (4) have supported the large cost due to physical inactivity, with an estimate cost to the health care system internationally of nearly 54 billion worldwide in 2013 (5). Therefore, physical activity has not only beneficial effects on individual physical, mental and social health, but also an impact on communities and countries as a whole (6).

While sport promotion has a long history in some countries, like Belgium and France, the promotion of health enhancing physical activity (HEPA) is still under development (6). This growing interest, potentially due to the increase of non-communicable disease and obesity (7), has encouraged other actors than the health sector to join their forces on strategies to promote PA (8). This engagement is in line with the health promotion approach (9), encouraging PA to be supported as part of daily life, across all settings (work, home, school, transport, community) and the development of health in all policies (collaborative approach by incorporating health considerations into decision-making across sectors and policy areas (10, 11)). Policy may be defined as legislative or regulatory action taken by government at different levels through formal written codes or standards (12). In other words, PA policy is *“a formal statement that defines PA as a priority area, states specific population targets and provides specific plan or framework for action”* (13). Policy is rarely a single decision, but a set of decisions or even non-decision, created within a dynamic of negotiations between interested parties, recognized as more effective if interests of the involved stakeholders are defined and their potential influence analyzed (14, 15). The objective of health in all policies is to get out of the ‘silos’ organization of the society and of policies (16), by encouraging

cross sectorial collaboration, such as for example between health, education and sport ministries, to answer to the necessity of dealing with health (especially PA) in comprehensive and inclusive ways, including making healthier choice easier choices (8, 16).

Despite the attention given to PA, previous work has shown that European policies were mostly prepared and implemented by a single actor, with health or sport ministry been the most implicated (around 55% of PA policy), but in other cases soliciting ministries of transport, environment or education (6). Recent findings have underlined that almost all European countries had developed a national policy on one or more of the HEPA sectors and that only 59% of the European countries have a specific national coordinating mechanism on HEPA promotion (8). Conceptually, countries have a unique influence on PA promotion, as this resulted from a socio-historical and cultural process. Previous work (6) has been centered on written documents or general indicators and has not taken the opportunity to compare internationally actors implicated in regard to the structure of the country and state organization, as well as their distinct dynamic in policy making process (17), especially about the type of PA targeted (e.g., sport, HEPA, active mobility...). To our knowledge, no previous study has identified mechanisms or instances enhancing '*physical activity in all policies*' and inter-sectorial collaboration, due to the structure and policy system of the country (for example comparing a centralized state like France and a three levels state like Belgium).

France is a Republic, ruled by a president, elected by direct universal suffrage for a five-year term. The government, led by a prime minister nominated by the president, develops and guides policy implementation. The prime minister is accountable to parliament, which exercises legislative power and is made up of the National Assembly and the Senate. The state defines the competencies of each level of administration. France is a civil law country whose laws and regulations (acts, ministerial decrees, and administrative orders) are broken down into more than 60 codes by subject area (e.g. public health code, social security code, social

action and family code). For major reforms and annual decisions, laws are enacted by legislation after discussion in parliament. Following enactment, decrees are issued by the prime minister. When specified in acts, some decrees must be assessed by the Council of State. Lower level regulations such as administrative orders are signed by the relevant minister.

Belgium is a constitutional monarchy, ruled by its seventh king, who does not wield power in the political sphere in its own, but acts in consultation with government ministers. Under the sixth reform of the state, the pyramid of the unitarian state made way for a more complex three-level structure. All three level are equal from the legal viewpoint, but can edict law only in regard to their competences: the Federal State (federal government and federal parliament), the Communities (Flemish, French, German-speaking) and the Regions (Walloon, Capital, Flemish). The Federal state include the entire Belgium territory, Walloon region entails part of the French speaking community and the whole German Community. Brussels Region entails the other part of French speaking community and part of Flemish community. Flemish region covers Flemish speaking community. Broadly speaking, the powers of the Federal State cover everything connected with the public interest (e.g., judicial system, army and federal police, social security, including health insurance, public debt, prices and incomes policy, etc.). Regions have powers in fields that are connected with their territory (e.g., economy, employment, agriculture, water policy, housing, public works, curative and preventive medicine, transport, environment, town and country planning). Since the speaking communities are based on the concept of “language” as a vehicle for culture, they have powers for culture, education, the use of languages, and assistance to individuals (protection of youth, social welfare, aid to families, immigrant assistance services, etc.).

To analyze the PA policy dynamic in Belgium and France, a network and policy making process (17) analysis will help to inform the key actors and their collaborations, questioning

the potential “physical activity in all policies” (11). Three main objectives were followed: 1/ to identify the competencies of ministries which play a role in HEPA and PA promotion, 2/ to question the presence of a leadership and coordination in HEPA policies implementation, 3/ to identify key public legal entities (e.g., agencies, administrations...) working on HEPA promotion and their relationship with ministries.

## MATERIALS AND METHODS

### Data collection

To collect and structure the data, the WHO HEPA PAT version 2 was used (18). The territory covered represents the whole country for France and the south part for Belgium (Federal, Wallonia, German and French Community, excluding Brussels and Flemish region). **Reasons for not including the Flemish region was due to the fact that health and sport competencies have been attributed to the Region and Communities since the sixth reform of the Belgian state. Brussels Region was contacted, but no answers were obtained.** The data collection started in France and Belgium in November 2014 and ended in January and April 2016 respectively. To have a common understanding and to able the comparison of the two countries, we use the concept competencies of ministries to analyze the data. In other words, the health and solidarity ministry is in charge of two competencies: health and solidarity). Two complementary, concurrent and iterative data collections were conducted: a document analysis and a qualitative data collection. Internet based search was realized on the website of the different ministries and public legal entities. As the promotion of HEPA goes beyond the health sector alone, any relevant national policy document entailing as keyword “physical activity” or “walking”, “cycling” were sought. The most recent version of the document was included in the inventory. Simultaneously, face-to-face or phone semi-structured interview (18 in France, 14 in Belgium) with experts in PA (recognized through their publications or

membership in public legal entities) or representative of government were **conducted** (see **Table 1 for details**). The interviewees were selected taking their sectors as well as function into account. After the document and interview analysis, a final seminar was organized in each country to discuss and validate the findings.

**Table 1: organization participating to interview, type of interview and country**

Organisation	Interview type	Country
General Operational Direction of Roads and Infrastructures (INFRASPORT)	Face to face	Belgium: Walloon Region
General Operational Direction of Mobility and Hydraulic Gates (RAVEL)	Face to face	Belgium: Walloon Region
General Operational Direction of Mobility and Hydraulic Gates : Mobility strategy	Face to face	Belgium: Walloon Region
Agency of Quality of Life	Participated to final seminar	Belgium: Walloon Region
General Administration of Sport	Face to face	Belgium: French Community
Youth aid : project and prevention service	Face to face	Belgium: French Community
Youth service	Phone interview	Belgium: French Community
General Administration of compulsory Education	Face to face	Belgium: French Community
Catholic health union	Face to face	Belgium
Birth and Child Office	Face to face	Belgium: French Community
President of the commission of risk prevention for health in sport	Phone interview	Belgium: French Community
Head of the faculty of motricity sciences, physical education and physiotherapy of the UCLouvain	Face to face	Belgium
Brussel's federation of General Practitioners	Face to face	
Department of Sport, Medias and Tourism	Face to face with health and elderly	Belgium: German community
Department of Health and Elderly	Face to face with sport	Belgium: German community
National Institute of Health Prevention and education	Phone interview	France
French Society of Professional in Adapted Physical Activity	Phone interview	France



Health Ministry – General Direction of Health	Face to face	France
French National Olympic and Sport Committee– Medical Commission	Face to face	France
Ministry of National Education	Face to face	France
Regional direction of youth, sport, social cohesion of Ile-de-France	Phone interview	France
Sports Ministry – Department of National resources for "Sport-Health-Wellbeing"	Phone interview	France
University Expert	Participated to final seminar	France
French Society of Sport and Exercise Medicine	Phone	France
Chair of the Sport and Health Commission (author of PNAPS: national plan for prevention through physical activity and sport. Preparatory Report of the Prevention)	Participated to final seminar	France
French Society of Sport and Exercise Medicine	Phone	France
Paris 13 University / Avicenne Hospital / French Society of Public Health	Participated to final seminar	France
General Commission for Equality of the territories	Phone	France
Interministerial Coordination for the Development of the Bicycle Use (CIDUV)	Phone	France
Ministry of Justice – Direction of penitentiary administration	Phone	France

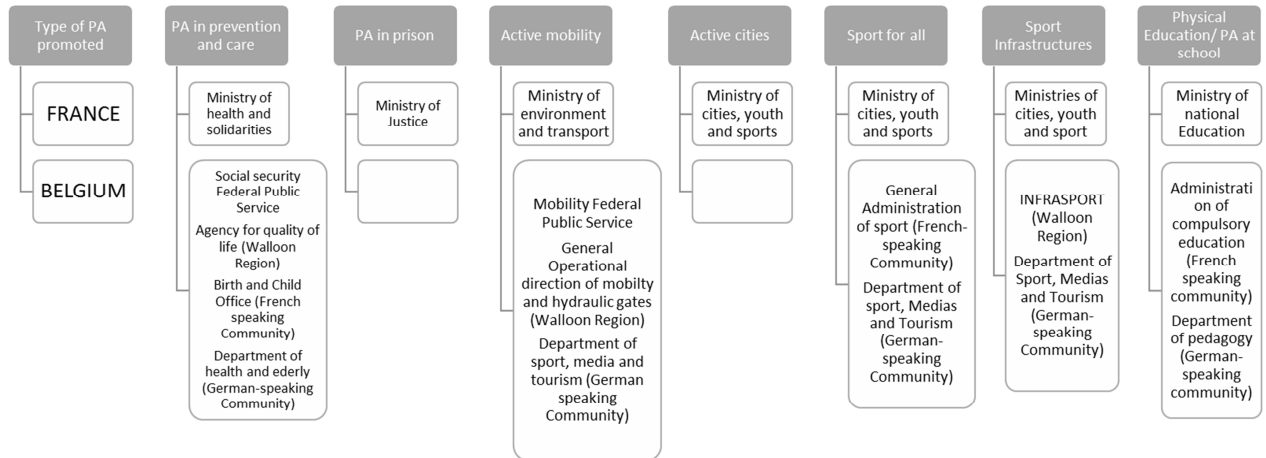
Based on the theoretical tenets of “health in all policies” (11), different characteristics of the actor network were analyzed: 1/ the multi-sectoriality (presence of PA policy not only in health sector), 2/ the presence of a leadership and coordination in PA promotion, 3/ the intersectorality (cross sectorial collaboration and public legal entities). Multi-sectoriality was assessed in regard to competencies’ of ministries, implicated in PA policies, and the type of PA they promoted (**physical education, active mobility, sport...**), using three levels to differentiate their policies: ministries’ competencies’ policy promoting HEPA (explicitly targeting PA to support health for population), ministries’ competencies’ policy promoting

PA (without mention of health), and ministries' competencies' policy promoting policies that could support PA without mentioning PA. Leadership and coordination was discussed within the different interviews and validation seminar, identifying public legal entities or mechanisms. The intersectorality was assessed using explicit references in policies documents and interview extracts about collaboration between ministries, with different types of relationship: 1/ formal and official through policies document, 2/ in construction, as actors as starting working together without official mention, 3/ punctual collaboration on common aims. Furthermore, intersectorality was questioned in regard to public legal entities supported by ministries which could have a role in HEPA policies implementation or delivery.

## RESULTS

### **Multi-sectoriality of HEPA**

The ministries' competencies promoting HEPA in both country come principally from the same sectors : health, sport, environment and transport, **as well as education**, but with different degree of implication and a focus on different type of PA (**see Figure 1**). Justice is active on PA policy in France, but not in Belgium. In France, two ministries participate to HEPA promotion without specific policy: the ministry of higher education and research can potentially support HEPA through teaching and research; the ministry of work, employment, professional training and social dialog promote health, and potentially PA within the work sector and environment. In Belgium, the Public Health, Food Chain and Environment FPS has not been cited as an actor in HEPA, as it has no responsibilities in health promotion.



*Figure 1. Type of PA promoted by ministries' competencies*

## **Leadership and coordination in HEPA**

In both countries, actors underline that there is no official instance or agency having a leadership on HEPA, but rather different actors that are implicated depending on the policy or the sector. *“Does a coordination platform exists in regard to HEPA. Formally, no, we sometimes have questions, prevention counselling, that are across different matters, sport-education, sport and health, but a general coordination, could such a thing exists? If it is to add a layer above the other, without a particular effect, this is just heavy.”* (General Administration of Sport, French speaking community).

In France, the National Sport-Well-being Plan in 2012, due to its dual piloting from health and sport ministries has placed these two ministries as non-official leaders recognized by non-governmental actors. *“There is no official leadership, but since the National Sport-Well-being Plan, an emerging leadership of Health and Sports ministry has been identified, which is stronger at regional level, than at national level”* (Collective Seminar, France).

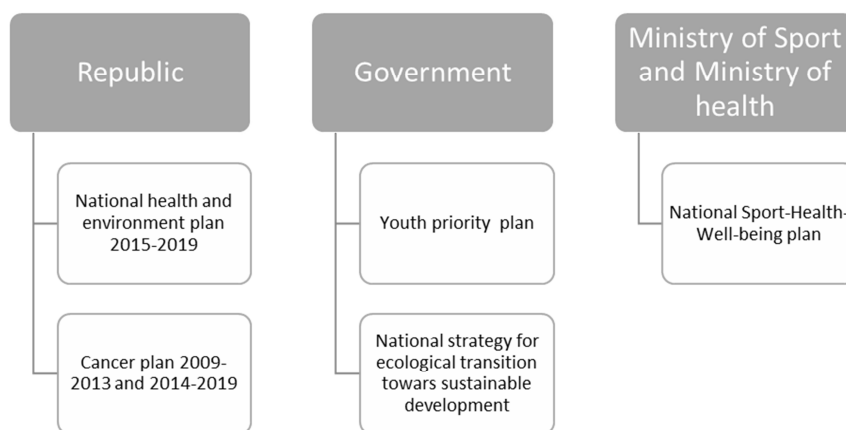
Specific permanent commission could be implicated in HEPA promotion: the general commission towards equity in territories (CGET), which implement the equity in territory

policy and the inter-ministries coordination for the development of cycling use (CIDUV), the national center for sport development (CNDS) funding among other sport for health and the national council of sport (CNS; counselling on sport policies). In French-speaking Belgium, policies are rather centered on sport specifically or on PA among the multiple determinants of health, letting us though that there are no leadership in Belgium, but rather places where HEPA could be discussed, and potentially indirectly targeted: The Commission of Risk Prevention in Sport, the Superior Sport Council, the Regional Cycling Commission, the Superior Health Council. Working on HEPA in an intersectoral manner in these commission is restrained by the fact that *“we (the commission of risk prevention in sport) can talk only about an activity that is ruled by the French-speaking community, like organized sport by sport federation, daily PA could not be regulated as easily, could you imagine a police officer asking a runner about its non-contraindication to PA practice?”* (President of the commission of risk prevention in sport).

In France, scientific societies implicated in HEPA promotion are the French Society of Public Health (SFSP), the French Society of Exercise and Sport Medecine (SFMES), the Academy of Medecine, the French Society of Nutrition (SFN), the association of researcher in physical and sport activities (ACAPS), the French-speaking association in adapted physical activity (AFAPA). Belgian scientific societies could also be solicited on HEPA, but are at the moment not alerted on this aim, *potentially explained by the size of the country: “In French-speaking community? No, there is not much, but there is no reason to have such, it’s too small, Belgium is too restrictive”* (President of the commission of risk prevention for health in sport)

### **Intersectorality: Ministries relationships**

To question the intersectorality between ministries, we analyzed the different policies documents and interview trying to understand how they collaborated. To facilitate the understanding, we decided to select the competencies of ministries in France, and due to the three levels of complexity in Belgium, we selected federal public service, administrations or department. **In France, the official relationship between the ministries ‘competencies are based on different policies coming from the French Republic or the whole government (see Figure 2). “Some inter-ministries policies exist and contribute to PA, but the system need to be go out of silos and health objectives have to become more coherent” (Collective seminar,**



France).

*Figure 2. Intersectoral policies in France*

In Belgium, despite a will of the French-speaking community to encourage cross-sectoral collaborations in its declaration of intentions 2014-2019, only the Walloon Cycling Plan support a collaboration between infrastructures and mobility administrations. Given this low number of collaborations in Belgium, we centered our work on informal relationship (see Figure 1 for details). At the regional and speaking community level, participants answered that they did not collaborated with the federal level. In the French speaking Community, some

relationships have existed between sport and education sector, but are frozen at the moment. In the sport sector, region and speaking community collaborates punctually, sharing their expertise on infrastructure and organization of sport respectively for specific promotion actions. The education and mobility administration also collaborate on cycling actions in schools, but this is not mentioned in policies. In the German community, a good communication and collaboration between the Health, Sport and Pedagogy departments exists in the administration.

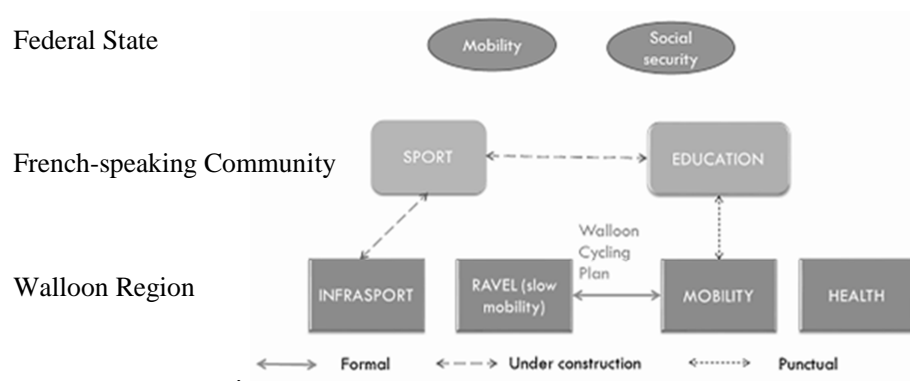


Figure 3 : relationship between administrations in Belgium

### Intersectorality: public legal entities

Looking at actors working on the implementation of policies, we considered public legal entities that relates closely to national ministries and how they provide support to HEPA policies. In France, an inter-ministerial committee for health has been recently created in 2014, working on enhancing health status of the French population and decreasing health inequalities, on encouraging health education and health promotion within public policies and ensuring the coordination of public policies towards health at local level. Two inter-ministerial coordination exist: the general commission towards equity in territories (CGET) and the inter-ministries coordination for the development of cycling use (CIDUV). The scientific expertise in the health sector are shared with the environment, work, agriculture and

alimentation ministries around one agency, the national agency of sanitary security of eating, environment and work (ANSES), evaluating the risks for health associated with eating, environment and work. Health also collaborates with the research sectors through different public legal entities: the national institute of health and medical research (INSERM) coordinating the scientific and operational biomedical research and the national institute of Cancer (INCa), coordinating actions against cancer. Two public legal entities work only for the health ministry: the National Authority for Health (HAS), regulating the health system and the National Public Health agency (Santé Publique France). The environment, sport and housing ministries have a technical and scientific support from the center of studies and expertise on risks, environment, mobility and layout (CEREMA), working on the implementation of policies for sustainable layout and development. The research and environment ministers rely on the environment and energy management agency to care about the transition towards a development model sober in energy and resources (ADEME) and on the French Institute of Science and Technology for Transport, Development and Networks (IFSTTAR) to realize, orient, animate or evaluate development and innovations in the transports, mobility and infrastructures domains. The sport ministry collaborates with finance minister to contribute to sports infrastructures and major events through the national center for sport development (CNDS). Sport ministry is also reinforced by four national resources centers (sport-health-well-being, sport and disability, sport, education, diversity and citizenship, nature sports) developing an expertise and tools in their field. Finally, the National Solidarity Fund for Autonomy is responsible for providing financial support and funding of support services to persons who have lost their independence, and is supported by the ministry in charge of elderly and disable, as well as the ministry in charge of finance.

In Belgium, at federal level, the Superior Council of Health formulates scientific advices for politics and health professionals, the Belgian health care knowledge center (KCE) act as an

interface between ministry of social security, ministry of public health and ministry of social affairs to provide scientific analysis and research, to advice policy makers on decisions relating to health care and health insurance. In the Walloon Region, the Walloon institute of evaluation, prospective and statistics (IWEPS) is a public scientific institute to help authorities' decisions. The regional cycling commission, include different ministries from the Walloon region and other stakeholders to implement the Walloon cycling plan. In the French speaking community, within the sport sector, the superior council of sport gives an expertise on sport aims to the sport ministry, the commission of risk prevention for health within sport works on the decrease of risks within and from sport practice.

## DISCUSSION

The present study has revealed that HEPA policies in France and in Belgium are at their early stage, as cross-sectoral collaboration between actors seems to be on ministries' agenda since 2012 in France, and only in declaration of intentions in Belgium. One of the criteria recommended for successful policy development is the involvement of different stakeholder (6) (ministries, private sector, public legal entities). In comparison to previous European study (6, 8), we found a larger diversity of ministries' competency implicated in HEPA promotion, but not more than half of the policies being cross-sectoral. **Nevertheless, ministries focused on the type of PA they have in responsibility (PE for education ministries' competencies), but rarely on different types of PA.** The novelty in France relies on plans coming emanating from the Republic or the Government as a whole, and not only collaborations between one or two ministries. This advance seems to enhance the appeal of ministries or public legal entities which have not HEPA as primary aims, but it is too early to draw conclusions in regard to the cross-sectoral dynamic at the moment. France seems to have more cross-sectoral policies, but some current plans, like the inter-ministerial ageing well plan have failed to keep the intersectorality created in their previous version. Reasons might be the enactment of a law on



adapting society to an ageing population in 2015. The presence of a centralized state seems to be a positive factor in regard to policies implicating the whole government, as the three level structure in Belgium, with different government at each level, complicate the presence of such policies.

Despite the diversity of ministries implicated in HEPA promotion, their collaborations are rarely formal, but rather punctual, without a structured agenda and common goals. No real mechanisms of consultation exist to create a policy, but rather some working group, that often disappear when the law is enacted or when the plan ended, or even started. In Belgium, the three levels structure complicate the collaboration at the different levels, where few links are made within each level, but even fewer between the different levels, despite complementarity in actions. Moreover, in the interviews, many actors outside the sport and health sectors stated that HEPA is not the central point of collaboration, but rather a small part of a large range of health determinants or other aims. Therefore, their priority relied first on the need of a common definition and lobbying within each sector, as only a small part of representative of ministries have been committed towards HEPA, in the same way than plans include only few minor points on HEPA promotion within larger objectives.

Previous work (19) has analyzed inter-sectoral health policy in regard to three criteria to question its feasibility: the availability of evidence, the degree of support and the availability of tools for implementation. Considering HEPA promotion in both countries, our results underline 1/ the lack of knowledge regarding evidences in HEPA promotion and the need of its importance in each sector, 2/ no problem of support or conflicts, but no real engagement towards HEPA, and no concrete prevalence objectives for the future. 3/ The absence of coordination, the lack of guidance or procedure in policy creation (with some working group created to propose objectives within short timeframe), 4/ the limited amount and the opacity

of funding allocated to HEPA in each sector are barriers to effective inter-sectoral collaboration.

Moreover, inter-sectoral leadership is lacking, despite the presence of different key public legal entities, which could play an active role. For example, the inter-ministerial committee for health in France was never solicited on HEPA aims. In both countries, lobbying towards HEPA in these instances could help to enhance the coordination mechanisms, such as having common goals for HEPA, making lobbying for HEPA, creating a professional network. The high number of public legal entities working on specific parts of HEPA promotion (e.g., active mobility, sustainable development, cancer prevention and treatment) increase the difficulty of creating an inter-sectoral coordination, for different reasons: 1/ impossibility of having a common agenda, 2/ the lack of definition of common goals, 3/ the diversity of professional profile and unease with inter-sectoral approaches (20) .

## CONCLUSIONS

HEPA inter-sectoral policies are at their early stage in France and Belgium, with only a five-year history in France and political will in Belgium. A broad diversity of sectors was implicated in HEPA policies: sport, health, transport, environment, and education, but often with light implication on HEPA. Despite this large range of ministries, no leadership or coordination exist to implement the HEPA policies, although different commission could work on this aim in their duty. No standardized procedure or mechanisms of consultation exists to enact HEPA policies. Ministries relationships are principally coming from plans implicating the whole government or republic in France, where in Belgium relationship are rather punctual. Public legal entities have an important role of inter-sectoral development in France, but their plurality could slow down the collective process. Implications rely on the need to define coordination for HEPA in each country, to support lobbying for HEPA in each

sector specifically and raise awareness about HEPA in the different commission that could support its development, as well as officially integrate the implication of the key public legal entities in HEPA delivery in policy document.

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